



Research Report

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Estimating the Effects of Further Expanding Health Insurance Coverage to Noncitizen Populations in Connecticut

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About This Report

As of July 2024, policymakers in Connecticut have used state funding to expand Medicaid and Children’s Health Insurance Program (CHIP) coverage to children (through age 15) and pregnant people who do not qualify for federally funded Medicaid or CHIP coverage due to their immigration status. Policymakers are considering further expansions that may extend HUSKY (Connecticut’s Medicaid program) coverage to the remaining population of children, and to adults. They are also considering expanding eligibility for HUSKY C, Connecticut’s Medicaid program for the aged, blind, and disabled, to immigrant populations. In this report, we use microsimulation modeling to estimate the impact of expansions of HUSKY eligibility to additional age groups (namely: 16–18, 19–25, 26–64, and 65+), as well as expanding HUSKY C eligibility.

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Summary

Noncitizen immigrants represent roughly 8 percent of the U.S. population, but represent more than 30 percent of the uninsured population (Buettgens and Ramchandani, 2023). Undocumented immigrants are generally ineligible for all forms of federally funded health insurance, including Medicaid, Marketplace, and Medicare coverage. Legally present immigrants who have held “qualified immigrant” (Health Insurance Market Place, undated) status for fewer than five years are generally ineligible for Medicaid¹ and Medicare coverage, though they are permitted to enroll in Marketplace coverage and receive subsidies.

A number of states have used state funding to extend health insurance coverage to immigrants who are ineligible for federally-funded coverage (referred to as “ineligible immigrants” throughout this report). Connecticut is one such state, which has extended HUSKY (Connecticut’s Medicaid program) coverage to a subset of immigrants in the state to date. There are four HUSKY programs that serve different populations:

1. HUSKY A: Medicaid for children aged 0–18, parents/caregivers, or pregnant people
2. HUSKY B: Children’s Health Insurance Program (CHIP) for children aged 0–18
3. HUSKY C: Medicaid for aged, blind, and disabled adults aged 19+
4. HUSKY D: Medicaid for adults aged 19–64 without minor children (the “expansion population”)

Connecticut policymakers first extended HUSKY coverage to ineligible immigrants in 2021, allowing income-eligible children 8 years of age and under to enroll in HUSKY A or HUSKY B, regardless of immigration status. The age threshold was extended to 12 in January 2023, and then, in July 2024, to 15 (Hirshman, 2014). Ineligible immigrants who are pregnant are also permitted to enroll in coverage via HUSKY B and can maintain that coverage for 12 months postpartum.

Policymakers are now considering further extending eligibility for HUSKY A and B to the remaining ineligible immigrant population of children through the age of 18. They are also considering expanding HUSKY A, B, and D to the adult population, with or without the additional expansion of HUSKY C. They are also considering options for covering the 65+ population; under existing eligibility requirements, only adults aged 19–64 qualify for HUSKY D, since individuals aged 65+ are assumed to be eligible for Medicare. However, covering seniors on HUSKY C could be much more expensive than covering them on HUSKY D, because HUSKY C has more generous coverage of long-term care. Therefore, we also considered a scenario in which HUSKY D eligibility is extended to seniors. In the scenarios we modeled,

¹ Some states waive the 5-year waiting period for legally present pregnant people and/or children.

these programs would otherwise retain all existing age- and income-based eligibility requirements, but would no longer have any requirements related to immigration status.

We summarize the details of these policy scenarios in Table S.1. We used microsimulation modeling to understand the effects of such expansions on insurance enrollment and state spending in Connecticut.

Table S.1. Policy Scenarios

Scenario	Eligibility for Immigrants			
	HUSKY A	HUSKY B	HUSKY C	HUSKY D
Current law	Children aged 0–15	Children aged 0–15; pregnant and postpartum individuals	None	None
	<i>Eligible populations in addition to those covered under current law</i>			
Scenario 1 (child and young adult)	Children aged 16–18; parents/caregivers aged 19–25	Children aged 16–18	None	Adults aged 19–25 without minor children
Scenario 2 (child and young adult + HUSKY C)	Children aged 16–18; parents/caregivers aged 19–25	Children aged 16–18	Adults aged 19–25	Adults aged 19–25 without minor children
Scenario 3 (all ages)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16–18	None	Adults aged 19–64 without minor children
Scenario 4 (all ages + HUSKY C)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16–18	Adults aged 19+	Adults aged 19–64 without minor children
Scenario 5 (all ages + HUSKY D for seniors)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16–18	None	Adults aged 19+ without minor children

Methods

COMPARE is a nationally representative microsimulation model in which individuals and households make choices about health insurance. We made several updates to the COMPARE microsimulation model to make it representative of Connecticut and to allow for analyses of the scenarios under consideration, including:

- Reweighting the data underlying the model to represent the population size and key demographics (e.g., age, sex, income, insurance status, race, and ethnicity) of Connecticut
- Imputing undocumented immigrant status using an algorithm informed by the literature that identifies potential undocumented immigrants by ruling out citizens, and individuals who report receiving benefits unavailable to undocumented immigrants (e.g., Medicaid, SSI) or who report having occupations that are not available to undocumented immigrants (e.g., police officer) (Passell and Cohn, 2018; Van Hook et al., 2021). The algorithm utilizes data from the Migration Policy

Institute (MPI) about the total number of undocumented adults and children in Connecticut.

- Imputing pregnancy status, using data specific to Connecticut, based on age, race, and ethnicity for women aged 15 to 45 years
- Imputing disability status in the undocumented immigrant population based on age, income, gender, race, ethnicity, and health status.

There are also uncertainties related to health insurance take-up and medical spending among undocumented immigrants. As a default, we assume both take-up and medical spending are similar to those of the general Connecticut population by demographic characteristics,² but we conduct sensitivity analyses using higher and lower take-up.

Results

Expanding eligibility for HUSKY by removing immigration status as an eligibility requirement would result in increased rates of insurance and increased costs to the state, though findings varied based on the age groups and HUSKY programs included in the expansion (see Table S.1). In particular:

- Total insurance enrollment would increase by 6,400 individuals when extending HUSKY A, B, and D to those aged 16–25 years old. The addition of HUSKY C for this age group would make little impact.
- Enrollment would increase by 22,600–24,400 when HUSKY eligibility is expanded to all individuals who would otherwise qualify, depending on whether HUSKY C is also expanded or whether seniors are made eligible for HUSKY D.
- The total number of individuals covered by HUSKY would increase by more than the change in total insurance coverage across all scenarios because a small number of immigrants previously covered by other insurance types (e.g., employer-sponsored coverage or off-marketplace individual market coverage) would switch to HUSKY.
- Costs to the state would be \$39–\$40 million when extending coverage to those aged 16–25 only.
- Costs would increase substantially when extending coverage to all ages (subject to the existing age requirements within each HUSKY program). Expanding HUSKY A, B, and D to all currently eligible ages (under Scenario 3) would result in the smallest increase in costs relative to current law, at \$186 million. The addition of HUSKY C for this group would lead to spending \$252 million relative to current law, due to the cost of long-term care under HUSKY C. Additionally expanding access to HUSKY D for seniors, rather than expanding HUSKY C, would cost the state \$203 million relative to current law.

² Note that this assumption differs from prior work conducted by RAND in this setting (see Rao, Girosi, and Eibner [2022]). In the prior work, our default assumption was that medical spending and insurance take-up rates would be lower among the undocumented immigrant population than among the general population. Since that work was published, anecdotal evidence from both Connecticut and other states has suggested that enrollment and costs of health insurance programs immigrants have exceeded predictions, leading to our updated assumptions in this work.

Table S.2. Summary of Changes in Enrollment and State Spending Relative to Current Law, 2025

	Scenario 1 (child and young adult)	Scenario 2 (child and young adult + HUSKY C)	Scenario 3 (all ages)	Scenario 4 (all ages + HUSKY C)	Scenario 5 (all ages plus HUSKY D for seniors)
Change in insurance enrollment (N)	6,400	6,400	21,700	23,100	22,400
Change in insurance enrollment (%)	12.3	12.3	41.9	44.5	43.2
Change in HUSKY enrollment (N)	6,900	6,900	22,800	24,400	23,600
Change in HUSKY enrollment (%)	34.8	35.0	115.7	123.7	119.5
Change in total costs to the state (in millions)	\$38.6	\$39.9	\$186.2	\$252.4	\$203.2
Change in total costs to the state (%)	37.5	38.7	180.6	244.8	197.1

Discussion

- Expanding Medicaid and CHIP coverage to children and young adults aged 16–25 would substantially reduce uninsurance among this population and comes at a relatively low cost to the state; the addition of HUSKY C would make little difference to this population because of the low rate of disability.
- Further expanding Medicaid coverage to the remaining adult population via HUSKY A, B, and D (Scenario 3) would increase insurance coverage by a greater proportion among adults through age 64, but to a much lesser extent to adults aged 65+, since adults aged 65 and older do not qualify for HUSKY D and would only gain coverage in this scenarios if they were a parent/caregiver to a minor child.
- Including HUSKY C in the expansion would result in an almost 40 percentage point reduction in uninsurance among seniors but would substantially increase costs to the state due to the coverage of long-term care under HUSKY C.
- Allowing seniors to enroll in HUSKY D would result in almost as large of an increase in insurance coverage among adults aged 65+ as the HUSKY C expansion but at a lower cost to the state. However, this would involve a difference in eligibility requirements relative to the federally funded HUSKY D program.

Contents

About This Report	iii
Summary.....	v
Tables	x
Chapter 1. Introduction.....	1
Chapter 2. Methodology	4
Imputation of Immigration, Pregnancy, and Disability Status.....	4
Reweighting of COMPARE Model	6
Insurance Take-Up and Medical Spending	7
HUSKY C Sub-Programs and Long-Term Care.....	9
Sensitivity Analyses	10
Reported Outcomes	10
Chapter 3. Results.....	11
Enrollment.....	11
Costs to Connecticut.....	13
Sensitivity Analyses	15
Chapter 4. Discussion	18
Limitations	19
Conclusions	20
Appendix A. COMPARE Overview	22
Overview	22
Health Insurance Enrollment Decisions.....	23
Health Care Spending.....	24
HUSKY C Eligibility	24
Appendix B. Baseline Profile of the Undocumented Population	27
Abbreviations	29
References	30

Tables

Table S.1. Policy Scenarios	vi
Table S.2. Summary of Changes in Enrollment and State Spending Relative to Current Law, 2025	viii
Table 1.1. HUSKY Eligibility Criteria.....	2
Table 1.2. Policy Scenarios	2
Table 3.1. Insurance Enrollment Among Ineligible Immigrants, 2025.....	12
Table 3.2. HUSKY Age Distribution Among Ineligible Immigrants, 2025	12
Table 3.3. Uninsurance Rates (Percent) Among Ineligible Immigrants by Age Category, 2025	13
Table 3.4. Costs to the State to Insure Ineligible Immigrants (in Millions of \$), 2025.....	14
Table 3.5. Costs to the State Per Capita and Per Newly Insured, 2025.....	14
Table 3.6. Insurance Enrollment Among Ineligible Immigrants Relative to Current Law Under Alternate Take-Up and Spending Assumptions, 2025	16
Table 3.7. Costs to the State Under Alternate Take-Up and Spending Assumptions (in Millions), 2025	16
Table A.1. Data Sources	23
Table B.1. Profile of the Undocumented Population	27

Chapter 1. Introduction

The proportion of individuals lacking health insurance in the United States has declined substantially since the Affordable Care Act was implemented; in 2022, only 8 percent of the population was uninsured (Kaiser Family Foundation, 2022).³ However, undocumented immigrants continue to be ineligible for all forms of federally funded health insurance, including Medicaid, Medicare, and the Marketplace. Therefore, uninsurance rates among undocumented immigrants remain high, with approximately half still uninsured as of 2023 (Kaiser Family Foundation, 2023-a). Additionally, legally present immigrants who have held “qualified immigrant” status for fewer than five years are ineligible for Medicaid and Medicare coverage, although they may qualify for Marketplace subsidies. Throughout this report, we use the term *legally present recent immigrants* to refer to this population. Nearly 20 percent of the legally present immigrant population remains uninsured.

To increase health insurance coverage among the noncitizen immigrant population, a number of states have enacted policies that expand access to Medicaid and/or Marketplace-like coverage for immigrants who would otherwise qualify if not for their immigration status. As of September 2024, 12 states plus the District of Columbia use state funding to provide Medicaid coverage to some or all immigrants who would qualify but for their immigration status (Kaiser Foundation, 2023; Rao et al., 2024). Because of uncertainties related to expected enrollment and costs in such programs, many states have rolled out such coverage incrementally, typically starting with children and/or pregnant people, before expanding to some or all of the adult population.

The state of Connecticut first expanded HUSKY (Connecticut’s state Medicaid program) coverage to immigrant children in 2021, allowing immigrant children 8 and younger who qualified based on household income to enroll regardless of immigration status. The following year, the state passed legislation extending coverage to children through age 12, and beginning in July 2024, coverage was further expanded to children through age 15 (Pohly, 2024).

Table 1.1 describes the four HUSKY programs and their eligible populations as of October 2024 (CT Department of Social Services, 2023; HUSKY Health Connecticut, undated). While all four HUSKY programs generally cover the same services, HUSKY C is the only program to cover use of institutional long-term services and supports (LTSS) and home and community-based services for periods of over 30 days.

³ This uninsurance rate reflects elevated Medicaid enrollment that was due to continuous enrollment requirements that were put in place for the duration of the COVID-19 public health emergency. However, even prior to the pandemic, uninsurance rates among the general population were low, at about 9.2 percent in 2019 (Kaiser Family Foundation, 2019).

Table 1.1. HUSKY Eligibility Criteria

Program	Eligible population	Household income requirements
HUSKY A	Parents/caregivers aged 19+	<138% of FPL
	Children aged 0–18	<201% of FPL
	Immigrant children aged 0–15	<201% of FPL
	Pregnant people and 12 months postpartum	<263% of FPL
HUSKY B (CHIP)	Children 0–18	201 – <323% of FPL
	Immigrant children aged 0–15	201 – <323% of FPL
	Pregnant and 12 months postpartum immigrants	<263% of FPL
HUSKY C	Adults aged 65+, or adults aged 19+ who are blind and/or disabled	Annual income < \$8,676/\$11,760* for single people/married couples + asset limit of \$1,600/\$2,400
	Employees with disability (MedConnect)	Annual income <\$75,000* + asset limit of \$10,000/\$15,000
	Institutionalized adults aged 19+	Annual income <\$2,829* + asset limit of \$1,600
	Adults aged 19+ requiring long-term care	Annual income <300% of Supplemental Security Income (SSI) + asset limit of \$1,600/\$2,400
HUSKY D (expansion population)	Adults aged 19–64 without minor children	<138% of FPL

NOTE: State-funded coverage for immigrants as of October 2024 is highlighted in blue.

*Income limits may be met after a spend-down period.

Policymakers in Connecticut are considering further expansions to HUSKY coverage for immigrants, including expanding HUSKY eligibility to the remaining population of immigrant children as well as to the adult population. They are also considering expanding eligibility for HUSKY C, which is the HUSKY program for aged, blind, and disabled Connecticut residents. HUSKY C is the primary eligibility pathway for adults aged 65 and older in Connecticut, and the income eligibility criteria (outside of those who are employed and disabled) are fairly narrow, as most individuals aged 65+ would have primary coverage via Medicare. However, undocumented immigrants and legally present recent immigrants do not qualify for Medicare. Therefore, we also estimated a scenario in which immigrant seniors would be eligible for HUSKY D (which is not generally available to individuals over age 65).

Any such expansions would be state-funded. We used RAND’s COMPARE microsimulation model (Cordova et al., 2013), customized to be representative of the state of Connecticut, to estimate the potential impact of the specific policy scenarios summarized in Table 1.2. All eligibility criteria related to age, income, and/or asset limits that apply for a given program (as noted in Table 1.1) also apply for the state-funded coverage for immigrants, other than in Scenario 5, which removes the upper age threshold for HUSKY D eligibility.

Table 1.2. Policy Scenarios

Scenario	Eligibility for Immigrants			
	HUSKY A	HUSKY B	HUSKY C	HUSKY D
Current law	Children aged 0–15	Children aged 0–15; pregnant and	None	None

		postpartum individuals		
	<i>Eligible populations in addition to those covered under current law</i>			
Scenario 1 (child and young adult)	Children aged 16–18; parents/caregivers aged 19–25	Children aged 16– 18	None	Adults aged 19–25 without minor children
Scenario 2 (child and young adult + HUSKY C)	Children aged 16–18; parents/caregivers aged 19–25	Children aged 16– 18	Adults aged 19–25	Adults aged 19–25 without minor children
Scenario 3 (all ages)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16– 18	None	Adults aged 19–64 without minor children
Scenario 4 (all ages + HUSKY C)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16– 18	Adults aged 19+	Adults aged 19–64 without minor children
Scenario 5 (all ages + HUSKY D for seniors)	Children aged 16–18; parents/caregivers aged 19+	Children aged 16– 18	None	Adults aged 19+ without minor children

Chapter 2. Methodology

We used the RAND COMPARE microsimulation model to estimate outcomes associated with expanding eligibility to Connecticut's state-funded HUSKY programs for immigrants, including immigrant enrollment in HUSKY, the number of newly insured, and costs to the state (including total and per capita).

COMPARE relies on nationally representative data and economic theory to analyze the effects of health policy changes. The data underlying the model include individuals and households, who choose insurance coverage (or choose to go uninsured) based on the costs and benefits of the plans available to them. The version of the model we used relies on several data sources, including the 2024 Current Population Survey (CPS) and 2018–2019 Medical Expenditures Panel Survey (MEPS).

We regularly update the model to reflect population growth, health care cost growth, and policy changes. A more detailed description of the COMPARE model is included in Appendix A. For previous work on insuring undocumented immigrants living in Connecticut, we developed a Connecticut-specific version of COMPARE, which included the addition of two key variables: immigration status and pregnancy status (Rao, Girosi, and Eibner, 2022). As these variables were not readily available in the data underlying COMPARE, we relied on imputation. We used the same methodology to impute immigration and pregnancy status for these analyses, which we summarize below. For the current analyses, we also needed to impute disability status in order to determine eligibility for HUSKY C. All three of these variables impact Medicaid eligibility in the context of our analyses. We then reweighted the model to be representative of Connecticut in 2022, using data from the American Community Survey 2022 regarding health insurance, income, age, gender, race, ethnicity and immigration status. We used a historical time series of total population size from the Connecticut Department of Public Health to extrapolate the total population size in year 2025. We assumed that the overall population composition is unchanged between year 2022 and 2025. However, this assumption has no impact on our estimates, since we focus on the undocumented population only, and this population is reweighted separately using data from the Migration Policy Institute. We list the data sources that we use for this analysis in Appendix Table A.1.

Imputation of Immigration, Pregnancy, and Disability Status

Immigration Status

The CPS data that underlie the COMPARE model includes information on whether a respondent is a U.S. citizen. However, for our analyses, we need detailed immigration status,

including whether someone is a qualified immigrant within the five-year waiting period. To assign undocumented immigrant status, we adapted algorithms suggested by prior literature to impute detailed immigration status using publicly available data (Passell and Cohn, 2018; Van Hook et al., 2021). To implement our method, we began with the entire population of individuals in the CPS data and applied a number of exclusion criteria to exclude individuals who are unlikely to be undocumented immigrants. In particular, we exclude those who reported being a U.S. citizen, receiving any form of federally funded health insurance,⁴ being employed by the government or having other employment that typically requires U.S. citizenship, or receiving any other federally-funded benefits (such as Supplemental Security Income (SSI) or Supplemental Nutrition Assistance Program (SNAP)). We then applied additional restrictions on the resulting pool of individuals to disallow assignment of undocumented immigrant status to younger siblings but not older siblings, and to children but not at least one of their parents. We sampled from the remaining pool of individuals to match population targets produced by the Migration Policy Institute (MPI, undated-a) for the United States as a whole. We then reweighted the entire data set to represent the size and demographics of the population of Connecticut, including the size and marginal distributions of key demographic variables within the undocumented immigrant population, using 2019 Connecticut-specific estimates from MPI (undated-b). We reweighted based on age, gender, income, years of U.S. residence, and health insurance status (Medicaid versus other insured versus uninsured). The reweighting approach is described in greater detail below. We made one additional adjustment to the size of the undocumented immigrant population in Connecticut. Enrollment data for Connecticut's existing state-funded HUSKY program for immigrant children aged 0–15 indicated that more than 14,000 children were enrolled as of July 2024 (Connecticut Data, undated). However, MPI estimated the total number of children in this age group to be only 7,000. Therefore, we adjusted the size of the population of children aged 0–15 to allow enrollment to align with the state's estimates. The MPI data have a number of limitations, but there are very few available sources of data on the size of the undocumented immigrant population. We also note that state representatives expressed there may be some issues with the Connecticut enrollment data. Namely, they are aware of an issue that is currently classifying some children who should qualify for the federally-funded HUSKY A or B programs as lacking documentation of immigration status, and therefore enrolling them under the state-funded HUSKY A or B programs for immigrants. The state is working to correct this issue, but estimated that actual enrollment is likely somewhere between the estimates suggested by the MPI data and the existing state enrollment data.

Identifying qualified immigrants within the five-year waiting period for Medicaid eligibility would be difficult using publicly available data, so we identified non-citizens who reported their year of U.S. entry as being within the prior five years as a proxy. There was some disagreement between these variables and individuals reporting receipt of Medicaid; therefore, in cases where

⁴ We did not apply this exclusion criteria for children aged 15 or younger who were reported as receiving Medicaid.

an individual reported non-U.S. citizenship, residency of fewer than five years, *and* receipt of Medicaid, we assumed that Medicaid status was correct and modified the years of residence to be greater than five.

Pregnancy Status

The CPS data do not report on pregnancy status, so we imputed the probability of pregnancy based on several individual characteristics and then sampled based on that probability to assign a pregnancy status to each female aged 15–45. The imputation was performed by combining Connecticut-specific fertility rates from 2023, obtained through CDC Wonder, with 2022 Connecticut data on all births (CT Department of Public Health, undated). We note that this likely represents an undercount of individuals who would be covered by HUSKY on the basis of pregnancy, as not all pregnancies end in live births.

Disability Status

In the legally present population, disability for the sake of HUSKY C eligibility is based on the following conditions:

- the individual receives SSI because they are blind or disabled
- the individual has a disability that limits their ability to work
- the individual receives any kind of disability income.

Since the definition of disability is partially tied to receipt of disability income, which is not available to the undocumented immigrant population, it is likely to miss a portion of the disabled undocumented immigrant population who would theoretically be eligible for HUSKY C. Instead, we assume that prevalence of disability is independent of immigration status and use the legally present population to impute disability in the undocumented population. Disability for the legally present population is defined using both self-reported disability and receipt of income linked to disability in the CPS data. Given our concern about potentially overlooking some disabled individuals, we avoid modifying the disability status of undocumented individuals who are already reported as being disabled.

Reweighting of COMPARE Model

COMPARE is a nationally representative model, so we used reweighting in order to make it representative of the state of Connecticut. We have used this methodology in prior work to conduct state-specific analyses (Rao, Girosi, and Eibner, 2022, 2024). To conduct the reweighting, we utilized Connecticut-specific demographic and insurance enrollment data plus the Connecticut-specific immigration status that we imputed as described above. We used the iterative proportional fitting (IPF) (Lomax and Norman, 2016) algorithm to assign new weights to each individual in the COMPARE model, so that the demographics and insurance status,

including those of the undocumented immigrant population, would be representative of Connecticut.

Due to the relatively small number of marginal values adjusted by the IPF algorithm compared to the approximately 144,000 CPS records, the algorithm converged smoothly. We validated the accuracy of the reweighting process by comparing the intended distribution of individual characteristics with the distribution observed in the reweighted COMPARE data. The IPF algorithm effectively matches the desired marginal distribution with relative errors on each of the components of the marginals being less than one part in ten thousand. This is well below the inherent uncertainty level of the simulation, which is larger than one part in hundred, since the uncertainty on the take up rates and on the number of undocumented immigrants alone are already larger than that. Since we cannot observe the underlying joint distribution of key variables for undocumented immigrants, we were unable to validate the distribution produced by the IPF algorithm. We used 2022 data representing Connecticut as the baseline for reweighting the model and reported simulation results for 2025.

Insurance Take-Up and Medical Spending

Take-up Rate

There may be reasons that health insurance take-up of a public health insurance option may look different for undocumented immigrants than it looks for the general population. Undocumented immigrants may face similar challenges as legally present immigrants to enroll in health insurance, such as language barriers or lack of understanding of the health insurance system and available options. However, undocumented immigrants may additionally avoid enrolling in publicly funded health insurance options due to fear of immigration enforcement action.

On the other hand, anecdotal evidence suggests that enrollment in existing state-funded health insurance programs that offer coverage to undocumented immigrants is higher than predicted. For example, the state of Illinois implemented a Medicaid-like coverage option for immigrants and found that enrollment was not only higher than predictions suggested but higher than predicted eligibility as well (Illinois Department of Healthcare and Family Services, undated-a, undated-b).

Because of these opposing factors that may impact take-up rates in the undocumented immigrant population, we assumed that on average, health insurance take-up rates in the undocumented immigrant population would mirror those observed in the general population in Connecticut. As of 2016, it was estimated that Medicaid take-up rates in Connecticut were around 96 percent for children and 92 percent for parent/caretaker adults aged 19-64 (Haley et al., 2018). We assumed that take-up rates for pregnant people would mirror those of children and that take-up rates of all other adults would mirror those of the parent/caretaker population. For

long-term care coverage under HUSKY C, there is additional “eligibility” criteria, in that those individuals must be in need of long-term care. However, we lack the necessary claims data to make this determination. Therefore, we assume that the ratio of the number of HUSKY C recipients who qualify based on age or disability to the number of HUSKY C recipients who qualify for long-term care coverage is the same within the ineligible immigrant population as in the general population.

Medical Spending

Similar to health insurance take-up rates, there are several reasons that medical spending may differ among undocumented immigrants relative to the general population:

- The “healthy immigrant effect,” (Kennedy, McDonald, and Biddle, 2006), which suggests that immigrants are healthier, on average, than the native-born citizens, predicts lower medical spending. This effect, however, may not apply to immigrant children, who tend to have higher rates of chronic disease and all-cause mortality than non-immigrant children (Ayalew et al., 2021; Baker, et al., 2015; Schmeer, 2019; Shor, Roelfs, and Vang, 2017) .
- Pent-up demand from individuals who have been uninsured for a long period of time could lead to higher medical spending, at least in earlier years of any new program.
- Adverse selection would suggest that if immigrants fear immigration enforcement action associated with enrolling in publicly funded health insurance, then those who risk enrolling would be sicker, with higher medical spending.

Since it is unclear whether we would expect undocumented immigrants to have higher or lower medical spending, on average, than the general population, we assume that medical spending for undocumented immigrants is similar to that of the general population for a given demographic profile. In order to assign to individuals enrolled in different HUSKY programs a yearly cost, we used data from the CT Department of Social Services (2019). The data contain per-member-per-month costs for HUSKY A, B, C, and D from March 2020 to September 2022. Under the assumption of constant growth rate, we extrapolated these data to year 2025. Since the data do not provide the age distribution in the HUSKY programs, we “borrow” the age distribution from the Medical Expenditures Panel Survey (MEPS) (years 2018 and 2019), after having it reweighted using MPI data so that it resembles the CT undocumented population, and having selected the self-identified Medicaid sub-population. Using each procedure, we assigned a per-capita yearly cost to each new enrollee in the HUSKY program based on their age in a way that is consistent with the current CT data. The exception to this procedure is for HUSKY long-term care, for which cost calculations are described in the next section.

We note that our assumptions related to Medicaid take-up rates and medical spending among undocumented immigrants differ from prior work conducted by RAND in this setting (see Rao, Girosi, and Eibner [2022]). In the prior work, our default assumption was that medical spending and insurance take-up rates would be lower among the undocumented immigrant population than

among the general population, which was driven by the limited available literature at the time. Since that work was published, anecdotal evidence from both Connecticut and other states has suggested that enrollment and costs of health insurance programs immigrants have exceeded predictions, leading to our updated approach in this work.

HUSKY C Sub-Programs and Long-Term Care

HUSKY C provides services to the population of aged, blind or disabled. However, within HUSKY C there are special programs, with different eligibility requirements, which are dedicated to specific sub-populations. One is Med-Connect (Type of Assistance code S05), which provides services to a small population of working disabled and has a much higher income eligibility threshold. The other programs provide services to individuals in need of long-term care (LTC), either in a home- and community-based care setting (Type of Assistance code W01) or in residential facility setting (Type of Assistance codes L01, L99). The population serviced by the LTC programs is approximately half of the entire population of the HUSKY C program (Connecticut Data, 2024).

The data at our disposal allow us to identify individuals who satisfy the income eligibility requirement, which has a threshold equal to the 300 percent of the maximum Supplemental Security Income (SSI) federal benefit rate. However, there are other eligibility requirements that require the knowledge of variables, such as the need of certain levels of care, that are simply unobserved. Hence some assumptions had to be made in order to estimate how many individuals will participate in such programs. Once the total number of individuals on HUSKY C has been determined, we compute the cost to the state by applying the average HUSKY C cost, which is known from the (Connecticut Department of Social Services, 2019, 2022).

The key assumptions that allow us to estimate the number of individuals on HUSKY C and the broad income groups are the following:

- 1) The number of enrollees in these programs is a proportion of the number of enrollees of the “standard” HUSKY C programs for aged, blind or disabled, and the proportions for each program can be computed from current HUSKY C data.
- 2) Take-up rates, as well as the prevalence of the unobserved variables that determine eligibility, are independent of the income group.

There are two main reasons behind these assumptions. One is that we simply do not have enough information to distinguish between different behaviors in sub-population of different income. The other is that these populations are characterized by urgent and demanding health care needs, and hence it is unlikely that income is an important driver of behavior, other than allowing some individuals to enroll. This is consistent with the literature on the elasticity of demand for care, which shows that the demand for urgent or emergency care is inelastic (Ellis et al., 2017; Liu and Chollet, 2006). There are clearly factors that could lead to violations of these assumptions. For instance, undocumented individuals may have different preferences for

receiving long-term care (LTC) in residential versus home or community settings. This could result in a deviation from the observed distribution of LTC programs within HUSKY C.

Sensitivity Analyses

To address the uncertainty in health insurance take-up rates, we conducted sensitivity analyses with alternative assumptions. Since take-up rates are already high in Connecticut (over 90 percent for both children and adults), we estimated results using a “high take-up rate” of 100 percent. For the “low take-up rate” for adults, we implemented a 25 percentage point reduction in take-up rates for both adults and children in order to provide estimates out outcomes reflecting a wider range of the take-up rate.

Reported Outcomes

For each policy scenario described in Table 1.2, we report the following outcomes:

- Enrollment in different insurance types among undocumented immigrants
- Uninsurance rates by age category
- Insurance status under current law among immigrants enrolled in Medicaid
- Costs to the state.

Chapter 3. Results

Enrollment

Table 3.1. summarizes the health insurance status of ineligible immigrants under current law and under each scenario in 2025. Scenario 1 extends eligibility for HUSKY A and B to children aged 16–18 and extends eligibility for HUSKY A and D to young adults aged 19–25. In this scenario, the total number of ineligible immigrants with health insurance increases by 6,400 (12.3 percent), and the total number insured on Medicaid increases by 6,900 (34.8 percent). The majority of individuals who gain Medicaid coverage were previously uninsured (6,400 individuals), while a small number (500) were previously covered by another form of health insurance (namely, off-Marketplace individual market coverage or employer-sponsored coverage). The additional expansion of HUSKY C eligibility to this population in Scenario 2 makes a minimal difference, with less than 50 additional individuals gaining coverage, the majority of whom were previously uninsured.

Table 3.2 summarizes the age distribution of individuals enrolled in the state-funded HUSKY options under current law and each policy scenario. Under current law, the majority of individuals enrolled in HUSKY are aged 15 or younger, although there are some individuals over age 15 who have coverage via the HUSKY B pregnancy and postpartum coverage option for immigrants. The expansion of HUSKY A and B to the remaining population of children results in an increase of approximately 1,800 individuals in all scenarios.

Expanding HUSKY eligibility to all otherwise-eligible adults in Scenarios 3, 4, and 5 substantially increases insurance coverage relative to current law. In Scenario 3, in which HUSKY A and D eligibility is expanded to the adult population, total insurance coverage rises by more than 21,000 individuals relative to current law (41.9 percent). The majority were previously uninsured, but 1,100 previously had another form of coverage. Total insurance coverage increases slightly in Scenario 4 (expansion of HUSKY C coverage) and Scenario 5 (expansion of HUSKY D to seniors) compared to Scenario 3 because of the additional options for seniors 65 and older in those scenarios. For every age group, HUSKY enrollment is slightly higher in Scenario 4 compared to Scenario 5, because of the more-generous income eligibility criteria for HUSKY C MedConnect coverage for employees with disability and long-term care programs.

Table 3.1. Insurance Enrollment Among Ineligible Immigrants, 2025

	Current law	Scenario 1: Child and young adult		Scenario 2: Child and young adult + HUSKY C		Scenario 3: All ages		Scenario 4: All ages + HUSKY C		Scenario 5: All ages + HUSKY D for seniors	
	N	N	Change from Current Law (%)	N	Change from Current Law (%)	N	Change from Current Law (%)	N	Change from Current Law (%)	N	Change from Current Law (%)
Total Insured	51,800	58,200	12.3	58,200	12.3	73,500	41.9	74,900	44.5	74,200	43.2
HUSKY	19,700	26,600	34.8	26,600	35.0	42,600	115.7	44,200	123.7	43,300	119.5
Other Insured	32,100	31,600	-1.6	31,600	-1.6	31,000	-3.6	30,800	-4.1	30,900	-3.7
Uninsured	70,200	63,800	-9.1	63,800	-9.1	48,500	-30.9	47,100	-32.9	47,800	-31.9

NOTE: “HUSKY” and “Other insured” categories may not sum to “total insured” due to rounding. Small changes in enrollment may also be obscured due to rounding, including a small increase in HUSKY enrollment in Scenario 2 relative to Scenario 1.

Table 3.2. HUSKY Age Distribution Among Ineligible Immigrants, 2025

Age Category	Current law	Scenario 1: Child and young adult	Scenario 2: Child and young adult + HUSKY C	Scenario 3: All ages	Scenario 4: All ages + HUSKY C	Scenario 5: All ages + HUSKY D for seniors
0-15	14,400	14,400	14,400	14,400	14,400	14,400
16-18	0	1,800	1,800	1,800	1,800	1,800
19-25	800	5,900	5,900	5,900	5,900	5,900
26-35	3,000	3,000	3,000	8,300	8,400	8,300
36-45	1,500	1,500	1,500	7,900	8,100	7,900
46-55	0	0	0	2,800	3,000	2,800
56-64	0	0	0	1,400	1,700	1,400
65+	0	0	0	0	800	800
Total	19,700	26,600	26,600	42,600	44,200	43,300

NOTE: “HUSKY” and “Other insured” categories may not sum to “total insured” due to rounding. Small changes in enrollment may also be obscured due to rounding. In particular, we find that fewer than 50 individuals aged 16–18 are pregnant and enrolled in HUSKY under Current Law, and just under 50 individuals aged 65+ enroll in HUSKY in Scenario 3

Table 3.3 summarizes rates of uninsurance by age category in each scenario. Under current law, 6.1 percent of ineligible immigrant children aged 15 and under remain uninsured, while uninsurance rates among the remaining population are above 50 percent in all age categories.

Under current law, uninsurance rates are highest among young adults aged 19–25 at over 80 percent, as young, healthy adults may have less incentive to purchase insurance on the individual market at full price and they (and their parents) may not have access to jobs that provide employer-based coverage. When HUSKY A and D become available to these young adults under Scenario 1, the uninsurance rate drops to just over 50 percent; this finding remains consistent across scenarios as the additional expansion of HUSKY C eligibility only has a very minor impact on this group. When the remaining adult population gains insurance coverage in Scenarios 3, 4, and 5, uninsurance rates among adults aged 26 through 64 drop by 15–25 percent. For adults aged 65 and over, Scenario 3, in which they qualify only for HUSKY A (Medicaid for parents/caregivers), has only a minimal impact on uninsurance. However, Scenarios 4 and 5, which expand access to HUSKY C and HUSKY D, respectively, reduce uninsurance much more substantially for those aged 65 and over.

Table 3.3. Uninsurance Rates (Percent) Among Ineligible Immigrants by Age Category, 2025

Age Category	Current law	Scenario 1: Child and young adult	Scenario 2: Child and young adult + HUSKY C	Scenario 3: All ages	Scenario 4: All ages + HUSKY C	Scenario 5: All ages + HUSKY D for seniors
0-15	6.1	6.1	6.1	6.1	6.1	6.1
16-18	68.0	16.3	16.3	16.3	16.3	16.3
19-25	81.1	52.5	52.4	52.5	52.4	52.5
26-35	54.9	54.9	54.9	38.7	38.2	38.7
36-45	64.9	64.9	64.9	44.3	43.9	44.3
46-55	69.7	69.7	69.7	52.9	52.1	52.9
56-64	63.5	63.5	63.5	44.9	41.1	44.9
65+	69.7	69.7	69.7	67.5	28.9	28.1
All ages	57.5	52.3	52.3	39.7	38.6	39.2

Costs to Connecticut

Tables 3.4 and 3.5 summarize the costs to the state for expanding HUSKY by age group, across scenarios, both overall (Table 3.4) and per capita (Table 3.5). The costs to expand HUSKY to the remaining population of children aged 16–18 is relatively low at \$6 million, or \$3,500 annually per capita and \$3,900 per newly insured individual. Similarly, the expansion to young adults aged 19–25 would cost the state of Connecticut \$32 million or just under \$7,000 annually, both per capita and per newly insured. This figure includes the high cost of insuring the few disabled young adults through HUSKY C. Expanding coverage to the remaining population

of adults who would otherwise be eligible for HUSKY substantially increases costs to the state. Total costs to the state under Scenario 3 are \$290 million, or \$186 million relative to current law, with the vast majority of the increased spending over Scenarios 1 and 2 being generated by the population aged 26–64. This is because in Scenario 3, the only eligibility pathway for adults aged 65 and over is via HUSKY A, so enrollment is very low. Spending increases for all adult age categories under Scenario 4, which includes the expansion of HUSKY C, because HUSKY C covers LTSS on a long-term basis (over 30 days), while HUSKY A, B, and D cover long-term care use of up to 30 days only. Per capita costs are similarly highest in the scenario that includes HUSKY C coverage.

Table 3.4. Costs to the State to Insure Ineligible Immigrants (in Millions of \$), 2025

Age Category	Current law	Scenario 1: Child and young adult	Scenario 2: Child and young adult + HUSKY C	Scenario 3: All ages	Scenario 4: All ages + HUSKY C	Scenario 5: All ages + HUSKY D for seniors
0-15	50.0	50.0	50.0	50.0	50.0	50.0
16-18	0.1	6.4	6.4	6.4	6.4	6.4
19-25	9.1	41.4	42.7	41.4	42.7	41.4
26-35	28.8	28.8	28.8	61.7	68.6	61.7
36-45	15.1	15.1	15.1	63.6	70.4	63.6
46-55	0.0	0.0	0.0	31.2	37.1	31.2
56-64	0.0	0.0	0.0	34.5	48.3	34.5
65+	0.0	0.0	0.0	0.6	32.1	17.6
Total	103.1	141.7	143.0	289.3	355.5	306.3

NOTE: Costs under current law for individuals aged 19–45 are for pregnant people. Costs under Scenarios 1–5 are inclusive of the costs to the state under Current Law.

Table 3.5. Costs to the State Per Capita and Per Newly Insured, 2025

Age Category	Current law	Scenario 1: Child and young adult	Scenario 2: Child and young adult + HUSKY C	Scenario 3: All ages	Scenario 4: All ages + HUSKY C	Scenario 5: All ages + HUSKY D for seniors
<i>Per Capita</i>						
0-15	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500
16-18	\$11,200	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500
19-25	\$10,100	\$6,900	\$7,100	\$6,900	\$7,100	\$6,900
26-35	\$9,700	\$9,700	\$9,700	\$7,400	\$8,100	\$7,400
36-45	\$9,900	\$9,900	\$9,900	\$8,100	\$8,700	\$8,100

Age Category	Current law	Scenario 1: Child and young adult	Scenario 2: Child and young adult + HUSKY C	Scenario 3: All ages	Scenario 4: All ages + HUSKY C	Scenario 5: All ages + HUSKY D for seniors
46-55	\$0	\$0	\$0	\$11,000	\$12,500	\$11,000
56-64	\$0	\$0	\$0	\$24,600	\$27,900	\$24,600
65+	\$0	\$0	\$0	\$11,900	\$40,200	\$22,000
All ages	\$5,200	\$5,300	\$5,300	\$6,800	\$8,000	\$7,000
<i>Per newly insured</i>						
0-15	N/A	N/A	N/A	N/A	N/A	N/A
16-18	N/A	\$3,900	\$3,900	\$3,900	\$3,900	\$3,900
19-25	N/A	\$6,800	\$7,000	\$6,800	\$7,000	\$6,800
26-35	N/A	N/A	N/A	\$6,400	\$7,600	\$6,400
36-45	N/A	N/A	N/A	\$7,900	\$8,800	\$7,900
46-55	N/A	N/A	N/A	\$11,600	\$13,200	\$11,600
56-64	N/A	N/A	N/A	\$25,300	\$29,500	\$25,300
65+	N/A	N/A	N/A	\$14,000	\$43,900	\$23,700
All ages	N/A	\$6,100	\$6,300	\$8,600	\$10,900	\$9,100

NOTE: Costs under current law for individuals aged 19–45 are for pregnant people. We assign the average cost of pregnancy under Medicaid to all pregnant individuals.

Sensitivity Analyses

Table 3.6 describes the insurance enrollment, relative to current law, in alternate versions of Scenarios 1–5 in which health insurance take-up rates are lower or higher than in the main analyses. The results followed expected patterns, with total insurance coverage increasing slightly in scenarios with higher take-up rates and vice versa. The differences in the high take-up scenarios are relatively small, on the order of a few percentage points, because health insurance take up rates in Connecticut (which informed the take-up rates in the main analyses) are high to begin with, so even setting them to 100 percent does not make a substantial difference. However, we note that it is possible that even a 100 percent take-up rate could produce an underestimate of enrollment and costs if the size of the undocumented immigrant population (per the MPI data) is underestimated. The difference between the main results and the low take-up scenarios are larger, since the difference in the take-up rate was larger.

Table 3.6. Insurance Enrollment Among Ineligible Immigrants Relative to Current Law Under Alternate Take-Up and Spending Assumptions, 2025

	Change from Current Law (%)				
	Scenario 1 (child and young adult)	Scenario 2 (child and young adult + HUSKY C)	Scenario 3 (all ages)	Scenario 4 (all ages + HUSKY C)	Scenario 5 (all ages plus HUSKY D for seniors)
Main analysis					
Total Insured	12.3	12.3	41.9	44.5	43.2
Medicaid	34.8	35.0	115.7	123.7	119.5
Other Insured	-1.6	-1.6	-3.6	-4.1	-3.7
Uninsured	-9.1	-9.1	-30.9	-32.9	-31.9
Low take-up rate					
Total Insured	9.0	9.0	30.5	32.5	31.5
Medicaid	25.5	25.6	84.4	90.2	87.2
Other Insured	-1.2	-1.2	-2.6	-3.0	-2.7
Uninsured	-6.6	-6.6	-22.6	-24.0	-23.3
High take-up rate					
Total Insured	13.2	13.2	45.3	48.2	46.7
Medicaid	37.3	37.5	125.0	133.7	129.2
Other Insured	-1.7	-1.7	-3.8	-4.5	-4.0
Uninsured	-9.7	-9.7	-33.4	-35.6	-34.5

Costs to the state under the high and low take-up scenarios are summarized in Table 3.7. The differences in costs to the state are smaller in the high take-up scenario, given the relatively small change in enrollment, and larger in the low take-up scenario. These scenarios can provide a helpful range of enrollment and costs for the state to consider.

Table 3.7. Costs to the State Under Alternate Take-Up and Spending Assumptions (in Millions), 2025

Age Category	Current Law	Scenario 1 (child and young adult)	Scenario 2 (child and young adult + HUSKY C)	Scenario 3 (all ages)	Scenario 4 (all ages + HUSKY C)	Scenario 5 (all ages plus HUSKY D for seniors)
Main analysis						
0-15	50.0	50.0	50.0	50.0	50.0	50.0

Age Category	Current Law	Scenario 1 (child and young adult)	Scenario 2 (child and young adult + HUSKY C)	Scenario 3 (all ages)	Scenario 4 (all ages + HUSKY C)	Scenario 5 (all ages plus HUSKY D for seniors)
16-18	0.1	6.4	6.4	6.4	6.4	6.4
19-25	9.1	41.4	42.7	41.4	42.7	41.4
26-35	28.8	28.8	28.8	61.7	68.6	61.7
36-45	15.1	15.1	15.1	63.6	70.4	63.6
46-55	0.0	0.0	0.0	31.2	37.1	31.2
56-64	0.0	0.0	0.0	34.5	48.3	34.5
65+	0.0	0.0	0.0	0.6	32.1	17.6
<i>Total</i>	<i>103.1</i>	<i>141.7</i>	<i>143.0</i>	<i>289.3</i>	<i>355.5</i>	<i>306.3</i>
Low take-up rate						
0-15	50.0	50.0	50.0	50.0	50.0	50.0
16-18	0.1	4.7	4.7	4.7	4.7	4.7
19-25	9.1	32.6	33.6	32.6	33.6	32.6
26-35	28.8	28.8	28.8	52.8	57.8	52.8
36-45	15.1	15.1	15.1	50.5	55.4	50.5
46-55	0.0	0.0	0.0	22.7	27.1	22.7
56-64	0.0	0.0	0.0	25.1	35.2	25.1
65+	0.0	0.0	0.0	0.4	23.4	12.8
<i>Total</i>	<i>103.1</i>	<i>131.3</i>	<i>132.3</i>	<i>238.9</i>	<i>287.1</i>	<i>251.3</i>
High take-up rate						
0-15	50.0	50.0	50.0	50.0	50.0	50.0
16-18	0.1	6.6	6.6	6.6	6.6	6.6
19-25	9.1	44.1	45.5	44.1	45.5	44.1
26-35	28.8	28.8	28.8	64.5	72.0	64.5
36-45	15.1	15.1	15.1	67.7	75.0	67.7
46-55	0.0	0.0	0.0	33.8	40.3	33.8
56-64	0.0	0.0	0.0	37.4	52.4	37.4
65+	0.0	0.0	0.0	0.6	34.8	19.1
<i>Total</i>	<i>103.1</i>	<i>144.7</i>	<i>146.1</i>	<i>304.7</i>	<i>376.6</i>	<i>323.2</i>

Chapter 4. Discussion

Policymakers in Connecticut are considering various options to reduce the uninsurance rate among the immigrant population and, in particular, among undocumented immigrants who are generally ineligible for any federally funded form of health insurance. Connecticut has already expanded access to HUSKY A (Medicaid) and HUSKY B (CHIP) for children through the age of 15 and for pregnant people through 12 months postpartum (CT Department of Social Services, undated). Policymakers are now considering further expansions to the remaining population of children, the young adult population aged 19–25, and the remaining adult population.

We estimated that expanding access to HUSKY A and B to the remaining population of children and expanding HUSKY A and D to young adults would increase total insurance coverage by over 6,000 individuals but that the additional expansion of HUSKY C to this population would have a relatively minimal effect, since most children and young adults would not qualify for the MedConnect program or require LTSS, both of which have more generous eligibility criteria relative to other HUSKY programs.

Expanding access to HUSKY A, B, and D to the remaining adult population who would otherwise be eligible would result in an increase of nearly 21,000 individuals, or 40 percent, relative to current law. Adding HUSKY C to this scenario would result in an additional 1,800 insured individuals, the majority of whom would be over age 65. We also considered the impact of extending HUSKY D eligibility to seniors, although HUSKY D is currently not available to individuals 65 and older, regardless of immigration status, since those individuals are generally eligible for Medicare. Since undocumented immigrants and legally present recent immigrants do not qualify for Medicaid, HUSKY D could be another pathway to HUSKY eligibility for immigrant seniors and could require less state funds, as HUSKY D does not cover long-term care stays over 30 days.

Expanding HUSKY A, B, and D access to individuals aged 16–25 would cost the state of Connecticut approximately \$39 million, and the addition of HUSKY C for this population would add slightly more than an additional million dollars. Expanding HUSKY A, B, and D to the entire population of ineligible immigrants over the age of 15 would cost substantially more, at \$186 million relative to current law. The additional expansion of HUSKY C to this population (under Scenario 4) would cost an additional \$66 million for 1,400 additional covered lives over Scenario 3, an annual cost of over \$47,000 per additional insured individual. This is because the expansion of HUSKY C pulls in high-cost individuals who are disabled or need long-term care. Expanding HUSKY D access to seniors (Scenario 5) rather than expanding HUSKY C (as in Scenario 4) would result in less than 1,000 fewer enrolled individuals relative to Scenario 4, and \$49 million less in state spending.

While our analyses estimate the costs of the proposed scenarios, they do not account for potential savings that may offset costs. For example, there may be less uncompensated care when individuals gain access to Medicaid, which could result in savings for hospitals and other providers. Beyond the direct savings, there may be additional savings relative to the emergency Medicaid program if individuals are able to avoid high-cost hospital or emergency department visits for chronic conditions such as diabetes due to increased access to primary care. Finally, the state could apply for a Medicaid 1115 waiver to potentially recoup some of the federal savings from insuring recent legally present immigrants on Medicaid, who otherwise may have received subsidies for Marketplace coverage. There may also be savings from the emergency Medicaid program, which covers a limited set of services to immigrants who would otherwise qualify for Medicaid during medical emergencies. The emergency Medicaid program is partially federally funded, so the state could see reduced spending in their own share of spending, and also potentially recoup a portion of the forgone federal match via an 1115 waiver.

Limitations

There are several limitations to consider when interpreting the results of this analysis:

- *Data on undocumented immigrant population:* We relied on the most recent estimates of the size, demographics, income, and health insurance status of the undocumented immigrant population as produced by the MPI. However, the MPI data rely on imputation and cannot be validated, and the most recent data are from 2019. In fact, we observed that Connecticut's enrollment data from its existing state-funded coverage for children suggested enrollment that was higher than the entire population of children in the same age range as predicted by MPI. It is possible that the MPI estimates are undercounts, the state's estimates are overcounts, or both. However, we adjusted the size of the population of children aged 0–15 as reported by the MPI to allow for enrollment as reported by Connecticut. In addition to this basic limitation of the MPI data, an additional limitation is that it includes one-way distributions of age, gender, income, and insurance status and does not include joint distributions of these key variables. Instead, we relied on statistical techniques that allow us to “borrow” these joint distributions from the CPS (described in more detail in the appendix). While the MPI data have a number of limitations, there are unfortunately very few sources of data on the undocumented immigrant population.
- *Take-up rate:* As we note in the methodology chapter, the expected take-up rates and medical spending for undocumented immigrants are difficult to predict. For example, although Connecticut does have aggregate enrollment data for its state-funded HUSKY programs for immigrants, it does not have estimates of the *eligible* population. Furthermore, there was some concern that the enrollment counts for the state-funded program may have been overstated, with individuals eligible for the

federally funded HUSKY program mistakenly categorized as being enrolled in the program for immigrants. To account for the uncertainty, we conducted sensitivity analyses with varied take-up rates.

- *Medical spending:* We do not have estimates of medical spending specifically among the population of undocumented immigrants who gain Medicaid coverage. Therefore, we utilize data on average spending within each HUSKY program and eligibility category (e.g., HUSKY A for children, HUSKY A for parents/caregivers, etc.) and weight the spending we assign from the MEPS data to match these targets.
- *HUSKY C eligibility:* While eligibility for HUSKY A, B, and D is relatively straightforward with income eligibility criteria defined relative to FPL, eligibility for HUSKY C is more complex. HUSKY C eligibility for blind or disabled individuals would typically go hand in hand with eligibility for federal SSI and/or income from Social Security Disability Insurance (SSDI). However, individuals who do not qualify for Medicaid due to their immigration status would similarly not qualify for SSI or SSDI, so we cannot rely on these designations to identify eligibility for HUSKY C. Furthermore, HUSKY C eligibility for other programs is based on a combination of an income threshold *and* an asset threshold, and individuals may qualify for HUSKY C after spending down their income on medical expenses. The CPS data are not sufficiently detailed to assess eligibility based on these criteria, so we instead relied on a combination of income and estimates of spend-down amounts, but did not capture the asset threshold. These factors likely cause our estimates of HUSKY C eligibility may be on the high end. Furthermore, we do not have the claims data necessary to identify individuals who would qualify for LTSS under HUSKY C; we therefore assume the same ratio of long-term care HUSKY C recipients to other HUSKY C recipients as in the general population.

Conclusions

Our analyses suggest that expanding Medicaid eligibility to immigrants who are ineligible only due to their immigration status would result in a substantial reduction in uninsurance among this population. Expanding coverage to children aged 16–18 and young adults through age 25 would reduce uninsurance among ineligible immigrants by 9 percent, while expanding coverage to all ages would reduce uninsurance by 30–32 percent, depending on the specific scenario. Expanding coverage to the remaining population of children and to young adults would cost the state \$39–\$40 million (depending on whether it expands HUSKY A, B, and D only or include HUSKY C in the expansion). Expanding coverage to the entire population over the age of 15 that would otherwise be eligible via HUSKY A, B, and D would cost the state \$186 million but would result in relatively small gains in coverage among individuals aged 65 and older; they are ineligible for HUSKY D, and therefore could only qualify for HUSKY if they are

parents/caregivers. Adding HUSKY C to the expansion would reduce uninsurance among seniors by nearly 40 percentage points, but at substantial added cost (\$252 million relative to current law), due to the high cost of long-term care under HUSKY C. An alternate option is to allow seniors to enroll in HUSKY D rather than expanding HUSKY C. This results in almost as large a reduction in uninsurance among this population as the HUSKY C expansion but at a lower cost (\$203 million), since HUSKY D does not cover institutional stays for periods longer than 30 days. This would require a change in policy for HUSKY D for immigrants relative to the general population, as HUSKY D for the expansion population is only available to adults aged 19–64, as seniors are expected to be eligible for Medicare. However, this could represent a lower-cost way for the state to cover seniors.

Overall, our analyses suggest that expanding HUSKY eligibility to ineligible immigrants in Connecticut could result in substantial reductions in the uninsurance rates but that costs to the state would vary depending on the age groups and HUSKY programs included in the expansion.

Appendix A. COMPARE Overview

Overview

The COMPARE microsimulation model uses economic theory and evidence from past experience to estimate how individuals, households, and firms will respond to health policy changes (Cordova et al., 2013). The model has been described extensively in past RAND work, including Rao et al., 2022; Rao, Girosi, and Eibner, 2022, 2024. The following description draws heavily from similar descriptions in these prior studies.

COMPARE relies on a nationally representative population of individuals, families, and firms using data from the 2024 CPS. We then assign a medical spending amount to each individual in the CPS using the medical spending of a similar individual (in terms of key demographic and health insurance variables) from the 2018–2019 MEPS data. To project outcomes to future years, we rely on population growth estimates reported by the U.S. Census Bureau and health care cost growth estimates from the Centers for Medicare & Medicaid Services’ National Health Expenditures Accounts (U.S. Census Bureau, 2021; Centers for Medicare & Medicaid Services, 2022).

Table A.1 lists the various data sources we rely on for these analyses.

Table A.1. Data Sources

Data	Source
State population totals by single year of age, race and ethnicity, year 2022	https://portal.ct.gov/dph/health-information-systems--reporting/population/population-statistics
ACS PUMS microdata for Connecticut, year 2022	https://www.census.gov/programs-surveys/acs/microdata/access.html
HUSKY C age distribution	Private communication, Connecticut department of Social Services
State population time series, 2010-2023	https://portal.ct.gov/dph/health-information-systems--reporting/population/annual-state-county-population-estimates
Medicare enrollment, 2024	https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment
HUSKY enrollment by Type of Assistance (TOA), 2012-2024	https://data.ct.gov/Health-and-Human-Services/DSS-Types-of-Assistance-TOA-Participation-by-Month/chsv-phja/about_data
Effectuated enrollment in Marketplace, 2024	https://www.cms.gov/files/document/early-2024-and-full-year-2023-effectuated-enrollment-report.pdf
State-level undocumented immigrant population statistics, 2019	https://www.migrationpolicy.org/programs/data-hub/state-immigration-data-profiles
Fertility rates by age, race and ethnicity, 2022	https://wonder.cdc.gov/controller/datarequest/D192
Total number of births, 2022	https://portal.ct.gov/dph/health-information-systems--reporting/hisrhome/vital-statistics-registration-reports
HUSKY PMPM and total cost by quarter, 2022	https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20230113/Medicaid%20Budget%20Overview.pdf
HUSKY PMPM and total cost by quarter, 2021	https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/Cost-Transparency_Nov22Update_FINAL1A.pdf

NOTE: Source links are as of October 15, 2024.

Health Insurance Enrollment Decisions

The COMPARE model typically uses a utility-maximization framework to model the health insurance enrollment decisions of individuals and families, allowing individuals and families to consider the costs and benefits of the health insurance options that are available to them. For this work, since we only consider the addition of a Medicaid option for undocumented immigrants, we simplify the model to reflect take-up of Medicaid that is consistent with Medicaid take-up

rates in the general Connecticut population, distinguishing only between adults and children. This approach offers the advantage of being easier to interpret compared to the utility maximization method, although it obscures some of the nuances of health insurance take-up decisions.

Health Care Spending

We assume that medical spending for undocumented immigrants is similar to that of the general population for a given demographic profile. In order to assign to individuals enrolled in different HUSKY programs a yearly cost, we used data from the CT Department of Social Services (2019). The data contain per-member-per-month costs for HUSKY A, B, C, and D from March 2020 to September 2022. Under the assumption of constant growth rate, we extrapolated these data to year 2025. Since the data do not provide the age distribution in the HUSKY programs, we “borrow” the age distribution from the Medical Expenditures Panel Survey (MEPS) (years 2018 and 2019), after having it reweighted using MPI data so that it resembles the CT undocumented population, and having selected the self-identified Medicaid sub-population. Using each procedure, we assigned a per-capita yearly cost to each new enrollee in the HUSKY program based on their age in a way that is consistent with the current CT data.

We are aware that there are different ways of measuring Medicaid costs, including via Form CMS 64 and state Medicaid account data. For these analyses, we use the per-member per-month HUSKY spending figures as calculated by the (Connecticut Department of Social Services, 2022).

HUSKY C Eligibility

Imputation of Disability Status in the Undocumented Population

In the legally present population, the disability variable used to determine eligibility for HUSKY C for blind/disabled individuals is based on the presence of one of the following:

- the individual receives SSI because they are blind or disabled
- the individual has a disability that limits their ability to work
- the individual receives any kind of disability income.

Since the definition of disability is partially tied to receipt of disability income that is not available to undocumented immigrants, it does not apply well to the undocumented population and is likely to miss a portion of the disabled population. We therefore assume that prevalence of disability is independent of immigration status and use the legally present population to impute disability in the undocumented population. The imputation is performed using a logit model that predicts disability as a function of age, income, race, sex and health status. The Area Under the Curve for this logit model is 0.86, indicating that the model is expected to predict accurately.

Modeling MedConnect in the Legally Present Population

When we apply the HUSKY C income eligibility rules for MedConnect to the entire legally present population (including citizens and permanent residents), we find that nearly 29,000 individuals are eligible and approximately 10,900 are on MedConnect. The actual size of MedConnect population in Connecticut is 3,600, suggesting that the model has an excess of nearly 7,3000 individuals.

The likely cause of this excess is the broad criteria that we use to identify potential disability status, which includes anyone who self-reports a disability that limits the amount of work they can perform. In order to better calibrate the data, we “turn-off” the disability indicator for increasing numbers of individuals, starting from those with the lowest probability of being disabled. This probability is estimated using the same model that is used to impute disability for the undocumented population. Applying this algorithm, we find that in order for the data set to be consistent with the Connecticut enrollment data, we need to turn off the disability indicator for anyone whose probability of being disabled is below 10.6 percent.

Modeling MedConnect in the Undocumented Immigrant Population

For the undocumented immigrant population, the disability variable has been imputed using the procedure described in the section “Imputation of Disability Status in the Undocumented Population” above. The procedure assigned each individual both a binary disability variable and a probability of being disabled. In order to estimate the eligibility of the undocumented for MedConnect, we apply the same criteria we applied to the legally present population and exclude individuals whose probability of being disabled is lower than the estimated threshold of 10.6 percent.

Modeling HUSKY C for the Aged/Disabled in the Legally Present Population

When we apply the income eligibility rule for the aged/blind/disabled component of the HUSKY C program to the legally present population of our data, without accounting for unearned income disregard or spend-down, we find that 50,811 individuals are eligible and 28,504 are on Medicaid. The actual size of the HUSKY C (aged/disabled) population in CT is 40,011, implying that unearned income and spend-down must account for the missing 11,507 individuals.

The combined effect of the unearned income disregard and spend-down is to effectively raise the yearly income eligibility threshold above the minimum threshold T_C , so that the *effective* threshold $T_C^{\text{effective}}$ for HUSKY C eligibility becomes:

$$T_C^{\text{effective}} = T_C + \text{spend-down} + \text{unearned income disregard}$$

For the legally present population the monthly disregard amount is computed directly from the CPS data by summing any form of unearned income, such as annuities, SS/SSI payments, disability pensions and retirement distributions.

In order to understand what is a level of spend-down that is consistent with our data we apply the HUSKY C eligibility rules for increasing values of the maximum spend-down amount and individual might have, leading to increasing numbers of eligible individuals and increasing sizes of HUSKY C population. We stop when the size of the HUSKY C population is equal to the target from the CT data.

Using this procedure, we determined that, in order for our data to be consistent with CT data, the yearly level of spend-down must be **at most** \$4,696.

Taking all the HUSKY C individuals who would not be eligible unless they did not have a positive level of spend-down, we can estimate their level of spend-down as the expenditures needed in order to meet the eligibility criteria. We find that the **average** yearly spend-down amount is \$2,114

Modeling HUSKY C for the Aged/Disabled in the Undocumented Population

In order to assign a spend-down level to the undocumented population potentially eligible for HUSKY C, we sample the spend-down levels from the legally present population estimated using the procedure described in the previous section.

Appendix B. Baseline Profile of the Undocumented Population

In Table B.1, we present the profile of the undocumented population based on the variables used for reweighting. The distribution of these variables is derived from the 2019 MPI data. The actual figures vary slightly from the MPI data because we adjusted them to align with the current enrollment of undocumented individuals in HUSKY A, as reported by the Department of Social Services (2024).

Table B.1. Profile of the Undocumented Population

	Population Size
Total	122,026
Age Category	
0-15	16,027
16-18	3,096
19-25	16,636
26-35	31,380
36-45	29,805
46-55	15,974
56-64	7,319
65+	1,788
Income (% of FPL)	
0-49	12,922
50-99	13,905
100-149	16,368
150-199	16,198
200-263	8,669
264-399	15,888
400+	38,076
Health Insurance Status	
Insured	51,834
Uninsured	70,192

Population Size	
Sex	
Male	68,032
Female	53,994
Country of Origin	
Americas	84,230
Not Americas	37,796
Labor Force Status	
Employed	73,000
Not in the Labor Force	42,026
Unemployed	7,000

Abbreviations

CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CPS	Current Population Survey
HUSKY	Connecticut's state Medicaid program
LTC	long-term care
LTSS	long-term services and supports
MEPS	Medical Expenditures Panel Survey
MPI	Migration Policy Institute
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income

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