Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States

Pooja Agrawal, MD, MPH, and Arjun Krishna Venkatesh, MD, MBA, MHS

We sought to evaluate the relationship between state-level implementation of the Patient Protection and Affordable Care Act (ACA) and resettlement patterns among refugees. We linked federal refugee resettlement data to ACA expansion data and found that refugee resettlement rates are not significantly different according to state-level insurance expansion or cost. Forty percent of refugees have resettled to states without Medicaid expansion. The wide state-level variability in implementation of the ACA should be considered by federal agencies seeking to optimize access to health insurance coverage among refugees who have resettled to the United States. (*Am J Public Health.* 2016;106: 662–663. doi:10.2105/AJPH.2015.303017)

With international crises occurring with greater frequency and intensity, millions of people around the world are being displaced. Approximately 65 000 refugees from more than 65 different countries are being resettled in the United States each year.[1] This figure is set to rise to 100 000 per year as a result of to the humanitarian crisis in Syria. Refugees are more likely to have medical and psychiatric conditions than other immigrants,[2–8] and insufficient preresettlement health care often results in acute decompensation of chronic illnesses and missed preventive care opportunities that necessitate health care attention upon resettlement.[9–11] Unfamiliarity with the complex US social systems creates unique challenges for refugees, including gaps in state insurance programs, employer-based insurance restrictions, or simply insufficient income to pay for health service or prescription copayments.[12,13]

US refugee resettlement involves coordination of services between federal agencies, nongovernmental organizations, and local service delivery organizations. As a result of the substantial variability in state social services provided to refugees, resettlement services have been described as a "lottery."[14] Passage of the Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148) was intended to expand access to comprehensive health insurance among vulnerable populations, particularly through the Medicaid program for eligible adult refugees and health insurance marketplaces (exchanges) for those not eligible for Medicaid. However, implementation of Medicaid expansion and the creation of exchanges have varied markedly between states, resulting in unanticipated gaps in health insurance access among refugees. The substantial variability in insurance premium costs among state-based exchanges has been cited as further impeding access to health care.[15]

We sought to describe the relationship between refugee resettlement patterns and state-level health care insurance expansions created by the ACA to inform national refugee resettlement efforts.

METHODS

We conducted a retrospective analysis of publicly available state-level refugee resettlement data from fiscal year 2014, obtained from the Office of Refugee Resettlement of the Department of Health and Human Services, linked to December 2014 state-level ACA expansion data from the Kaiser Family Foundation. We obtained annual state census data from the 2010 US Census (2014 American Community Survey 5-year estimates) and calculated state-level refugee resettlement rates per 100 000 population to standardize our comparisons. To describe differences in health care access based on state-level resettlement burdens, we grouped states into the following categories: no formal resettlement program (< 1 resettled refugee per 100 000 population per year or < 30 resettled refugees per year), low (below median) resettlement rate (< 23 refugees per 100 000 population), or high (above median) resettlement rate (≥ 23 refugees per 100 000 population).

For our secondary analysis, we obtained 2015 data from healthcare.gov on the "bronze-level" plan, the lowest-cost health insurance plan in each state and the federal health insurance exchange. The pretax credit bronze-level plan priced for a 30-year-old nonsmoker was used to compare premium costs between states. We report state-level descriptive statistics regarding resettlement patterns and ACA-related Medicaid expansions or the creation of state-based health insurance exchanges. We used the Wilcoxon rank-sum test to compare differences in the average number of refugees resettled and the refugee resettlement rate by state according to Medicaid expansion or access to state-based exchanges. We also compared monthly premium costs between states with low and high resettlement rates.

RESULTS

A total of 69 985 refugees were resettled to 21 low-resettlement (median = 17.7 refugees per 100 000 population) and 22 high-resettlement (median = 34.5 refugees per

ABOUT THE AUTHORS

The authors are with the Department of Emergency Medicine, Yale University School of Medicine, New Haven, CT.

Correspondence should be sent to Pooja Agrawal, MD, MPH, Department of Emergency Medicine, Yale University School of Medicine, 464 Congress Ave, Suite 260, New Haven, CT 06519 (e-mail: pagrawalmd@gmail.com). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted November 27, 2015.

doi: 10.2105/AJPH.2015.303017

TABLE 1—Refugee Resettlement According to States' Implementation of the Patient Protection and Affordable Care Act: United States, 2014

	State Medicaid Expansion			State-Based Exchange		
	Yes (n = 28)	No (n = 23)	$P^{a,b}$	Yes (n = 17)	No (n = 34)	$P^{a,c}$
Total no. of refugees resettled	41 684	28 301		25 543	44 442	
No. of refugees per state			.47			.56
Mean (SD)	1489 (1550)	1230 (1606)		1503 (1610)	1307 (1561)	
Median (IQR)	856 (252–2530)	978 (141–1467)		1019 (317–1941)	637 (141–2443)	
No. of refugees per capita			.64			.31
Mean (SD)	24 (18)	22 (18)		26 (16)	21 (19)	
Median (IQR)	21 (11–35)	20 (5–27)		21 (16–35)	21 (4–27)	

Note. IQR = interquartile range.
[a]Wilcoxon rank-sum test.
[b]Difference in means and medians between states with and without Medicaid expansion.
[c]Difference in means and medians between states with and without state-based exchanges.

100 000 population) states, with no active resettlement in 7 states (Figure A, available as a supplement to the online version of this article at http://www.ajph.org). Overall, 41 684 refugees (60%) were resettled to 28 states that expanded Medicaid coverage (median = 856 refugees per state; range = 0–6108), whereas 28 301 refugees (40%) were resettled to 23 states that did not expand coverage (median = 978; range = 0–7214; Table 1). In terms of high-resettlement states facing the greatest resettlement burden, 19 407 refugees (median = 28.0 refugees per 100 000) were resettled to 10 high-resettlement states without expanded Medicaid coverage, and 22 366 refugees (37.8 per 100 000) were resettled to 12 high-resettlement states with expanded coverage ($P = .55$).

A median of 1019 refugees resettled to the 17 states that created exchanges (range = 2–6108), which was not significantly different than the median for the 34 states using the federal insurance exchange (637; range = 0–7214; $P = .56$). The average monthly premium for a bronze health insurance plan was not significantly different between high-resettlement states ($151) and low-resettlement states ($141; $P = .48$). The 3 states with the highest resettlement rates all had monthly insurance premiums above the national average of $147.

DISCUSSION

Although current resettlement patterns do not disproportionately place refugees in states without Medicaid coverage expansion or more expensive health care insurance exchange plans under the ACA, the considerable variability in state-based implementation of the ACA can yield substantially different health insurance options for low-income refugees. More than 1 in 3 refugees have resettled to a state with no Medicaid expansion.

These results demonstrate a substantial opportunity for policymakers to consider health insurance access in refugee resettlement efforts. Given the extensive screening conducted prior to resettlement, federal agencies could take into account refugees' health status when determining resettlement locations and allocate them to states with friendly resettlement policies and favorable insurance access. Given that state expansion of Medicaid or creation of exchanges is politically unlikely in the near future, the Department of Health and Human Services could consider extending unique subsidies to refugees seeking to purchase health insurance on exchanges, similar to its policy regarding child-care support for select needy families.[16] In addition, states that might not broadly expand Medicaid coverage as a result of budgetary constraints but seek to support vulnerable refugees could broaden eligibility criteria for state insurance programs.

Such policies have the potential to make health care transitions safer for refugees as well as provide the income security available through access to health insurance coverage. Eliminating the lottery effect among resettled refugees will require focused policy interventions beyond the broad changes in coverage enacted in the ACA. AJPH

CONTRIBUTORS

P. Agrawal was chiefly responsible for originating and designing the study, writing the article, and developing related figures. A. K. Venkatesh contributed to the design of the study, the statistical analyses, and critical reviews of the article.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this study because no human participants were involved.

REFERENCES

1. Refugee Processing Center. Worldwide Refugee Admissions Processing System (WRAPS) data. Available at: http://www.wrapsnet.org. Accessed January 5, 2016.

2. Mollica RF, Poole C, Son L, Murray CC, Tor S. Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *J Am Acad Child Adolesc Psychiatry*. 1997;36(8):1098–1106.

3. Marshall GN, Schell TL, Elliott MN, Berthold SM, Chun C. Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA*. 2005;294(5):571–579.

4. Gerritsen AA, Bramsen I, Devillé W, van Willigen LH, Hovens JE, van der Ploeg HM. Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Soc Psychiatry Psychiatr Epidemiol*. 2006;41(1):18–26.

5. Lifson AR, Thai D, O'Fallon A, Mills WA, Hang K. Prevalence of tuberculosis, hepatitis B virus, and intestinal parasitic infections among refugees to Minnesota. *Public Health Rep*. 2002;117(1):69–77.

6. Ackerman LK. Health problems of refugees. *J Am Board Fam Pract*. 1997;10(5):337–348.

7. Yun K, Hebrank K, Graber LK, Sullivan M, Chen I, Gupta J. High prevalence of chronic non-communicable conditions among adult refugees: implications for practice and policy. *J Community Health*. 2012;37(5):1110–1118.

8. Steel Z, Silove D, Phan T, Bauman A. Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. *Lancet*. 2002;360(9339):1056–1062.

9. Adams KM, Gardiner LD, Assefi N. Healthcare challenges from the developing world: post-immigration refugee medicine. *BMJ*. 2004;328(7455):1548–1552.

10. Van Damme WI, Van Lerberghe WI, Boelaert M. Primary health care vs. emergency medical assistance: a conceptual framework. *Health Policy Plan*. 2002;17(1):49–60.

11. Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare barriers of refugees post-resettlement. *J Community Health*. 2009;34(6):529–538.

12. Ku L, Matani S. Left out: immigrants' access to health care and insurance. *Health Aff (Millwood)*. 2001;20(1):247–256.

13. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. *Health Aff (Millwood)*. 2007;26(5):1258–1268.

14. Brick K, Cushing-Savvi A, Elshafie S, Krill A, McGlynn Scanlon M, Stone M. *Refugee Resettlement in the United States: An Examination of Challenges and Proposed Solutions*. New York, NY: Columbia University School of International and Public Affairs; 2010.

15. Karaca-Mandic P, Fulton BD, Hollingshead A, Scheffler RM. States with stronger health insurance rate review authority experienced lower premiums in the individual market in 2010-13. *Health Aff (Millwood)*. 2015;34(8):1358–1367.

16. Blau D, Tekin E. The determinants and consequences of child care subsidies for single mothers in the USA. *J Popul Econ*. 2007;20(4):719–741.