Colorado's Five-Year-Bar Removal and Coverage Among Immigrant Children

Abstract

Background: CHIPRA Section 214 lets states cover lawfully residing immigrant children without requiring completion of the federal five-year waiting period. Colorado implemented the child policy for MAGI Medicaid and CHP+ on July 1, 2015, followed by a July 1, 2016 non-MAGI cleanup.

Methods: I use ACS state-year coverage contrasts for children ages 0-17, comparing recent immigrant children with US-born children. Colorado is compared with synthetic donor states that did not adopt the child CHIPRA-214 option by 2020. The preferred design treats 2015 and 2016 as transition years.

Results: In 2017-2020, Colorado's recent-immigrant child coverage contrast improved relative to the synthetic counterfactual by +18.1 percentage points for any coverage, +10.0 for public coverage, and +18.3 for Medicaid or means-tested public coverage. Any coverage is most stable; Medicaid is positive but donor-sensitive.

Conclusions: Colorado is a plausible public-data case study, not evidence of a pooled national CHIPRA effect. Direct enrollment evidence is the next improvement, and a later version will likely use the Colorado APCD for utilization and spending.

Key Takeaways

- Colorado's CHIPRA-214 child implementation has a verifiable July 1, 2015 MAGI Medicaid/CHP+ date and a July 1, 2016 non-MAGI cleanup.
- ACS synthetic-control contrasts show improved coverage among recent immigrant children relative to US-born children after the transition period.
- The manuscript should stay in a cautious case-study frame until HCPF administrative counts, donor-state verification, and Colorado APCD extensions are added.

Keywords

Medicaid; CHIP; immigrant health; children; synthetic control; Colorado; health insurance

Introduction

Federal Medicaid and CHIP rules have long created a coverage boundary for immigrant families. Many lawfully present immigrants face a five-year waiting period before qualifying for federally financed full-benefit Medicaid or CHIP. CHIPRA Section 214 gave states the option to remove that waiting period

for lawfully residing children and pregnant people. The policy is substantively important because it can turn a child's immigration-status waiting period into immediate access to full-scope public coverage; it is also empirically difficult because public surveys do not identify the exact lawfully residing subgroup affected by the rule.

The broader pooled CHIPRA-214 design does not support a national causal interpretation. Longer-tenured immigrant placebo groups move with the headline estimates, and the cleanest national subgroup without pre-CHIPRA state-funded immigrant coverage is null or wrong-signed. That pattern rules out a broad pooled causal claim.

Colorado, however, remains a narrower and more credible case-study lead. HCPF and CMS materials document a delayed child implementation: MAGI Medicaid and CHP+ coverage for lawfully residing children was implemented effective July 1, 2015, and non-MAGI child categories were cleaned up effective July 1, 2016. That timing creates a state-specific public-data question: did coverage among recent immigrant children improve after the documented eligibility change, relative to a synthetic counterfactual?

This paper answers that question with a deliberately modest estimand. It studies the ACS contrast between recent immigrant children and US-born children. Recent immigrant children are not the same thing as lawfully residing children under CHIPRA Section 214, but they are the public-data group most exposed to a five-year-bar removal. The contribution is therefore a transparent case study: it tests whether Colorado's documented policy change is visible in public survey coverage data, while identifying the administrative data needed for a stronger mechanism test.

Data and Methods

The analysis uses ACS microdata processed into state-year coverage contrasts. The sample is children ages 0-17. For each state and year, I compute coverage rates for recent immigrant children, longer-tenured immigrant children, and US-born children. The primary analytic outcome is the recent-immigrant-minus-US-born contrast for three coverage measures: any health insurance coverage, any public coverage, and Medicaid or means-tested public coverage. The longer-tenured-immigrant-minus-US-born contrast is retained as a placebo because longer-tenured immigrants should be less directly exposed to the five-year-bar removal.

Colorado is the treated state. The event is July 1, 2015. Because implementation was operationally staggered and HCPF/CKF materials identify a July 1, 2016 non-MAGI cleanup, the preferred timing treats 2015 and 2016 as transition years. The preferred post window is 2017-2020, with a no-2020 sensitivity covering 2017-2019.

The primary donor pool contains states that did not adopt the child CHIPRA-

214 option by 2020 and that are not known pre-CHIPRA child immigrant coverage states in the project adoption panel. I estimate synthetic-control and ridge-augmented synthetic-control paths using pre-2015 state-year coverage contrasts. Sensitivity checks exclude Idaho because of its 2020 ACA Medicaid expansion, restrict to ACA-expansion-by-2014 donors as a stress test, and compare the target contrast with the longer-tenured placebo contrast.

The analysis is intentionally not written as an individual-level causal effect. ACS does not observe lawfully residing status, five-year-bar exposure, eligibility approval, aid code, or program enrollment channel. The estimates are best read as public-data evidence on whether Colorado's policy change coincided with improved coverage among a plausible exposed group.

Results

The preferred 2017-2020 results show a positive Colorado target gap across all three coverage outcomes. Any coverage is the strongest and most stable result. The target ASCM gap is +18.1 percentage points, while the longer-tenured placebo gap is -4.7 percentage points; the target-minus-placebo difference is +22.8 percentage points. This means Colorado's recent-immigrant child coverage contrast improved substantially more than the corresponding placebo contrast.

Medicaid or means-tested public coverage also rises in the base design. The target ASCM gap is +18.3 percentage points. The longer-tenured placebo gap is +6.0 percentage points, leaving a target-minus-placebo difference of +12.3 percentage points. This direction matches the expected policy mechanism, but the Medicaid result is more donor-sensitive than any coverage.

The public-coverage result is positive in the base donor pool, with a target ASCM gap of +10.0 percentage points. However, public coverage and Medicaid should be presented as secondary relative to any coverage because donor weights are more concentrated and because excluding Idaho changes the contrast. The ACA-expansion-only stress pool is not a credible primary donor pool by itself and turns negative; that result is a warning about donor comparability, not a reason to discard the Colorado case study.

Administrative sources support the timing but not the realized enrollment mechanism. The HCPF Title XXI compilation identifies CHIP SPA #24 / CO-15-0024 as submitted April 8, 2016, approved May 4, 2016, and effective July 1, 2015. CMS Medicaid SPA CO-15-0035 and HCPF/CKF materials independently support July 2015 MAGI Medicaid/CHP+ implementation and July 2016 non-MAGI cleanup. HCPF budget narratives contain forecast fragments labeled HB 09-1353 Removing 5-year Bar on Legal Immigrants, including MAGI child and SB 11-008 child estimates, but those are model adjustments rather than realized enrollment counts.

Discussion

The Colorado child branch is now strong enough to write as a cautious case study. It is not strong enough to revive the original pooled CHIPRA-214 manuscript. The core distinction matters: the pooled design tried to estimate a national CHIPRA effect and failed the placebo gate; the Colorado branch asks whether one documented delayed implementation is visible in public survey coverage contrasts.

The result is substantively plausible. Colorado had an implemented eligibility change, an operational cleanup year, and positive post-transition ACS gaps for recent immigrant children. Any coverage is the most credible endpoint because it is less tied to a single administrative category and remains stable across the base and exclude-Idaho variants. Medicaid and public coverage are consistent with the policy pathway but should be framed as supportive rather than definitive.

Several limitations should be explicit. First, ACS cannot identify the precise lawfully residing children made newly eligible by CHIPRA Section 214. Second, the target group is a proxy based on immigrant tenure, not an eligibility flag. Third, donor comparability is fragile because Colorado's ACA expansion and marketplace infrastructure changed family coverage around the same period. Fourth, the public administrative sources do not provide realized child enrollment counts by Medicaid versus CHP+, MAGI versus non-MAGI, month, county, or aid code. Fifth, 2020 is an unusual coverage year and must be accompanied by no-2020 sensitivity.

The next empirical improvement is an HCPF administrative extract. The ideal file would provide de-identified counts of children under 19 approved or enrolled through the CHIPRA Section 214 / HB 09-1353 five-year-bar removal, by month, program, MAGI/non-MAGI status, county, aid code, age band, and new approval versus active enrollment. That would verify the mechanism directly.

A second improvement, likely for a later version of the paper, is to use the Colorado All Payer Claims Database. The Colorado APCD could move the paper beyond coverage activation toward utilization, spending, and continuity of care after enrollment. The APCD would not by itself solve the eligibility-flag problem, but linked or appropriately stratified APCD/Medicaid claims could test whether the coverage change translated into primary care, emergency department, pharmacy, or total spending changes among children whose coverage pathway changed.

Conclusion

Colorado's delayed CHIPRA Section 214 implementation for lawfully residing children is visible in ACS coverage contrasts after the transition period, especially for any coverage. The finding is useful as a state case study and as a guide for administrative follow-up. It should not be presented as a revived pooled CHIPRA causal estimate until direct enrollment data and stronger donor-state

verification are available.

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Tables

Table 1. Core 2017-2020 ASCM Results

Outcome	Post	Pool	Donors	Target	Placebo	Diff.	RMSPE
Any	2017-2020	Base	11	18.1	-4.7	22.8	7.9
Public	2017-2020	Base	11	10.0	6.6	3.4	6.4
Medicaid	2017-2020	Base	11	18.3	6.0	12.3	7.8

Notes: This table compares observed outcomes with counterfactual or donor-based benchmarks. Gaps, weights, and fit measures are reported where relevant to evaluate the comparison.

Table 2. Main Robustness Matrix

Outcome	Post	Pool	Donors	Target	Placebo	Diff.	RMSPE
Any	2017-2019	ACA expansion only	2	-8.9	-11.9	3.0	13.6
Any	2017-2019	Base	11	14.1	-4.8	18.9	7.9
Any	2017-2019	No Idaho	10	14.3	-4.5	18.8	7.9
Any	2017-2020	ACA expansion only	2	-5.7	-8.8	3.2	13.6
Any	2017-2020	Base	11	18.1	-4.7	22.8	7.9
Any	2017-2020	No Idaho	10	18.9	-4.5	23.5	7.9
Medicaid	2017-2019	ACA expansion only	2	-4.5	-3.5	-1.0	12.3
Medicaid	2017-2019	Base	11	15.8	4.9	11.0	7.8
Medicaid	2017-2019	No Idaho	10	8.3	12.2	-4.0	8.3
Medicaid	2017-2020	ACA expansion only	2	-2.1	1.0	-3.1	12.3
Medicaid	2017-2020	Base	11	18.3	6.0	12.3	7.8
Medicaid	2017-2020	No Idaho	10	10.0	7.8	2.2	8.3

Notes: Target, placebo, difference, and RMSPE columns are percentage points. Public means any public coverage. Medicaid means Medicaid or other means-tested public coverage. Donor-weight details are reported in the source tables.

Figures

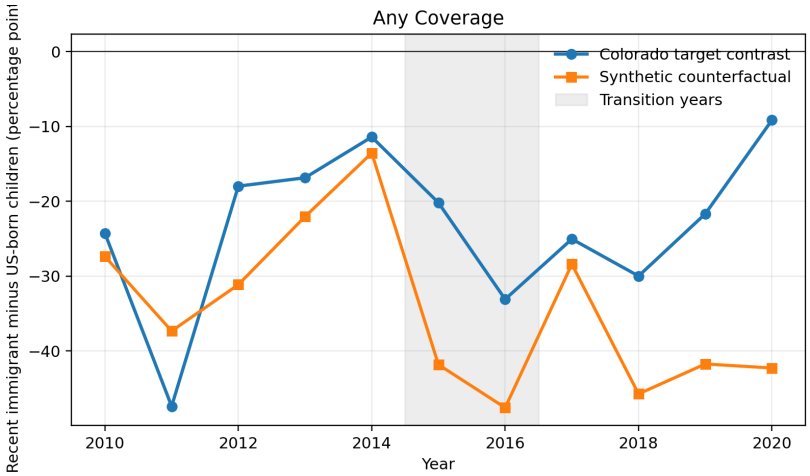

Figure 1: Any coverage target and synthetic paths. The y-axis is the recent-immigrant-minus-US-born child coverage contrast in percentage points. The shaded region marks the 2015-2016 transition period

Note: This figure compares estimates across groups or specifications for the any coverage paths. It is intended to make effect heterogeneity and subgroup precision easier to assess.

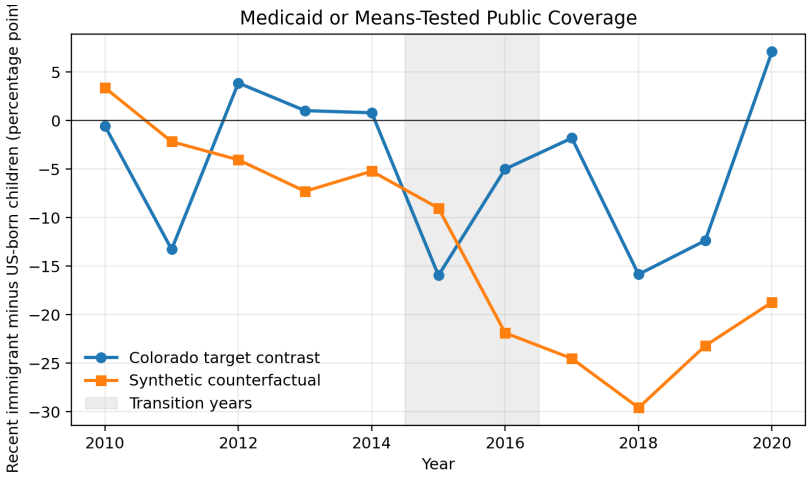

Figure 2: Medicaid or means-tested public coverage target and synthetic paths. The y-axis is the recent-immigrant-minus-US-born child coverage contrast in percentage points. The shaded region marks the 2015-2016 transition period

Note: This figure compares estimates across groups or specifications for the medicaid paths. It is intended to make effect heterogeneity and subgroup precision easier to assess.