Restoring Medicaid Eligibility for COFA Migrants: Early Evidence from ACS Coverage Data

Abstract

The Consolidated Appropriations Act, 2021 restored Medicaid eligibility for migrants from the Republic of the Marshall Islands, the Federated States of Micronesia, and Palau who live in the United States under the Compacts of Free Association. This short research report asks whether that federal eligibility restoration is visible in public American Community Survey coverage data. I use IPUMS USA ACS microdata from 2014-2024 to identify COFA noncitizen migrants by birthplace and compare their coverage changes after 2021 with low-income non-COFA Asian and Pacific Islander noncitizen adults. In a national low-income difference-in-differences model, Medicaid or means-tested public coverage among COFA migrants increases by 8.8 percentage points relative to the comparison group. A stricter triple-difference model that contrasts low-income and higher-income adults is smaller and statistically indistinguishable from zero. Arkansas, home to a large Marshallese community and a visible 2021 state implementation process, is substantively important but underpowered in ACS: year-specific COFA cells are small and synthetic-control diagnostics have poor pre-treatment fit. The results support a cautious interpretation: public ACS data provide suggestive national evidence of coverage gains after COFA Medicaid restoration, but Arkansas-specific causal evaluation requires administrative enrollment data or pooled survey designs.

Background

Citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau may live and work in the United States under the Compacts of Free Association. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act excluded many COFA migrants from the federal Medicaid eligibility category of "qualified non-citizens," leaving many people dependent on emergency Medicaid or patchwork state coverage. The Consolidated Appropriations Act, 2021 reversed that exclusion. CMS guidance states that, effective December 27, 2020, states and D.C. were required to provide full Medicaid benefits to otherwise eligible COFA migrants and that COFA migrants were exempt from the usual five-year waiting period.

Arkansas is a natural focal case. Northwest Arkansas has one of the largest Marshallese communities in the continental United States, and state implementation was visible. The Arkansas Coalition of Marshallese reported that on February 23, 2021, the Arkansas Legislative Council approved a rule change clarifying Medicaid eligibility for COFA adults who met other eligibility requirements. The organization described the change as affecting more than 12,000 Arkansans. The policy was federal, however, not Arkansas-only. The

empirical problem is therefore to separate a federal COFA eligibility restoration from contemporaneous coverage shocks, including the pandemic-era Medicaid continuous-enrollment period.

This report treats the ACS as a first public-data screen. The question is not whether the ACS can adjudicate legal eligibility perfectly. It cannot observe Freely Associated State citizenship directly. Instead, it asks whether ACS-observable COFA migrant and COFA-origin groups show coverage changes consistent with the Medicaid restoration.

Data

I use the IPUMS USA ACS extract staged as `usa_00012`, covering 53,626,881 person records. The Phase 3 builder restricts to adults ages 19-64 in 2014-2024, household residents, and either:

- COFA noncitizen migrants, identified by COFA birthplace codes and `CITIZEN == 3`; or
- non-COFA Asian/Pacific Islander noncitizen comparison adults.

The builder retains 382,164 analysis records and collapses them to 2,194 state-year/group cells. The main coverage outcomes are uninsurance, any coverage, Medicaid or means-tested public coverage, any public coverage, private coverage, employer coverage, direct-purchase coverage, and negative-control coverage types.

The codebook check matters. The staged IPUMS extract uses `BPLD` 71041 for Marshall Islands, 71042-71046 for Micronesia and FSM states, and 71048 for Palau. Northern Mariana Islands is `BPLD` 71047 and is excluded because CNMI is a U.S. territory, not a COFA state. Detailed race and ancestry codes are used as broader COFA-origin sensitivity flags, not as the primary legal-status measure.

Empirical Approach

The main national comparison is a low-income difference-in-differences design:

```
Y = alpha + beta(COFA migrant x post-2021) + year FE + state FE + error
```

The treatment group is low-income COFA noncitizen migrant adults, ages 19-64, with income between 1 and 138 percent of the federal poverty level. The control group is low-income non-COFA Asian/Pacific Islander noncitizen adults in the same age range. The pre-period is 2014-2019. The post-period is 2021-2023. I omit 2020 because of pandemic-era ACS quality issues and treat 2024 as a sensitivity year because the Compact Impact Fairness Act changed eligibility for other federal public benefits and the Medicaid unwinding was still nearby.

I also estimate a stricter national triple-difference specification that compares

the COFA/non-COFA post-2021 change among low-income adults with the corresponding change among higher-income adults:

```
Y = alpha + beta(COFA migrant x post-2021 x low-income) + year FE + state FE + error
```

Finally, I run two Arkansas diagnostics:

1. An Arkansas-only triple-difference model; and
2. A synthetic-control-style check that treats low-income Arkansas COFA noncitizen migrants as the treated unit and constructs a donor path from low-income non-COFA Asian/Pacific Islander noncitizen cells, excluding Hawaii, Oregon, Washington, and California because of likely COFA or adult immigrant-coverage policy contamination.

The Arkansas analyses are diagnostic rather than dispositive because ACS cell sizes are small.

Results

Cell Support

The national ACS screen has enough support for pooled analysis, but Arkansas is thin year by year. Arkansas COFA noncitizen-migrant cells clear the `n >= 25` reporting threshold in only 4 of 11 state-years. Broader Arkansas COFA-origin cells clear that threshold in 7 of 11 state-years. Low-income Arkansas COFA migrant cells are smaller still. This is the first major finding: ACS can support a national screen, but Arkansas-specific ACS inference is fragile unless years are pooled or administrative data are obtained.

National Difference-in-Differences

The national low-income DiD produces the most encouraging signal. Medicaid or means-tested public coverage rises by 8.8 percentage points among low-income COFA noncitizen migrants relative to low-income non-COFA Asian/Pacific Islander noncitizens after 2021 (SE 3.9 percentage points, $p = 0.026$). The uninsurance coefficient is -3.4 percentage points (SE 3.7, $p = 0.354$), and the any-coverage coefficient is +3.4 percentage points (SE 3.7, $p = 0.354$).

In plain language: the outcome most directly tied to the policy, Medicaid/public coverage, moves in the expected direction in the national low-income comparison. The broader any-coverage and uninsurance outcomes move in the expected direction but are not precise.

National Triple Difference

The stricter national DDD weakens the conclusion. The Medicaid/public coverage coefficient is -2.5 percentage points (SE 7.6, $p = 0.744$). The uninsurance coefficient is -6.5 percentage points (SE 6.7, $p = 0.335$), and the any-coverage

coefficient is +6.5 percentage points (SE 6.7, p = 0.335). These estimates are too noisy to support a strong causal claim.

The divergence between the low-income DiD and the stricter DDD is important. It may reflect the limited size and instability of the higher-income COFA comparison cells, real composition changes, or residual confounding in the simpler low-income DiD. It means the public-data conclusion should be framed as suggestive rather than definitive.

Arkansas Diagnostics

Arkansas is not strong enough in ACS for a clean standalone causal report. In the Arkansas-only DDD, the uninsurance coefficient is -21.9 percentage points (SE 20.8, p = 0.291), any coverage is +21.9 percentage points (SE 20.8, p = 0.291), and Medicaid/public coverage is -4.6 percentage points (SE 9.4, p = 0.623). These are large but very imprecise and unstable.

The Arkansas synthetic-control check also warns against overinterpretation. Pretreatment fit is poor for uninsurance and any coverage, with pre-period RMSPE around 0.327. Mean post-treatment gaps imply worse Arkansas COFA coverage relative to the synthetic comparison, but those gaps are not credible as causal estimates because the pre-period fit is already poor. The Medicaid synthetic check has better pre-fit, with RMSPE around 0.040, but the post gaps are mixed across 2021-2023.

Interpretation

The public ACS evidence is publishable only with a narrow, honest framing. The strongest claim is not that Arkansas provides clean causal proof. It does not. The stronger and more defensible contribution is that a national ACS screen detects a policy-consistent increase in Medicaid coverage among low-income COFA noncitizen migrants after the federal restoration, while also showing the limits of public survey data for evaluating small, legally distinctive migrant populations.

That framing has three useful contributions:

1. It documents a major but understudied federal immigrant-eligibility restoration.
2. It shows that ACS birthplace and detailed race/ancestry fields can partially recover COFA populations for coverage monitoring.
3. It establishes that Arkansas, despite its policy importance, likely requires administrative COFA enrollment data, pooled ACS windows, or community-linked data for credible state-specific inference.

This is therefore best positioned as a short research report, research note, or data-and-policy brief. A full-length causal article would need either state Medicaid administrative enrollment counts by COFA status or a stronger pooled design using multiple years and broader COFA-origin definitions.

Limitations

First, ACS cannot directly observe Freely Associated State citizenship or legal Medicaid eligibility. Birthplace is the closest public proxy for COFA migrant status, while detailed race and ancestry codes capture broader COFA-origin communities that may include U.S.-born people not legally affected by the restoration.

Second, the policy occurred during the COVID-19 continuous-enrollment period. Non-COFA comparison groups help absorb common Medicaid enrollment shocks, but the estimate should still be interpreted as the effect of restoration as implemented during an unusual pandemic-era coverage regime.

Third, small cells are a first-order problem. This is especially true in Arkansas low-income COFA cells, which are substantively central but statistically thin.

Fourth, 2024 is complicated by both the Medicaid unwinding and the Compact Impact Fairness Act, which expanded COFA eligibility for other federal public benefits. For that reason, 2024 should be treated as a sensitivity year rather than the core post-period.

Conclusion

The 2021 COFA Medicaid restoration appears to leave a measurable trace in national ACS coverage data, especially in Medicaid/public coverage among low-income COFA noncitizen migrants. The evidence is not strong enough to make a clean Arkansas-only causal claim, and the stricter triple-difference specification does not confirm the simpler low-income DiD. The most credible short-report conclusion is therefore cautious but useful: public ACS data suggest coverage gains after COFA Medicaid restoration and reveal where public survey data stop being enough. For Arkansas, the next decisive step is COFA-specific administrative Medicaid enrollment data.

Source Notes

- CMS SHO 21-005, October 18, 2021: CAA section 208 enacted December 27, 2020; states and D.C. required to provide full Medicaid benefits to otherwise eligible COFA migrants; Federal Data Services Hub logic updated June 13, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21005.pdf
- Arkansas Coalition of Marshallese, February 25, 2021: Arkansas Legislative Council rule change on February 23, 2021; described as clarifying Medicaid eligibility for COFA adults and affecting more than 12,000 Arkansans. https://www.arkansasmarshallese.org/updates/2021/2/25/arkansas-pacific-islander-community-leaders-advance-new-law-that-expanded-health-care-eligibility-for-more-than-12000-arkansans
- U.S. Department of the Interior COFA overview. https://www.doi.gov/oia/COFAinUS

- USDA FNS July 12, 2024 memo on Compact Impact Fairness Act / COFA public benefits eligibility. https://www.usda.gov/sites/default/files/guidance-documents/FNS.consolidated-appropriations-act-cofa-memo.pdf