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New Yorkers For Accessible Health Coverage

Analysis of New York State Coverage Expansion Proposals: Potential Impact on Immigrants

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INTRODUCTION

As New York State explores proposals to insure more New Yorkers, improve the quality of health care, and reduce health disparities, understanding the unique barriers immigrants face gaining access to coverage will be paramount for any proposal's success. This issue brief examines the extent to which various coverage proposals address immigrant concerns.

Background

New York State's Immigrant Population

More than one-fifth (4.2 million) of New York State's population is comprised of immigrants.¹ More than half of these immigrants are naturalized citizens. The remaining two million immigrant New Yorkers are non-citizens, including 1.4 million legally residing immigrants (i.e., legal permanent residents or green card holders, refugees, and asylees), and about 650,000 undocumented immigrants (e.g., individuals who crossed the border without government permission, individuals who overstayed their temporary visas, and persons with temporary permission to reside here while their case is resolved).²

Immigrant Insurance Coverage in New York State

Non-citizen New Yorkers are about three times more likely than citizens to be uninsured (35 percent versus 12 percent, respectively).³ Although non-citizens comprise one-tenth of New York State's population, they comprise more than a quarter (28 percent) of the State's uninsured under the age of 65.⁴

Lack of insurance and other barriers make immigrants less likely than U.S.-born citizens to have a usual source of care, to have visited a health professional in the past year, or to receive primary and preventive care.⁵ While immigrants are less likely to be disabled than U.S.-born citizens, they have health needs which include increasing rates of chronic disease and disability among the elderly, workplace injuries among the younger, working population, and mental health needs deriving from homeland traumas and adjustment difficulties.⁶

Why Immigrants Lack Health Coverage

There are several important factors that contribute to immigrants' lower rates of health insurance:

- ▶ **Economic barriers.** A disproportionate number of immigrants work in jobs where employers are less likely to offer coverage. Although immigrants in New York work in all sectors and occupations,⁷ they

1. 2006 American Community Survey, Migration Policy Institute, <http://www.migrationinformation.org/datahub/acscensus.cfm#>, last visited November 1, 2008. The term "immigrant" is used throughout this report to refer to people who were born in another country, regardless of their legal status or whether they have become citizens.

2. *ibid.*

3. Cook, A., Williams, A., and Holahan, D., "Health Insurance Coverage in New York, 2005–2006," United Hospital Fund, May 2008. Figures are from the 2006 and 2007 March supplements to the Current Population Survey. Statistics on uninsurance rates differentiate only between citizens (which include both U.S.-born and naturalized citizens) and non-citizens, rather than between U.S.-born citizens and immigrants. Relevant categories of non-citizen immigrants are set forth in Appendix II to this issue brief.

4. *ibid.*

5. "Five Basic Facts on Immigrants and their Health Care," Kaiser Family Foundation, March, 2008.

6. Dubard, C., and Massing, M., "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association*, 2007: 297(10): 1085–1092; American Psychological Association, "The Mental Health Needs of Immigrants," Public Policy Statement, 2008, <http://www.apa.org/ppo/ethnic/immigranthealth.html>, last visited January 8, 2009.

7. Dyssegaard Kallick, D. "Working for a Better Life: A Profile of Immigrants in the New York State Economy," Fiscal Policy Institute, November 2007.

disproportionately work in low-wage jobs, for small firms, and in occupations and industries in which offers of insurance are less common (e.g. agriculture, service, construction, labor).⁸

- **Legal restrictions.** The Federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or PRWORA) placed new restrictions on Permanently Residing Under Color of Law (PRUCOL)⁹ immigrants' and legal permanent residents' eligibility for Medicaid and State Child Health Insurance Programs, creating categories of Qualified Aliens eligible for such coverage and Non-Qualified Aliens who are not. New York extended benefits to PRUCOL immigrants with State-only funding as a result of a 2001 court decision.¹⁰ But this decision did not address the rights of unauthorized immigrants and temporary visa holders, who are treated as eligible only for coverage of emergency services under Medicaid. In effect, PRWORA has stigmatized the use of public insurance programs among immigrants and deterred enrollment by creating confusion about eligibility.¹¹

Federal law also restricts the eligibility of immigrants for Medicare. Immigrants who are eligible for Social Security Disability or Retirement benefits because they have a sufficient work history are also eligible for Medicare as long as they are lawfully residing in the U.S. Lawfully residing immigrants include lawful permanent residents (LPRs), refugees, asylees, and, generally, anyone who has been admitted to the U.S. and has not violated the terms of admission. Lawful permanent residents who do not have a sufficient work history to be covered under Social Security are only able to purchase coverage, however, if they have continuously resided in the U.S. for five years. A significant number of older immigrants in New York lack Medicare coverage.¹²

- **Perceived and potential immigration consequences.** There are three such consequences that concern immigrants:

- *Public Charge.* A public charge is someone found by immigration officials or the courts to be, or likely to become, primarily dependent on the government for subsistence. Public charges are inadmissible to the United States. Many immigrants fear that enrollment in public health coverage programs will classify them as a public charge and preclude them from obtaining LPR status, acquiring a visa to travel to the U.S., or naturalizing. The Federal government has clarified that the use of non-cash benefits, such as Medicaid, does not render an individual a public charge,¹³ but reluctance to enroll because of this concern is widespread.¹⁴

8. Alker, J. and Ng'andu, J. "The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer," The Kaiser Commission on Medicaid and the Uninsured, June 2006;

Ku, L. "Why Immigrants Lack Adequate Access to Health Care and Health Insurance," Migration Policy Institute, September 2006; Capps, R., Kenney, G., Fix, M. "Health Insurance Coverage of Children in Mixed-Status Immigrants Families." *Snapshots of America's Families*, 3:12, 2003.

9. **PRUCOL (Permanently Residing Under Color Of Law):** PRUCOL immigrants, living in the U.S. with the knowledge and permission or acquiescence of U.S. Citizenship and Immigration Services (USCIS) and whose departure the USCIS does not contemplate enforcing. It is a term that is used only for public benefits eligibility and is not a formal immigration status recognized by the USCIS. It encompasses a number of different statuses and circumstances recognized by USCIS, defined more precisely in Appendix II to this issue brief, including: immigrants with pending green card or asylum applications; persons with Temporary Protected Status; and persons granted stays of deportation.

10. *Aliessa v. Novello*, 96 NY2d 418 (2001).

11. Maloy, K, "Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Services," The George Washington University Medical Center School of Public Health (2000).

12. Gray, B., Scheinmann, R., Rosenfeld, P., and Finkelstein, R., "Aging Without Medicare: Evidence from New York City," *Inquiry* 43:211–221 (Fall 2006). See also <http://www.nycmccap.org/guide/chap12b.html>.

13. For the guidance, see <http://www.uscis.gov/files/article/Public.pdf>.

14. Lessard, G., Ku, L. "Gaps in Coverage for Children in Immigrant Families," *The Future of Children*. Vol. 13, Num. 1, Spring 2003,101–115; (*footnote continued on page 5*)

- *Sponsor Concerns.* Many New Yorkers have signed affidavits of support to sponsor their family members for legal permanent residency. The affidavit used since December 1997 is an enforceable agreement purporting to hold the sponsor financially responsible for any means-tested benefit that the sponsored immigrant uses, including Medicaid and the State Children’s Health Insurance Program. The vast majority of states have refrained from suing sponsors for repayment of medical assistance benefits, and no such attempt has ever been made in New York. In fact, the New York State Department of Health has stated that sponsor liability will not be enforced until federal regulations, which have never been issued, are in force. Nonetheless, this risk to the sponsor’s financial well-being causes understandable reluctance on the part of a sponsored immigrant to enroll in coverage.¹⁵ There is also a common misconception that an individual who has enrolled in public health insurance will not be eligible to sponsor a family member.¹⁶
 - *Concerns about Reporting of Immigration Status.* Medicaid workers are not required to report individuals whom they suspect or believe to be undocumented to Federal immigration authorities. However, many immigrants have substantial concerns that any interaction with any government agency could lead to them or a family member being reported to the U.S. Immigration and Customs Enforcement, and possibly deported.¹⁷
- **Cultural and linguistic barriers.** Immigrants’ lack of familiarity with the U.S. health care system diminishes their ability to fully participate in this system. They may lack understanding of how private insurance works and why it should be purchased, either because their country of origin had only a rudimentary health insurance system or because it had a universal, government-run system. In addition, despite numerous legal protections guaranteeing meaningful access to government-funded services for limited-English proficient (LEP) individuals, immigrants cite language barriers as the single biggest obstacle to accessing coverage and health care.¹⁸ In New York State, language barriers affect 2.3 million LEP individuals, including one-quarter of New York City’s residents.¹⁹ Moreover, LEP individuals account for 42 percent of New Yorkers below the poverty level, who are among the individuals most likely to meet income eligibility requirements for public insurance.²⁰

(footnote #14 continued from page 4)

Hill, I., Dubay, L., Kenney, G., Howell, E., Courtot, B., Palmer, L. “Improving Coverage and Access for Immigrant Latino Children: The Los Angeles Healthy Kids Program,” *Health Affairs*. Vol. 27, Num 2. March/April 2008. 550–559;

Flores, G., Abreu, M., Chaisson, C., Meyers, A., Sachdeva, R., Fernandez, H., Francisco, P., Diaz, B., Diaz, A., Santo-Guerrero, I. “A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children,” *American Academy of Pediatrics*. 2005. 1433–1441;

Pitkin, K., Escarce, J., Lurie, N. “Immigrants and Health Care: Sources of Vulnerability,” *Health Affairs*, 2007, 26:5. 1258–1268.

15. See footnote 11.

16. NYIC Focus group, Staten Island, NY, December 9, 2008; NYIC Focus group, Flushing, NY December 18, 2008.

17. Flores, G., Abreu, M., Chaisson, C., Meyers, A., Sachdeva, R., Fernandez, H. Francisco, P., Diaz, B., Diaz, A., Santo-Guerrero, I. “A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children,” *American Academy of Pediatrics*. 2005. 1433–1441;

Berk, M., Schur, C., Chavez, L., Frankel, M. “Health Care Use Among Undocumented Latino Immigrants,” *Health Affairs*, Vol 19, Num 4. July/August 2000, 51–64.

18. NYIC Immigrant Health Access and Advocacy Collaborative Reports. 2002–2008; Lessard, G., Ku., L. “Gaps in Coverage for Children in Immigrant Families,” *The Future of Children*. Vol. 13, Num. 1 Spring 2003, 101–115;

Flores, G., Abreu, M., Olivar, M., Kastner, B. “Access Barriers to Health Care for Latino Children,” *Arch Pediatr Adolesc Med.*, Vol. 152, Nov 1998. 1119–1124;

Perry, M., Kannel, S., Valdez, R., Chang, C. “Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey,” The Kaiser Commission on Medicaid and the Uninsured, January 2000.

19. 2000 U.S. Census Bureau.

20. *ibid.*

ANALYSIS

We reviewed six major health insurance expansion proposals submitted by stakeholders and public policy experts to the New York State Partnership for Coverage hearings in the fall of 2007.²¹ We also reviewed three additional proposals being modeled by the Urban Institute for the State²² under an appropriation in the 2007–2008 New York State budget (See Table 1).

Table 1: New York State Health Care Reform Proposals Reviewed

Proposal Name	Presented at Partnership for Coverage Hearings	Modeled by Urban Institute
Community Service Society's "Cornerstone for Coverage"	■	
United Hospital Fund's "Blueprint for Coverage"	■	
Assemblyman Richard Gottfried's "New York Health Plus"	■	■
Empire/Excelsus Blue Cross Plans	■	
Manhattan Institute for Public Policy's "Rx New York"	■	
United Health Group	■	
Single Payer "Medicare for All"		■
Combined Public-Private Reform		■
The Freedom Plan		■

The Combined Public-Private Reform being modeled by the Urban Institute broadly conforms to the United Hospital Fund's Blueprint for Coverage, and the Freedom Plan incorporates many features advocated by the Manhattan Institute's Rx NY proposal.

We analyzed these plans with respect to three issues:

1. whether the proposal explicitly mentions immigrant coverage as an issue requiring a strategy;
2. whether there are features of the plan that could increase immigrant coverage; and
3. whether there are features that could adversely affect immigrant coverage.

21. See "Interim Report to Governor David A. Paterson," May 28, 2008, http://partnership4coverage.ny.gov/reports/interim_report_2008-05-28.h, last viewed January 8, 2009

22. The proposals are described in Partnership for Coverage, "Modeling of Options for Expansion of Health Insurance Coverage for New Yorkers," June 30, 2008, http://partnership4coverage.ny.gov/reports/modeling_instructions_2008-06-30.htm, last viewed January 8, 2009.

Findings

The details of the analysis appear in Appendix I appended to this issue brief. The key findings include:

- a. Several plans, including the Community Service Society's Cornerstone for Coverage, Assembly Member Gottfried's New York Health Plus, and all the other plans being modeled by the Urban Institute, envision extending coverage to all residents of the State, implicitly including immigrants. Only the Cornerstone for Coverage explicitly addresses changing eligibility rules to open enrollment to certain immigrants in public programs from which they are now barred.
- b. Only one plan, the Manhattan Institute's Rx NY, addresses barriers to immigrant enrollment other than eligibility rules and proposes a particular strategy to address those barriers. This strategy—outreach to educate immigrants about their ability to buy coverage—is quite minimally defined, however.
- c. Most of the proposals rely on voluntary enrollment to expand the number of New Yorkers with health insurance coverage. One plan, the United Hospital Fund Blueprint for Coverage, envisions a potential mandate that individuals buy their own coverage if they do not obtain it through an employer. The most likely vehicle for implementation of a mandate is through the income tax system, but the Blueprint does not address whether or how such an enforcement strategy would work to expand coverage among undocumented immigrants and others likely to work in the informal economy.
- d. None of the proposals that rely on expansions of public coverage addresses the concern among immigrants about being considered a public charge by virtue of using subsidized public coverage.
- e. None of the proposals that rely on expansions of public coverage addresses the fear of immigrants and their sponsors that sponsor liability provisions in state and federal law will be used to seek reimbursement from sponsors for the value of public program benefits used by the sponsored immigrants.
- f. None of the proposals that rely on expansions of public coverage addresses the concern of undocumented immigrants that they may be discovered and reported to immigration authorities by virtue of being officially enrolled in any public program at all.
- g. None of the proposals addresses how they will overcome the linguistic barriers faced by 2.3 million New Yorkers to enrolling in and navigating the coverage system. Only one proposal, New York Health Plus, recognizes reduction of language barriers as an important goal.
- h. Proposals that rely less on public coverage and more on private coverage as the vehicle for expanded coverage are more likely to avoid immigrant concerns about their most common enrollment barriers like public charge and sponsor liability, so long as the private coverage is clearly distinguished from public programs and its exemption from common immigration-related concerns are clearly articulated and made known to immigrant New Yorkers.
- i. None of the proposals seems likely to have any net negative effect on rates of immigrant insurance coverage. As currently articulated, however, the proposals are also not likely to bring immigrant enrollment to the same level as enrollment of native born New Yorkers, since none proposes measures to allay immigrant-specific fears, only one addresses language barriers, and only one proposes any type of immigrant outreach strategy.

CONCLUSION

Immigrants face many of the same barriers to health coverage as their fellow New Yorkers. Many lack insurance because they cannot afford it or work in jobs where their employers do not offer it. But immigrants' access to coverage is also diminished by barriers particular to them, including restrictive eligibility rules in public programs, potential jeopardy to their immigration status from being deemed public charges, fears of claims against their sponsors if they use public benefits, fears of immigration status disclosures, and cultural and linguistic barriers.

Virtually all the proposals currently put forth for expanding health coverage in New York State could have beneficial effects on immigrant coverage. To the extent these proposals leave a residual population without coverage, however, it is likely that a disproportionate share of those uninsured will be immigrants. Few plans address the over-65 population where Medicare coverage gaps for immigrants are becoming a significant public health concern.

Only one health reform plan put forward in New York State thus far suggests explicit changes to the eligibility rules that bar immigrants in public programs. Only one plan suggests even a minimal strategy to address the cultural barriers to enrollment. No plan includes the strategies – including clarification of and education regarding statutes that may be interpreted to equate use of public health benefits with public dependency and similar measures – that must be employed to address the deleterious effects of the public charge and sponsor liability aspects of immigration and public benefits laws. Nor does any plan include strategies to promote confidentiality, which may be necessary to overcome immigrant fears of enrollment.

If New York is to achieve universal or near universal coverage, substantially increased health insurance coverage rates among immigrants will be key. Immigrants comprise such a large percentage of New York's uninsured, with such a distinct set of barriers, that they are a group of New Yorkers for whom particular measures are warranted. Cultural barriers are often cited as a primary reason that immigrants are uninsured; it is assumed that there is something about our system that immigrants just do not understand. This review of coverage proposals in which immigrant enrollment strategies generally are addressed parenthetically, if at all, suggests that there is another cultural barrier at work—that there are special aspects of the challenges faced by immigrants which policymakers just do not understand either.

APPENDIX I: COVERAGE EXPANSION PROPOSALS: IMPACT ON IMMIGRANTS

Community Service Society Cornerstone for Coverage

Cornerstone for Coverage would expand coverage by making public health insurance universally available to all New York residents, aged 19 to 64. The public coverage platform would be the Family Health Plus/Child Health Plus programs. Premiums would be subsidized for individuals up to 500 percent of the poverty level, and calibrated so that they would never exceed 6 percent of income.

Does the proposal specifically address the coverage of immigrants?

Yes. This is the only proposal which explicitly provides that all immigrants, regardless of immigration status, would be entitled to coverage under its provisions.

How could the proposal enhance immigrant coverage?

By making Family Health Plus and Child Health Plus coverage available to all New York residents between 19 and 64, "regardless of immigration status," at a sliding scale premium determined according to a formula to establish affordability, the Cornerstone proposal seems likely to substantially expand immigrant enrollment. It would change the current rules which restrict Family Health Plus and Medicaid to adults who are lawful immigrants (including PRUCOL) so that even undocumented immigrants could enroll.

The proposal to charge premiums may give this proposal a particular advantage over Assembly Member Gottfried's New York Health Plus proposal in enrolling immigrants. Both the general public and immigrants themselves may perceive such a program as more akin to traditional insurance than to a public program. The general public may therefore object less to inclusion of immigrants, who will not be perceived as benefiting unduly from taxpayer expenditures, while the immigrants themselves may find participation less stigmatizing and less likely to implicate public charge or sponsor liability concerns.

How could the proposal hurt immigrant coverage?

The proposal would be unlikely to hurt immigrant coverage in any respect. However, there are reasons it could lead to sub-optimal levels of enrollment.

Because enrollment is voluntary and the coverage would be provided through publicly subsidized health plans, immigrants might avoid enrolling, as they do in currently available plans, unless other steps are taken to assure that their receipt of benefits would not render them public charges or lead to sponsor liability. Additionally, to fully reach all immigrants, the proposal would have to adjust the existing eligibility rules for Family Health Plus, and Child Health Plus not only to eliminate income barriers as the Cornerstone contemplates, but also to cover people over 65, so as to include the significant number of immigrant elders who lack the work credits or residence history to qualify for Medicare.

United Hospital Fund Blueprint for Coverage

Blueprint for Coverage assesses whether universal coverage could be achieved by a mix of public and private coverage expansions, building on existing programs. It suggests that universality could be achieved by simplification of enrollment rules for existing public programs; raising the income level for enrollment in Family Health Plus and providing a limited buy-in opportunity for individuals up to 300 percent of poverty; imposing

an assessment on employers who do not provide health coverage to employees; establishing an insurance exchange through which individuals could purchase coverage; and imposing a mandate on individuals that they buy insurance if their employers do not provide it for them.

Does the proposal specifically address the coverage of immigrants?

Yes. It notes that immigration concerns deter some people from public coverage. It leaves for future resolution, however, “clarification of how immigration status may affect individual participation in reform efforts.” It does not propose any specific changes to eligibility for public or private programs which are restricted based on immigration status.

How could the proposal enhance immigrant coverage?

By projecting an increase of enrollment to 98 percent of the population at full roll out, the plan of necessity would increase immigrant enrollment dramatically. Uninsured immigrants comprised 893,000 of the State’s 16.5 million nonelderly residents in 2005–2006, or 5.4 percent of the nonelderly population (UHF, Health Insurance Coverage in New York, 2005–2006, pages 47–48). More than half the currently uninsured immigrants would presumably have to be covered if the overall 98 percent coverage rate were achieved.

The proposal’s rule changes would not, however, directly address immigration status. The Blueprint would enhance coverage in public programs through administrative rule changes that change income eligibility levels, simplify enrollment and avoid administrative churning. It does not, however, propose any immigration-related rule changes:

- ▶ It does not propose to explicitly eliminate sponsor deeming or sponsor liability statutes to remove public health insurance from the array of programs to which those concepts apply.
- ▶ It does not propose to create eligibility for Medicaid and other public insurance programs with State only financing for undocumented immigrants similar to that extended under the Aliessa case to PRUCOL and other federally non-qualified immigrants.
- ▶ Finally, it does not change any programs for people over 65, chiefly immigrants, with insufficient work history to qualify for Medicare.

One way in which the Blueprint can be seen as specifically affecting immigrants is in its proposal for individual insurance mandates. By creating an affirmative legal mandate for participation, it may provide a countervailing force to the disincentives and fears immigrants have about enrolling in coverage, assuming that they are sufficiently educated about the health coverage system to distinguish between public and private coverage and therefore to overcome their reservations about enrollment tied to concerns about public charge or sponsor liability. UHF points out, however, that the individual mandate would most effectively be enforced through the tax system, and it estimates that 370,000 non-tax filers would be excluded from the system. It may safely be assumed that immigrants, particularly undocumented immigrants in the informal economy, make up a significant portion of this group.

How could the proposal hurt immigrant coverage?

Nothing in this proposal would be likely to diminish the current extent of immigrant coverage.

New York Health Plus

New York Health Plus would permit all New Yorkers, regardless of income, to enroll either in a Family Health Plus or Child Health Plus managed care plan, or in a state run indemnity plan modeled on Medicare. It would require no premium payments, but would instead be financed through the tax system. Employers could continue to offer group coverage to their employees and to receive some sort of tax subsidy for doing so.

Does the proposal specifically address the coverage of immigrants?

No, but it implicitly encompasses immigrants by defining the scope of its proposal as encompassing “every New York resident,” and noting that New York currently covers federally non-qualified immigrants in its public programs, providing a precedent for covering more of them. It characterizes the adjustment of accounts with the federal government, distinguishing between those who are federally qualified, and hence eligible for federal matching funds, and those who are not, as a “bookkeeping” challenge.

How could the proposal enhance immigrant coverage?

By basing eligibility for free coverage on residence alone, the plan would automatically provide coverage for most immigrant residents, but the extent of its success at covering immigrants would depend upon the rules adopted as to how residence is proven, and on whether the definition of residence is extended to some current categories of nonimmigrant aliens (residing here temporarily, for example, on special work visas) and those lacking a documentable connection to the State.

Further, although the proposal does not specifically identify immigrants when it enumerates those suffering from disparities in access to coverage and care, it does include those with language barriers. By seeking to address disparities in access to health resources (by providing central planning to ensure that such resources are available in underserved areas) and by seeking to reduce language access barriers, the plan would undoubtedly increase immigrant access.

To fully reach all immigrants (including those over 65 with inadequate work credits to qualify for Medicare), the proposal would have to adjust the existing eligibility rules for Family Health Plus and Child Health Plus not only to eliminate income barriers, as it contemplates, but also to cover people over 65.

How could the proposal hurt immigrant coverage?

If New York Health Plus were implemented precisely as set forth in the proposal, none of its features would hurt immigrant coverage. As a system financed through the tax system, however, certain political challenges must be confronted. The proposal is explicit about the political challenges of expanding coverage, and the need to convince the public that they will ultimately save money by eliminating insurance premiums and copayments to finance care largely through taxes. The proposal does not deal with the potentially explosive political question of a tax-based financing system which would cover all residents without regard to their immigration status or whether they participate in the tax system. The political dynamic which led New York to abandon its proposed rules extending issuance of drivers’ licenses to undocumented immigrants might again be confronted.

At the same time, as with other proposals which rely on expansion of publicly-funded coverage, steps to mitigate concerns among immigrants about public charge or sponsor liability would have to be taken in order to achieve near universality.

Empire / Excellus Blue Cross

The Empire/Excellus Blue Cross plan would expand coverage in the private market sector by making coverage more affordable. It would accomplish this in the individual market by merging it with the small group market. It would accomplish this in the small group market by expanding the State-run reinsurance system (the stop loss pool) for high cost claims to include claims in the small group market, requiring several hundred million dollars in additional funding. It would also increase medical loss ratios and reduce State surcharges on individual coverage, while allowing individuals to purchase a broader range of products than the single standardized benefit package they are currently permitted to buy. Existing government programs would remain in place.

Does the proposal specifically address the coverage of immigrants?

No. It should be noted however, that this proposal purports only to make improvements to certain market segments and to increase coverage, not to present a solution for universal coverage.

How could the proposal enhance immigrant coverage?

The proposal would preserve the current government and employer-based coverage, but would expand coverage chiefly by merging the small group and individual markets, making individual coverage cheaper, and providing reinsurance subsidies, currently only used in the individual and Healthy New York markets, to the small group market.

The individual market allows enrollment based on proof of residence, not citizenship or immigration status, and would offer an easy route to coverage for those immigrants able to afford it.

Enhancing small group coverage is a less certain way to boost immigrant coverage. On one hand, some immigrant communities are significantly economically dependent on small businesses, so strengthening the availability of small group coverage could expand immigrant coverage. However, many immigrant businesses, and particularly many undocumented immigrants, rely on informal employment relationships. Small group coverage as currently constituted requires formal employment relationships, including tax reporting of the covered employees on the employer's quarterly NYS-45 tax form. Any system which emphasizes employer group coverage as the basis for expansion risks leaving out the informal employment economy with its large number of immigrant employees.

How could the proposal hurt immigrant coverage?

Nothing in this proposal would be likely to diminish the current extent of immigrant coverage. Although the proposal does not advocate this step, it does point to a potential risk to immigrant access to care if the financing of any coverage expansion relies on re-direction of charity care funds that support safety net programs for the uninsured upon which many immigrants rely.

In addition, to the extent that the proposal relies upon more variation in insurance products for the individual and small group markets, including enhanced opportunity to buy Healthy New York or high deductible insurance products, it could have the effect of lessening the quality of coverage and leaving more immigrants who currently have coverage underinsured.

While the proposal assumes small group premiums would be reduced through enhanced reinsurance, both the proponents' analyses and independent analysis by United Hospital Fund have predicted that a market merger alone, without supplemental funding, could increase premiums for small groups. While the extent of the effect

is a matter of debate, it is possible that enactment of market merger without additional subsidy could, while reducing cost in the individual market, increase costs in the small group market, eroding coverage there for immigrants and non-immigrants alike.

Manhattan Institute’s Rx New York

Rx New York would expand coverage through the private insurance market rather than public programs. It would promote private coverage through reducing regulation, including community rating and guaranteed issue rules, and by reducing coverage mandates. It would authorize new products, such as short term insurance and products aimed at young adults, and would promote “consumer directed” (high deductible) health plans to reduce premiums. Rx New York would expand the menu of options which small businesses could offer. Finally, it would encourage development of insurance products targeted to immigrants, with the State supporting sale of these products through public education targeted at immigrants about insurance options.

Does the proposal specifically address the coverage of immigrants?

Yes. This is the only plan that specifically proposes a strategy for immigrant enrollment.

How could the proposal enhance immigrant coverage?

If effectively executed, Rx New York’s proposal for increased outreach to immigrants, to “better inform this population that one does not need to be a citizen to purchase private insurance and to have access to America’s top-quality health-care system” could in fact lead to greater immigrant participation. Rx New York also correctly points out that many immigrants “avoid seeking private coverage out of fear of jeopardizing their residency status—or, in the case of illegal immigrants, being found.” Although the report does not discuss the degree to which there is real jeopardy from such participation, its implicit message is that any jeopardy from the purchase of health coverage should be eliminated and that outreach to immigrants should focus in part on explaining why the perception of jeopardy is inaccurate.

How could the proposal hurt immigrant coverage?

The report acknowledges that New York has achieved a better than average rate of insurance coverage through the strategies it has pursued to date, including a heavy emphasis on public coverage. It objects to the continued pursuit of those strategies. It objects to a coverage strategy emphasizing public programs because of the crowd-out effects such a strategy would have (reducing employer provided coverage), and the taxpayer expense involved (which it calls “unaffordable”). Thus, it says, “both the uninsured and the taxpayer may be better off without trying to achieve universal coverage—at least, not the kind that New York has been pursuing for the last 25 years.” It notes that a large number of the uninsured are young, relatively healthy, and not poor, and suggests that a loosening of regulations to increase availability of low cost, high deductible products, reintroduction of medical underwriting and reduced mandates would have a significant impact in enrolling that population.

There is at least a significant possibility that these aspects of Rx New York’s suggested strategy, while not reducing the numbers of insured immigrants, would lead to a considerable decrease in immigrants’ ability to manage their health costs:

- While many immigrants are indeed young and healthy, they are on average poorer than the State as a whole.

- Further, they are concentrated in certain occupations which tend not to offer group coverage, and in which the coverage which is available (such as Healthy New York) offers limited benefits.
- By encouraging the increased sale of limited benefit coverage with high cost sharing, Rx New York would increase the risk that the immigrants who comprise a significant portion of the working poor will, if they do experience serious or chronic illness or disability, be at risk of incurring high medical debt and personal bankruptcy.

In addition, Rx New York's proposed changes to the individual market—namely relying on a high risk pool with small subsidies for the medically uninsurable—will diminish coverage opportunities for older immigrants and those with serious or chronic illnesses or disabilities.

United Health Group

United Health Group proposes to make individual coverage more affordable by establishing a single pool for individual purchasers, separate from but administered by the New York State Health Insurance Program. It anticipates significant savings from the centralization of administration and would assure quality by using the NYSHIP network of providers. Over the long term, United Health Group would permit variation in benefit designs, underwriting of individual coverage, and creation of a high risk pool.

Does the proposal specifically address the coverage of immigrants?

No, but it should be noted that this proposal purports to make improvements only to certain market segments and to increase coverage, not to present a solution for universal coverage.

How could the proposal enhance immigrant coverage?

The proposal would preserve the current government and employer based coverage, and would expand coverage chiefly by centralizing the individual market into a single administrative structure and opening new product choices to individuals. The individual market requires only proof of residence, not citizenship or immigration status, and enhanced affordability and expansion would offer an easy route to coverage for those immigrants able to afford it. The enrollment increases which could be anticipated from such changes, however, are modest (fewer than 20,000 individuals), and would be unlikely to lead to a substantial decrease in the numbers of uninsured immigrants.

How could the proposal hurt immigrant coverage?

Nothing in this proposal would be likely to diminish the current extent of immigrant coverage. Because it does not rely on any changes with respect to the small group market, it is also unlikely to adversely affect coverage in that market on which many immigrants rely. However, to the extent that the proposal relies upon greater variation in benefit packages and premium costs for the individual market, including enhanced opportunity to buy high deductible insurance products, it could have the effect of increasing the costs of the most comprehensive coverage and leaving more immigrants and others who currently have coverage underinsured.

Single Payer Medicare for All

This proposal would provide a standard set of benefits to which all New York residents would be entitled, financed universally through taxes. Private insurers would have no role. Non-institutional providers would be

reimbursed on a fee-for-service basis, while hospitals and clinics would operate within global budgets. A State agency would be created to run the system, including health care planning and quality assessment.

Does the proposal specifically address the coverage of immigrants?

The “target population” for this model and all proposals to be modeled by the State includes “all New York residents who do not qualify for Medicare. This includes all citizens, legal resident non-citizens and undocumented non-citizens.” This is a truly universal approach, especially as it would include residents 65 and older and people with disabilities who may not, because of inadequate work records or residence history, qualify for Medicare. Although dubbed “Medicare for All,” it presumably does not share such Medicare eligibility requirements or it would be unable to encompass its target population.

How could the proposal enhance immigrant coverage?

Any program defined as universally as this one, with its specific inclusion of immigrants, could not help but dramatically expand coverage among immigrant communities. If (as seems unlikely and perhaps unachievable, given ERISA preemption issues) it were to truly abolish private insurance coverage and enroll everyone in a single program, it would probably, as a legal matter, obviate the concern that enrollment in a public type of coverage could constitute one a public charge. A program which benefits every resident would have to be understood as simply a service provided by government to all within its borders, like police protection. With financing separated entirely from determinations of need, enrollment could not be equated with dependency.

How could the proposal hurt immigrant coverage?

Notwithstanding the advantages of a single payer system for dealing with public charge and sponsor liability concerns from a legal perspective, substantial public education would have to be done to convince legally residing immigrants that joining a government-run system does not present such risks. Undocumented immigrants who might not be as concerned about public charge or sponsor liability rules, on the other hand, might still wish to avoid a government-run system for fear that their recorded presence in any official government record creates a risk. In this regard, elimination of private coverage options may actually reduce the likelihood of some people enrolling in coverage, especially if the system cannot adequately assure that enrollment records will be unavailable to other government agencies.

The Combined Public-Private Proposal

This model bears a strong resemblance to the UHF Blueprint for Coverage proposal. It assumes the further elements of merging the individual and small group markets, and allowing adjustments to community rating (age banding) in the private insurance market. It assesses increases in Family Health Plus eligibility up to 200 percent of the federal poverty level and Child Health Plus up to 400 percent of the federal poverty level. It contemplates different formulae for buy-ins to public programs and requires that all individual and small group insurance purchases be conducted through an insurance exchange, with all employers offering Section 125 plans. It assesses the use of premium subsidies and stop-loss reinsurance mechanisms to promote affordability.

Does the proposal specifically address the coverage of immigrants?

Unlike the Blueprint, this proposal includes “all New York residents who do not qualify for Medicare. This includes all citizens, legal resident non-citizens and undocumented non-citizens.” As with the Medicare for All model, this is a truly universal approach, especially as it would include residents 65 and older who may

not, because of inadequate work records, qualify for Medicare. The proposal does not specify any changes specifically targeted to immigrant enrollment, however.

How could the proposal enhance immigrant coverage?

Any program defined as universally as this one, with its specific inclusion of immigrants, could not help but dramatically expand coverage among immigrant communities. Reliance on means-based public programs for lower income residents, however, could perpetuate the barriers associated with public charge and sponsor liability concerns, which now tend to limit immigrant enrollment. Whether those barriers are compensated for by increased access to and subsidies for private coverage may depend on whether individual coverage is made mandatory. This proposal will be modeled both with an individual mandate and without.

How could the proposal hurt immigrant coverage?

Nothing in this proposal would be likely to diminish the current extent of immigrant coverage.

Freedom Plan

The Freedom Plan relies principally on the private insurance market to increase coverage. It assesses the impact of reducing mandated benefits in health policies, promoting use of high deductible health plans, and providing refundable tax credits to support the purchase of coverage. It also would expand the availability of Healthy New York coverage, and increase the reinsurance pools designed to cover high cost claims both in the Healthy New York and the regular standardized direct pay markets. It would make adjustments to community rating and loosen regulation of HMO marketing practices.

Does the proposal specifically address the coverage of immigrants?

As with all proposals modeled by the State, this model's target population includes "all New York residents who do not qualify for Medicare. This includes all citizens, legal resident non-citizens and undocumented non-citizens." However, although the target by definition is a universal one, it does not appear that either the aim or the expectation of this approach is universal coverage. Rather, it rests on introducing greater flexibility in the marketplace to attract more voluntary participation and on tax credits to encourage participation. The proposal does not specify any changes specifically targeted to immigrant enrollment.

How could the proposal enhance immigrant coverage?

Making private insurance cheaper may increase the likelihood that young, healthy immigrants will enroll in voluntary coverage. Because private insurance is available to all who can show residence, regardless of immigration status, it can be considered immigrant friendly and likely to enhance immigrant participation. As Rx New York suggests, however, such a strategy may also require a substantial public relations component to explain to immigrants their opportunities in this market.

How could the proposal hurt immigrant coverage?

The plan's reliance on tax credits as a means of encouraging enrollment is likely to be ineffective in inducing enrollment by those undocumented immigrants who are employed in the informal economy. The skewing of a major coverage incentive according to taxpaying status could result in increasing the proportion of the uninsured who are immigrants. Additionally, as with the Rx New York proposal, the emphasis on loosening insurance regulation and adjustments to community rating rules are likely to result in problems of underinsurance and in greater barriers to coverage for older immigrants and immigrants with serious or chronic health conditions or disabilities.

APPENDIX II: CLASSIFICATION OF IMMIGRANTS

For those who would like a better understanding of the technical distinctions among classes of immigrants referred to in the analysis, the authors are grateful to Barbara Weiner, Esq. of the Empire Justice Center for providing these definitions.

Qualified Alien – benefits-related classification established by Congress in the 1996 federal welfare reform legislation that includes a number of immigration statuses such as permanent resident and refugee. PRWORA requires that to be eligible for assistance under any *federal benefit program*, an applicant must be either a U.S. citizen or national or an immigrant in a Qualified Alien status. Immigrants in a Qualified Alien status include:

- Lawful permanent residents (green card holders);
- Humanitarian-based immigrants, including:
 - Refugees and asylees;
 - Persons granted “withholding of deportation” (people who were in process of being deported but who made a case that they would face persecution or torture if returned to their home country);
 - Cuban/Haitian entrants (nationals of Cuba or Haiti who are known to the US Citizenship and Immigration Services (USCIS) and have been granted parole or who are in the process of applying for asylum or are in deportation proceedings, but don’t have a final order of removal);
 - Amerasians (permanent residents who are the children of Vietnamese mothers and U.S. service members—primarily associated with the Vietnamese conflict. Few immigrants fit into this category), and
 - Victims of Trafficking (persons who have been found by the government to have been brought into the country by fraud or force for the purpose of forced sex or commercial labor).
- Cross Border Native Americans (at least 50 percent Native American blood);
- Persons paroled into the U.S. for one year or more for humanitarian reasons or in the public interest;
- Lawfully residing members of the armed forces or honorably discharged veterans and their dependents; and
- Battered spouses and children of U.S. citizens or lawful permanent residents with a petition pending before the United States Citizenship and Immigration Services (USCIS) who are no longer living with their abuser.

Lawfully Residing Immigrant—a more inclusive term than qualified alien and includes not only those immigrants but also immigrants who are residing in the U.S. with the permission of USCIS.

PRUCOL – a benefits-related immigration category that was eliminated as a federal category by PRWORA, but which New York retained as a result of the 2001 New York Court of Appeals case, *Aliessa v. Novello*. That category includes non-citizens who are held to be “Permanently Residing Under Color of Law,” commonly referred to by its acronym, PRUCOL. Before the 1996 welfare reform law, PRUCOL was also a federal immigrant eligibility category. People who are considered PRUCOL because USCIS (or in a few cases, U.S. Immigration and Customs Enforcement) has given them permission to remain in the U.S. and include those who have been granted:

- **Deferred Action** – which means that USCIS has no immediate intention of deporting the individual out of humanitarian reasons or because the person may have an opportunity to get permanent status;
- **An Order of Supervision** – which is granted to someone who was ordered deported but because of humanitarian considerations or because there is no country to which the person may be deported is permitted to remain in the U.S.;

- **Parole of less than 1 year** – which may be granted to a person for humanitarian reasons until a determination of admissibility can be made (except Cubans or Haitians who, if paroled into the U.S., are considered entrants and are in the qualified alien category);
- **A “K3” or “K4”[1] visa** – which may be granted to spouses and children of US citizens who are waiting for the processing of their applications for permanent residence;
- **A “V” visas** – which may be granted to the spouses and children of lawful permanent residents (LPR) who are waiting for the processing of their immigration applications based on petitions filed before December of 2000;
- **A “U” visa** – which may be granted to people who have been victims of serious crimes and who are willing to cooperate with law enforcement to prosecute the perpetrator; and
- **Temporary Protected Status (TPS)** – which may be granted to persons coming from a country that is going through civil strife or has had a natural disaster, where the President of the US has determined that nationals of that country who were in the U.S. at a certain point in time should be allowed to stay until conditions in their home country improve.
- Individuals who have applied for the PRUCOL classifications listed above or for any other immigration benefit and whose application is pending before the USCIS. So, for example, an applicant for asylum or for adjustment of status to permanent residence or for a “U” or “T” visa is considered PRUCOL.
- Someone on whose behalf an immediate relative petition has been approved is also considered PRUCOL. (An immediate relative petition is a petition filed by a U.S. citizen on behalf of his or her spouse, parents or minor, unmarried child.)
- A person who can show that (s)he has continuously resided in the U.S. since before January 1, 1972 is considered PRUCOL. A person in these circumstances is a *registry alien* and has a right under the Immigration and Nationality Act to file for permanent residence based solely on their length of residence.

Note: Although the K3/K4, T, U and V visas are non-immigrant visas and non-immigrants are not generally eligible for medical assistance, these particular visas all lead to a potential for permanent residence and therefore are different than, for example, student or tourist visas. Undocumented Immigrants—immigrants who do not have authorization to reside in the United States nor any claim to “residence under color of law.” They may have come into the U.S. (“entered”) without being inspected and admitted by a border and customs official or they may have come into the country with a non-immigrant visa and failed to leave when their period of authorized stay ended (“overstay”).