



## EXPANDING ACCESS TO HEALTH INSURANCE COVERAGE FOR LOW-INCOME IMMIGRANTS IN NEW YORK STATE

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## EXECUTIVE SUMMARY

Historically, New York has been a welcoming gateway for immigrants to the United States. Today, 4.2 million foreign-born people reside in New York State, and of these, approximately 1.7 million are naturalized citizens. The vast majority of New York's 2.5 million non-citizen immigrants are here legally, and the vast majority work. Immigrants pay approximately 15.2 percent of the state's income taxes and 17.4 percent of its residential property taxes. Nevertheless, like many citizens, a significant number of immigrants lack access to health insurance through their jobs. Unlike citizens, however, many low-income *legal* immigrants are ineligible for the Medicaid program solely because of their immigrant status.<sup>1</sup>

### **The Impact of Welfare Reform Legislation on Health Insurance Coverage**

With the enactment of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the federal government withdrew its contribution to Medicaid coverage for many legal immigrants except for the treatment of emergency medical conditions. Specifically, most legal immigrants who entered the country after August 22, 1996, are ineligible for federal Medicaid for five years after their arrival. Even after five years, the vast majority will remain ineligible because PRWORA deems the income of the immigrant's sponsor to be available to the immigrant. In addition, lawfully present immigrants known as PRUCOLs—Persons Residing Under Color of Law—are ineligible for Medicaid regardless of their residency duration in the United States (see Appendix A for more on PRUCOLs).

A number of states, including New York's neighboring states of Connecticut, Massachusetts, New Jersey, and Pennsylvania, responded to these federal changes by electing to provide comprehensive health coverage for federally ineligible legal immigrants using state funds.<sup>2</sup> New York did not, denying Medicaid and Family Health Plus (FHP)—a Medicaid expansion—to most PRUCOLs and adult immigrants entering the United States after August 22, 1996. (See Appendix B for a comparison of the benefits offered by Medicaid, FHP, and Child Health Plus (CHP).) Under New York law, most federally ineligible adult immigrants may receive only emergency care and services under New York's Prenatal Care Assistance Program (PCAP), which covers prenatal care,

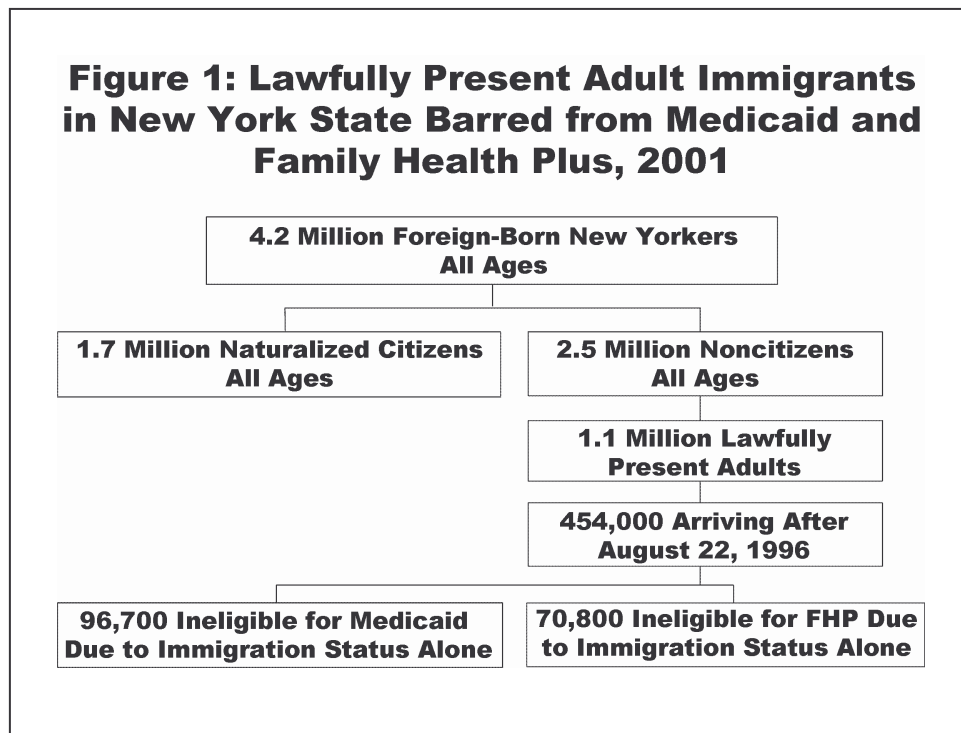
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<sup>1</sup> For purposes of this report, a legal immigrant is a non-citizen immigrant who is lawfully present in the United States. This term does not include tourists, students, or business visitors who are here temporarily.

<sup>2</sup> This report refers to state-funded Medicaid programs to describe Medicaid look-alike programs funded largely or exclusively with nonfederal dollars.

deliveries, and postpartum care. New York does, however, permit the parents of immigrant children to enroll them in its CHP program, covering the costs with state-only dollars.

Nearly 1.1 million legal non-citizen adults live in New York State, 454,000 of whom arrived in the United States after August 22, 1996. Of these people, approximately 96,700 would be eligible for Medicaid but for their immigrant status, and an additional 70,800 would be eligible for FHP. Thus, more than 167,000 lawfully present, non-citizen adults who reside in New York State have incomes low enough to qualify for Medicaid or FHP (see Figure 1, below). By 2003, the number of lawfully present, non-citizen adults with incomes below Medicaid or FHP limits will exceed 238,000. The vast majority of these low-income immigrants will be uninsured, yet barred from participation in the Medicaid program by the federal and state welfare reform laws.



### **The Consequences of Uninsurance**

The consequences of uninsurance for these immigrants, their families, and their health care providers are devastating. Without health coverage, federally ineligible immigrants are less likely to receive primary and preventive care, and more likely to rely on emergency rooms as their regular source of care, to undergo avoidable hospitalizations, and to experience adverse health outcomes. Moreover, the care they receive on an emergency basis is likely to be far more expensive than the routine primary and preventive care that could have prevented the medical emergency.

New York's policy of limiting Medicaid coverage to emergency care and PCAP services for federally ineligible immigrants has a negative impact not only on the health of individual immigrants, but on the public health as well. Individuals who lack primary care coverage are unlikely to receive routine screenings and treatment for communicable diseases, thus impeding New York's efforts to curb the spread of tuberculosis, HIV, sexually transmitted diseases, and other threats to public health.

Further, hospitals and community health centers are staggering under the burden of providing uncompensated care for the growing number of uninsured immigrants. Hospitals are required by law to treat anyone who arrives for care in their emergency rooms, regardless of their ability to pay or their payment source. Hospitals are, however, increasingly unable to discharge immigrants who were admitted on an emergency basis and are medically ready for discharge because they are ineligible for Medicaid's payments for the long-term care or rehabilitation services they require. These immigrants languish indefinitely and unnecessarily in hospital beds, when they could be cared for more appropriately at home or in nursing facilities.

### **State-Funded Insurance Options for Low-Income Immigrants in New York State**

This report explores three options for addressing problems created by Medicaid eligibility restrictions enacted as part of federal and New York State welfare reform. All three options provide lawfully present immigrant adults with government-subsidized health insurance. For each option, the report's analysis projects enrollment levels and costs, and discusses programmatic advantages and disadvantages. Although even higher levels of uninsurance are likely to be found among undocumented immigrants, this report focuses on immigrant adults who were entitled to Medicaid prior to welfare reform and have since become ineligible. The focus on legal immigrants should not be interpreted to minimize the problems of uninsurance among undocumented immigrants, for their problems are at least as great as those of legal immigrants. However, the data on undocumented immigrants are less extensive and precise than the data available on legal immigrants, making it far more difficult to estimate with any degree of accuracy participation rates and costs of any insurance expansion. Finally, the report does not address immigrant children who are no longer eligible for Medicaid because they are covered under the state's CHP program.

#### *Option One*

The first option would restore full Medicaid coverage to adult immigrants to the extent that it was available before welfare reform, and it would expand FHP to cover the same categories of immigrants. This approach places legal immigrants on the same footing



as citizens and provides the most comprehensive solution to the problem of uninsurance. Like the other two options, it assumes that New York repeals its sponsor-deeming law; otherwise, the proposed insurance options would be available to very few immigrants. The vast majority would be deemed to have incomes greater than the Medicaid and FHP income level restrictions as a result of imputing to them the incomes of their sponsors.

Assuming participation rates comparable to those found in other subsidized insurance programs, in the first year of operations, option one is projected to cover close to 5,900 people at an incremental cost to the state of approximately \$10.8 million. By the third year, enrollment is projected to reach approximately 33,000, and the incremental costs are expected to grow to approximately \$66.3 million. These costs to the state and local social services districts reflect the availability of federal funds for emergency services and prenatal care and deliveries. They also reflect the availability of funds that the state and local social services districts would have spent in the absence of a new program for immigrants, on emergency Medicaid, and on PCAP services for the newly covered immigrants. Additionally, as described below, if expenditures on parents for services other than emergency care and PCAP services were designated as maintenance of effort (MOE) spending under the state’s Temporary Assistance to Needy Families Program (TANF), the state and local governments could reduce the amount they are currently spending on cash assistance to meet TANF’s MOE requirements and replace it with federal TANF dollars.<sup>3</sup> Figure 2, below, provides a picture of the *incremental* costs of adopting this option.

**Figure 2: Costs of Restoring Medicaid and Expanding FHP to Legal Immigrants**

	<b>Year One</b>	<b>Year Three</b>
Total Eligible Population	167,425	238,036
Projected Enrollment	5,851	33,275
Total Cost	\$21.1 million	\$126.4 million
Federal Contribution	\$5.7 million	\$33.8 million
Total Nonfederal Cost	\$15.5 million	\$92.6 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and Prenatal Care Assistance Program (PCAP) for Program Enrollees	\$4.7 million	\$26.4 million
Incremental Costs (new, nonfederal)	\$10.8 million	\$66.3 million
Increased TANF MOE	\$5.7 million	\$33.9 million
Net Financial Plan Impact	\$5.1 million	\$32.4 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

<sup>3</sup> The TANF program was created by PRWORA to replace the Aid to Families with Dependent Children program. It provides block grants for states to fund cash assistance for needy families and other types of assistance and services that promote the preservation of intact families, employment, and prevention of out-of-wedlock pregnancies.

A variation of this option would be to restore eligibility for Medicaid but not for FHP. As Figure 3 illustrates, restoring Medicaid eligibility alone would likely cover approximately 3,400 individuals in the first year of operations and nearly 17,800 by the third year of operations. In any case, even if immigrants were permitted to participate in both Medicaid and FHP, in year one the Medicaid-only numbers shown below are more probative given the continuing delay in implementation of any FHP program.

**Figure 3: Costs of Restoring Medicaid Alone to Legal Immigrants**

	<b>Year One</b>	<b>Year Three</b>
Total Eligible Population	96,652	127,183
Projected Enrollment	3,378	17,779
Total Cost	\$13.3 million	\$74.1 million
Federal Contribution	\$3.3 million	\$18.0 million
Total Nonfederal Cost	\$10.0 million	\$56.0 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and PCAP for Program Enrollees	\$4.3 million	\$23.8 million
Incremental Costs (new, nonfederal)	\$5.7 million	\$32.3 million
Increased TANF MOE	\$3.2 million	\$17.9 million
Net Financial Plan Impact	\$2.5 million	\$14.4 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

*Option Two*

The second option would offer only FHP coverage to federally ineligible immigrant adults, as CHP is now available to immigrant children. Under this approach, immigrants would be eligible for FHP’s comprehensive benefit package, including primary care, inpatient care, and prescription drugs, but they would not be eligible for the full Medicaid benefit package available to citizens and certain immigrants. Most notably, these immigrants would be ineligible for long-term care services. Using FHP income limits, the incremental costs in the first year would be approximately \$8.3 million, and by the third year would be approximately \$52.2 million. As with option one, these incremental costs reflect the availability of federal funds for emergency and PCAP services and are net amounts of what would have been spent by the state and local districts in any case on these immigrants (see Figure 4 below). Further, as with option one, spending on parents for services other than emergency and PCAP services could be designated as TANF MOE, thereby permitting state and local governments to replace a portion of their cash assistance spending with federal TANF dollars.

**Figure 4: Costs of Providing FHP to Legal Immigrants Eligible for Medicaid and FHP**

	Year One	Year Three
Total Eligible Population	167,425	238,036
Projected Enrollment	5,851	33,275
Total Cost	\$18.6 million	\$112.3 million
Federal Contribution	\$5.7 million	\$33.8 million
Total Nonfederal Cost	\$13.0 million	\$78.6 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and PCAP for Program Enrollees	\$4.7 million	\$26.4 million
Incremental Costs (new, nonfederal)	\$8.3 million	\$52.2 million
Increased TANF MOE	\$3.9 million	\$24.3 million
Net Financial Plan Impact	\$4.4 million	\$27.9 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

### *Option Three*

The third option would create a new and limited insurance program for adult immigrants based on the early outpatient CHP model. The capitated benefit package would include primary and preventive care and prescription drugs. Inpatient and emergency care would be available on a fee-for-service basis. Inpatient care, however, would be available only to the extent that it qualified as emergency care eligible for federal financial participation. Like the FHP approach, this model would not include long-term care services. In addition, like the existing CHP program, this option would require higher-income participants to pay premiums of \$9 per member per month. While the number of likely participants and their associated costs have not been modeled for this option, significant savings are unlikely compared to option two due to extraordinarily high administrative costs and the likelihood of adverse selection among enrollees.

In evaluating the cost of the three options, it is important to bear in mind that even the most expensive option represents less than 0.1 percent of the state’s total \$24 billion Medicaid budget now, and less than 0.3 percent in three years.

### **Maximizing Federal Support**

Under each of the options, the state would take steps to maximize the flow of federal dollars to New York. As noted above, the state would continue to receive federal reimbursement for approximately half the costs incurred for treating emergency care, both inpatient and outpatient, as well as for prenatal care, deliveries, and postpartum care. In addition, by designating the state’s payment for other services for parents with minor children as MOE under the federal TANF block grant, New York could make progress

toward meeting its TANF MOE requirement. To avoid an MOE shortfall and federal penalties in the last two fiscal years, the state has inflated the state and local contributions to cash assistance while reducing the federal TANF contribution to cash assistance. If the state designated its payments for health care for immigrant parents as MOE, it could reduce the amount by which it has inflated the state and local shares of cash assistance and replace it with federal TANF dollars. A potential shortfall was projected to exceed \$200 million in state fiscal year 2000–01, far more than the projected annual costs of any of the proposed insurance expansion options even in the farthest years.

## **Conclusion**

The incomes and tax burdens of non-citizen New Yorkers are comparable to those of citizens, with more than 30 percent of their incomes paid in taxes. Although their tax dollars support the Medicaid program, welfare reform laws deny large numbers of legal non-citizen immigrants access to the Medicaid program when they fall on hard times. As a result, the rate of uninsurance among non-citizen immigrants is twice that of citizens.

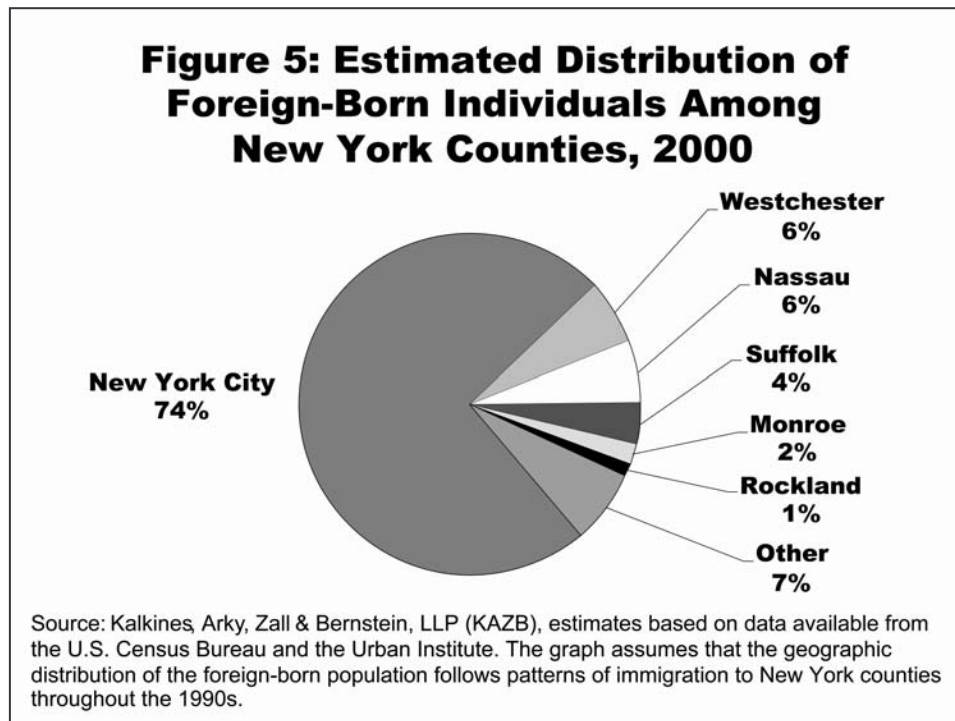
Not surprisingly, hospitals and community health centers serving low-income communities report increasing numbers of uninsured immigrants requiring free care, often for debilitating and acute conditions that could have been treated more effectively and efficiently at an earlier non-emergent stage. Yet federal Medicaid will not cover primary and preventive care—it will cover only costly emergency care. Emergency Medicaid expenditures exceeded \$250 million in 1999 for adult immigrants (both legal and undocumented), of which approximately \$125 million was borne by the state and local social services district. The incremental costs of making full Medicaid available to low-income legal immigrants are relatively minimal. This investment will go a long way, however, in addressing essential health care needs of these immigrant patients and the critical financial needs of the safety net hospitals and community health centers that serve them.

Welfare reform restrictions on access to health care coverage are bad health policy and bad economics. While federal action revising PRWORA's health insurance restrictions is warranted, New York State cannot afford to wait.

## I. A PROFILE OF THE IMMIGRANT POPULATION IN NEW YORK AND THE IMPACT OF PRWORA'S MEDICAID ELIGIBILITY RESTRICTIONS

Approximately 4.2 million foreign-born New Yorkers live throughout the state, accounting for roughly 23 percent of the population.<sup>4</sup> This percentage doubles that of the early 1970s but is still far below the high point of the twentieth century in 1910, when 43 percent of the state's population was foreign-born.<sup>5</sup> Immigration flows into New York over the past 10 years reversed what would have been a decrease in the state's population.<sup>6</sup>

Approximately three of four foreign-born New Yorkers—some 3.2 million individuals—reside in New York City. Relatively large concentrations of foreign-born New Yorkers also live in Nassau, Suffolk, Rockland, and Westchester counties, as well as in the upstate counties of Erie, Monroe, and Onondaga (see Figure 5). Immigrants residing outside New York City tend to have been in the country longer and have higher incomes than those living in the city.



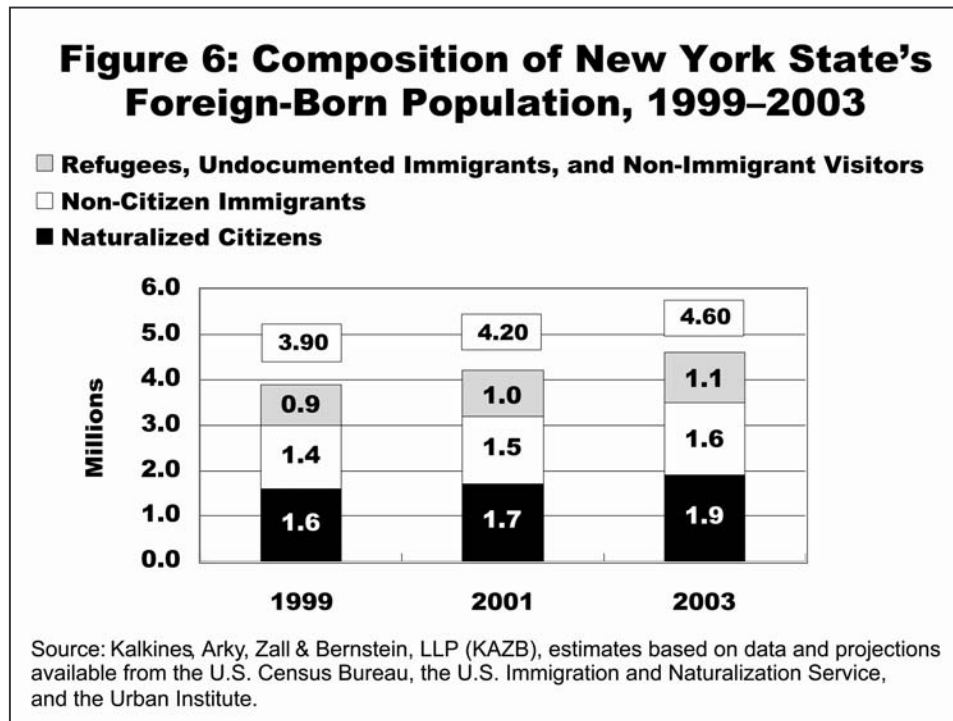
<sup>4</sup> U.S. Census Bureau, 1999 (New York State total population); Kalkines, Arky, Zall & Bernstein LLP (KAZB) 2000 (estimate of the foreign-born population based on data from the U.S. Census Bureau and the U.S. Immigration and Naturalization Service). See Appendix E for more information.

<sup>5</sup> Gibson, C. and Lennon, E. *Historical Census Statistics on the Foreign-born Population of the United States: 1850–1990*. U.S. Bureau of the Census, Population Division Working Paper 29 (February 1999), Table 13.

<sup>6</sup> Camarota, S. “Immigrants in the United States—2000: A Snapshot of America’s Foreign-Born Population,” Center for Immigration Studies: January 2001.

### Immigrant Status of New York's Foreign-Born Population

Among New York State's 2001 population of 4.2 million foreign-born individuals are an estimated 1.7 million naturalized citizens, 1.5 million lawfully present, non-citizen immigrants, and approximately 1 million undocumented immigrants, refugees, students, and other non-immigrant visitors.<sup>7</sup> (See Figure 6.)



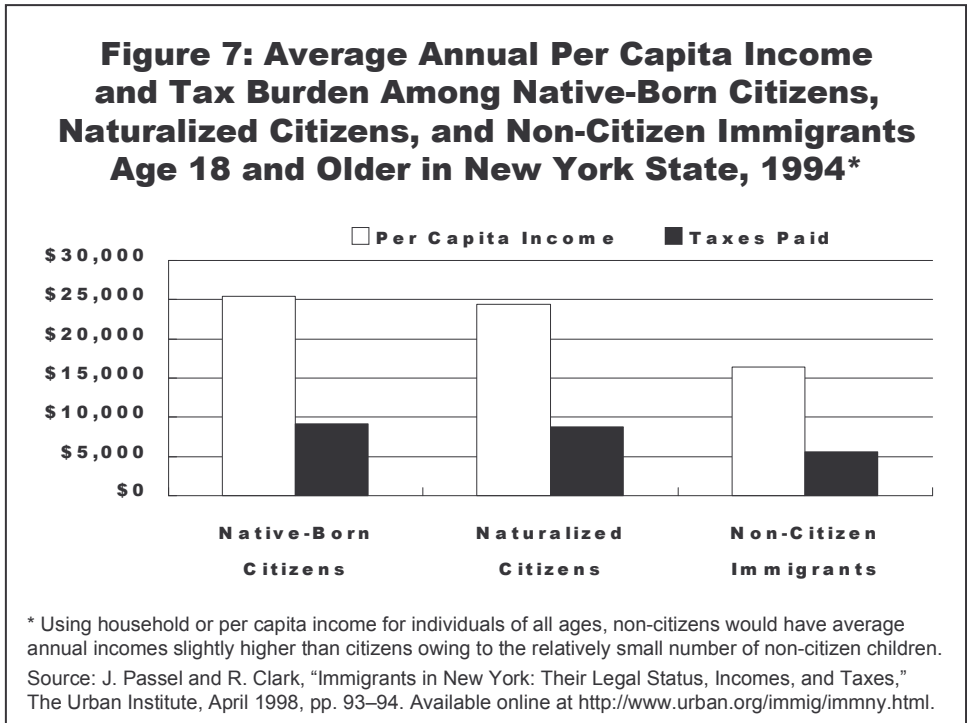
### Immigrants' Contribution to the New York Economy

Immigrants residing in New York do not differ significantly from native-born citizens in their ability to achieve self-sufficiency and make substantial economic contributions. According to an analysis of 1994 tax data conducted by the Urban Institute, native citizen New Yorkers age 18 and older earned an average of \$25,500 per year and paid 36 percent of their incomes in federal, state, and local taxes.<sup>8</sup> Foreign-born, naturalized citizens age 18 and older earned slightly less—\$24,400 per year—but also paid 36 percent of their incomes in taxes. Among non-citizen legal immigrants, legal permanent residents age 18 and older had per capita annual incomes of \$16,800 and paid 35 percent of their incomes

<sup>7</sup> KAZB estimates based on data and projections available from the U.S. Census Bureau, the U.S. Immigration and Naturalization Service, and the Urban Institute. See Appendix E for more information.

<sup>8</sup> Passel, J., and R. Clarke. "Immigrants in New York: Their Legal Status, Incomes, and Taxes," the Urban Institute: April 1998, pp. 93–94. Includes unemployment insurance and FICA taxes paid by employers on behalf of their workers. Percentages included in Table 3a of cited report are net of these payments. Available online at <http://www.urban.org/immig/immny.html>.

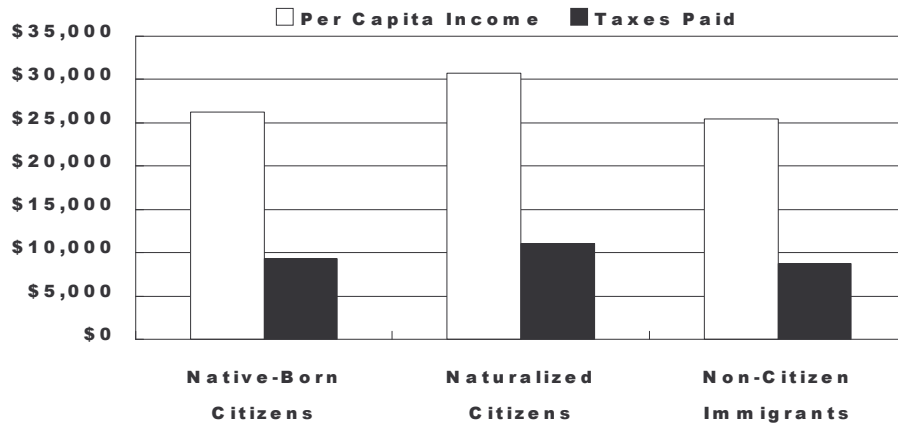
in taxes (see Figure 7). Immigrants pay approximately 15.2 percent of the state’s income taxes and 17.4 percent of the state’s residential property taxes.<sup>9</sup>



Immigrants residing in counties outside New York City make even greater economic contributions. In tax year 1994, naturalized citizens had higher per capita incomes than native citizens and paid a significantly greater amount in federal, state, and local taxes, while non-citizen immigrants had incomes and tax burdens similar to that of native citizens (see Figure 8).

<sup>9</sup> Passel and Clark, April 1998, p. 8.

**Figure 8: Average Annual Per Capita Income and Tax Burden Among Native-Born Citizens, Naturalized Citizens, and Non-Citizen Immigrants Age 18 and Older in Upstate New York State, 1994**

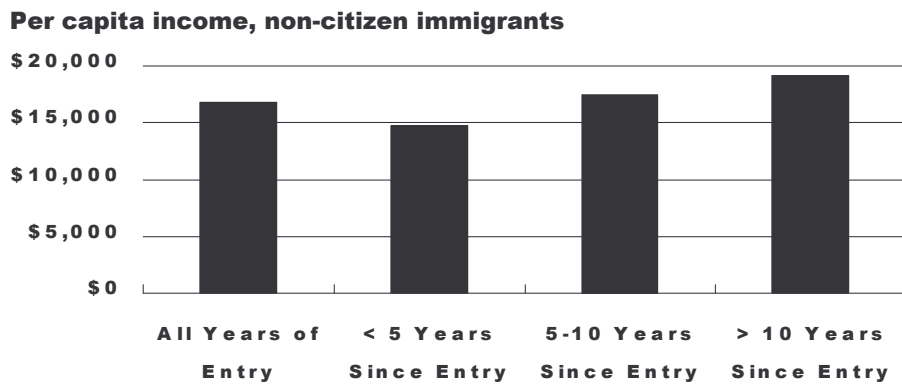


Source: J. Passel and R. Clark, "Immigrants in New York: Their Legal Status, Incomes, and Taxes," The Urban Institute, April 1998, p. 93.

While statewide per capita incomes and tax burdens are broadly similar for non-citizens and citizens, average incomes of immigrants tend to be lower for the first few years in which they reside in the United States, reflecting the lower-paying, less desirable jobs often available to immigrants when they first arrive (see Figure 9). It bears mentioning that these first few years of marginal income while individuals are gaining a foothold in a new society are the same years that immigrants are banned from participating in Medicaid.



**Figure 9: Average Annual Per Capita Income of Non-Citizen Immigrants Age 18 and Older in New York State by Number of Years Since Entry into the United States, 1994**



Source: J. Passel and R. Clark, "Immigrants in New York: Their Legal Status, Incomes, and Taxes," The Urban Institute, April 1998, p. 93. Data are for legal permanent residents only. The pattern holds true for other immigrants as well.

In addition to their direct contributions to New York's tax base, immigrants act as an engine of growth for the New York economy. Based on a review of the extensive research on the impact of immigration on labor markets across the country, researchers from the Urban Institute concluded that immigrants create more jobs than they themselves fill. They do so directly by starting new businesses, and indirectly through their expenditures on U.S. goods and services.<sup>10</sup>

A study of the apparel industry in New York in the 1980s reached the same conclusion: the steady flow of immigrants resulted in numerous garment industry jobs being retained in New York that otherwise would have been lost.<sup>11</sup> Researchers found that the presence of a large number of immigrants also created a number of other jobs, most likely a result of immigrant workers spending their wages in the local economy. Studies of the restaurant and construction industries in New York and elsewhere found that low-wage labor markets are segmented along immigration status: new immigrants compete for jobs with the immigrants who immediately preceded them, rather than impacting the job prospects of native-born citizens.<sup>12,13</sup> Additionally, housing statistics

<sup>10</sup> Fix, M., Passel, J., Enchautegui, M., and Zimmermann, W. "Immigration and Immigrants: Setting the Record Straight," the Urban Institute, 1994, p. 47.

<sup>11</sup> Waldinger, R. "Immigration and Industrial Change in the New York City Apparel Industry," *Hispanics in the U.S. Economy*, George J. Borjas and Marta Tienda (eds.). (Orlando: Academic Press, Inc.), 1985. Cited in Fix et al, 1994.

<sup>12</sup> Bailey, T. "A Case Study of Immigrants in the Restaurant Industry," *Industrial Relations*, Vol. 24, 1985, pp. 205-221.

from across the country indicate that immigrants contributed approximately 15 percent to the net growth in homeownership in recent years.<sup>14</sup> Given their relatively large share of the population in New York State, immigrants probably provided an even greater stimulus to the real estate and construction sectors, which are both large employers in the New York region.

More recently, a number of analyses have underscored the importance of immigrants in fueling the country's economic expansion by filling the hundreds of thousands of new jobs created each year.<sup>15,16</sup> A Long Island mailing company was featured in *The New York Times* for its reliance on immigrant workers to fill essential jobs that would otherwise go unfilled.<sup>17</sup> Without this pool of available workers, the company would not have been able to grow to its current size. A separate *Times* article published in 2001 summed up the frustration of a growing number of employers in New York and across the country: "Especially in today's tight labor market, America can't function without immigrants—and there aren't enough legal ones ...."<sup>18</sup>

Federal Reserve Chairman Alan Greenspan reached a similar conclusion in testimony before Congress when he observed that "aggregated demand is putting very significant pressures on an ever-decreasing available supply of unemployed labor."<sup>19</sup> Far from sounding the call to limit immigration, Chairman Greenspan suggested that the "one obvious means that one can use to offset that is expanding the number of people we allow in."<sup>20</sup>

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<sup>13</sup> Bailey, T. *Immigrant and Native Workers: Contrasts and Competition*, (Boulder: Westview Press), 1985.

<sup>14</sup> Data cited in Farrell, C. "A Foundation for the Economy to Build On," *BusinessWeek* January 5, 2001. Available online at [http://www.businessweek.com/bwdaily/dnflash/jan2001/nf2001015\\_017.htm](http://www.businessweek.com/bwdaily/dnflash/jan2001/nf2001015_017.htm).

<sup>15</sup> Zellner, W., Arndt, M., and Borrus, A. "How Immigrants Keep the Hive Humming," *BusinessWeek* April 24, 2000. Available online at <http://www.businessweek.com/careers/content/jan1990/b3678102.htm>.

<sup>16</sup> Farrell, C. "Educated Immigrants Are Steroids for the New Economy" *BusinessWeek*, July 14, 2000. Available online at <http://www.businessweek.com/bwdaily/dnflash/jul2000/nf00714g.htm>.

<sup>17</sup> LeDuff, C. "Immigrants Provide Employee Answer for Long Island Mailing Company," *The New York Times*, February 4, 2001 (section 1, page 30).

<sup>18</sup> Schmitt, E. "Americans (a) Love (b) Hate Immigrants," *The New York Times*, January 14, 2001 (section 4, page 1). For a discussion of the high-tech sector's reliance on immigrants to fill essential jobs, see: Testimony of Kenneth M. Alvares, Vice President Sun Microsystems, Inc., before the U.S. Senate Committee on the Judiciary (Hearing on The High-Tech Worker Shortage and Immigration Policy), February 25, 1998.

<sup>19</sup> Testimony of Alan Greenspan before the U.S. Senate Committee on Banking, January 26, 2000.

<sup>20</sup> *Ibid.*

## **The Growing Number of Uninsured and the Impact of PRWORA on Adult Immigrants Living in New York**

In New York State, a staggering 46 percent of all non-citizens (almost 1.1 million individuals) are currently uninsured.<sup>21</sup> (See Figure 10 for current and projected numbers of uninsured non-citizens.) Uninsurance rates are even higher among low-income recent immigrants—individuals now barred from participating in Medicaid and Family Health Plus (FHP). Of low-income, adult non-citizens who have resided in this country for less than 5 years, it is estimated that 70 percent lack insurance.<sup>22</sup> Today, approximately 117,000 lawfully present adult non-citizens who would qualify for Medicaid (68,000) or for FHP (49,000) are uninsured because of their immigrant status.<sup>23</sup> These numbers are projected to increase to 167,000 (89,000 eligible for Medicaid and 78,000 eligible for FHP) by 2003 (see Figure 10).

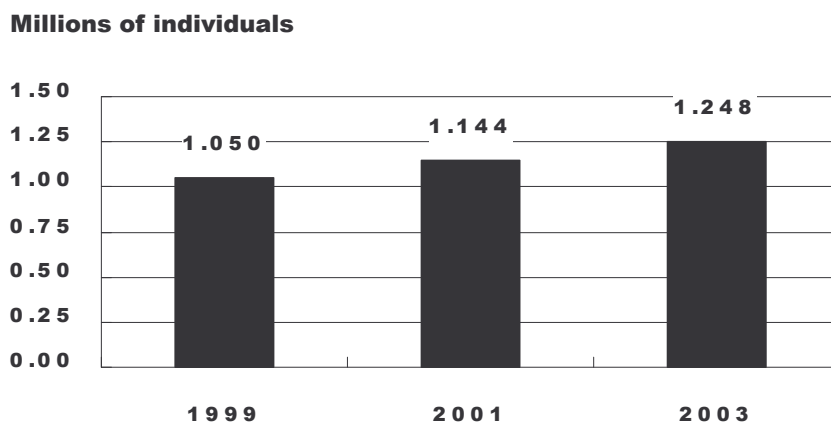
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<sup>21</sup> KAZB estimate based on data from U.S. Census Bureau, *March 2000 Current Population Survey*, adjusted to reflect the fact that uninsurance rates for the general population are 6.3 percent higher in New York than for the nation as a whole.

<sup>22</sup> KAZB estimate based on data from U.S. Census Bureau, *March 2000 Current Population Survey* and U.S. Census Bureau, *Profile of the Foreign Born 1997* and adjusted to reflect the fact that uninsurance rates for the general population are 6.3 percent higher in New York than for the nation as a whole.

<sup>23</sup> Figures do not include undocumented immigrants and other non-immigrant visitors not eligible for Medicaid or children and refugees who continue to be eligible for health care coverage. These figures also do not include income-eligible PRUCOLs because there is insufficient data to estimate their numbers. Many PRUCOLs residing in the United States at the time of PRWORA's enactment were restored to SSI and therefore Medicaid coverage as a result of federal legislation. PRUCOLs with AIDS and those residing in nursing homes are covered as of August 1997 under New York's Medicaid eligibility provisions. In any event, we do not believe that the number of income-eligible PRUCOLs who would participate in this program is large enough to significantly affect the cost estimates. To account for the inclusion of PRUCOLs, we adjusted the distribution of enrollees across aid categories to reflect the higher percentage of elderly and disabled individuals among PRUCOLs than among recent immigrants. (See Appendix E for details.)

**Figure 10: The Growing Number of Uninsured Immigrants in New York State, 1999–2003**



Source: Kalkines, Arky, Zall & Bernstein, LLP (KAZB), estimates based on data and projections available from the U.S. Census Bureau and the U.S. Immigration and Naturalization Service.

### **Consequences of Uninsurance for Immigrants and Their Families**

Compared with adults who have health insurance coverage, the uninsured are less likely to have a regular source of care or to recently have seen a physician.<sup>24</sup> In New York City, seven of 10 uninsured working-age adults have no regular source of health care to use when they are ill or need medical advice.<sup>25</sup> When individuals lack a regular source of care, research suggests that they will have fewer ambulatory care visits with less preventive care, and will be more likely to forgo needed care such as checkups or treatment for particular ailments.<sup>26</sup> Lack of regular and routine care results in the uninsured having more unnecessary emergency room visits, more avoidable hospitalizations, and more adverse outcomes.<sup>27,28,29,30</sup>

<sup>24</sup> American College of Physicians, American Society of Internal Medicine, “No Health Insurance? It’s Enough To Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health,” 2000.

<sup>25</sup> Sandman D., Schoen C., DesRoches C., and Makonnen M. *The Commonwealth Fund Survey of Health Care in New York City*, February 1998.

<sup>26</sup> Bartman B., Moy E., and D’Angelo L. “Access to Ambulatory Care for Adolescents: The Role of a Usual Source of Care,” *Journal of Health Care for the Poor and Underserved*, Vol. 8, No. 2, 1997; Ayanian J., Weissman J., Schneider E., Ginsburg J., Zaslavsky A. “Unmet Health Needs of Uninsured Adults in the United States,” *Journal of the American Medical Association*, Vol. 284, No. 16, October 25, 2000.

<sup>27</sup> Bartman B. et al, 1997.

<sup>28</sup> Sandman D. “Caring for the Uninsured: The Urban Dilemma,” *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 75, No. 1, March 1998.

<sup>29</sup> Hoffman C. and Schlobohm A. *Uninsured in America: A Chart Book*, Kaiser Commission on Medicaid and the Uninsured, Second Edition, May 2000.

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### **The Consequences of Lack of Health Insurance**

A senior physician treating patients at the William F. Ryan Community Health Center in New York City can point to many low-income immigrant families when asked about the problem of the uninsured. He cites the case of an uninsured immigrant woman in her early fifties who came to the clinic with a gangrenous toe. Though the woman had known for years that she had diabetes, she had received no regular care or treatment for it. As a result she had to have an above-knee amputation and during the operation developed a blood infection due to her untreated, uncontrolled diabetic condition. The woman required painful and debilitating surgery, a costly six-week hospital stay, and rehabilitation and physical therapy all because her diabetes had been left untreated.<sup>31</sup>

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A recent article in *The New York Times* highlighted the tragic consequences of an immigrant parent's uninsurance.<sup>32</sup> The article told the story of an undocumented mother with sickle cell anemia. Because she had no health coverage and was unable to afford the expensive medications necessary to treat her condition, she would cycle in and out of emergency rooms and hospital beds. Each time she was admitted to the hospital, her son had to be placed in foster care because she had no family or friends who could care for him. The son was devastated by the repeated separations from his mother and ran away from his placements. Eventually, the city moved to terminate the mother's parental rights. Had the mother simply received the ongoing health care she required, the city would not have had to place the child, and the child would not have been scarred by repeated separations from his mother.

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### **Consequences of Uninsurance for the Public Health**

Lack of insurance coverage not only has a negative impact on the health of the individual immigrant, but also on the public health. Primary care is integral to diagnosing, treating, and containing communicable diseases.<sup>33</sup> When individuals are denied primary care health coverage, they often do not receive screenings for tuberculosis, sexually transmitted diseases, HIV infection, and other diseases. Although such screenings may be available at local health departments, individuals at risk are less likely to visit such a facility to obtain a test for a communicable disease than as part of a routine visit with a regular health care

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<sup>30</sup> Ayanian J. et al., October 25, 2000.

<sup>31</sup> Interview with Dr. Daniel J. Baxter, M.D., Associate Medical Director, William F. Ryan Community Health Center, November 20, 2000.

<sup>32</sup> Bernstein N. "Family Law Collides with Immigration and Welfare Rules," *The New York Times*, November 20, 2000, Section B, Page 1.

<sup>33</sup> Welton, W.E., Kantner, T.A., Moriber Katz, S., "Integrating Our Primary Care and Public Health Systems: A Formula for Improving Community and Population Health," *Primary Care: America's Health in a New Era*, Donaldson, M.S., Yordy, K.D., Lohr K.N., Vanselow, N.A., eds., Institute of Medicine, 1996; interview with Dr. Daniel Baxter, November, 20, 2000.

provider.<sup>34</sup> Moreover, individuals without primary care coverage are unlikely to receive the treatment and counseling they require to prevent transmission of the disease to others.<sup>35</sup>

The risks presented by denying Medicaid primary care coverage are highlighted by the rising tuberculosis rate among the foreign-born population in New York City. Although the rate of tuberculosis cases in the city among the native-born dropped significantly between 1990 and 1998, the rate among the foreign-born increased slightly. As a result, the rate of tuberculosis among the foreign-born rose from half that of the native-born in 1990 to more than twice that of the native-born in 1998.<sup>36</sup>

### **Barriers to Care Unique to Immigrants and Their Families**

In addition to higher rates of uninsurance, immigrants face unique circumstances that may lead to underutilization of health care services. Factors may include language differences; lack of cultural competency among some providers; discrimination; fear of being reported to the Immigration and Naturalization Service (INS); and misinformation about eligibility for services. Together, these factors account for low-income adult non-citizens being twice as likely nationally as low-income adult citizens to lack a usual source of care (37 percent vs. 19 percent)<sup>37</sup> and to report having neither a regular ambulatory care visit nor an emergency room visit in the past year (41 percent vs. 21 percent).<sup>38</sup>

Immigrants' lack of insurance is likely to have a negative impact on family members who are citizens as well. Half of immigrant-headed households in New York State include at least one citizen.<sup>39</sup> Immigrant parents may be reluctant to apply for benefits for their citizen children for various reasons: the fear of detection and deportation, the erroneous belief that their child's use of benefits will bar them from naturalizing, the worry that they will be unable to sponsor a relative, or the concern that they will have to repay the government for benefit use.<sup>40</sup> This spillover effect of immigration-related

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<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> "Welfare Reform and Health Care: The Wrong Prescription for Immigrants," New York Immigration Coalition, based on research by Solutions for Progress, Nov. 2000, pp. 38-39, citing Bureau of Tuberculosis Control, New York City Department of Health, *Information Summary: 1998*, pp. 13-14. According to the report, while the rates of tuberculosis among the foreign-born remained steady from 1990 to 1998, the rates among the native-born dropped significantly.

<sup>37</sup> Ku L., and Matani S. "Immigrants' Access to Health Care and Insurance on the Cusp of Welfare Reform," the Urban Institute, 2000.

<sup>38</sup> Ibid.

<sup>39</sup> Fix M., and Zimmerman W. "All Under One Roof: Mixed-Status Families in an Era of Reform," the Urban Institute, June 1999.

<sup>40</sup> Ibid.

restrictions will surely hamper the state's effort to enroll eligible children into the Child Health Plus (CHP) program.<sup>41,42</sup>

### **Impact of Immigrant Restrictions on Health Care Providers**

The withdrawal of federal and state funds from health insurance for low-income immigrants has shifted the financial burden to hospitals and community health centers. Nationally, low-income adult non-citizens are twice as likely as low-income adult citizens to use hospital outpatient departments or community health centers as their regular sources of care (39 percent vs. 20 percent).<sup>43</sup>

Predictably, hospitals and community health centers that have traditionally served vulnerable populations and are located in high-immigrant neighborhoods are disproportionately impacted as the number of uninsured immigrants continues to increase. Many of these providers have already started to feel the impact of the growing number of low-income residents in New York who are barred from Medicaid eligibility by virtue of their immigrant status. New York City public hospitals serving neighborhoods with large numbers of immigrants experienced a 20.5 percent increase in self-pay patients from 1996 to 1998, compared to a 10.5 percent increase at city public hospitals in other neighborhoods.<sup>44</sup>

A recent report on emergency room usage by the uninsured in New York City found that, excluding patients admitted to the hospital, 75 percent of all emergency room visits in 1998 were for conditions that were either non-emergent or emergent but treatable in a primary care setting.<sup>45</sup> Given the disproportionately large number of uninsured immigrants in New York, it is likely that many of these avoidable emergency room visits were made by low-income immigrants no longer eligible for full Medicaid.

Although low-income immigrants are eligible for emergency care under Medicaid, state policy does not permit immigrants to preregister for Medicaid coverage of emergency care. An application for benefits must be filed at the time of service. Because of

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<sup>41</sup> Kaiser Commission on the Uninsured, 2000; see also L. Ku, and S. Blaney, "Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage," Center on Budget and Policy Priorities, Oct. 10, 2000.

<sup>42</sup> Ku L., and Blaney S., October 10, 2000.

<sup>43</sup> Ku L., and Matani S., the Urban Institute, 2000.

<sup>44</sup> New York Immigration Coalition, "Welfare Reform and Health Care: The Wrong Prescription for Immigrants," November 2000.

<sup>45</sup> Billings J., Parikh N., and Mijanovich T. "Emergency Room Use: The New York Story," The Commonwealth Fund, November 2000.

the complex application process and the extensive documentation required, however, hospitals frequently are unable to complete the Medicaid application before the patient is discharged after a short hospital stay. It is almost always too time-consuming and costly for hospital staff to assist with Emergency Medicaid applications on behalf of patients treated in the emergency room and released without an inpatient admission.<sup>46</sup> Thus, Emergency Medicaid, as currently administered, will do little to stem the financial blow hospitals serving a large percentage of immigrant patients will likely feel as the number of uninsured immigrants barred from Medicaid continues to grow.<sup>47</sup>

As recently reported in the *Wall Street Journal*, many hospitals are already feeling the financial and clinical effects of coverage restrictions enacted with the Personal Responsibility and Work Opportunity Reconciliation Act of 1995 (PRWORA).<sup>48</sup> Hospitals have no discharge option for patients who are eligible only for Emergency Medicaid but who require rehabilitation or long-term care services. These patients no longer need acute inpatient care but are too frail to be discharged into the community. Rehabilitation facilities, home care agencies, and private nursing homes rarely accept patients who are unable to pay for their care. Thus, hospitals have no choice but to retain patients for whom inpatient care is no longer clinically appropriate. During periods of peak utilization, the beds occupied by these patients are not available to those truly in need of acute care, and hospitals may have to turn away all but emergency admissions.

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Billings J., Parikh N., and Mijanovich T. "Emergency Department Use in New York City: A Substitute for Primary Care?" The Commonwealth Fund, November 2000.

<sup>46</sup> New York Immigration Coalition, 2000.

<sup>47</sup> Ibid.

<sup>48</sup> Lagnado L. "Emergency Medicaid Policy Binds Sick Immigrants Without an Exit," the *Wall Street Journal*, October 18, 2000.



## II. WELFARE REFORM AND THE FEDERAL RETREAT FROM SUPPORT FOR MEDICAID COVERAGE FOR IMMIGRANTS

### **The Personal Responsibility and Work Opportunity Reconciliation Act of 1996**

Until federal welfare reform in 1996, the federal Medicaid program offered coverage to virtually all low-income immigrants who were lawfully present in the United States. This longstanding policy underwent a major reversal in PRWORA.<sup>49</sup> While the legislative details are complex, the bottom line is straightforward: the federal government will not contribute to the non-Emergency Medicaid costs of (1) most lawfully present immigrants who entered the country on or after August 22, 1996, the date that PRWORA was enacted; or (2) lawfully present immigrants known as PRUCOLs (Persons Residing Under Color of Law), regardless of how long they have lived in this country (see Appendix A for details regarding PRUCOLs).

These new exclusions are in addition to the longstanding exclusion of undocumented immigrants from full Medicaid coverage. In 1997, Congress extended PRWORA's framework for immigrant eligibility to the federal State Children's Health Insurance Program (SCHIP), thereby denying states federal funds for the costs of immigrant children participating in their SCHIP programs.

Under PRWORA, only certain legal immigrants are eligible for federally funded Medicaid. To describe those immigrants who may potentially qualify for Medicaid, PRWORA created a new classification for non-citizens: "qualified aliens."<sup>50</sup> This category includes legal permanent residents (those with a so-called green card) as well as refugees and asylees (see below), among others. The operative term is *potentially*. As described below, many qualified aliens are not in fact eligible for full Medicaid coverage.

Qualified aliens who were in the United States before August 22, 1996, are eligible for full Medicaid coverage.<sup>51</sup> Most immigrants who arrived here on or after August 1996 are eligible for emergency care only, until they meet a five-year residency

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<sup>49</sup> P.L. 104-93 (August 22, 1996); 42 U.S.C.A. § 602 et seq. (2000).

<sup>50</sup> A qualified alien is defined in PRWORA as a (an): Legal Permanent Resident (LPR); refugee; asylee; immigrant who has had deportation withheld; immigrant granted parole for at least one year; immigrant granted conditional entry; battered immigrant or her dependent child. 8 U.S.C.A. § 1641 (2000).

<sup>51</sup> 8 U.S.C.A. §§ 1612 (b), §1613 (a) (2000). In addition, certain American Indians born in Canada are eligible for Medicaid and are not subject to the five-year bar. 8 U.S.C.A. §§ 1612 (b) (2) (E); 1613 (d).

requirement.<sup>52</sup> Even after five years of United States residency, many will still not qualify as a result of a provision in PRWORA that deems their sponsors' income as available to them for purposes of determining their Medicaid eligibility.<sup>53</sup> This policy, known as sponsor deeming, can be an insurmountable barrier to Medicaid eligibility<sup>54</sup> since sponsors are required to have incomes at or above 125 percent of the federal poverty level—incomes well in excess of Medicaid income thresholds in New York State.<sup>55</sup>

## SELECTED IMMIGRATION TERMS<sup>56</sup>

*Asylee:* An asylee is a person unable or unwilling to return to his or her home country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a particular social group. Unlike a refugee, an asylee is deemed as present in the United States when he or she requests permission to stay.

*Lawful Permanent Resident (LPR):* A lawful permanent resident (or permanent resident alien) is a non-citizen who is legally accorded the privilege of residing permanently in the United States. LPRs are issued “green cards” and are permitted to apply to naturalize after five years of residency in the United States.

*Legal Immigrant:* For purposes of this report, a legal immigrant is a non-citizen immigrant who is lawfully present in the United States. This term does not include tourists, students, or business visitors who are here temporarily.

*Parolee:* A parolee is a non-citizen admitted into the U.S. in an emergency or to promote an overriding public interest. Parolees are typically admitted for humanitarian, legal, or medical reasons.

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<sup>52</sup> 8 U.S.C.A. § 1613 (a) (2000). Certain qualified immigrants are exempt from PRWORA's five-year bar: refugees; asylees; Cuban and Haitian entrants; Amerasian immigrants; immigrants whose deportation has been withheld; non-citizens on active U.S. military duty or honorably discharged from the U.S. military and their families; and legal permanent residents who have 40 qualifying quarters of work in the U.S. 8 U.S.C.A. § 1613 (b).

<sup>53</sup> 8 U.S.C.A. 1631 (2000).

<sup>54</sup> Since sponsor-deeming will not take effect as a practical matter until five years from the enactment of PRWORA (i.e., August 2001), the U.S. Department of Health and Human Services has not yet promulgated regulations for implementing sponsor-deeming under the Medicaid program.

<sup>55</sup> 8 U.S.C.A. 1183a (f) (E) (2000). In addition, under PRWORA, affidavits of support executed by sponsors were made legally enforceable. Thus, sponsors are liable for the cost of public benefits obtained by those they sponsor. Sponsors are not liable, however, for the cost of Emergency Medicaid. P.L. 104-193, Title IV, subtitle C, §423(d) (Aug. 22, 1996).

<sup>56</sup> These definitions were derived in large part from “Glossary and Acronyms,” Immigration and Naturalization Service, <http://www.ins.usdoj.gov>, and “Common Immigration Terms,” prepared by the Immigration Policy Project of the National Conference of State Legislatures (July 31, 1997).

*Persons Residing Under Color of Law (PRUCOLs):* PRUCOL is not an official immigration status for purposes of entering the United States. Rather, it is used to refer to a number of immigrant classifications that indicate that a person is legally present under statutory authority and may remain in the United States under administrative discretion. Generally, PRUCOLs are non-citizens residing in the United States for an indefinite period of time with the knowledge of the Immigration and Naturalization Service (INS) and whose departure the INS does not contemplate enforcing.

*Qualified Alien:* This term was first used in the PRWORA as a means of defining immigrant eligibility for public benefits. A qualified alien is a non-citizen immigrant with one of the following statuses: legal permanent resident, refugee, asylee, or alien paroled into the United States for at least one year; alien granted withholding of deportation; alien granted conditional entry; certain battered alien spouses and their children; or American Indian born in Canada.

*Refugee:* A refugee is a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a particular social group.

*Sponsor:* An immigrant seeking to join his or her family in the United States must have an affidavit of support from a sponsor. Generally, sponsors must be United States citizens, nationals, or lawful permanent residents, 18 years of age or over, residents of the 50 states or D.C., and the petitioner for admission of the immigrant. Sponsors must have incomes of at least 125 percent of the federal poverty level. Their affidavit of support is a legally enforceable agreement to provide financial assistance to the sponsored immigrant.

*Undocumented Immigrant:* An undocumented immigrant is a person living in the United States without official authorization, either by entering the country illegally or by violating the terms of his or her visa.

PRUCOLs are one significant group of lawfully present immigrants who are not considered “qualified” and are excluded from the federal Medicaid program under PRWORA—even if they were living in the U.S. prior to its enactment. Generally, PRUCOLs are immigrants who are residing in the United States for an indefinite period with the knowledge of the INS and whose departure the INS does not contemplate enforcing. Although they were eligible for full Medicaid benefits until the enactment of

PRWORA, they are now eligible only for emergency care.<sup>57</sup> (See Appendix A for a further discussion on PRUCOLs.)

PRWORA gave states the option of covering these immigrants at their own expense. Accordingly, at least nine states, including New York's neighbors—Connecticut, Massachusetts, New Jersey, and Pennsylvania—elected to cover post-enactment immigrants and non-qualified immigrants using state funds (see Appendix B for a complete list of states). With a few very limited exceptions, New York did not.

### **Immigrant Eligibility for Medicaid Under New York's Welfare Reform Act of 1997**

In August 1997, New York State enacted its own Welfare Reform Act to implement the new federal law.<sup>58</sup> Unlike its neighbors, New York opted to provide full Medicaid coverage only to immigrants eligible for federally funded Medicaid.<sup>59</sup> New York also incorporated PRWORA's sponsor-deeming requirements into state law.<sup>60</sup> However, using state and local funds, New York extended full Medicaid to two limited groups of immigrants:

- PRUCOLs residing in residential health care facilities or a residential facility licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities and receiving Medicaid as of August 4, 1997; and
- PRUCOLs diagnosed with AIDS and receiving Medicaid as of August 4, 1997.<sup>61</sup>

Immigrants subject to PRWORA's five-year ban and sponsor-deeming, PRUCOLs (other than the two groups described above), and undocumented immigrants in New York are eligible only for emergency care and for services furnished under New York's Prenatal Care Assistance Program (PCAP). PCAP is a Medicaid-funded program for pregnant women with incomes up to 200 percent of the federal poverty level. New York, unlike other states, receives federal financial participation for PCAP services provided to federally ineligible immigrants as a result of a federal court order.<sup>62</sup>

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<sup>57</sup> 8 U.S.C.A. § 1611 (b) (2000).

<sup>58</sup> McKinney's Laws of New York , 1997, c. 436, pt. B, §7.

<sup>59</sup> N.Y. Social Services Law § 122.

<sup>60</sup> N.Y. Social Services Law § 122 (4).

<sup>61</sup> N.Y. Social Services § 122 (1)(c).

<sup>62</sup> *Lewis v. Grinker*, 965 F.2d 1206 (2d Cir. 1992).

The decision to restrict immigrant Medicaid benefits reflected the concern of a number of policymakers that immigrants from other states would flood into New York seeking Medicaid coverage if it offered benefits to all lawfully present immigrants. Whatever the validity of that concern in 1997, it is significantly diminished now that all states bordering New York, with the exception of Vermont, have extended state-funded Medicaid to immigrants.

### **Immigrant Eligibility for FHP, Child Health Plus, and Other Health Insurance Programs in New York**

Restrictions on immigrant eligibility for Medicaid are equally applicable to FHP, the state's Medicaid expansion for low-income uninsured families whose income puts them just beyond Medicaid's limits. (See Appendix C for Medicaid, FHP, and CHP income standards.) Enacted in January 2000, FHP offers health coverage through a managed care delivery system with benefits comparable to a commercial benefit package and without any long-term care benefit.

New York adopted a different approach to immigrant eligibility in its CHP program. CHP was established in 1990, long before enactment of the State Children's Health Insurance Program (SCHIP) as part of the federal Balanced Budget Act of 1997. Like FHP, CHP currently provides a comprehensive benefit package delivered through managed care plans. And like FHP, it does not cover long-term care services.

When the federal SCHIP was enacted and incorporated PRWORA's immigrant exclusions, New York was faced with a troublesome dilemma: it could terminate coverage of immigrant children already enrolled in the program to meet federal mandates or it could cover those children with state funds. Rather than deny coverage to needy children, New York continued its policy of covering immigrant children regardless of their immigrant status.

### **Subsidized Health Coverage for Immigrants in New York State**

New York provides subsidized health coverage through several programs in addition to Medicaid. New York residents, regardless of immigrant status and date of entry, are eligible for the following:

- *Child Health Plus*: Coverage of primary and acute care for children under age 19 with incomes up to 250 percent of the federal poverty level.

- *Healthy New York*: Coverage of primary and acute care for uninsured low-income workers; the program generally requires substantial cost-sharing and employer participation.
- *Elderly Pharmaceutical Insurance Coverage (EPIC)*: Prescription drug coverage for adults age 65 or over with incomes up to \$55,000 if married and up to \$35,000 if single.
- *AIDS Drug Assistance Program (ADAP)*: Drug assistance and insurance premium subsidies for persons with HIV infection who meet income standards.

### **III. OPTIONS FOR EXPANDING HEALTH COVERAGE FOR LOW-INCOME IMMIGRANTS IN NEW YORK STATE**

At the federal and state level, efforts have been made to address the devastating impact of PRWORA on immigrants. A number of bills have been introduced in Congress to expand Medicaid coverage to certain lawfully present immigrants—namely pregnant women, children, and their parents.

President Clinton included in his federal fiscal year 2001 budget submission a proposal to restore Medicaid and expand SCHIP to cover qualified pregnant women, children, and parents who entered the United States on or after August 22, 1996. The Family Care Act of 2000 (S.2923/Kennedy) would also provide Medicaid and SCHIP coverage for pregnant women, children, and parents who are legally present in the United States but otherwise ineligible based on their immigrant status or date of entry. The Immigrant Children's Health Improvement Act (S.1227/Moynihan) would provide Medicaid and SCHIP coverage for legal immigrant pregnant women and children who are otherwise ineligible for these programs based on immigrant status or date of entry. None of these proposals is under active consideration.

Instead of waiting for a federal solution to the problem, at least 10 states have established state-funded programs to provide the equivalent of Medicaid coverage to federally ineligible, lawfully present immigrants. In most of these states, post-1996 immigrants and PRUCOLs are eligible for Medicaid coverage on the exact same terms as citizens. The remaining states offer immigrants a somewhat more restricted benefit package. (See Appendix B for a more complete analysis.)

New York has not yet elected to follow these 10 states by adopting a comprehensive approach to providing health coverage for federally ineligible immigrants. As the detrimental impact of PRWORA on immigrants, their citizen family members, the health care safety net, and the public health reach dramatic proportions, however, the lack of such an approach is becoming impossible to ignore. The following sections of this report offer three options for addressing the health coverage gaps among New York State's low-income immigrants. Each option would provide a comprehensive benefit package to lawfully present immigrants, although the scope of benefits offered by each vary. The variations in benefit packages, in turn, drive differences in costs among the three options. All three options attempt to maximize the federal contribution to the program.

### **Option One: Restore Medicaid and Expand FHP**

The approach that would most fully address the problems of immigrants and their health care providers is a restoration of the status quo prior to welfare reform. In other words, the eligibility rules for immigrants—including sponsor-deeming requirements—that were incorporated into the New York State Medicaid program as part of welfare reform would be repealed so that any category of immigrant who would have been eligible for Medicaid before welfare reform would be eligible for Medicaid again. In addition, FHP would be made available to the same categories of immigrants. Under this approach, for purposes of Medicaid and FHP eligibility, lawfully present immigrants would be on the same footing as citizens.

All lawfully present immigrants who meet financial eligibility standards would have access to the full range of Medicaid benefits, not merely emergency care. The same Medicaid managed care participation requirements that apply to citizens would also be applied to immigrants. Immigrants with incomes or resources above the Medicaid standards, but within the standards for FHP, would be eligible for FHP on the same terms as citizens. Thus, like citizens enrolled in FHP, they would be required to join a managed care plan as a condition of coverage and would have access to the more limited range of benefits offered under FHP. (See Appendix D for a list of FHP benefits).

Federal financial participation would be claimed for emergency room visits and emergency admissions and services provided under the PCAP program, since federal Medicaid is available for those services. Under federal law, immigrants otherwise ineligible for Medicaid are eligible for care and services necessary to treat an “emergency medical condition,” which is defined as:

“[a] medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (A) placing the patient’s health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part.”<sup>63</sup>

Emergency care expressly excludes treatment related to an organ transplant.<sup>64</sup>

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<sup>63</sup> 42 U.S.C.A. § 1396b (v) (3) (2000).

<sup>64</sup> 8 U.S.C.A. § 1611 (b) (1) (A) (2000).



This approach offers a simple and comprehensive solution to the problems caused by the immigrant eligibility changes under welfare reform. It would require no new administrative structures because all administrative functions would be performed under the Medicaid and FHP programs. Moreover, unlike the options discussed below, this option minimizes distinctions between immigrants and citizens that complicate program operations and deter participation.

In addition to administrative simplicity, this approach offers the potential for better health outcomes. It provides benefits needed to minimize unnecessary emergency room utilization and avoidable hospitalizations by providing a comprehensive benefit package offered by Medicaid and FHP, including primary and preventive care, prescription drugs, diagnostic tests, and inpatient care. (See Appendix D for a list of covered benefits.) In addition, it provides coverage of long-term care services for individuals who meet Medicaid's income and asset limits. Accordingly, this option would permit immigrants to receive the appropriate level of care, including skilled nursing and rehabilitation, instead of languishing in hospitals because they are unable to pay for long-term care and are too frail to be discharged to their homes.

The only potential disadvantage to this approach is its cost. However, because New York currently covers expensive emergency care, as described below, the state is already bearing a significant portion of this cost, and the incremental costs of full coverage are minimal. Other states have apparently determined that the cost of this approach is outweighed by its advantages. California, Connecticut, Maine, Minnesota, Nebraska, New Jersey, and Pennsylvania have all opted to treat lawfully present immigrants like citizens for the purpose of providing health care coverage.

### **Option Two: Provide Only FHP Coverage to Immigrants**

Under this approach, lawfully present immigrants who meet financial eligibility standards for Medicaid or FHP would be eligible for FHP only. Like citizens enrolled in FHP, they would be eligible for an array of benefits through a managed care delivery system, including primary and preventive care, inpatient care, prescription drugs, and mental health care. They would not be eligible for Medicaid's more generous benefit package even if they met Medicaid's income and asset standards. The most significant differences between the Medicaid and FHP programs are the exclusion of long-term care services from FHP and the requirement that all FHP enrollees join a managed care plan. Thus, unlike citizens and federally qualified immigrants, they would not be able to obtain Medicaid coverage of long-term care, even if it were medically necessary and they were financially eligible.

Although this approach is less generous than the first option, it would provide a broad benefit package comparable to employer-based coverage. It would, for instance, provide the prescription drug coverage and primary and preventive care that could avert many emergency room visits and lengthy hospitalizations.

This approach would not, however, address the problems of patients with long-term care or rehabilitation needs. Thus, under this proposal, safety net hospitals would continue to be faced with patients who are medically ready for discharge but incapable of paying for the long-term or rehabilitative care they need.

On the positive side, this proposal would not require a new administrative infrastructure, as it could be incorporated into the FHP administration. At least two other states, Delaware and Massachusetts, have determined that providing a more limited benefit package for federally ineligible immigrants is an appropriate response to the Medicaid eligibility changes brought by welfare reform. In Delaware and Massachusetts, federally ineligible immigrants are eligible for coverage of primary and preventive care and hospitalizations, but not long-term care.

Finally, this approach parallels New York's method of covering low-income immigrant children. CHP provides comprehensive health coverage to immigrant children through a managed care system; there is no Medicaid option.

### **Option Three: Provide a Limited Benefit Package Based on the Early CHP Model**

A third approach to covering lawfully present federally ineligible immigrants would be to develop a new, more limited program to address certain health care needs. This option would involve the creation of a separate subsidized outpatient health insurance program based on the model of the early CHP program.<sup>65</sup>

Under this scenario, coverage would include primary and preventive care, diagnostic tests, and prescription drugs provided through managed care plans. Inpatient care would be limited to that which qualifies as emergency care under federal regulations and would be reimbursed through the Medicaid fee-for-service program. As a practical matter, most inpatient admissions in the Medicaid program qualify as treatment for an

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<sup>65</sup> When first enacted in 1990, CHP provided coverage for outpatient services only. N.Y. Ch. 922, 1990. Children requiring hospitalization were “converted” to Medicaid by spending down their excess income and assets. The state has since expanded the program to cover inpatient care and other previously excluded services, such as dental and vision care.

emergency medical condition under federal regulations.<sup>66</sup> Likewise, prenatal care, labor, delivery, and postpartum care would be covered under New York's PCAP program. Modest premiums of \$9 per member per month would be charged to defer costs.

Like the second option, this option is slightly less expensive because it would not cover long-term care or rehabilitation. However, this discount in cost comes at a price: the approach does nothing to address the issue of federally ineligible immigrants admitted to hospitals for emergency care who cannot be discharged because they lack the means to pay for their required outpatient care. Moreover, this approach would encourage unnecessary use of the emergency room and inpatient admissions for treatments and procedures that could be delivered on an ambulatory basis, such as kidney dialysis and minor surgery. In addition, health plans would have little financial incentive to manage the care of these enrollees since they would not be responsible for emergency and inpatient care, nor would they reap the financial benefits of reduced hospital utilization.

Furthermore, the wisdom of using premiums to defer costs is questionable. Modest premiums would contribute little toward offsetting the cost of the proposal: at \$9 per member per month, with an enrollment of approximately 3,378 in the first year, premiums would generate only \$365,000 in revenue. However, even modest premiums would deter enrollment, particularly among healthy immigrants.<sup>67</sup> Thus, a program with cost-sharing would leave a larger portion of the target population uninsured and would lead to significantly higher average costs among enrollees due to adverse selection, resulting in little overall savings.

Finally, this option would involve significant administrative investments for a relatively small number of enrollees. The creation of a new program is costly, requiring system changes, training of personnel, new contracts with health plans, and consumer education. Indeed, the additional costs associated with administrative changes would consume some of the savings associated with the reduced benefit package.

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<sup>66</sup> N.Y., Ch. 2, 1988.

<sup>67</sup> Ku, L. and Coughlin, T. "The Use of Sliding-Scale Premiums in Subsidized Insurance Programs," the Urban Institute, March 1997.

#### IV. COST COMPARISON

From a programmatic, as opposed to fiscal, perspective, all three options present clear advantages and disadvantages. The political debate, however, may of necessity be driven by cost considerations. The key factors that account for the variation in costs between the three options are:

1. Coverage of long-term care benefits.
2. Inclusion of a fee-for-service component.
3. Need for new administrative systems and procedures.

This section examines the costs associated with each of the three options discussed above. The analysis applies both phase-in and participation rates to calculate the number of eligible immigrants likely to enroll in the first and third years of any insurance expansion. Experience in New York State and across the country suggests that new insurance programs take time to implement, with program enrollment starting up slowly over a several year period and rarely ever reaching the full target enrollment level. Efforts to enroll low-income immigrants would likely face an even slower initial start-up as outreach efforts would be needed to overcome significant misinformation and other barriers to enrollment within immigrant communities. The analysis assumes that over a five-year period these efforts would achieve a Medicaid participation rate of approximately 35 percent—the current participation rate among federally eligible immigrants.<sup>68</sup>

The projected enrollment numbers are then multiplied by the projected costs associated with each enrollee to calculate the total or gross costs of each option. The total costs to the state and local social services districts are reduced by federal funds available to cover emergency and PCAP services provided to immigrants. To arrive at the *incremental* costs to the state and local social services districts of each option, the remaining costs are then reduced further by the money the state and local districts would have spent anyway on emergency and PCAP services for program enrollees. Finally, the incremental costs are reduced further to the extent that spending on parents contributes to the state's TANF

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<sup>68</sup> KAZB estimate based on the Medicaid participation rate for all adults in New York State in 1998 (see Thorpe, K. "Medicaid Eligible, But Uninsured: The New York State Experience," United Hospital Fund, October 2000, p. 4) adjusted downward for the decline in participation rates for immigrants as calculated by researchers at the Urban Institute (see Fix, M. and Passel, J. "Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97," the Urban Institute, March 1999, Table 1.

MOE and permits the state and local governments to supplant a portion of their spending on cash assistance with federal TANF dollars.

### **Costs of Option One: Restore Medicaid and Expand FHP**

To arrive at an estimate of the costs of option one—the Medicaid/FHP approach—the costs associated with the Medicaid portion of the program are calculated first. The statewide average is used for Medicaid managed care premiums for the non-aged, non-disabled population plus average Medicaid expenditures for their medications. For the aged and disabled population, average Medicaid fee-for-service expenditures in these categories are relied on. These figures are weighted to reflect regional variations in the immigrant population (see Appendix E for details) and the distribution of immigrants among aid categories.<sup>69</sup> Assuming an enrollment of 3,378 individuals in the first full year of operations, total first-year costs for the Medicaid component would be \$13.3 million. By the third year of operations, enrollment in the Medicaid component could reach 17,779, at a total cost of approximately \$74.1 million.

To calculate the cost of the FHP component of option one, the analysis starts with the statewide weighted average Medicaid managed care premium for adults. It adds the costs associated with prescription drugs and additional mental health, dental, and vision benefits included in the FHP package but not in the Medicaid managed care rates. Also deducted from the Medicaid premiums are the portion of premiums associated with services and supplies that are not covered by FHP, such as non-emergent transportation and home health care. The same participation and start-up rates are assumed for FHP as for the Medicaid component to arrive at a gross first-year cost for the 2,473 additional FHP enrollees of \$7.9 million. By the third year of operations, assuming extensive outreach and enrollment efforts, the FHP component could reach a total of 15,496 enrollees at a gross cost of approximately \$52.3 million.

Thus, aggregating the costs of the two components of the proposal, the gross first-year cost of option one would be approximately \$21.1 million, and the gross third-year cost would be approximately \$126.4 million.

A less costly variation on this option would be to restore Medicaid coverage without the FHP expansion. As noted above, the total cost of this approach would be \$13.3 million in year one and \$74.1 million in year three.

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<sup>69</sup> Estimates were derived from the Medicaid Reference Statistics, federal fiscal year 1997–99, New York State Department of Health, Office of Medicaid Management, online SURS Information Retrieval System.

Federal funds would be available for approximately 42 percent of the program costs associated with emergency care and for 50 percent of the costs associated with services provided under New York's PCAP program.<sup>70</sup> In the first year, New York would receive approximately \$3.3 million in federal reimbursement for costs associated with emergency and PCAP care under the Medicaid component. By the third year, federal matching funds for emergency and PCAP care under the Medicaid component would amount to approximately \$18 million.

For the first year of the FHP component, New York would receive approximately \$2.4 million in federal reimbursement for emergency and PCAP care. And by the third year of operations, the FHP component would draw approximately \$15.7 million in federal reimbursement for emergency and PCAP care. In total, by the third year of operations, the two components together should draw approximately \$33.8 million in federal reimbursement for emergency and PCAP care.<sup>71</sup>

Moreover, the nonfederal share of emergency and PCAP expenditures is currently paid by the state and localities. This amount must be deducted from gross costs to arrive at the net spending this option would require. To arrive at the incremental costs of the proposed expansion, Figure 11 below sets out the costs for each of the options and juxtaposes them with the amount that the state and local social services districts would have spent on emergency and PCAP services for federally ineligible immigrants absent implementation of any insurance expansion.

In addition, as described more fully in Part V, if the state designated nonfederal spending on services other than emergency and PCAP care as TANF MOE spending, the state and local social services districts could reduce their spending on cash assistance (which is currently inflated to satisfy MOE requirements) and replace it with federal TANF funds.

### **Figure 11: Option One: Costs of Restoring Medicaid and Expanding FHP**

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<sup>70</sup> Because the state does not receive federal financial participation in costs associated with non-disabled adults under the age of 65 who are not pregnant and do not have minor children, federal reimbursement accounts for slightly less than 50 percent of these costs. See methodology, Appendix E.

<sup>71</sup> Estimates of federal reimbursement were derived using New York State Department of Health, Office of Medicaid Management, Online Retrieval System, Medicaid Emergency Services Recipients, Ages 21+, federal fiscal year 1999.

	<b>Year One</b>	<b>Year Three</b>
Total Eligible Population	167,425	238,036
Projected Enrollment	5,851	33,275
Total Cost	\$21.1 million	\$126.4 million
Federal Contribution	\$5.7 million	\$33.8 million
Total Nonfederal Cost	\$15.5 million	\$92.6 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and Prenatal Care Assistance Program (PCAP) for Program Enrollees	\$4.7 million	\$26.4 million
Incremental Costs (new, nonfederal)	\$10.8 million	\$66.3 million
Increased TANF MOE	\$5.7 million	\$33.9 million
Net Financial Plan Impact	\$5.1 million	\$32.4 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

A variation of this option would be to restore eligibility for Medicaid but not for FHP. As Figure 12 illustrates, restoring Medicaid eligibility alone would likely cover approximately 3,400 individuals in the first year of operations and 17,800 by the third year of operations. In any case, even if immigrants were permitted to participate in both Medicaid and FHP, in year one the Medicaid-only numbers below are more probative given the continuing delay in implementation of any FHP program.

**Figure 12: Costs of Restoring Medicaid Alone to Legal Immigrants**

	<b>Year One</b>	<b>Year Three</b>
Total Eligible Population	96,652	127,183
Projected Enrollment	3,378	17,779
Total Cost	\$13.3 million	\$74.1 million
Federal Contribution	\$3.3 million	\$18.0 million
Total Nonfederal Cost	\$10.0 million	\$56.0 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and PCAP for Program Enrollees	\$4.3 million	\$23.8 million
Incremental Costs (new, nonfederal)	\$5.7 million	\$32.3 million
Increased TANF MOE	\$3.2 million	\$17.9 million
Net Financial Plan Impact	\$2.5 million	\$14.4 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

### **Costs of Option Two: Provide FHP**

To develop the costs of this option, the cost assumptions made in calculating the FHP component of option one were repeated. If immigrants with incomes at or below the FHP eligibility thresholds were permitted to enroll, the gross first-year costs would be approximately \$18.6 million. By the third year of operations, gross costs would be approximately \$112.3 million.

As in option one, federal matching funds would be available for services provided under PCAP and for emergency care. In the first year of operations, under FHP income limits, New York would receive approximately \$5.7 million in federal reimbursement for emergency and PCAP care. By the third year of operations, New York should receive approximately \$33.8 million in federal reimbursement for emergency and PCAP care under FHP limits.

Figure 13 below compares the gross costs of this option with the amount that the state and local social services districts would have spent on emergency and PCAP care for the projected enrollees without implementation of any insurance expansion, thereby highlighting the incremental costs. In addition, it highlights the proposal’s impact on the state’s TANF MOE spending.

**Figure 13: Option Two: Costs of Providing FHP to All Legal Immigrants Eligible for Medicaid and FHP**

	Year One	Year Three
Total Eligible Population	167,425	238,036
Projected Enrollment	5,851	33,275
Total Cost	\$18.6 million	\$112.3 million
Federal Contribution	\$5.7 million	\$33.8 million
Total Nonfederal Cost	\$13.0 million	\$78.6 million
Offset—Anticipated Expenditures Under Current Law for Emergency Medicaid and PCAP for Program Enrollees	\$4.7 million	\$26.4 million
Incremental Costs (new, nonfederal)	\$8.3 million	\$52.2 million
Increased TANF MOE	\$3.9 million	\$24.3 million
Net Financial Plan Impact	\$4.4 million	\$27.9 million

Note: Dollar amounts are rounded to the nearest \$0.1 million.

A comparison of options one and two shows that it would not cost the state a great deal more to make full Medicaid, as opposed to only FHP with no long-term care services, available to low-income immigrants. Not only is the provision of long-term care services of critical importance to a small number of immigrants, it would help New York City and counties with public long-term care facilities that must now bear the full brunt of the costs of these needy and costly patients. Figure 14 below compares the costs of options one and two. Appendix F lists the county and city long-term care facilities that now or in the future may be compelled to care for uninsured immigrants.

**Figure 14: Comparison of Options One and Two**

Option One (Assuming	Option One	Option Two (Assuming	Option Two
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	<b>Medicaid Income Limits)</b>	<b>(Assuming FHP Income Limits)</b>	<b>Medicaid Income Limits)</b>	<b>(Assuming FHP Income Limits)</b>
Estimated Number Income-Eligible for Medicaid	96,652	96,652	96,652	96,652
Estimated Number Income-Eligible for FHP	0	70,773	0	70,773
Estimated Number of Participants	3,378	5,581	3,378	5,851
Total Nonfederal Costs	\$10.0 million	\$15.5 million	\$7.5 million	\$13.0 million
Incremental Costs Net of Anticipated Expenditures Under Current Law	\$5.7 million	\$10.8 million	\$3.2 million	\$8.3 million
Increased TANF MOE	3.2 million	5.7 million	1.8 million	3.9 million
Net Financial Impact	2.5 million	5.1 million	1.4 million	4.4 million

### **Costs of Option Three: Provide Outpatient Benefits Package**

While the number of likely participants and their associated costs have not been modeled for this option, the costs of option three are likely to be nearly as great as for option two. The benefits would be almost identical to FHP. Any revenue derived from cost-sharing would likely be minimal, unless premiums and copayments were so high as to make the program unaffordable. For example, if 3,378 individuals enrolled in the first year and paid annual premiums of \$9 monthly each, the state would collect only \$365,000. The administrative costs associated with collecting the premiums, disenrolling members who failed to pay, and re-enrolling them when they commenced payment would likely offset much of the revenue. Additional administrative costs associated with implementing the variations of FHP or establishing a new CHP-like program would likely consume much of the remaining savings.

## V. IMPLEMENTATION ISSUES

While some of the options involve unique administrative challenges, a number of implementation issues are common to all of the options:

Maximizing federal funds

Local share and geographic scope

Enrollee cost-sharing, sponsor-deeming, and liability

State constitutional issues

### **Maximizing Federal Funds**

#### *Federal Medicaid Funds*

As noted above, the state may claim federal matching funds for a significant portion of its costs in providing health care to low-income immigrants. To draw federal Medicaid funds, New York must structure its immigrant coverage so that emergency (both inpatient and outpatient) and PCAP services are identifiable and delivered in compliance with federal Medicaid requirements. This would be easy in a fee-for-service system: the state could continue its existing processes for submitting claims related to immigrants who are otherwise ineligible for Medicaid.

Under a managed care delivery system, seeking federal reimbursement for discrete services would be more complex. Specifically, when managed care plans are paid a monthly capitation for a specified benefit package, inpatient, emergency, and prenatal care are not separately delineated. Through encounter data and claims submissions, however, it is possible to separate services eligible for federal financial participation (FFP) from those that are not. In fact, the obligation to separately delineate certain services and costs occurs now with respect to abortion services. These services are included in both the Medicaid managed care and CHP capitation payment, but are not eligible for federal matching funds and accordingly must be carved out of the state's submissions for FFP.

Further precedent exists for this approach. The state used a similar mechanism for claiming FFP for Medicaid furnished to Home Relief (HR) beneficiaries<sup>72</sup> prior to

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<sup>72</sup> Prior to the enactment of New York's Welfare Reform Act in 1997, the Home Relief program offered cash assistance and state-funded Medicaid for adults without dependent children and intact families that were ineligible for the federal Aid to Families with Dependent Children program. With the passage of the Welfare Reform Act, Home Relief was renamed "Safety Net Assistance." It continues to provide cash assistance and Medicaid for adults without dependent children.

approval of the state's 1115 waiver. Prior to the waiver, the state could not draw FFP for HR beneficiaries. However, the state was permitted to claim federal disproportionate share hospital (DSH) payments for the inpatient costs of HR beneficiaries. Initially, the state did not claim DSH payments for HR beneficiaries voluntarily enrolled in Medicaid managed care plans. In 1996, however, it asked Medicaid managed care plans to separately submit inpatient cost data for HR enrollees to enable it to secure federal DSH funds with respect to these costs. A similar mechanism could be developed with respect to the emergency and PCAP services delivered to immigrants enrolled in managed care plans.

Another alternative would be to calculate the portion of the monthly premium that represents emergency and PCAP services for federally ineligible immigrants and seek FFP for those expenditures. It is unclear whether the Health Care Financing Administration (HCFA) would approve such a mechanism. Not every enrollee would utilize emergency or PCAP services, but the state could seek reimbursement of that portion of every premium. Like the state, the federal government would benefit from the transfer of risk to managed care plans. To the extent that actual emergency and PCAP costs exceeded that portion of premium payments, HCFA would save money.

In addition to FFP for emergency and PCAP services received by adults, another source of federal funds is to date untapped in New York. The state is currently forgoing FFP for emergency and PCAP services rendered to immigrant children enrolled in CHP who meet Medicaid's financial eligibility criteria. There appears to be no reason for the state to forfeit federal matching funds for these services. Claiming FFP would enhance the state's federal Medicaid revenue and reduce the level of state funds needed to finance the CHP program. This would free up state funds to underwrite a new program for federally ineligible immigrant adults.

Of the 10 states that have enacted state-funded Medicaid programs for federally ineligible immigrants, none has sought federal reimbursement for emergency care delivered through managed care plans. Several, including California, Massachusetts, and Minnesota, have simply forfeited the funds. Connecticut, Nebraska, and Washington bar federally ineligible immigrants from their capitated managed care programs. Massachusetts and New Jersey are in the process of developing a means of claiming federal reimbursement for emergency services.<sup>73</sup>

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<sup>73</sup> Telephone interview with Tricia Spellman, Massachusetts Division of Medical Assistance, November 15, 2000; and telephone interview with Katherine Plant, New Jersey Division of Medical Assistance, October 2, 2000.

*Temporary Assistance to Needy Family Maintenance of Effort Funds*

In addition to drawing federal Medicaid matching funds for its emergency and PCAP spending on federally ineligible immigrants, the state could count other spending (other than PCAP and emergency care payments) toward its maintenance of effort (MOE) requirements under the federal Temporary Assistance to Needy Families (TANF) program. By designating its spending on health coverage for immigrant families as MOE spending, New York could more easily meet its MOE requirement and maximize its collection of federal TANF funds.

While this report has focused considerable attention on the provisions of PRWORA that limit immigrant access to health care insurance, PRWORA's primary goal was to redesign the country's welfare or cash assistance program, moving beneficiaries from welfare to work. PRWORA created the TANF program, which provides states with block grants and substantial flexibility in implementing its goals.

To obtain a block grant, a state must spend state funds in an amount equal to at least 75 percent of that which it spent in 1994 on its Aid to Families with Dependent Children program. (If a state is not meeting its work requirements, the requirements jump to 85 percent.) The funds must be spent on low-income families to advance the goals of the TANF program. This obligation is referred to as the state's MOE requirement. When a state fails to meet this requirement, its TANF grant is reduced by one dollar for each dollar of MOE shortfall.<sup>74</sup> The state must replace the lost TANF dollars with state or local funds, and it loses its federal Welfare-to-Work grant. If a state fails to meet the MOE requirement for two consecutive years, its TANF block grant is reduced by an additional 2 percent.<sup>75</sup>

State funds spent to provide health care to immigrant families whose incomes are below the TANF income level count toward the MOE requirement. Specifically, PRWORA permits states to include in their MOE calculation state expenditures on "qualified activities" for "eligible families." To be an eligible family, a family must: (1) include a child living with his or her custodial parent or other adult caretaker relative (or a pregnant woman); and (2) be financially eligible according to the appropriate income/resource standards established by the state in its TANF plan. Eligible families include those eligible for TANF assistance, as well as those who would be eligible but for

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<sup>74</sup> 42 U.S.C.A. § 609(a)(7) (2000).

<sup>75</sup> Ibid. Thus, TANF MOE dollars could be used to finance health coverage for federally ineligible, needy families with children. Coverage for adults without minor children would have to be financed with general fund dollars.

the time limit on the receipt of federally funded assistance or PRWORA's restrictions on benefits to immigrants. Thus, eligible families may include certain non-citizens.<sup>76</sup>

Qualified activities include any “services or benefits that are reasonably calculated to accomplish a purpose of the TANF program.”<sup>77</sup> Among the purposes of the TANF program that would be advanced by expanding health coverage for federally ineligible immigrants are: (1) providing assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) ending the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; and (3) preventing and reducing the incidence of out-of-wedlock pregnancies.<sup>78</sup> In fact, in published guidance to states, the United States Department of Health and Human Services has instructed that states may:

“Use state MOE funds ... to pay for medical services (e.g., for treatment of substance or alcohol abuse not paid by Medicaid) or to provide medical coverage for families that lack medical benefits (e.g., for families ineligible for transitional Medicaid or for adults whose children are served by Medicaid or CHIP).”<sup>79</sup>

New York's full TANF block grant is \$2.433 billion. To draw the full amount of federal funds, the state must expend at least \$1.7 billion of its monies annually on qualified activities benefiting needy families. The New York State Division of Budget projected that, in state fiscal year 2000–01, New York would face a potential shortfall in MOE spending of approximately \$247 million. To avoid the federal penalties described above, New York has increased its state and local shares of TANF program spending and reduced the federal share of cash assistance.

By dedicating MOE funds to health care for federally ineligible immigrants, New York could make progress toward meeting its MOE target. The state and county governments, currently paying an inflated share of public assistance costs to avoid an MOE shortfall, could reduce their public assistance spending if additional MOE spending were available. In short, although New York would not be able to draw federal Medicaid

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<sup>76</sup> Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance, “Helping Families Achieve Self-Sufficiency: A Guide on Funding Services for Children and Families through the TANF Program,” p. 4.

<sup>77</sup> Ibid.

<sup>78</sup> Ibid., p. 2.

<sup>79</sup> Ibid., p. 18.

matching funds for spending unrelated to emergency or PCAP services, it would be able to replace a portion of cash assistance spending with federal TANF dollars.

### **Local Share and Geographic Scope**

New York's Medicaid program is funded through a combination of federal, state, and local dollars. Generally, the federal government pays for half the cost of Medicaid-covered services. With the exception of long-term care services, the state and local governments split the nonfederal share of Medicaid, including Emergency Medicaid and PCAP for immigrants. Local governments pay only 10 percent of the cost of long-term care, while the state pays 40 percent. Prior to the 1115 waiver, the state and local social services districts split the full cost of Medicaid for HR beneficiaries, since there was no federal match for this class.

Given the traditional role of local social services districts in financing Medicaid services, a health insurance expansion for immigrants could implicate these districts. For most counties, the cost of a Medicaid restoration would be minimal due to small immigrant communities. In New York City and its suburbs, the costs would be more significant. Those counties, however, are also the ones hardest hit by the welfare reform eligibility changes—in the form of deficits at public hospitals, public health costs, and other social welfare costs. Upstate counties, such as Erie and Onondaga, are similarly hit by the changes.

Moreover, counties are already paying a substantial sum for emergency care for federally ineligible immigrants. With comprehensive coverage, expenditures for emergency care and lengthy hospitalizations would likely decline. Instead of seeking routine health care in the emergency room, at an exorbitant cost, immigrants could obtain less expensive care on an outpatient basis. Instead of spending weeks in the hospital because they could not afford post-discharge care, immigrants could be discharged when medically appropriate and treated on an outpatient basis at a lower cost.

Finally, 40 counties, as well as New York City, have public long-term care facilities (see Appendix F). Today, the costs of legal immigrants in these facilities are borne entirely by the city or county. If Medicaid were extended to these immigrants, the state would split the costs with the local districts.

Alternatively, the program could be implemented at county option. This is the approach adopted for the state-funded Food Assistance Program for immigrants ineligible for federal food stamps. Some counties would welcome a restoration of Medicaid for

immigrants and would be willing to pay for it. From a programmatic perspective, however, a county opt-in may be unwise. Counties might decline to participate out of fear that immigrants in neighboring counties would flock to the county that provides them with Medicaid coverage. Counties that would experience almost no fiscal hit from the program might decline to participate, leaving a small number of needy immigrants with no regular source of care.

### **Cost-Sharing, Sponsor-Deeming, and Liability**

Any of the options described above could incorporate enrollee or sponsor cost-sharing. If premiums and copayments were charged, however, they would contribute little toward offsetting the cost of the proposal unless they were sizeable.<sup>80</sup> Even modest premiums would deter enrollment, particularly among healthy immigrants.<sup>81</sup> Thus, a program with cost-sharing would leave a larger portion of the target population uninsured and would lead to significantly higher average costs among enrollees due to adverse selection, resulting in little overall savings.

Sponsor-deeming requirements are even more problematic. Currently, both federal and state laws require that sponsor incomes be included in calculating the incomes of immigrants applying for Medicaid. As a practical matter, the impact of these sponsor-deeming requirements will not be felt until the end of 2001, when some immigrants start to meet PRWORA's five-year residency requirement. However, given that PRWORA requires sponsors to have household incomes in excess of 125 percent of the federal poverty level, sponsor-deeming requirements will effectively undermine any efforts to expand health insurance to low-income immigrants by driving their deemed income above the Medicaid and FHP income limits. Thus, to make any immigrant insurance expansion meaningful, New York would have to repeal the sponsor-deeming requirements of the State Social Services Law.

Under PRWORA, affidavits of support signed by sponsors were made legally enforceable.<sup>82</sup> Thus, sponsors are liable for any Medicaid-covered services except emergency care received by those they sponsor.<sup>83</sup> Although a state-funded program could

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<sup>80</sup> For example, assuming an enrollment of 3,000 and premiums of \$100 annually, total annual collections would be only \$300,000. With the cost of coverage approximating \$9.5 million, the premiums and copayments would be insignificant and would barely justify the administrative costs that would be incurred in collecting them.

<sup>81</sup> Ku, L. and Coughlin, T. "The Use of Sliding-Scale Premiums in Subsidized Insurance Programs," the Urban Institute, March 1997.

<sup>82</sup> 8 U.S.C.A. § 1183a (2000).

<sup>83</sup> P.L. 104-193, Title IV, Subtitle C, § 423(d), Aug. 22, 1996.

incorporate this sponsor liability, it would likely have a strong deterrent effect on enrollment and create the same adverse selection effect as premiums and copayments.

### **State Constitutional Issues**

Obviously, any program to provide health coverage to low-income immigrants must meet the requirements of New York's constitution. In particular, the state constitution includes a provision that requires the state to provide "aid, care and support of the needy . . . in such manner and by such means, as the legislature may from time to time determine."<sup>84</sup> Thus, any restrictions on the benefits available to immigrants or limits on the geographic scope of the program would be subject to scrutiny under Article XVII. Indeed, the constitutionality of existing limits on Medicaid for lawfully present immigrants is currently under review in the State Court of Appeals, the state's highest court.<sup>85</sup> The scope of Article XVII's mandate and the limits on legislative discretion will be examined in that case, and the court's decision may provide guidance for the implementation of a state-funded health insurance program for immigrants.

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<sup>84</sup> N.Y.S. Const. Art. XVII, § 1.

<sup>85</sup> *Aliessa v. Novello*, 274 A.O. 2d 347 (1<sup>st</sup> Dept. 2000).



## VI. CONCLUSION

The exclusion of legal immigrants from full Medicaid coverage has had a devastating impact of the personal health of these immigrants, their families, the public health, and New York's health care safety net. As the number of federally ineligible immigrants grows, the impact of this policy will intensify. County governments will be faced with a growing number of uninsured immigrants in public hospitals and nursing homes. In addition, the financial viability of safety net hospitals and community health centers will be jeopardized.

With little additional spending, New York could resolve these problems. Option one—the restoration of Medicaid and expansion of FHP to cover federally ineligible immigrants—provides the most comprehensive solution. Unlike Option Two—which would offer only FHP—it includes coverage of long-term care services, which is critical to safety net hospitals and county nursing homes. Moreover, the cost of option one is not significantly greater than for option two. Finally, option three offers little cost savings and substantial administrative investment.

Under any of the options, incremental state spending would be minimal. And any spending on coverage for families, other than emergency and PCAP spending, could be designated as TANF MOE. This would permit the state to replace a portion of its cash assistance spending with federal TANF funds. Clearly, there is no reason—programmatic or fiscal—to continue to deny low-income, legal immigrants the same access to health coverage as is available to citizens.

## APPENDIX A. WHO IS A PRUCOL?

Persons Residing Under Color of Law—PRUCOL—are not under a single official immigration status conferred by the Immigration and Naturalization Service (INS). Rather, PRUCOL is an umbrella term that describes a number of immigration statuses under which an individual could receive public assistance and Medicaid prior to welfare reform. As a general matter, PRUCOLs are immigrants who are residing in the United States for an indefinite period with the knowledge of the INS and whose departure it does not contemplate enforcing.

Before enactment of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), New York’s Medicaid program covered the following PRUCOLs:

- Lawful temporary residents under the amnesty programs who were exempt from five-year disqualification
- Refugees; asylees; aliens granted withholding of deportation; parolees; Cuban/Haitian entrants; and conditional entrants
- Aliens granted indefinite voluntary departure, stay of deportation, suspension of deportation, or order of supervision
- Aliens granted voluntary departure for a definite period, applicants for an adjustment of status, or U.S. citizen’s relative with an approved I-130 petition
- Aliens residing in the United States with INS knowledge and permission and whose departure the INS does not contemplate enforcing<sup>86</sup>

Following are actual examples of individuals in New York State who are described as PRUCOLs and would have been eligible for Medicaid on the same basis as citizens prior to enactment of PRWORA and New York’s Welfare Reform Act. They are now barred from the program:

Mrs. K. is an elderly and disabled Holocaust survivor from Eastern Europe who entered this country as a “parolee in the public interest.” She has

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<sup>86</sup> See 18 NYCRR 360-3.2 (j) for current PRUCOL regulations.

applied to the INS for an adjustment of status to legal permanent resident. Her application is pending.

Mrs. C. is an elderly and disabled immigrant from Italy who came to this country to live with her citizen children after her husband died. She has petitioned the INS for an adjustment of status and her petition is pending.

Mrs. A. is an immigrant from Africa who entered this country legally with her seven-year-old daughter to live with her husband, a legal permanent resident. After her arrival, her husband denied the existence of the marriage, thereby calling into question her immigration status. She has petitioned the INS for deferred action status and her application is pending.

Mrs. N. is an elderly and disabled immigrant from Greece who immigrated to the United States in 1974. She lives with her daughter and her U.S. citizen grandchildren. She applied to the INS for an adjustment of status to legal permanent resident. While her application was pending, she was described as a PRUCOL for Medicaid eligibility purposes. Her application was recently granted and she has become a legal permanent resident.

**APPENDIX B. MEDICAID ELIGIBILITY FOR IMMIGRANTS IN SELECTED STATES**

<b>STATES</b>	<b>PRUCOLS</b>	<b>PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEES AND ASYLEES</b>	<b>POST-1996 QUALIFIED IMMIGRANTS</b>	<b>UNDOCUMENTED</b>	<b>DEEMING</b>
California	Eligible for MediCal on the same basis as citizens if pregnant; a parent with minor children; disabled; under age 21; disabled; or over age 65.  Childless, non-disabled adults are eligible for emergency care and may be eligible for non-emergency care and may be eligible for non-emergency care under the county-administered programs.	Eligible for MediCal on the same basis as citizens if pregnant, a parent with minor children; under age 21; disabled; or over age 65.  Childless, non-disabled adults are eligible for emergency care and may be eligible for non-emergency care under county-administered programs.	Eligible for MediCal on the same basis as citizens if pregnant, a parent with minor children; under age 21; disabled; or over age 65.  Childless, non-disabled adults are eligible for emergency care and may be eligible for non-emergency care under county-administered programs.	Eligible for emergency care, prenatal care, and long-term care.  May pre-qualify for emergency care.	Not in state-funded programs.

STATES	PRUCOLS	PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEES AND ASYLEES	POST-1996 QUALIFIED IMMIGRANTS	UNDOCUMENTED	DEEMING
Connecticut	<p>Eligible for Medicaid if receiving SSI.</p> <p>Eligible for coverage under the State Medical Assistance for Non-Citizens (SMANC) program on the same basis as citizens if pregnant, a minor child, a parent of a minor child, aged, or disabled.</p>	<p>Eligible for Medicaid if pregnant, a minor child, a parent of a minor child, aged or disabled, on the same basis as citizens.</p> <p>Eligible for coverage under the state-administered General Assistance program, if a childless, non-disabled adult.</p>	<p>Eligible for Medicaid on the same basis as citizens, after 5 years of residence in the U.S.</p> <p>Eligible for coverage on the same basis as citizens (no five-year requirement) under the State Medical Assistance for Non-Citizens (SMANC) program if pregnant, a minor child, a parent of a minor child, aged or disabled.</p>	<p>Eligible for emergency care.</p> <p>Eligible for care in a long-term care facility if such care is an appropriate and cost-effective alternative to continued hospitalization, provided that the patient has been a Connecticut resident for at least five years.</p>	Yes.
Delaware	<p>Children, pregnant women, parents of minor children, aged and disabled eligible for Medicaid (except long-term care), on the same basis as citizens.</p>	<p>Children, pregnant women, parents of minor children, aged, disabled, and childless, non-disabled adults eligible for Medicaid on the same basis as citizens.</p>	<p>Eligible for coverage on the same basis as citizens (no five-year requirement) under the state-administered General Assistance program, if a childless, non-disabled adult.</p> <p>Pregnant women, parents with minor children, children, aged and disabled eligible for Medicaid (except long-term care).</p> <p>Childless, non-disabled adults are subject to a five-year waiting period.</p>	<p>Pregnant women, children, parents of minor children, aged and disabled eligible for emergency care.</p>	Not in state-funded program.

<b>STATES</b>	<b>PRUCOLS</b>	<b>PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEEES AND ASYLEES</b>	<b>POST-1996 QUALIFIED IMMIGRANTS</b>	<b>UNDOCUMENTED</b>	<b>DEEMING</b>
Maine	Eligible for Medicaid on the same basis as citizens if children, pregnant women, parents of minor children, adults age 65 and over, or disabled adults.	Eligible for Medicaid on the same basis as citizens if children, pregnant women, parents of minor children, adults age 65 and over, or disabled adults.  Childless, non-disabled adults are not eligible.	Eligible for Medicaid on the same basis as citizens if children, pregnant women, parents of minor children, adults age 65 and over, or disabled adults.	Eligible for emergency Medicaid if pregnant, under age 21, parent of a minor child, age 65 or over, or disabled.	Not in state-funded program
Massachusetts	Eligible for full Medicaid coverage (MassHealth Standard) on the same basis as citizens if receiving Medicaid on 6/30/97, had long-term care application pending on 7/1/97, or residing in a long-term care facility on 6/30/97.	Eligible for full Medicaid coverage (MassHealth Standard) on the same basis as citizens if pregnant women, children, parents of minor children, adults age 65 and over, or disabled.  All others are eligible for MassHealth Basic.	Eligible for MassHealth Basic on the same basis as citizens.	May pre-qualify for emergency care. Eligible for MassHealth Limited – provides Medicaid coverage of emergency care (broadly defined).  Eligible for Healthy Start for prenatal care.	Not in state-funded programs.
	All others eligible for MassHealth Basic – includes all Medicaid benefits except eyeglasses, hearing aids, adult day care, hospice, nursing facility care, and transportation. Services accessed through managed care delivery system only.				

<b>STATES</b>	<b>PRUCOLs</b>	<b>PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEES AND ASYLEES</b>	<b>POST-1996 QUALIFIED IMMIGRANTS</b>	<b>UNDOCUMENTED</b>	<b>DEEMING</b>
Minnesota	Eligible for Medicaid on the same basis as citizens if pregnant, minor child, parent of minor child, age 65 or over, or disabled.  Childless, non-disabled adults eligible for General Assistance Medical Care, which does not cover long-term care.  Higher income individuals eligible for MinnesotaCare, which does not cover long-term care.	Same as PRUCOL eligibility and coverage.	Same as PRUCOL eligibility and coverage.	Eligible for Medicaid for emergency care. May pre-qualify for emergency care.  Pregnant women eligible for Medicaid.  Individuals who are under age 18, age 65 and over, or disabled are eligible for GA Medical Care, which does not cover long-term care.	Yes.

STATES	PRUCOLS	PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEES AND ASYLEES	POST-1996 QUALIFIED IMMIGRANTS	UNDOCUMENTED	DEEMING
New Jersey	Eligible for Supplementary Prenatal Care Program, if spouse or child of citizen and have a pending application for adjustment of status; applicant for asylum; or withholding of deportation.	Eligible for Medicaid and FamilyCare coverage on the same basis as citizens.  FamilyCare does not cover long-term care.	Eligible for Medicaid and FamilyCare coverage on the same basis as citizens.  FamilyCare does not cover long-term care.	Eligible for emergency care if pregnant, a parent of a minor child, a child, aged or disabled.	Yes.
	Eligible for Special Medicaid Program if eligible for long-term care services and residing in a nursing facility prior to January 29, 1997.		Eligible for Special Medicaid Program if eligible for long-term care services and residing in a nursing facility prior to January 29, 1997.		
	Eligible for Medicaid if receiving SSI.				
	Eligible for emergency care if pregnant, parent of a minor child, a child, aged or disabled.				



<b>STATES</b>	<b>PRUCOLS</b>	<b>PRE-1996 QUALIFIED IMMIGRANTS AND REFUGEES AND ASYLEES</b>	<b>POST-1996 QUALIFIED IMMIGRANTS</b>	<b>UNDOCUMENTED</b>	<b>DEEMING</b>
New York	Eligible for Medicaid if in a nursing home or diagnosed with AIDS as of Aug. 4, 1997 and receiving Medicaid on that date.	Eligible for Medicaid on the same basis as citizens.	Eligible for Medicaid after five-year ban.	Eligible for emergency care and prenatal care.	Yes.
	Eligible for Medicaid if receiving SSI.		Eligible for emergency care and prenatal care.		
	Eligible for prenatal and emergency care.				
Nebraska	Eligible for prenatal and emergency care.	Eligible for Medicaid on the same basis as citizens.	Eligible for Medicaid on the same basis as citizens.	Eligible for prenatal care and emergency care.	Yes.
Pennsylvania	Children, pregnant women, parents of minor children, adults age 65 and over, and disabled adults eligible for Medicaid on the same basis as citizens.	Same as PRUCOL eligibility.	Same as PRUCOL eligibility.	Eligible for emergency care only.	NA.
	Childless, non-disabled adults eligible on the same basis as citizens for Medically Needy (spend-down) program and for Health Sustaining Medications program.				



## APPENDIX C. MEDICAID FHP AND CHP INCOME STANDARDS

### A. Medicaid\*

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Pregnant women	185% of the federal poverty level (FPL)
Children under age 1	185% of FPL <sup>87</sup>
Children age 1-6	133% of FPL
Children age 6-19	100% of FPL <sup>88</sup>
Families	
TANF-related	approx. 50% of FPL (TANF standard of need)
Medically Needy	approx. 80% of FPL (depending on family size)
Aged/Disabled	approx. 80% of FPL (depending on family size)
Childless, Non-Disabled Adults	approx. 50% of FPL (Safety Net standard of need)

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\* Eligibility for Medicaid is based on net income.

### B. Family Health Plus\*\*

When fully implemented, FHP will provide health coverage to parents of minor children with incomes up to 150 percent of the FPL and to childless adults with income up to 100 percent of the FPL.

\*\* Eligibility for Family Health Plus is based on gross income.

### C. Child Health Plus

Children up to age 19 with household incomes up to 250 percent of the FPL are eligible for subsidized coverage. Children with household incomes above 250 percent of the FPL may purchase coverage by paying the full premium.

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<sup>87</sup> Legislation was enacted this year to expand Medicaid eligibility to children under age 1 and pregnant women with incomes up to 200 percent of the federal poverty level. In addition, legislation was enacted to provide coverage of family planning services to individuals with incomes up to 200 percent of the federal poverty level. This expansion will take effect 180 days after the necessary federal waiver is approved.

<sup>88</sup> In 1998, legislation was enacted to expand Medicaid eligibility for children ages 6 to 19 to households with incomes up to 133 percent of the federal poverty level. Federal approval of this expansion is pending.

**APPENDIX D. SERVICE COMPARISON\***

<b>Federally Mandated Services</b>	<b>Medicaid</b>	<b>CHP</b>	<b>FHP</b>
Inpatient Hospital	Y	Y	Y
Outpatient Hospital	Y	Y	Y
Physician Services	Y	Y	Y
Medical and Surgical Dental	Y	Y	Y
Nursing Facility (21 and older)	Y	N/A	N
Home Health Services	Y	Y**	Y**
Medical Supplies	Y	N	N
Durable Medical Equipment	Y	Y	Y
Family Planning Services and Supplies	Y	Y	Y
Rural Health Clinic	Y	Y	Y
Lab	Y	Y	Y
X-ray	Y	Y	Y
Nurse Practitioner	Y	Y	Y
FQHCs	Y	Y	Y
Midwife	Y	Y	Y
EPSDT	Y	Y	Y
Medicare Co-Insurance and Deductibles for OMBs, Chiropractors, Podiatrists, Portable X-ray, and Clinical Social Work	Y	N/A	N/A

<b>Federally Optional Services</b>	<b>Medicaid</b>	<b>CHP</b>	<b>FHP</b>
Free-standing clinics	Y	Y	Y
Nursing Facility (21 and younger)	Y	N	N
ICF/DD	Y	N	N
Optometrist and eyeglasses	Y	Y	Y
Prescription Drugs	Y	Y	Y
Therapeutic Services - PT/ST/OT	Y	Y	Y
Dental Services	Y	Y	Y**
Audiology and Hearing aids	Y	Y	Y
Clinical Psychologist	Y	Y	Y
Private Duty Nursing	Y	N	N
Diagnostic, Screening, Preventive and Rehabilitative Services	Y	Y	Y
Personal Care	Y	N	N
Non-Emergency Transportation	Y	N	N
Emergency Transportation	Y	N	Y
Hospice	Y	N	N
Case Management	Y	N	N
Inpatient Psychiatric Care	Y**	Y**	Y**

\* This comparison was taken from the Department of Health's request for a Section 1115 waiver amendment, June 30, 2000, with respect to the state Family Health Plus program.

\*\* Some limits apply.

## APPENDIX E. METHODOLOGY

### 1. Estimating the size of New York State's adult immigrant population, their incomes, geographic distribution, and insurance status

To determine the size and demographic characteristics of New York's foreign-born population, we used data from the U.S. Census Bureau published in *Profile of the Foreign-Born Population in the United States, 1997*. Data from the Census Bureau's March *Current Population Survey* (1995 to 1999) were used to estimate the percentage of adults among immigrants arriving within five years and their poverty status and family composition.

To classify the foreign-born population by immigration status, we relied on analyses of tax records prepared by the Urban Institute (Passel, J., and Clark, R. "Immigrants in New York: Their Legal Status, Incomes, and Taxes," the Urban Institute: April 1998). We trended these data forward using Immigration and Naturalization Service (INS) data for New York's share of immigrant admissions for 1998 and 1999 and Census Bureau projections of immigrant flows for 2000–2003. We used INS data with respect to the current number and growth in numbers of undocumented immigrants in New York and assumed that New York will receive the same percentage of the national total of undocumented immigrants as it receives of documented immigrants. We also used INS data to project the annual number of naturalizations among New York non-citizen immigrants. We used a Census Bureau estimate to account for immigrant outflows.

We estimated the distribution of immigrants by county using county-level net international migration data from the U.S. Census Bureau and tax data from the Urban Institute (Passel, J. and Clark, R., 1998).

### 2. Estimating participation rates of the eligible adult immigrant population

We estimated the number of adult non-citizens income-eligible for Medicaid by assuming that approximately 61 percent of adults with income below the federal poverty level would be income-eligible for Medicaid (based on Thorpe, K. and Florence, C. "Medicaid Eligible, But Uninsured: The New York State Experience," United Hospital Fund, 2000.). We used data presented by Thorpe and Florence for low-income adults in New York State to estimate that 35 percent of adults with incomes below the Medicaid eligibility level would participate in Medicaid. Thorpe

and Florence estimated that 40 percent of income-eligible adults participated in Medicaid in New York in 1998; we trended this percentage forward based on a decline in participation rates among immigrants quantified by the Urban Institute (Ku L., and Matani S. “Immigrants’ Access to Health Care and Insurance on the Cusp of Welfare Reform,” the Urban Institute, 2000). Ku and Matani found that Medicaid participation rates among immigrants nationally declined by 19 percent between 1994 and 1997. We assumed this decline continued until 2000 and then leveled off, in keeping with the halt in the decline in the Medicaid rolls that occurred in 2000.

There is some reason to believe that FHP-eligible individuals would be likely to participate in greater numbers than Medicaid-eligibles (e.g., higher-income population, less Medicaid stigma, and less interaction with local social services agencies). However, we assumed the participation rate would be no better than for Medicaid in light of the significant challenges in overcoming language and cultural barriers, as well as widespread apprehension of being deported among immigrants. Therefore, we assume that enrollment would ramp up gradually: in the first year of program operations, 10 percent of the target population (i.e., 35 percent of all eligibles) would enroll. In the second and third years, 20 percent and 40 percent of the target would enroll respectively.

### **3. Estimating the distribution of participants among aid categories**

To project the costs of the different options, we first projected the enrollment mix of low-income immigrants. We then developed a distribution of immigrants across Medicaid aid categories by adjusting the distribution of adult Medicaid eligibles reflected in the New York State, Department of Health, Office of Medicaid Management, Medicaid Reference Statistics [henceforth “Medicaid Reference Statistics”] for federal fiscal year 1999. We made a slight upward adjustment to include 19- and 20-year-olds in the category for eligibles ages 21 to 64. We reduced the percentage of elderly and disabled among the current Medicaid enrollment mix to account for the fact that only 2.6 percent of the new immigrant population is over age 65 (based on the Census Bureau’s *Profile of the Foreign-Born Population in the United States, 1997* and the fact that few immigrant SSI recipients begin receiving benefits within the first five years of their residence in the United States (based on data from the Social Security Administration cited in Fix, M., et al., “Immigration and Immigrants: Setting the Record Straight,” the Urban Institute, 1994.). We also increased the relative percentage of Aid to Families with Dependent Children recipients among new immigrants to account for the significantly higher percentage of

adults with children who are likely to enroll given the population's familiarity with the Child Health Plus program (for which immigrants are eligible) and the greater proportion of women of child-bearing age among recent immigrants as compared to the general Medicaid population.

#### **4. Estimating the cost of providing full Medicaid coverage for participants**

We estimated the average cost per enrollee based on April 2000 New York State Medicaid managed care premiums for non-SSI-related enrollees, weighted to reflect the likely geographic distribution of immigrant enrollees. We adjusted these premiums upward to account for Medicaid-covered benefits outside the managed care benefit package, using the Medicaid Reference Statistics for federal fiscal year 1999. We held 1999/2000 year costs constant until 2001 to reflect the recent trend in New York State Medicaid and then trended average costs upward by 3 percent per year starting in 2001 to account for the likely up-tick in medical inflation.

For SSI-related enrollees, we used fee-for-service cost data from the Medicaid Reference Statistics for federal fiscal year 1999 in light of the small SSI-related enrollment in Medicaid managed care and the significant role that benefits outside the managed care benefit package (long-term care and pharmacy) play in driving total costs for these enrollees.

Average costs per aid category were then multiplied by projected enrollment levels to estimate total costs.

#### **5. Estimating the cost of providing FHP coverage for participants**

To estimate the FHP premiums for this population, we began with April 2000 New York State Medicaid managed care premiums, as reported by the state Department of Health. We adjusted these premiums to account for differences in the benefit package between Medicaid managed care and FHP. Most notably, the FHP package includes prescription drugs, whereas the Medicaid managed care benefit package does not. In addition, FHP includes a more generous mental health benefit than Medicaid managed care, along with several other minor modifications. In keeping with Medicaid cost projections, we trended these premium amounts for inflation by applying a 3 percent annual trend factor starting in 2001.

Premiums for each aid category were then multiplied by projected enrollment levels to estimate total costs.

## **6. Estimating the federal financial contribution to coverage and offsetting state and local expenditures**

To calculate the amount of federal financial participation (FFP) the state will be eligible for, we estimated the percentage of total costs that will be attributable to emergency care and prenatal care and delivery services, which will qualify for federal matching funds.

For emergency costs we first estimated the participation rate and average costs for Emergency Medicaid in 1999. We obtained data from the New York State Department of Health to determine the total number of adult Emergency Medicaid users and total expenditures in 1999. We calculated the participation rate by estimating the total number of individuals eligible for Emergency Medicaid in 1999, namely undocumented immigrants and lawfully present non-citizens who arrived in the country after August 22, 1996. We estimate that there were 140,000 adults eligible for service under Emergency Medicaid in 1999, yielding a participation rate of 11.34 percent and an average cost of \$15,792.50 per person. We then multiplied this participation rate and average cost by the total number of Medicaid and FHP enrollees in 2001 and 2003 to get the total cost of emergency services under the expansion program. We assume approximately 16 percent of these costs will be attributable to Home Relief (HR) enrollees who are not eligible for a federal matching payment. We then calculated the total amount of FFP by multiplying the remaining 84 percent of total costs by 50 percent.

For the costs of prenatal care and delivery, which are eligible for federal matching funds under PCAP, we estimated the number of live births to immigrant women covered by Medicaid and FHP in 2001 and 2003. We obtained the birth rate for all women older than 18 years in New York from the New York State Department of Health and adjusted the rate upward to account for a larger share of women of child-bearing age among immigrant women than the general population and a higher birth rate among non-citizens as compared to the general population (based on data from U.S. Census Bureau, March 1995 *Current Population Survey* and the June 1998 *Current Population Survey*). We then multiplied the expected birth rate by the estimated number of female Medicaid and FHP enrollees to get the total number of births, which we then multiplied by the cost of prenatal care and delivery services. Because all PCAP



beneficiaries are eligible for FFP, we multiplied the total cost by 50 percent to estimate the amount of FFP available.

To estimate the level of state and local expenditures for emergency services and prenatal care and deliveries absent the restoration of eligibility for lawfully present immigrants, we repeated the same calculations as above. However, we assumed that there would be no spending on Emergency Medicaid for FHP enrollees with income above the Medicaid limits absent the restoration because we assume the state's FHP waiver did not expand eligibility for Emergency Medicaid. Additionally, because expenditures on HR beneficiaries are not eligible for federal financial participation, we assume the nonfederal share of HR Emergency Medicaid spending would be 100 percent.

**APPENDIX F. COUNTY-RUN LONG-TERM CARE FACILITIES  
IN NEW YORK STATE**

Albany	Albany County Nursing Home Ann-Lee Homes
Broome	Willow Point Nursing Home
Cattaraugus	The Pines Healthcare & Rehabilitation Centers (2) Cattaraugus County Department of Nursing Homes
Cayuga	Cayuga County Nursing Homes
Chautauqua	Chautauqua County Home
Chenung	Chenung County Nursing Facility
Clinton	Clinton County Nursing Home
Columbia	Pine Haven Home
Delaware	Delaware County Countryside Care Center
Erie	Erie County Medical Center SNP Erie County Home
Essex	The Horace Nye Home
Franklin	Franklin County Nursing Home
Fulton	Fulton County Residential Health Care Facility
Genesee	Genesee County Nursing Home
Lewis	Lewis County RHCF
Livingston	Livingston County Campus SNF (2) Livingston County SNF
Monroe	Monroe Community Hospital
Montgomery	Montgomery Meadows Residential Health
Nassau	A. Holly Patterson Geriatric Center
New York City	Coler-Goldwater Specialty Hospital and Nursing Facility Gouverneur Skilled Nursing Facility Dr. Susan B. Smith McKinney Nursing and Rehabilitation Center Sea View Hospital Rehabilitation Center and Home  New York City Health and Hospitals Corporation Home Care Agency

Niagara	Mount View Health Facility
Onondaga	VanDuyyn Home & Hospital
Ontario	Ontario County Health Facility
Orange	Department of Residential Health Care Services
Orleans	Orleans County Nursing Home
Oswego	Andrew Michaud Nursing Home
Otsego	The Meadows
Rensselaer	Van Rensselaer Manor
Rockland	Department of Hospitals
Saratoga	Saratoga County Maplewood Manor
Schenectady	Glendale Nursing Home
Steuben	Steuben County Health Care Facility
Suffolk	John I. Foley SNF
Sullivan	Sullivan County Adult Care Center
Ulster	Golden Hill Health Care Center
Warren	Westmount Health Facility
Washington	Pleasant Valley
Wayne	Wayne County Nursing Home
Westchester	Taylor Care Center
Wyoming	Wyoming County Nursing Facility

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**#444** *Creating a Seamless Health Insurance System for New York's Children* (February 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

**#435** *Emergency Department Use in New York City: A Survey of Bronx Patients* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

**#434** *Emergency Department Use: The New York Story* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

**#433** *Emergency Department Use in New York City: A Substitute for Primary Care?* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

**#340** *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (July 1999). Jocelyn Guyer and Cindy Mann, Center on Budget and Policy Priorities. The authors show how New York could make a substantial dent in its number of uninsured working adults if it took advantage of a little-known legislative opportunity and raised the income eligibility level for subsidized health insurance.

**#264** *The Commonwealth Fund Survey of Health Care in New York City* (March 1998). David R. Sandman, Cathy Schoen, Catherine DesRoches, and Meron Makonnen. This survey of more than 4,000 New York City residents, conducted by Louis Harris and Associates, Inc., found that a New Yorker was 50 percent more likely to be uninsured than the average American, that the vast majority of the City's uninsured live in working families and have low incomes, and that the City's public hospitals, emergency rooms, and clinics provide an important safety net for the uninsured.