



**HEALTH COVERAGE FOR IMMIGRANTS IN NEW YORK:  
AN UPDATE ON POLICY DEVELOPMENTS AND NEXT STEPS**

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FIELD REPORT

July 2002

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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## **HEALTH COVERAGE FOR IMMIGRANTS IN NEW YORK: AN UPDATE ON POLICY DEVELOPMENTS AND NEXT STEPS**

### **Introduction**

Legal immigrants' ability to obtain public health insurance coverage in the state of New York has dramatically improved in the wake of recent court decisions and executive and legislative actions. The New York State Court of Appeals' June 2001 decision in *Aliessa v. Novello* restored full Medicaid eligibility to legal immigrants who were eligible for Medicaid coverage before the state implemented federal welfare reform and who meet the program's income guidelines.

Consequently, New York has extended coverage to legal immigrants under Family Health Plus (FHP), its new insurance program for low-income adults. These changes, which affect those who have lived in the United States for less than five years and those classified as "permanently residing under color of law" (PRUCOLs), could benefit approximately 200,000 residents. There are currently no federal matching funds for coverage provided to these legal immigrants under Medicaid and FHP.

New York State also provides prenatal care coverage for undocumented mothers, although it must also finance this care with state and local funds alone because of a 2001 decision in *Lewis v. Thompson*, in which the U.S. Court of Appeals for the Second Circuit held that undocumented women have no right to such coverage under the U.S. Constitution. In addition, New York continues to provide health coverage for undocumented children through Child Health Plus (CHP).

Immigrants who live in New York State are thus once again entitled to a broad range of publicly subsidized health benefits. Only one significant gap remains in the state's health care programs for low-income immigrants—undocumented adults are ineligible for any benefits other than prenatal, postpartum, and emergency care.

This report reviews the ways in which federal welfare reform restricted legal immigrants' access to Medicaid and how the *Aliessa* decision provides coverage to those who were previously denied. It also examines the way in which New York State is implementing both *Lewis* and *Aliessa* and it identifies remaining issues, including states' need for federal financial assistance to help provide health coverage to legal immigrants on the same basis as citizens. In addition, the report considers the national implications of the federal government's retreat from supporting Medicaid coverage for immigrants. Specifically, it discusses how one of the arguments upon which the court relied in

*Aliessa*—violation of the U.S. Constitution’s equal protection clause—could resonate beyond New York and prompt similar decisions in other states’ courts.

### **How Welfare Reform Restricted Immigrants’ Medicaid Eligibility**

Until 1997, legal immigrants in New York State had access to the full range of Medicaid benefits on the same basis as citizens; undocumented immigrants were eligible only for emergency and prenatal care. Enactment of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and New York’s Welfare Reform Act of 1997 sharply restricted this coverage—many legal immigrants who had previously been eligible for Medicaid were excluded from the program, retaining access only to emergency and prenatal care. Specifically, under PRWORA, most legal immigrants who entered the United States on or after August 22, 1996, were excluded from federally funded Medicaid coverage for their first five years of residence. Most immigrants known as PRUCOLs were barred from Medicaid regardless of their date of entry or duration of residence.<sup>1</sup>

In implementing the federal law, New York opted to provide full Medicaid coverage only to immigrants who were eligible for federally funded Medicaid and to two limited groups of PRUCOLs. The former group included “qualified aliens” who arrived in the U.S. before August 22, 1996, and qualified aliens who arrived subsequently and resided in the U.S. for at least five years.<sup>2</sup> Certain qualified immigrants, including refugees and those granted political asylum, are exempt from the five-year residency requirement.<sup>3</sup> Those in the latter group (PRUCOLs) to whom New York extended full Medicaid coverage were:

- recipients of Medicaid as of August 4, 1997, who were also residents of residential health care facilities or residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities; and
- recipients of Medicaid as of August 4, 1997, who were also diagnosed with AIDS.<sup>4</sup>

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<sup>1</sup> 8 U.S.C. § 1613(a); 8 U.S.C. § 1611(a); 8 U.S.C. § 1641(b). 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. Generally, a PRUCOL is a noncitizen 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. See 18 N.Y.C.R.R. § 360-3.2(j); *Aliessa v. Novello*, 96 N.Y.2d 418, 422 n.2 (2001).

<sup>2</sup> 8 U.S.C. § 1611(a). “Qualified aliens” are legal permanent residents (those with a “green card”); refugees, asylees, immigrants whose deportation has been withheld, immigrants granted parole for at least one year, immigrants granted conditional entry; battered immigrants and their dependent children. 8 U.S.C. § 1641.

<sup>3</sup> 8 U.S.C. § 1613(b).

<sup>4</sup> N.Y. Social Services L. § 122(1)(c).

The remaining immigrants—both PRUCOLs and most qualified immigrants who arrived after August 1996 and had resided in the United States for less than five years—were eligible only for emergency and prenatal care under Medicaid, regardless of their status. Furthermore, in compliance with the 1996 federal act, New York State enacted legislation that would “deem,” or attribute, the income and resources of an immigrant’s sponsor to the immigrant when he or she applied for Medicaid (except with respect to emergency care).<sup>5</sup> New York also adopted legislation known as “sponsor liability” that requires local social services districts to request reimbursement from the sponsor for any medical expenses (other than emergency care) that the state or federal government incurs on behalf of the sponsored immigrant. Consistent with the federal law’s provisions, the legislation also permits the local districts to commence legal action to recover such expenses.<sup>6</sup>

Subsequently, a Commonwealth Fund–sponsored research report released in March 2001 estimated that approximately 1.1 million non-citizens in New York State were uninsured. Moreover, the report estimated that about 167,000 *legal* adult immigrants in the state were financially eligible for Medicaid or FHP but were barred from participation solely because of their immigration status.<sup>7</sup> This number was expected to grow to 238,000 over three years.

***Aliessa v. Novello Restores Immigrant Coverage; Lewis v. Thompson Limits It***

In response to New York’s exclusion of legal immigrants from its Medicaid program, 12 legal immigrants with potentially life-threatening conditions brought a class action lawsuit in 1998 that challenged the policy’s constitutionality under the New York and U.S. Constitutions. Meanwhile, the New York Immigration Coalition, along with hospitals, community health centers, and the state’s healthcare workers’ union, among others, launched a campaign to restore the pre-welfare-reform rules.

The judicial process yielded results before the political one. In *Aliessa v. Novello*,<sup>8</sup> the State Court of Appeals—New York’s highest court—held in June 2001 that the exclusion of legal immigrants from full Medicaid coverage violated Article XVII of the

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<sup>5</sup> 8 U.S.C. §§ 1631, 1613(c)(excluding emergency Medicaid from definition of federal means-tested public benefit); N.Y. Social Services L. § 122(4). While mandating “sponsor deeming” in federally funded Medicaid, PRWORA gave states the option of implementing deeming in state-funded programs. 8 U.S.C. § 1632.

<sup>6</sup> 8 U.S.C. § 1183a(b); N.Y. Social Services L. § 122(5).

<sup>7</sup> D. Bachrach, K. Lipson, and A. Tassi, *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State*, The Commonwealth Fund, March 2001.

<sup>8</sup> 96 N.Y.2d 418 (2001).

New York Constitution and the equal protection clause of both the New York and U.S. Constitutions. Article XVII of the State Constitution provides that:

The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature from time to time may determine.<sup>9</sup>

Thus, the court said, care for the needy in New York “is not a matter of legislative grace; it is a constitutional mandate.”<sup>10</sup> Following long-established precedent, the court ruled that the legislature may not refuse “to aid those whom it has classified as needy.”<sup>11</sup> Because the state had deprived legal immigrants of “an entire category of otherwise available basic necessity benefits,” based on “an overly burdensome eligibility condition having nothing to do with need,” the court held that the state had violated the mandate of Article XVII.<sup>12</sup>

It further held that New York’s exclusion of certain immigrants from full Medicaid coverage was subject to strict scrutiny under the state and federal equal protection clauses and that the exclusion could not pass that test.<sup>13</sup> Congress, the court reasoned, had not mandated a uniform national approach to Medicaid benefits as a matter of federal immigration policy. Instead, it had given the states the option to offer benefits at their own expense.<sup>14</sup> As a result, New York’s policy was not entitled to the same deference as a federal immigration law. Since the state could not identify any compelling interest that the exclusion of these immigrants from full Medicaid coverage would promote, its policy violated the state and federal equal protection clauses.<sup>15</sup>

The *Aliessa* decision made the full range of New York’s Medicaid program available to all lawfully present legal immigrants—in general, it restored the pre-welfare reform status quo to the state. However, the 1996 federal law (PRWORA) forces New York to bear the full cost of all non-emergency care of PRUCOLs and most recent immigrants with less than five years of residence in the United States. An almost simultaneous decision nullified the federal government’s obligation to help provide prenatal care for undocumented immigrants.

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<sup>9</sup> New York State Constitution, Article XVII, § 1.

<sup>10</sup> *Aliessa v. Novello*, 96 N.Y.2d at 428, quoting *Tucker v. Toia*, 42 N.Y.2d 1, 7 (1977).

<sup>11</sup> *Id.* at 428.

<sup>12</sup> *Id.* at 429.

<sup>13</sup> *Id.* at 435.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* at 432, 436.

Exactly two weeks before the *Aliessa* decision was issued, the U.S. Court of Appeals for the Second Circuit reversed earlier court decisions that had directed New York to provide Medicaid coverage of prenatal care for illegal immigrants, and required the federal government to pay its share of the costs.<sup>16</sup> In *Lewis v. Thompson* (formerly entitled *Lewis v. Grinker* and first filed in 1979), the court ruled that the U.S. Constitution does not grant undocumented immigrants the right to Medicaid coverage of prenatal care.<sup>17</sup> The Second Circuit concluded that PRWORA's exclusion of undocumented immigrants from such coverage does *not* violate the equal protection clause of the U.S. Constitution despite the "substantial harm" to citizen children of alien mothers that was likely to ensue from the denial of prenatal care.<sup>18</sup>

The plaintiffs in *Lewis* had challenged the constitutionality of the federal, rather than the state law. As a result, and unlike the state Court of Appeals in *Aliessa*, the Second Circuit relied on the federal government's "broad power over naturalization and immigration"<sup>19</sup> to hold that the statute in question must merely be "rationally related" to a "legitimate governmental purpose."<sup>20</sup> The court found that the denial of prenatal care to undocumented immigrants was "rational" because it could conceivably deter illegal immigration into the United States.<sup>21</sup> The Second Circuit also concluded that citizen children of undocumented mothers likewise lack an equal protection right to prenatal care.<sup>22</sup> However, these children are constitutionally entitled to automatic Medicaid coverage at birth to the same extent as a child born to a citizen mother receiving Medicaid at the time she delivers.<sup>23</sup>

Because earlier *Lewis* decisions had recognized a federal right to prenatal care for undocumented immigrants, the federal government had been sharing New York's costs associated with such care for undocumented immigrants, as well as PRUCOLS and qualified immigrants within the five-year ban. As a result of the latest *Lewis* iteration, New York lost its entitlement to these federal funds at the same time that the *Aliessa* court ordered the state to provide full Medicaid coverage to qualified immigrants and PRUCOLS.

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<sup>16</sup> *Lewis v. Grinker*, 965 F.2d 1206 (2d Cir. 1992)

<sup>17</sup> *Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001).

<sup>18</sup> *Lewis v. Thompson*, 252 F.3d at 579, 584.

<sup>19</sup> *Id.* at 583–84. The *Aliessa* court applied strict scrutiny because it was analyzing a State law, as opposed to a federal law, and the State law did not implement a uniform federal immigration policy. *Aliessa*, 96 N.Y.2d at 435–36.

<sup>20</sup> *Lewis v. Thompson*, 252 F.3d at 582–83.

<sup>21</sup> *Id.* at 583–84.

<sup>22</sup> *Id.* at 586–87.

<sup>23</sup> *Id.* at 591–92.

### **New York State’s Response to *Aliessa* and *Lewis***

The state acted within days to notify its local social services districts of the *Aliessa* decision. It issued a series of “GIS [General Information System] messages” to local commissioners informing them of the scope of the decision and the appropriate procedures to follow in processing Medicaid applications from immigrants. As before, applicants must document immigration status and date of entry in order for the state to properly claim federal financial participation. This is particularly complex for PRUCOLs: The state’s primary GIS message enumerates 12 categories of PRUCOLs and lists a variety of Immigration and Naturalization Service (INS) forms that may be used to document an applicant’s assertion of PRUCOL status.<sup>24</sup> In addition, a letter from the INS or specified stamps in immigrants’ passports may be used to verify certain PRUCOL categories.

New York State’s prompt directions to local districts to comply with the *Aliessa* mandate applied only to processing *new* applications and re-certifications of eligibility. The state did not act to provide immediate Medicaid to all immigrants who had been denied coverage before the *Aliessa* decision and were receiving cash assistance under the state’s Safety Net Assistance program, available to lawfully present immigrants regardless of their status. Safety Net Assistance recipients are generally eligible for Medicaid, but immigrants within the five-year ban and PRUCOLs had been denied coverage. Since the *Aliessa* decision, many Safety Net Assistance recipients have obtained Medicaid coverage when they have recertified their eligibility for cash assistance or filed a separate Medicaid application. State Health Department officials are currently developing instructions to local districts to expedite Medicaid coverage for immigrant Safety Net recipients who were previously denied.

The *Aliessa* decision also affected the state’s Child Health Plus (CHP) program.<sup>25</sup> CHP B—the portion of the program available to children from higher-income households and other children ineligible for Medicaid—had always covered immigrant children, regardless of their status or date of arrival. However, CHP B eligibility is conditioned on *ineligibility* for CHP A (Medicaid for children). *Aliessa* made some immigrant children enrolled in CHP B eligible for Medicaid, and these children were required to transition to CHP A. To minimize interruptions in coverage, the state instructed CHP health plans to

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<sup>24</sup> New York State Department of Health, Office of Medicaid Management, GIS 01 MA/026, July 16, 2001, Attachment A.

<sup>25</sup> The CHP program is divided into two components: CHP A and CHP B. CHP B provides subsidized health coverage for children with family incomes of up to 250 percent of the federal poverty level. CHP A is Medicaid for children. FHP is a Medicaid-funded program that offers a less extensive benefit package to families with incomes up to 150 percent of the federal poverty level and individuals with incomes up to 100 percent of the federal poverty level.

implement *Aliessa*-related transfers at the same time as each enrollee's yearly recertification of eligibility, unless the family opted to transfer before its recertification date. Nonetheless, some disruption in coverage is inevitable.

In addition, *Aliessa* resulted in an expansion of coverage under New York's emerging FHP program. In October 2001, the state directed local social services districts to handle FHP applications from immigrants in the same manner as Medicaid applications.<sup>26</sup> Subsequent guidance to local districts regarding implementation of FHP reiterates the eligibility of PRUCOLs and immigrants otherwise subject to the federal five-year ban.<sup>27</sup>

In recognition of the importance of prenatal care to healthy births and its cost-effectiveness, and in spite of the *Lewis* decision, New York State has assumed the federal share of costs of prenatal and postpartum care for undocumented immigrants. Legislation that provides statutory authority for the state to continue this policy was enacted in March 2002.<sup>28</sup>

### **Unresolved Implementation Issues**

Three questions about the implementation of *Aliessa* remain—the use of sponsor deeming; the imposition of sponsor liability; and state reimbursement of medical expenses incurred by immigrants and their health care providers prior to *Aliessa* that should have been covered by Medicaid. The state has postponed implementation of sponsor deeming and liability in anticipation of federal regulations governing those policies. Moreover, in light of *Aliessa* and other New York precedents, it is unclear whether sponsor deeming is permissible under the state Constitution.<sup>29</sup> Discussions between the state and the plaintiffs' lawyers in *Aliessa* about state reimbursement of medical expenses incurred by otherwise eligible immigrants and their health care providers prior to the court's decision are continuing.

### **Obstacles to Coverage**

Legal immigrants living in New York are now eligible for the full range of Medicaid benefits, but much remains to be done in order to ensure that they gain access to those benefits. All Medicaid applicants face administrative obstacles to enrollment—these can be even more burdensome for immigrants. In addition to documenting residency, income,

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<sup>26</sup> N.Y.S. Dept. of Health, Office of Medicaid Management, GIS 01 MA/033, Oct. 2, 2001.

<sup>27</sup> N.Y.S. Dept. of Health, Office of Medicaid Management, 01 OMM/ADM-6, Nov. 2, 2001, at 10.

<sup>28</sup> Laws of New York, Ch. 16 of 2002, §§ 1-4.

<sup>29</sup> *Minino v. Perales*, 79 N.Y.2d 883 (1990).

resources, and family composition, immigrants must document their status.<sup>30</sup> This is particularly difficult for PRUCOLs, because of the numerous PRUCOL categories and various forms and/or letters that must be used to verify their status. This is bewildering to the applicant, and it may also overwhelm the social services workers. Some social services districts have mistakenly denied Medicaid coverage to PRUCOL applicants who do not provide a social security number, even though the Social Security Administration has refused to issue social security numbers to PRUCOLs.<sup>31</sup>

Immigrants face other unique obstacles to coverage. First, language barriers and a lack of cultural competency among social services agencies inhibit immigrant's Medicaid participation. Second, there is widespread confusion regarding eligibility for benefits, not just among immigrants themselves, but also among the health care providers that serve them and social services workers charged with determining eligibility.<sup>32</sup> While the state has done an admirable job of getting the word out to local commissioners, local eligibility workers must be adequately trained in the new rules and procedures. Third, there is fear and misinformation among immigrants about the consequences of Medicaid enrollment. Many believe that receipt of any public benefits will render them a "public charge" and jeopardize their immigration status.<sup>33</sup> This belief continues despite a 1999 INS clarification stating that receipt of Medicaid (except for long-term care) should not result in a public charge determination that would jeopardize an immigrant's residence status.<sup>34</sup> Some immigrants, unsure of their own or a family member's immigration status, may decide not to apply for benefits for themselves or their children because they fear that their status or the family member's will be reported to the INS.<sup>35</sup>

### **Next Steps**

*Aliessa* restored access to public health insurance to legal immigrants in New York State. However, if the decision's potential is to be turned into reality, considerable work remains. There must be aggressive outreach to overcome confusion and fear that could prevent widespread immigrant enrollment in Medicaid and FHP. This effort should involve trusted community-based organizations and health care providers that serve

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<sup>30</sup> Recently enacted legislation eliminates the requirement that applicants for Medicaid document their resources. Laws of New York, Ch.1 of 2002, Part A, § 51.

<sup>31</sup> Telephone interview with Ellen Yacknin, Greater Upstate Law Project, Feb. 19, 2002.

<sup>32</sup> Telephone interview with Elisabeth Benjamin, Legal Aid Society, Feb. 20, 2002.

<sup>33</sup> L. Ku and S. Matani, *Immigrants' Access to Health Care and Insurance on the Cusp of Welfare Reform*, Urban Institute, June 2000, at 1, citing C. Schlosberg and D. Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care*, National Health Law Program and National Immigration Law Center, May 1998, available at [www.healthlaw.org/pubs/19980522publiccharge.html](http://www.healthlaw.org/pubs/19980522publiccharge.html).

<sup>34</sup> *Id.* Department of Justice, Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689-93 (May 26, 1999).

<sup>35</sup> *Barriers to Benefits Access Faced by Immigrant Families*, National Immigration Law Center, June 2000, at 5.

immigrants, as well as the media, and state and local governments. This is only the first step. In addition, social services workers charged with determining eligibility must be re-trained in the new policies and documentation requirements. Already, directives to local commissioners ensured consistent implementation of these highly complex procedures at the ground level. Administrative directives with obsolete information about immigrant eligibility should be officially rescinded, and Department of Health personnel should conduct training sessions for eligibility workers across the state, while local social services districts implement quality reviews of front-line decisions.

Finally, a significant gap in health coverage for low-income immigrants remains. Undocumented immigrants are still ineligible for Medicaid or FHP coverage of primary, preventive and acute care, other than emergency and prenatal services. Until this gap is bridged, undocumented immigrants will do without necessary care and continue to use emergency rooms as their source of primary care.

### **National Implications**

Federal welfare reform created pressure on states to eliminate publicly subsidized health coverage for immigrants. However, many states besides New York have assumed responsibility for providing this coverage. At least 10 states, including California, New Jersey, Massachusetts, and Connecticut, offer comprehensive, government-funded health coverage to legal immigrants whose immigration status makes them ineligible for federal Medicaid.<sup>36</sup> Other states provide benefits to non-citizen children and pregnant women.

Given its holding under the federal equal protection clause, the *Aliessa* decision has national implications for states that have not voluntarily continued to provide health benefits to legal immigrants. *Aliessa* was decided by a state court and involved a challenge to a state law implementing PRWORA. However, the New York State law in question closely mirrored the federal law's provisions and, by extension, the immigrant eligibility laws other states have adopted. If other state courts follow New York's lead, similar state laws that restrict immigrant eligibility for public benefits could be overturned on equal protection grounds. In fact, an Arizona appellate court recently cited *Aliessa* in support of its holding that Arizona's state- and county-funded health benefits programs, which restricted eligibility for immigrants to a greater extent than federal law required, violated the equal protection clause of the U.S. Constitution.<sup>37</sup>

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<sup>36</sup> Bachrach, Lipson, and Tassi, at Appendix B.

<sup>37</sup> *Kurti v. Maricopa County*, 33 P.3d 499, 505–06 (2001).

Whether states assume the responsibility for providing health benefits to immigrants through legislative action or judicial mandate, they generally bear the full cost of this coverage because federal financial participation is currently unavailable for many immigrants. Legislation that would expand federally funded Medicaid to certain immigrants, primarily pregnant women and children, is pending in Congress.<sup>38</sup> There is an urgent need for changes in federal policy to provide New York and other states with fiscal relief and to ensure that immigrants across the nation are treated equally and have appropriate access to public benefits regardless of their state of residence.

### **Conclusion**

Recent policy changes help ensure that low-income, legal immigrants in the state of New York once again have the opportunity to participate fully in New York's Medicaid and FHP programs. Improved access to health insurance coverage could in turn have a positive effect on immigrants' health status, on the fiscal health of providers who serve them, and on the public health. With effective outreach and enrollment efforts, legal immigrants will have access to primary and preventive care, their providers will no longer be forced to provide staggering amounts of uncompensated care, and the public health will be served through increased screenings and treatment for disease.

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<sup>38</sup> Immigrant Children's Health Improvement Act, S.582/H.R. 1143 (would provide federal financial participation for states that opt to provide Medicaid or CHIP coverage to legal immigrants who are pregnant women or children); FamilyCare Act, S.1244/H.R.2630 (would provide federal financial participation for states that opt to provide Medicaid or CHIP coverage to legal immigrants who are pregnant women, parents of minor children, or children).

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**#523** *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (March 2002). Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney. This report, based on the Fund's 2001 Health Care Quality Survey, reveals that on a wide range of health care quality measures—including effective patient–physician communication, overcoming cultural and linguistic barriers, and access to health care and insurance coverage—minority Americans do not fare as well as whites.

**#526** *Quality of Health Care for Hispanic Populations* (March 2002). Michelle M. Doty and Brett L. Ives. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Hispanics.

**#507** *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by the New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

**#485** *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

**#484** *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

**#473** *Coordinating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (October 2001). Korbin Liu, Sharon K. Long, Matthew Storeygard, and Amanda Lockshin, The Urban Institute. According to the authors, a New York State demonstration program offering managed care to low-income adults who require long-term care appears to be enrolling more patients than previous programs and offering an expanded range of services.

**#453** *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of

employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

**#458** *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

**#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.

**#425** *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

**#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.

**#370** *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

**#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.