



Maximizing Health Care Reform for New York's Immigrants

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Prepared by
New York Immigration Coalition



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Executive Summary

The 2010 Patient Protection and Affordable Care Act (ACA) presents a crucial opportunity to bring about near universal coverage and transform how health care is provided and paid for throughout the United States. Stated for full implementation by 2014, the keystone of the ACA's reforms is the Health Benefit Exchange. The ACA provides states a large degree of flexibility with how they structure these health insurance marketplaces.

Implementation of the ACA has the potential to expand coverage for millions of uninsured people in 2014, but achieving this potential in New York will depend on policy choices the State makes right now. As a longstanding leader in promoting policies that ensure equal access for immigrants, New York should be at the forefront of promoting immigrant-friendly exchanges. It will be up to the states to craft immigrant-friendly exchanges that maximize immigrant participation. While the ACA creates some barriers to coverage for immigrants, it also provides states policy choices that can have positive implications for immigrant insurance eligibility and access to care.

It is therefore critical for New York to design an exchange that ensures equal access for immigrants. As of 2010, New York's population included 4.3 million immigrants.¹ For the 2.2 million immigrants in New York who are naturalized citizens, their citizenship status eliminates any bar to eligibility.² The remaining 2.1 million noncitizen immigrants in New York, both undocumented and lawfully residing, face unique challenges.³

Under the ACA, the 625,000 undocumented immigrants in New York will be barred from most types of public coverage and from purchasing coverage in the Exchange with their own money.⁴ However, for the 1.4 million lawfully residing immigrants in New York, the ACA provides states with flexibility to maximize access to coverage.⁵ Success will depend on the choices New York State makes.⁶

For all immigrants, but particularly this group of 1.4 million lawfully residing immigrants, the ACA offers both opportunities and challenges for New York to serve its residents. A fundamental principle guiding the ACA is that access to health insurance coverage for all is needed to create greater equity in the health care system, improve health outcomes, and bring down health care costs. Enabling immigrants to access coverage is necessary to achieve these goals. Yet health care reform is occurring in a political climate that is increasingly hostile to

¹ Migration Policy Institute, <http://www.migrationinformation.org/DataHub/state.cfm?ID=NY#3>.

² Ibid.

³ "Noncitizens" refers to immigrants who are not naturalized citizens. This includes undocumented immigrants, legal permanent residents, and immigrants on temporary visas or who are in the process of adjusting their status. The term "immigrants" will be used in this paper to encompass both naturalized citizens and noncitizens.

⁴ <http://www.pewhispanic.org/2011/02/01/authorized-immigrant-population-brnational-and-state-trends-2010/>.

⁵ Ibid.

⁶ Immigrants are disproportionately likely to remain uninsured after the Exchange is implemented. Two years after Massachusetts launched its exchange in 2006, nearly one in three of the remaining uninsured adults in Massachusetts were noncitizens. <http://www.rwjf.org/files/research/67248.MassReform2008UninsuredBrief.pdf>, p. 3.

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immigrants. This is simultaneously one of the most daunting and most promising moments for improving immigrant access to health care in New York State. In order for New York to ensure optimal inclusion of this population in health reform implementation, the New York Immigration Coalition (NYIC) proposes a number of immigrant-friendly measures to ensure an inclusive, accessible and well-functioning health care system.

The purpose of this paper is to maximize the inclusion of immigrants in the implementation of health reform and guide New York State policymakers in achieving this goal. This paper's recommendations will highlight how New York policymakers can preserve and promote immigrant access to coverage and thus mitigate the ongoing disparities between citizens and noncitizens in the arena of health care.

Among NYIC's recommendations:

IMMIGRANT ELIGIBILITY

- **New York should continue to provide State-funded Medicaid program coverage for PRUCOL** (persons who are Permanently Residing Under Color of Law)⁷ classified immigrants currently covered in New York State who will not qualify under the ACA definitions of “lawfully present” that determine eligibility for the individual exchanges. **This will enable certain cases, such as asylum applicants, to be able to access coverage.**
 - In New York, certain immigrants deemed to be PRUCOL, such as individuals applying for adjustment of status or asylum or those granted deferred action, are eligible to apply for State-funded Medicaid. It is crucial that New York continue to support health care for these immigrants not covered by Federal Medicaid dollars. The ACA's “lawfully present” definition of immigrants eligible to purchase insurance through the Exchange can be combined with New York's PRUCOL classification to bring as expansive a group of immigrants into the health care system as possible.
- **New York should issue an administrative clarification that the State's PRUCOL classification extends to individuals whose removal is not being pursued by the Department of Homeland Security (DHS), such as DREAM (undocumented) youth, as per the prosecutorial policies recently articulated by the Obama administration**—even where no affirmative relief, like deferred action or stay of removal, has been granted.
 - The Department of Health and Human Services (HHS) recently clarified that DREAM youth who are granted Deferred Action for Childhood Arrivals (DACA) under the new Federal program are not eligible under the ACA. New York should clarify that it will fund the health care coverage of DACA grantees and other recipients of similar prosecutorial discretion/deferred action statuses whereby the DHS is not pursuing their removal from the country.

⁷ www.health.ny.gov/health_care/medicaid/reference/mrg/other-eligibility-requirements.pdf, p.641.

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- **New York should explore developing an insurance product for undocumented immigrants** that would stabilize health care for undocumented populations, provide cost savings, and allow the State to better predict its health care expenditures.
 - Currently, New York provides for uninsured populations through charity care funds that are administered in an ad-hoc manner, difficult to access, and vulnerable to cuts. Crafting an insurance product for undocumented immigrants who are ineligible for other insurance options may be a financial and strategic necessity.

DOCUMENTATION AND VERIFICATION FOR IMMIGRANTS

- **New York should ensure that errors in immigration status verification systems, such as SAVE** (Systematic Alien Verification for Entitlements), **do not incorrectly exclude immigrants who are eligible for health care.** The Exchange website must provide opportunities for immigrants who do not pass initial verification through SAVE and the new Federal Data Services Hub to provide paperwork to the State for a secondary review. New York should allow applicants a reasonable opportunity to provide documentation while seeking private coverage in the Exchange, as is already required for public insurance programs.
 - The Federal SAVE database often contains errors, and false negative results for immigrant eligibility can lead to immigrants being unfairly denied benefits. If immigrants do not pass initial immigration status verification process, the State Exchange should give them additional opportunities to verify their immigration status for the purpose of Exchange eligibility. The SAVE system puts the documentation burden on the individual, even when government data sources contain the needed documentation to verify status. Given this burden, immigrants should be given a reasonable timeframe to obtain and provide those documents.
- **New York should allow individuals to provide their “A” number (Alienation Registration Number) orally, an option permitted in the final Federal regulations.**
 - When used in combination with providing other identifying information that can be matched to the “A” number, such as name, date of birth, and country of nationality, verbal provision of the “A” number should be sufficient to verify the individual’s immigration status and thus eligibility. An “A” number that can be used to determine eligibility is valid even if the applicant’s documents indicate that his or her “A” number has expired.
- **New York should expand and inform the policy options by providing input on forthcoming Federal guidance.** For example, New York can use its experience to inform Federal guidance on what documentation is allowable to resolve inconsistencies in Exchange eligibility verification, including verification of immigrant status.
 - As a State with a rich knowledge of immigrant issues and a longstanding experience of being at the forefront of immigrant access, New York should share its invaluable perspective to inform strategies and policies for other states and the Federal government to include immigrants in their exchanges.

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- **New York should not require additional documentation or verification for the Small Business Health Options Program (SHOP) Exchange**, as applicants' statuses are already verified through the I-9 form.
 - Because immigration status is already verified through the I-9 form upon an employee's hire, there is no need to reverify immigration status for the purpose of the Exchange. Reverification would be costly and time-consuming for small businesses and add to their administrative burden, imposing a deterrent on small business participation in the SHOP insurance Exchanges.

MARKETING, ENROLLMENT, AND OUTREACH TO IMMIGRANT COMMUNITIES

- **New York should craft segmented marketing campaigns** with different messages for New York's diverse immigrant communities.
 - There is no one-size-fits-all approach to marketing for immigrants. Perceptions of insurance vary between immigrant communities, and marketing efforts targeting immigrant communities should be tailored to meet their diverse needs. A branding strategy that is compelling to Mexican-American communities may not resonate with the Russian immigrant population, for example.
- **New York should adopt a "No Wrong Door" policy for mixed-status families.**
 - Under ACA, consumers will be able to apply for coverage at any enrollment site without having to know in advance which coverage programs they are applying for. This goal will be tested by mixed-immigration-status families, when different members of the same family qualify for different programs because of variation in immigrant status.
- **New York should ensure that grants and funding for Navigators reach community-based organizations (CBOs) that are embedded in immigrant and other underserved communities.**
 - The ACA requires states to implement Navigator programs to assist individuals with Exchange enrollment. Navigators are on the front lines of the Exchange, providing consumers with information and individual assistance with enrollment. A diverse, culturally and linguistically competent Navigator program will be critical to immigrant coverage.
- In addition to the formal Navigator designation process, **New York should fund a separate outreach and education program for smaller community-based organizations (CBOs) by rolling out multi-year grants of varying sizes.**
 - Smaller immigrant CBOs are crucial to reaching small immigrant communities whose needs are not met by larger providers, but they are often not equipped to handle large state grants such as those provided by the Navigator program. Offering grants of varying sizes will allow smaller CBOs to connect with the hardest-to-reach immigrant populations.

Executive Summary *(continued)*

OVERSIGHT, COMMUNITY INPUT, AND MONITORING

- **New York should establish a Health Disparities Workgroup.** Immigrant voices and input in the Exchange development are necessary to receive feedback throughout implementation and to make the Exchange responsive to immigrant needs. New York should follow Maryland's example in institutionalizing input from immigrants and other groups that experience disparities, by convening a Health Disparities Workgroup with official status in the governance process.
- **New York should designate the Exchange, not the Qualified Health Plans that sell products in the Exchange, to collect premiums.** Premium collection by the Exchange could also be an opportunity to gather data about immigrant coverage continuity, denials, or disruptions and Limited English Proficiency (LEP) access among products sold within the Exchange.



Introduction

The passage of the Patient Protection and Affordable Care Act (ACA)⁸ in 2010, slated for full implementation by 2014, presents a crucial opportunity to open the door to quality health care for millions of immigrants in New York and across the nation. At the center of Federal health care reform is the creation of health insurance marketplaces called exchanges, which will allow individuals in each state to purchase affordable health insurance. Each state may establish its own insurance Exchange, and states that do choose to operate a state-based Exchange have a large degree of flexibility with how they structure these insurance marketplaces. As a major transformation of the nation's health care system, the ACA offers the promise of greatly expanded access to health insurance for millions nationwide.

The opportunity to expand coverage is particularly important for immigrants, who are significantly more likely than non-immigrants to be uninsured.⁹ However, eligible immigrants may face many hurdles to accessing new coverage, including language barriers and barriers to obtaining required documentation. It is therefore crucial for New York to design an insurance Exchange that ensures equal access for immigrants. Moreover, the creation of the health Exchange must be carefully coordinated with the concurrent redesign of Medicaid and the safety net system in New York State. An estimated 1.4 million New Yorkers, including undocumented immigrants who were excluded from the ACA's coverage expansions, will remain uninsured post-reform and rely on safety net providers.¹⁰

The purpose of this paper is to propose recommendations for designing an Exchange that will open doors to improve access to health care for immigrants across New York State. The New York Immigration Coalition (NYIC) has developed a set of recommendations that will guide New York State policymakers in ensuring that no one is left behind in accessing health care services. This paper's recommendations will highlight how New York policymakers can ensure inclusion of immigrant populations in the implementation of New York's Exchange and thus mitigate the ongoing disparities between citizens and noncitizens in the arena of health care.

BACKGROUND: NEW YORK'S HEALTH COVERAGE AND IMMIGRANT POPULATION CHARACTERISTICS

In New York, noncitizens (both undocumented immigrants and those with legal status) tend to be uninsured at higher rates than their citizen counterparts. This persistent inequality must be addressed if New York hopes to move toward greater health insurance coverage as a State. The ACA presents an important opportunity to close the gap between the insured and uninsured

⁸ *Patient Protection and Affordable Care Act. Public Law no. 111-148 (2010)*, 2010. Print.

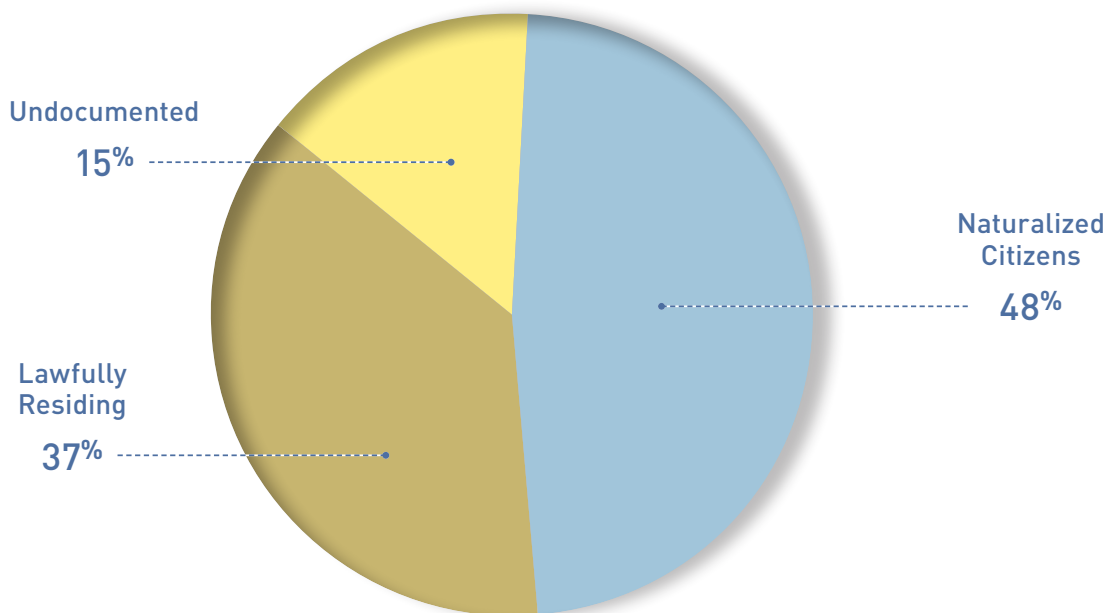
⁹ Source: U.S. Census Bureau. *Current Population Survey, Annual Social and Economic Supplement, 2011*. <http://www.census.gov/cps/data/cpstablescreator.html>. Accessed July 2012.

¹⁰ Boozang, P., Dutton, M., Lam, A., Bachrach, D. "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010, p. 5. <http://nyshealthfoundation.org/resources-and-reports/resource/implementing-federal-health-care-reform-a-roadmap-for-new-york-state>.

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by offering to significantly expand access to New Yorkers who are citizens or lawful residents. Because the majority of immigrants in New York are either citizens or lawful residents, the majority of immigrants will also benefit from the implementation of the ACA if it is structured with a focus upon immigrant inclusion.

FIGURE 1. New York Immigrant Population by Immigration Status 2010



SOURCES:

<http://www.migrationinformation.org/DataHub/state.cfm?ID=NY#3>

<http://www.pewhispanic.org/2011/02/01/authorized-immigrant-population-national-and-state-trends-2010/>

New York's 2010 population was 19.3 million, 15% (or 2,886,000) of which was uninsured.¹¹ New York State's residents include 4.3 million immigrants (22.3% of the population), about 2.2 million of whom are naturalized citizens,¹² 1.4 million of whom are lawfully residing, and 625,000 of whom are undocumented.¹³ Therefore, approximately 85% of immigrant New Yorkers are either citizens or legal residents.

¹¹ U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2011. <http://www.census.gov/cps/data/cpstables.html>.

¹² Migration Policy Institute, <http://www.migrationinformation.org/DataHub/state.cfm?ID=NY#3>.

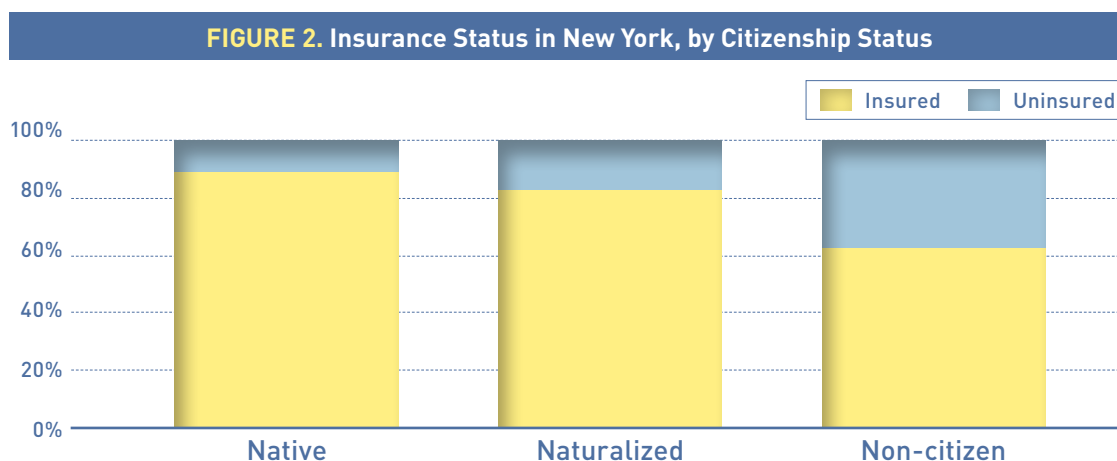
¹³ <http://www.pewhispanic.org/2011/02/01/authorized-immigrant-population-national-and-state-trends-2010/>.

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Noncitizens¹⁴ constitute a disproportionately high percentage of the uninsured, including those who are eligible for public health insurance but are not enrolled.¹⁵ New York's noncitizens are more than three times as likely as citizens to lack health insurance:¹⁶ whereas 12% of all citizens are uninsured, 37% of noncitizens are uninsured.¹⁷ Reasons for this disparity include noncitizens'

Approximately 85% of immigrant New Yorkers are citizens or legal residents

higher rates of employment by small businesses that do not offer insurance, an underutilization of public insurance programs owing to a lack of awareness of their rights, concerns about immigration consequences of accessing such services, and language and other barriers.



SOURCE: U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2011.¹⁸

Undocumented immigrants represent only 3.5% of New York's total population, but they are currently 15% of New York's uninsured.¹⁹ After health reform is implemented, 20%–30% of the

¹⁴ "Noncitizens" refers to immigrants who are not naturalized citizens; the term includes undocumented immigrants, legal permanent residents, and immigrants on temporary visas or who are in the process of adjusting their status. The term "immigrants" will be used in this paper to encompass both naturalized citizens and noncitizens.

¹⁵ Holahan, D., Cook, A., Powell, L. "New York's Eligible but Uninsured," United Hospital Fund, 2008.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Table created by NYC from data at: <http://www.census.gov/cps/data/cpstablescreator.html>.

¹⁹ Boozang, P., Dutton, M., Lam, A., Bachrach, D. "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010, p. 4. <http://nyshealthfoundation.org/resources-and-reports/resource/implementing-federal-health-care-reform-a-roadmap-for-new-york-state>.

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State's uninsured will be undocumented immigrants, or more if New York is able to improve enrollment in public health insurance programs without creating an insurance program for undocumented populations.²⁰

Meanwhile, more than 2.5 million New Yorkers over the age of five, or 13.5% of New York's population over the age of five, have Limited English Proficiency (LEP), meaning they need interpretation or translation services to communicate effectively.²¹ A little more than half of that population speaks Spanish; the other half speak nearly 150 other languages and dialects.²² While many LEP individuals live in downstate New York, upstate areas also have high numbers of Spanish speakers as well as growing refugee populations who need language assistance services.

It is expected that 1.5 – 2.0 million individuals in New York will remain uninsured even after health care reform is fully implemented.²³ The majority will be citizens and legal immigrants who are eligible for insurance but not enrolled; individuals who still cannot afford the cost of health insurance; and others who are exempt from the individual mandate or who choose to pay the tax penalty rather than enroll in coverage.²⁴ However, the share of the uninsured population who are undocumented immigrants will likely grow as the ACA is implemented; this group is specifically excluded from the new coverage benefits of the ACA and is already excluded from most public health insurance programs.

Because the ACA explicitly bars undocumented individuals from purchasing insurance through the individual Exchange, charity care and emergency Medicaid will continue to play an important role in providing coverage for these populations. While undocumented immigrants are not be able to participate in New York's individual Exchange, opportunities still may exist for undocumented populations to buy into the small business (SHOP) Exchange. In addition, enrollment and outreach efforts for the Exchange could offer mixed-status families and undocumented individuals opportunities to become better educated about other health care options outside of the Exchange.

New York has historically gone above and beyond Federal requirements to provide access to immigrants not covered under Federal law. Although Federal law imposes a five-year waiting period for federally-funded Medicaid benefits for lawful permanent residents, New York courts have ruled²⁵ that lawful permanent residents must have access to State-funded Medicaid and Family Health Plus.²⁶ New York also provides coverage to undocumented children through

²⁰ Ibid.

²¹ Source: U.S. Census Bureau, 2011 American Community Survey <http://factfinder2.census.gov/faces/tableservices/j>.

²² Ibid.

²³ Boozang, P., Dutton, M., Lam, A., Bachrach, D. "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010.
<http://nyshealthfoundation.org/resources-and-reports/resource/implementing-federal-health-care-reform-a-roadmap-for-new-york-state>.

²⁴ Ibid.

²⁵ *Aliessa v. Novello*, 96 N.Y.2d 418, 754 N.E.2d 1085, 730 N.Y.S.2d 1 [2001].

²⁶ <http://www.empirejustice.org/assets/pdf/issue-areas/public-benefits/eligibility-pb-immigrants.pdf>.

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the Child Health Plus program and to undocumented mothers for prenatal, delivery, and postpartum care through the Prenatal Care Assistance Program (PCAP). The State must continue to play an important role in funding the health care needs of New Yorkers who have been excluded from the ACA's coverage options.

New York has historically gone above and beyond Federal requirements to provide access to immigrants not covered under Federal law. The State must continue to play an important role in funding the health care needs of New Yorkers who have been excluded from Federal reform throughout the ACA implementation process.

In general, the ACA offers numerous opportunities to increase coverage, access, and quality of care for historically underserved communities. At least six ACA provisions target immigrants and minorities specifically:²⁷

1	The mandate that Qualified Health Plans (QHPs) provide linguistically and culturally appropriate materials through enrollment and appeals process;
2	Reaffirmation and strengthening of existing civil rights protections;
3	Restructuring and elevation of the Office of Minority Health and the National Institute on Minority Health and Health Disparities;
4	Provisions for the diversification of the health care workforce;
5	The collection of data on health disparities, including questions about primary language and greater granularity about race and ethnicity; and
6	Grants for demonstration projects and research on cultural competency training.

Other ACA provisions such as increasing funding for community health centers, which are disproportionately used by communities of color,²⁸ and the ACA's provisions for Community Transformation Grants will also impact health outcomes in immigrant communities. It is crucial that New York take advantage of these provisions to reduce health disparities and take immigrant health access issues into consideration at every point of Exchange development.

A fundamental principle guiding the ACA is that access to health insurance coverage for all is needed to create greater equity in the health care system, improve health outcomes, and bring down health care costs. Providing coverage to immigrants is necessary to achieve these

²⁷ "The Affordable Care Act: Coverage Implications and Issues for Immigrant Families." Office of the Assistant Secretary for Planning and Evaluation, Offices of Human Services Policy, US Department of Health and Human Services April 2012. aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

²⁸ "Issue Brief: Moving toward Equity: Health Reform Creates a Foundation for Eliminating Disparities." Families USA, May 2010.

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goals, yet health care reform is occurring in a political climate that is increasingly hostile to immigrants. This is simultaneously one of the most daunting and most promising moments for improving immigrant access to health care in New York State in recent history.

PAPER STRUCTURE AND METHODOLOGY

This paper develops a series of recommendations for how New York can maximize the inclusion of immigrants in the implementation of health reform and ensure immigrants' access to coverage. The recommendations were developed through a review of scholarly and policy literature; in-depth interviews with stakeholders and experts;²⁹ and close reviews of health reform implementation in three early-adopter states: Massachusetts, California, and Maryland. Massachusetts was chosen because it had implemented a health insurance exchange prior to the ACA; California was the first state to pass Exchange legislation following the ACA's passage; and Maryland was an early adopter with a substantial immigrant population that offered a useful contrast in the different choices it has made in establishing its Exchange. The NYC's expertise in immigrant community health issues in New York State, combined with lessons from early implementing states, guides our recommendations for New York.

The paper is divided into five major areas: Eligibility of Noncitizens in New York's Health Benefit Exchange; Documentation and Verification; Marketing, Enrollment, and Outreach to Immigrant Communities; Oversight, Community Input, and Monitoring; and Securing the Safety Net. The report identifies where New York can have the greatest impact in structuring its Exchange to ensure immigrant access and proposes a robust set of recommendations for how New York can guarantee that immigrant communities will have full access to New York's Exchange. In sum, the recommendations provide a roadmap for advocates to work with State and Federal partners to ensure that all New Yorkers, regardless of income or immigration status, have access to health care.

²⁹ See Acknowledgements for list of experts interviewed.

Eligibility of Noncitizens in New York's Health Benefit Exchange

BACKGROUND

Access to health care for noncitizens, both undocumented immigrants and those with legal status, has undergone significant transformations under Federal law in recent decades. A series of changes at the Federal level has determined the context for immigrant inclusion under the current reforms of the ACA. In August of 1996, President Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) into law.³⁰ By limiting eligibility for all Federal public benefit programs, including Medicaid, for noncitizens to those with a “qualified alien” status, PRWORA was to be the first in a series of laws governing the access of noncitizens to health care. After PRWORA, however, the country has moved in the other direction, to greater inclusion of immigrants in the nation’s public health care system. The ACA offers some hope that the nation’s health system will continue its trajectory toward greater immigrant inclusion.

In a move toward increasing flexibility for states in providing immigrant coverage, in 2002 the Department of Health and Human Services (HHS) gave states the option of using Federal funds to provide prenatal care to pregnant women whose lack of legal status made them ineligible for Medicaid. The Department did so through an “unborn child” amendment to the Federal regulations implementing the State Children’s Health Insurance Program (CHIP).³¹ Approximately a dozen states, including California, Massachusetts, Rhode Island, and Washington, have implemented this option, but New York has not.³²

In the 2009 CHIP Reauthorization Amendments (CHPRA),³³ states were granted the option to extend Federal CHIP and Medicaid eligibility to children and pregnant women who are “lawfully residing” in the U.S. The amendments also eliminated the five-year bar for those women and children who had entered the U.S. after August 22, 1996, and added several categories of noncitizens, namely those lawfully residing in the U.S. who were not included in the “qualified alien” classification of PRWORA. New York has taken this option.

The ACA is the most recent law to address the eligibility of noncitizens for subsidized health care benefits. Under the ACA, all “lawfully present” noncitizens are eligible to use the Health Benefit Exchange to purchase private health insurance and, for those financially eligible, to obtain tax credits and subsidies to help pay for it. This essentially extends CHPRA’s expansion of

³⁰ *Personal Responsibility and Work Opportunity Reconciliation Act*, Pub. Law 104-193 (August 22, 1996).

³¹ The Children’s Health Insurance Program was created by the Balanced Budget Act of 1997. The regulatory amendment extending SCHIP eligibility to fetuses was published in 67 Fed. Reg. 9936 (March 5, 2002).

³² The initial Unborn Child State Plan amendments restrict states to providing coverage and prenatal care for the fetus only, not the mother. The subsequent 2009 CHPRA amendments expand the option to provide coverage for the mother as well.

³³ *Children’s Health Insurance Program Reauthorization Act of 2009*, Pub. Law 111-3.

Eligibility of Noncitizens in New York’s Health Benefit Exchange *(continued)*

the definition of eligible noncitizens (i.e., pregnant women and children “lawfully residing” in the U.S.) to all noncitizens lawfully in the U.S. Although the ACA uses the term lawfully “present” rather than using CHPRA’s term lawfully “residing,” the implementing regulations clarify that to be eligible to purchase health insurance through the Exchange, the noncitizen must be residing in the State or region covered by the Exchange.³⁴

IMMIGRANT ELIGIBILITY CLASSIFICATIONS UNDER EXISTING LAW

Definitions related to immigrant status (for example, what it means to be “lawfully present”) and eligibility for public benefits vary by program, both at the Federal level and within New York State. Some programs follow a more inclusive definition while others are more restrictive. Following is an overview of a range of eligibility classifications under existing law, along with recommendations for defining the immigrant population for health reform implementation in New York State.

Immigrant Eligibility Classifications in the Federal Medicaid Program

The eligibility rules governing noncitizen participation in the health care system in New York are extremely complex.³⁵ The complexity itself serves as a barrier to access, requiring benefit agency workers administering the programs, many of whom are largely unfamiliar with the country’s immigration laws, to understand the many variations in status that noncitizens may hold and, further, how that status affects a noncitizen’s eligibility for a wide variety of medical assistance programs. The ACA provides a welcome expansion of noncitizen inclusion in the Health Benefit Exchange; nevertheless, it does not change the Medicaid immigrant eligibility rules and thus adds to the complexity involved in determining the program for which a noncitizen with a particular status is eligible.

The noncitizen eligibility rules in the Federal Medicaid³⁶ program were first set out in PRWORA. PRWORA required noncitizens to be in a “qualified alien status” in order to receive benefits under the program. In addition, because Medicaid and CHIP were defined as “means tested” Federal benefits, a five-year bar (a waiting period) was imposed on all noncitizens arriving in the U.S. after August 22, 1996, with the exception of humanitarian-based immigrants, who are exempted from the bar. For non-exempt immigrants who arrive after August 1996 under sponsorship, PRWORA required that the income and resources of the immigrant’s sponsor be accounted for in determining the immigrant’s income eligibility for Federal means-tested programs.

Under the provisions of PRWORA, the term “qualified alien” refers to individuals in the following categories:

- Lawful permanent residents;
- Humanitarian immigrants:

³⁴ [45 CFR Section 155.305(a)(3). See 77 Fed.Reg. 18310, March 27, 2012, at page 18452.]

³⁵ For a chart of eligibility by immigration status, see: <http://www.empirejustice.org/assets/pdf/issue-areas/immigrant-rights/immigrant-eligibility-chart.pdf>.

³⁶ These rules also apply to the Family Health Plus program, which is considered a Medicaid expansion program.

Eligibility of Noncitizens in New York’s Health Benefit Exchange *(continued)*

- Conditional Entrants (classification in use before 1980),
- Asylees, Refugees, and individuals granted withholding of removal/deportation,
- Cuban/Haitian Entrants as defined in the Refugee Education Assistance Act of 1980, and
- Amerasians;
- An individual paroled into the U.S. for a period of at least one year (a humanitarian, not a criminal-related classification); and
- Under certain circumstances, an abused or battered child or spouse of a U.S. citizen or lawful permanent resident who has an approved or pending I-130 family petition or an I-360 self-petition under the Violence Against Women Act.³⁷

Specific provisions in PRWORA add lawfully residing veterans and active duty service members, together with their immediate families, as well as American Indians born in Canada, to the list of noncitizens eligible for Medicaid and other benefits.³⁸ Pursuant to provisions in the Victims of Trafficking and Violence Protection Act of 2000, victims of trafficking were made eligible for benefits on the same basis as refugees. In December 2009, pursuant to Section 8120 of the Department of Defense Appropriation Act of 2010, Iraqi and Afghan Special Immigrants were also provided access to public benefit programs on the same terms as humanitarian-based immigrants.

As noted, the 2009 CHPRA provisions expanded access to Medicaid and CHIP by giving states the option of extending coverage to “lawfully residing” pregnant women and children. (New York amended its State plan to exercise this option.) To be eligible, the women and children had to be lawfully present and meet the Medicaid state residency rules.³⁹ The five-year bar and sponsor income deeming and reimbursement provisions of PRWORA were eliminated for this group.

Immigrant Eligibility Classifications in New York State’s Medicaid Program

In 1997, New York implemented Federal welfare reform by enacting a State statute that, among other provisions, provided Medicaid eligibility to noncitizens only if (with a few exceptions) they were eligible for the Federal Medicaid program.⁴⁰ Because this statute would have excluded many noncitizens lawfully residing in the State from access to the State’s Medicaid program, a case called *Aliessa v. Novello* was brought to challenge these restrictions. In June 2001, in a unanimous decision, the Court of Appeals held that, although the Federal government was constitutionally permitted to make distinctions between and among citizens and lawfully residing noncitizens in the provision of benefits, New York’s attempt to do so violated equal protection and New York’s constitutional guarantee of aid and care of the needy.⁴¹ As a result,

³⁷ 8 USC Section 1641(b) and (c).

³⁸ 8 USC Section 1612 (b)(2) and (3).

³⁹ These rules are found at 42 CFR section 435.403.

⁴⁰ See NY Social Services Law Section 122(c).

⁴¹ *Aliessa v. Novello*, 96 N.Y.2d 418, 754 N.E.2d 1085, 730 N.Y.S.2d 1 (2001).

Eligibility of Noncitizens in New York’s Health Benefit Exchange *(continued)*

New York’s State-funded Medicaid program, as well as Family Health Plus (New York’s Medicaid expansion program), are now required to cover not only noncitizens who fall within the “qualified alien” classification (regardless of whether they have a sponsor or are within their first five years of residence in the U.S.) but also those noncitizens deemed to be “permanently residing under color of law” (PRUCOL).

PRUCOL is not in itself an immigration status, but rather is a benefit program-defined noncitizen eligibility category. The term first came into use in the 1980s and was defined within the context of each individual Federal benefit program.⁴² Congress essentially did away with the PRUCOL classification for the purpose of Federal benefit eligibility in 1996, when it enacted PRWORA. However, New York and several other states, including Massachusetts and California, still use it in determining noncitizen eligibility in State- and locally-funded programs.⁴³ In New York, as a result of the *Aliessa* decision, in addition to noncitizens in a “qualified alien” status, individuals deemed PRUCOL are eligible for the State-funded Medicaid program.

Included in the PRUCOL classification are noncitizens:⁴⁴

- who have been paroled into the U.S. for a period of less than one year;
- who are under an Order of Supervision;
- who have been granted an indefinite stay of deportation;
- who have been granted indefinite voluntary departure (a pre-1997 humanitarian-based status);
- on whose behalf an immediate relative petition has been approved and family members covered by the petition;⁴⁵
- who have filed an application for adjustment of status to lawful permanent resident under Section 245 of the Immigration and Nationality Act (INA) that the U.S. Citizenship and Immigration Services (USCIS) has accepted as “properly filed”;
- who have been granted deferred action;
- who have been granted Deferred Enforced Departure;
- who entered and continuously resided in the U.S. before January 1, 1972 (registry eligible);

⁴² This is the basis for the difference between the definition of PRUCOL in New York’s health programs as compared to its State-funded welfare program. OTDA (the Office of Temporary and Disability Assistance) uses the narrower definition developed within the context of the Aid to Families with Dependent Children (AFDC) program.

⁴³ <http://www.nilc.org/guideupdate.html>. National Immigration Law Center: Medical Assistance Programs for Immigrants in Various States 122–23 & 126–27.

⁴⁴ Revised Desk Guide: “Documentation Guide to Citizenship and Immigrant Eligibility for Health Coverage in New York State”, available at www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma009att.pdf.

⁴⁵ Defined to include the spouse, parent, or unmarried children of a U.S. Citizen/Legal Permanent Resident who has filed an I-130 relative petition on their behalf. See Medicaid Resource Guide (MRG) at page 455.37e. Updated as of November 2009; available at www.health.ny.gov/health_care/medicaid/reference/mrg/november2009.htm.

Eligibility of Noncitizens in New York's Health Benefit Exchange *(continued)*

- who have been granted suspension of deportation under Section 244 of the INA;⁴⁶ and
- in general, any noncitizen living in the U.S. with the knowledge and permission or acquiescence of the Federal immigration agency and whose departure the agency does not contemplate enforcing, including but not limited to:
 - Individuals applying for adjustment of status, asylum, or suspension of deportation/cancellation of removal, or requesting deferred action,⁴⁷
 - Citizens of the Federated States of Micronesia and the Marshall Islands,
 - Individuals granted Temporary Protected Status (TPS) and those applying for TPS,
 - Individuals with a K, V, S or U visa or applying for such a visa, and
 - Individuals who have applied for Deferred Action under certain conditions.⁴⁸

This last, general category is designed to cover two situations:

- when “...it is the [immigration] agency’s policy or practice not to enforce the departure of aliens in a particular category, and the alien falls within that category;” or
- when, “based on all the facts and circumstances of the alien’s case, it appears that the Federal immigration agency is permitting the alien to reside in the United States indefinitely.”⁴⁹

A comparison of these PRUCOL categories with the ACA’s “lawfully present” classifications described below demonstrates that New York, in some very important respects, provides a larger health care safety net for noncitizens.

Immigrant Eligibility Classifications in the ACA

Under the ACA, immigrant eligibility is determined by the definition of “lawfully present.”

To be eligible to purchase private insurance in the Health Benefit Exchange and, if financially eligible, to receive Federal assistance to do so, an *applicant*⁵⁰ must be a citizen or national of the U.S. or a noncitizen “lawfully present.” The definition of “lawfully present” in the final rule

⁴⁶ Removal proceedings have replaced deportation proceedings and are governed by Section 240 of the Immigration and Nationality Act (INA) so the reference here should be to individuals granted cancellation of removal. INA Section 244 now covers Temporary Protected Status.

⁴⁷ The failure of the immigration agency to respond to a request for deferred action will support the PRUCOL classification but only after six months have passed since the request was made and provided that the noncitizen or his or her advocate “made reasonable and good faith efforts to follow-up on the status of the request during this six month period.” MRG page 455.37.

⁴⁸ MRG, at 650-654.

⁴⁹ New York State Department of Health *Informational Letter 07 OHIP/INF-2* (March 15, 2007). Available at www.health.ny.gov/health_care/medicaid/publications/docs/inf/07inf-2.pdf.

⁵⁰ The final rule makes a distinction between an “applicant” and “application filer,” and thus provides for the access of mixed status households to the Exchange where some, though not all, members are citizens or “lawfully residing” noncitizens and it is the ineligible member who is filing the application. See 76 Fed.Reg. 51202, 51229 (August 17, 2011).

Eligibility of Noncitizens in New York's Health Benefit Exchange *(continued)*

on eligibility determinations in the Exchange was adopted from the definition used under the ACA's Pre-Existing Condition Insurance Plan (PCIP).⁵¹ The definition of "lawfully present" for the Exchange is also the same as that used in CHPRA in 2009, for noncitizens who are pregnant or children.

In the final rule defining "lawfully present" for Exchange eligibility purposes, HHS opened the door to a more expansive definition of "lawfully present" in the future. Specifically, in the final rule, HHS states that, "...to the extent that the Secretary amends the definition [of lawfully present] for Medicaid and CHIP in future rulemaking, we intend to adjust the Exchange rules accordingly."⁵² Additionally, in its response to public comment published with the final rule, HHS stated that, with regard to a more expansive definition of "lawfully present," it "...will consider commenters' recommendations in developing future rulemaking on this definition as it relates to Medicaid, CHIP and the Exchange." (77 Fed.Reg. 18310, at 18314.) This provides the necessary flexibility to adapt to future changes in noncitizen and immigrant classifications in the INA.

The term "lawfully present" under the ACA includes the following:

- A noncitizen with a "qualified alien" status as defined in Section 431 of PRWORA;⁵³
- An individual in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;⁵⁴
- A noncitizen who has been paroled into the U.S. pursuant to section 212(d)(5) for a period of less than one year, except for a person paroled for prosecution, for deferred inspection, or pending removal proceedings;
- An individual who belongs to one of the following classes:
 - Temporary resident status pursuant to Section 210 or 245A of the INA;
 - Temporary Protected Status pursuant to Section 244, including those with a pending application who have been granted employment authorization;
 - Granted employment authorization under:
 - 8 CFR 274a.12(c)(9) – an applicant for adjustment under various provisions of the INA;
 - 8 CFR 274a.12(c)(10) – an applicant for cancellation of removal;
 - 8 CFR 274a.12(c)(16) – a registry applicant;

⁵¹ 45 CFR 152.2, adopted for the Exchange in 45 CFR 155.20. See 77 Fed. Reg. 18310, 18445, (March 27, 2012).

⁵² 76 Fed. Reg. at 51206.

⁵³ As described on page 13 of this report.

⁵⁴ The proposed rules require that a noncitizen lawfully present "must be reasonably expected to be so for the entire period for which enrollment is sought." 45 CFR section 155.305(a)(1). In addition, the rule requires that the noncitizen be a resident of the state in which he is applying for coverage through the Exchange. In light of the residence requirement, some groups submitting comments have urged the removal of the "reasonable expectation" requirement as redundant and difficult to implement.

Eligibility of Noncitizens in New York's Health Benefit Exchange *(continued)*

- 8 CFR 274a.12(c)(18) – an individual under an Order of Supervision;
- 8 CFR 274a.12(c)(20) – an individual with a completed legalization application (SAW applicant);
- 8 CFR 274a.12(c)(22) – an individual with a completed legalization application under section 245a of the INA; or
- 8 CFR 274a.12(c)(24) – an individual who has filed an application for adjustment pursuant to the LIFE Act;
- Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended;
- Currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
- Currently in deferred action status; or
- Whose visa petition has been approved and who has a pending application for adjustment of status;
- An applicant for asylum, withholding of removal, or under the Convention Against Torture who has been granted employment authorization or, for applicants under the age of 14, whose application has been pending for at least 180 days;
- Who has been granted withholding of removal under the Convention Against Torture; or
- A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA.

New York's PRUCOL and the ACA's "Lawfully Present" Eligibility Classifications Compared

Federal law after 1996 excludes many immigrants from accessing Federal health benefits through its definition of "lawfully present." However, New York's definition of PRUCOL, a category of immigration status for the purpose of determining eligibility benefits, is broader and more inclusive than the Federal definition of "lawfully present." Under New York law, by qualifying as PRUCOL, many additional immigrants are eligible for State-funded benefits, even when they do not meet Federal eligibility standards.

One of the main differences between the PRUCOL eligibility classification under New York's State Medicaid program and the "lawfully present" classification under the Health Benefit Exchange is that the latter requires applicants for an immigration benefit (for example, applicants for adjustment of status) to have been granted employment authorization before they will be considered "lawfully present."⁵⁵ However, to be considered PRUCOL in New York for Medicaid purposes, applicants for an immigration benefit do not have to have employment authorization. Thus, applicants for adjustment of status, asylum, TPS, or U visas, for example, are eligible for New York Medicaid even if they do not have employment authorization and,

⁵⁵ One notable exception is that applicants for Special Immigrant Juvenile status need not have employment authorization before being considered eligible to participate in the Exchange.

Eligibility of Noncitizens in New York’s Health Benefit Exchange *(continued)*

in some cases, are not yet eligible to apply for it. This is particularly important for asylum applicants, who must wait for six months after filing an application for asylum before they become eligible to apply for an Employment Authorization Document (EAD).

Additional differences include:

- In New York’s Medicaid program, a noncitizen residing in the U.S. under an Order of Supervision is eligible for benefits. Under the ACA, an individual with an Order of Supervision must have applied for and been granted an EAD in order to be eligible to participate in the Exchange.
 - For example: Ms. Noncitizen was ordered deported, but she has a young U.S. citizen daughter with health problems, so she is being allowed to stay in the country temporarily under an Order of Supervision. She is eligible for Medicaid under the PRUCOL category, but to be eligible for the Exchange, she must also apply for and be granted employment authorization.
- In New York, a noncitizen who can show that he or she entered the U.S. before January 1, 1972, and has continuously resided in the country since that time is eligible for Medicaid under the PRUCOL classification without filing an application for adjustment of status. Under the ACA, the application for adjustment must have been filed and employment authorization based on the pending application granted before the individual is eligible to participate in the Exchange.
- In New York, immediate relatives with an approved I-130 petition are considered PRUCOL. Under the ACA, they must have filed an application for adjustment and have work authorization in order to be eligible to participate in the Exchange.

In one respect, noncitizen eligibility in the Exchange is more inclusive than the PRUCOL definition under New York’s Medicaid program. Specifically, noncitizens in a nonimmigrant status (students, for example) are considered “lawfully present” and eligible to apply for health insurance through the Exchange if they can show that they reside in the State and region where they are applying. These noncitizens in a nonimmigrant status, such as those on temporary or student visas, are generally not eligible for Medicaid in New York, though there are several exceptions. New York does consider the following noncitizens as PRUCOL for Medicaid purposes:

- noncitizens with K3/K4, S, U, or V visas
- noncitizens who have been granted Temporary Protected Status (TPS).

Those nonimmigrants who are included in New York’s definition of PRUCOL include individuals with K3/K4, S, U, or V visas. These are individuals who, by definition, either have an adjustment of status application pending or will eventually become eligible to apply for adjustment of status. Nonimmigrants with TPS are also classified as PRUCOL in New York’s Medicaid program. TPS, granted to individuals from countries that have experienced civil unrest or natural disasters, is often renewed, sometimes for decades (while “temporary” in name, it is often “permanent,” or at least very long term, in fact).

Eligibility of Noncitizens in New York’s Health Benefit Exchange *(continued)*

ELIGIBILITY RECOMMENDATIONS

In order to ensure maximum immigrant access through the eligibility determination process of New York’s Exchange, the NYC makes the following recommendations:

- **New York should continue to provide Medicaid program coverage for PRUCOL classified immigrants currently covered in New York State who do not qualify under the ACA definitions of “lawfully present” that determine eligibility for the Individual Exchanges.** In light of the broader coverage available under the State’s Medicaid program to certain groups of noncitizens under New York’s PRUCOL classification, New York must maintain its State-funded Medicaid and/or a comparable program for those noncitizens who, though PRUCOL, are not included among the applicants considered eligible for assistance under the Health Benefit Exchange.
- **New York should issue an administrative policy clarification that the State’s PRUCOL classification extends to individuals such as DREAM (undocumented) youth whose removal is not being pursued by DHS pursuant to the exercise of prosecutorial discretion under the Obama administration’s recently articulated policy, even where no affirmative relief, like deferred action or stay of removal, has been granted.**
- **For those ineligible to participate in the Exchange, New York should explore developing an insurance product for undocumented immigrants** that would stabilize health care for undocumented populations, provide cost savings, and allow the State to better predict its health care expenditures.



Documentation and Verification

BACKGROUND

Just as there is considerable variation in the definitions and eligibility requirements for immigrants across programs and localities, there is no universally accepted process for verifying immigration status. These inconsistencies create confusion, and some requirements are prohibitively onerous. Following is an overview of a range of approaches to documentation and verification, along with recommendations for streamlining this process in New York’s Health Benefit Exchange.

VERIFICATION OF LAWFUL STATUS: SAVE

Current Verification of Lawful Status: The Department of Homeland Security’s SAVE System

Section 1411 of the ACA requires verification that a person who is to be covered through a plan in the individual market Exchange,⁵⁶ or who is claiming a premium tax credit or reduced cost-sharing, is a citizen or national of the U.S. or a lawfully present noncitizen. Verification will be accomplished through the Federal Data Services Hub. Applicants will be asked to attest either that they are a U.S. citizen or national or, if not, that they are lawfully present in the U.S. Through the hub, the Social Security Administration (SSA) will verify the name, social security number, and date of birth of citizen applicants. The applicant’s attestation of citizenship will be considered substantiated if it is consistent with SSA data. The noncitizen applicant’s attestation of lawful presence will be considered substantiated if it is consistent with information contained in the DHS databases, accessible through the Systematic Alien Verification of Entitlements (SAVE) system.⁵⁷

Currently, states verify immigration status for the purpose of determining the eligibility of noncitizens for public benefits directly through the SAVE program. The SAVE system was established pursuant to Congressional authorization in the Immigration Reform and Control Act of 1986 and is codified at section 1137 of the Social Security Act or 42 U.S.C. §1320b-7. It is an electronic database specifically designed to verify immigration status for public benefits purposes. The Federal benefit programs that are required to use SAVE to verify eligible immigration status include:

- Medicaid⁵⁸ (except Emergency Medicaid);
- Temporary Assistance for Needy Families (called Family Assistance in N.Y.);
- The State Nutrition Assistance Program (also known as Food Stamps), at state option;

⁵⁶ The recommendations below argue that these verification requirements should not be carried over to the SHOP side of the Exchange.

⁵⁷ *Treatment of Noncitizens Under the Patient Protection and Affordable Care Act*, Alison Siskin, CRS, March 22, 2011.

⁵⁸ New York requires the use of SAVE for verification of status for Medicaid when the applicant provides an expired immigration document or a document that is not clear or appears fraudulent and in cases where PRUCOL status rests on a pending application for immigration benefits. See New York State DOH Transmittal 04 ADM-7: *Citizenship and Alien Status Requirements for the Medicaid Program*, October 26, 2004.

Documentation and Verification *(continued)*

- Unemployment Insurance;
- Higher education grant and loans; and
- Certain rental housing programs.

Verification through SAVE is not required for the purpose of verifying immigration status for the Supplemental Security Income (SSI) program if the document provided by the applicant has not expired and contains all the information necessary to determine eligibility, and Cuban/Haitian entrant status is not material to eligibility.⁵⁹

The SAVE system uses an individual's name, Alien Registration number ("A" number), date of birth, and other identifying information to verify the immigration status attested to by the individual. It relies on the Alien Status Verification Index (ASVI) database, which contains information on more than 60 million noncitizens.⁶⁰ Benefit agencies have access to SAVE through a Web-based electronic interface. If verification cannot be obtained electronically, the search will go to the next levels, the first of which require that a copy of the document be sent to SAVE. If verification still cannot be accomplished, a manual search through the files must be done.

The key to SAVE for verification of status is the immigration document number (for example, on the permanent resident card, on the employment authorization document, or on the I-94 Arrival and Departure Record) and the person's name, date of birth, and nationality. If the initial search turns up a "no match," the next step is an additional verification where a DHS staff member manually does an electronic search through the various DHS databases. If this step does not yield verification, the G-845 Document Verification Request form is submitted along with the relevant immigration documents.⁶¹ Verification through use of the G-845 is required if sponsorship information is sought. The G-845 Supplement can be used to get additional information such as the date the individual entered the U.S., the date status was granted and when it expires, special provisions for victims of abuse, and the sponsor's affidavit of support. It is especially useful where the noncitizen presents unfamiliar documentation or materials that do not contain an "A" number.⁶²

Because this procedure can be lengthy, the SAVE statute provides that if an applicant makes a written declaration but cannot present the required documentation, or if the documentation is presented but not verified, the benefit agency is not allowed to delay, deny, or reduce the individual's eligibility for benefits until it has provided a reasonable opportunity to the individual to submit evidence indicating a satisfactory status. SAVE also provides that the audit trail generated under the system shall not be used by the immigration service for non-criminal, administrative enforcement of immigration laws.

⁵⁹ POMS Section SI 00502.115: *Verification of Alien Eligibility with the Department of Homeland Security (DHS)*. Available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0500502115>.

⁶⁰ *Systematic Alien Verification for Entitlements (SAVE) Program User Manual*, INS, September, 2000.

⁶¹ *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, Ruth Ellen Wasem, CRS, November 2, 2009.

⁶² *SAVE Program User Manual*.

Documentation and Verification *(continued)*

For New York, an alternative to direct connection to the SAVE system should be especially welcome. The Web-based SAVE system is, even after many years, not yet fully operational statewide (although it is at least partially operational in New York City, which has a separate agreement with USCIS). Eligibility workers in New York City's social services agency, the Human Resources Administration (HRA), must use SAVE to verify immigration status for both the public assistance and food stamp programs.⁶³ In the rest of New York, local districts are required to manually complete a USCIS Form G-845S Document Verification Request, "...and send this completed form along with photocopies of the front and back of all USCIS documents to their respective USCIS Office for....aliens who are applying for temporary assistance.... [or who are] being added to the assistance unit....[or] any time there is a change in alien status in a temporary assistance case."⁶⁴ This process does not apply to Medicaid-only cases.

With respect to Medicaid, the New York State Department of Health directs the districts in Medicaid-only cases to use the manual SAVE system if an applicant's documentation does not clearly indicate a particular immigration status, is expired, or is questionable in any respect. Local districts are also directed to use SAVE Form G-485 to verify the current status of an application in cases where PRUCOL status is sought based on a pending application with USCIS for an immigration benefit.⁶⁵

One of the weaknesses of verifying immigration status with SAVE is the requirement that an actual document containing the "A" or other document number be submitted. Although the system can actually accomplish verification with just the "A" number and identifying information, SAVE rules require that the State and/or local public benefit agency review an actual document containing the applicant's "A" number in hand when inputting the data into the system. This can present an insurmountable burden to low-income immigrants who may have lost their documents or had them stolen. As long as the individual can provide his or her "A" number orally, this in combination with providing identifying information that can be matched to it (such as name, date of birth, and country of nationality) should be sufficient to verify the status of the applicant for benefits. The Final Rule implementing verification of status through the Exchange allows for that.

Verification of Lawful Status Under the Exchange

The Final Rules for both Medicaid and the Exchange under the ACA promise some real improvements in the verification procedures currently in place under SAVE. Rather than requiring a direct connection between SAVE and the various State benefit agencies, in the future, for the purpose of verifying citizenship and immigration status for both the Exchange and the Medicaid/CHIP agencies, HHS will act as the intermediary between

⁶³ HRA, Family Independence Administration, Policy Directive #07-31-SYS, Systematic Alien Verification for Entitlements (SAVE) Program. Available at http://onlineresources.wnyc.net/nychra/docs/_07-31-sys.pdf.

⁶⁴ New York State Office of Temporary and Disability Assistance, Temporary Assistance Source Book, Chapter 24, Section F, updated 5/17/2011, available at www.otda.ny.gov/programs/temporary-assistance/TASB.pdf.

⁶⁵ New York State Department of Health, Medicaid Reference Guide, at 649, updated January 2009.

Documentation and Verification *(continued)*

the agencies and SSA and DHS through the federally managed data services hub. (See 77 Fed. Reg. 18310 at 18358; 42 CFR 435.949.) At this point, it appears that the databases will remain the same, but the data access will be centralized and streamlined. State agencies are charged for verification through the SAVE system, but HHS does not anticipate charging the Exchanges or the State Medicaid and CHIP agencies for use of the hub. (See the Commentary in 77 Fed. Reg. 17144, at 17178, March 23, 2012.)

As noted above, one of the particular difficulties with the SAVE system has been putting the documentation burden on the applicant for benefits, even when government data sources contain the needed documentation to verify status. It is not uncommon for low-income immigrants, particularly those who have been in the U.S. for many years or who have experienced periods of homelessness, to have lost or misplaced their documentation. Under these circumstances, New York's benefit agencies point to the SAVE system's documentation requirements as the reason for the agency's inability to verify their immigration status and thus grant benefits, even if the applicant can provide the necessary information, such as an "A" number, which could be verified against DHS records.

In the Final Rule for the Exchange, HHS clarifies that the provision by the applicant of his "A" number or other information (for example, the I-94 Arrival/Departure Record number) is considered compliance with the requirement that the applicant provide verifying information of his or her immigration status.⁶⁶ Similarly, the Final Medicaid Rule provides that although self-attestation of immigration status is not acceptable to verify citizenship or immigration status, what is required is either electronic verification or other documentation, and that other documentation does not refer exclusively to paper documentation provided by the applicant. Thus, the applicant's oral provision of immigration status identifying information, which can be verified in DHS records, should be sufficient.⁶⁷

DOCUMENTATION AND VERIFICATION RECOMMENDATIONS

To ensure maximum immigrant access through the documentation and verification process of New York's Exchange, the NYC makes the following recommendations:

- **The Exchange website must include a State-level backstop for PRUCOL classification and immigrants who do not pass initial verification through SAVE and the new Federal Data Services Hub.** The ACA requires a unified application process for Medicaid and the exchanges. States are required to verify people for Medicaid eligibility before they verify people for the exchanges. Thus, the Federal Hub will be verifying both SAVE and other eligibility requirements for both the Exchange and Medicaid. As mentioned above, SAVE does not cover all statuses. There will need to be a backstop on the State level through the New York Health Options Enrollment Center (staffed by State employees and MAXIMUS) to ensure that people who do not qualify under SAVE or who fail verification through the new Federal Hub have an opportunity to have their

⁶⁶ See 77 Fed.Reg. 18310 at 18361.

⁶⁷ See 77 Fed.Reg. 17144 at 17174.

Documentation and Verification *(continued)*

status reviewed at the State level. In other words, individuals whose immigration status is not verified through the Federal hub must be able to take their paperwork to the State for review.

- **New York should allow applicants seeking private coverage in the Exchange a reasonable opportunity to provide documentation, as is already required for public insurance programs.**
- **An individual should be allowed to provide his or her “A” number orally.** In combination with identifying and matchable information, such as name, date of birth, and country of nationality, this should be sufficient to verify the status of the applicant for benefits. The final regulations allow for this.
- **New York should try to expand and inform the policy options by providing input on forthcoming Federal guidance.** For example, New York can use its experience to inform Federal guidance on what documentation is allowable to resolve inconsistencies in Exchange eligibility verification, including verification of immigrant status.

Although the ACA explicitly bars undocumented individuals from purchasing insurance through the individual Exchange, opportunities may exist for undocumented populations to buy into the small business (SHOP) exchange.

- **New York should not require additional documentation or verification for the SHOP Exchange.⁶⁸** New York should not subject beneficiaries of small group plans to additional documentation and verification requirements. Employers already verify employees’ immigration status through the I-9 process, and this should not be needlessly duplicated. Unnecessary documentation requirements would result in substantial costs to small businesses and governments. They would create hurdles for many (immigrants and native citizens alike), including people born outside of hospitals, those who have lost documents in disasters like fires or hurricanes, and the homeless. Additional documentation and verification requirements would put the Exchange at a disadvantage in competing for small business customers if insurance sold outside the Exchange had significantly fewer paperwork burdens.
- **New York should continue to allow for attestation of income or letters from an employer for non-traditional workers,** as is currently done in New York’s public insurance programs.

⁶⁸ The Small Business Health Options Program (SHOP) Exchange will allow small businesses to pool their insurance policies together in a shared market in order to spread risk across the market and lower costs for businesses.

Marketing, Enrollment, and Outreach to Immigrant Communities

BACKGROUND

Although New York's Exchange implementation has already been set in motion, now is an opportune moment to influence Exchange implementation to ensure immigrant inclusion. The State is in the process of making many fundamental decisions about how to structure the Exchange, including crucial decisions about how outreach and enrollment will be conducted. One of the critical findings from the Massachusetts experience with establishing an individual health insurance exchange over the last six years is that immigrants and Limited English Proficient (LEP) populations are disproportionately likely to remain uninsured after Exchange implementation. Two years after Massachusetts launched its exchange in 2006, almost one in three of the remaining uninsured adults in Massachusetts were noncitizens.⁶⁹ More broadly, a 2008 report found that those who remain uninsured were likely to have the following characteristics:

- Male, young, and single;
- Racial/ethnic minorities and noncitizens;
- Limited English Proficient; and
- Living in a household where there was no adult able to speak English well or very well.⁷⁰

Language barriers and fears of immigration consequences for accessing public benefits may account for these statistics. States with large immigrant populations, like New York, must learn from the experience in Massachusetts and make it a high priority to conduct targeted outreach to immigrants and LEP populations.

Two years after Massachusetts launched its exchange in 2006, almost one in three of the remaining uninsured adults in Massachusetts were noncitizens.

Immigrant inclusion must be taken into consideration in designing the Exchange's infrastructure, in shaping the direct points of contact that the Exchange will have with immigrant communities, and in looking beyond the doors of the Exchange. If New York implements these recommendations, the State will make tremendous strides toward increasing access to health care for immigrants in New York and building a healthier state for all New Yorkers.

⁶⁹ <http://www.rwjf.org/files/research/67248.MassReform2008UninsuredBrief.pdf>, p. 3.

⁷⁰ *Ibid.*, p. 2.

Marketing, Enrollment, and Outreach to Immigrant Communities *(continued)*

The key principle that should guide the Exchange's enrollment design is the "no wrong door" approach: consumers should be able to apply for any program at any enrollment site without specifying which program they are applying for. This principle is particularly crucial as it applies to mixed-status families, families in which some members are U.S. citizens and others are undocumented. Although undocumented immigrants are ineligible to participate in the Exchange, they should still be able to receive information about and apply for other

The key principle that should guide the Exchange's enrollment design is the "no wrong door" approach: consumers should be able to apply for any program at any enrollment site without specifying which program they are applying for.

health programs for which they are eligible (such as Emergency Medicaid) at venues where families apply for insurance coverage. The situation of citizen children with undocumented parents is particularly challenging. For example, in the case of tax rebates, the Exchange will have to grapple with the fact that undocumented parents who do not have Social Security numbers could be applying for benefits for their citizen children. The no wrong door approach for mixed-status families should also apply to the website, which will be a primary point of enrollment.

LANGUAGE ACCESS

Language barriers remain the most persistent obstacles to health care and health insurance for LEP New Yorkers; language access will be key to ensuring their participation in the Exchange. Interpretation and translation will be necessary at every point of contact with the Exchange, from enrollment to billing to appeals processes.⁷¹

Pursuant to Federal, State and local laws and policies, all public agencies are obligated to provide free interpretation and translation services to Limited English Proficient consumers. In 2008, Mayor Bloomberg issued Executive Order 120, a citywide language access policy requiring every New York City agency that has direct access to consumers to provide language assistance in the top six languages spoken by New Yorkers.⁷² Governor Cuomo's Executive Order 26 requires statewide language access for all State agencies serving the public, and translation of all vital documents into the State's six most common languages.⁷³

⁷¹ http://www.healthlaw.org/images/stories/Short_Paper_5_The_ACA_and_Language_Access.pdf.

⁷² http://www.nyc.gov/html/adulted/html/about/executive_order.shtml.

⁷³ <http://www.governor.ny.gov/executiveorder/26>.

Marketing, Enrollment, and Outreach to Immigrant Communities

Language Access Recommendations

In addition to complying with existing laws, the NYIC recommends that New York's Exchange meet three basic requirements regarding language services:

1	Translation of notices and vital documents when 5% or 500 LEP individuals are included in an Exchange, to a maximum of 15 languages;
2	Inclusion of translated taglines in at least 15 languages on all Exchange notices and vital documents and websites with information on how to access translated materials and oral language assistance; and
3	Provision of effective oral communication for all LEP individuals, regardless of whether translation or other thresholds are met.

Specifically, New York should take the following practical steps to ensure that language barriers do not impede immigrants from accessing the Exchange:

- The Departments of Health and Insurance, as well as the entity that administers the Exchange, should designate language access coordinators responsible for creating and implementing language access policies and procedures for the Exchange.
- The State should ensure competent interpretation and translation services at all levels of the State Exchange.
 - All consumer access points, from phone to website to postal mail to in-person assistance, should provide meaningful access to LEP individuals. The provision of language assistance services may include the use of trained bilingual staff, trained in-person interpreters, language banks, and telephonic interpretation services.
 - Issues of language and cultural competence should inform workforce and hiring policies, and workers with direct consumer contact should be trained on the language access policy and working with LEP consumers.
- The Exchange should provide language assistance services in all direct service interactions – including translation of written information about insurance options, cost, enrollment, subsidies, appeals, and other issues. This can include access to a telephone language line if in-person language assistance is not available.
- Exchange websites should follow Federal guidance on language accessibility, be translated in the most common languages in New York, and provide taglines and information on how to obtain interpretation services in multiple languages. Web-based translation tools, such as Google translate and Babel Fish, are notoriously inaccurate and are not acceptable.
- New York should adopt taglines in at least 15 languages (the requirement for public documents issued by the Social Security Administration), and multiple language prompts should be included in toll-free hotlines. New York is currently in the process of implementing

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taglines following Governor Cuomo's 2011 Executive Order 26.⁷⁴ New York should look to California as a model; its Department of Managed Health Care requires that notices include taglines in 12 languages, with the following tagline:

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in [your language], first call your health plan's phone number at 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at xxx-xxx-xxxx.⁷⁵

- Qualified health plans' summaries of coverage and claims and appeals processes should be translated into the six most common languages and include multilingual taglines, as required under New York's Executive Order 26.
- New York State should require health insurers to provide and pay for interpretation, translation, and literacy-appropriate information, including Medicaid reimbursement for interpretation services, a Medicaid Redesign Team Health Disparities Workgroup recommendation that was included in Governor Cuomo's 2012-2013 budget.⁷⁶
- The State should include funding for language assistance services when applicable in grant and waiver requests to the U.S. Department of Health and Human Services.
- The State should provide training for individuals who provide direct customer assistance in the Exchange, as well as Navigators, Facilitated Enrollers, In-Person Assistors, and Consumer Assistance Programs, that includes information about immigrants' unique concerns, as well as techniques and tools for allaying immigrants' concerns.

MARKETING THE EXCHANGE

The Exchange also must meet the challenge of attracting immigrants and other minorities. To ensure minority participation, the Exchange will need to target them specifically in plans for marketing and outreach for the Exchange.

California's marketing plan, designed by the marketing communications company Ogilvy and Mather, developed specific marketing plans for various racial and ethnic groups and then subdivided those groups by age. For the Latino population, California's marketing plan emphasized certain principles, such as using technology (e.g., smart phones, social media) to reach younger Latinos, and recognizing the unique needs of different demographics within the Latino community.⁷⁷

For the Asian market, California's research suggested targeting venues such as casinos and card clubs, karaoke bars, the Asian import car club scene, Asian Pacific Islander (API)

⁷⁴ <http://www.governor.ny.gov/executiveorder/26>.

⁷⁵ <http://familiesusa2.org/conference/health-action-2012/toolkit/content/pdfs/ACA-language-access.pdf>.

⁷⁶ See www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_phaseii_enacted.xls.

⁷⁷ http://www.healthexchange.ca.gov/BoardMeetings/Documents/V_CHBE_DHCS_MRMIB_Comprehensive_Marketing_Outreach_Plan_6_15_12.pdf. p. 68-73, p. 87-89.

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college fraternities, and factory outlets and further investigating opportunities at venues such as reflexology centers and cell phone shops. In addition, the marketing plan emphasized a grassroots approach working closely with grassroots organizations and opinion leaders and influencers within Asian Pacific Islander communities.

For this market research to be effective, it is crucial for the marketing and outreach plans to be based on focus groups with immigrant communities in diverse languages. In California, only one focus group was conducted in Spanish, but New York should do better. The Spanish-language focus group in California did not have the same experience with insurance coverage as the English-speaking groups.

A 2010 NYC study conducted focus groups with Mexican, Korean, and Russian-speaking individuals to assess their views of health insurance.⁷⁸ Among the findings were that immigrant perceptions about the immigration consequences (such as fears that using public benefits could lead to liability for their immigration sponsors, or concerns about whether using health care or insurance will affect an individual's ability to adjust status to lawful permanent resident, get a green card, or naturalize) posed a barrier to immigrant access to health insurance. Specifically, use of certain public assistance benefits can lead to immigration consequences (immigrants who accept cash benefits can cause their sponsors to be liable to pay back those benefits), but many immigrants do not know that health programs like Medicaid and the Exchange are exempted from this policy. Accordingly, it is crucial for the development of marketing strategies to incorporate language-specific focus groups and segmented market research in order to create strategies to overcome culturally and linguistically-specific barriers to participation in the Exchange.

Marketing Recommendation

In order to better market to and reach immigrant populations, the NYC makes the following recommendation:

- **New York should conduct segmented marketing and conduct immigrant focus groups** to develop different messaging and strategies for diverse populations, targeting specific demographics with unique messages. Market research for the campaigns should include focus groups conducted in multiple languages to reflect the cultural and linguistic diversity of the State.

NAVIGATORS: OUTREACH AND ENROLLMENT

Another crucial choice faced by states implementing exchanges is the question of how to define Navigators, who will be on the front lines in interacting with immigrant populations as they navigate the Exchange system. Navigator programs are mandated under the ACA to provide consumers assistance with enrollment in the Exchange, but each State has flexibility to design its own unique Navigator program. As a direct point of contact for consumers during the enrollment process, an effective Navigator program that is culturally competent and linguistically appropriate will be key to the Exchange's success in enrolling immigrant communities.

⁷⁸ http://72.34.53.249/~thenyc/sites/default/files/UHF_NYIC_Mutual%20Responsibility_Imm%20Perspectives%20on%20Ins_021110.pdf.

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There is also significant evidence from the experiences of other states about the importance of developing capacity for peers in immigrant communities to conduct outreach and enrollment activities. The Massachusetts example demonstrates that peers are vital for delivering the message in public education efforts. Massachusetts's generous multi-year funding to community-based organizations and public education campaigns were a key to success in implementing its Exchange.⁷⁹ Massachusetts's outreach approach has been characterized as "top down, bottom up," incorporating both mainstream and grassroots approaches to outreach. The State's enabling exchange legislation included funds for grants to nonprofit groups that provide outreach and enrollment assistance to residents who may be eligible for public coverage and "who may require individualized support due to geography, ethnicity, race, culture, immigration or disease status."⁸⁰ The State allocated funds each year for community groups to do outreach via door-knocking and sent the message to a broader public via public service announcements featuring the Boston Red Sox.⁸¹ The State's generous funding, including private sector resources, throughout the entire outreach and enrollment process, was key to providing enrollment assistance to immigrants and for providing the State with further feedback about implementation as outreach workers reported back from consumers they educated. New York should follow a similar model.

Similarly, in addition to the formal Navigator designation process, the California Health Exchange Board has recommended funding a separate outreach and education program for 2013, with weighting funds to be used toward the second half of year when enrollment commences. The Board has recommended a diverse range of funds, from seed grants to small community-based organizations (CBOs) to larger grants for institutions to disseminate via sub-grants.⁸² Maryland is also allocating grants of varying sizes to nonprofits that serve diverse communities. California advocates have also emphasized the need for ongoing outreach, so this funding stream should not be conceived as a one-shot infusion of funds but rather an ongoing program.

A funding stream for community organizations of various sizes to assist in outreach for hard-to-reach populations such as immigrants is an invaluable complement to the formal Navigator program, and the NYIC strongly urges New York to adopt this approach. Immigrant communities are best equipped to bring information about the Exchange and other programs to its own immigrant members, but they must be provided with adequate resources to do so.

Navigators Recommendations

In order to ensure that Navigators reach immigrant and LEP populations, the NYIC makes the following recommendations:

- **The State should require that Navigator programs, regardless of the type, actively work to alleviate immigrants' fears of accessing public insurance.** Navigators should alleviate immigrants' concerns

⁷⁹ Alker, Joan, Sabrina Corlette, Joe Tuschner and JoAnn Volk. "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned. Robert Wood Johnson Foundation. www.power2u.org/downloads/Mass-health-care-reform-2011.pdf; www.rwjf.org/files/research/74070mass.pdf; and Ibid.

⁸⁰ Ibid.

⁸¹ Long, S. and Masi. P. "Access and Affordability: An Update to Health Reform in Massachusetts." *Health Affairs*, May 28, 2009. Quoted in Ibid.

⁸² June 19, 2012, California Exchange Board Meeting, 1:24.

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about enrolling in public health insurance or using a government-funded Exchange by actively allaying immigrants' concerns about public charge (concern that using public health insurance or buying insurance through government-run Exchange will prohibit someone from legalizing or naturalizing), sponsor liability (concern that an immigrant's sponsor will have to pay for the immigrant's use of insurance or health care services), and reporting to immigration officials (fear that enrollment in public health insurance or use of health care services may lead to the deportation of the immigrant or a family member).

- **New York should ensure that funding for Navigators reaches community-based organizations (CBOs) that are embedded in immigrant and other underserved communities.** Culturally and linguistically appropriate advocates at community groups who are trusted by the communities they serve are best situated to provide navigation, outreach and enrollment assistance to their communities, and many have a strong track record of doing so. Groups should be able to use the funding to assist all New Yorkers, regardless of the health program for which they may be eligible.
- **The Exchange should provide ongoing training to all Navigator staff members in language access policies and procedures, including those related to working with interpreters and LEP individuals, immigrant eligibility for public programs, immigrant concerns, and cultural competency.** Issues of language and cultural competence should also inform workforce and hiring policies. Language access procedures can include the use of trained bilingual staff, trained in-person interpreters, language banks, and telephonic interpretation services. While it is generally the responsibility of the Exchange to finance the Navigator programs, apart from navigation services provided for the Medicaid and CHIP programs (which are eligible for Federal funding), care must be taken to ensure that Navigator programs have adequate funds for ongoing training and technical support.
- **The State should support multi-year grants to immigrant CBOs of varying sizes.** In addition to the formal Navigator designation process, New York should fund a separate outreach and education program for smaller community-based organizations by rolling out multi-year grants of varying sizes. Many small CBOs serving immigrant communities may not have the capacity to apply for large State grants, yet they are struggling financially and cannot conduct outreach and provide Exchange enrollment assistance without compensation. These are the groups that are located in the communities that are hardest to reach and who have the unique ability to deliver messages to immigrants in their own language with cultural competence. Multi-year funding is also crucial, as the Exchange rollout will be a process over several years, and ongoing assistance will be needed. For smaller CBOs, it is crucial that New York adopt this approach and allocate multi-year funding streams to local community groups for education and outreach.
- **The State should conduct targeted trainings for small businesses in immigrant communities.** New York should build on current practices by New York City's Office of Public Health Insurance and Small Business Assistance Program (SBAP) to conduct targeted campaigns around SHOP exchanges for businesses in immigrant communities.

Oversight, Community Input, and Monitoring

BACKGROUND

As New York State develops and shapes its Health Benefit Exchange, it will face key decision points on issues of deep concern to immigrants and other vulnerable populations. The policies and processes for ensuring confidentiality in the Exchange and collecting data about applicants' race, ethnicity, and language, for example, will in part determine whether immigrants perceive the Exchange as welcoming and well-functioning or frightening and cumbersome. At the same time, data can be a crucial source of information, helping the State and advocates identify whether and where the Exchange is adequately meeting the needs of applicants and enrollees, including immigrants. Securing input from representatives of immigrant and vulnerable communities as key stakeholders informing the design of the Exchange is an important component in ensuring that the Exchange will meet the needs of these vulnerable populations.

COMMUNITY INPUT

The ACA allows states to elect what kind of corporate entity the Exchange will be: State-run, independent public entity, or nonprofit. In contrast to states (like Massachusetts, California, and Maryland) that have opted for a quasi-governmental structure, New York's Exchange has been established as a State-run organization. In terms of stakeholder input, New York's Executive Order 42 establishes the Exchange and Regional Advisory Committees, "...consisting of consumer advocates, small business consumer representatives, health care providers, agents, brokers, insurers, labor organizations, and any other appropriate stakeholders."⁸³ Immigrants and other consumers will need to have an active voice in the Regional Advisory Committees (RACs) if their needs and concerns are to influence implementation.

Immigrants constitute more than 20% of New York's total population, speaking nearly 150 languages and dialects, and representing dozens of cultures and religions; the formal Exchange advisory structure should reflect this diversity. The Massachusetts experience demonstrates that the remaining uninsured population after Exchange implementation will disproportionately comprise immigrants and LEP populations. As such, immigrants should be included throughout the implementation process as essential stakeholders.

New York has already determined the initial composition of its five RACs: Western New York; Central New York/Finger Lakes; Capital District/Mid-Hudson/Northern New York; New York City/Metro; and Long Island.⁸⁴ On the New York City/Metro RAC, several committee members represent immigrant communities, including NYC's Director of Advocacy. However, to ensure

⁸³ <http://www.governor.ny.gov/press/04122012-E0-42>.

⁸⁴ http://www.healthcarereform.ny.gov/health_insurance_exchange/regional_advisory_committees.htm.

Oversight, Community Input, and Monitoring *(continued)*

appropriate representation on the RACs throughout the State, each RAC should reserve seats for representatives of vulnerable populations, including immigrants. More importantly, New York should formalize the role of RACs and stakeholders in providing input on the development of the Exchange.

Community Input Recommendations

In order to ensure an Exchange structure that is responsive to community needs, the NYIC makes the following recommendations:

- **New York should formalize immigrant representation on Regional Advisory Committees.** Massachusetts specifically reserved a seat on its Connector board for a consumer advocate. The consumer seat is an important structural and symbolic function. Although New York has included immigrant community representatives on the Regional Advisory Committees (RACs), New York should ensure specific consumer representation in addition to representation for immigrants, LEP populations, communities of color, and other minority constituencies on each RAC. Moreover, New York should develop a structure of the RACs to communicate amongst themselves and to ensure feedback will be centralized between the diverse regions across the State. This will be especially important for areas upstate and in Western New York with lower immigrant density, which could benefit from consultation and feedback with the New York metro area RAC, which includes number of immigrant organization representatives.
- **New York should establish a Health Disparities Workgroup.** Perhaps the most pressing lesson from Maryland for New York is its establishment of a Public Health, Safety Net and Special Populations Workgroup with formal standing. Maryland's exchange legislation created a range of advisory committees and requires the Exchange Board to consult with the committees. It is important that the Board is required to consult with the workgroup in an official capacity. New York should follow Maryland's example in institutionalizing input from immigrants and other groups that experience disparities and convene a Health Disparities Workgroup with official status in the governance process.
- **The State should incorporate ongoing feedback loops and provide the opportunity for linguistically diverse consumers to provide input and suggestions.** The implementation of health care reform will be an ongoing, evolving process, and it is unlikely we will get it right on the first try. There must be mechanisms for New Yorkers who are affected by the changes, including New Yorkers who speak languages other than English, to provide input and feedback on how the rollout is going and what should be improved.

DATA COLLECTION

On June 29, 2011, HHS released standards for implementing Section 4302 of the ACA, regarding collection of data related to race, ethnicity, language, gender, and disability status. These new data standards will offer New York an opportunity to collect more detailed data about Asian and Pacific Islanders, Native Hawaiians, and Hispanic/Latino populations and to monitor health disparities with greater precision. At the same time, it is crucial for states to implement data

Oversight, Community Input, and Monitoring *(continued)*

collection mechanisms at the local level. States must also put in place safeguards to ensure confidentiality of all data collected through the Exchange and protect against sharing of information across government agencies.

Data Collection Recommendations

In order to take advantage of this important opportunity to collect data about the needs of immigrants and other vulnerable communities, the NYIC makes the following recommendations:

- **New York should implement the recommendations adopted by the Medicaid Redesign Team (MRT).** Among the MRT recommendations adopted in New York State's 2012-2013 Budget were several key recommendations to reduce health disparities in immigrant communities. These recommendations have not yet been implemented, so New York should ensure that these recommendations are fully incorporated into the development of the State's Exchange:
 - **Data Collection.** State funding is available to implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on demographic data, including race and ethnicity. In addition, funding is available to support data analyses and research to facilitate DOH work with internal and external partners to promote programs and policies that address health disparities, improve quality, and promote appropriate and effective utilization of services (including the integration and analysis of data to better identify, understand, and address health disparities).
 - **Data Collection for Mixed-Status Families.** Immigrant and mixed-status families, in which different family members may have different immigration or citizenship statuses, encounter greater barriers to health care than do citizen families. Children in mixed families, who may be eligible for public insurance, are more likely to be uninsured than children in the general population, owing to parents' lack of education about their rights in the health care system and fears of immigration consequences of accessing public services. Collecting data about this vulnerable group is important to informing outreach and intervention efforts.

The NYIC recommends the inclusion of a non-mandatory data standard to collect information about immigration, citizenship status, and health care eligibility of family members. We suggest the use of the citizenship and mixed-status family categories used in the California Health Interview Survey (CHIS). The survey is designed to be non-threatening, but the collection of this information should not be mandated, as it could generate fear in some immigrant communities and hinder the success of entities engaged in work such as enrollment of individuals in public programs.

- **Primary Language.** New York can require the Exchange to collect primary language data of applicants and enrollees, and requests for the provision of language assistance services. Determinations of appropriateness and usability should also include the feedback of LEP individuals. In order to capture health disparities in population surveys and at the point of care, the collection of primary language spoken is necessary. Collecting population-wide information about primary language is also essential to developing interventions to improve health care access for Limited English Proficient individuals. Entities should be encouraged

Oversight, Community Input, and Monitoring *(continued)*

to collect data on written language proficiency. While this information is often correlated with spoken language proficiency, it is important information for developing health interventions and communicating health care information to patients in clinical settings. Written language proficiency is also closely related to health literacy, which is well documented to impact health outcomes.

- **Exchange as premium collector.** The Exchange should be in charge of premium collection for the purposes of data collection. If the Exchange is cut out of interactions after the initial enrollment, the State will lose the opportunity to collect data about Exchange utilization after consumers have signed up.⁸⁵ In particular, premium collection could be an opportunity for the State to collect data about immigrant coverage continuity, denials, or disruptions, and about LEP access among products sold within the Exchange.

More specifically, advocates have pointed to the benefits of having the Exchange bundle and collect premiums, as it increases identification with the Exchange and allows for improved data collection. This could be a crucial source of information for utilization of the Exchange, in particular for information about LEP and immigrant behavior within the Exchange. Such information would be difficult to obtain if it were being collected by different plans.⁸⁶ Therefore, New York should have the Exchange act as a premium aggregator rather than leaving premium collection to the Qualified Health Plans and having consumers pay plans directly by default.

CONFIDENTIALITY

New York should explicitly incorporate Section 1411 of the Affordable Care Act into its Exchange policies and procedures limiting the inquiries, use, and disclosure of information provided by applicants. Assurances of confidentiality are especially important for immigrant communities. Fear of information being shared with immigration officials can act as a major deterrent for immigrants seeking to access benefits. In mixed-status families, where citizen children are entitled to full benefits, immigrants may forego health benefits that they have a right to out of fear that they will put undocumented members of the family at risk. For example, a citizen child of an undocumented parent has a right to Medicaid and to participate in the Exchange, but the family may not access those benefits out of fear of releasing information about the undocumented parent that could put the parent in jeopardy of deportation. It is extremely important that public campaigns assure immigrant communities that their information is maintained as confidential as is possible under the law and that safeguards are put into place to ensure this confidentiality.

⁸⁵ Telephone conversation with Anthony Wright. July 18, 2012.

⁸⁶ http://www.healthexchange.ca.gov/BoardMeetings/Documents/July_19_2012/VIII-B_CHBE_PremiumAggregationPresentation_7-19-12.pdf.

Oversight, Community Input, and Monitoring *(continued)*

The Exchange and other new programs should create confidentiality policies ensuring that information about immigration status will not be reported to law enforcement or immigration officials, and notify applicants of the policy, as is currently done in New York’s public health insurance programs.⁸⁷

Confidentiality Recommendation

For the Exchange to assure appropriate confidentiality, the NYIC makes the following recommendation:

- **New York should ensure that procedures for claiming and obtaining an exemption from the individual mandate are streamlined.** In addition, the State should not solicit unnecessary information, and should protect the confidentiality of the information, share information only for purposes of determining eligibility for the exemptions, and include due process protections.

⁸⁷ Comparable policies exist in the Medicaid program, see GIS 04 MA/014 - Reporting Immigrant Status and Disclosure of Medicaid Benefits Information. The Access NY Health Care application also includes this helpful Confidentiality Statement in the very beginning of the Instructions: *“CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.”* and later clearly states: *“The state will not report any information on this application to the USCIS.”*

Beyond the Exchange: Securing the Safety Net

Undocumented immigrants and some others will remain uninsured after the Exchange is implemented, so the safety-net system will remain an important component of New York's public health infrastructure. Because the ACA reduces funding and changes funding formulas for uncompensated care for Disproportionate Share Hospitals in anticipation of broader insurance coverage, it is crucial that the safety net and charity care programs be monitored and protected.

An important lesson from Massachusetts is that safety-net facilities have continued to serve the uninsured after health care reform was instituted. For uninsured patients, community health centers (CHCs) have become an even more important source of primary care. Despite the significant reduction of levels of the uninsured in Massachusetts that followed its health care reform, the demand for care at safety-net facilities continues to rise. Prior to the reform, the majority of uninsured patients obtained primary care from CHCs or clinics of safety-net hospitals (e.g., public or charity hospitals) and specialty and inpatient care from safety-net hospitals. Many stakeholders had anticipated that if uninsured individuals gain insurance coverage and have more choices of providers, patients would shift away from the safety net, and consequently, the role of the safety net would diminish. In reality, community health centers in Massachusetts experienced an increase of patients when the number of uninsured persons decreased.⁸⁸ Similarly, visits to safety-net hospitals' clinics grew as more people gained insurance. Between 2005 and 2009, the total number of patients served increased by 31%.⁸⁹ Although the number of uninsured patients treated at CHCs declined, the centers became a relatively more important strand in the safety net as providers of care for Massachusetts residents who remained uninsured. The ratio of CHC patients to uninsured State residents rose from 22% in 2006 to 38% in 2009. Most safety-net patients do not consider these facilities as providers of last resort; rather, they prefer the types of care that are offered there. The newly insured continued to seek care in the safety net.⁹⁰ In spite of increasing rates of insurance as a result of health care reform in Massachusetts, the demand for services from safety-net facilities also grew.

RECOMMENDATIONS FOR SECURING THE SAFETY NET

As the examples of states that have already implemented exchanges demonstrate, the safety-net system will continue to play a crucial role after ACA implementation. In order to protect

⁸⁸ Leighton Ku, PhD, MPH; Emily Jones, MPP; Peter Shin, PhD, MPH; Fraser Rothenberg Byrne, MPA; Sharon K. Long, PhD Ku et al. (2011) Safety-Net Providers after Health Care Reform: Lessons from Massachusetts. *Arch Intern Med.*; 171, 1379-1384. Retrieved from <http://archinte.ama-assn.org/cgi/content/abstract/171/15/1379>.

⁸⁹ Ibid.

⁹⁰ Ibid.

Beyond the Exchange: Securing the Safety Net *(continued)*

New York's safety net post-Exchange implementation and ensure access to financial assistance programs outside the Exchange, the NYC makes the following recommendations:

- **Individuals who are not eligible for, are exempt from, or choose not to enroll in health insurance, should be screened for, enrolled in, and given a card for a statewide financial assistance program.**

Hospitals and community health centers are already mandated by law to provide financial assistance (e.g., sliding fee scales, charity care, discounted care) to individuals who lack or have inadequate health insurance. The Exchange offers a tremendous opportunity to standardize application and enrollment for these financial assistance programs.

- **The Exchange should provide information to applicants about financial assistance and other programs to individuals who are ineligible to participate in the Exchange, such as undocumented immigrants.**

It is important to note that the exclusion of undocumented immigrants specifically pertains to eligibility to buy private insurance in the individual Exchange;⁹¹ it does not prohibit these individuals from accessing other information or applying for other programs in the Exchange.

Hospitals and community health centers are already obligated to help their patients apply for financial assistance at their facilities.⁹² Because the Exchange will already screen families and individuals for income and family size for insurance eligibility purposes, the same application and information could be used to enroll in a statewide financial assistance program. This would alleviate the administrative burden on health care providers and uninsured patients alike, and help alleviate uninsured individuals' primary barrier to care: cost.

The NYC's community-based partners regularly report that their uninsured clients have difficulty getting information about and applying for financial assistance programs, especially at private hospitals. Standardizing the application process through the Exchange would improve hospitals' compliance with the law, improve patients' access to affordable care, and improve the State's ability to demonstrate the need for continued Disproportionate Share Hospital funding to reimburse for care provided to the uninsured.

- **New York should restructure its Indigent Care Pool (ICP) allocation.** The ICP is the pool of money hospitals receive to provide care to the uninsured and underinsured. However, under the current system, the dollars do not follow the patients, and the hospitals that provide most of the care to uninsured and underinsured populations do not receive a share of the funds that adequately reflects this burden.
 - Improve accountability and transparency of the ICP by allocating 100% of the Pool based on the amount of actual care provided to uninsured patients. The dollars should follow the patient.

⁹¹ Patient Protection and Affordable Care Act, §1312.

⁹² NYS Public Health Law § 2807-k (2006) - Hospital Financial Assistance Law requires all general hospitals, both public and private, to provide notice about, and help uninsured and underinsured patients with incomes lower than 300% of the Federal Poverty Level to apply for, sliding scale discounts. Federally qualified health centers, in order to be eligible for enhanced Federal financing, must also provide care to all patients regardless of ability to pay.

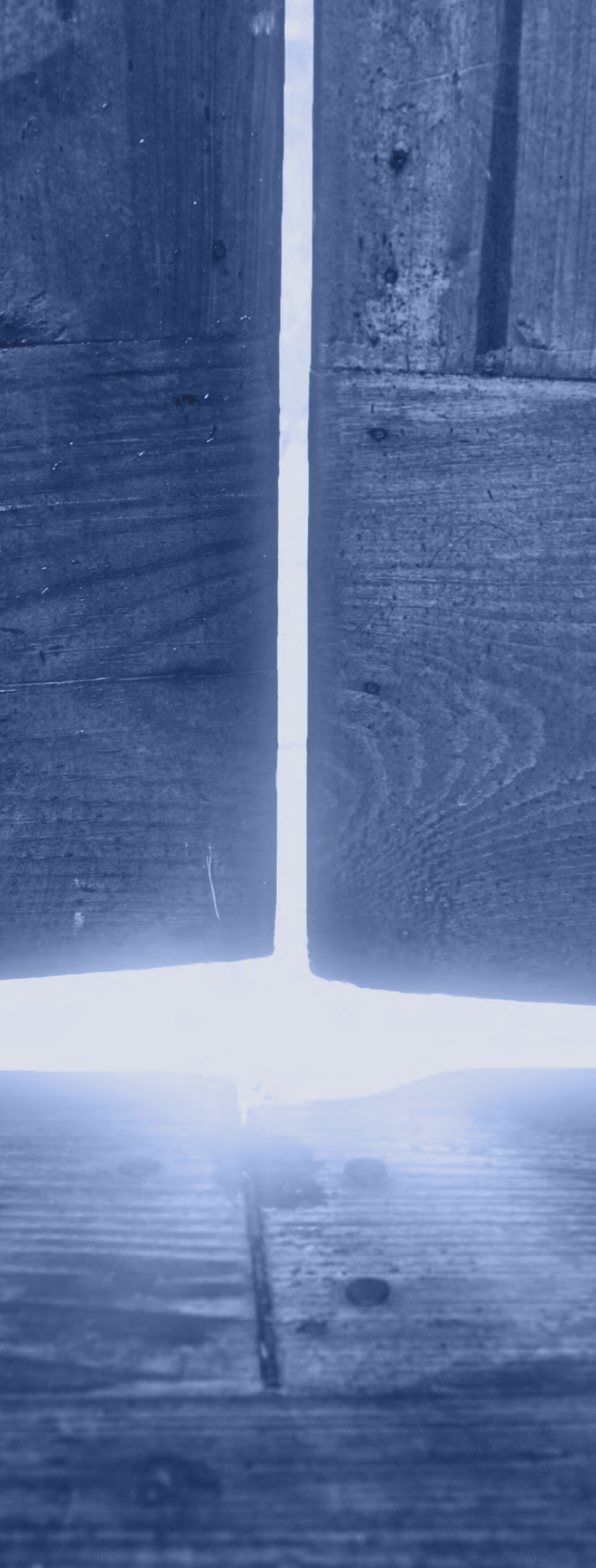
Beyond the Exchange: Securing the Safety Net *(continued)*

- The State should consider redirecting the ICP to directly compensate providers, by unit of service, for care provided to the uninsured.
- The State should explore redirecting the Indigent Care Pool to fund a health insurance plan for the uninsured.
- **The Exchange should be designed to strengthen and encourage integration and collaboration with the health care safety net** so that uninsured individuals do not fall through the cracks.
- **The State should maintain current eligibility levels, as well as benefits, in New York’s public health insurance programs.** The implementation of health reform should not result in a loss of coverage for any person who currently has it. The State should ensure comparable, affordable coverage for all children currently covered in New York’s Child Health Plus program once the State Children’s Health Insurance Program phases out in 2019, or as early as 2015.
- **New York should explore developing an insurance product for undocumented immigrants** that would stabilize health care for undocumented populations, provide cost-savings, and allow the State to better predict its health care expenditures.

Conclusion

While the early stages of the Exchange development are a crucial moment to work to ensure an immigrant-friendly Exchange, it will be necessary to continue to monitor the implementation process in coming years. The development of the Exchange will be an ongoing process that will require New York to modify elements of the Exchange, as Massachusetts did in the early years of implementing its insurance Exchange. In particular, the role of NYIC and other advocates for vulnerable populations in providing feedback and recommendations will be critical in ensuring no populations are left out of health reform. Moreover, as a State with high immigrant density and a longstanding commitment to providing health care to immigrants, New York must pave the way nationally as a model of immigrant inclusion. The NYIC hopes that this report can serve as an important resource both statewide and nationally for guiding immigrant-friendly implementation of health reform.





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