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Health Insurance and Immigrants: Obstacles to Enrollment and Recommendations

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EXECUTIVE SUMMARY

Two million New Yorkers are noncitizens. To a much greater extent than citizens, they lack health insurance. A substantial majority of these noncitizens reside here legally, as lawful permanent residents (green card holders), refugees, asylees, or temporary residents, yet they fall short in their rates of coverage. Asylum seekers and people who have applied to adjust status to lawful permanent resident face even greater barriers to coverage, while undocumented immigrants may face almost insuperable obstacles to coverage. This report examines why immigrants are less likely to be insured, and draws on case examples collected since 2001 by members of the New York Immigration Coalition's Immigrant Health Access and Advocacy Collaborative to illustrate the most common barriers to health coverage.

Several factors contribute to the high uninsured rate among noncitizens. They disproportionately work in lower paying jobs and for small firms that tend not to provide health insurance. Lawful permanent residents may be barred from enrolling in Medicare until they have resided in the U.S. for five years or if they lack the requisite work history. Undocumented immigrants are categorically barred from means based public health insurance programs like Medicaid and Family Health Plus, as well as Medicare, regardless of how long they have lived in the United States. Medicaid, Family Health Plus and Child Health Plus (CHP) are open under New York law to lawfully residing noncitizens, and CHP is open to all children regardless of immigration status because New York uses state funding to provide coverage where the federal government does not provide eligibility, but even lawfully residing immigrants are at times wrongfully excluded from enrolling by local officials, and a significant number of eligible noncitizens remain uninsured. Noncitizens, mostly lawful permanent residents, comprise 16% of the 800,000 State residents in total who are eligible for public programs but remain uninsured.¹

The lagging enrollment rates in public coverage among noncitizens, even when immigration status barriers are eliminated, can be attributed to several sources. Many who know they have the option to enroll are reluctant to do so because they fear adverse repercussions to their immigration status:

- Many have been advised erroneously that receipt of public health insurance benefits could lead to their being considered a "public charge," which would disqualify them from adjusting their status to lawful permanent resident. While being found to be a public charge is common for an applicant for lawful permanent residence who has received long term home or institutional care benefits under Medicaid, the routine use of Medicaid or other types of health benefits, which may help keep an individual a productive, contributing member of society, are not relevant in the public charge determination. Yet inappropriate public charge findings by immigration officials have significantly compromised New York's ability to enroll lawfully present immigrants in Medicaid, even though they are eligible for the program.
- Some lawfully residing immigrants believe that their ability to sponsor relatives for admission to the United States would be adversely affected by their own public insurance enrollment. Others who are themselves sponsored by relatives refuse to enroll in government insurance because they have been deterred by the prospect that their sponsors could be asked to repay the government for care they receive. Sponsorship of close relatives is the major route to lawful permanent residence for immigrants in the United States, and fears of infringement on sponsorship or claims against sponsors are major inhibitors to health insurance enrollment. Improper requests for repayment of medical benefits by some U.S. consular officials and by a state government, which have no legal authorization, have intensified these concerns among lawfully present noncitizens.
- Some noncitizens who lack authorization to reside in the U.S. fear that enrollment in a government sponsored health insurance poses risks of disclosure and reporting of their presence and status to

immigration authorities. To the extent that individuals are uncertain about their legal status, or the status of their family members, the fear of reporting engenders more reluctance to enroll, especially among children, who are eligible for affordable health insurance in New York regardless of their immigration status.

- Some noncitizens do not enroll because cultural, linguistic, and navigational barriers prevent them from understanding or overcoming obstacles to the insurance system. Particular obstacles are immigrants not knowing their rights to enroll or being unable to successfully complete what can be a confusing if not bewildering enrollment process, even for native-born New Yorkers.

There are means of reducing each of the barriers to enrollment identified above, which we recommend adopting.

Summary of Chief Recommendations

The economic barriers can be addressed through adequate subsidy systems to allow low income workers to enroll in affordable health insurance, whether through employers or independently. As of the publication of this issue brief, the United States Congress is debating proposals to widen coverage by both mandating the purchase of coverage and subsidizing those who cannot afford to meet the mandate. The current proposals would extend options to purchase affordable health insurance to many citizens and lawfully residing noncitizens, but would cut off undocumented individuals from access to affordable health insurance. Even among citizens and legal immigrants, it remains to be seen, however, whether the mandated coverage will be truly affordable for workers, or whether large numbers of workers and their family members will be exempted or punished for failure to meet a mandate to purchase insurance they cannot afford.

The legal barriers to enrollment in public insurance programs can be addressed through repeal of the federal government's "five year bar" on Medicare and Medicaid enrollment for lawful permanent residents. Work programs to enable recent immigrants to satisfy the work experience requirement for Medicare enrollment could also increase insurance for lawfully present noncitizens. Perhaps most significantly, New York could fulfill its obligation under the State constitution to care for the needy by making public coverage available to all residents, regardless of their immigration status.

The current debate in Washington offers little hope for any federal liberalization of immigrant coverage rules this year, but making coverage universal may, as it becomes a reality, highlight the perverse unfairness of preventing participation in a universal system by taxpaying legal residents. In New York, voluntary change by the State to the scope of eligibility for Medicaid and Family Health Plus may be unlikely due to fiscal considerations, but because a constitutional obligation is involved litigation remains a potential instrument of change.

Reluctance to enroll in public insurance because of "public charge" concerns can be addressed through a strong public education campaign, involving federal and state government officials, community-based organizations, and the immigration bar, to eradicate in immigrants' minds (and the minds of their immigration lawyers) the notion that enrolling in public coverage equates with being a public charge. The federal government should strengthen its 1999 guidelines making clear that public health insurance enrollment is not considered relevant in a "public charge" determination. Federal officials should also carefully monitor and control immigration officers who improperly apply public charge principles to exclude immigrants from adjusting their legal status.

Sponsorship concerns can be similarly addressed through strong and coordinated public education campaigns, but also through changes to federal and state law to remove covered health expenses from the categories of public benefits that can be recovered from sponsors. Unauthorized demands for repayment of benefits made by consular and similar officials should be monitored and prevented.

Concerns regarding reporting of personal data should be addressed by clarifying that information about health care consumers, including immigration status information, is confidential, including any information provided to exchange or connector entities. Enrollment practices should be carefully examined to ensure that personal information such as Social Security Numbers and immigration status is sought only to the extent strictly necessary to determine eligibility for public health insurance and with appropriate guarantees of privacy. The state should do more to explain its Medicaid privacy protections to applicants. Rules similar to New York City's Executive Orders 34 and 41 restricting the collection and dissemination of applicants' personal information by public employees should be adopted statewide, and penalties for public employees who improperly disseminate sensitive personal information should be increased.

Finally, the cultural, linguistic and navigational barriers confronting immigrants in the health insurance system should be addressed more assertively. New York State should rigorously enforce existing language access rules, and improve support of community-based outreach, education and navigation programs that are culturally and linguistically appropriate. The state should make resources and centralized tools such as translated applications and outreach materials accessible online. It should also assist with testing and certification of bilingual staff so providers and agencies that interact with the public can comply with laws and provide higher quality services.

Even if all of these recommendations were adopted, a substantial number of noncitizen residents, especially but not exclusively those who are without legal status, will remain reluctant to participate in any system where their immigration status might be exposed or where they fear accruing a debt to the government. For the population that will continue to live and die without health insurance even after health reform, it is essential that the medical safety net is preserved and strengthened, including robust hospitals and community health clinics. Those facilities, moreover, must receive adequate, accountable public funding to compensate them for the provision of care to low-income citizens and immigrants alike who will continue to lack coverage, including noncitizens who will continue to be denied government sponsored health insurance.

BACKGROUND

A disproportionate share of New York's uninsured residents are noncitizens.² As New York moves toward its goal of insuring more residents, policymakers must consider the real and perceived barriers faced by its 4.2 million foreign-born residents. These barriers to health care and coverage for immigrant New Yorkers include economic factors, legal restrictions on immigrant eligibility for Medicaid and Medicare, perceived immigration consequences of using public insurance and health care, financial liability of immigrants' sponsors, and linguistic and cultural barriers. These barriers are compounded by general confusion and misperceptions about immigrant eligibility for public insurance and health care on behalf of social services and health care providers as well as immigrants themselves. After examining these barriers in detail, the report offers recommendations to federal and state policymakers to reduce their effects.

Immigrants³ throughout the United States are much more likely to be uninsured than native-born citizens. Due to higher rates of uninsurance, immigrants are less likely than citizens to have a usual source of medical care, to have visited a physician in the past year, or to receive primary or preventive care.⁴ Children of immigrants are more likely than native-born children to have never visited a physician or not have had a physician visit in more than three years (15% of immigrant children have gone without medical care, compared to 2% of U.S.-born children).^{5,6} Immigrants also use emergency room services at lower rates.⁷

The problem of access to affordable health care is most acute for immigrants who have arrived in the U.S. most recently, because they are considerably poorer and face greater legal and language barriers. When one controls for socioeconomic circumstances, health, language proficiency, and legal status, immigrants who have been in the U.S. more than five years approach the rate of insurance coverage of native-born citizens. But for newer immigrants the problem is acute: there is a great disparity in coverage rates even controlling for the various other factors that generally correlate with coverage.⁸ In order to address these disparities and increase immigrants' access to health insurance and affordable care, specific barriers must be addressed.

Characteristics of Immigrants in the U.S. and New York State

Of New York State's 19.3 million residents, nearly 22%, or 4.2 million, are immigrants.⁹ Immigrants comprise 26% of the State's workforce, and more than 22% of New York State's economic output.¹⁰

More than half of the immigrants in New York State are naturalized citizens (52%), which is higher than the national average of 43%.¹¹ The balance, about 2 million people, are noncitizens. The noncitizen population includes all lawfully residing immigrants who have not yet had the opportunity to become naturalized citizens, as well as immigrants who are not authorized to reside in the U.S. (undocumented immigrants). Roughly 1.4 million people in this group have lawful status, but are not yet citizens. These lawfully residing immigrants include lawful permanent residents (LPRs, or green card holders), refugees, asylees, and lawfully present temporary immigrants. The proportion of New York's foreign-born population in these categories (33%), is higher than the national proportion of immigrants who are lawful permanent residents, refugees, asylees and lawfully present temporary immigrants, which is about 27%.

Of the 2 million noncitizens, approximately 700,000 (or 15% of New York's total immigrant population) are here without lawful status.¹² According to Jeffrey Passel from Pew Hispanic Center, whose methodology for estimating the unauthorized population is widely replicated,¹³ about 10% of the undocumented population are people who have temporary permission to reside in the U.S. or whose immigration status is unresolved, such as those waiting for a ruling on their application to adjust status to lawful permanent residence, people with temporary protected status, and asylum applicants.¹⁴

Immigrants and Insurance in New York

Noncitizens are disproportionately uninsured. Noncitizens – lawful residents as well as unauthorized immigrants – comprise 12% of New York State’s population, but represent more than a quarter (29%) of the roughly 2.3 million uninsured New Yorkers under the age of 65.¹⁵ In New York City, with its large immigrant population, 41% of the City’s non-elderly uninsured are noncitizens.¹⁶ Noncitizens are three times as likely as citizens to be uninsured. Among non-elderly noncitizens, 34% lack health insurance compared to 11% of citizens in New York State.¹⁷

Lower health coverage rates among immigrants, compared with citizens, are the result of three principal factors which will be further explored:

1. Many immigrants work in sectors of the economy that are less likely to provide employer sponsored health insurance. Only 35% of noncitizens have employer-sponsored insurance, compared with 62% of citizens.¹⁸
2. Many immigrants are explicitly barred by law from using government health insurance programs, and restrictions to Medicaid and Medicare apply to lawful residents as well as unauthorized immigrants.
3. Immigrants who are eligible for affordable health insurance face unique barriers to enrollment related to family-based immigration, implementation of government policies, misperceptions, and cultural and language barriers.

In New York, public health insurance coverage rates are slightly higher for noncitizens than citizens—27% of noncitizens have public coverage compared to 23% of citizens,¹⁹ suggesting that immigrants understand the importance of health insurance and will enroll in affordable coverage when application assistance is available, as through New York State’s successful community-based Facilitated Enrollment program.

Federal law prohibits unauthorized noncitizens and many who have not resided in the U.S. for five years in a particular status from enrolling in public health insurance programs. However, New York State uses State dollars to finance public health insurance coverage for some noncitizens. Thus, lawfully residing adults may enroll in public insurance in New York. All children are permitted to enroll in the State’s Child Health Plus program regardless of immigration status, which requires that all but the lowest-income families pay premiums.

It is worth noting that public health insurance coverage is not free for most immigrants; immigrants pay public insurance premiums (where applicable) and co-pays, just as other New Yorkers.

REASONS NONCITIZENS LACK INSURANCE AND RECOMMENDATIONS TO INCREASE ENROLLMENT

I. Economic Factors Restricting Access to Employer-Sponsored Insurance

A review of the literature and data for New York State shows that a significant part of the disparity in health insurance coverage among immigrants results from labor market conditions. In particular, immigrants tend to work in low-wage jobs and in occupations, industries, and for small firms that are less likely to offer group health coverage.^{20 21 22 23} Low-income workers, regardless of citizenship status, are less likely to have an offer of coverage from an employer, and immigrants in New York earn 9%-19% less per hour than their native-born counterparts with the same educational attainment.²⁴ In addition, noncitizens are over twice as likely to work in construction jobs as citizens, and have higher rates of employment in agricultural, labor, and service industries. Uninsured rates in these industries are over 30% for all workers, regardless of immigration status, compared to 19% of workers who lack insurance across all industries.²⁵

Finally, immigrants are more likely to work in small firms. In fact, 55% of noncitizens are employed in firms with fewer than 100 workers, compared to 44% of naturalized and 42% of native citizens. Firms with fewer than 100 employees were 25% less likely than larger firms to offer health benefits to employees in 2005.²⁶

Even after statistically adjusting for difference in job type, salary level, and similar factors, immigrant workers are still less likely to be offered insurance through their employers. Some employers may avoid offering health benefits by classifying immigrants differently than workers who receive benefits, for example, by classifying immigrants as contract, temporary, or part-time workers. Others, rather than directly hiring workers, lower their costs by working through contractors who may not offer benefits to their contracted employees.²⁷

Policy Recommendations to Enhance Private Coverage Among Noncitizens

For those noncitizens who are working and earn too much for public health insurance, there is a need for access to more affordable health insurance coverage. The Federal government or New York State could create more generous government subsidy systems for low-income workers and their employers to purchase coverage at a reasonable cost. One way to do this would be to establish effective insurance exchanges, or connectors—which would be available to authorized and unauthorized noncitizens—as described in our second issue brief in this series, and which would distribute subsidies. These connectors would be integrated with immigrant community institutions and can effectively accrue enrollment.

II. Legal Restrictions on Eligibility for Public Health Insurance

A second contributing factor to the higher rates of uninsurance among immigrants is the legal restrictions on eligibility for public health insurance programs imposed by Congress based on immigration status and duration of residence, and, in the case of Medicare, on a sufficiently long work history. The United Hospital Fund estimates that some 800,000 New Yorkers are eligible for public health insurance but uninsured. Among these 800,000 individuals, noncitizens represent a disproportionate share (16%) of the eligible but uninsured. In total, about 140,000 noncitizens are eligible for public health insurance but uninsured.²⁸

History of Legal Restrictions for Medicaid and CHIP

The federal government enacted restrictions on legal immigrants' eligibility for public benefit programs, including Medicaid, the Children's Health Insurance Program (CHIP), food stamps, welfare, and Supplemental Security Income (SSI), in the welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). The law prohibits most lawful permanent residents admitted after the law's enactment from receiving federally-supported Medicaid or CHIP coverage during their first five years of lawful status in the United States (commonly referred to as the "5-year bar"). Unauthorized immigrants already were ineligible for these programs. The law also prohibits federal public benefits for many immigrants who are lawfully residing in the U.S. and are in the process of obtaining permanent residency, or who have permission to remain in the U.S. indefinitely, referred to under previous federal law as individuals who are Permanently Residing Under Color Of Law (PRUCOL).

Almost half of states, including New York, use state funds to finance public health insurance coverage for this group of previously eligible immigrants. Many states also use the option under the federal CHIP program to provide prenatal care regardless of immigration status.²⁹

New York extended Medicaid eligibility to lawfully residing immigrants during the 5-year bar period, as well as to many PRUCOL immigrants. The policy was affirmed by a 2001 Court of Appeals decision, *Aliessa v. Novello*.³⁰ Also using State dollars to finance, New York has provided coverage under CHIP to nearly all children regardless of their immigration status.

In February 2009, with the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA), Congress gave states the option of extending federal Medicaid and CHIP coverage to lawfully residing children and pregnant women regardless of their date of entry into the U.S.³¹ New York submitted its State Plan Amendment to the federal government to take up this option in April 2009.

The PRUCOL category covered pursuant to the *Aliessa* decision has been construed broadly for purposes of the state law. While the PRUCOL category is broad, it is not broad enough to encompass those here without documentation who are not known to the government.

Medicare

With respect to Medicare, the program has restricted immigrant participation from its creation. Medicare Part A (for inpatient, skilled nursing, and home care) and Part B (physician services, outpatient treatment, and medical supplies and equipment) have always required as a condition of eligibility that one be "(A) 65 years or older or disabled; and (B) a citizen or (C) an alien³² lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment." 42 U.S.C. 1395(o).³³ In contrast to the federal eligibility rules for Medicaid that restrict access to Medicaid and other public benefit programs until an immigrant has been in lawful status for five years, it is possible for an immigrant to become eligible for Medicare the day she gains lawful status, so long as she can prove continuous residence in the U.S. the five years prior.

Premium free Medicare Part A is available to lawfully present individuals who have accumulated sufficient work history of their own or through their spouse or parent. Sufficient work is defined as having worked for 40 quarters. Lawful permanent residents of any age with a disability who have not accumulated sufficient work history, but who have resided continuously in the U.S. for five years may be able to purchase Medicare A and B.³⁴

Although most studies of the uninsured focus on the under-65 population, based on the assumption that there is universal coverage among seniors, this restrictive Medicare rule and the Medicare work history requirements have resulted in an elderly population in New York which is far from universally covered through Medicare. Significantly, between 16% and 20% of seniors in New York State are not covered by Medicare, including many lawfully residing immigrants such as lawful permanent residents, refugees, and asylees.³⁵ Despite their lawful presence, these immigrants tend not to qualify for Medicare because they do not have sufficient work history.

Massachusetts has dealt with the barriers to noncitizen medical coverage by making lawfully residing immigrants over age 65, or who have a disability and are between ages 18 and 64, eligible for the state's Essential health plan available in the Connector.³⁶

Possible Policy Changes to Increase Enrollment

Both federal and state policy changes should be undertaken to remove the legal enrollment barriers faced by immigrants.

Federal Recommendation

Remove the "five-year" continuous residency requirement for Medicare for immigrants in appropriate legal status. Remove the five-year waiting period in Medicaid for lawfully residing immigrants. Permit transfer of work quarters from immediate family members to applicants who lack sufficient quarters to qualify for Medicare.

State Recommendation

The Legislature, in compliance with the New York Constitution's mandate for aid to the needy, should extend coverage to undocumented immigrants in all public programs designed to enroll the needy. Everyone who lives and works in the state contributes to its prosperity, and all should have access to affordable health care. This expansion could be accomplished by opening the program to anyone, regardless of immigration status, who can demonstrate a residence, whether temporary or permanent,³⁷ and the requisite need. At the same time, the Legislature should amplify the resources of the public hospitals and clinics which must continue to provide services for those who cannot demonstrate such residence or fear doing so. Enforcing hospitals' compliance with the Hospital Financial Assistance Law of 2007 and directing funding for uncompensated care to hospitals based entirely on their provision of benefits under that law could ensure adequate resources for that care. The state's EPIC program, which currently helps low to moderate income seniors pay for prescription drugs, could, if expanded to disabled people under age 65 also provide much-needed benefits to disabled immigrants.

With respect to Medicare, the State could also institute a work program to provide adequate work credits to seniors and, to the extent possible, the disabled, to qualify for Medicare benefits.

III. Concerns about Public Health Insurance and Immigration Status

Many noncitizens are eligible for public health insurance coverage and many more could be eligible. But concerns about how this coverage may affect their immigration status are a barrier to enrollment.

Several categories of noncitizen concerns about applying for coverage are commonly voiced through surveys, by clients of New York Immigration Coalition member organizations, at hundreds of trainings conducted by the New York Immigration Coalition since 2001, and are well-documented in the literature. There are three main concerns: 1) public charge, 2) sponsor concerns about financial liability and impact on ability to sponsor relatives in the future; and 3) reporting of immigration status and fear of deportation.

Public charge concerns are related to the perceived consequence of using a public benefit, such as public health insurance, on an immigrant's ability to adjust status and become a lawful permanent resident. Sponsor concerns deal mainly with concerns about how using public health insurance may prohibit an immigrant from sponsoring family members in the future; and that sponsors may be ultimately responsible for a sponsored immigrant's medical bills or costs of Medicaid coverage (sponsor liability). Confidentiality concerns stem from fear that an individual's or family member's immigration status information could be shared between a government agency such as a Medicaid office and federal immigration enforcement agencies.^{38 39 40 41}

This section provides an overview of each of these three policies, the Federal and State laws governing how they should be implemented; and specific examples of how they have been implemented in practice. As the following discussion indicates, these policies are not always implemented as the law prescribes. These policies are also extremely complicated, leading to misunderstanding among noncitizens. Together, these policies raise concerns among noncitizens that even though they may be eligible for public health insurance, enrolling in public coverage could jeopardize their or their families' immigration opportunities or current status. Each of the three subsections concludes with specific Federal and State recommendations that could address concerns among noncitizens and encourage them to take up public health insurance for which they are eligible.

A. The Immigration Process at a Glance

Part of the complexity and confusion derives from the immigration process itself, in which immigrants interact with the system at different points for different reasons.

Getting a "green card" (adjusting status to lawful permanent resident) and then eventually becoming a citizen is often a long and complex process.

The federal agency in charge of immigration is the Department of Homeland Security (DHS), which is made up of three agencies responsible for distinct functions. U.S. Citizenship and Immigration Services (USCIS) is the agency responsible for processing applications for adjustment of status (green card), citizenship, and other immigration benefits. U.S. Immigration and Customs Enforcement (USICE) is responsible for enforcing immigration and customs laws and is in charge of investigating, detaining, and removing people who are found to not be in the country lawfully. The third agency, U.S. Customs and Border Protection (USCBP) controls the borders and regulates who enters and exits the country.

The process to become a lawful permanent resident and then a citizen can range from about four years to over twenty-eight years, depending on the category under which the person is immigrating, and what country the individual is from. Nearly every individual who wishes to become a naturalized citizen must first obtain lawful permanent residency.⁴² An individual may be eligible to become a lawful permanent resident (LPR) a variety of different ways, and the U.S. limits how many people in most of those different categories can become an LPR each year. According to DHS data about New York in 2008, the four most common categories of immigrants who adjusted to lawful permanent residence were those sponsored by family members, refugees or asylees, those sponsored by employers, and diversity lottery winners.⁴³

Family Sponsorship

By far the most common way an individual obtains lawful permanent residency is by a family member's petition. U.S. citizens can petition for their spouses, minor children, and parents. This is the one category on which the U.S. does not place an annual numerical limit. U.S. citizens may also sponsor adult married and unmarried children and siblings, but there is a numerical limit based on the immigrant's country of origin. Lawful permanent residents (LPRs or green card holders) may sponsor their spouses, minor children, and adult unmarried children, but there are annual limits on how many LPRs may sponsor their family members.⁴⁴

In New York, nearly 95,000 of the 143,679 individuals who obtained lawful permanent residency in 2008 were family members of citizens or LPRs (66% of all individuals who became LPRs). Currently, due to annual numerical limits, some individuals have to wait as long as twenty-three years before they become eligible to become a permanent resident. Moreover, if that individual is not already residing in the United States, they are expected to wait outside the U.S. that entire time before obtaining a visa to travel to the U.S. and reunite with the family member who is petitioning for them.

Refugees and Asylees

In 2008 the second most common way that immigrants in New York obtained lawful permanent residence was to adjust from the status of refugee or asylee.⁴⁵ A refugee or asylee is someone who fled their country of origin due to fear of persecution. In most cases, a refugee must go through a third country other than the U.S. or their country of origin, where they are granted refugee status by the United Nations, and placed in the U.S. In contrast, an asylee applies for asylum after they have arrived at a port of entry to the U.S. or already entered the United States. In 2008, 22,792 refugees and asylees became LPRs in New York, 16% of all individuals who became LPRs.

Employer Sponsorship

An individual may also become a lawful permanent resident through his or her employer. There are many restrictions, however, on employer-based immigration. Only certain individuals with extraordinary ability or skill, or those who have experience performing a job for which qualified workers are not available in the United States, may be eligible for employer-based immigration. Not all individuals who are granted visas to work will be eligible to adjust status to lawful permanent resident, however. There is a national annual cap of 140,000 individuals who may become lawful permanent residents based on an employer petition. In 2008 in New York 16,579 individuals became LPRs as a result of employer-based immigration (12%).

Diversity Lottery

Individuals from countries that do not send many immigrants to the U.S. also have the option to participate in the Diversity Visa Lottery. The name of the program expresses its intent: to diversify immigration to the United States. Therefore, individuals from countries that send many people to the U.S., through either family-based or employment-based immigration cannot participate. The Diversity Immigrant Visa Program offers 50,000 visas each year, drawn from random selection among entries of individuals who are from countries with low rates of immigration to the United States.⁴⁶ Citizens of countries like China, Mexico, and the Philippines are not eligible for the diversity lottery because of the high numbers of immigrants from those countries who already reside in the U.S. In New York 7,762 diversity lottery winners became LPRs in 2008 (5%).

Finally, there are special categories of immigrants who may also become LPRs, such as victims of crime, victims of trafficking, widows or widowers of U.S. citizens, etc. In 2008 in New York 1,562 such individuals became lawful permanent residents (1%).

Becoming a Citizen

An individual who obtains lawful permanent residency generally must wait five years before they submitting a written application for naturalization with USCIS. With some exceptions, the individual must also:

- Be age 18 or older; and
- Be a person of good moral character; and
- Pass a Civics test demonstrating basic knowledge of U.S. history and government; and
- Complete a period of continuous residence and physical presence in the United States; and
- Be able to read, write and speak basic English.⁴⁷

With these basic outlines of the immigration process in mind, we can consider the concerns of noncitizens about potential impediments to legalization and naturalization.

B. Public Charge Concerns

We use the term “public charge” as shorthand for the concern that an immigrant’s use of public programs will affect that individual’s ability to obtain lawful permanent residence, acquire a visa, or naturalize, because he or she might be considered a public charge. The concept of public charge has been part of immigration law for over 100 years. It is a ground of inadmissibility that affects certain individuals applying to adjust status to lawful permanent resident (most green card applicants), as well as certain individuals applying from a foreign consulate for a visa to travel to the U.S. In reality, there is no basis for the concern that the receipt of public benefits by those who are already LPRs will have an effect on their ability to naturalize.

An individual’s adjustment application or visa may be denied if a U.S. immigration official determines that an individual is, or may become, primarily dependent on the government for subsistence.⁴⁸ In other words, the intending immigrant will not be granted permission to enter the U.S. or to adjust to lawful permanent resident if immigration authorities determine that he or she is, or is likely to become, primarily dependent on the government for basic subsistence, and therefore a public charge.

Immigrants Subject to Public Charge Determinations

Public charge determinations affect immigrants who are on a pathway to LPR status, such as the foreign born spouse, child, parent or sibling of a U.S. citizen or LPR, foreign born workers who are being sponsored by their employers for LPR status, and winners of the diversity visa lottery (“green card lottery”), in which individuals may qualify for green cards without the traditional sponsorship requirements. The public charge issue potentially affects 80% to 90% of lawfully residing immigrants who are here through family- and employer sponsorship or the diversity visa lottery.

Immigrants Not Subject to Public Charge Determinations

Certain types of immigrants who become eligible to adjust status are not subject to the public charge determination, including refugees, asylees, and children who apply for LPR status as Special Immigrant Juveniles.

Finally, public charge determinations are not made at the point of naturalization. Once an individual obtains lawful permanent residency, enrolling in and using public benefits legitimately will not prevent the individual from becoming a naturalized citizen. So long as an individual does not obtain a benefit fraudulently, e.g. by providing false information or documentation, the use of any kind of public benefit, including public health insurance, is not against the law, does not constitute a good moral character issue, and thus does not prevent a lawful permanent resident from becoming a U.S. citizen.

The following discussion on public charge pertains only to those immigrants who are subject to the determination at their consular or adjustment of status interview.

Public Charge Determination

The governing statute vests considerable discretion in the consular or immigration officer and the Attorney General to determine who is a public charge, relying not on an objective standard, but on “the opinion” of the official making the determination. The statute does dictate that certain factors must be considered, at a minimum, which include the immigrant’s: (I) age; (II) health; (III) family status; (IV) assets, resources, and financial status; and (V) education and skills.⁴⁹ The statute also permits the official to consider any affidavits of support by the individual’s sponsors.

In terms of public benefits, in general, only cash benefits for income maintenance purposes are relevant in public charge determinations. The use of Medicaid is relevant only in cases when it pays for long-term institutionalized care such as in nursing homes and psychiatric hospitals, as these payments cover essentially shelter, food and basic care for the individual.⁵⁰

Courts have made clear that the deciding official’s discretion is quite broad, a factor which has effectively precluded much litigation over how the provision has been applied. Courts have retained, however, the power to judge the validity of general rules adopted by immigration officials as to who might be a public charge, finding, for example, that they could not judge the self-sufficiency of an immigrant based on his or her ability to support other family members, only on the ability to support him or herself.⁵¹

In contrast to the immigration law’s exclusions of “psychopathic personalities,” used to exclude lesbian and gay immigrants for generations, the propriety of excluding likely public charges has never been seriously disputed.

The constraints of rationality imposed by the constitutional requirement of substantive due process and of nondiscrimination exacted by the equal protection component of the due process clause do not limit the federal government’s power to regulate either immigration or naturalization. Thus, the Constitution does not require our national immigration policy to be consistent with the prohibition of discrimination by federal agencies and by state governments and private persons.⁵²

Even if the government were required to show a rational basis for the exclusion of public charges, presumably the oft-repeated rationale – that opening the door to immigrants requiring public support could jeopardize the financial integrity of the government – would be a convincing one.

Public Charge and Public Health Insurance

Despite the long history of the “public charge” provision, enrollment in health coverage has not historically been a significant component in the evaluation of a person’s likelihood to become a public charge, for the simple reason that major publicly funded health insurance programs, under which the beneficiary could be plausibly said to be benefitting from public expenditure, did not exist before 1965, when Medicare

and Medicaid were both created. In addition, Medicare, with its work history requirement (see discussion of Medicare coverage requirements, above), its coverage of people in all income categories, and the premium payments it charges for Part B could be seen as more akin to a private insurance program than a charitable program.

Medicaid presents a slightly different picture. Use of Medicaid long-term institutionalized care, such as that received in nursing homes and psychiatric hospitals, has been considered a basis for finding someone to be a public charge. As to the other care Medicaid covers, when the program was first created there does not appear to have been any generally perceived inconsistency between residing in the U.S. lawfully and using public health insurance. Indeed, the 1986 immigration law imposed limits on the theretofore almost unfettered discretion of the Attorney General in interpreting the “public charge” exclusion, with the statute strongly implying that receipt of cash assistance, rather than in-kind benefits, was the deciding factor. Regulations made the implicit distinction between cash assistance and in-kind assistance explicit:

“Public cash assistance” means income or needs-based monetary assistance, to include but not limited to Supplemental Security Income, received by the alien or his or her immediate family members through federal state, or local programs designed to meet subsistence levels. It does not include assistance in kind, such as food stamps, public housing, or other non-cash benefits, nor does it include work-related compensation or certain types of medical assistance (Medicare, Medicaid, emergency treatment, services to pregnant women or children under 18 years of age, or treatment in the interest of public health).⁵³

Two major laws passed in 1996 gave rise to concerns that using health care and other non-cash benefits would lead to immigration problems – Welfare Reform (PRWORA), which imposed waiting periods for public insurance benefits and more generally stigmatized receipt of public benefits, and The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA). IIRAIRA considerably strengthened immigration law enforcement, weakened the due process rights of immigrants, and expanded the circumstances that could subject an individual to deportation or removal from the U.S. Although neither PRWORA nor IIRAIRA altered the law on public charge, misinformation and abuses that followed the passage of these laws helped create a climate of fear in immigrant communities of even the smallest transgression of the rules, and thus a disincentive to enrollment in public health insurance programs.

Concerns and Misconceptions about Public Charge in New York

Based on hundreds of trainings conducted for community members, advocates, health care providers, and government agencies by the New York Immigration Coalition (NYIC) since 2001, it is apparent that the public charge rules cause significant confusion and fear among immigrants and immigration legal service providers alike, with the result that some immigrants refuse to apply for the health coverage programs for which they are eligible.

Medicaid program Facilitated Enroller agencies, including Make the Road New York and Public Health Solutions, inform the NYIC that one of the most common concerns immigrants face about applying for health insurance is the fear of being determined to be a public charge, and consequently having to abandon residence in the U.S. for themselves and possibly their families. Immigrants and their families are not aware that the public charge determination is made only at the adjustment or green card interview (not at random intervals, such as when hospitalized, or later when seeking to naturalize); that it does not apply to certain types of immigrants such as refugees, asylees, and victims of violence; and that using

public health insurance (other than for institution-based long term care) should not, by itself, trigger a public charge determination.⁵⁴

The following comments collected by the NYIC from immigrants and insurance enrollers represent the general concerns held by many lawfully present immigrants:

- “My husband has his green card, but I don’t want him to apply for Medicaid because he might be a public charge and not be able to become a citizen.”⁵⁵
- “I didn’t want to apply because maybe they are going to say that I’m a public load. I’d rather stay the way I am without insurance than to [risk that].”⁵⁶
- One enroller tells of a client who “didn’t want to use her Medicaid card anymore because she [was] applying for a green card...she said she read on the Internet that it can be used against her.”⁵⁷
- Another enroller recalls a client who believed that his brother was denied a green card because the immigration officer saw that he had used Medicaid. According to the insurance enroller: “People don’t want to deal with the system at all. We did try to help, a lot. When it comes to this, [it’s] serious, they won’t listen...”⁵⁸
- In a focus group for lawfully residing Korean immigrants eligible for public insurance but uninsured, many expressed the belief that use of health care or insurance would negatively affect the process to adjust their immigration status. One participant said, “Rejection, isn’t that almost guaranteed if the interviewer finds out that you had used Medicaid or Family Health Plus? If not rejection, then probably a lengthened process.”⁵⁹
- “I used to have Medicaid, but terminated it when someone told me that I shouldn’t use such public benefits. It made sense, later when I go in for an [immigration] interview, such record wouldn’t work in my favor. I even have diabetes, and need more than \$150 just to pay for my medications. When I had Medicaid, I only had to pay \$5. Now, \$150, month after month...”⁶⁰
- A Korean facilitated enroller explained that parents would rather pay a monthly fee to acquire Child Health Plus B, than to have free insurance through Child Health Plus A. Although both are government insurance programs offered in New York State, they believe there is less risk of being found public charge if immigrants pay something for their health insurance.⁶¹

These cases illustrate the breadth of misperceptions about public charge among lawfully present immigrants who are in many cases eligible for government health insurance, but avoid enrolling as a result of their fears about potential immigration consequences.

In addition, the NYIC surveyed its member organizations to better understand the reasons why immigrant constituents were uninsured. Asked whether “immigrants are afraid that using benefits will affect their immigration status or they won’t be able to sponsor a family member or adjust their status,” 23 organizations said that was often the response, 8 sometimes, and only 2 indicated that such concerns were never encountered among their immigrant clients. Public charge concerns were more widespread than any other barrier barrier explored in that survey.^{62 63}

Federal Attempts to Address Confusion

Thus, the 1996 welfare reform law deeply stigmatized the use of public benefits in general, and the eligibility restrictions for legal immigrants that were imposed specifically to discourage new immigrants from utilizing government benefits further served to emphasize the perceived negative consequences for immigrants, and caused a steep decline in immigrant enrollment nationally. Subsequently, the federal government issued guidance in 1999 to clarify that receiving Medicaid or SCHIP, or other non-cash benefits, would not result in a public charge determination and denial of an individual's application for lawful permanent residence.⁶⁴ The guidelines, and an associated Questions and Answers document, were issued "to alleviate growing public confusion" over the question of public charge.⁶⁵ These guidelines and a similar transmittal by the State Department to consular offices remain in effect. The proposed regulations that accompanied the guidance were not adopted as final regulations. Although the guidance is not binding on the courts, it governs the USCIS and remains a significant articulation of federal policy in the area.

Erroneous Interpretation of Public Charge Despite Revised Federal Guidance

Nonetheless, it seems that immigrants had some basis to draw the equation between use of public programs and experiencing difficulties in adjusting their status. Immigrants who are in long term or institutional care face multiple barriers, associated not only with their use of benefits, but with their health status, age and income. The evaluation of risk of becoming a public charge is multivariate, with great discretion by the decision-maker, including considerations of factors that may be associated with individuals who use or need public benefits (income, age, disability, health issues, employment status, etc.). In a 2002 report, the National Immigrant Law Center notes that in making discretionary decisions unrelated to the public charge ground of inadmissibility, judges and immigration authorities can sometimes take receipt of public benefits into account.⁶⁶

Of course, there is a strong argument that for some immigrants, use of coverage enables them to maintain the health that enables continued work and thus avoiding becoming a public charge. But immigration officials charged with making decisions have continued at times to use Medicaid enrollment inappropriately as a factor, sometimes the sole factor, in determining that intending immigrants or those trying to adjust status are excludable. Over a several year period, the Garden City, NY USCIS office and, to a lesser degree, the major office at Federal Plaza in Manhattan have issued denials of adjustment of status based on a history of Medicaid enrollment.

From 2006 to 2007, the NYIC collected a series of denial letters received by adjustment of status applicants after their interviews. In each of the letters, the Immigration Services Officer (ISO) reviewing the case determined that the applicant was a public charge because of their use of Medicaid or hospital charity care, and thus denied the application for adjustment. The denials illustrate certain ISO's misapplication of the public charge rule, which resulted in the applicants having to file expensive and unnecessary motions to reopen, as well as a misunderstanding of the term "public assistance." Each adjustment case that came to advocates' attention was eventually approved, but only after the applicant filed a motion to reopen the case, or if too much time had passed to file a motion to reopen, renewed their application. Others who did not have the assistance of advocates or attorneys likely suffered removal, or left the country.

The denials appear to have been based on the erroneous classification of medical benefits, such as Medicaid and hospital financial assistance, as public assistance.⁶⁷ The majority of the denials are based

solely on the applicant's use of the Medicaid program, rather than based on the applicant's totality of circumstances, even though an applicant's use of non-cash benefits, such as public health insurance, is not sufficient grounds for determining him or her to be a public charge. None of the individuals affected by these bureaucratic errors were using Medicaid for long term, institutionalized care.⁶⁸

There is a need to monitor such abuses to ensure that federal officials comply with and enforce this policy effectively.

Efforts to Rectify Misinterpretations of Public Charge

Legal representatives filed motions to reopen the cases brought to the NYCIC in which use of the health benefit was the sole reason for determining the applicant to be a public charge, and the applications were eventually approved by the U.S. Citizenship and Immigration Service (USCIS). However, it is unknown how many total adjustment applicants have been wrongly denied solely for their use of Medicaid or charity care. It is safe to say that these cases that came to the attention of the NYCIC are but a fraction of the actual number of wrongful denials.

Addressing these wrongful denials and the practices of USCIS required a considerable effort by immigration advocates, who had to document the extent of the problem, raise it at USCIS regional liaison meetings, and advocate with the District Director.⁶⁹ The District Director acknowledged that advocates' concerns had been considered and additional training was provided to Immigration Services Officers (ISOs) regarding the public charge issue.⁷⁰ Since that time, reported cases of wrongful denials by ISOs based on Medicaid enrollment have diminished considerably, but not entirely evaporated, as evidence by one reported recurrence in December 2008.⁷¹

Armed with that administrative success, advocates then had to develop a program to inform members of the public that they could again rely on the federal guidelines of 1999 that made clear the distinction between health benefits and cash assistance. The public education effort, developed with support from this grant from New York State Health Foundation,⁷² faced the challenge that if the message to immigrants about public charge were focused on the exceptional circumstances (including receipt of long term care benefits) when enrollment in public health insurance coverage could contribute to a public charge determination if other factors are present,⁷³ it might further confuse people and contribute to a chilling effect on enrollment. To give the public the true picture, that enrollment in public insurance itself should not be a bar to adjusting status, would require a multipronged approach, with a particular view to reaching under-resourced applicants who lack connections to low-cost legal services and who might not know of their options to file a motion to reopen their case if their application is wrongfully denied.

Education and Outreach by New York State Government

One approach was to enlist the authoritative voice of government agencies. The NYCIC met with the New York State Department of Health (NYSDOH) representatives overseeing the department's stepped up outreach and enrollment efforts, to share the latest developments on public charge, useful messaging, and to offer training to facilitated enrollers, lead agencies, and other newly hired outreach workers. It has been very helpful that the New York City Office of Citywide Health Insurance Access, on its website, tried to address the fears induced by decisions like those rendered at Garden City by assuring that enrollment in Medicaid should not affect one's ultimate ability to adjust status.⁷⁴

Education and Outreach by Immigration Lawyers and Advocates

A second approach has been through the immigration lawyers and authorized representatives, as well as notarios and other unauthorized representatives, on whom immigrants rely for advice. An advocate from Shorefront YM-YWHA in southern Brooklyn reported recently that immigration lawyers serving the Russian-speaking community routinely counsel clients to cancel existing medical coverage, and that often, despite being educated by caseworkers at Shorefront Y, the clients choose to heed their lawyers' advice rather than risk problems at their adjustment interview.⁷⁵ According to the enroller, for some, getting their immigration papers is more important than health.

At roundtable discussions on the issue hosted by the NYIC with member agencies and legal services partners, participants cited an almost universal practice of immigration attorneys advising their clients who plan eventually to seek adjustment of status not to enroll in Medicaid or similar public programs. Our findings are similar to those of the Maloy study from George Washington University in 2000: "We frequently heard reports that immigration lawyers are advising their clients not to use Medicaid in order to avoid any risk of problems." It is apparent that many of these advisors, who might have legitimate concerns regarding clients receiving institutionalized long term care benefits, lacked information about other types of enrollment (including the possibility of community based long term care which would be consistent with working) and their effect, or lack thereof, on public charge.

These advisors continued to counsel their clients to avoid public coverage, even to the detriment of their health status. From the immigration lawyer's perspective, adjustment of status is easier if one does not have to overcome an administrative exclusion decision based on Medicaid enrollment, even if that decision could be overturned. Avoiding that hurdle might save the client money in lawyer's and USCIS fees, but the amount saved might be offset by medical expenses the client may have to bear without the coverage. Moreover, the adjustment effort could be hurt if health conditions worsen, due to deferred treatment, to the extent that the immigrant is debilitated and at greater risk of actually becoming a public charge.

Education and Outreach by Community Members

The third, and perhaps most critical aspect of public education is to get the message to trusted community members and intermediaries. Years of wrongful public charge denials of adjustment and misdirected questions based on public health insurance enrollment have taken a severe toll in community misconception. Immigrants know of them, and tell one another about them. This may be why one study found that speakers of languages other than English were three times as likely to have someone in the family say it was not a good idea to enroll in Medicaid than was the case for English speakers.⁷⁶

The health advocates in the NYIC's Health Collaborative have consistently indicated that, as trusted resources in their respective communities, if they are able to educate their clients about the USCIS guidance on public charge, then immigrants' concerns are sufficiently alleviated such that they apply for coverage for themselves or for their children. Sometimes, however, the warnings from family and friends prevail, as do the stories passed on throughout the community about the difficult line of questioning posed at adjustment interviews.

The warnings are so pervasive that many eligible individuals and families remain without coverage. An advocate at Haitian Americans United for Progress in Cambria Heights, Queens, remarked that the word-of-mouth warnings against applying for public coverage are exceptionally strong and hard to counteract in the Haitian community.⁷⁷ One mother of three from the Dominican Republic admitted that despite her knowledge that public health insurance should not trigger a public charge determination, she continued

to worry because of her friend's experience at his green card interview. She reported that her friend was asked at his adjustment interview if he "got help from the government," to which he responded he did not. Then later on he admitted he had had Medicaid in the past, and was reprimanded by the USCIS clerk, "What do you think Medicaid means? Medicaid is a form of help from the government." In the opinion of the authors, the immigration authority was incorrect, but in practice an applicant to adjust status is ill-equipped on their own to defend against a bureaucrat who misunderstands or misapplies the laws. The persistence of such errors can have a profoundly negative impact on the lives of individuals who seek to reside lawfully in the U.S.⁷⁸

Issues Related to Public Charge: Repayment of Benefits & Visa Acquisition Complications at US Consulates

The NYIC has received troubling reports of immigrants being asked to repay their use of a public insurance benefit, either by an Immigration Services Officer at the adjustment interview, or by a visa-granting Consulate Officer. This practice appears to be a violation of the public charge rule, and is not backed by official policy. Neither the USCIS nor the Federal nor New York State Medicaid programs have issued an official policy to collect repayment of public health insurance benefits from individuals who are eligible for and have received the benefits lawfully (i.e., not through submitting false information or documentation). Nonetheless, at a training conducted at the Nassau County Local Department of Social Services on July 3, 2007, eligibility workers identified cases where immigrant beneficiaries presented at their office asking to repay their use of Medicaid. They said they had been told by USCIS they had to repay Medicaid before they could get their green card. The LDSS workers said they had to turn the beneficiaries away in these instances because it was administratively impossible to process their request.

Other cases came to the attention of the NYIC in May 2004 of women whose visas had been denied, reduced or revoked because they had enrolled in the Prenatal Care Assistance Program (PCAP) for the birth of their child. In each case, the woman had delivered a child in New York City and had used PCAP in the past while in the U.S. on a temporary visa; the women exited the U.S. and upon attempting to re-enter were confronted by consular staff who inquired about the birth of the citizen child, and indicated that the woman was "public charge" and had to pay back the government for the delivery. In one case, the woman was asked to pay back the U.S. government \$3,000 and was denied a visa to re-enter;⁷⁹ in a second case the woman and her child were put on a plane back to Africa (she was fleeing for their safety for political reasons);⁸⁰ and the third case the woman was allowed passage at Kennedy airport but for a shorter stay and was told that her multiple-entry visa was being revoked.⁸¹

Concerned that PCAP beneficiary information had been shared between the U.S. Consulate or U.S. Immigration and Customs Enforcement (USICE) and the New York State Department of Health (NYSDOH) or New York City Human Resources Administration, the NYIC verified with the NYSDOH that they had not reported any information about benefit usage to USICE. As a result of this advocacy, the NYSDOH issued General Information System (GIS) 04 MA/014, on July 22, 2004, which clarified not only that the NYSDOH does not share information about beneficiaries with any agency at the Department of Homeland Security, but also that the NYSDOH "generally may not accept payment from individuals who attempt to repay the State for Medicaid benefits.... The mere past receipt of Medicaid, in the absence of an overpayment or fraud, does not create debt...and therefore the beneficiary is not indebted to the State." A more detailed description of this GIS appears later in this report.

While consular staff may make a public charge determination before issuing a visa, the guidance from the State Department is clear on several relevant issues: 1) the definition of public charge does not include

use of health benefits, except when in receipt of institutionalized long term care services; 2) use of health benefits should not affect an individual's ability to obtain a visa; 3) a consular officer is not authorized to request repayment of benefits. . Finally, regarding repayment of benefits, the guidance states: "A consular officer should not inquire into the need to repay to the government any subsistence cash benefit or cost of institutionalization the alien may have received. It is the role of the government agencies that have provided the benefit to 1) make formal determinations of fraud or overpayment before they can request repayment, and 2) insure that people are notified of the determinations and their right to file appeals." ⁸²

The U.S. Department of Health and Human Services also issued a letter to State Medicaid Directors on December 17, 1997, in the year following enactment of both PRWORA and IIRAIRA, to clarify sharing of information between State Medicaid programs and immigration services. This letter states clearly that beneficiary information shall not be shared by the Medicaid program, "State Medicaid agencies are not authorized to provide information about the receipt of benefits or the dollar amount of these benefits to the INS, the State Department or immigration judges..."⁸³ The letter also clarifies the issue of repayment of benefits: "the Medicaid program has no authority to collect repayments of benefits from current or former beneficiaries except in cases where those benefits were fraudulently received or an overpayment has occurred."

Despite this clear guidance, the practice of U.S. consular officers making inquiries into visa applicants' previous use of public health insurance and then requesting repayment before issuing visas, appears to continue. At an August 19, 2008 training at Jamaica Hospital, two employees shared stories of people whose children's births were paid for by Medicaid, who had returned to their home country (Trinidad and Guyana, respectively), and were denied visas to return until they repaid the Medicaid benefits.

Recommended Policy Changes to Increase Enrollment

The broad articulation of federal policy in these guidelines has not sufficed to avert the deterrent effect of the PRWORA rules on even qualified immigrant coverage. To overcome that effect, four policy recommendations are proposed:

1. Federal immigration authorities, with assistance and complementary efforts from community-based organizations, should undertake ongoing monitoring of decision-making at the local and regional immigration offices, and should educate immigration personnel regarding the public policy favoring health coverage as a communal duty, rather than as taking advantage of public benefits.
2. To support this effort New York State health officials should strongly articulate the same policy goal, publicly declaring the State's desire that all potentially eligible people enroll. As we have learned in the commercial insurance context, the State's imprimatur on health insurance programs can strongly influence immigrant enrollment.⁸⁴
3. State health officials, in collaboration with community-based organizations, should create public education campaigns about the issue for immigrants themselves to clarify what public charge is and which benefits are relevant to the public charge determination, similar to Federal guidance issued in 1999. Nuances such as the distinction between long term care in an institutional setting and in the community should be the subject of education both for immigrants and for officials dealing with them.
4. The organized bar, through its immigration law committees, and through specialized immigration law and ethnic bar associations, should create continuing legal education programs for immigration attorneys and accredited Bureau of Immigration Appeals representatives to both suggest the benefits of health coverage enrollment and provide materials which can be used in connection with

petitions for adjustment of status to demonstrate that such enrollment does not render one a likely public charge.

C. Sponsor Concerns

A second common issue deterring many immigrants from enrolling in public health insurance is sponsor concerns. Potential sponsors worry that if they enroll in public health insurance they may not be able to sponsor family members in the future. In addition, immigrants and their sponsors worry about the sponsors' financial liability should the immigrant apply for health coverage or use health care.

What is a Sponsor?

The most common way for an immigrant to become a lawful permanent resident is through sponsorship by a U.S. citizen or lawful permanent resident family member.⁸⁵ The sponsorship affidavit is a mechanism to avoid a finding by USCIS or consular or immigration officer that the person is likely to become a public charge.⁸⁶ Between 2005 and 2007, two-thirds of New York's 450,000 new lawful permanent residents were sponsored by family members.⁸⁷ New York, therefore, is home to hundreds of thousands of individuals who are sponsoring relatives for their green cards.

The sponsor's affidavit of support (USCIS form I-864) used for family based visa petitions is an enforceable contract between the sponsor and the U.S., obliging the sponsor to support the immigrant at 125% of the Federal Poverty Level.⁸⁸ The sponsor must have income equivalent to at least 125% of the Federal Poverty Level for his or her family, including the sponsored immigrant as a family member for purposes of that computation. If the sponsor cannot meet this threshold, he or she may find a joint sponsor who can independently meet the income qualification.⁸⁹

Sponsorship and Public Health Insurance

The definition of sponsor contains no reference in any respect to the sponsor's own use of public health insurance benefits. In New York State, because of relatively expansive income eligibility rules for public health coverage, it is possible to be both eligible for public insurance coverage (e.g. Family Health Plus) and make sufficient income to sponsor a family member for immigration purposes. Moreover, sponsors who make less than 125% FPL must find another sponsor who meets this requirement. Such sponsors may have public health coverage, and sponsor a family member. In general, an individual who has signed an affidavit of support, or who wishes to sponsor a family member in the future, may apply for public health insurance for which the individual and his family are eligible, but confusion persists.

By signing an affidavit of support, the sponsor is also agreeing to potentially repay the U.S. for the means-tested benefits that the sponsored immigrant may use. This is referred to as "sponsor liability." Under federal law, the obligation of support in affidavit of support form I-864 is enforceable by the sponsored individual, and by the federal government or any lower level of government which supplied the sponsored person with means-tested benefits.⁹⁰ The affidavit of support is enforceable for up to ten years after the last use of non-emergency Medicaid or other "means tested public benefit," or until the immigrant either naturalizes, secures credit for forty quarters of work history, abandons his/her LPR status, or dies.⁹¹ The statute provides that a state or political subdivision which has been advised of the use of a means-tested public benefit—including public health insurance—by a sponsored individual, other than costs of an emergency condition, may seek reimbursement from the sponsor.⁹² USCIS clarified in regulations that the agency is required to request reimbursement only in cases where it intends to pursue the sponsor

for repayment. For a variety of reasons, neither New York nor any other State is currently attempting to enforce these affidavits.⁹³

Contributing to the chilling effect of sponsor liability on immigrants' enrollment in public insurance coverage, New York's close neighbor, Connecticut, has attempted to sue sponsors in the past, most recently and most visibly in early 2007. At that time, as a result of legal questions raised by immigrant rights and legal services groups, Connecticut Attorney General Richard Blumenthal requested that Department of Social Services (DSS) desist from suing 300 sponsors for their sponsored immigrants' use of public benefits.⁹⁴ This was not a one-time effort. Four years earlier, the same department contacted a sponsor residing in New York regarding his mother's use of Connecticut Medicaid for eight months, and demanded that he repay over \$8,500. DSS did not respond to the sponsor's request for a breakdown of the costs.

Sponsorship-Related Fears and Deter Enrollment in Public Programs

Although the vast majority of states have not attempted to sue sponsors, immigrants and their sponsors are aware of the risks. The risks are sufficiently high that individuals make critical decisions about their health, sometimes choosing to forego needed care and coverage, to safeguard their sponsor from any financial risk.

Fear of being unable to sponsor family members is often a reason given for not enrolling in public health programs.⁹⁵ For example, a Haitian immigrant interviewed about access to health care remarked, "They tell me that if you request such assistance for your children, when you need to apply for a relative back home to enter this country, you may not be able to. I am always asking myself whether these types of assistance will have any consequences on my children in the future. I am always afraid of applying for public assistance. Even though they enrolled me in the WIC program at the hospital, I never used it."⁹⁶ In another example, a young Chinese couple wished to sponsor their parents. To save money, they sent their two young children back to China to be taken care of by the children's grandparents. The young mother had a stomach ulcer and needed medical care, but refused to apply for Medicaid because she was afraid it would affect her ability to sponsor her parents and reunite with her parents and children.

In two recent focus group sessions conducted by the NYIC with Spanish- and Korean-speaking immigrants, most participants were confused about the rules regarding sponsorship and were concerned that it would not be possible for them to sponsor a family member if they used public health insurance.⁹⁷

In NYIC's 2002 survey among the organizations which are part of its Immigrant Health Access and Advocacy Collaborative (Health Collaborative), over 80% of responding organizations reported that clients often or sometimes were reluctant to apply for health benefits for fear that their sponsors would have to repay the benefits. Nearly two-thirds reported that their clients did not apply for health coverage because their sponsors did not want them to. About half said their clients were dissuaded from applying because agency personnel at the programs they were applying for told them that they could not get health benefits if they had sponsors. Such statements by bureaucrats are false and reprimandable.⁹⁸

The NYIC has also collected numerous cases of individuals who not only declined to enroll in public insurance coverage, but also delayed or forwent needed medical care because of sponsor concerns. The cases range from a 76-year old man who refused treatment for chronic health conditions,⁹⁹ to an elderly woman who forwent cataract surgery, to others who declined needed nursing home care and home care.¹⁰⁰ Additionally, an 80-year old refused to seek follow-up treatment for a heart condition, a 60-year old woman refused rehabilitative care following a stroke, and a Chinese woman refused follow-

up care to treat injuries sustained from a fall.¹⁰¹ In each of these cases, the individuals were lawfully residing immigrants who were delaying their care as a result of fears related to their sponsors' potential financial liability.

The unfortunate dilemma for many is whether to enroll in the coverage for which they are eligible, get the care they need now, and risk having the sponsor be sued at some time in the future; or to not enroll or to delay the needed care, but risk potentially greater financial consequences later should the individual's health deteriorate and require urgent care. The second option only perpetuates a health care system that excludes low income individuals from affordable coverage options and which perversely favors acute care over preventive, primary, rehabilitative and long term care, thus endangering public health.

Recommended Policy Changes to Increase Enrollment

Both Federal and State policy changes are needed to adequately address sponsor fears and encourage those who are eligible to enroll in public health insurance.

1. The clearest way to deal with sponsor liability fears would be for Congress to eliminate any sponsor liability when the public benefits received relate to health care benefits, as it did for lawfully present children and pregnant women covered by states electing the option under CHIPRA. Even if this does not happen, USCIS should participate in public service announcements addressing this issue. USCIS could provide more explicit information to sponsors who are completing the affidavit of support, clarifying their right, and the right of any immigrant they sponsor, to use medical benefits such as Medicaid without jeopardizing their right to be sponsors. In addition, USCIS could issue a directive or offer guidance to its field offices affirming the rights to health coverage enjoyed by sponsors and immigrants adjusting status.
2. Regardless of action taken on the federal level, New York State law should be changed to strike problematic language suggesting a mandate to pursue sponsors for Medicaid benefits received. With federal health reform likely to involve considerably greater numbers of individuals in subsidized insurance coverage, perhaps even mandating participation, sponsor liability becomes even more inappropriate. It would be particularly unfair for the government to mandate coverage but then to create disincentives to using that coverage by penalizing sponsors if the coverage is used.

D. Concerns About Privacy and Reporting of Immigration Status

Although Medicaid workers and health care providers are not required to report individuals whom they suspect or believe to be undocumented to federal immigration authorities, many undocumented individuals and their family members have substantial concerns that any interaction with government agencies or the health care system in general could lead them or a family member to be reported to U.S. Immigration and Customs Enforcement (USICE), and possibly deported. For example, an undocumented individual applying for Emergency Medicaid for himself or for Child Health Plus for his children may be concerned that information about his immigration status may be shared between the hospital or Medicaid and USICE. Researchers including Glenn Flores and Mark Berk have also documented this concern.^{102 103}

Examples of Noncitizens' Concerns

Hesitation to enroll because of concerns about confidentiality has been a theme in personal histories elicited by the New York Immigration Coalition at focus groups and in stories collected by its member groups in the Health Collaborative. While breaches of confidentiality seem to be relatively rare, the NYIC

has recorded two cases in 2008 where it seems immigration authorities were notified about a patient's status after it was revealed in the course of that individual's interaction with the health care system.

Example 1: One case involved a Chinese couple from Aurora, NY, in the Finger Lakes region. The couple was seriously injured when they were struck by a vehicle while crossing the street on their way home from work.¹⁰⁴ The Buffalo News reported that "U.S. Border Patrol went to the hospital, both to interpret and to determine the two victims' immigration status."

For the hospital to call U.S. Border Patrol for either of these reasons would be highly inappropriate (the hospital denied doing it, and the call may have emanated from the sheriff's department). First, under New York State's public health law, all hospitals are required to provide free interpretation services by a person who is qualified to interpret health-related information, by bilingual staff, contracted in-person interpreters, or contracted telephonic interpreters. Additionally, ascertaining a patient's immigration status information is completely irrelevant to providing medical services, especially treatment for injuries sustained in a car accident. Hospitals are obligated under the federal law Emergency Medical Treatment and Active Labor Act (EMTALA) to treat and stabilize anyone who presents with an emergency, regardless of ability to pay, insurance status, or immigration status. Ascertaining the patient's immigration status is necessary to screen for public health insurance eligibility, but regardless of an individual's status, there are state and federal reimbursement streams available to a hospital to help cover that person's care—whether the person is eligible for Medicaid, Emergency Medicaid, or Indigent Care Pools to subsidize the hospital's financial assistance program.

Example 2: The second case involved an undocumented, limited-English proficient Korean family in Englewood, New Jersey. The father, who was admitted to the hospital for treatment of cancer, was asked at registration, and truthfully responded, that he and his family had neither insurance nor green cards. He listed one of his adult daughters as an additional contact person. The week he was admitted, three uniformed USICE officers appeared at the daughter's house and detained both her and her sister. It appears likely that a hospital worker contacted USICE about the family's status.¹⁰⁵ With help from a lawyer referred by American Friends Service Committee, the daughters met bail and were released while the father was in the hospital being treated for tuberculosis and undergoing surgery for cancer.

Such betrayals of trust only instill fear in immigrant communities of using health services. They compound the general confusion immigrants have about using health care services. There is confusion about to what services immigrants have a right, and specific fear that immigration status information will be shared with immigration authorities and could result in being deported and separated from one's family. For example, an undocumented Haitian woman worried that she might not be able to obtain prenatal care due to her immigration status.¹⁰⁶ Others wondered where they could go to seek medical care if they had no documents proving their identity, or whether they could seek medical care without getting in trouble if they have an expired work permit.¹⁰⁷

Example 3: As with other barriers or perceived barriers mentioned in this report, concerns about the consequences of presenting as an undocumented immigrant cause some individuals to avoid care completely or to not apply for public insurance for which they may be eligible.

A Mexican woman interviewed in 2004, for example, said she had heard that if an unauthorized immigrant goes to a hospital, she will be reported to USICE and deported.¹⁰⁸ In June 2008, a man who went to an emergency room in New York City for treatment of kidney stones was afraid to apply for Emergency Medicaid because he feared his immigration status would be reported to USICE and he would be

deported.¹⁰⁹ A Peruvian woman said that she had heard that hospitals simply will not see patients who speak a language other than English, or who “don’t have the right documents, or if you don’t have Medicaid,” and that is why she does not go to the hospital. She said, “I have never had the urge to find out. ... You know, sometimes that is scary.”¹¹⁰

Rules Protecting Confidentiality

The rules governing hospitals, health care facilities, and social services offices prohibit sharing an immigrant’s status with any other agency, except when it is necessary to verify the individual’s immigration status for the purpose of determining eligibility for a benefit such as Medicaid. But this policy and procedure is generally not communicated clearly to individuals seeking services. Often, very personal questions about an individual’s identity, income, and SSN are asked at an individual’s first interaction with a health care facility, and with little or no explanation. The information is needed so that the provider can determine how the individual’s care is going to be reimbursed, whether through a public insurance program, with assistance from the facility’s financial assistance program, or billed fully to the patient. Particularly if the patient does not speak English well, these explanations are often simply not communicated and the individual is in a vulnerable position, unsure of how his or her personal information will be used.

Health advocates report challenges in their efforts to reassure clients about the safety of using health benefits and its effect on immigration status. A health advocate working with the South Asian community relates his lack of confidence and inability to guarantee safety, “...I let them know that technically it’s not going to happen, but... I just wonder. Even today, I was like, ‘yeah, [the agency] is not supposed to [report you], but then they end up doing things that they aren’t supposed to do... So I usually say there’s no hundred percent guarantee for anything. But we have never heard about anyone being arrested or denied for these things.”¹¹¹

It is no small wonder that there would be such concern. The programs for which immigration status is a criterion of eligibility are closely intertwined with programs for which there is no such eligibility criterion, and the same agencies may be gathering information for both types of programs. There is inconsistency between laws which require protection of sensitive immigration-related information and laws which could be interpreted to require divulging of such information.

Laws Governing Social Security Numbers and Immigration Status

There are two principal categories of information regarding immigration status which may be of concern to immigrants:

1. Direct representations about immigration status and proof, through green cards and other documents, of one’s legal status.
2. Social Security numbers (SSNs), the absence of which may be taken, incorrectly, as evidence of lack of legal status.

When a specific immigration status is a criterion of eligibility for a public program the applicant is required to prove his or her status and to provide a SSN so income or other verifying information can be checked. Such disclosure is required for Medicaid and Family Health Plus (FHP). Proof of immigration status is not required for emergency Medicaid, Child Health Plus, Prenatal Care Assistance Program (PCAP), and charity care provided under New York’s 2007 Hospital Financial Assistance Law.¹¹² However, the hospitals which submit applications for emergency Medicaid and consider applications for sliding scale financial assistance

should first screen the individual for eligibility for regular Medicaid. For the latter programs the enrolling agencies must make judgments about income, and will often request an individual's SSN.

There are different rules applicable to SSNs and to other immigration related information.

Federal Laws

PRIVACY ACT: The federal Privacy Act of 1974, at Sec 7a¹¹³ prohibits states from denying an individual any benefit based on his or her refusal to disclose a SSN unless the disclosure is required by federal statute. The law permits states to request the voluntary disclosure of SSNs, provided the voluntary nature of the response and the use to be made of the information is disclosed.

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) requires public hospitals, private health care providers, health plans and Medicaid administrators (covered entities under the law) to hold broad categories of "Protected Health Information"(PHI) as confidential. Immigration related information unrelated to health has no similar specific federal statute protecting its confidentiality. The Privacy Rule promulgated by the Department of Health and Human Services¹¹⁴ to implement HIPAA legislation defines PHI as individually identifiable information, including demographic data, which relates to the individual's past present or future physical or mental health or condition, the provision of health care to the individual, or the payment for that care. Whether a patient's immigration status, taken on its own, would constitute PHI has never been determined by a court.¹¹⁵ A statement in a medical record which links a person, his or her immigration status, and medical treatment would clearly constitute PHI and could not be disclosed unless under circumstances authorized by HIPAA.

HIPAA's protections and the potential points at which they might lose force become particularly uncertain when dealing with new sorts of entities that may soon assume much greater roles in health coverage enrollment. "Connector" entities were not well defined concepts when HIPAA was enacted. HIPAA does apply to health care clearinghouses, these are defined as entities like billing services that process non-standard information into standard data formats or transactions.¹¹⁶ It seems unlikely that that definition would extend to connectors like facilitated enrollers (especially community-based organizations that are not agents of health plans but enroll people in them), or Massachusetts' state run Connector, or New York's nonprofit HealthPass.

SOCIAL SECURITY ACT: Beyond HIPAA, the Social Security Act, §1902(a)(7), requires that state Medicaid plans safeguard the use and disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.¹¹⁷ This limitation is echoed in regulation.¹¹⁸

PRWORA and IIRAIRA: Both PRWORA and IIRAIRA¹¹⁹ contain provisions invalidating any laws or rules that would prohibit government agencies from sending information to or requesting information from federal immigration authorities regarding the immigration status of an individual. Federal agencies have clarified that notwithstanding these provisions, information about Medicaid applicants/recipients remains confidential and should not be shared for purposes that are not directly related to the administration of the Medicaid program or plan.

Centers for Medicare and Medicaid Services (CMS) Guidelines. As described more fully below, since 2000 CMS has instructed state Medicaid programs not to seek social security numbers or immigration status information from non-applicants for coverage, including parents of applicant children, except to the limited extent necessary to verify income.

New York State Laws and Regulations

STATE MEDICAID IMPLEMENTATION: New York State law has provisions parallel to the Social Security Act restricting the ability to use and disclose information obtained in the Medicaid application process to purposes directly connected with administering the Medicaid program.¹²⁰ Further, to ensure compliance with HIPAA, the State Department of Health has restricted access to PHI only to certain limited categories of employees.¹²¹ To implement the Medicaid rules restricting dissemination of information about Medicaid applicants, the State Office of Medicaid Management has specifically prohibited the State Medicaid Office and local district social service offices from providing information about receipt of benefits or amount of benefits to USCIS, the State Department, or immigration judges, unless such information relates directly to administering the Medicaid program.¹²²

PHYSICIAN-PATIENT PRIVILEGE RULES: Another state rule of general application with respect to private information in the medical context is New York's physician-patient privilege.¹²³ The rule protects from disclosure information obtained by health care providers, which the patient intends to be confidential, if that information was acquired through the application of professional skill or knowledge in the course of a physician-patient relationship and is necessary for the physician to treat or diagnose the patient.¹²⁴ A broader rule, that of the American Medical Association Code of Medical Ethics, does provide more generally that "information disclosed to a physician by a patient should be held in confidence" unless the patient expressly consents to disclosure. That rule could protect immigration status information in the possession of a physician.

NEW YORK CITY EXECUTIVE ORDERS: New York City in 2003 adopted Executive Orders 34 and 41, limiting City officers and employees from inquiring about individuals' immigration status and prohibiting them from disclosing immigration status to any person or entity unless related to suspicion of illegal activity (not including unlawful presence), or necessary to determine eligibility for programs or services or if required by law.

These executive orders take this form because the federal courts held that an earlier version, Executive Order 124, first issued in New York City in 1989, prohibiting City officials and agencies from voluntarily disclosing immigration status to USICE, was invalid as an attempt to undermine a particular federal policy in an area appropriately regulated by the federal government. The Second Circuit Court of Appeals held that a state or one of its subdivisions did not have the power to do this under the U.S. Constitution.¹²⁵

Executive orders 34 and 41 are thus broader than their predecessor. They appear to meet the objections voiced by the Second Circuit because they do not target the federal enforcement process. However, federal authority over immigration might well be deemed so broad that it preempts any law which even has an indirect effect of frustrating federal enforcement efforts.¹²⁶ Nonetheless outreach and education to immigrant communities about the EOs have not only helped to alleviate immigrants' fears about interacting with city agencies but have also helped to reinforce similar policies at individual city entities, such as Health and Hospitals Corporation, New York City's public hospital system.

Gaps in the Rules

Thus, there are several overlapping rules which seem to have either the intent or the likely effect of protecting individuals who apply for or use public programs from having their immigration status disclosed to agencies charged with enforcing the immigration laws. While these rules should reduce the risks for those who lack status if they interact with the health coverage system, it is possible to identify several potential gaps in that protection, including:

- ambiguity about whether information regarding immigration status is protected as health information;
- the legal transfer of information from HIPAA-covered programs to public programs not covered by HIPAA's confidentiality restrictions;
- the possibility that state and local laws restricting the disclosure of information about applicants for or enrollees in coverage might be deemed unenforceable in light of federal statutes that seek to encourage the flow of information about immigration status to enforcement authorities.

Threats to Confidentiality

In addition to these threats to confidentiality arising out of the structure of the rules, there are threats arising out of the application of rules in real life. When public programs or private insurance plans request SSNs, they may not always clearly convey, especially to people of limited English proficiency, the voluntary nature of the disclosure. They may thereby deter applications from eligible enrollees.

Similarly, an applicant whose own immigration status is not an impediment to eligibility may face requests for disclosure of information regarding other family members who may have concerns about disclosure of immigration information. U.S. citizens or lawful permanent residents eligible for public programs may live in families with others who are undocumented, for example, and may avoid applying for coverage if they fear information about those family members will be revealed. The likelihood of confusion is particularly high when enrollment in programs like Temporary Assistance for Needy Families (TANF or cash assistance) and Food Stamps, based on household units, is joined with enrollment in programs based on individual eligibility, like Medicaid and Child Health Plus, undertaken by a single agency with a single application form.

Federal Efforts to Address Threats to Confidentiality

To address this problem, the Centers for Medicare and Medicaid Services (CMS), beginning in 2000, issued guidance to the states regarding the application process for public benefits. Although no specific statute addressed the solicitation of immigration information, CMS strongly suggested that states would run afoul of Title VI of the Civil Rights Act, prohibiting discrimination based on national origin, if they demanded disclosure of immigration status or SSNs from non-applicants for coverage unless federal law required them to obtain that information. With respect to children applying for Medicaid and Child Health Plus, the guidance emphasized that states could not require non-applicant parents to disclose their immigration status or SSNs as a condition of enrolling the child. While states could request parental SSNs to verify family income, they would have to make clear that the disclosure of SSNs is voluntary, that the SSNs could only be used to verify income, and that their failure to provide the SSNs would not affect the eligibility of an otherwise eligible child.

States with consolidated application forms were advised to restructure the forms to avoid seeking immigration information or SSNs from family members who were not applying for benefits, and to make clear that such information, when sought, would not be shared with federal immigration authorities.

The above guidance reflects the federal government's recognition that failure to protect information regarding immigration status could discourage enrollment among populations who need the most encouragement to enroll. But because the federal government's voice on this issue has hardly been monolithic, with a far less solicitous attitude about protecting information outside the context of health programs, immigrants are still understandably wary about any programs which request information that might in some way reflect immigration status.

Existing Remedies

The remedies for breaches of confidentiality under the rules described above are limited. In most cases, individuals cannot sue to collect damages if their privacy rights are breached. Enforcement is principally through public authorities:¹²⁷

Federal Law

- HIPAA provides no private right to sue if personal health information is disclosed in violation of the law's restrictions.¹²⁸ Only the Secretary of Health and Human Services can pursue civil penalties. Criminal punishment is possible as well for intentional disclosures of PHI, and disclosure under false pretenses,¹²⁹ but again this does not imply a private claim would also be available even for intentional violations. Indeed, the presence of criminal penalties is likely to suggest to a court that other enforcement mechanisms, such as private rights of action, have been deliberately left out. The scope of covered entities under HIPAA may also not be broad enough to cover all situations in which individual immigration related information is divulged.
- Title VI of the Civil Rights Act does provide a right to sue for damages for intentional discrimination based on national origin. However, individuals cannot sue for damages if there is simply a discriminatory effect (such as discouraging immigrants from enrolling in coverage) as a by-product of such acts as gathering information about social security numbers for income verification. If a hospital receiving federal funding were to demand disclosure of SSNs by patients it would likely violate CMS guidelines because it would lead some immigrants to avoid availing themselves of hospital services, but there would be no private right to sue to enjoin this practice.
- The Federal rules that require state Medicaid plans to safeguard information regarding applicants and to use and disclose such information only for purposes "directly connected with the administration of the plan"¹³⁰ and parallel state rules¹³¹ also provide no explicit private claim for violations. Federal agencies could deal with breaches by the state through withholding of funding or other penalties, while the state could discipline employees who violate the rules.¹³² Private claims against agencies or public employees that violate the rules are unlikely to be recognized.¹³³

State and local laws

- New York City Executive Order 41, discussed above, permits individuals whose confidential information has been disclosed in violation of the order to complain to City government or to a hospital regarding the violation. There is no explicit grant of a private claim for violations, however, nor a clear enforcement mechanism.
- The American Medical Association Code of Medical Ethics, which provides that "information disclosed to a physician by a patient should be held in confidence" unless the patient expressly consents to disclosure, is enforced through physician disciplinary proceedings before the Office of Professional Medical Conduct. This procedure does not provide for private damage claims against physicians.

Recommended Policy Changes to Increase Enrollment

Federal

- USICE should create a policy that safeguards individuals whose status was documented or reported while seeking health care services or benefits for themselves or their children from detention actions or removal proceedings, except in cases where the individual is suspected of illegal activity other than mere status as an unauthorized immigrant.

- The provisions of the Social Security Act with respect to requesting SSNs for public program eligibility or services should be strengthened. Rather than leave it to state discretion whether to request SSNs in circumstances where it might dissuade otherwise eligible applicants from enrolling, requests for SSNs should be prohibited in such circumstances. "Voluntary" disclosures of SSNs should require written acknowledgments from the individual that he or she was advised of the voluntary nature of the disclosure and should specify on the form what uses will and will not be made of the information. A rule should preclude use by USICE or other immigration authorities of any immigration related information obtained in the course of an application for health plan enrollment or use of health plan benefits.
- HIPAA should be clarified to establish without a doubt that immigration related information, including Social Security numbers, constitutes protected health information (PHI) for applicants and enrollees in coverage. The law should be amended to subject connector and exchange entities HIPAA's restrictions on disclosure of information, given their increasingly significant part in the enrollment process and their likely far greater role under federal health care reform.

State

- The State should edit its guidance to Medicaid offices entitled "Reporting Immigrant Status and Disclosure of Medicaid Benefits Information" (General Information System Message (GIS 04 MA/014), dated 07/22/04, to accurately reflect federal guidance on the same issue. This guidance was written in response to the problem mentioned in another section of this report of women who had previously been Prenatal Care Assistance Program (PCAP) beneficiaries being wrongly denied visas to enter the U.S. because the consular officer wrongly determined them to be public charge. In response to inquiries as to whether the NYS DOH had disclosed information about Medicaid beneficiaries with USCIS or foreign consulates, the Office of Medicaid Management issued GIS 04 MA/014 to "clarify the law with respect to the disclosure of information about an individual's receipt of Medicaid benefits [and] also describe why the New York State Department of Health generally may not accept payment from individuals who attempt to repay the State for Medicaid benefits." The GIS states on page 2:

New York State policy is that the Local Department of Social Services (LDSS) should never report an applicant to USCIS. The only exception to this rule, however, is that if USCIS has issued a final order of deportation and the LDSS sees this order, the LDSS must report the individual to the USCIS.

The GIS, as written, does not account for the differences, as defined by the Federal government, between handling of Medicaid and public assistance applications, specifically that there are no reporting requirements for Medicaid. Accordingly, the "exception" in GIS 04 MA/014 should be rewritten to accurately reflect the Federal government's longstanding position that no reporting of any kind is required of persons enrolling in Medicaid.

- Confidentiality protections modeled on New York City's executive orders 34 and 41 protecting personal information from disclosure by public employees who maintain such information should be imposed statewide by executive orders or regulations. In general, such statewide policies would improve overall public safety as it could encourage victims and witnesses to report crimes and may protect immigrants' access to general state services in their communities. A statewide policy would also reinforce policies and practices at health care facilities and benefit-granting agencies. The State could impose more explicit and meaningful penalties on public employees who violate confidentiality rules. The state's best interests are protected when immigrants do not have to fear every contact with state authorities will lead to questions about their immigration status. In the spirit of ensuring equal access for all New Yorkers, this

policy would also restore confidence in those residents living in “mixed status” families to access general and public safety services without endangering a family member’s status.

Agency

- In the interest of preserving public health, fulfilling their missions to provide care to everyone in their communities, and allaying fears of accessing health care among one of the most vulnerable communities, health care providers and benefit granting agencies should create clear, simple confidentiality policies that reassure immigrants about the privacy of all their information. New York City’s Health and Hospitals Corporation’s (HHC) confidentiality policy and resultant outreach to immigrant communities are best practices worth emulating, and have resulted in widespread acknowledgment within immigrant communities that it is safe to go to HHC. Immigrants’ recognition of these policies has been evident at presentations conducted for immigrant-serving CBOs and community members. Participants acknowledge that HHC will not turn anyone away because of their immigration status, and will not report patients or their families to immigration authorities.
- In addition to cultural and linguistic competency training, consistent training of all front-line staff at health care providers and public benefit agencies is needed around immigrants’ unique concerns. Such training would help ensure that all patients are treated with patience and respect, and that appropriate time is taken to explain the complicated process for getting access to care and applying for insurance or affordable health care at hospitals and clinics in New York State. Training of front-line staff should be the responsibility of the health care providers and public benefit agencies, with supervision by the State Department of Health.
- Finally, more direct advertising to immigrant groups should be used to advise them of their confidentiality rights and that SSNs and other confidential information elicited through the process of enrolling in health plans will be protected and not shared with immigration authorities. The agencies performing the enrollment, whether they are public agencies or contracting private health plans, should be responsible for the advertising.

IV. Cultural, Linguistic, Agency, and Navigational Barriers

A. Cultural and Linguistic Barriers

Immigrants’ lack of familiarity with the U.S. health care system and other navigational issues are additional barriers to their participation in the health care system. Depending on the health care systems in their countries of origin, immigrants may be unfamiliar with either the U.S. system based on private purchase of coverage for health needs or with the U.S.’s patchwork system of health services and insurance or payment options.¹³⁴

Linguistic barriers are the most highly documented barriers to coverage, and to health care in general, for immigrants and other limited-English proficient (LEP) individuals. Despite years of intense advocacy by the NYC and its Health Collaborative and historic changes in local and state law, language barriers at hospitals and public benefits offices remain insurmountable and life threatening for many New Yorkers. In New York, linguistic barriers confront a huge number of people—2.3 million people (13% of the State’s total population), including 1.8 million New York City residents, (one-quarter of the NYC population) are limited-English proficient (LEP) and do not speak English well enough to navigate the health care and coverage system in English. Moreover, LEP individuals account for 42% of New Yorkers below the poverty level.¹³⁵

Particularly at public benefits offices, clients routinely complain of being treated with disrespect because they do not speak English well—told they will not be served in their own language, scolded for not speaking English fluently (e.g. told they need to learn English or told to bring their own interpreter), or worse, blatantly ignored—all of which cause individuals to feel embarrassed, humiliated, upset, and unwilling to return. One health advocate from the Arab community insists on accompanying each of his clients to the local Medicaid office in Queens so as to shield them from the mistreatment they often face at the office.¹³⁶

The NYC and its partners in the Health Collaborative have documented the persistence of language barriers for years and have led advocacy efforts that have resulted in policy achievements at both the state and local levels that serve as national examples. Therefore, this report will not focus on additional examples of language barriers, or policy recommendations.¹³⁷ Numerous federal, state and local laws require government agencies, including Medicaid offices, as well as health care providers and pharmacies to provide free interpretation and translation services for their clients, patients, and customers. These laws include regulations adopted in 2006 requiring all hospitals in New York State to provide free language assistance services to any patient who has limited English proficiency,¹³⁸ State laws also require health care insurers and health maintenance organizations to ensure beneficiaries' access to culturally and linguistically competent care.¹³⁹ New York City Executive Order 120 requires all city agencies to be accessible to all limited-English proficient New Yorkers.¹⁴⁰ New York City Local Law 73 requires language assistance services at HRA offices. There are also laws requiring immediate provision of interpreters in all New York City emergency rooms,¹⁴¹ and requiring language assistance services at all chain pharmacies in New York City,¹⁴² not to mention protections at the Federal level which date back to 1964.¹⁴³ While this report will not focus on additional examples of language barriers, or policy recommendations to address them,¹⁴⁴ it is incumbent on us to point out that there are still serious issues to be faced in implementing these laws. Serious communication barriers persist and result in medical harm and poor quality care, despite the existing laws.

Leadership is needed at all levels, including at the regulatory level and service delivery level, to ensure better compliance with these existing laws by all health care providers and benefits agencies. Without such compliance, over 2 million limited-English proficient New Yorkers will never have meaningful access to health care and coverage in New York State, and will be forced to delay care or insurance coverage or forego them altogether. Linguistic accessibility is every bit an important aspect of quality care as any other measure. It follows that universal health care in New York is possible only if full linguistic accessibility is also achieved.

National data paint a very similar picture, though much of the research outside of New York concentrates on Spanish-speakers. For example, researchers Gabrielle Lessard and Leighton Ku also identified language and cultural barriers as foremost barriers to coverage for immigrant children.¹⁴⁵ In another study about the perceptions of Latino parents, language was again chosen as the greatest single barrier to health care.¹⁴⁶ In a national survey conducted by Michael Perry and other researchers, nearly half of Spanish speakers (46%) reported they did not complete the enrollment process for Medicaid because the forms and information were not translated into their language, while half reported that the belief that application materials would not be available in their language discouraged them even from trying to enroll their child.¹⁴⁷

Possible Policy Changes to Increase Enrollment

- Federal, state and local governments should support community-based outreach, education and navigation programs that are culturally and linguistically appropriate.
- Federal, state and local governments should enforce language access laws, regulations, and policies, and provide resources and centralized tools (e.g. translated applications and outreach materials accessible online, assistance with testing and certification of bilingual staff) to providers and agencies that interact with the public to help them comply with laws and provide quality services. Government at all levels should provide incentives to providers and public agencies based on performance and best practices.

B. Agency Failures to Follow Eligibility Rules

Immigrant eligibility for public insurance programs in New York State is much more expansive than in many other states across the country, thanks to a combination of effective advocacy by communities and proactive public policy by elected officials.

Eligibility workers must understand complicated information about dozens of types of immigration statuses, the various types of documentation that an immigrant may present to prove their status, as well as the administrative procedures necessary to verify status and obtain federal financial matching dollars when possible. Efforts in New York State to simplify and streamline the application process for public insurance programs are sometimes at odds with federal provisions such as recent guidelines that citizens must document their citizenship status by providing original documentation such as an original birth certificate. The documentation guide used by Medicaid eligibility workers for determining whether an individual meets the citizenship and immigration status requirements for Medicaid and FHP in New York State is now 12 pages long, illustrating the complex knowledge required to implement the program well.

Considerable training of New York City Human Resources Administration and county Local Departments of Social Services (LDSS) front-line and eligibility determination staff is necessary to fully understand immigrant eligibility, to recognize the many different types of documents an individual may present to prove their status and eligibility, and to thereby reduce inappropriate denials of coverage. It is distressing that immigrants are still denied Medicaid and other public benefits because workers do not understand, or choose not to comply with, the eligibility rules allowing lawfully present immigrants to enroll.

For instance, community-based members of the NYC Health Collaborative recently reported that PRUCOL immigrants have been turned away from HRA and hospital-based Medicaid offices in Queens and told they are not eligible because of their immigration status.¹⁴⁸

In addition, Collaborative advocates report that the same offices have turned eligible applicants away because they did not have a Social Security Number.¹⁴⁹ In another example on Long Island, an eligibility worker told an applicant that no one over age 21 may apply for Medicaid without a Social Security number, not even refugees or victims of trafficking.¹⁵⁰ In fact, not only is it possible for an individual to be both eligible for Medicaid and not eligible for a SSN, the DSS worker should assist an individual to apply for a SSN and obtain proof of his application, even if he is not eligible for a SSN. A classic example is a woman with appropriate status (PRUCOL) who presented a valid Employment Authorization Document (EAD, or work permit) and was in the process of obtaining lawful permanent residency, and who was told by a Medicaid eligibility worker that she was not eligible because she “had no legal status.”¹⁵¹

There has also been a failure to recognize that information necessary to obtain federal financial participation in Medicaid is not essential for an individual to have the right to enroll in the state’s Medicaid

program. For example, the Medicaid application requires an immigrant's date of entry into the U.S. and the date the immigrant obtained a qualified immigration status in order to obtain federal financial participation for that beneficiary's enrollment. However, that information has no bearing on an individual's eligibility for coverage—New York offers coverage to lawfully residing immigrants within their first five years of residence, using state-only funds to do so. Nonetheless, a private insurer contracted to provide Medicaid disenrolled 130 children from coverage because these dates had been left blank on children's applications.¹⁵²

At a training provided to LDSS workers on Long Island, eligibility workers admitted to denying applications if applicants submitted old or "expired" documents proving their immigration status (e.g. an "expired green card" form I-155 and I-151).¹⁵³ Lawful permanent residency is a type of immigration status that does not "expire," even though the card does, and the NYS Department of Health has issued specific guidance making it clear that "expired" green cards are an acceptable proof of immigration status.¹⁵⁴ Immigrant applicants are obliged to provide the best documentation of their status that they have. LDSS workers may verify an applicant's immigration status with USCIS, but only in circumstances when clarity is needed. In the example above, since lawful permanent residency is a type of immigration status that does not expire, not only should an "expired" permanent residency card be sufficient proof of status, further verification from USCIS would be superfluous. Such blatant failures of county-administered public benefits offices to adhere to the law result in a direct increase in the number of uninsured residents of New York State.

Finally, unduly long delays processing applications for public health insurance, perhaps because of immigration issues, can have both health consequences for the individual awaiting coverage, and other life-changing consequences. In a case from Urban Justice Center in September 2008, a client and his family returned to their home country of Pakistan to avoid medical bills for needed care while the patient's application for Medicaid coverage was pending. Long Island Department of Social Services delayed their Medicaid determination for over 6 months, in violation of the law.¹⁵⁵ Another enroller expressed frustration that despite being a "great help," a program like Emergency Medicaid often will not notify an applicant of their eligibility until six months after she applies.¹⁵⁶

C. Navigation Problems

The last large set of enrollment obstacles have to do with problems individuals have navigating the complex insurance application, recertification, and managed care bureaucracies,¹⁵⁷ as well as immigrants' general lack of awareness about their options to enroll in insurance. In one case, inadequate information about her rights to health insurance led a pregnant Yemini woman and her family remained uninsured for seven months despite having legal status and being qualified for Medicaid.¹⁵⁸

Health advocates from the NYC's Health Collaborative report that community education presentations regularly elicit questions about what options are available—e.g. whether an undocumented immigrant has a right to get medical care, if there is any relief from unaffordable medical bills,¹⁵⁹ what kinds of immigrants are eligible for public health insurance,¹⁶⁰ and how to obtain health care if uninsured.¹⁶¹

It is not surprising, given the myths perpetuated in the media about undocumented immigrants' "unlawful" use of benefits, that undocumented immigrants in New York would not realize that at least their U.S. citizen children would be eligible for insurance, as documented recently by advocates at Filipino American Human Services Inc. (FAHSI).¹⁶² Community-based advocates, who are culturally and linguistically accessible, and who educate their communities and help them navigate the health care and coverage

systems, play a vital role in bridging this gap. To illustrate, an elderly Filipino couple in Queens who are lawful permanent residents and eligible for Medicaid because of their lack of income, would have remained uninsured as they had been for years because they did not know they were eligible for any assistance, but were assisted to enroll in affordable coverage at FAHSI.¹⁶³

Recommended Policy Changes to Increase Enrollment

- The New York State Department of Health should provide consistent and in-depth training to front-line public benefits and Medicaid enrollment staff on immigrant eligibility, immigrant concerns, and cultural and linguistic sensitivity.

CONCLUSION

Lack of health coverage among immigrants clearly has many causes for which a variety of potential solutions can be envisioned. It is anomalous, indeed, that as the federal government has debated universalization of health coverage throughout 2009 and early 2010, lawmakers have not at the time of this writing yet endorsed removing the restrictions in Medicaid and Medicare for lawfully residing immigrants. While advocates and immigrant communities have been fighting to restore fairness to legal immigrants since 1996 and it remains a main priority for these groups during the federal health reform debate, it is also worthwhile to remember that not all the restrictions on immigrant coverage are rooted so directly in federal legislation.

Without legislation, federal health officials can undertake such reforms as adopting regulations to prohibit mere enrollment in public health coverage from being used as a basis for a public charge finding. They can publicize the policy goal of enrolling everyone in coverage and reassure immigrants that their information will not be misused.

At the state level, provided federal reform leaves states room to expand coverage above and beyond the federal baseline, the State can do much to include the vast majority of the immigrant population in its expansion plans. Again, any regulatory changes will require simultaneous linguistically and culturally competent public education, in an intensive and thoughtful way, to obtain optimal results.

Regardless of these efforts, there is likely to be a residual immigrant population without coverage even after “universal” health coverage is achieved. For that population, it is essential that a robust safety net of medical providers be maintained and adequately funded.

Reaching immigrants is the key and the biggest challenge to achieving truly universal health coverage. Recognition that there are policy and practice changes that can indeed reach them and incorporate them into a system is the first step toward meeting that challenge.

GLOSSARY OF IMMIGRATION TERMINOLOGY

asylee: a foreign-born individual in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Asylees are eligible to adjust to lawful permanent resident status after one year of continuous presence in the United States. These immigrants are limited to 10,000 adjustments per fiscal year.

citizen: includes both native-born and naturalized citizens.

immigrant; foreign-born: individual residing in the U.S. who was born in another country.

lawful permanent resident (LPR, green card holder): Lawful permanent residents (LPRs) are foreign nationals who have been granted the right to reside permanently in the United States. In general, an immigrant must first adjust their status to lawful permanent resident before becoming eligible to apply to naturalize,

naturalized citizen: foreign-born person who was eligible to submit a naturalization application, and whose citizenship was approved by the Department of Homeland Security,

noncitizen: an immigrant who has not naturalized, including all lawfully residing immigrants who have not yet naturalized (e.g. LPRs, asylees, refugees), as well undocumented immigrants.

PRUCOL (Permanently Residing Under Color Of Law): PRUCOL immigrants are residing in the U.S. with the knowledge, permission, or acquiescence of U.S. Citizenship and Immigration Services (USCIS) and whose departure from the U.S. the USCIS does not contemplate enforcing. It is a term that is used only for public benefits eligibility and is not a type of status that is recognized by USCIS, rather it is used to categorize certain immigrants in a number of different statuses and circumstances that have been recognized by Immigration authorities;

refugee: an individual who is outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Refugees are subject to ceilings by geographic area set annually by the President in consultation with Congress and are eligible to adjust to lawful permanent resident status after one year of continuous presence in the United States.

undocumented, out-of-status, unauthorized, illegal immigrant: an immigrant who does not have permission to be in the U.S. It includes people who entered the country without permission and without being inspected by US Customs and Border authorities (50%-65%), as well as immigrants who entered legally on temporary visas (student, employment, visitor) and overstayed the authorized time period (25%-40%). About 10% are in a "quasi-legal" status—e.g. immigrants awaiting green cards, awaiting asylum, or who have a status that permits them to stay in the U.S., at least temporarily, while their case is resolved, such as extended voluntary departure, temporary protective status, etc.

U.S.-born or native-born citizen: an individual who was either born within U.S. territory or acquired citizenship through descent from a citizen.

ENDNOTES

1. Holahan, D. and Cook, A. "Characteristics and Health Insurance Coverage of New York's Non-Citizens," United Hospital Fund, July 2009. Figures are from the Urban Institute analysis of 2006 Annual Social and Economic Supplement to the Current Population Survey.
2. Throughout this document, the term *non-citizen* is used to characterize immigrants residing in the U.S. who have not naturalized. Non-citizens include immigrants who are living here lawfully, as well as those who lack legal status. Uninsurance rates are commonly derived using U.S. Census data which captures citizenship status, but not immigration status. See the Glossary of immigration terminology at the end of this Issue Brief.
3. Throughout this document, the terms *immigrant* and *foreign-born* are used interchangeably. People residing in the U.S. who were born in another country are defined as immigrants, regardless of whether they are citizens or lack legal status.
4. "Five Basic Facts on Immigrants and their Health Care," Kaiser Family Foundation. March, 2008.
5. Guendelman, S., Halpin Schauffler, H., Pearl, M. "Unfriendly Shores: How Immigrant Children Fare in the U.S. Health System," *Health Affairs*, January/February 2001, 258-266.
6. Ku, L. and Matani, S. "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs*, 2001, 20:1. 247-256.
7. Lessard, G., Ku, L. "Gaps in Coverage for Children in Immigrant Families." *The Future of Children*. (Spring 2003) 13(1): 101-115.
8. Cunningham, P., Artiga, S., "How Does Health Coverage and Access to Care for Immigrants Vary by Length of Time in the U.S.?" Kaiser Family Foundation, June, 2009
9. "2006 American Community Survey," Migration Policy Institute, <http://www.migrationinformation.org/datahub/acscensus.cfm#>, last visited November 1, 2008.
10. Dyssegaard Kallick, D. "Working for a Better Life: A Profile of Immigrants in the New York State Economy," Fiscal Policy Institute, November 2007.
11. *ibid.*
12. Note that in an analysis by Jeffrey Passel of Pew Hispanic Center for the FPI report: Dyssegaard Kallick 2007, he estimated 650,000 undocumented immigrants in New York. In a more recent estimate, Pew Hispanic Center estimates that in 2008 there were 925,000 undocumented immigrants in New York State. See Passel J. and Cohn, D., *A Portrait of Unauthorized Immigrants in the United States*, Pew Hispanic Center, April 2009. The statistic cited here is from Holahan and Cook 2009 to be consistent with data cited from the same report on coverage rates of New York's noncitizens, and is also derived from imputations designed for the March 2006 *Current Population Survey* by Jeffrey Passel.
13. Estimates of the unauthorized are based on data from Census and Current Population Surveys. Because the Census Bureau does not ask people their immigration status, the estimates are derived using a methodology that essentially subtracts the estimated legal-immigrant population from the total foreign-born population. The residual is treated as a source of data on the unauthorized immigrant population.
14. Analysis by Jeffrey Passel of Pew Hispanic Center for the FPI report: Dyssegaard Kallick, D. 2007.
15. Holahan and Cook 2009
16. *ibid.*
17. *ibid.*
18. Holahan and Cook 2009.
19. Holahan and Cook 2009.
20. Alker, J. and Ng'andu, J. "The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer," The Kaiser Commission on Medicaid and the Uninsured, June 2006.
21. Ku, L. "Why Immigrants Lack Adequate Access to Health Care and Health Insurance," Migration Policy Institute, September 2006.
22. Capps, R., Kenney, G., Fix, M. "Health Insurance Coverage of Children in Mixed-Status Immigrants Families." *Snapshots of America's Families*, 3:12, 2003.
23. Holahan and Cook 2009
24. Dyssegaard Kallick 2007.
25. Alker and Ng'andu 2006.
26. *ibid.*
27. Alker and Ng'andu 2006.
28. Holahan and Cook. "Characteristics and Health Insurance Coverage of New York's Noncitizens." <http://www.uhfnyc.org/assets/651>
29. Fremstad, S. and Cox, L. "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance," The Kaiser Commission on Medicaid and the Uninsured, November 2004.
30. 96 NY2d 418 (2001). See <http://www.nilc.org/immspbs/health/health011.htm>. The statute enacted following the Aliessa decision is at Social Services Law §§ 122(1)(c)(ii) and 158(1)(g).

The court found that if states conformed their own coverage rules to the federal restrictions it would violate both the U.S. and New

York State Constitutions' equal protections clauses, as well as the state's mandate to provide for the aid, care, and support of the needy. In *Khrapunskiy v. Doar*, 2009 NY Slip Op 3761, the Court of Appeals recently seemed to undercut some of the rationale of *Aliessa*, holding that the State had no obligation to create a parallel program for aged, blind and disabled non-citizen New Yorkers to fill in the gap when they ceased to be eligible for federal SSI payments under the welfare reform law.

Section I of Article XVII of the State Constitution is worded quite broadly:

The aid, care and support of the needy are public concerns and shall be provided by the State and by such of its subdivisions and in such manner and by such means as the Legislature may from time to time determine.

The Court of Appeals has recognized the breadth of the affirmative obligation placed on the state as precluding the denial of aid to those determined needy on any basis other than the assessment of need. It has invalidated on that ground a state law imposing a "sponsor-deeming" provision (deeming an immigrant's sponsor's assets available to the immigrant) that would have potentially rendered a needy immigrant ineligible for home relief. Applying these holdings, at least one lower court has held that "This constitutional provision requires the State to come to the aid of all needy residents without regard to, *inter alia*, race, religion, sexual orientation or immigration status," thus requiring the provision of emergency shelter and financial assistance to an undocumented immigrant. Another lower court has invalidated a requirement that one reside in the state for 6 months before being eligible for Home Relief. Although federal immigration law says that states that bar unqualified immigrants from coverage will be deemed to have used the least restrictive method possible of encouraging immigrant self-reliance, thus insulating such rules from challenges based on the equal protection clause, New York's State constitutional mandate for care to the needy would not appear to recognize any permitted exception based on a policy promoting immigrant self-reliance. There does not, therefore, appear to be a compelling legal justification for excluding undocumented residents of New York from the State's own Medicaid program, even though they were not included in the plaintiff class in *Aliessa* and continue to be excluded by State statute from the category of eligible enrollees.

31. Public Law 111-3. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.pdf%20%20%20.

32. alien: neither a U.S. citizen nor a U.S. national (person from American Samoa or Swains Island). INA sec. 101(a)(3).

33. This requirement was upheld against constitutional challenge by the U.S. Supreme Court in *Mathews, Secretary of Health, Education, and Welfare v. Diaz et al.*, 426 U.S. 67 (1976). The court unanimously held that the federal government could legitimately premise participation in benefit plans like Medicare on citizenship. It also held that the government could, without violating the constitution, distinguish between aliens who had been here longer, and had therefore shown a commitment to the country more akin to citizens, and those who were newly arrived. It rejected the notion that dividing citizens from aliens and longer-term aliens from newcomers constituted invidious discrimination based on alienage, finding the federal government's power to make such distinctions arose from its prerogatives to conduct foreign relations.

States, however, do not have similar prerogatives to discriminate against aliens. In *Graham v. Richardson*, 403 U.S. 365 (1971) the Supreme Court overturned state laws that restricted benefits to citizens, holding that the ability to draw such distinctions between citizens and aliens belonged exclusively to the federal government. Once the federal government had determined to admit someone, that person was entitled to equal treatment by the states.

34. Weiner, B. "Community, Migrant and Homeless Health Center Handbook: Immigrant Eligibility for Publicly Funded Health Care Benefits," Community Health Care Association of New York State, Empire Justice Center, New York State Health Foundation, December 2008.

35. Gray, Finkelstein, et al.

36. Section 16D of chapter 118E <<http://www.mass.gov/legis/laws/mgl/118e-16d.htm>>: , (7) ... a person who is not a citizen of the United States but who is either a qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or is otherwise permanently residing in the United States under color of law shall be eligible to receive benefits under MassHealth Essential if such individual meets the categorical and financial eligibility requirements under MassHealth; provided further that such individual is either age 65 or older, or between age 19 and 64, inclusive, and disabled. Such individual shall not be subject to sponsor income deeming or related restrictions. Unlike many public benefit programs, MassHealth does not consider the immigrant's sponsor's income ("sponsor deeming") to be part of the immigrant's own income in determining eligibility for subsidies.

The funding for this coverage, however, has been a victim of Massachusetts's budget crisis, with hospice, dental and skilled nursing facility care being cut for immigrants. A. Goodnough, "Massachusetts Cuts Back Immigrants' Health Care", *New York Times*, August 31, 2009, http://www.nytimes.com/2009/09/01/health/policy/01mass.html?_r=1&scp=1&sq=Massachusetts%20immigrant%20health%20care&st=cse

37. Current state practice is to exclude from Medicaid persons such as students here on temporary residence visas, not because they are in unlawful immigration status but because they are by virtue of their temporary status not defined as residents. Even when such persons are in the process of adjusting to LPR status, and therefore qualify as "PRUCOLS" for purposes of the *Aliessa* decision, some counties refuse their enrollment in state-funded Medicaid.

38. Lessard, G. and Ku., L 2003.

39. Hill, I., Dubai, L., Kenney, G., Howell, E., Courtot, B., Palmer, L. "Improving Coverage and Access for Immigrant Latino children: The Los Angeles Health Kids Program." *Health Affairs*. Vol. 27, Num 2. March/April 2008. 550-559.

40. Flores, G., Abreu, M., Chaisson, C., Meyers, A., Sachdeva, R., Fernandez, H. Francisco, P., Diaz, B., Diaz, A., Santo-Guerrero, I. "A

Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." *American Academy of Pediatrics*. 2005. 1433-1441.

41. Pitkin, K., Escarce, J., Lurie, N. "Immigrants and Health Care: Sources of Vulnerability." *Health Affairs*, 2007, 26:5. 1258-1268.

42. There is an exception for certain people serving in the military, although in general, an individual must be a lawful permanent resident or U.S. citizen to serve in the military.

43. <http://www.dhs.gov/files/statistics/data/dslpr.shtm>. Last visited October 6, 2009.

44. http://www.migrationpolicy.org/pubs/FS18_FamilyImmigration_062007.pdf. Last visited October 12, 2009.

45. This differs from national data. Nationally, the second most common way someone obtains lawful permanent residency is through employer-based immigration. New York has a higher proportion of refugees and asylees than the rest of the country.

46. <http://www.uscis.gov>. Last visited October 12, 2009.

47. http://www.uscis.gov/files/nativedocuments/Permanent_Residents_%20Naturalization.pdf. Last visited October 12, 2009.

48. U.S. immigration law, as codified at 8 USC 1182(a)(4)(A), currently provides that:

Any alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible.

This provision has, in various modified forms, been a feature of American law for over 100 years. Earlier versions of this exclusion were connected with exclusion provisions for "vagrants" and "beggars."

49. 8 U.S.C. 1182(a)(4)(B)

50. There is some danger that long term care in general may be equated with public charge. As more long term care is moved into community settings, often enabling people with disabilities to support themselves, it will be important to educate immigration officials about the distinctions in types of long term care so that immigrants with disabilities who are unlikely to rely on public funds for subsistence are not wrongfully denied adjustment of status or entry.

51. *Perales v. Thornburgh*, 967 F.2d 798 (2d Cir. 1992).

52. *In re Longstaff*, 716 F.2d 1439 (5th Cir. 1983).

53. [52 Fed. Reg. 16209 \(1987\)](#)

54. NYC Health Collaborative Reports; 8/9/01, 4/2/02, 12/04, 8/07, 3/08, 4/08, 9/08.

55. NYC Health Collaborative Report, 10/08.

56. NYC Health Collaborative Reports, 12/04

57. Freij, M., J. Rejeske, A. Gurvitch, A. Ferrandino, and L. Weiss, "Mutual Responsibility": A Study of Immigrant Enrollment in Health Insurance in New York City." New York Immigration Coalition, February 2010.

58. *ibid.*

59. *ibid.*

60. *ibid.*

61. *ibid.*

62. NYC, Immigrant Health Access Survey, January 13, 2003.

63. Public charge fears are not unique to New York but are national in scope. In one study from 2000, principal investigator Kathleen Maloy interviewed 225 immigrants at four sites around the country: Chicago, IL; Washington, DC; San Diego, CA; and Brownsville, TX. The study concluded that the 1996 laws had led to diminished coverage among immigrants. The most striking finding was "the number of immigrants who don't access their legitimate use of Medicaid out of fear that it could jeopardize their ability to become a legal, permanent resident or U.S. citizen, and the frequent reports by non-citizen parents of their reluctance to access services for their citizen children out of fear of putting themselves or other non-citizen family members at risk."

A 1998 Urban Institute report on Los Angeles County, for instance, said "fear and confusion" about the changes have had a "chilling effect" on use of benefits for which immigrants remain eligible. From 1996-98, approved applications for welfare and Medi-Cal (California's Medicaid program) for families headed by noncitizens fell 52 percent; for citizen-headed families, there was no change. Another Institute study issued last March found much the same: use of public benefits, including Medicaid, by noncitizen households fell 35 percent from 1994-97 versus 14 percent for citizens.

Perhaps the most rigorous study of the effect of the 1996 laws on immigrant health enrollment was conducted by Kandula, et al, "The unintended impact of welfare reform on the Medicaid enrollment of eligible immigrants," in [Health Services Research](#). They noted a steep decline among "qualified" immigrants – those who under the law retained their eligibility for public programs after the new laws went into effect. They found that the decline in qualified immigrant enrollment rates persisted "after controlling for socioeconomic differences, state policy, and state unemployment," and that a "spillover effect" of the law was to deter already resident immigrants from enrolling despite the purported target of the law being future immigrants only.

Welfare reform may have raised fear in immigrants, resulted in misinformation about eligibility and how Medicaid affects applications

for citizenship (Feld 2000; Nolan et al 2000; Stuber et al 2000). Although policymakers claimed they only intended to deter the Medicaid enrollment of future lawfully residing immigrants, they appear to have deterred the Medicaid enrollment of immigrants already residing lawfully in the United States. Policies that attempt to target only a subset of a larger group may fail in their effort to be specific, and instead, have spillover effects to the broader population.

64. For the guidance, see <http://www.uscis.gov/files/article/Public.pdf>. Last accessed December 30, 2008.

65. 64 Fed. Reg. 28689, 28693 (May 25, 1999).

66. National Immigration Law Center, "Immigrant Friendly Health Coverage, Outreach and Enrollment," http://www.nilc.org/immspbs/health/Issue_Briefs/Immigrant-Friendly_App_Enrllmnt.PDF. Indeed, in 2006 one federal appeals court rejected the argument that use of Medicaid benefits should not be taken into account in determining the likelihood of an alien becoming a public charge. In Hernandez v. Gonzalez, 195 Fed. Appx. 43 (6th Cir. 2006), a decision which the court did not recommend for publication or to be relied upon as precedent, the court upheld the decision of an Immigration Law Judge to remove the petitioner based on, among other things, her use of Medicaid to cover the hospital bill for the birth of her baby. The court explicitly declined to follow nonbinding guidelines issued in May, 1999 by the Justice Department with respect to public health insurance coverage.

67. In each denial letter, the term "public assistance" is used incorrectly; the misunderstanding of the term may have contributed to the Immigration Services Officer's (ISO's) incorrect determination. Each letter refers to "Medicaid" or, in one case, "New York State hospital benefit"—presumably charity care or financial assistance—as "public assistance." In the public benefits sphere, "public assistance" is generally used to refer only to the cash assistance programs. In fact, New York Social Services Law clarifies that *public assistance* "...refers to family assistance, safety net assistance and veteran assistance." Social Services Law Section 2, subd. 19. The use of public assistance, as discussed, may indeed be a determinant of public charge, but in none of the cases had the applicant actually received cash assistance.

68. The NYIC reviewed nine cases of adjustment of status applications that were denied because the applicant was found to be, or found likely to be, a public charge based on the applicant's use of Medicaid or, in one case, New York State hospital benefits. The determinations were all based on adjustment of status interviews that occurred between April, 2006 and September, 2006. In seven of the nine cases, the applicant's use of Medicaid or hospital financial assistance was the sole reason cited for determining that the applicant was, or was likely to become, a public charge. In all cases the ISO (What is ISO? Please spell out.) specifically classified Medicaid or New York State hospital benefit as "public assistance" or "a form of public assistance." Source: NYIC archived cases, 7 USCIS adjustment of status denial letters stating "...you are currently receiving New York State Hospital benefit, the benefit that is considered as Public Assistance, therefore your application is hereby denied..." (5/5/06);

"...you have admitted and provided an evidence that you are currently receiving Government benefit such as: WellCare/Medicaid. A benefit that is considered as Public Assistance, therefore you are considered to be a Public Charge..." (5/31/06);

"...you admitted to receiving public assistance in the form of state funded health insurance (Medicaid). Accordingly, your application for adjustment status is denied..." (6/13/06);

"[the applicant] argues that the Immigration Judge wrongly relied on Petitioner's receipt of public funds to pay her hospital bills for giving birth to her infant child. ... Petitioner's prior public assistance did not form the only basis for the IJ's [Immigration Judge's] determination." (8/18/06);

"...you have been receiving Medicaid (a means tested form of income) since the year 2003. Because you have been and are currently receiving a form of public assistance provided by the government the Service finds you likely to become a public charge. Accordingly, your application for adjustment of status is denied." (9/11/06);

"Because you have been and are currently receiving a form of public assistance provided by the government, the Service finds you likely to become a public charge. Accordingly, your application for adjustment of status is denied." (9/14/06);

"You testified that you had started receiving support from Medicaid, for non-emergency medical care. Because you are currently receiving a form of public assistance the Service finds you likely to become a public charge. Because you have been found likely to become a public charge the Service has determined you to be inadmissible as per Section 212 of the Immigration and Nationality Act." (9/26/06).

69. To address the wrongful denials, the NYIC first queried a group of legal representatives, some of who were representing the denied applicants, advocates, and facilitated enroller lead agencies, to gauge the extent of the problem and to document known cases. Thomas Shea, an immigration attorney at the NYIC, and the liaison for immigration legal services representatives and USCIS, raised the issue at USCIS regional liaison meetings at the end of 2007 and was told USCIS would look into the issue.

Then, the NYIC, on behalf of 16 legal services agencies and facilitated enroller lead agencies, sent a letter to the District Director of USCIS on December 12, 2007, highlighting the wrongful denials, and arguing that: 1) health benefits should not be considered in public charge determinations, as consistent with USCIS national policy; 2) ISOs misunderstood which benefits in New York are classified as "means-tested" and "public assistance"; 3) these denials have created a chilling effect within immigrant communities which could jeopardize public health

70. On March 10, 2008 the NYIC received a response from the USCIS District #3 Director. The letter stops short of affirming the District's official policy, but indicates that the December 12, 2007 letter had been discussed "at length with the management staff in the District, including the Garden City, New York Field Office and with our local USCIS Chief Counsel staff." The letter states that both the Counsel and managers carefully evaluated the Council's recommendations "in light of implementing regulations and USCIS national policy, including public information previously released" and that District Adjudications Officers (now Immigration Services Officers) in the New York and Garden City Field Offices had received additional training on factors to consider when assessing the public charge

issue. Finally the District Director directs advocates to alert the District #3 office in case of additional cases and gives a specific fax number to contact. Advocates view it as a positive outcome that, in effect, affirms the 1999 federal guidance which states that an adjustment of status applicant cannot be determined to be a public charge for use of health benefits, including Medicaid and low-cost care at hospitals.

71. An application for adjustment was delayed because of an ISO request for additional information about enrollment in Medicaid. The immigration lawyer was instructed to share the case with USCIS District #3, as requested by the District Director in her March 2008 letter. It is not known whether the case has been resolved.
72. The NYIC convened the group mentioned above on January 28, 2008, February 26, 2008, and March 17, 2008 to discuss the recent developments and advocacy in more detail, and to develop up-to-date messaging on the issue for immigrants, facilitated enrollers, community-based advocates, immigration lawyers, and health care providers who may or may not condition billing negotiations on a patient's application for public health benefits.
73. This was the message of Q&A materials developed for community members in the past by the NYIC, entitled *Concerns about Public Benefits*, Appendix. Available online at www.thenyic.org.
74. http://www.nyc.gov/html/hia/html/public_insurance/faq.shtml#faq4 While the intention of the City's reassurance is appropriate, the failure to acknowledge the potential risks and nuances of the issue may diminish the effect of the reassurance, particularly when there is another trusted source of information, such as a family member or immigration lawyer, giving a very contrary message.
75. NYIC Health Collaborative Report, August 2008.
76. Feinberg E, Gardner J, Walker DK, Swartz K, Zaslavsky A. "Barriers to Medicaid Enrollment: Lessons from a State Initiative." *Abstr Acad Health Serv Res Health Policy Meet*. 2000; 17: UNKNOWN. Abstract Presented by: Emily Feinberg, R.N., M.Sc.
77. NYIC Health Collaborative meeting, 7/1/08.
78. NYIC Health Collaborative Report, 12/04.
79. Telephone call from affected individual "R." 4/23/04.
80. Telephone call from Legal Aid Society regarding 7/16/02 case. 5/6/04.
81. Case documented by Cabrini Immigrant Services. 4/28/04
82. *ibid.* pg. 56.
83. HHS, Health Care Financing Administration, Center for Medicaid and State Operations, December 17, 1997.
84. New Yorkers for Accessible Health Coverage and the New York Immigration Coalition, Connecting Immigrants to Commercial Health Coverage (June, 2009).
85. In 2007, of the nearly 1.1 million new LPRs, 47% were sponsored by an immediate relative of a U.S. citizen, 18.5% came through other family sponsorship; 15.4% were sponsored by an employer; 12.9 adjusted from a refugee or asylees status, and 4% were diversity lottery winners.
Terrazas, A., and Batalova, J. "The Most Up-to-Date Frequently Requested Statistics on Immigrants in the United States," Migration Policy Institute, December 12, 2008. For purposes of the immigration law, only parents, spouses and children, not siblings, are defined as immediate family members.
86. 8 U.S.C. 1183a
87. Terrazas, A., and Batalova, J. "The Most Up-to-Date Frequently Requested Statistics on Immigrants in the United States," Migration Policy Institute, December 12, 2008.
88. 8 U.S.C. 1183a(a)(1)(A)
89. 8 U.S.C. 1183a(f)
90. 8 U.S.C. 1183a(a)(1)(B)
91. Wiley, D. "Issues Affecting Access to Benefits for Immigrants: Sponsor Liability," National Immigration Law Center, December 2007. http://www.nilc.org/DC_Conf/dc-conf2007/wrkshp_materials/2-1_PBbarriers_dw_dj.pdf. Last accessed December 30, 2008.
92. 8 U.S.C. 1183a(b)(1)(A)
93. The federal statute provides that the Attorney General will adopt regulations to implement the reimbursement requests to sponsors. New York, despite having enacted a statute to clarify that Medicaid is a means-tested program subject to reimbursement requests, has informed the NYIC through personal communications that it awaits federal adoption of implementing regulations or guidance before enforcing the policy.
94. Ann Marie Somma, State Suing Immigrants' Sponsors; Controversy Centers on Public Assistance, *Hartford Courant*, March 1, 2007, at A1 <http://pqasb.pqarchiver.com/courant/access/1225313941.html?dids=1225313941&FMT=ABS&FMTS=ABS:FT&type=current&date=Mar+1%2C+2007&author=ANN+MARIE+SOMMA%3BCourant+Staff+Writer&pub=Hartford+Courant&edition=&startpage=A.1&desc=STATE+SUING+IMMIGRANTS%27+SPONSORS+%3B+CONTROVERSY+CENTERS+ON+PUBLIC+ASSISTANCE>
95. NYIC, Immigrant Health Access Survey, January 13, 2003.
96. Interview conducted in conjunction with an unpublished report by NYIC and NYAM, 2004.
97. NYIC Focus group, Staten Island, NY, December 9, 2008; NYIC Focus group, Flushing, NY December 18, 2008.

98. NYIC, *Immigrant Health Access Survey*, January 13, 2003
99. NYIC Health Collaborative Report, 2007.
100. NYIC Health Collaborative Report, 2002.
101. NYIC Case histories, ND.
102. Flores, G., Abreu, M., Chaisson, C., Meyers, A., Sachdeva, R., Fernandez, H. Francisco, P., Diaz, B., Diaz, A., Santo-Guerrero, I. "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children." *American Academy of Pediatrics*. 2005. 1433-1441.
103. Berk, M., Schur, C., Chavez, L., Frankel, M. "Health Care Use Among Undocumented Latino Immigrants," *Health Affairs*, Vol 19, Num 4.July/August 2000, 51-64.
104. Case submitted by Empire Justice Center, 11/15/07.
105. Case submitted by YKASEC Empowering Korean Communities, 2/21/08.
106. NYIC Health Collaborative Report, 8/01.
107. NYIC Health Collaborative Report, 2/21/08.
108. NYIC Health Collaborative Report, 12/04.
109. Telephone call from Hudson River Health Care, 6/17/08.
110. NYIC Health Collaborative Report, 12/04
111. Freij, M. et al. 2010.
112. Pub Health L §2807-k(9-a)
113. 5 U.S.C. § 552(a)
114. 45 C.F.R. §160 et seq.
115. There would be little question that PHI would include a person's revelation of his or her immigration status in the context of seeking mental health counseling for anxiety arising out of that status. Revelations of immigration status in contexts less related to treatment may be more problematic, but in most cases the information is so interrelated with more clearly protected PHI that it is inevitably treated as PHI.
116. 45 C.F.R. 160.103: Health care clearinghouse means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:
 1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
117. 42 U.S.C. 1396a(a)(7)
118. 42 C.F.R. § 431.301
119. 8 U.S.C. § 1644 and 8 U.S.C. §1373(b)
120. New York Social Services Law § 369(4)
121. 06 OMM/ADM – 1, Attachment 3
122. GIS 04 MA/014, p. 1, available at <http://onlineresources.wnyc.net/pb/docs/04ma014.pdf>
123. Civil Practice Law & Rules § 4504
124. State v. General Electric Co., 607 N.Y.S.2d 181 (3rd Dept. 1994)
125. City of New York v. U.S., 179 F.3d 29 (2d Cir. 1999)
126. Huyen Pham, "The Constitutional Right Not to Cooperate? Local Sovereignty and the Federal Immigration Power." 74 U.Cin. L. Rev 1371 (2006).
127. U.S. Department of Health and Human Services, Office of Civil Rights, Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits, last revised January 21, 2003, <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/origin/policyguidanceregardinginquiriesintocitizenshipimmigrationstatus.html>, last visited July 7, 2009, and Questions and Answers regarding the Guidance, last revised March 24, 2006, http://www.hhs.gov/ocr/civilrights/resources/specialtopics/origin/triagency_q&as.html, last visited July 7, 2009
128. Slue v. New York University Medical Center, 409 F. Supp. 2d 349 (S.D.N.Y. 2006).
129. 42 U.S.C. §§ 130d-6(b)(1), (2)
130. 42 U.S.C. § 1396a(a) (7), echoed in regulation at 42 C.F.R. §431.301
131. New York Social Services Law § 369(4)

132. 18 N.Y.C.R.R. § 357.6
133. See *Gonzaga Univ. v. Doe*, 122 S. Ct. 2268 (2002), no private claim for unauthorized release of educational records, *Ellison v. Cocke County*, 63 F.3d 467, 469 (6th Cir. 1995)(No private right of action for violation of confidentiality of drug treatment records); *Zona v. Clark Univ.*, 436 F. Supp. 2d 287 (D. Mass 2006)(same, mental health treatment records); *Canal Refining Co. v. Corrallo*, 616 F. Supp. 1035 (D.D.C. 1985)(no private claim for improper disclosure in response to FOIA requests).
134. For example, lack of knowledge about the system, including confusion on multiple aspects of eligibility such as employment, legal residency, child's age, and whether a child's guardian must be biological parent, were major barriers to coverage found by Glenn Flores and researchers who conducted focus groups in Boston. Flores, G., Abreu, M., Brown, M., Tommany-Korman, S. "How Medicaid and the State Children's Health Insurance Program Can Do a Better Job of Insuring Uninsured Children: The Perspective of Parents of Uninsured Latino Children." *Ambulatory Pediatrics*. Vol 5, Num 6. Nov-Dec 2005. 332-340
135. 2000 U.S. Census Bureau.
136. September 2, 2008.
137. For the NYIC's most recent report on language access in a health setting, go to <http://thenyic.org/templates/documentFinder.asp?did=853>. New York Immigration Coalition, Make the Road NY, Korean Community Services of Metropolitan New York. *Now We're Talking: A Study on Language Assistance Services at Ten New York City Public and Private Hospitals*, April 2008.
138. New York State Code of Rules and Regulations Section 405.7.
139. Insurance Law §§3217a, 4324, 4408; Public Health Law §§4403 and 4408.
140. http://thenyic.org/images/uploads/EO-120_Text.pdf
141. NYC Administrative Code §17-174.
142. Language Access in Pharmacies Act, Intro 859-A (September 3, 2009).
143. Title VI of the Civil Rights Act of 1964. 42 U.S.C. §2000d, et. seq.
144. For the NYIC's most recent report on language access in a health setting, go to <http://thenyic.org/templates/documentFinder.asp?did=853>. New York Immigration Coalition, Make the Road NY, Korean Community Services of Metropolitan New York. *Now We're Talking: A Study on Language Assistance Services at Ten New York City Public and Private Hospitals*, April 2008.
145. Lessard, G. and Ku., L. 2003.
146. Flores, G., Abreu, M., Olivar, M., Kastner, B. "Access Barriers to Health Care for Latino Children." *Arch Pediatr Adolesc Med.*, Vol. 152, Nov 1998. 1119-1124.
147. Perry, M., Kannel, S., Valdez, R., Chang, C. "Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey," The Kaiser Commission on Medicaid and the Uninsured, January 2000.
148. NYIC Health Collaborative Report, 05/09
149. NYIC Health Collaborative Report, 08/09.
150. September 26, 2006, submitted by Catholic Charities of Rockville Center.
151. July 2002, submitted by Haitian Americans United for Progress.
152. March 22, 2007, submitted to NYIC.
153. NYIC training at Nassau County Department of Social Services, June 13, 2007.
154. See GIS 02 MA/027 regarding *Expired Permanent Resident Cards* (I-155, I-151) "*green cards*." Additionally, in the latest DOH Informational Letter on PRUCOL INF 08 OHIP/INF-4, the NYS DOH clarifies that if an applicant presents expired documents (other than a green card) or questionable documents, the eligibility worker may verify an immigrant's case status by checking online on the USCIS website or by sending a Document Verification Request, Form G-845, (also known as a Systematic Alien Verification for Entitlements (SAVE) Request). The INF states:
- As a general rule, the district worker should also send a G-845 Document Verification Request when the documentation does not clearly indicate a particular immigration status, the alien has presented expired documents or the worker has reason to believe that the documentation may be questionable in any respect. Ibid, p. 4* Importantly, the INF does not state that the immigrant is responsible for producing updated or different documentation, it is the LDSS worker's responsibility for verifying with USCIS that applicant's status. It is critical that LDSS workers follow this policy so that eligible individuals are not turned away and told they are either ineligible, or responsible for producing documents they simply do not have and may not be required to submit.
155. September 2, 2008.
156. Freij, M. et al. 2010.
157. October 2005, Haitian Americans United for Progress; March 2006, Make the Road NY
158. Freij, M. et al. 2010.
159. January 2008, submitted by Make the Road NY; March 8, 2008, submitted by North Fork Spanish Apostolate; February 13, 2006, submitted by Reconciliation and Culture Cooperative Network (RACCOON); April 2008, North Fork Spanish Apostolate
160. March 8, 2008, submitted by Haitian Americans United for Progress; April 2008, submitted by South Asian Council for Social Services; March 31, 2008, RACCOON

161. January 2008, submitted by Make the Road NY; October 2005, submitted by RACCOON; March 18, 2008, CARECEN
162. April 2008.
163. April 2008, submitted by Filipino American Human Services, Inc.