How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents?

An Analysis of Three Coverage Options

By Elisabeth R. Benjamin, MSPH, JD

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All mistakes are, of course, the author's.

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Executive Summary

The Patient Protection and Affordable Care Act ("ACA") has helped millions of New Yorkers to secure affordable, quality health coverage, many for the first time. However, many unauthorized immigrant New Yorkers are left without coverage; ineligible for Medicaid, the new Essential Plan, or Qualified Health Plans in the New York State of Health Marketplace. Lack of coverage is burdensome for immigrants and our greater society alike. For immigrant families, lack of coverage can mean excess mortality and morbidity, as well as financial ruin. Everyone else contributes to the hidden health costs for the uninsured through government-financed payment mechanisms such as uncompensated care funding and public and private payer cost shifting.

In New York, despite the State's expansive public insurance programs, as many as 457,000 unauthorized, uninsured immigrants remain ineligible for coverage. This paper explores options for New York State to fill the void left by the ACA and provide health coverage to the most vulnerable—either because of their income or age—of these immigrants who are "uninsurable" because of their ineligibility for most federal coverage programs. We offer New York policymakers practical, affordable, high-quality coverage options that would solidify our State's leadership position in welcoming new Americans.

The three coverage options investigated here are: (1) a comprehensive "Essential Plan" for undocumented adults with incomes below 200 percent of the Federal Poverty Level ("FPL"); (2) a Young Adult plan for undocumented immigrants between the ages of 19 and 29 that builds upon New York State's popular Child Health Plus program; and (3) a high deductible "Bronze Plan" with first dollar preventive care and emergency services for undocumented adults who are eligible for Emergency Medicaid. For each option, the paper describes the kind of benefits offered, who would be covered, and how much it would cost.

These State coverage options would extend health insurance to between 90,100 and 241,600 immigrant New Yorkers, at a cost ranging from $78 million to $462 million annually. The first option, which opens the State's Essential Plan to all low-income New Yorkers, would cost the most, $462 million, but it would also cover the most people, roughly 111,100 New Yorkers. The second option, offering coverage to 27,900 young adults, could potentially act as an interim measure, and is the most affordable at $78 million. The final option, purchasing a Bronze Plan for very low income immigrants, would cost the State $307 million, and would provide free preventive and emergency care to 85,000 New Yorkers. Even the most ambitious of these proposals would result in a less than 1 percent increase in our State's health budget of roughly $60 billion.[1]

New York State has a long and illustrious history as a gateway for new Americans. This paper demonstrates that affordable, high quality and viable options exist that both improve the lives of our newest State residents and close the coverage gap left by the Affordable Care Act.

Table 1: Summary of Coverage Options, Enrollment, and Costs

Program Option	Number Eligible	Estimated # of Enrollees	Total Annual State Costs	Annual State Cost per Enrollee
1. Essential Plan	241,600	111,100	$462,000,000	$4,157
2. Young Adult	90,100	27,900	$78,000,000	$2,804
3. Bronze Plan	203,600	85,000	$307,000,000	$3,606

Introduction

Immigrant Coverage: The unfinished business of health reform

The Affordable Care Act ("ACA") has benefitted over 2 million New Yorkers by enrolling them into comprehensive, affordable health coverage through the New York State of Health Marketplace.[2] But while the ACA has significantly improved options for most New York State residents, nearly half a million uninsured unauthorized immigrants face severely limited coverage options compared to their citizen and lawful immigrant counterparts. This is true despite their contributions to our State—the Institute on Taxation and Economic Policy estimates that in 2012, undocumented immigrants paid over $1 billion in state and local taxes in New York.[3]

Historically, New York State has adopted several measures to address the health needs of immigrant residents, making the State a national leader in immigrant access and coverage. For example:

- In the 1980s, New York extended Medicaid coverage to undocumented pregnant women.[4]
- In 1990, New York enacted its landmark Child Health Plus program, which now provides coverage to all children who are ineligible for Medicaid—including undocumented children—up to the age of 19.[5]
- In 2001, in the *Aliessa* case, New York's highest court held that nearly all low-income, non-qualified "aliens" are eligible for full Medicaid benefits, in spite of a federal law barring federal Medicaid funding for this population.[6]
- For the remaining low-income, undocumented immigrant population, New York offers the jointly (federal/State) financed Emergency Medicaid program and, in 2007, expanded the scope of its benefits to cover the costs of treating end stage renal disease and cancer.[7]

Through these programs, New York State has cobbled together coverage for selected groups of immigrants, including: undocumented children at all income levels, pregnant women up to 200 percent of the Federal Poverty Level ("FPL"), and people who experience medical emergencies with incomes below 138 percent of the FPL. New York State is not entirely alone—as many as 18 other states offer some form of coverage to their non-citizen residents above and beyond the jointly federally/state-funded Emergency Medicaid program—but New York has done more to provide coverage to immigrants than almost any other state.[8]

Continuing New York's laudable history of providing coverage to immigrants, the New York State of Health Marketplace is designed to be as welcoming as possible to eligible undocumented immigrant families and individuals, enrolling them into Child Health Plus and pre-qualifying them for Emergency Medicaid.

New York City, too, is attempting to address the health needs of its undocumented residents. In October 2015, the Mayor's Task Force on Immigrant Access issued a report that calls upon the State to explore strategies to provide coverage to the State's undocumented immigrants and proposes that the City launch a "direct access" program for New York City's undocumented immigrants in the interim.[9] With an initial $6 million in funding, the program is slated to begin in 2016 and will serve 1,000 immigrants.

As critical as these efforts have been, however, the current coverage system leaves most undocumented adults without comprehensive coverage options.

This fissure in New York's coverage landscape is problematic both for immigrant families and for society at large. At the individual level, numerous studies indicate that people without coverage are more likely than their insured counterparts to delay seeking preventive care and services for serious and chronic health conditions.[10] Surveys indicate that people without coverage report that they avoid accessing medical care for fear of costs associated with receiving treatment.[11] When they do seek treatment, it is of lower quality,[12] and they are at higher risk of incurring medical debt and/or bankruptcy.[13] Recent research now shows that access to coverage is associated with significant

reductions in mortality[14] and improvements in mental health,[15] at least in part due to higher continuity of care.[16]

Lack of coverage for a significant portion of New York's population also causes problems for the broader health care system because it causes payers and providers to charge more to the insured population in order to offset the losses in providing care to the uninsured.[17] Unauthorized immigrants use health care less than U.S. citizens. However, when they do utilize care, unauthorized immigrants rely on the publically-financed uncompensated care system, using it two times more than their legal immigrant and citizen counterparts.[18] Exacerbating this situation is the ACA's gradual reduction in federal Disproportionate Share Hospital ("DSH") funding, which traditionally has offset the cost of hospital care for the uninsured and is slated to begin ratcheting down in 2017.[19] New York State receives more of this funding than any other state[20] and is likely to be the state hardest hit by these cuts.[21]

How many immigrant New Yorkers are without coverage because of their immigration status?

New York has the fourth largest "unauthorized" immigrant population in the country, after California, Texas, and Florida. According to the Migration Policy Institute ("MPI"), there are 867,000 unauthorized immigrants amongst New York's 19 million residents (of whom 74 percent or 643,000 live in New York City).[22] Ninety percent (786,000) of New York's unauthorized population are adults age 19 and over, and 25 percent (217,000) are young adults, age 19–29.[23] MPI further estimates that 53 percent, or 457,000, of undocumented immigrants in New York are uninsured.[24]

However, not all "unauthorized" immigrants are ineligible for coverage. The term "unauthorized immigrants" includes both the undocumented and many categories of lawful immigrants who are eligible for coverage under New York State-funded Medicaid or federally-subsidized Marketplace coverage through Qualified Health Plans or the Essential Plan. For example, the term "unauthorized" immigrants includes some New York immigrants who are permanently residing under color of law ("PRUCOL"). While the lowest-income PRUCOL adults are eligible for Medicaid or Essential Plan coverage, some of the higher income PRUCOL adults do not have access to Marketplace coverage (neither Essential Plan nor Qualified Health Plans). Five of the over a dozen categories of PRUCOL adults are referred to as the "residual PRUCOLs," described in Box One, and can access Medicaid (if low-income), but cannot access Essential Plan or Marketplace coverage (if moderate or high-income).[25] By contrast, all

Important Immigration Terms

Undocumented Immigrants: Undocumented immigrants refer to people who entered the United States without inspection by Customs and Border Protection or who stayed beyond their period of authorized stay. *In New York, some undocumented immigrants are eligible for: Medicaid (for low-income pregnant women only); Child Health Plus (for children under the age of 19); Emergency Medicaid (for low-income people who are experiencing medical emergencies).*

PRUCOL (Permanently Residing Under Color of Law): People who are PRUCOL can show that USCIS or ICE (the main federal immigration agencies) have given permission or know (and therefore acquiesce to their presence) that they are seeking to live permanently in the United States. Many PRUCOL people are considered "lawfully present," but some are not (and hence, are ineligible for ACA benefits). They are not considered undocumented for the purposes of getting health insurance. *In New York, all low-income adult PRUCOLs are "immigrant"-eligible for Medicaid or the Essential Plan. But a small number of adult "residual PRUCOLs," with incomes above the Medicaid levels, are ineligible for the Essential Plan and Marketplace coverage because of their immigrant status (e.g. Deferred Action for Childhood Arrivals, applicants for deferred action).*

Unauthorized Immigrants: This is a general term used by researchers. It refers to people who are undocumented, but includes many people who are PRUCOL. Their eligibility for coverage is determined by whether the unauthorized immigrant is PRUCOL or undocumented.

unauthorized children currently have access to Medicaid or Child Health Plus (if a "residual PRUCOL" or undocumented), with cost sharing at higher income levels.

Unfortunately, there are no comprehensive estimates breaking down the unauthorized population into those who are and are not eligible for a subsidized coverage option. Drawing upon available published information and expert estimates, the CSS team constructed an estimate of the population in New York State who are currently ineligible for subsidized coverage due to immigration status. For example, the CSS team used data indicating that there are 53,000 PRUCOL immigrants currently enrolled in New York State-funded Medicaid because of litigation brought on behalf of PRUCOL and other immigrants.[26] Similarly, CSS used data compiled by experts at the Kaiser Family Foundation that estimated 12 percent of the 2.2 million uninsured in 2014, or 264,000 people in New York State, are ineligible for Medicaid or Marketplace coverage due to their immigration status.[27] CSS also integrated available data about the numbers of undocumented immigrants into our estimates. Since 2014, low-income undocumented adults have been able to pre-qualify for Emergency Medicaid through the Marketplace. To date, 68,000 have done so.[28]

Table 2 displays the estimated number of immigrants in New York State by their age and immigration status, to help distinguish immigrants who currently do not have access to coverage from the broader unauthorized immigrant estimates available from MPI and others.

Table 2 indicates that the 867,000 unauthorized immigrant population in New York State consists of approximately: 330,000 undocumented adults; 456,100 PRUCOL adult immigrants; and 80,900 unauthorized children below the age of 19 years. It also describes these groups by coverage status. Of the undocumented adult immigrants, 264,000 are uninsured. Of this number, 68,000 undocumented immigrants have prequalified for Emergency Medicaid and 196,000 have not. An additional 32,000 immigrants have enrolled into Emergency Medicaid in the past and another 34,000 are estimated to have other or private coverage (for example, spousal coverage).[29] The table further describes the coverage distribution of the PRUCOL adults. Of the 456,100 total estimated PRUCOL immigrants in New York State, an estimated 180,900 are uninsured; 53,000 are enrolled into Medicaid; and 222,200 have other/private coverage. Appendix A provides further methodological detail about these estimates.

Table 2: Unauthorized NYS Population by Coverage and Immigration Status (Baseline)

	Unauthorized Adults (Age 19+)						Unauthorized Children (Age 0–18)		Total Unauthorized	
	Undocumented Adults		PRUCOL Adults		Total Unauth. Adults (Undoc. + PRUCOL)					
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Uninsured Total	264,000	80%	180,900	40%	444,900	57%	12,100	15%	457,000	53%
- Prequalified for ER Medicaid	68,000	21%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- Not prequalified for ER Medicaid	196,000	59%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medicaid/CHP (incl. Historic ER Medicaid)	32,000	10%	53,000	12%	85,000	11%	56,600	70%	142,500	16%
Other/Private	34,000	10%	222,200	48%	255,300	32%	12,000	15%	267,500	31%
Total	**330,000**		**456,100**		**786,100**		**80,900**		**867,000**	

These estimates represent the current categorization of New York's unauthorized immigrants by status category. But, as described below, many immigrant adults could change from undocumented to PRUCOL status if a 2014 Executive Order issued by President Obama were in effect.

President Obama's Executive Order

On November 20, 2014, President Obama issued a far-reaching Executive Order, called Deferred Action for the Parents of Americans and Lawful Permanent Residents ("DAPA") and expanding the existing Deferred Action for Childhood Arrivals ("DACA") program ("DACA/DAPA"). The DACA/DAPA Order built upon a more modest federal 2012 administrative measure, called Deferred Action for Childhood Arrivals, which granted immigration relief to undocumented immigrants who had arrived in the United States while they were children.[30]

If implemented, President Obama's DACA/DAPA Executive Order would profoundly change the immigration status of hundreds of thousands of New York's undocumented immigrant population, by essentially rendering them newly "PRUCOL." Those who are low-income would be eligible for State-funded Medicaid (or the Essential Plan), as a result of 2001 *Aliessa* litigation, described above. But on February 17, 2015, a Texas District Court stayed the implementation of President Obama's DACA/DAPA Executive Order. On November 9, 2015, the U.S. Court of Appeals for the Fifth Circuit upheld the lower court's decision and the case is headed for the Supreme Court for a final determination.

At the time of publication of this report, the outcome of the DACA/DAPA Order is unclear. Accordingly, while the main body of this report assumes that DACA/DAPA will not be implemented, Appendix B presents an alternative series of eligibility, enrollment and cost estimates in the event that the President's Executive Order is implemented.

Coverage Options

This report investigates three coverage options for addressing the coverage needs of undocumented immigrant New Yorkers: (1) a comprehensive Essential Plan Option (New York's name for the ACA's Basic Health Plan option) for 241,600 undocumented adults with incomes below 200 percent of the FPL; (2) a Young Adult Option for 90,100 undocumented immigrants between the ages of 19 and 29 that builds on our State's Child Health Plus program; and (3) a Bronze Plan Option for 203,600 undocumented adults who could pre-certify for Emergency Medicaid. Table 3 presents a brief overview of the coverage options.

Because the vast majority of New York's unauthorized immigrants are low-income, many of these options seek to leverage Medicaid funding, whenever possible. Medicaid

Table 3: Description of Coverage Options: Enrollee Eligibility, Benefits, and Premiums

	Eligible Population	Federal Poverty Level	Actuarial Value/ Cost Sharing	Monthly Premium	Enrollment Period
1. Essential Plan	**241,600** Undocumented and PRUCOL adults	< 200% of FPL	.95–.99	$0 < 150% of FPL $20 >150% of FPL	Year-round, continuous open enrollment
2. Young Adult	**90,100** Undocumented and PRUCOL adults age 19–30	< 400% of FPL	.70–.99	$0-$175 pm/pm sliding fee scale	3-month open enrollment and/or special enrollment periods under the ACA
3. Bronze Plan	**203,600** Undocumented adults	< 138% of FPL	.60 + value of Emergency Medicaid benefits	$0	3-month open enrollment and/or special enrollment periods under the ACA

is a public insurance program that is jointly funded by the federal and New York State governments, typically on a fifty-fifty basis.

A description of each option, the numbers of immigrants who are eligible, the number estimated to enroll, and the 2016 State costs to offer coverage are described below.

Option One: The Essential Plan

Beginning January 1, 2016, New York State will become the second state in the nation to offer a Basic Health Plan (renamed the "Essential Plan" in New York). State policymakers opted to offer the Essential Plan for two reasons: first, it significantly improves the affordability of coverage for low-wage New Yorkers; and second, it offers the State substantial federal funding—at least $645 million annually—for covering many of the *Aliessa* immigrants who were previously enrolled in State-only funded Medicaid.[31]

The Essential Plan Option is the most generous of the three options presented by this paper. For enrollees, the coverage is both affordable in terms of no or very low premiums and cost-sharing while still offering extremely comprehensive benefits. Unlike the other two options, it has the flexibility of continuous year-round open enrollment, meaning that consumers can join at any time, without waiting for an annual open enrollment or qualifying for a special enrollment period. While the Essential Plan Option is the most expensive of three options presented here, it is cost-efficient for the State because it builds off of public health—rather than commercial—insurance plan networks. As a separate public risk pool, it would have little or no impact on the State's individual commercial insurance market and risk pool.

The Essential Plan Option: What are the benefits?

The Essential Plan offers comprehensive health coverage in a health plan with no deductibles, very low cost-sharing, and no, or very low, premiums. For example, the premium is free for individuals with incomes below 150 percent of the FPL and $20–$40 a month for people between 150 and 200 percent of the FPL, depending upon whether an individual opts for vision and dental.[32] The plan's actuarial value, or the portion of health care paid for by the plan versus an enrollee, is generous, pegged between 95 and 99 percent, or equivalent to a comprehensive platinum plan offered on the New York State of Health Marketplace.[33] In 2016, 14 health plans in New York are participating in the Essential Health Plan program.

The Essential Plan Option: Who would be eligible and who would join?

Under this option, the Essential Plan would be available to an additional 241,600 adult immigrants who are age 19 or over (and thus over age for New York's Child Health Plus program) and below 200 percent of the FPL. Most of these enrollees would be undocumented adults, but a small number of "residual PRUCOL" adults who are currently ineligible for the Essential Plan or other qualified health plans on the Marketplace would also be enrolled. This latter group could be separately covered as described in Box One.

As described in Table 4, the eligible population is comprised of four groups:

1. historic enrollees in the State's Emergency Medicaid program opting into the Essential Plan;
2. new enrollees with incomes below the Medicaid level of 138 percent of the FPL (including uninsured people and those who have pre-qualified for Emergency Medicaid);
3. new enrollees with incomes between 138 and 150 percent of the FPL who will be charged no premiums; and
4. new enrollees with incomes between 150 and 200 percent of the FPL who will be paying $20 per month premiums.

Table 4 describes the number and percent of people expected to enroll in, or "take-up," an Essential Plan

Option. The take-up rates of the four groups of potential enrollees depends on their past use of the health care system or the amount of premiums and cost sharing they are expected to incur when they enroll in the Essential Plan.

The first group is those who were historically enrolled into the Emergency Medicaid program. They are most likely to enroll because they have health needs and have already overcome barriers to entering a State insurance program, such as fear of disclosing their immigration status to a government entity. They could easily enroll with the Essential Program when they utilize the system. We estimate that 85 percent of the "Historic Emergency Medicaid Enrollees" are likely to enroll.

The next two groups of Essential Plan enrollees would have no premiums and slightly different State-specified benefit packages and cost-sharing, which are set by income levels (those below 138 percent of FPL; and those between 138 and 150 percent of FPL).[34] These two groups do not necessarily have high health needs. While some may have pre-qualified for Emergency Medicaid, others may be more reticent about joining a public program than the Historic Emergency Medicaid program enrollees.[35] Forty-one percent of these newly-eligible populations are likely to join.[36]

Table 4: Essential Health Plan Option
Total Eligible and Take-up by Income Group

	Total Eligible	Take-up
Historic Emergency Medicaid Users < 138% of FPL ($0 monthly premium)	32,300	27,400 (85%)
New Enrollees < 138% of FPL ($0 monthly premium)	171,300	69,700 (41%)
New Enrollees 138% to 150% of FPL ($0 monthly premium)	13,500	5,500 (41%)
New Enrollees 150% to 200% FPL ($20 per member/per month)	24,500	8,500 (35%)
Total Enrolled	**241,600**	**111,100 (46%)**

The final group, newly-eligible enrollees between 150 and 200 percent of poverty, will pay premiums, which may be experienced as a barrier to entry (although not a very great one) and so a smaller number (35 percent) are estimated to enroll. Collectively, these latter three groups are referred to as the "New Enrollees" as opposed to the "Historic Medicaid Enrollees."

The Essential Plan Option: How much would it cost?

Determining the costs of offering the Essential Plan to New York's undocumented immigrants requires a series of assumptions, broken down here into five steps. First, we start with a baseline of cost data from the State's Family Health Plus ("FHP") program. While the FHP program ended in 2015, its claims data is illustrative because it: enrolled beneficiaries with a similar risk and income profile, used similar provider networks, and offered similar benefit packages as the Essential Plan. Second, we conduct a population analysis of the groups likely to join (discussed above). Third, we make morbidity and selection adjustments for the projected enrollee population. Fourth, we apply other actuarial adjustments, such as incorporating estimates for geographic distribution of the enrollee population, medical trend, administrative costs, and the unique benefit packages offered to enrollees based on their income levels. And finally, we estimate the cost offsets between the gross costs of the Essential Plan Option from the costs of the existing Emergency Medicaid program to determine the net cost of the program to New York State. These steps are described in turn below.

Population Cost Analysis. Determining the costs of offering the Essential Plan to undocumented New Yorkers requires an analysis of the estimated medical and administrative costs of offering the program to potential enrollees. In this case, because there are two very different populations entering the program, CSS estimated first the costs associated with enrolling the Historic Emergency Medicaid enrollees, who are relatively sick, and second, the costs associated with the New Enrollees, who are relatively healthy.

- **Historic Emergency Medicaid Population.** As shown in Table 5, CSS analyzed 2011 New York State Medicaid claims data which indicates that $493 million in claims were incurred for the 32,000 Emergency Medicaid enrollees.[37] Of these, 87 percent of the claims were for hospital inpatient services and four percent were for dialysis. The cost on a per enrollee basis was nearly $15,000 a year, or $1,250 per month.[38]
- **New Enrollee Population.** There are 209,000 New Enrollees who would be eligible for the Essential Plan. CSS assumes that the New Enrollee population is as healthy, if not healthier, than the FHP population.[39]

Morbidity and Selection Adjustments. The CSS team modeled morbidity and selection adjustments using data from the 2014 Federal Actuarial Value Model, as shown in Table 6. Morbidity is a term that describes the disease and condition burden in the cohort population. Selection is a term that reflects the probability that sicker people are more likely to join sooner than healthier people. We calculated selection adjustments based on four assumptions about the relative risk of the population.[41] Key to these adjustments is the principle that initial program enrollees are likely to be sicker than their counterparts.

As described in Table 4, of the total eligible population of 241,600, we estimate the following enrollment rates: 85 percent of the Historic Emergency Medicaid enrollees (27,400); 41 percent of the New Enrollees who have no premium (75,200); and 35 percent of the New Enrollees who will be paying a $20 premium (8,500). We then developed an actuarial model which produced a morbidity adjustment of 5.2 from the FHP baseline for the Historic Emergency Medicaid Enrollees and .89 for the New Enrollees, reflecting their healthier status.[42]

Table 5: New York Emergency Medicaid Claims Distribution

Service	CY 2011 Medical Costs	% Distribution
Inpatient	$430,785,039	87.4%
Prof Services During Inpatient	$4,519,034	0.9%
Primary Care	$4,180,237	0.8%
Specialty Care	$7,604,710	1.5%
Renal Dialysis	$19,706,825	4.0%
Diag/Lab/Xray	$6,531,873	1.3%
Pharmacy	$7,134,525	1.4%
Other Amb/Surg	$3,993,527	0.8%
All Other	$8,355,831	1.7%
Total	**$492,811,601**	
2011 Unique Enrollees[40]	32,984	
Cost per Enrollee	$14,941	

Table 6: Essential Plan Option Costs and Adjustments

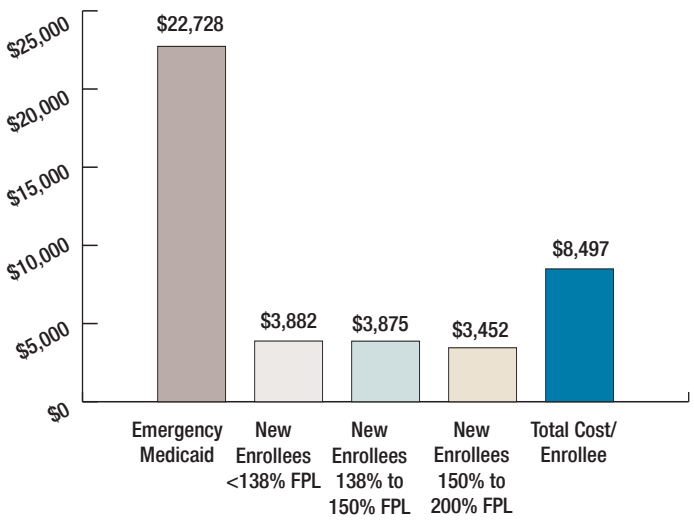
NY Essential Plan Projected Expenses	Historic Emergency Medicaid	New Enrollees
Total 2012 FHP Claims PM/PM	**$284**	**$284**
Morbidity Adjustment	5.20	1.00
Selection	n/a	.89
Pent Up Demand	n/a	1.00
Provider Reimbursement	n/a	1.00
Total Medical Claims	**$1,478**	**$253**
Area Adjustment	1.00	1.00
Annual Trend Assumption	1.03	1.03
CY 2016	$1,667	$285
Administration	10.3%	10.3%
Total Monthly Expenses	**$1,858**	**$317**
Total Annual Expenses/EE	**$22,296**	**$3,808**

Geographic Adjustments. To account for the regional differences in per member per month premiums across the State, the CSS team modeled expense assumptions based on the projected distribution of enrollment in the eight different rating regions of the State: Albany, Buffalo, Mid-Hudson, New York City, Rochester, Syracuse, Utica, and Long Island. We adjusted the Family Health Plus claims costs to reflect the immigrant population's geographic distribution using data from the American Community Survey data. Since the regional distribution of the FHP population is not that different from the immigrant population, the adjustment is minimal.

Table 7: Essential Plan Benefit Adjustment

Enrollee Population	Benefit Adjustment	Cost
Historic Emergency Medicaid	1.019	$22,728
New Enrollees < 138% FPL	1.019	$3,882
New Enrollees 138% to 150% FPL	1.017	$3,875
New Enrollees 150% to 200% FPL	0.969	$3,692

Figure 1: Essential Plan Annual Cost per Member



Trend and Administration Adjustments. The CSS team applied a 3 percent annual trend assumption from the 2012 FHP annual claims. We adopted a 10.3 percent administration cost assumption based upon our review of the FHP 2012 claims and administrative data.

Table 6 describes these adjustments and indicates that the monthly per member cost for the Historic Emergency Medicaid enrollees would be $1,858, or $22,296 per member per year. The monthly cost for the New Enrollee population would be $317 per member per month, or $3,808 per member per year.

Benefit Adjustments. The Essential Plan program offers four different benefit packages, based upon an enrollee's income level. These packages are slightly more generous than the FHP benefit package. Accordingly, to design an Essential Plan for the immigrant population, the CSS team made a series of additional adjustments to the FHP claims data to reflect the Essential Plan benefit package designs, reflected in Table 7.

In summary, the average cost per member per month would be $708, or $8,500 per year.[43] The total costs for covering an estimated 111,100 immigrant enrollees would be $944,300,000, described in Table 8. However, these total annual costs are potentially offset by savings to the State's Emergency Medicaid program.

Table 8: Total Annual Health Care Costs Including Emergency Medicaid Benefits

Total Enrolled	**111,100**
Average Cost per enrollee	$8,500
Cost PM/PM	$708
Historic Emergency Medicaid Enrollees	$623,000,000
New Enrollees <138% of FPL	$270,400,000
New Enrollees 138% to 150% of FPL	$21,300,000
New Enrollees 150% to 200% of FPL	$29,600,000
Total Annual Costs	**$944,300,000**

State Savings Estimates

Under the Essential Plan Option, New York would continue to receive federal financial participation for the emergency services provided to Essential Plan enrollees who would have been otherwise covered by the jointly financed Emergency Medicaid program. There is precedent for such a move, given that the State has historically claimed federal Medicaid reimbursement for emergency services provided in State-funded health programs (e.g. the *Aliessa* population enrolled in State-only funded Medicaid). These savings are potentially significant, since we estimate 85 percent of the Historic Emergency Medicaid enrollees would enroll in the Essential Plan program, absent the immigration eligibility bar.

Total State Costs of the Essential Plan Option

The CSS team analyzed the distribution of the 2011 Emergency Medicaid beneficiary claim and encounter data by various services for the Historic Emergency Medicaid population to understand what percentage of services are covered by the Emergency Medicaid benefit. Then we analyzed the distribution of claims by various services for high cost claimants from the federal actuarial value calculator. We assumed that this federal distribution is similar to the Historic Emergency Medicaid population. Similarly, we analyzed 2012 FHP claims distribution by various services assuming this population is a good representation of the New Enrollee population.

Table 9: Total Annual Cost of Essential Plan with Emergency Medicaid Offset

Total Enrolled	**111,100**
Total Gross Annual Costs	$944,300,000
Less Emergency Medicaid Covered Services	$482,300,000
Total Annual Program Costs	**$462,000,000**

The CSS team assumes that New York State would continue to draw down federal reimbursement for emergency services provided to those who would have been eligible for Emergency Medicaid consistent with the historical trend. Accordingly, as discussed in Table 9, we estimate that Emergency Medicaid funds would cover almost half of the cost of providing Essential Plan coverage to all New York State undocumented immigrants. Accounting for these cost offsets, the State's total annual cost of offering an Essential Plan program to immigrants would be $462 million, which would be $346 per member per month, or $4,157 per member per year. These costs are in addition to the State and federal government's spending for the Emergency Medicaid program.

The Essential Plan "Clean Up" Option

An extremely modest prequel to offering the Essential Plan to all undocumented New Yorkers below 200 percent of the FPL would be to "clean up" the existing eligibility cliff for a small group of legal immigrants who are *eligible* for New York State Medicaid, but are *ineligible* for federally funded Essential Plan and/or Qualified Health Plans through the Marketplace. Helped by this measure would be five categories of legal immigrants, called the residual "PRUCOLs." These immigrants were excluded from coverage under the ACA, despite their lawful status. They consist predominately of younger adult immigrants who have Deferred Action for Childhood Arrivals (DACA) status, with incomes between 138 percent and 200 percent of FPL (those below 138 percent of FPL are already eligible for Medicaid under the *Aliessa* decision described above).

CSS estimates that approximately 5,500 immigrant New Yorkers would be eligible for this measure, of which approximately 2,200 would enroll.

The cost per member per month would be $393, or $4,721 annually. The total cost of "cleaning up" the Essential Plan, or eliminating this coverage cliff for the residual PRUCOL immigrants, would be $10.3 million.

Option Two: Young Adult Option

The goal of this option is to provide young adult immigrants with access to coverage that is equivalent to the coverage offered to their citizen counterparts in the Essential Plan or through Qualified Health Plans in the Marketplace. The Young Adult Option would build upon New York's strong commitment to young people evidenced by both our universally available (regardless of income or immigration status) Child Health Plus program and our progressive young adult coverage law in the commercial market which requires employers and insurance carriers to offer young adults the opportunity to stay on their parent's plans until the age of 29 (three years more than required under the ACA).

The Young Adult Option offers State policymakers an incremental opportunity to address the coverage needs of many unauthorized New Yorkers. Because it would be a separately-rated public risk pool, like Child Health Plus, it is able to provide high quality coverage to young immigrants at a more affordable price than they would experience in the individual market. However, provider networks would potentially be less comprehensive.

The Young Adult Option: What are the benefits?

The Young Adult Option would build off of the success of New York's Child Health Plus (CHP) program, a program that offers comprehensive health coverage through managed care plans on a sliding scale. CHP is open to all New York children, regardless of immigration status. The Young Adult Option would offer comprehensive, subsidized coverage to undocumented and DACA young adults between the ages of 19 and 29 who are ineligible for Medicaid, Essential Plan, or Marketplace coverage due to their immigration status.

The Young Adult Option attempts to mirror the coverage offered to their young adult citizen and qualified immigrant peers. As displayed in Table 10, those who are below 200 percent of the FPL would enroll in plans with benefits and premiums that mimic the Essential Plan. People below 138 percent of FPL would have free premiums and benefits with an actuarial value of .99; people with incomes between 150 percent and 200 percent of the FPL would pay $20 and have benefits with an actuarial value of .95. Those above 200 percent of the FPL would be eligible to enroll in coverage that mimics the Qualified Health Plan, subsidies, benefits and premiums in the Marketplace. However, the

Table 10: Young Adult Premiums in the Marketplace versus CSS Option

Enrollee Income as a Percent of FPL	Midpoint Annual Income	Estimated Monthly Enrollee Premium in Marketplace	Estimated Monthly Enrollee Premium CSS YA Option	Actuarial Value in CSS YA Option
0% to 138% of FPL	$8,100	$14	$0	.999
138% to 150% of FPL	$16,900	$50	$0	.997
150% to 200% of FPL	$20,400	$90	$20	.95
200% to 250% of FPL	$26,300	$160	$160	.73
250% to 300% of FPL	$32,100	$239	$175	.70
300% to 400% of FPL	$40,800	$329	$175	.70

Young Adult Option would be offered through public plans and as a result, may have smaller provider networks. Their premiums would range from $160 to $175 (the maximum premium) per member per month for silver level plans with actuarial values between .70 and .73.[44]

Like CHP enrollees, the Young Adult Option enrollees would have a separate risk pool from New York's individual market.[45]

The Young Adult Option: Who would join?

Table 11 indicates that approximately 90,100 undocumented and "residual" PRUCOL adults would be eligible for the Young Adult Option. We assume that take-up would be highest for the portion of the population who would be eligible for Emergency Medicaid at 44 percent. This rate is lower for this population than the take-up rate used for the Essential Plan Option for two reasons: (1) there is a limited three month open enrollment period; and (2) young adults take-up at lower rates than older adults. We assumed a slightly lower rate for enrollees with free premiums or those below 150 percent of the FPL (41 percent). The take-up rate declines significantly as premiums increase. In total, we estimate that approximately 27,900 young adults would enroll in the Young Adult Option.

Table 11: Young Adult Option Take-up

	Eligible Young Adults	Take-up	% Take-up
Historic Emergency Medicaid Beneficiaries	6,300	2,700	44%
New Enrollees			
0% to 138% of FPL	38,700	15,900	41%
138% to 150% of FPL	7,700	3,200	41%
150% to 200% of FPL	14,000	4,900	35%
200% to 250% of FPL	6,400	800	12%
250% to 300% of FPL	5,600	100	2%
300% to 400% of FPL	11,400	300	2%
Total	**90,100**	**27,900**	**31%**

The Young Adult Option: How much would it cost?

To estimate the costs of a "CHP-like" Young Adult Option, CSS analyzed the 2012 FHP claims data, which had an average per member per month cost of $284. We then made the following series of adjustments: (1) a downward age adjustment of 40 percent based on the demographic distribution in the New York State individual market and federal age factors; (2) an upward administrative adjustment of 10.3 percent derived by analyzing the FHP claims data; (3) an annual 3 percent medical trend adjustment; and (4) a 1.15 selection adjustment in recognition that sicker eligible members of the population are more likely to join than healthier counterparts.[46]

As described in Table 12, the total annual cost to the State of New York to offer a Young Adult Option would be

Table 12: Young Adult Option Enrollment and Costs

Family Poverty Ratio	Take-up	Total State Expenses	State Expense PM/PM
0% to 138%	18,600	$55,715,000	$250
138% to 150%	3,160	$9,447,000	$249
150% to 200%	4,900	$12,782,000	$217
200% to 250%	800	$219,000	$23
250% to 300%	140	$0	$0
300% to 400%	280	$0	$0
Total	**27,880**	**$78,163,000**	**$234**

$78 million. The average per member per month cost to the State is $234, which represents a blend across the income spectrum, less the premiums paid by the higher-income enrollees. Lower income beneficiaries below 200 percent of FPL receive free or extremely low-cost, high actuarial value plans, which cost the State more to offer. Those above 200 percent FPL receive lower actuarial value plans equivalent to the Qualified Health Plans offered to their citizen counterparts in the Marketplace. Members incur a larger portion of the premium as their income increases, meaning that the State portion is lower. Enrollees above 250 percent of the FPL will pay a maximum monthly premium of $175. This premium is discounted to reflect the lower actuarial value public plans that are offered to them through this option. The total State expenses of $78 million reflect the deduction of the member premiums described in Table 10.

Option Three: Bronze Plan for Low-Income Adults

The Bronze Plan Option is designed to supplement the existing Emergency Medicaid program by providing undocumented immigrants with coverage for preventive care and other non-emergent health services, with a deductible. Low-income undocumented immigrant New Yorkers with incomes below 138 percent of FPL currently are eligible to receive limited care under the jointly funded federal/State Emergency Medicaid program. Emergency Medicaid pays for the cost of care for individuals who are experiencing a medical emergency, or have imminently life-threatening conditions such as end stage renal disease or cancer. However, Emergency Medicaid does not cover the treatment of conditions that are non-emergent, for example, preventive care, sick visits, elective surgery, maintenance medications, and so forth.

From the State's perspective, the Bronze Plan Option would be a more affordable option to cover many adult immigrants than offering the Essential Plan. It potentially appeals to those policymakers who prefer to build off of commercial insurance markets and "consumer-driven," or high-deductible, health insurance product designs. While addressing these free-market values, the Bronze Plan Option pragmatically leverages federal/state Medicaid funding to bring down the program costs for the State. A significant draw-back to building off the State's commercial markets is that there may be adverse price consequences for the State's individual risk pool. From the consumer's perspective, the Bronze Plan Option leaves them vulnerable to more health care costs than they would experience under the Essential Plan Option; however, the universe of these costs is capped at $6,850—and in most cases would probably be much less.

The Bronze Plan Option: What is it?

Under the Bronze Plan Option, the State of New York would purchase Bronze plan coverage for enrollees who qualify for Emergency Medicaid and opt to enroll in the Bronze Plan Option. In 2016, the standard Bronze plan has a $3,500 deductible for all non-preventive care. Preventive care is free. After the deductible has been met, there is typically a 50 percent co-insurance for care between $3,500 and $6,850. Pharmacy medications above the deductible are subject to standard co-payments, not co-insurance. Under the Bronze Plan Option, Emergency Medicaid would "wrap" around an individual's Bronze plan, so the enrollees would have first dollar coverage for services paid for through Emergency Medicaid.

Bronze Plan Option enrollees would have no cost-sharing for: the monthly Bronze plan premium, preventive care, and medical emergencies, including the treatment of cancer or end stage renal disease. For some enrollees, the Bronze plan deductible and co-insurance will be met by the Emergency Medicaid program. However, for all other services beyond the Emergency Medicaid benefits, enrollees would be responsible for meeting the $3,500 deductible and paying a 50 percent coinsurance up to the out-of-pocket maximum of $6,850, after which the Bronze plan assumes full responsibility for any additional claims. New York State would pay the Bronze plan premium and would continue to split the costs of providing emergency care through the Emergency Medicaid program with the federal government.

To reduce selection and parallel the benefits offered to citizens and authorized immigrants, enrollment would be limited to the three-month annual open enrollment period similar to qualified health plans in the Marketplace. Enrollees in this program would be part of New York State's individual market risk pool.[47]

The Bronze Plan Option: Who would join?

As described in Table 13, approximately 203,600 undocumented immigrant adults with incomes below 138 percent of FPL would be eligible to participate in the Bronze Plan Option. Three groups of immigrants would enroll in the Bronze Plan Option. The first group, discussed above in the Essential Plan Option section, is the 32,000 Historic Emergency Medicaid population. Because they are sicker, they are more likely to interact with the health system and enroll into Emergency Medicaid. When this occurs during the three months of open enrollment, we assume that they will have a high take-up rate (85 percent). During the other nine months of the year, we assume that they will have the same 40 percent take-up rate as their counterparts who do not utilize Emergency Medicaid. Combining this elevated rate for three months with the standard rate for the other nine months yields a net take-up rate of 51 percent for the Historic Emergency Medicaid population.

The second group of enrollees will be a portion of the roughly 68,000 who have previously pre-qualified for Emergency Medicaid through the New York State of Health Marketplace since 2013.[48] The final group of enrollees is the 103,300 uninsured undocumented low-income adult immigrants who have not pre-qualified for Emergency Medicaid. We estimate that combined, the 171,300 New Enrollees will have a roughly 40 percent take-up rate.

The Bronze Plan Option: How much would it cost?

In the individual market, New York State follows "pure" community rating rules. Accordingly, no premium adjustments can be made for age, disability, or other enrollee characteristics. However, the State does permit geographical rating adjustments which recognize the local cost structures across eight rating regions. The CSS team assessed the 2016 Bronze plan premiums across insurance carriers and regions.[49] To account for the regional differences in per member per month Bronze premiums across the state, the CSS team obtained premiums for each insurer on the Marketplace for the eight different rating regions of the state: Albany, Buffalo, Mid-Hudson, New York City, Rochester, Syracuse, Utica, and Long Island. These premiums were then composited using the immigrant population's geographic distribution calculated by CSS

Table 13: Bronze Plan Option
Eligible Population & Take-up Estimates

Enrollee Population	Total Eligible	Take-up
Historic Emergency Medicaid (high cost/utilization)	32,300	16,500 (51%)
New Enrollees below 138% of FPL (lower cost/utilization)	171,300	68,500 (40%)
Total	**203,600**	**85,000 (42%)**

Table 14: Bronze Plan Option
Gross Costs

Total Enrollment	**85,000**
Annual cost per enrollee	$4,400
Cost PM/PM	$366
Total Annual Costs	**$374,000,000**

based on our analysis of American Community Survey data. The insurer premiums are a composite derived using insurer enrollment distributions on the Marketplace.[50] We determined that the 2016 Bronze plan premium rates are $366 per member per month, or $4,400 per member per year.

As described in Table 14, the total gross cost to New York State of offering the Bronze Plan Option would be $374 million. This is the product of the annual cost per enrollee times the number of expected enrollees.

However, as with the Essential Plan Option discussed above, the State's costs of offering the Bronze Plan Option can be offset by State savings from the Emergency Medicaid program. To determine these savings, the CSS team first estimated the current costs of the New York Emergency Medicaid program, which is roughly $15,000 per enrollee.[51] Table 15 indicates that the federal/State government will no longer be spending $15,000 per enrollee for the Historic Emergency Medicaid program enrollees, rather it will be spending only $6,850 (the maximum out of pocket).[52] The resulting $8,150 per member annual savings, or $135 million in all, will be shared between the State and the federal government. The CSS team does not make any savings adjustments for the newly pre-qualified Emergency Medicaid enrollees, although there will be some additional savings from this group as well.

Accordingly, as summarized in Table 16, the net State cost of offering the Bronze Plan Option to 85,000 undocumented low-income New Yorkers would be $307 million, or roughly $300 per member per month. The premium-free Bronze Plan Option would have other systemic costs in the form of increasing the prices in New York's individual market.[53]

Table 15: Bronze Plan Option State Savings Estimate

Emergency Medicaid Cost per Enrollee	$15,000
Emergency Medicaid Maximum Liability	$6,850
Savings per Enrollee	$8,150
Historic Emergency Medicaid Users Enrolled	16,500
Total Savings	**$135,000,000**
State Savings	**$67,000,000**

Table 16: Bronze Plan Option Total Net Annual State Costs

Total Enrollment	**85,000**
Total Gross State Cost	$374,000,000
Total State Emergency Medicaid Savings	$67,000,000
Annual Net State Cost (Gross State Cost – Emergency Medicaid Savings)	**$307,000,000**
Annual Net State Cost per Enrollee	$3,606
Net State Cost PM/PM	**$300**

Conclusion

Table 17 summarizes the three coverage options explored in this paper. The most comprehensive policy solution explored here is the first coverage option, which consists of the State offering the Essential Plan to 241,600 immigrant New Yorkers who are currently ineligible because of their immigration status and who have incomes less than 200 percent of the FPL. The Essential Plan Option would cost the State approximately $462 million per year, or roughly $4,157 per enrollee. A substantial portion of these costs could be underwritten by the State's $645 million or more annual savings related to securing federal financing to offer the Essential Plan to the formerly entirely State-funded *Aliessa* immigrants, described above.[54]

An initial policy option in lieu of covering all unauthorized adults immediately would be to start by offering coverage to New York's 90,100 young adult immigrant New Yorkers. The Young Adult Option would build upon New York's strong commitment to young people evidenced by both our universally available (regardless of income or immigration status) Child Health Plus program and our progressive young adult coverage law in the commercial market which requires employers and insurance carriers to offer young adults the opportunity to stay on their parent's plans until the age of 29 (three years more than required under the ACA). The Young Adult Option would cost the State approximately $78 million per year, or around $2,804 per member per month.

A final policy option would be to build upon New York's commercial insurance market by offering high-deductible Bronze plans to 203,600 very low-income immigrant New Yorkers. The Bronze Plan Option would wrap around the Emergency Medicaid benefit for which the population is currently eligible. While the Bronze Plan Option would cost less than the Essential Plan option—$307 million—it potentially would have the unintended consequence of increasing the premiums in New York's individual market, due to the influx of higher cost enrollees.

In conclusion, each of these options offers practical and affordable programmatic solutions that New York State could take to substantially improve the lives of New York's newest State residents, enhance the health of our communities, and help stabilize the State's health care delivery system. These three options provide New York an opportunity to continue to lead the country in promoting policies that offer immigrants equal opportunities to those afforded to their citizen counterparts.

Table 17: Summary Table of Immigrant Coverage Options

Program	Actuarial Value	Number Eligible	Estimated # of Enrollees	Total State Costs	State Cost per Enrollee PM/PM	Annual State Cost per Enrollee
1. Essential Plan	.95–1.00	241,600	111,100	$462,000,000	$346	$4,157
2. Young Adult	.99–.70	90,100	27,900	$78,000,000	$234	$2,804
3. Bronze Plan	.60	203,600	85,000	$307,000,000	$300	$3,606

Appendix A: Population Estimation and Take-Up Methodology Notes

As discussed in the body of the report, to estimate the population of immigrants who would be newly eligible for health insurance coverage under CSS three coverage proposals, it is necessary to determine the number of undocumented and PRUCOL immigrants, and to segment these groups by age and income. While there are a number of published estimates of the number and characteristics of "unauthorized" immigrants,[55] there is no existing source which distinguishes the number or characteristics of the subcategories of undocumented and PRUCOL immigrants, categories that are highly relevant to eligibility for health insurance programs in New York State.

Unauthorized Immigrant Population by Immigration Status and Coverage

Based on data from Migration Policy Institute ("MPI"), discussed above, the CSS team use a total unauthorized immigrant population baseline of 867,000 in New York State, of which 457,000 (53%) are uninsured. MPI derived its estimates from the Census Bureau's 2009–2013 American Community Survey data. This uninsured number, the most important population baseline number for estimating coverage and costs of the CSS coverage proposals, is consistent with recent estimates from Mayor de Blasio's Task Force on Immigrant Health Care Access. The Task Force estimated that 345,000 unauthorized immigrants in New York City, or an estimated 460,000 statewide (using 74% of NYS unauthorized immigrants residing in NYC from MPI),[56] are uninsured.[57]

To analyze and model coverage options for immigrants who do not currently have access to public health insurance programs in New York State, it is necessary to further segment the "unauthorized" immigrant population into two groups: (1) PRUCOL immigrants; and (2) undocumented immigrants. MPI, the Task Force, and all other existing unauthorized population estimates include a significant but unknown number of immigrants who are PRUCOL. Undocumented immigrants (who are not eligible for Medicaid or other public programs) are the remainder. Accordingly, the CSS team could not directly use these estimates in order to analyze the policy proposals discussed in this report.

The CSS team utilized available data points for immigrant groups with specific status and coverage to estimate the total populations of undocumented and PRUCOL immigrants, and to inductively fill in the gaps for coverage/immigration status cells where data is not available in order to distribute the unauthorized population. Specifically, the CSS team estimates that:

- Unauthorized children (all are eligible for Medicaid/CHIP in NYS) – 80,100 total, or 9% of total unauthorized population.[58] The CSS team assumes 70% are enrolled in Medicaid; 15% are uninsured; and 15% have private/other coverage.[59]
- Total Unauthorized Adults – 786,100 total, or 91% of total unauthorized population.[60]
    - Undocumented adults – 264,000 uninsured.[61] The CSS team assumes an 80% uninsurance rate to derive total adult undocumented estimate of 330,000; we use State Department of Health ("SDOH") data that there are approximately 32,000 Historic Emergency Medicaid enrollees (10%);[62] we assume 10% have private/other coverage as remainder.
    - PRUCOL adults (remaining unauthorized adults). We estimate 456,100 total (786,100 minus 330,000).We assume 181,000 are uninsured (445,000 adult unauthorized uninsured from MPI minus 264,000 undocumented uninsured from Kaiser); we use SDOH data that there are 53,000 enrolled in Medicaid,[63] and we assume that the remaining 222,200 have private/other coverage.

The result of this process yields the CSS population estimates shown in Table 2 of the main report. These population segments are then used going forward to estimate eligibility and take-up in the three CSS coverage options.

Population Distribution by Income and Age

The population segments by status and coverage discussed above are then distributed by income and age to identify populations who are currently eligible for existing programs, or who would become eligible for the CSS proposed coverage options.

This distribution was initially conducted using age and income distributions from the MPI profile of the New York State unauthorized population,[64] supplemented with data from the Census Bureau's Current Population Survey Annual Social and Economic Supplement ("CPC ASEC") for the New York State non-citizen population.[65] However, the MPI income distribution was not consistent with data recently communicated to CSS by SDOH on the number of immigrants pre-qualifying for Emergency Medicaid in New York State since 2013.[66] Given the large number of low-income immigrants qualifying for Emergency Medicaid (68,000 pre-qualifying excluding 32,000 Historic Emergency Medicaid users), take-up among the estimated undocumented adults below 138% of FPL using the MPI distribution would have been over 65%, an unrealistically high rate.

To yield a reasonable take-up rate of 40% of current eligibles pre-qualifying for Emergency Medicaid, the MPI income distribution was adjusted to redistribute immigrants to lower income levels. This re-distribution was executed by assigning the number of undocumented immigrants to the under 138% of FPL income group that would constitute 40% pre-qualification take-up, and then distributing the higher income undocumented proportional to MPI. More detail on this and other methodological issues with the population estimates is available from the authors upon request.

Take-Up Estimates for CSS Coverage Proposals

Utilizing the population distribution by status, coverage, age and income described above, the CSS team then identified populations of eligible immigrants for each of the three coverage options. Different take-up rates were utilized for different income and coverage groups, as detailed for each option in the body of the report.

Overall, as discussed in the report, the CSS team utilized a medium take-up rate of 40% for newly-eligible adult populations, and 30% for newly-eligible young adults. This take-up rate takes into consideration the following factors: (1) the observed take-up rate for Qualified Health Plans in New York's Marketplace;[67] (2) the number of undocumented immigrants pre-qualifying for Emergency Medicaid through the Marketplace as discussed above; and (3) the fact that some enrollees may be more reticent about joining a public program because of their immigration status.[68] While this paper shows only the medium take-up scenario, the authors also constructed low (30%, or 20% for young adults) and high (50%, or 40% for young adults) take-up scenarios. Results are available upon request from the authors.

This overall take-up rate for new enrollees was then distributed by income for the Essential Plan and Young Adult Options, to reflect selection due to sliding scale member cost sharing. In this case, take-up was assumed to be higher for lower income beneficiaries with little or no cost sharing and to decline as income and member premium cost increases. No curve was applied for the Bronze Plan Option because only those below 138% FPL are eligible and there is no member premium differential.

The above applies only to the new enrollee groups. The other key group which will transition into the proposed CSS coverage options would be the Historic Emergency Medicaid users. These beneficiaries could enroll relatively easily into more comprehensive coverage at the time that they are receiving care through Emergency Medicaid, as they would already be interacting with the system at that point in time. As such, we assume that this group would have high take-up rates (medium take-up of 85%, low 75%, high 95%) if enrollment into comprehensive coverage is available at the time they are receiving Emergency Medicaid services.

The Essential Plan Option has continuous enrollment, so the Historic Emergency Medicaid users would all have the higher take-up rate. In contrast, the Bronze Plan and Young Adult options mirror Marketplace Plans and would only have three months of open enrollment. So, in the Bronze

Plan Option the Historic Emergency Medicaid population would have the high 85% enrollment rate for one-quarter of the population, and the standard 40% take-up rate (30% for young adults) for the remaining three-quarters of the population. This would yield a net take-up rate for the Historic Emergency Medicaid group of just over 50% for the Bronze Plan and 44% for the Young Adult Options due to the lower new eligibles take-up assumption for young adults.

Appendix B: DACA/DAPA Expansion Model Population Profile, Enrollment and Costs

In 2014, President Obama issued a far-reaching Executive Order expanding the existing 2012 Deferred Action for Childhood Arrivals ("DACA") program and creating the new Deferred Action for the Parents of Americans and Lawful Permanent Residents (DAPA) program. This Executive Order ("DACA/DAPA") was subsequently stayed, and is currently pending appeal to the Supreme Court of the United States.

If the President's DACA/DAPA expansion goes into effect, it will profoundly change the immigration status distribution of the unauthorized population in New York State. Specifically, a significant number of additional non-qualified immigrants who previously would have been considered undocumented would become PRUCOL, and as such would become eligible for Medicaid coverage in New York State.

MPI estimates that in New York State there are currently 80,000 DACA immigrants, prior to any expansion.[69] If the 2014 Executive Order were to go into effect, an additional 24,000 immigrants would be protected under expanded DACA and 231,000 immigrants would be protected under DAPA, for a total DACA/DAPA population of 338,000.[70]

Relative to Table 2 of the main report, Alternate Table 2 displayed here shows the distribution of the unauthorized immigrant population if the DACA/DAPA expansion were implemented. Most notably, 258,000 undocumented adults are rendered PRUCOL, leaving only 72,000 total undocumented adults or less than one-quarter of the current number in the non-expansion scenario. The

Alternate Table 2: Unauthorized NYS Population by Coverage and Immigration Status (DACA/DAPA Expansion Scenario)

	Unauthorized Adults (Age 19+)						Unauthorized Children (Age 0–18)		Total Unauthorized	
	Undocumented Adults		PRUCOL Adults		Total Unauth. Adults (Undoc. + PRUCOL)					
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Uninsured Total	57,600	80%	387,300	54%	444,900	57%	12,100	15%	457,000	53%
- Prequalified for ER Medicaid	8,900	21%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
- Not prequalified for ER Medicaid	48,700	59%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medicaid/CHP (incl. Historic ER Medicaid)	7,000	10%	78,000	11%	85,000	11%	56,600	70%	142,500	16%
Other/Private	7,400	10%	248,800	35%	255,300	32%	12,000	15%	267,500	31%
Total	**72,000**		**714,100**		**786,100**		**80,900**		**867,000**	

coverage mix of the undocumented remains the same as the non-expansion baseline, but the shift of undocumented people with higher uninsurance rates into the PRUCOL pool significantly increases the estimated uninsurance rate for PRUCOLs, from 40% to 54%.

Table 18 illustrates the number of New Yorkers who would be eligible for the three CSS coverage options, with and without DACA/DAPA expansion, by DACA/DAPA status. The number of eligible *decreases* in all three scenarios.

- In the existing State Essential Plan, newly PRUCOL individuals below 138% of FPL would be eligible for Medicaid coverage, and thus would not enroll in the Essential Plan Option modelled here. However, DACA/DAPA PRUCOL individuals from 138–200% of FPL would enroll in State-only funded coverage in the Essential Plan Option—in the baseline (non-Expansion) scenario this is the small "Residual PRUCOL" population discussed in the main report. In the Expansion scenario this population is much larger.

Table 18: Eligibility for CSS Proposed Coverage Options by DACA/DAPA Status

	BASELINE (no DACA/DAPA Expansion)			
	Undocumented	**DACA PRUCOL**	**Non-DACA PRUCOL**	**Total Eligible**
1. Essential Plan	236,100	5,500	0	**241,600**
2. Young Adult	60,600	3,500	26,000	**90,100**
3. Bronze Plan	203,600	0	0	**203,600**
	DACA/DAPA Expansion Scenario			
	Undocumented	**DACA/DAPA PRUCOL**	**Non-DACA/DAPA PRUCOL**	**Total Eligible**
1. Essential Plan	51,700	42,100	0	**93,800**
2. Young Adult	13,200	15,800	26,000	**55,000**
3. Bronze Plan	44,600	0	0	**44,600**

Alternate Table 17: Summary Table of Immigrant Coverage Options (DACA/DAPA Expansion Scenario)

Program	Actuarial Value	Number Eligible	Estimated # of Enrollees	Total State Costs	State Cost per Enrollee PM/PM	Annual State Cost per Enrollee
1. Essential Plan	.95–1.00	93,800	40,700	$168,000,000	$343	$4,119
2. Young Adult	.99–.70	55,000	16,700	$40,000,000	$198	$2,380
3. Bronze Plan	.60 + Emergency Medicaid Benefits	44,600	18,600	$82,000,000	$366	$4,398
4. BHP Clean Up	.95	42,086	16,830	$79,000,000	$393	$4,716

- Similarly, under the Young Adult Option expansion scenario, newly PRUCOL young adults below 138% of FPL would be eligible for Medicaid coverage and thus would not enroll in the Young Adult Option. Both DACA/DAPA and non-DACA/DAPA PRUCOL young adults would be eligible for coverage in the Young Adult Option above 138% of FPL, up to 400% of FPL with sliding scale premiums.
- The Bronze Plan Option is only available to undocumented immigrants below 138% FPL, thus the number of individuals eligible for this program declines dramatically at large numbers of undocumented individuals gain PRUCOL status.

Alternate Table 17, displayed here, illustrates the estimated eligibility, enrollment, and costs in each of the three CSS coverage proposals. Generally speaking, the results discussed above for the change in eligibility translate roughly proportionally into enrollment and cost decreases. There is some improvement in the overall selection and cost profile for the Essential Plan and Young Adult Options, as a significant portion of lower income, higher cost undocumented immigrants move out of the baseline estimates for these programs and into state-funded Medicaid as PRUCOL under the *Aliessa* case. However, the cost per enrollee is only marginally lower in the Expansion scenario results than in the baseline scenario results reflected in Table 17 of the main report. This is due to a greater percentage of individuals that are not eligible for the Emergency Medicaid benefit and therefore their costs are not offset by the Emergency Medicaid Program. In addition, different morbidity assumptions are used for the historic Emergency Medicaid population under the Expansion scenario.

NOTES

1. *See* "New York State Department of Health Budget Briefing Book, 2015-2016," ("Total Federal, State and local Medicaid spending is expected to be $62 billion in 2015–16.") at 99, available at: https://www.budget.ny.gov/pubs/executive/eBudget1516/fy1516littlebook/HealthCare.pdf; *see also* J. Helgerson, "MRT Update—Progress-to-Date, DSRIP and the Road to Value-Based Payment," ("Current Medicaid spend in New York is approximately $59 billion annually (also 2nd in nation)"), at 3 (July 2016), available at: http://www.uhfnyc.org/uploads/Files/Presentations/2015_Medicaid_Jason_Helgerson.pdf.

2. New York State of Health, "2015 Open Enrollment Report," (July 2015).

3. M. Gardner et al., "Undocumented Immigrants' State & Local Tax Contributions," Institute on Taxation and Economic Policy, at 3 (April 2015), available at: http://www.itep.org/immigration/.

4. *See Lewis v. Grinker*, No. 79-1740, 1987 WL 8412, at *8 (E.D.N.Y. Mar. 5, 1987); *see also* Catholic Immigration Legal Network, Inc., "Eighteen States Offer Prenatal Care to Undocumented Immigrant Women,"(indicating that New York is one of two states with State-only funding for prenatal coverage for undocumented women)(Nov. 2013), available at: https://cliniclegal.org/resources/articles-clinic/eighteen-states-offer-prenatal-care-undocumented-immigrant-women-nov-2013.

5. *See* N.Y. Pub. Health Law §2510 (McKinney's 2015).

6. *Aliessa v. Novello*, 730 N.Y.S.2d 1 (2001).

7. *See* New York State Department of Health, General Information System 07 MA/017, (Sep. 9, 2007), available at: https://www.health.ny.gov/health_care/medicaid/publications/pub2007gis.htm.

8. *See* National Immigrant Law Center, "Medical Assistance Programs for Immigrants in Various States," (Sep. 2015); available online at: http://nilc.org/document.html?id=159. All 50 states and DC provided some form of Emergency Medicaid, as of 2010. Legal Momentum and Morgan Lewis, LLP, "Emergency Medicaid for Non-Qualified Immigrants," (undated), available at: http://iwp.legalmomentum.org/public-benefits/health-care/17.1_Emergency-Medicaid-Chart-MANUAL-ES.pdf.

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Adults," *Am. J. of Pub. Health*, 99(12) 2289-2295 (2009); S. Collins et al., "Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief," The Commonwealth Fund, (2011), available at: http://www.commonwealthfund.org/Surveys/2011/Mar/2010-Biennial-Health-Insurance-Survey.aspx; J. Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *J. of the Am. Med. Ass'n.*, 297(10):1073-84 (2007); S. Rhodes et al., "Cancer Screening—United States, 2010," Centers for Disease Control, (2012), available at: http://www.cdc.gov/mmwr/pdf/wk/mm6103.pdf.

11. *See, e.g.*, R. Riffkin, "Cost Still a Barrier Between Americans and Medical Care, Gallup, (Nov. 2014), available at: http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx; Community Service Society of N.Y., "Findings from a Statewide Poll on Health Reform in New York," (Feb. 2008).

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13. A. Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *The Q. J. of Econ.*, Oxford University Press, vol. 127(3), at 1057-1106 (2012); D. Himmelstein et al., "Medical bankruptcy in the United States, 2007: Results of a National Study." *Am. J. of Med.*, 122(8):741-6 (2009), available at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

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15. K. Baicker et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New Eng. J. of Med.*, 368: 1713-1722 (2013).

16. J. Hadley, *supra*, n. 12.

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21. Office of the New York City Comptroller, "Holes in the Safety Net: Obamacare and the Future of the New York City Health and Hospitals Corporation," (2015), available at: http://comptroller.nyc.gov/wp-content/uploads/documents/Holes_in_the_Safety_Net.pdf.; E. Allen et al., "Linking Medicaid Expansion and Cuts to Disproportionate-Share Hospitals," *Obstetrics & Gynecology*, 126(2):442-45 (2015); L. Ku et al., "Safety-Net Providers After Health Care Reform: Lessons From Massachusetts," *Arch. of Intern. Med.*, 171(15):1379-1384 (2011).

22. Migration Policy Institute ("MPI"), "Unauthorized Immigration Population Profiles," available at: http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles (867,000). Another researcher, Jeffrey Passel of Pew Hispanic Center, estimates that there are 875,000 unauthorized immigrants. *See* J. Passel et al.,"Population Decline of Unauthorized Immigrants Stalls, May Have Reversed," Pew Hispanic Center, (Sept. 2013), available at: http://www.pewhispanic.org/files/2013/09/Unauthorized-Sept-2013-FINAL.pdf (875,000).

23. *See* MPI, *supra*, n. 22, custom tabulation for CSS by Manatt Health Solutions.

24. *Id.*

25. The five categories of "residual" PRUCOL adults are: (1) Deferred Action for Childhood Arrivals; (2) people who have requested Deferred Action; (3) immediate relatives with approved I-130 status; (4) registry aliens; and (5) non-citizens who are residing in the United States with the knowledge and acquiescence of the USCIS/ICE. *See* Empire Justice Center, "Health Coverage Crosswalk: Eligibility by Immigration Status," (August 2015),

available at: http://www.empirejustice.org/assets/pdf/publications/reports/health-coverage-crosswalk.pdf.

26. D. Holahan, "The Estimated Impact of a Basic Health Basic Health Program in New York," New York Health Benefit Exchange, (July 2013), available at: https://www.health.ny.gov/health_care/medicaid/redesign/basic_health_program_workgroup/docs/2013-07-31_Essential Plan _presentation.pdf. These 53,000 immigrants are PRUCOL and are distinct from the 162,000 Lawful Permanent Residents who are subject to the five year bar for federal financial participation in the Medicaid program. Together, these two groups constitute the "*Aliessa*" population.

27. "How Will the Uninsured in New York Fare Under the Affordable Care Act?" Kaiser Family Foundation, (Jan. 2014), available at: http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-new-york/

28. New York Department of Health, personal communication with the authors (Aug. 2015).

29. New York University analysis of 2011 New York State Medicaid claims and encounters for Emergency Medicaid beneficiaries ("NYU Data"), provided to CSS in October 2014.

30. United States Citizenship and Immigration Service, "What is DACA?" available at: http://www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-daca.

31. E. Benjamin et al., "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," Community Service Society, (2012); *see also* D. Holahan, *supra*, n. 25; "New York State Department of Health, "FY 2016 Executive Budget and Global Cap Update," (Feb. 2015), available at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-16_executive_budget_webinar.pdf.

32. New York State of Health, plan finder, https://nystateofhealth.ny.gov/individual (last visited Nov. 23, 2015).

33. CSS assumes the following actuarial values: .999 for enrollees below 138% of the FPL; .997 for enrollees between 138% to 150% of FPL; and .950 for enrollees between 150% and 200% of FPL.

34. The State set slightly different actuarial values for the plans that these two income groups enroll in when it issued the Essential Plan.

35. *See, e.g.*, K. Hacker et al., "Barriers to Health Care for Undocumented Immigrants: A Literature Review." *Risk Mgmt. & Healthcare Pol'y,* 8:175-183 (2015).

36. The estimated take-up rate takes for the Newly Eligible Enrollees is based on three factors: (1) the observed take-up rate for Qualified Health Plans in New York's Marketplace; (2) the number of undocumented immigrants pre-qualifying for Emergency Medicaid through the Marketplace; and (3) the fact that some enrollees may be more reticent about joining a public program because of their immigration status. Based on our analysis of the New York State of Health 2015 Open Enrollment Reports, data from the Current Population Survey, and data recently released from NYSDOH on the number of immigrants prequalifying for Emergency Medicaid, CSS modeled a range of take-up rates: a low of rate of 30%; moderate rate of 40%; and a high rate of 50%. For this report, we used a moderate take-up rate of 40%.

37. NYU Data, *supra*, n. 29.

38. Gorman Actuarial reviewed the DRGs for these claims and found that the most common claims related to the following illnesses: heart failure, renal failure, alcohol abuse, chemotherapy, diabetes, HIV. Gorman compared this data with the public available data for the NY Pre-Existing Condition Insurance Plan (NY PCIP) where the annual cost per enrollees was $43,698. Gorman determined that while the Emergency Medicaid population is high risk, it is not as costly as the NY PCIP program (both because of the nature of the morbidity and the reimbursement rate structure).

39. 2012 New York State Medicaid Managed Care Operating Reports, provided to CSS by Manatt Health Solutions.

40. The 32,984 enrollment count is from 2011, the year the authors had Emergency Medicaid claims data (the NYU data). This count is slightly higher than the 2013 population count used above (received from the New York State Department of Health).

41. Gorman made four assumptions when calculating the risk and selection adjustments: (1) New York's FHP has an equivalent risk as the commercial market, represented in the 2014 federal AV Calculator; (2) the relative risk of the eligible undocumented immigrant population (241,600) is equivalent to the FHP and commercial market; (3) the Historical Emergency Medicaid enrollees have the highest risk of the undocumented immigrant population; and (4) the highest risk population will join first.

42. The CSS team used the following actuarial model. We assigned the eligible enrollees into 10 cohorts from most expensive to least expensive. We then allocated each cohort into two categories: (1) the Historic Emergency Medicaid population; and (2) the New Eligibles. Because of their morbidity, the Historic Emergency Medicaid enrollees were distributed solely in the top

two cohorts, while the new enrollees were distributed across cohorts two through ten. We applied their respective take-up rates and then calculated a weighted average claims relativity for each population which determined our morbidity/selection adjustment. This model produced a 5.2 adjustment for the Historic Emergency Medicaid enrollees and a 0.89 for the New Enrollees, reflecting their healthier status. These adjustments were calculated under the medium take-up scenario.

43. This cost is net of the $20 per member per month paid for by the estimated 8,500 premium paying members between 150% and 200% of FPL.

44. While the premiums for the higher-income immigrants in the Young Adult option would be more affordable than the premiums faced by their non-immigrant counterparts enrolled in Marketplace qualified health plans, the Young Adult plans would likely have less robust networks because they are using a public—as opposed to a commercial—plan model.

45. Because New York is a pure community-rating state, it is much less costly to offer Young Adults a separately-rated "CHP-like" option. As part of this study, the CSS team modeled the separate option of developing a Young Adult program that would enroll people in coverage that mimics the Qualified Health Plans offerings in the New York State of Health Marketplace with their respective financial assistance levels. The CSS team rejected this Young Adult Marketplace Option because its cost of $120 million was roughly double the Young Adult Option that builds upon our CHP program described in this report.

46. Selection adjustments were made based on take-up assumptions. Low take-up assumptions utilized a 20% selection adjustment, medium take-up assumptions utilized a 15% adjustment and a high take-up utilized a 10% adjustment. Medium take-up is used in this paper.

47. At the time of writing, there is more than 400,000 enrollees in New York's individual market. The CSS team estimates that the premiums in the individual market would increase by about 10% to 15%, were this option adopted.

48. Author communication with New York State Department of Health staff, August 2014. The popularity of the Emergency Medicaid Pre-Qualification program seems remarkable at first glance. However, the CSS team believes three factors contributed to its popularity: (1) the ease of enrollment into the program through the New York State of Health Marketplace; (2) the Fall 2014 announcement of President Obama's DAPA program; and (3) the Spring 2015 announcement of a NYC City ID, designed to ease documentation issues for immigrant New York City residents.

49. New York State Department of Financial Services, "2015 and 2016 Average Approved Premium Rates—Individual Market," available at: http://www.dfs.ny.gov/consumer/health/2015_and_2016_avg_approved_ind_rates.pdf.

50. New York State of Health, *supra*, n. 2.

51. NYU Data, *supra,* n. 29.

52. CSS assumes no savings from the newly enrolled pre-qualified Emergency Medicaid enrollees and the uninsured population.

53. Gorman estimate that the influx of the Emergency Medicaid beneficiaries into New York's Individual Market through the Bronze Plan Option could cause a 10 to 15 percent increase in premiums.

54. *See* E. Benjamin et al., *supra*, n. 31.

55. *See, e.g., supra,* n. 22, *see also* J. Passel et al., "A Portrait of Unauthorized Immigrants in the United States." Pew Hispanic Center, (April 2009), available at: http://pewhispanic.org/files/reports/107.pdf; D. Holahan et al., "Characteristics and Health Insurance Coverage of New York's Non-Citizens," United Hospital Fund, (2009), available at: http://nyshealthfoundation.org/uploads/resources/characteristic-health-insurance-coverage-noncitizens-july-2009.pdf; S. Wallace et al., "Undocumented Immigrants and Health Care Reform." UCLA Center for Health Policy Research, (Aug. 2012), available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf

56. *See* MPI, *supra,* n. 22.

57. Task Force on Immigrant Health Care Access, *supra,* n. 9.

58. *See* MPI, *supra,* n. 22.

59. Assumptions by CSS, based on non-citizen population distribution from 2014 Current Population Survey, Annual and Social Economic Supplement. Tabulation from CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

60. *See* MPI, *supra,* n. 22.

61. Kaiser Family Foundation, *supra,* n. 20.

62. NYU Data, *supra,* n. 29.

63. *See* D. Holahan, *supra,* n. 25.

64. *See* MPI, *supra*, n. 22.

65. 2014 Current Population Survey, Annual and Social Economic Supplement. Tabulation from CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

66. Author communication with New York State Department of Health staff, August 2014.

67. F. Blavin et al, "Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area Revised," Urban Institute, (May 2013), available at: http://info.nystateofhealth.ny.gov/sites/default/files/Uninsured%20New%20Yorkers%20Substate%20Regions%20Report%2C%20May%202013_1.pdf; New York State of Health, *supra*, n.2.

68. *See, e.g.*, K. Hacker et al., *supra,* n. 35.

69. MPI, "Deferred Action for Childhood Arrivals (DACA) Profiles," available at: http://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles.

70. MPI, "MPI: As Many as 3.7 Million Unauthorized Immigrants Could Get Relief from Deportation under Anticipated New Deferred Action Program,"available at: http://www.migrationpolicy.org/news/mpi-many-37-million-unauthorized-immigrants-could-get-relief-deportation-under-anticipated-new.

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