SAFEGUARDING IMMIGRANT COVERAGE

PROTECTING AND EXPANDING HEALTH CARE COVERAGE FOR ALL IMMIGRANTS IN NEW YORK STATE

A REPORT BY MAKE THE ROAD NEW YORK
JANUARY 2017
Safeguarding Immigrant Coverage

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Safeguarding Immigrant Coverage
Expanding Health Coverage
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The Patient Protection and Affordable Care Act—commonly known as the Affordable Care Act (ACA)—that was passed into law in 2010 provides more options to access free or low cost health insurance. The ACA, through the New York State of Health, provided insurance to more than two million New Yorkers as of February 4th, 2015 (New York State of Health, 2015). While New York State has made important strides in providing coverage, key populations in the state remain uninsured. According to the Migration Policy Institute, there are 873,000 undocumented immigrants in New York State. Of those, more than half—approximately 457,000—are uninsured (Migration Policy Institute, 2013b). Additionally, this number of uninsured individuals may increase in the years to come, since the incoming administration has made it a priority to dismantle the ACA.

Being uninsured is linked to higher rates of chronic disease and less access to health care providers. One of the main groups of immigrants that are not eligible for health insurance are undocumented immigrants. Due to federal laws, undocumented immigrants are explicitly excluded from even purchasing full price insurance on the Marketplace and are generally not eligible for public insurance. Another group of immigrants who may remain uninsured are those immigrants that are considered to be Permanently Residing under the Color of Law (PRUCOL) with income that is too high to qualify for state funded Medicaid. These are individuals who are not permanent legal residents of the U.S., but the U.S. Citizenship and Immigration Services (USCIS) knows of their presence and has committed not to deport them. PRUCOL individuals in New York State who meet certain income requirements are eligible for state-funded Medicaid because of the 2001 Aliessa v. Novello decision (Aliessa v. Novello, 730 N.Y.S.2d 1).

To better assess this issue landscape, Make the Road New York (MRNY) collected 838 surveys, and conducted eight focus groups, virtually all of which were with Latino immigrants, who approached the organization for help in accessing health services.

The aim of this research was to address the following questions:

1. Does having health insurance lead to increased access to health care for immigrants?
2. How can New York State increase health insurance coverage for the remaining uninsured immigrants?

Our analysis of this data produced the following key findings:

• Having health insurance more than doubled the rate at which someone had a person that he or she considered a personal doctor or health care provider.
• Having health insurance increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional about his or her health. Insurance also increases the likelihood that an individual goes to the doctor when he or she is sick or in need of care. Approximately 90% of people who had insurance for 3 months to 1 year had seen a primary
care provider in the last year, compared with 70% of uninsured individuals.

- Having insurance decreases the rate that patients use outpatient hospitals or emergency rooms for health care, and increases use of clinics and doctors’ offices. 28% of uninsured individuals surveyed receive regular care at a hospital outpatient department compared to 13% after being insured for 3 months, 12% after being insured for 6 months and 9% after being insured for more than one year. After having insurance for 6 months or more, 50% receive care from a doctor’s office compared to 20% of the uninsured.

- Having health insurance reduces community members’ stress related to financial difficulties by decreasing their concerns that they will be left with overwhelmingly high medical bills if they get sick or have an accident.

- Approximately 82% of individuals who are uninsured are very worried about being able to pay for their medical bills compared to 47% of individuals who have been insured for more than one year.

- There is a strong interest among the remaining uninsured for an affordable health insurance option. For example, 87% of uninsured and ineligible respondents would rather have health insurance than go to a clinic and pay a sliding fee scale.

Given these findings, this report recommends that New York State take the following steps to protect and expand health access for Latino and immigrant New Yorkers:

**KEY RECOMMENDATIONS**

1. Protect health insurance coverage options at the federal and state level to ensure that individuals currently insured remain insured.

2. Create a comprehensive, low cost insurance program for undocumented immigrants and PRUCOL immigrants who are currently ineligible for insurance that includes key services such as primary care, dental, emergency care, and prescriptions.

3. Build off of New York City’s new Action Health NYC initiative to improve access to services and more coordination of care for undocumented immigrants as an interim solution while these individuals remain uninsured.

4. Target health insurance outreach in immigrant communities: conducting outreach by trusted community members or community organizations in immigrant communities will lead to increased enrollment in insurance for those who are eligible, thus leading to increased utilization of care.
The Patient Protection and Affordable Care Act—commonly known as the Affordable Care Act (ACA)—that was passed into law in 2010 provides more options to access free or low cost health insurance. The ACA allowed each state the option of expanding health insurance coverage by increasing the eligibility limits for Medicaid. The ACA also created new health coverage options that can be purchased through the Health Benefits Exchange, known as the “Marketplace” (De Jung & Weiner, 2013). New York State implemented the New York State of Health Marketplace, a web site where individuals can purchase public and private health insurance and be screened for tax credits and subsidies. The ACA, through the New York State of Health, provided insurance to more than two million New Yorkers as of February 4th, 2015 (New York State of Health, 2015).

As reported in February 2016, over 2.8 million New Yorkers obtained health insurance through the Marketplace as of January 31st, 2016, the end of the 2016 open enrollment period. According to data released by the Centers for Disease Control and Prevention, the rate of uninsured New Yorkers decreased from 10% to 5% between September 2013 and September 2015 (New York State of Health, 2016).

New York State has traditionally provided more health insurance options to immigrants than the federal government. For example, based on the 2001 Aliessa v. Novella ruling by the New York Court of Appeals, New York State must “provide aid, care and concern” for lawfully admitted permanent residents and individuals who are Permanently Residing under the Color of Law (PRUCOL) (Berlinger, Calhoon, Gusmano, & Vimo, 2015, p. 9). These are individuals who are not legal residents of the U.S., but the U.S. Citizenship and Immigration Services (USCIS) knows of their presence and has committed not to deport them. One main category of immigrants who are considered PRUCOL are those who are remaining in the country because of the 2012 immigration Executive Action “Deferred Action for Childhood Arrivals” (DACA). Additionally, the federal government imposes a five-year waiting period for lawful permanent residents (except pregnant women and children) to receive federally funded Medicaid. However, the New York Court of Appeals in the Aliessa v. Novello decision ruled that all lawfully
president immigrants must have access to State-funded Medicaid during the five-year federal waiting period (New York Immigration Coalition, 2013).

New York State also provides some health insurance coverage options to undocumented immigrants. For example, all undocumented immigrant children under the age of 19 receive health insurance via the Child Health Plus Program (CHP). The families eligible for CHP pay a monthly premium based on their income (New York State Department of Health, n.d.-a). Additionally, New York State has a program called Medicaid for Pregnant Women (previously known as PCAP), which provides state-funded Medicaid to undocumented mothers for prenatal, delivery, and postpartum care (New York Immigration Coalition, 2013).

Undocumented immigrant adults are eligible for Emergency Medicaid in New York State if they are income-eligible. Emergency Medicaid covers the treatment of conditions, including emergency labor and delivery, that “manifest [themselves] by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient’s health in serious jeopardy, serious impairment to bodily function; or serious dysfunction of any bodily organ or part” (New York State Department of Health, n.d.-b, n.p). In 2013, the New York State Department of Health issued a directive (GIS 13 MA/09), which allowed undocumented immigrants to prequalify for Emergency Medicaid through the New York State of Health Marketplace, the online portal to apply for health insurance. These individuals are issued a Medicaid benefit card, distinguishable as emergency-only via the coding in the card, which is valid for 12 months but only able to be used during emergency situations (Arnold, 2013).

All residents of New York State, regardless of immigration status, can access New York’s Hospital Financial Assistance Program, also known as charity care provided they meet the income guidelines. Hospitals are required to provide care to everyone regardless of their insurance or immigration status. Uninsured and undocumented New Yorkers also rely heavily on New York’s safety net system. The safety net system is defined by the Institute of Medicine as those providers that “organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable patients (Berlinger, Calhoon, Gusmano & Vimo, 2015, p. 5).” For example, the major safety net systems in New York City are The New York City Health + Hospitals (formally known as New York City Health and Hospitals Corporation), the nation’s largest public hospital system, and Federally Qualified Health Centers (FQHC’s), non-profit organizations that offer primary and preventative care (Berlinger, Calhoon, Gusmano, & Vimo, 2015). The safety net systems offer sliding scale fees based on income, but do not take into account one’s immigration status (De Jung & Weiner, 2013).
New York City has also made important strides over the past few years to improve access to care for uninsured immigrants. For example, in June 2014, Mayor Bill de Blasio launched the Task Force on Immigrant Health Care access and released a report in October 2015. The Task Force brought together city agencies, health care providers, and advocates to identify barriers to health care access and recommend steps to improve access to care for immigrants. One of the recommendations that came out of the Task Force was the creation of a direct access program, now called Action Health NYC (The Mayor’s Task-force on Immigrant Healthcare Access, 2015). Action Health NYC offers low- or no-cost coordinated health care to enrollees who are immigrant New Yorkers that currently do not have access or qualify for health insurance, contingent upon income-eligibility. Participants will have access to primary and specialty health care. The program features a primary care home model, in which patients have an opportunity to build a relationship with health professionals who understand their individual medical history and health care needs, as well as additional care support mechanisms for individuals with high-risk chronic conditions. The Council also has several initiatives dedicated to improving immigrants access to healthcare, such as the Immigrant Health Initiative and Access Health NYC. Access Health NYC is a city-wide initiative that funds community-based organizations to provide education, outreach, and assistance to all New Yorkers about how to access health care and coverage.

While New York City and State have made important strides in providing coverage and improved access to care, key populations in the state remain uninsured. According to the Migration Policy Institute, there are 873,000 undocumented immigrants in New York State. Of those, more than half—approximately 457,000—are uninsured (Migration Policy Institute, 2013b). Being uninsured is linked to higher rates of chronic disease and less access to health care providers. One of the main groups of immigrants that are not eligible for health insurance are undocumented immigrants. Due to federal law, undocumented immigrants are explicitly excluded from even purchasing full price insurance on the Marketplace and are generally not eligible for public insurance.

The ACA and the resulting New York State of Health have been an enormous boon for expanding access to health insurance and coverage for New Yorkers, but the Latino and immigrant populations still face substantial barriers to coverage.
Another group of immigrants who may remain uninsured are those immigrants that are considered to be PRUCOL with income that is too high to qualify for state funded Medicaid. According to a report by the Community Service Society (CSS), there are 5,500 PRUCOL individuals with income between 138-200% of the federal poverty level who will remain uninsured (Benjamin, 2016).

PRUCOL individuals in New York State who meet certain income requirements are eligible for state-funded Medicaid because of the 2001 Aliessa v. Novello decision (Aliessa v. Novello, 730 N.Y.S.2d 1). Most PRUCOL individuals will also be eligible for the Basic Health Program, called the “Essential Plan.” In 2014, New York State approved the Essential Plan to offer public health coverage to New Yorkers with income under 200% of the federal poverty level beginning in January 2016. Because federal dollars are being used to fund the Essential Program, New York State is moving PRUCOL immigrants from state funded Medicaid to the Essential Plan. This will allow New York to access federal dollars to help pay for insurance for some individuals that are currently on insurance paid for by the state. However, the Obama administration released a policy announcement that excluded deferred action-eligible individuals from health insurance options through the ACA (Mann, 2012). In New York, these immigrants will remain on state-funded Medicaid if they are income eligible, and they will not be moved to the Essential Plan. However, if their income is above the Medicaid income limit, they are not eligible for any insurance. As mentioned above, there are 5,500 PRUCOL individuals who will not have coverage. Thus, there remain significant gaps in coverage.

This disparity in health insurance eligibility has a negative impact on immigrant families and society at large. According to the report recently released by CSS called “How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents,” individuals without coverage are more likely than their insured counterparts to avoid seeking necessary medical care for fear of the costs associated with it. When they do seek care, they are often left with debilitating medical bills and debt and receive lower quality care (Benjamin, 2016).

The number of uninsured individuals may increase in the years to come, since the incoming administration has made it a priority to dismantle the ACA. If the ACA were dismantled, there is a risk of losing the Medicaid expansion in New York State, the Essential Plan, Qualified Health Plans, and subsidies and tax credits, among many others benefits and programs. This would have an enormously detrimental impact on the indi-
individuals who gained insurance through these programs over the past few years.

In short, the ACA and the resulting New York State of Health have been an enormous boon for expanding access to health insurance and coverage for New Yorkers. The coverage gains should be protected and expanded upon, since Latino and immigrant populations still face substantial barriers to coverage. To better assess this issue landscape, Make the Road New York collected 838 surveys, and conducted 8 focus groups, virtually all of which were with Latino immigrants, who approached the organization for help in accessing health services. In what follows, we present data collected from both those who were able to obtain health insurance and those who were not eligible due to their immigration status.

The findings of the surveys are clear:

• Having health insurance more than doubled the rate at which someone had a person that he or she thinks of as his or her personal doctor or health care provider.

• Having health insurance increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional about his or her health. Insurance also increases the likelihood that an individual goes to the doctor when he or she is sick or in need of care.

• Having insurance decreases the rate that patients use outpatient hospitals or emergency rooms for health care, and increases use of clinics and doctors’ offices.

• Having health insurance reduces community members’ stress related to financial difficulties by decreasing their concerns that they will be left with overwhelmingly high medical bills if they get sick or have an accident.

• There is a strong interest among the remaining uninsured for an affordable health insurance option.
METHODOLOGY

Make the Road New York (MRNY) is one of several organizations across New York State that enrolls thousands of individuals a year in health insurance. Given MRNY’s deep connection to immigrant community members, we conducted a quantitative and qualitative analysis of the effects of having health insurance on utilization of care.

The surveys centered on two questions:

1. Does having health insurance lead to increased access to health care for immigrants?

2. How can New York State increase health insurance coverage for the remaining uninsured immigrants?

As part of answering the second question, our research explored which of several options listed below is best from the community perspective to cover the remaining uninsured immigrants. We explored these four coverage options because they are the ones that have been examined most closely by policy makers and stakeholders, and they appear to be feasible options from a policy perspective.

The data shed light on several policy options explored in the report by Elisabeth Benjamin with CSS to cover the remaining uninsured immigrants (Benjamin, 2016).

State funded Basic Health Program (“Essential plan”): Eligible enrollees who are not Medicaid eligible will be eligible for the Essential Plan, but funded with state only dollars. There will be little to no cost for enrollees.

BHP “Clean up” option (cover the “residual” PRUCOLs): This option eliminates the cliff for immigrants who are eligible for Medicaid but not the Essential Plan or federal subsidies on the Marketplace. This option would offer state-only funded Essential Plan to immigrants who are ineligible for federally funded Essential Plan or federal subsidies because of their immigration status.
Young Adult Coverage for undocumented and PRUCOL adults between the ages of 19 and 30 up to 400% of FPL: Eligible enrollee will receive a plan similar to Child Health Plus, where they will receive sliding fee scale financial assistance based on their income. These enrollees will receive comprehensive coverage that mimics New York State of Health subsidies to young adults. High deductible Bronze plan to supplement Emergency Medicaid for low-income undocumented adults below 138% of FPL: Eligible enrollees will receive free preventative and emergency care but all other care is subject to a $3000 deductible. There will be no monthly premium associated with this option.

To fully answer the questions about how health insurance affects access to health care and examine the gaps that remain, MRNY collected and analyzed longitudinal data to assess the effect of having health insurance over a span of time (3 months, 6 months and more than 1 year) on those who were able to acquire it through the New York State of Health. MRNY also collected data from undocumented immigrants at one point in time who are not eligible for health insurance due to their immigration status. MRNY collected data for three different groups on health care and health status to inform the advocacy strategy. The groups were the following:

- Latino immigrants in New York who are not eligible for health insurance due to their immigration status. That includes undocumented immigrants and certain PRUCOL immigrant. Participants in this group only received the baseline survey.
- Latino immigrants who are uninsured but are eligible for health insurance at the start of the study and subsequently enroll in insurance. This group was observed over time, and received the baseline survey when the individuals applied for insurance at a MRNY office and were uninsured. They received a follow-up survey three months and six months after obtaining insurance to assess the utilization of care post enrollment.
- Individuals who have had insurance for more than one year, and who were already insured once we met with them to complete the survey. These individuals only received one survey.

The sample consisted of individuals who came to MRNY offices in Brooklyn, Queens, Staten Island, and Long Island and were interested in participating in the survey. We recruited participants from MRNY nightly committee meetings that focused on immigration, workers, and housing issues. Additionally, participants were recruited through MRNY health insurance enrollers who identified individuals who applied for and received health insurance, as well as those who did not qualify for health insurance due to their immigration status.
MRNY completed 286 baseline surveys (annotated throughout as “baseline”) with uninsured individuals, 157 follow-up surveys three months after enrollment in health insurance (annotated throughout as “<3 months”), 123 follow-up surveys 6 months after enrollment in health insurance (annotated throughout as “< 6 months”). Additionally, MRNY completed 180 surveys with immigrants who are not eligible for insurance because of their immigration status (included in the baseline survey results below) and 92 surveys with individuals who have had insurance for more than one year (annotated throughout as “> 1 year”). Additionally, MRNY conducted 4 focus groups with individuals who enrolled in health insurance, and 4 focus groups with undocumented immigrants. For the purposes of the analysis, the baseline survey results for individuals who are eligible to enroll in insurance and undocumented are combined.

The key findings from this project are:

- Having health insurance more than doubled the rate at which someone had a person that he or she thinks of as his or her personal doctor or health care provider.

- Having health insurance increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional about his or her health. Insurance also increases the likelihood that an individual goes to the doctor when he or she is sick or in need of care.

- Having insurance decreases the rate that patients use outpatient hospitals or emergency rooms for health care, and increases use of clinics and doctors’ offices.

- Having health insurance reduces community members’ stress related to financial difficulties by decreasing their concerns that they will be left with overwhelmingly high medical bills if they get sick or have an accident.

- There is a strong interest among the remaining uninsured for an affordable health insurance option.

1) Having health insurance more than doubled the rate at which someone had a person that he or she thinks of as their personal doctor or health care provider.

The data presented in Table 1 (see below) demonstrate clearly that those who have insurance are much more likely to have someone they think of as their personal doctor than those who do not have insurance. Being eligible for insurance and enrolling in insurance greatly increases the chances of having a primary care doctor. Insured individuals have more options to seek care, and can make appointments with a specific provider, unlike those who are uninsured. Those ineligible for insurance felt limited in their ability to have someone they considered their personal doctor.
Below are focus group and interview responses that illustrate this trend.

- “I take advantage of the insurance that I have. I have my own doctor that is able to see me, and knows me and my body well.”

- “I am a member of Make the Road New York and have Medicaid. My husband has Medicaid too; he had a brain tumor... having health insurance has helped us a lot. We both are able to have our own doctors.”

- “It is so much better to have your own doctor! That way they know me, they know my body, understand my body, and will be able to provide the best attention for me because they know me. They will be able to diagnose any potential illness because they could just pull up my record and have everything available to them.”

One person interviewed was Nester Ramirez (pictured left) who was 89 years old when interviewed and had Medicare at the time of the interview, which allowed him to have a primary care provider. He stated: “I don’t know what I would do without insurance. I am 89 years old and need regular medical attention. I am lucky that with health insurance, I am able to receive the care I need and have a relationship with a primary care provider.”
Therefore, individuals with insurance appreciate having access to a primary care provider who they know and trust. Those without insurance would prefer to have a primary care provider who they can regularly visit who understands their needs.

2) Having health insurance increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional about his or her health. Insurance also increases the likelihood that an individual goes to the doctor when he or she is sick or in need of care.

The data presented in Table 2 (see below) demonstrate clearly that those with insurance are more likely to have seen a primary care provider in the past six months than those without insurance. Additionally, individuals without insurance are more likely than those with insurance to have gone more than one year without seeing a primary care provider. Approximately 90% of people who had insurance for 3 months to 1 year had seen a primary care provider in the last year, compared with 70% of uninsured individuals. The data presented in Table 3 (next page) demonstrates that while individuals with and without insurance are both more likely to visit a doctor when they are sick, than avoid receiving care, those without insurance are more likely than those with insurance to avoid seeking care when sick. 35% of those without insurance avoided seeking care when sick in the past 12 months, compared to 28% of those insured for 3 months and 15% of those insured for 6 months.

**TABLE 2: RECENT DOCTOR’S VISITS**

Below are focus group and interview responses that illustrate this trend.

- “I wish it (Emergency Medicaid) would cover general checkups, it just isn’t enough for me. I can’t do anything with it, or use it for anything at all. If I had health insurance, I would go to the doctor as needed.”
When Margarita Camacho Cruz (pictured right) was pregnant, she was able to access Medicaid for Pregnant Women, which allowed her to access the care she needed. She was able to receive regular visits with her primary care provider. However, after her pregnancy, due to her immigration status she will lose her coverage, and is worried that she will no longer be able to receive the same care as when she was insured.

**TABLE 3: DOCTORS’ VISITS WHEN SICK**

<table>
<thead>
<tr>
<th>Has there been a time in the past 12 months when you were sick and did not go to the doctor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>90</td>
</tr>
</tbody>
</table>

- “It is important for me to have health insurance, because if something was wrong the doctor would be able to check me beforehand. I would have access to that preventive care that is so important.”
- “I am going frequently to the doctor. I try to use those services as much as possible. Every time that I get a medical service I always ask the nurse to call me when it is time to come back for another visit. You need to take advantage if you have insurance. I do not wait until I get sick.”
- “I am able to get the services I need with insurance. I can get referrals to see a gynecologist or get a colonoscopy done. Those are very important services. I make sure to go to these doctors often to make sure everything is okay.”
Therefore, having health insurance increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional. It is also much harder for individuals without insurance to access regular care.

3) **Having insurance decreases the rate that patients use outpatient hospitals or emergency rooms and increases use of clinics and doctors’ offices.**

The data presented in Table 4 (see below) demonstrate that access to insurance changes where an individual receives care. The longer an individual is insured, the more likely he/she is to receive services from a clinic or health center or from a doctor’s office. Uninsured individuals are most likely to receive hospital outpatient services than any other form of care, and are the group of individuals who rely most on hospital outpatient services. For example, 28% of uninsured individuals surveyed receive regular care at a hospital outpatient department compared to 13% after being insured for 3 months, 12% after being insured for 6 months and 9% after being insured for more than one year. After having insurance for 6 months or more, 50% receive care from a doctor’s office compared to 20% of the uninsured.

Furthermore, uninsured individuals are more likely than any other group to not receive care from the same place regularly or not receive care at all. 14% of the uninsured don’t get care at all and 6% don’t receive care at one place. After having insurance for more than one year, only 1% doesn’t receive care at all and 3% don’t receive care at one place in particular.

### TABLE 4: PREVENTATIVE CARE LOCATIONS

<table>
<thead>
<tr>
<th>Location</th>
<th>Baseline</th>
<th>&gt;3 month</th>
<th>&gt;6 month</th>
<th>&gt;1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/health center</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor’s office</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>2%</td>
<td>5%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t get preventative care</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Don’t go to one place</td>
<td>2%</td>
<td>5%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>SOME OTHER PLACE</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Individuals in the baseline/uninsured group were asked “when you obtain insurance, do you plan to seek medical services that you did not have before.” In the follow up surveys and surveys with insured individuals they were asked the question “did having insurance help you seek medical care?” The data presented in table 5 (see below) demonstrates that those without insurance, when reflecting on the possibility of obtaining coverage, plan on seeking medical care that they can not receive while being uninsured. Additionally, those with insurance believe that having insurance helped them seek medical care. Virtually 100 percent of those who obtained insurance one year before highlighted the greater access to health care.

TABLE 5: BENEFIT OF HAVING INSURANCE

Below are focus group and interview responses that illustrate this trend.

- “I am not working at the moment, and I cannot just depend on going to the ER for things that happen. It would be important for me to have my own doctor and have access to these clinics and places that would take care of me, instead of just waiting or not being taken care of at the ER. [Having insurance] would change my life and where I go to get care. I would not go to the ER anymore.”
- “I would prefer to enroll into a health insurance plan if I had the option, because I would get better attention at a doctor’s office at the emergency room.”
- “I would feel more comfortable [having health insurance], because I would have my own doctor that can take care of me. I wouldn’t have to worry about waiting in line at a clinic or hospital. I wouldn’t have to worry about having to go to the emergency room as well to get care, and not get treated or left for last.”
- “I got very sick. We lost insurance when my husband lost his job. That became a big issue. We paid little by little because chemo therapy is very expensive. I did not know I was going to become sick. Well now I have insurance again. I can get the treatment I need in the right place.”
Having health insurance decreases the rate that patients use outpatient hospitals or emergency rooms and increases the use of clinics and doctors’ offices. Additionally, having insurance helps individuals access the medical care that they need.

**4) Having health insurance reduces community members’ stress related to financial difficulties by decreasing their concerns that they will be left with overwhelmingly high medical bills if they get sick or have an accident.**

The data presented in Table 6 (see below) demonstrate clearly that those without insurance are extremely worried about the medical bills that they will receive if they see a doctor without insurance, thus increasing their stress levels. Conversely, those who have had insurance for longer periods of time are less worried about receiving high medical bills than uninsured individuals. Approximately 82% of individuals who are uninsured are very worried about being able to pay for their medical bills compared to 47% of individuals who have been insured for more than one year.

Maria Zhunio, a member of MRNY states, “before I had health insurance I was scared to go to the doctor since I didn’t want to be left paying thousands of dollars in medical bills. Now that I am insured, I don’t worry as much about the medical bills since I trust that my health insurance will cover most of the costs. I am no longer as stressed, and feel much healthier.”

**TABLE 6: INSURANCE EFFECT ON MENTAL HEALTH**
An individual is more at ease with insurance. The thought of needing to pay high medical bills is extremely stressful, and possessing insurance helps allay that type of concern.

- “It is so important for me! I would feel more comfortable knowing I have insurance. I would feel secure knowing that I can receive attention.”
- “I would feel secure knowing that I have coverage, especially for emergencies. I never know if something could happen to me now, an hour from now, or who knows when. Knowing I have health insurance would help me feel at ease.”
- “It is extremely important because mentally and economically I would feel more comfortable and secure, knowing that health insurance would cover services and the things I need to keep me healthy!”
- “I would feel secure because it would assure me that I will be healthy and have a healthy family too.”
- “I am worried all the time, not having health insurance, because at times I wonder, what if I have an illness, and I didn’t know. With health insurance, I wouldn’t have to worry about seeking medical care. I would feel comfortable and secure.”
- “I feel good knowing that I do not have to pay a huge medical bill after using a lot of services. It makes me feel less stressed and worried about having to pay for all of this, especially dealing with an illness. Mentally it helps me feel comfortable and secure.”
- “Without coverage, major bills and debt happens. It is really scary. But health insurance is so important for children; they get colds, their teeth hurt, accidents happen. Having health insurance is like a guardian for me, I feel safe.”

Therefore, having insurance helps decrease one’s stress level related to financial difficulties by decreasing his/her concerns of being left with overwhelmingly high medical bills. Those without insurance are extremely worried about the bills they will receive, and individuals with insurance feel more confident knowing that they have insurance to cover some or all of the costs.

Zeferino Perez, a member of Make the Road New York stated: “The first thing they ask you when you go to the doctor is if you have documents. They ask: ‘Do you have documents? Do you have insurance?’ If you say no, they put you to the side, and don’t attend to you.”
5) There is a strong interest among the remaining uninsured for an affordable health insurance option.

The surveys conducted with individuals who are uninsured and ineligible for insurance asked several questions that were unique to those individuals. These questions were based on the findings of the feasibility study conducted by CSS (Benjamin, 2016). The questions were based on one’s income and age range. The majority of the individuals surveyed earn low incomes (i.e., income below 138% of FPL). The goal of these questions was to understand those individuals’ ability and/or willingness to pay for insurance, and the likelihood that they would purchase insurance if one of the policy options were to be implemented. These surveys provide community input, which will help develop an advocacy strategy for health-focused, immigrant-serving community based organizations. Participants were asked questions related to the four policy options discussed above.

a) State funded Basic Health Program (“Essential plan”)

The data presented in Table 7 (see below) suggest that 95% of individuals with income below 138% FPL are able and willing to pay up to $15 per month for health insurance, and of those surveyed, all would apply for insurance if it were free. Additionally, more than half of individuals with income between 138-150% FPL are willing to pay up to $50 per month for insurance and 61% of individuals with income between $150-200% FPL are willing to pay $90 for insurance. Nonetheless, as the price goes up, it becomes less affordable and accessible to immigrant community members.

**TABLE 7: ABILITY TO PAY FOR ESSENTIAL PLAN FOR ALL IMMIGRANTS**
Below are focus group and interview responses that illustrate immigrant community members’ willingness to pay low-to-moderate monthly amounts to have insurance.

• “I would prefer to enroll into a health insurance plan because I would get better attention at a doctor’s office than at a clinic or the emergency room. In my case, my income varies month to month, but if I had to decide on a cost of a plan, I would pay $30 a month, just for myself, because that is what I can afford. The maximum that I would pay is $50, if everything is covered.”

• “I am not working at all now. I had an injury that happened to me years ago, and have so many expenses at home. But I would pay up to $25 for just myself. That is all I can truly afford.”

• “I would pay for a basic health insurance program. Especially for preventive services. I would feel secure and stable knowing I have coverage. It is almost like a life insurance. I would pay $50.00, at most, each month, just for myself. I think that is a decent amount to pay and is a realistic price.”

Undocumented immigrants interviewed for this study prefer to have insurance than remain uninsured, and are able and willing to pay a low-to-moderate amount for the insurance, as long as it is affordable based on their income.

b) BHP “Clean up” option (cover the “residual” PRUCOLs)

As seen in Table 8 (see below), “Residual PRUCOL” immigrants with whom we spoke able/willing to pay up to $20 for health insurance, but would prefer it to be free if their income is below 150% of FPL. It is important to note though that the sample size for this survey was only 46 individuals, so caution should be exercised in interpreting results.

![Table 8: Essential Plan for “Residual PRUCOLS”](image)

<table>
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<th></th>
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</tr>
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<tbody>
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<td>Free &lt;150% FPL</td>
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</tr>
<tr>
<td>$20 (&lt;150% FPL)</td>
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c) Young Adult Coverage for undocumented and PRUCOL adults between the ages of 19 and 30 up to 400% of FPL
The data presented in Table 9 (see below) suggest that young adults between the ages of 19-30 whose income is less than 138% of FPL are able and willing to pay $15 for comprehensive health insurance with no deductible. However, they are less likely to pay $20 for insurance. Individuals with income between 138-200% FPL may be able and willing to pay $50-90 for insurance depending on their income, but there are still some individuals who would choose to remain uninsured. The majority of individuals surveyed are low income with income below 138% of FPL. It is important to therefore note that the sample population of individuals surveyed with income between 138-250% of FPL is extremely small.

**TABLE 9: COVERAGE FOR YOUNG ADULTS**

![Chart showing willingness to pay for insurance]

Our results suggest that young adults between the ages of 19-30 are able and willing to pay for health insurance. In particular, those of low income (below 138% of FPL) are able and willing to pay $15 for a comprehensive health insurance plan with no deductible.

d) High deductible Bronze plan to supplement Emergency Medicaid for low-income undocumented adults below 138% of FPL

The data presented in Table 10 (see below) demonstrate clearly that individuals surveyed are not interested in a high deductible plan, even if the plan itself and emergency and preventative services were free. This is mainly due to the fact that low-income families generally do not have access to a lot of saved resources so are unable to pay a large lump sum of money at once before their insurance starts to cover the costs.
In addition to exploring different coverage options and costs as seen above, participants were asked questions regarding the most necessary services, and their preference of coverage versus sliding fee scale services. Everyone who participated in this survey was asked to select the top three services they would like to be covered by health insurance. As seen in Table 11, the top services that were chosen were primary care, dental care, emergency services and prescription drugs. This information will be helpful in advocating for different policy options, because these are the services that are in highest demand.

**TABLE 11: SERVICES FOR UNDOCUMENTED IMMIGRANTS**
Below are focus group and interview responses that illustrate this trend.

• “If I had to choose two services only I would choose primary care and the dentist—because that is absolutely necessary, it is very important. However surgical services and specialists, and even transportation to the doctor, would be a dream for me to have access and coverage for. “

• “Having health insurance is important in my case, because it would help with the medicine and the medical equipment to treat my diabetes. It would allow me to better access doctors and receive the proper medical care I need.”

• “I want it all! Dental care, medications, OB/GYN, and vision. This is so important for me as a woman, because all of this changes as we get older. I would pay at least $40 for myself each month to get coverage. It is a dream!”

The data demonstrate that the most important services that undocumented immigrants want to be covered by health insurance are primary care, dental, emergency room and prescription services.

Finally, in this study, we asked questions related to an individual’s preference for health insurance versus improved access to services. While the end goal of having insurance is to have improved access to providers, the data presented in Table 12 (see below) suggest that undocumented immigrants clearly want to have the security of having health insurance, instead of just relying on safety net providers.

**TABLE 12: NEED FOR HEALTH INSURANCE IN ADDITION TO A CLINIC**

Would you rather go to a clinic and pay a sliding fee scale per visit or have health insurance?

- Clinic
- Health insurance

13%

87%
CONCLUSION

In short, the ACA and the resulting New York State of Health have been an enormous boon for expanding access to health insurance and coverage for New Yorkers. The coverage gains should therefore be protected and expanded upon, since Latino and immigrant populations still face substantial barriers to coverage. To better assess this issue landscape, MRNY collected 838 surveys and conducted 8 focus groups—virtually all of which were with Latino immigrants—who approached the organization for help in accessing health services. This report presented data collected from both those who were able to obtain health insurance and those who were not eligible due to their immigration status. The results of our surveys and focus groups suggest that having health insurance increases the likelihood that someone will have a person that he or she thinks of as his or her personal doctor or health care provider. Having insurance also increases the likelihood that someone will have more regular visits with his or her doctor or another health care professional about his or her health and an individual will more likely go to the doctor when he or she is sick or in need of care. Having health insurance decreases the rate that patients use outpatient hospitals or emergency rooms for health care, and increases use of clinics and doctors’ offices.

Individuals without insurance are more likely to be worried about receiving medical bills that they cannot afford. Having health insurance reduces community members’ stress related to financial difficulties by decreasing their concerns that they will be left with overwhelmingly high medical bills if they get sick or have an accident. Finally, as seen in the surveys and focus groups with undocumented immigrants, there is a strong interest among the remaining uninsured, for an affordable health insurance option.

Given these findings, this report recommends that New York State take the following steps to protect and expand health access for Latino and immigrant New Yorkers:

1. Protect health insurance coverage options at the federal and state level to ensure that individuals currently insured remain insured.
2. Create a comprehensive, low cost insurance program for undocumented and PRUCOL immigrants who are currently ineligible for insurance that includes key services such as primary care, dental, emergency care, and prescriptions.
3. Build off of New York City’s new Action Health NYC initiative to improve access to services and more coordination of care for undocumented immigrants as an interim solution while these individuals remain uninsured.
4. Target health insurance outreach in immigrant communities: conducting outreach by trusted community members or community organizations in immigrant communities will lead to increased enrollment in insurance for those who are eligible, thus leading to increased utilization of care.
REFERENCES


Accessed on May 1, 2016.

Safeguarding Immigrant Coverage
Protecting and Expanding Health Coverage for all Immigrants in New York State