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Holes in the Safety Net: Obamacare and the Future of New York City's Health & Hospitals Corporation

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I. EXECUTIVE SUMMARY

Five years after its passage, the Patient Protection and Affordable Care Act (“ACA”) has been rightly hailed as a historic accomplishment. The expansion of Medicaid, creation of subsidized health insurance exchanges, and other ACA-related reforms have provided coverage to over 11 million previously uninsured Americans—many of them low and moderate-income workers.

The ACA’s provisions have dramatically improved the health insurance landscape for consumers. Changes in eligibility, requirements fostering broad participation, and improvements to the purchasing process have created a fairer, more transparent, and more accountable marketplace. Indeed, nationally, health insurance premiums on the exchanges have generally increased at a slower pace or even fallen. Rates in the official health benefits exchange—New York State of Health—decreased by at least 50 percent in 2014 compared to what was available in the individual market prior to the ACA.¹

While the ACA has unquestionably been of great benefit, the law contains one drawback that is of particular relevance to New York City: proposed reductions of up to 43 percent in Disproportionate Share Hospital (DSH) payments—the dedicated federal funding stream that states distribute to hospitals to partially offset the costs of caring for large numbers of uninsured patients.^{2,3} The percentage reduction will be larger for “high DSH” states like New York that have historically received generous allocations.⁴

Reductions in DSH payments will hit New York City particularly hard given our high number of uninsured residents. Prior to the first ACA open enrollment period, an estimated 1.2 million New York City residents were uninsured. Just under 500,000 City residents enrolled as of April 15, 2014, of which 80 percent reported having no insurance at the time of enrollment. An estimated 800,000 remained uninsured as of March 2014, the end of the first open enrollment period.⁵

Many of these uninsured residents are undocumented immigrants, who are largely ineligible for public health insurance like Medicaid and prohibited from purchasing private coverage under the ACA.

Data about undocumented immigrants is particularly dependent upon the use of estimation methodologies. New York City does not allow service providers to inquire about immigration status to encourage the use of available services. Beyond that, because of the often drastic consequences associated with “coming out of the shadows,” it can be difficult to reach and count members of this community.

The New York City Health and Hospitals Corporation (“HHC”), the largest municipal healthcare system in the country, is the primary provider of healthcare to the City’s over 500,000 undocumented immigrants.⁶ During Calendar Year 2014, HHC reported treating 431,000 uninsured patients.⁷ As a result, HHC is uniquely threatened by the proposed decrease in DSH payments.

The City has a long, complex history of financial support for HHC. While the budget battles have been heated at times, the City has ultimately helped HHC to maintain its mission.⁸ For that reason, the City has a strong interest in ensuring that other revenue sources on which HHC

depends are maximized to the fullest extent possible to place the Corporation on a path toward long-term financial stability.

This report, by New York City Comptroller Scott M. Stringer, explores the potential impact of the DSH reduction on HHC. The report makes the following findings:

- While the ACA is making headway in reducing the number of uninsured New Yorkers, progress is gradual, and the projected savings do not come close to offsetting the proposed DSH cuts. Indeed, there exists a significant divergence between the proposed DSH funding reduction for HHC and the projected decrease in the number of uninsured patients HHC expects to treat. HHC currently reflects a 24 percent reduction in its DSH revenue from the federal cut in 2019. However, HHC reported that the number of uninsured patients dropped by only 1.3 percent from FY 2013 to FY 2014. Going forward, HHC only predicts an additional drop of 7.2 percent in its uninsured patient pool by 2019.
- Revenue from new enrollees in HHC’s MetroPlus private health insurance plan is only expected to offset about 28 percent of the DSH cut.
- As a result, even under what may prove to be optimistic assumptions, HHC expects to finish FY 2019 with a cash position of only \$44 million, down from \$1 billion projected at the end of FY 2015. If not for the projected loss of \$381 million in DSH revenue in 2019, HHC’s cash position would improve from a projected \$44 million to \$425 million.

While the U.S. Department of Health and Human Services has delayed the implementation of DSH cuts until 2017, the Comptroller makes the following recommendations in order to strengthen HHC’s financial condition and reduce pressure on the City to fill the gap created by the DSH reduction:

1. *Delay the DSH cuts.*

Congress should postpone implementation of the DSH cuts until a fuller picture of the numbers, characteristics, and geographic distribution of the remaining uninsured emerges and the impact of the proposed cuts—particularly on financially-stressed safety-net hospitals like HHC—can be accurately assessed.

2. *Make Undocumented Immigrants Eligible for Coverage under the ACA.*

Congress should allow undocumented immigrants to enroll in health insurance offered through the ACA exchange, with access to the tax credits available under the law to make buying and using coverage affordable. This would extend the benefits of this landmark law to a vulnerable population, keep all New Yorkers healthier and help stabilize the financial status of the hospitals treating them.

While New York should strongly advocate for the preceding much-needed policy changes on the federal level, there are several additional steps that should be considered at the State and City level:

3. *Create a state-funded insurance program for undocumented immigrants and others who do not purchase health insurance.*

The FY 2016 New York State budget authorizes a new health insurance option, known as the Basic Health Plan (BHP). Created as part of the ACA, the plan will replace State monies with federal funds to provide very low cost insurance to lower-income New Yorkers who don't qualify for Medicaid and/or find it difficult to afford insurance through the exchange, even with subsidies. Certain categories of non-citizen immigrants will be eligible for the BHP, saving the State an estimated \$300 million annually.⁹ Unless and until the ACA eligibility rules are changed, the State should explore the feasibility of reserving these funds to cover undocumented immigrants through the BHP.

4. *Implement a more equitable DSH formula based on the share of uninsured patients treated.*

The State Legislature should promptly implement a more equitable formula that targets the DSH funding pool to hospitals based upon their actual delivery of care to high quantities of the uninsured. The final 2015-2016 New York State budget continues for another three years the transition period for fully implementing changes adopted in 2013 to align the intra-state DSH distribution formula with ACA requirements. During the transition period, the percentage changes in funding levels are capped and gradually increase each year. While this cushions the impact for hospitals losing funds, it also perpetuates a system that has historically short-changed HHC. A more equitable distribution would help HHC obtain its fair share of the available DSH dollars.

5. *The City should require HHC to collect and disseminate the costs associated with treating the uninsured and additional information about where the uninsured are treated (by hospital and otherwise) to the extent feasible without making inquiries about immigration status.*

This information would help inform policy-makers and other stakeholders more fully about the nature and extent of the financial burden HHC experiences in carrying out its mission and provide a stronger foundation for initiatives to mitigate the impacts.

A healthy city is a strong city. As Dr. Ramanathan Raju, HHC's Chief Executive Officer noted at a recent policy breakfast, "Most of you here in this room today likely do not imagine yourself using our facilities...But I would argue you do have a stake in the good health of the cook preparing the meal in your favorite restaurant and the good health of your nanny, and the good health of your housekeeper...My health depends on that cook's health, upon that maid's health, upon your health."¹⁰

In addition to the individual health consequences, failing to care for those who are sick increases long-term economic risk to the city and its broader health. Indeed, the Council of Economic Advisers provided a strong case for passage of the ACA based on its economic impacts. Being uninsured is associated with poor health, which in turn, increases the likelihood of lost work time, increased financial risk, disability, and shorter life expectancy. Helping our workforce stay healthier not only reduces taxpayer obligations for healthcare and other costs, it also increases employment and economic growth.¹¹

As the City's provider of last resort, HHC acts as a safety net, promoting the public health of every New Yorker, not only those directly seeking healthcare at HHC.

New York City will continue to honor our historic promise to welcome immigrants from every corner of the globe. In so doing, we must ensure that our municipal health care system is on firm financial footing so that it can continue to serve the next generation of New Yorkers.

II. DEFINING THE PROBLEM: UNDOCUMENTED AND UNINSURED

The Affordable Care Act (“ACA”), passed in 2010, has paved the way for millions of New Yorkers statewide to obtain public and private health insurance. Approximately 400,000 of New York City’s 1.2 million uninsured signed up for coverage by the end of the first open enrollment period in March 2014.^{12 13}

Furthermore, New Yorkers now enjoy increased access to primary and preventive care, standardization of benefit packages, and exchanges that allow easier comparisons of insurance plans and prices.¹⁴

Despite the law’s successes, worries remain about a provision that could negatively impact the financial well-being of “safety-net” hospitals—which expect to continue to be the providers of choice for uninsured patients.¹⁵

The principal federal funding stream defraying a portion of the cost of charity care since 1981 is known as Disproportionate Share Hospital (DSH) payments. Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of uninsured individuals.¹⁶ Federal law establishes an annual DSH allotment for each state and defines the costs eligible for compensation at the hospital level.¹⁷ Federal DSH allotments totaled \$11.6 billion in FFY 2014.¹⁸

DSH monies are particularly important to public hospitals, which tend to be “safety net” facilities. A 2008 survey by the National Association of Public Hospitals and Health Systems found these funds alone underwrote 22 percent of uncompensated care for their members.¹⁹

The ACA included a provision directing the federal Department of Health and Human Services to make aggregate reductions in federal Medicaid DSH allotments. Nationally, Medicaid DSH payments are expected to decline by a cumulative \$35.1 billion between fiscal years 2017 and 2024, with projected one year drops of as much as 43 percent.²⁰

While New York’s share of DSH funds has been generous, the ACA includes a provision for larger percentage reductions in “high DSH” states like New York.²¹ In FFY 2014, New York State’s share of the national DSH allotment was estimated at 14.7 percent. Based on this proportion and the scheduled reductions, New York State’s portion of the cut is projected to total over \$5 billion between fiscal years 2017 and 2024.

This cut is based on the premise that safety-net hospitals will see sharp decreases in the number of low income, uninsured patients with the advent of the ACA, thereby lowering the need for DSH funds to cover unreimbursed care.

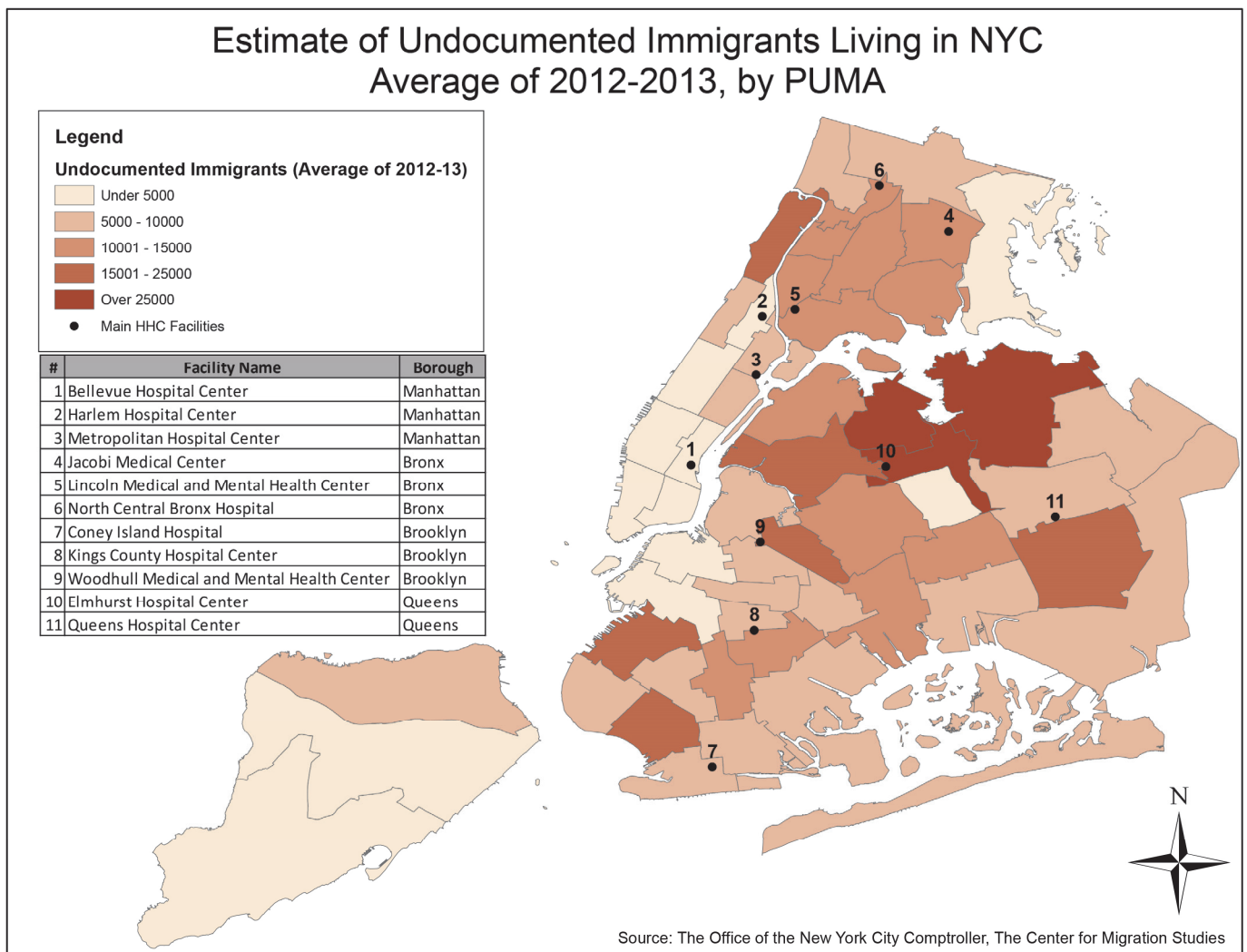
While this logic may apply in other parts of the U.S., there is reason to believe that facilities run by New York City’s public hospital system, the Health and Hospitals Corporation (“HHC”), will continue to see significant demand for healthcare from uninsured individuals.²²

This is because a substantial portion of HHC’s uninsured patients are undocumented immigrants, who are prohibited by the ACA from enrolling in health insurance offered through the exchange, except to pre-qualify for Emergency Medicaid, or to obtain public coverage for children and pregnant women.²³

New York State had approximately 875,000 undocumented immigrants in 2012, the fourth highest state total after California, Texas, and Florida.²⁴ The number of undocumented immigrants in New York City is estimated to be over 500,000.²⁵

While some undocumented immigrants are able to obtain insurance through their workplace or by purchasing coverage with their own funds on the private market, an analysis of Census data by the Center on Migration Studies (CMS) estimates that 369,518 undocumented immigrants in New York City lack health insurance coverage.²⁶

Map 1: Estimate of Undocumented Immigrants Living in New York City



According to the CMS data, the largest populations of undocumented immigrants are found in Northern Manhattan, Central Queens, and Eastern Brooklyn.²⁷ The locations of HHC’s 11 hospitals are included as a reference point in Map 1 above. With the exception of Bellevue Hospital in Manhattan, the facilities are located within or near areas with significant populations

of undocumented immigrants. While HHC does not inquire about immigration status,²⁸ three hospitals—Lincoln Medical Center in the Bronx, Elmhurst Hospital in Queens, and Woodhull Medical Center in Brooklyn—are located in areas that CMS estimates have the highest proportion of immigrants who are undocumented and uninsured (see Appendix).

The ACA's primary goals include improving health and access to health care. Without insurance, the ability to obtain needed medical care can be compromised as well as financial security. Uninsured individuals are four times more likely than the insured to delay or skip needed medical care. Studies have found that undocumented adults and their children are less prone than U.S. citizens to use emergency department care, visit a physician or nurse on an outpatient basis, or use mental health or dental services.²⁹ In California, undocumented adults under 65 were more than twice as likely to report having no usual source of care or to report making no doctor visits in the past year.³⁰

Consequently, many undocumented immigrants have unaddressed health issues. In recognition of the importance of healthcare to physical and cognitive development, all undocumented children and pregnant women have access to insurance coverage in New York. While Emergency Medicaid is available to New York City's low-income undocumented immigrants to defray the costs of stabilizing their condition in the event of an acute condition of sufficient severity, access to primary and preventive services is not covered.³¹

HHC has always maintained a strong commitment to serving the undocumented immigrant community, in part by creating a linguistically and culturally welcoming healthcare environment.³² According to Dr. Ramanathan Raju, CEO of HHC:

Every quality health center in New York City serves undocumented immigrants in our society. But the New York City Health and Hospitals Corporation has got a large portion of them that seek care and get care. It has to do with the fact that that's our mission—that we will serve everybody irrespective of their economic status, irrespective of their race, color, ethnicity and immigration status. That is a fundamental mission of the Health and Hospitals system. That mission is not for sale; we are not going to move away from it.³³

While serving all who walk through the doors is an inviolable commitment, the financial challenge imposed by New York's high number of uninsured, undocumented immigrants will remain.³⁴ In fact, one study projects that the percentage of undocumented New Yorkers under the age of 65 without insurance will actually *increase* from 50 percent in 2012 to 52 percent in 2016.³⁵

III. HEALTH INSURANCE CHALLENGES FOR IMMIGRANTS AND THE EFFECT ON HHC

Under the ACA, “lawfully present” non-citizens are permitted to obtain both private and public insurance through the health benefit exchange.³⁶ New York State uses its own funds to extend Medicaid coverage to additional non-citizen categories.³⁷

To obtain private or public insurance, however, federal laws require that the person seeking coverage provide information about their immigration status and certain information about their household members to determine eligibility.

As a result, while undocumented immigrants are at a particular disadvantage when it comes to obtaining and paying for healthcare, even immigrants lawfully in the U.S. face significant barriers to securing health insurance.

One such barrier is faced by “mixed-status families,” which include both documented and undocumented individuals.³⁸ According to the Pew Research Center, as of 2010, 16.6 million Americans live in families with at least one unauthorized immigrant, including at least 9 million who live in households that include at least one unauthorized adult and at least one U.S.-born child.³⁹

Despite the fact that information obtained as part of the health insurance application process on the exchange will not be used to enforce immigration law,⁴⁰ many potential immigrant enrollees are justifiably concerned about the possible immigration ramifications of applying for coverage. As a July 2014 poll by the Kaiser Family Foundation found, “most remaining uninsured Hispanics (54%) [in California], and 37 percent of those Hispanics eligible for ACA coverage options, say they worry that enrolling in coverage would bring attention to their family’s immigration status.”⁴¹

In addition to the challenges faced by mixed-status families, advocates have reported a number of additional concerns expressed by immigrants about enrolling through the exchange.⁴²

At an October 2014 City Council oversight hearing on the first enrollment period, a representative from the New York Immigration Coalition observed that “although everyone...has options for health care in New York, many immigrants are confused about them—and many don’t even know that they *have* options.”⁴³

Elisabeth Benjamin, a healthcare advocate with the Community Service Society, has noted that for individuals who are trying to adjust their status and obtain a green card, there is misinformation about which government benefits can be used without negatively impacting immigration status. “While community-based Medicaid can be used by immigrants without any concern about its impact on the regularization of their immigration status, Medicaid used to pay for long term, residential care, might have an impact. Understandably, this is a confusing distinction for the immigrant community to understand. Many believe that there is a generalized problem with using Medicaid, and accordingly, might be loath to enroll.”⁴⁴

Advocates have also noted that literacy, language and cultural barriers, as well as a lack of targeted outreach during the first open enrollment period, reduced participation among eligible non-citizens. Although both the City and the State announced new strategies to combat these barriers, until the enrollment breakdown for 2015 is made available, it is not possible to say what impact, if any, these additional measures have had.⁴⁵

Even immigrants who are insured remain at risk of losing coverage, including:

- Individuals who lose Medicaid eligibility as a result of an increase in their household income. With certain exceptions, Medicaid is not available to individuals who earn more than 133 percent of the federal poverty guidelines, or \$15,654.⁴⁶
- Individuals who are ineligible for subsidies through New York's exchange, and low- and moderate-income individuals who receive subsidies, may not be able to afford the cost of insurance.⁴⁷

Given these challenges, insurance coverage within the immigrant community will continue to be a concern for HHC in the foreseeable future. HHC has established a financial assistance program, HHC Options, which offers payment plans to uninsured individuals, including the undocumented, based on a sliding-scale fee schedule. In 2012 and 2013, 212,000 and 245,000 patients, respectively, participated.⁴⁸ The payments generated from this program, however, do not nearly cover the actual cost of providing care to these individuals.⁴⁹

As the uninsured, particularly those who are undocumented, continue to turn to HHC for care, HHC will face mounting financial pressures arising from the unreimbursed costs of delivering these healthcare services unless policy changes are made.

IV. ASSESSING THE POTENTIAL IMPACT OF REDUCTIONS IN HHC'S DISPROPORTIONATE SHARE HOSPITAL REVENUE

Under current projections, HHC expects to face budget deficits of over \$1 billion beginning in FY 2017 that will grow in subsequent years. The loss of Federal DSH funding is a significant component of HHC's long-term fiscal difficulties, posing sizeable risks to HHC's bottom line.

The proposed cut of \$381 million in Federal DSH revenue represents about one-quarter of HHC's projected deficit of \$1.54 billion in FY 2019. Despite the loss of the Federal DSH dollars, the City expects to maintain its share of the DSH support, effectively over-matching the Federal portion. Therefore, the full impact of the ACA-related cuts has been partially mitigated.⁵⁰ Without these City funds, the DSH cuts would have totaled \$762 million in FY 2019.

HHC currently projects to end FY 2015 with a cash balance in excess of \$1 billion. However, by FY 2019, its cash position will erode to only \$44 million, largely due to a projected \$827 million cut in federal DSH revenue between FY 2017 and FY 2019. Cash position is an indicator of financial strength and liquidity.⁵¹ It does not represent a surplus from operating results.

Data tabulated after the first enrollment period under the ACA reveals the uninsured population's continued reliance on HHC for care. During the first ACA open enrollment period, nearly 500,000 New York City residents signed up for insurance through the Exchange. Despite expectations that the ACA would dramatically reduce the number of uninsured patients, the reality is that progress has been extremely slow. Between FY 2013 and FY 2014, the number of uninsured patients treated by HHC had dropped by only 1.3 percent.⁵²

HHC is also not expecting significant reductions in its uninsured patient population in the future, projecting an additional drop of 7.2 percent in the uninsured by 2019.⁵³ This may prove to be overly sanguine since the drop in the uninsured patient population was marginal in the first enrollment period.

This imbalance would imperil HHC's finances by penalizing HHC for continuing to act as the provider of last resort to New York City's uninsured.⁵⁴

While revenue from new enrollees to HHC's MetroPlus insurance program is expected to offset about 28 percent of the DSH cut, data provided by HHC to the Office of the Comptroller suggests that MetroPlus enrollment may not reach initial estimates.⁵⁵

HHC enrolled approximately 45,000 members into MetroPlus through the first year of the ACA.⁵⁶ By February 2015, only 29,000 were still enrolled, a decline of over one-third. HHC attributed the loss to "members who failed to pay premiums and related issues."⁵⁷ This attrition occurred despite the fact that MetroPlus was one of the least expensive options offered through the exchange for New York City.⁵⁸

As mentioned earlier, revenue from the HHC Options sliding-scale payment program, which serves as the City's designated alternative for undocumented immigrants who are not eligible to obtain insurance through the exchange, does not approach the actual cost of providing care to these individuals.⁵⁹ Between 2012 and 2014, an average of 92 percent of billed charges were written-off for patients participating in the program.⁶⁰

In the aggregate, HHC expects to experience real financial pain, even under what may prove to be optimistic assumptions.

When HHC has operating deficits that cannot be closed on its own, New York City taxpayers must ultimately fund the gap. Historically, the City has provided support to HHC when the agency faced severe budget shortfalls. Most recently, the City opted to cover the costs of collective bargaining increases totaling nearly \$1.9 billion through FY 2019 and the write-off of \$300 million in payments owed to the City from FY 2013. In the event that HHC faces severe budget shortfalls in future years, it is likely that the City will need to continue to provide additional financial support to the Corporation.

V. RECOMMENDATIONS

While the U.S. Department of Health and Human Services has delayed the implementation of DSH cuts until 2017, the Comptroller makes the following recommendations for actions at the federal, state and local levels to strengthen HHC's financial condition and reduce pressure on the City to fill the gap created by the DSH reduction:

1. *Delay the DSH cuts.*

Congress should postpone implementation of the DSH cuts until a fuller picture of the numbers, characteristics and geographic distribution of the remaining uninsured emerges and the impact of the proposed cuts—particularly on financially stressed safety-net hospitals like HHC--can be accurately assessed.

HHS's recently-issued final rule prescribes that DSH payments to a hospital cannot exceed the uncompensated costs of services to individuals who “have no health insurance (or other source of third party coverage).” The rule also provides for increased auditing of DSH payments based on the cost of each service provided to the uninsured.⁶¹

This approach appears to cover unreimbursed care to undocumented, uninsured immigrants—who have no other source of third party coverage—and may serve to better direct funds to hospitals like HHC that provide substantial amounts of treatment to these vulnerable populations. Nonetheless, given the dramatic size of the proposed cuts, HHC will, at best, be getting a larger slice of a shrinking pie.⁶²

Shifting the proposed cuts by even one year would move HHC from a position of having little or no cash reserves in 2019 to one with approximately \$400 million on hand. Even at this level, HHC would experience a 60 percent decrease from its projected cash position at the end of Fiscal Year 2015.

2. *Make Undocumented Immigrants Eligible for Coverage under the ACA.*

Congress should allow undocumented immigrants to enroll in health insurance offered through the ACA exchange, with access to the tax credits available under the law to make buying and using coverage affordable. This would extend the benefits of this landmark law to a vulnerable population, keep all New Yorkers healthier and help stabilize the financial status of the hospitals treating them.

While New York should strongly advocate for the preceding much-needed policy changes on the federal level, there are several additional steps that should be explored at the State and City level:

3. *Create a state-funded insurance program for undocumented immigrants and others who do not purchase health insurance.*

The State should explore the feasibility of using its own funds to cover undocumented immigrants through the Basic Health Plan (BHP).

The FY 2015-2016 New York State budget authorizes a new health insurance option—the BHP—which would assist low-income New Yorkers who earn just above the Medicaid eligibility line or are unable to afford insurance through the exchange.⁶³ Certain groups of low-income, lawfully-present immigrants will also qualify for the federally-subsidized BHP, helping the State to save an estimated \$300 million annually.⁶⁴ Unless and until the ACA eligibility rules are changed, the State should explore the feasibility of reserving these funds to cover undocumented immigrants through the BHP.

Created as part of the ACA, the program provides federal funds to the State equal to 95 percent of the insurance premium tax credit that would have been available to the eligible individual purchaser in the state insurance exchange. This helps defray the cost to state governments of making insurance more affordable for low- and moderate-income individuals. The plans must include at least the same 10 essential health benefits required under the ACA.⁶⁵

If the BHP is found to be in the financial interest of the State, beginning as soon as 2016, it would be offered at all times through New York’s state insurance exchange by private insurers to individuals under age 65. Premiums for eligible BHP participants—and potentially cost-sharing for co-pays and deductibles—will be well below the standard plans in the exchange, ranging from \$0-\$20 per month.⁶⁶ Consistent with federal law, participants in New York’s program will maintain continuous eligibility for 12 months, even if their incomes fluctuate—a common occurrence especially at the lower end of the eligible income span.

Estimates from the Urban Institute predict that up to 468,000 New Yorkers could be eligible for the Plan, which has the potential to significantly impact the low- and moderate-income population most likely to remain uninsured even with the ACA.⁶⁷ With federal funds available to partially reimburse the State for the cost of coverage for some categories of non-citizen immigrants under the BHP,⁶⁸ the State will have flexibility to redirect monies currently spent for that purpose to extend the individual and societal benefits of the ACA to low-income undocumented immigrants who have virtually no access to affordable private health insurance.⁶⁹

4. ***Implement a more equitable DSH formula based on the share of uninsured patients treated.***

The final 2015-2016 New York State budget continues for another three years the transition period for fully implementing changes adopted in 2013 to align the intra-state DSH distribution formula with ACA requirements. During the transition period, the percentage changes in funding levels are capped and gradually increase each year. While this cushions the impact for hospitals losing funds, it also perpetuates a system that has historically short-changed HHC. The State Legislature should promptly implement a more equitable formula that targets the DSH funding pool to hospitals based upon their actual delivery of care to high quantities of the uninsured. Such a change would help HHC obtain its fair share of the available DSH dollars.

5. *The City should require HHC to collect and disseminate the costs associated with treating the uninsured and additional information about where the uninsured are treated (by hospital and otherwise) to the extent feasible and without making inquiries about immigration status.*

This information would help inform policy-makers and other stakeholders more fully about the nature and extent of the financial burden HHC experiences in carrying out its mission and provide a stronger foundation for initiatives to mitigate the impacts.

VI. CONCLUSION

New York City has a proud tradition of welcoming immigrants from all corners of the globe. As a result, HHC, with its mission of serving all New Yorkers regardless of their ability to pay, will continue to provide healthcare for a significant percentage of New York's undocumented, uninsured immigrants. The proposed cuts to DSH far exceed HHC's projected reductions in the number of uninsured and projected increases in revenue from insured patients. This policy further undermines HHC's fiscal solvency and threatens the scope and quality-of-care provided to low-income New Yorkers across the five boroughs. It is vital that we begin to take steps now to address these potential negative impacts, protect New York City taxpayers and preserve HHC's ability to provide affordable, accessible, quality health care to its patients.

VII. APPENDIX

Table 1: Estimates of Undocumented and Uninsured NYC Residents

Community District Name	Undocumented Immigrants that are Uninsured (Avg. 2012-2013)	Undocumented Immigrants (Avg. 2012-2013)	Percent of Undocumented Immigrants that are Uninsured (Avg. 2012-2013)
Bronx CD 1 & 2--Hunts Point, Longwood & Melrose	9,929	12,948	76.68%
Bronx CD 3 & 6--Belmont, Crotona Park East & East Tremont	8,465	12,161	69.60%
Bronx CD 4--Concourse, Highbridge & Mount Eden	8,808	12,450	70.74%
Bronx CD 5--Morris Heights, Fordham South & Mount Hope	9,917	14,926	66.44%
Bronx CD 7--Bedford Park, Fordham North & Norwood	7,293	12,640	57.70%
Bronx CD 8--Riverdale, Fieldston & Kingsbridge	2,526	5,003	50.48%
Bronx CD 9--Castle Hill, Clason Point & Parkchester	7,780	13,853	56.16%
Bronx CD 10--Co-op City, Pelham Bay & Schuylerville	1,707	2,502	68.21%
Bronx CD 11--Pelham Parkway, Morris Park & Laconia	7,380	10,486	70.37%
Bronx CD 12--Wakefield, Williamsbridge & Woodlawn	5,213	8,442	61.75%
Brooklyn CD 1--Greenpoint & Williamsburg	3,407	5,949	57.26%
Brooklyn CD 2--Brooklyn Heights & Fort Greene	1,244	3,063	40.60%
Brooklyn CD 3--Bedford-Stuyvesant	3,864	5,302	72.87%
Brooklyn CD 4--Bushwick	16,950	22,680	74.73%
Brooklyn CD 5--East New York & Starrett City	6,193	11,760	52.66%
Brooklyn CD 6--Park Slope, Carroll Gardens & Red Hook	1,695	3,027	56.00%
Brooklyn CD 7--Sunset Park & Windsor Terrace	19,015	23,058	82.47%
Brooklyn CD 8--Crown Heights North & Prospect Heights	4,005	6,335	63.22%
Brooklyn CD 9--Crown Heights South, Prospect Lefferts & Wingate	4,316	8,102	53.27%
Brooklyn CD 10--Bay Ridge & Dyker Heights	5,252	7,351	71.44%
Brooklyn CD 11--Bensonhurst & Bath Beach	8,885	16,262	54.64%
Brooklyn CD 12--Borough Park, Kensington & Ocean Parkway	7,183	9,778	73.46%
Brooklyn CD 13--Brighton Beach & Coney Island	4,072	6,893	59.07%
Brooklyn CD 14--Flatbush & Midwood	9,609	13,689	70.19%
Brooklyn CD 15--Sheepshead Bay, Gerritsen Beach & Homecrest	3,588	7,321	49.01%
Brooklyn CD 16--Brownsville & Ocean Hill	3,956	7,253	54.54%
Brooklyn CD 17--East Flatbush, Farragut & Rugby	5,702	11,598	49.16%
Brooklyn CD 18--Canarsie & Flatlands	4,103	8,337	49.21%
Manhattan CD 1 & 2--Battery Park City, Greenwich Village & Soho	377	4,059	9.28%

Community District Name	Undocumented Immigrants that are Uninsured (Avg. 2012-2013)	Undocumented Immigrants (Avg. 2012-2013)	Percent of Undocumented Immigrants that are Uninsured (Avg. 2012-2013)
Manhattan CD 3--Chinatown & Lower East Side	1,754	2,976	58.93%
Manhattan CD 4 & 5--Chelsea, Clinton & Midtown Business District	430	4,461	9.64%
Manhattan CD 6--Murray Hill, Gramercy & Stuyvesant Town	1,298	2,954	43.92%
Manhattan CD 7--Upper West Side & West Side	373	3,514	10.61%
Manhattan CD 8--Upper East Side	698	5,619	12.42%
Manhattan CD 9--Hamilton Heights, Manhattanville & West Harlem	4,212	7,558	55.72%
Manhattan CD 10--Central Harlem	2,051	3,672	55.85%
Manhattan CD 11--East Harlem	4,256	7,225	58.90%
Manhattan CD 12--Washington Heights, Inwood & Marble Hill	10,214	16,943	60.29%
Queens CD 1--Astoria & Long Island City	7,094	11,953	59.35%
Queens CD 2--Sunnyside & Woodside	12,760	18,145	70.32%
Queens CD 3--Jackson Heights & North Corona	34,217	41,203	83.04%
Queens CD 4--Elmhurst & South Corona	21,858	28,590	76.45%
Queens CD 5--Ridgewood, Glendale & Middle Village	8,499	13,355	63.64%
Queens CD 6--Forest Hills & Rego Park	2,751	4,724	58.23%
Queens CD 7--Flushing, Murray Hill & Whitestone	23,165	33,531	69.09%
Queens CD 8--Briarwood, Fresh Meadows & Hillcrest	5,564	9,622	57.83%
Queens CD 9--Richmond Hill & Woodhaven	6,917	12,307	56.20%
Queens CD 10--Howard Beach & Ozone Park	5,001	9,443	52.95%
Queens CD 11--Bayside, Douglaston & Little Neck	3,900	5,926	65.81%
Queens CD 12--Jamaica, Hollis & St. Albans	11,191	19,078	58.66%
Queens CD 13--Queens Village, Cambria Heights & Rosedale	4,917	8,612	57.09%
Queens CD 14--Far Rockaway, Breezy Point & Broad Channel	3,868	5,961	64.89%
Staten Island CD 1--Port Richmond, Stapleton & Mariner's Harbor	7,058	9,243	76.36%
Staten Island CD 2--New Springville & South Beach	1,889	3,083	61.27%
Staten Island CD 3--Tottenville, Great Kills & Annadale	1,149	1,771	64.87%
Total	369,518	578,697	-

Source: Center for Migration Studies, Based on PUMA districts

For more information on the methodology for this data, see: <http://jmhs.cmsny.org/index.php/jmhs/article/view/38>

VIII. ACKNOWLEDGMENTS

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IX. ENDNOTES

- ¹ <http://www.nytimes.com/2013/07/17/health/health-plan-cost-for-new-yorkers-set-to-fall-50.html?adxnnl=1&adxnnlx=1395248805-NYTEM/SvQwIKqR/sxaY/Eg&pagewanted=all>
- ² Comptroller Stringer identified another gap in the Affordable Care Act in a recent report—“Time to Deliver”—which explored how women are unable to access coverage on the exchange when they get pregnant outside the open enrollment period. The Comptroller called on the federal government and the State of New York to classify pregnancy as a “qualifying event” that would permit women to sign up outside the regular open enrollment period. *See*: http://comptroller.nyc.gov/wp-content/uploads/documents/Pregnancy_and_the_Affordable_Care_Act.pdf.
- ³ DSH funding may also take into account a hospital’s share of Medicaid patients and its lower rate of reimbursement compared to private insurance. <http://www.advisory.com/daily-briefing/blog/2013/09/for-states-not-expanding-medicaid-dsh-cuts-will-deal-a-tough-blow>; <http://www.healthlaw.org/publications/qa-disproportionate-share-hospital-payments-and-the-medicaid-expansion>; <https://www.fas.org/sgp/crs/misc/R42865.pdf>, p.11
- ⁴ https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-09-27_mrt_payment_reform_dsh.pdf
- ⁵ For estimate of pre-ACA New York City Uninsured, *see*: http://www.nyc.gov/html/hia/downloads/pdf/City%20Planning_OCHIA_Population_Trends_0614.pdf
For ACA enrollment in New York City, *see*: http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf
- ⁶ Based on an analysis of U.S. Census PUMA data, the Center for Migration Studies estimated New York City’s undocumented immigration population as 566,122. <http://data.cmsny.org/puma.html>
- ⁷ Based on an unduplicated count. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁸ <http://www.ibo.nyc.ny.us/iboreports/HHC0308.pdf>;
http://www.cbcny.org/sites/default/files/REPORT_HHC_11062014.pdf
- ⁹ https://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-15_executive_budget_webinar.ppt
- ¹⁰ Citizens Budget Commission Breakfast Meeting, November 18, 2014.
http://www.cbcny.org/sites/default/files/EVENT_REMARKS_11182014.pdf
- ¹¹ <https://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/>
- ¹² For estimate of pre-ACA New York City Uninsured, *see*: http://www.nyc.gov/html/hia/downloads/pdf/City%20Planning_OCHIA_Population_Trends_0614.pdf
For ACA enrollment in New York City, *see*: http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf
New York State of Health estimates that 80 percent of enrollees in the first open enrollment period were

uninsured at the time of enrollment: <http://www.healthbenefitexchange.ny.gov/news/press-release-ny-state-health-details-information-nearly-1-million-who-enrolled-through>

¹³ New York City enrollment figures have not been released for the 2015 enrollment period, which ended on February 15, 2015. Eighty-eight percent of enrollees statewide reported that they had no insurance at the time of enrollment. <http://www.healthbenefitexchange.ny.gov/news/press-release-ny-state-health-ends-second-open-enrollment-more-21-million-enrollees>

¹⁴ As a longtime leader in health insurance reform, New York State already had in place some of the most critical reforms advanced by the Affordable Care Act, including guaranteed eligibility regardless of one's health condition and expanded access to Medicaid.

¹⁵ http://www.academyhealth.org/files/FileDownloads/AHPolicybrief_Safetynet.pdf;
<http://www.ncbi.nlm.nih.gov/pubmed/24889948>; <http://www.ncbi.nlm.nih.gov/pubmed/25367999>

¹⁶ This funding also takes into consideration treatment of a high proportion of Medicaid patients because Medicaid reimbursement rates are often insufficient to cover the cost of care. Separate allocations are also made to hospitals treating large percentages of Medicare patients. For a detailed history of the DSH program, see: Michael Gusmano and Frank J. Thompson, "The Safety Net At the Crossroads? Whither Medicaid DSH?" in *The Health Care Safety Net in a Post-Reform World*, eds. Mark A. Hall and Sara Rosenbaum, 2012, Chapter 7.

¹⁷ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-disproportionate-share-hospital-dsh-payments.html>

¹⁸ <https://www.federalregister.gov/articles/2014/02/28/2014-04032/medicaid-program-preliminary-disproportionate-share-hospital-allotments-dsh-for-fiscal-year-fy-2014#t-3>

¹⁹ <http://essentialhospitals.org/wp-content/uploads/2013/12/2009-Public-Hospital-Financial-Characteristics-.pdf>

²⁰ Cole ES, Walker D, Mora A, Diana ML., "Identifying hospitals that may be at most financial risk from Medicaid disproportionate-share hospital payment cuts," *Health Affairs*, November 2014.

²¹ <http://www.ncbi.nlm.nih.gov/pubmed/25367999>

²¹ https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-09-27_mrt_payment_reform_dsh.pdf and <https://www.fas.org/sgp/crs/misc/R42865.pdf>

²² HHC provided 70 percent of all hospital clinic care to the uninsured in New York City and over 50 percent of clinic care for the uninsured in New York State in 2012. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015; On the inpatient side, while HHC hospitals accounted for 18 percent of total discharges citywide, 45 percent of discharges of uninsured patients emanated from HHC facilities. http://www.cbcny.org/sites/default/files/REPORT_HHC_11062014.pdf;

²³ President Obama affirmed this policy in his recent executive action on immigration, which does not grant covered individuals access to the ACA insurance exchanges.

²³ <http://www.nytimes.com/2014/11/20/us/politics/obamacare-unlikely-for-undocumented-immigrants.html>; While undocumented immigrants are permitted to pre-certify for Emergency Medicaid through the exchange, federal law bars undocumented immigrants from public health insurance programs, including Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). Undocumented immigrants must meet all other applicable eligibility requirements, e.g., age, income for Emergency Medicaid, CHIP, and coverage for pregnant women, which are paid for with New York State funds.

²⁴ <http://www.empirejustice.org/assets/pdf/publications/reports/exchange-portal-report.pdf>

²⁴ <http://www.pewhispanic.org/2013/09/23/3-state-patterns/>.

²⁵ Based on an analysis of U.S. Census PUMA data, the Center for Migration Studies estimated New York City's undocumented immigration population as 566,122. <http://data.cmsny.org/puma.html>

²⁶ 2012-2013 average. For more information on the methodology used by the Center for Migration Studies, see: <http://jmhs.cmsny.org/index.php/jmhs/article/view/38>.

²⁷ See *Appendix* for full data.

²⁸ HHC's promise of privacy reflects Executive Order 41, which directs city employees to protect confidential information, including immigration status, belonging to people seeking city services. Executive Order 41 was issued to ensure that all New Yorkers, including immigrants, can access city services that they need and are entitled to receive. <http://www.nyc.gov/html/hhc/lincoln/html/patients/immigrant.shtml>;

²⁸ <http://www.nyc.gov/html/hhc/html/news/press-release-20110516-immigrant-status-private.shtml>

²⁹ Nationally, the uninsured were found to be four times more likely than the insured to delay or skip needed medical care, and also more likely to do without filling prescriptions, to be hospitalized for preventable conditions, and to die prematurely. Michael K. Gusmano, "Undocumented Immigrants in the United States: Use of Health Care," March 27, 2012 citing Derose, Kathryn Pitkin, Benjamin W. Bahney, Nicole Lurie and Jose J. Escarce. "Review: Immigrants and Health Care Access, Quality, and Cost" *Medical Care Research and Review* 2009; 66(4): 355-408.; <http://kff.org/report-section/the-uninsured-a-primer-how-did-health-coverage-change->

[under-the-aca/](#)

- ³⁰ Overweight/Obesity rates were highest among undocumented immigrants compared to the other categories, according to results from the California Health Survey.
http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Aug/1699_Wallace_undocumented_uninsured_barriers_immigrants_v2.pdf
- ³¹ Emergency Medicaid is available at incomes below 138% of the FPL. In addition, New York covers outpatient dialysis for undocumented immigrants as well as some cancer treatment. Federally Qualified Health Centers provide primary and preventive services on a sliding scale for the uninsured, including the undocumented. However, access to ongoing preventive care and chronic disease management, as provided for under the ACA, would likely decrease the long-term costs of healthcare for this population and ease the stress associated with episodic bouts of serious illness that require emergency room care. In addition, access to diagnostic, laboratory, specialist and in-patient care are all critical to the well-being of the undocumented and uninsured.
http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Aug/1699_Wallace_undocumented_uninsured_barriers_immigrants_v2.pdf; <http://www.undocumentedpatients.org/nyc-report-april-2015/>
- ³² Research has shown that access to a linguistically and culturally can encourage parents to obtain and use insurance coverage for their children and help uninsured, undocumented individuals seek health care on a timely basis. See: Nancy Berlinger and Michael K. Gusmano, “Undocumented Patients: Undocumented Immigrants and Access to Health Care,” The Hastings Center, March 2013 at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2321295 and Michael K. Gusmano, “Undocumented Immigrants in the United States: Use of Health Care,” March 2012, at <http://www.undocumentedpatients.org/issuebrief/health-care-use/>
- ³³ <http://www.cityandstateny.com/27/28/30/nyc-hhc-ceo-dr.-ramanthan-raju.html#.VRM5NfnF8tl>.
- ³⁴ HHC estimates that 150,000-180,000 of the City’s undocumented immigrants are expected to be eligible under President Obama’s recently-announced executive action on immigration, of which 40% to 50% may be income-eligible for State-funded Medicaid. Implementation of the executive action has been delayed pending the outcome of litigation. Moreover, there are no estimates currently available about how many of this group may actually enroll in Medicaid, obtain employer-sponsored insurance, or the potential impact on HHC. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ³⁵ http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Aug/1699_Wallace_undocumented_uninsured_barriers_immigrants_v2.pdf, p. 13. Given the high cost of living in New York, including the cost of health insurance, some experts believe that actual uninsured rates among undocumented immigrants are higher.
- ³⁶ While this category is fairly expansive on paper, according to an analysis by the Empire Justice Center, few immigrants qualify for a number of the covered classifications.
<http://www.empirejustice.org/assets/pdf/publications/reports/exchange-portal-report.pdf>
- ³⁷ To comply with the New York State Court of Appeals’ decision in *Aliessa, et al. v. Novello*, 96 N.Y. 2d 418 (2001), New York uses state funds to provide healthcare coverage for certain categories of immigrants who do not qualify for federal Medicaid. The Empire Justice Center reports that the New York State Department of Health has further expanded the categories of immigrant eligibility to the point that the “list...excluded basically only the undocumented and noncitizens with nonimmigration visas.”
<http://www.empirejustice.org/assets/pdf/publications/reports/exchange-portal-report.pdf>
- ³⁸ See: <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>
- ³⁹ <http://www.pewhispanic.org/2011/12/01/authorized-immigrants-length-of-residency-patterns-of-parenthood/>.
- ⁴⁰ <http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>
- ⁴¹ <http://kff.org/health-reform/press-release/survey-finds-approximately-3-4-million-previously-uninsured-adult-californians-obtained-coverage-since-start-of-the-affordable-care-acts-first-open-enrollment-period/>
- ⁴² A study by the Urban Institute documented concerns among mixed-status families applying for Medicaid and other government-sponsored human service programs. Among the study’s findings: applications for benefits do not always clearly indicate that parents only need citizenship information and Social Security numbers for their children, not themselves, when applying for child-only benefits, and fears about contact with public officials can be more relevant for some unauthorized immigrant parents with U.S.-born children who fear forcible separation from their families if their legal status becomes known.
<http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>
- ⁴³ The New York Immigration Coalition, “Testimony on NYC and the Affordable Care Act: Where Are We Post-Roll Out and How Can We Boost Access to Care,” before the New York City Council Committee on Health, October 23, 2014.

- ⁴⁴ <http://www.capitalnewyork.com/article/albany/2014/09/8553417/whats-next-obamacare-new-york>; quote updated by speaker, April 2015.
- ⁴⁵ <http://www.capitalnewyork.com/article/albany/2014/09/8553417/whats-next-obamacare-new-york> and testimony by Sonia Angell, Deputy Commissioner, NYC Department Of Health and Mental Hygiene, Marjorie A. Cadogan, Executive Deputy Commissioner, New York City Human Resources Administration, and Marlene Zurack, Senior Vice President and Chief Financial Officer, NYC Health and Hospitals Corporation, before the New York City Council Committee on Health, October 23, 2014.
<http://www.nyc.gov/html/doh/downloads/pdf/public/testi/testi20141023.pdf>
- ⁴⁶ In New York, Infants to age one and pregnant women are eligible up to 223% of the federal poverty level and children age 1 through 18 years are eligible up to 154% of the federal poverty level. *See*:
http://www.health.ny.gov/health_care/medicaid/#qualify.
- ⁴⁷ If the cost of the second least expensive silver plan in the Marketplace exceeds 8 percent of household income, the requirement to purchase insurance or pay a penalty is waived under the ACA. *See*:
<https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/>.
- ⁴⁸ Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁴⁹ *See*: <http://www.nyc.gov/html/hhc/downloads/pdf/hhc-options-2014-04-english.pdf>. Under the New York Hospital Financial Assistance Law, each hospital receiving DSH payments is required to establish a financial assistance program that limits charges for uninsured patients, and provides financial assistance on a sliding-scale basis to help uninsured patients pay their hospital bills. For an analysis of flaws in the implementation of the Hospital Financial Assistance Law and recommendations to improve the allocation of funds, see
<http://www.cssny.org/news/entry/study-finds-that-most-funding-goes-to-hospitals-that-fail-to-inform-needy-p>
- ⁵⁰ This “over-match” is in addition to the matching funds already provided by the City to draw down DSH funds. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁵¹ http://www.investopedia.com/terms/c/cash_position.asp
- ⁵² Based on a gross count. <http://www.nyc.gov/html/ops/downloads/pdf/pmmr2015/hhc.pdf>
- ⁵³ HHC reports treating 431,000 uninsured patients in CY 2014 and projects that 400,000 patients are expected to remain uninsured and continue to use HHC services in 2019. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁵⁴ A recent report highlighted the growing role of retail health clinics as a limited safety-net provider and notes their potential to offer cost-effective preventive services for the uninsured as well as increase enrollment in government programs such as SNAP. The authors recommend that local and state government explore public-private partnerships, including financing and tax credits, to encourage clinics to open in under-served areas. *See*:
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419415
- ⁵⁵ HHC projects Exchange Revenue Gains of \$108 million in CFY 2019 against a projected DSH federal funds loss of \$381 million. Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁵⁶ Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015. The New York State of Health open enrollment report provides a higher figure: 55,000.
http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf
- ⁵⁷ Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁵⁸ http://www.cbcny.org/sites/default/files/REPORT_HHC_11062014.pdf
- ⁵⁹ *See*: “Health Care Options for Immigrants” http://www.nyc.gov/html/hia/html/home/home_immigrants.shtml
- ⁶⁰ *See*: <http://www.nyc.gov/html/hhc/downloads/pdf/hhc-options-2014-04-english.pdf> and Communication from Health and Hospitals Corporation to Office of the New York City Comptroller, March 2015.
- ⁶¹ The rule also applies to uncompensated costs for care to individuals who are Medicaid-eligible.
<https://www.federalregister.gov/articles/2014/12/03/2014-28424/medicaid-program-disproportionate-share-hospital-payments-uninsured-definition>.
- ⁶² Separately, New York State is implementing a Medicaid waiver, known as Delivery System Reform Incentive Payment, or DSRIP. Participating hospitals will receive payments based on their ability, among other goals, to reduce avoidable hospital admissions by 25 percent. Although beyond the scope of this study, the implications for HHC funding merit further consideration, given that reaching this goal with a large proportion of uninsured patients may pose particular challenges.

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- ⁶³ Between 133 percent and 200 percent of the federal poverty level (FPL), or \$26,720 to \$40,180 for a family of three.
- ⁶⁴ In New York, this will include MAGI-eligible aliens lawfully present in the US with household incomes equal to or below 133% of the FPL if ineligible for Medicaid due to immigration status as well as individuals admitted for permanent residence or permanently residing in the U.S. under color of law (PRUCOL) who are ineligible for Medicaid, or who are non-citizens in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a) (15). NY CLS Soc Serv Sec 369-gg 3(d) and (7); Section 45, Paragraph (g) of subdivision 1 of Section 366 of the Social Services law.
- ⁶⁵ On March 12, 2014, the Centers for Medicare and Medicaid Services published the Basic Health Plan final rule and payment notice for 2015 in the Federal Register: <https://www.federalregister.gov/articles/2014/03/12/2014-05299/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in>
- ⁶⁶ Individuals earning between 150 percent and 200 percent of the FPL will pay a premium of \$20 per month; individuals earning between 133 percent and 150 percent will pay no premiums.
- ⁶⁷ For a more detailed discussion of the BHP, see: <http://www.cssny.org/publications/entry/bridging-the-gapJune2011RevisedJanuary2012>
- ⁶⁸ BHP covers lawfully present non-citizens who are ineligible for Medicaid or CHIP due to immigration status, such as waiting status, with incomes between zero and 200 percent of the FPL. <http://ccf.georgetown.edu/all/two-states-on-the-path-to-the-basic-health-program-2/>
- ⁶⁹ For an overview of current State and local programs for the uninsured operating in Los Angeles, San Francisco, Houston, Massachusetts and Nevada, see: Berlinger, Nancy, Claudia Calhoun, Michael K. Gusmano, and Jackie Vimo, Undocumented Immigrants and Access to Health Care in New York City: Identifying Fair, Effective, and Sustainable Local Policy Solutions: Report and Recommendations to the Office of the Mayor of New York City, The Hastings Center and the New York Immigration Coalition, April 2015 at <http://www.undocumentedpatients.org/nyc-report-april-2015/>



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