



## THE NUTS AND BOLTS OF NEW YORK'S HEALTHCARE MARKETPLACE: A Tool Kit for Caregivers and Advocates

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# SPECIAL THANKS TO...

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## ABOUT EMPIRE JUSTICE CENTER

Empire Justice Center is a statewide, public interest law firm with offices in Albany, Rochester, White Plains and on Long Island. The mission of Empire Justice is to make the law work for all New Yorkers. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to legal services programs and community based organizations. As an advocacy organization, Empire Justice engages in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, Empire Justice provides legal assistance to those in need and undertakes impact litigation to protect and defend the rights of disenfranchised New Yorkers.

## ABOUT CHCANYS

Founded 40 years ago, CHCANYS is New York State's Primary Care Association. CHCANYS' mission is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high-quality, community-based health care services, including a primary care home. CHCANYS works closely with the more than 60 federally qualified health centers (FQHCs) that operate approximately 600 sites across the state. They provide high quality, cost-effective primary health care to anyone seeking care, regardless of the patients' insurance status or ability to pay. CHCANYS works to increase access to health care for all New Yorkers through a program of health policy leadership, regulatory reform, and grassroots advocacy and to support FQHCs with tools and information necessary to maintain and improve existing programs, strengthen core services, and build new programs.

# THE NUTS AND BOLTS OF NEW YORK'S HEALTHCARE MARKETPLACE

## INTRODUCTION

This toolkit is intended to provide caregivers and advocates for low income consumers with an understanding of what New York's Health Insurance Exchange has to offer their patients and clients. New York opened ***New York State of Health: the Official Health Plan Marketplace*** on October 1, 2013. The Marketplace represents a tremendous advancement in providing access to affordable health insurance coverage and has the potential to reduce the ranks of New York's uninsured by over a million people.

New York's Marketplace implements three fundamental advancements for low income patients and consumers as laid out in the federal Affordable Care Act:

- New application technology,
- Expanded eligibility for Medicaid, and
- Federal subsidies to help those over-income for public programs afford private insurance.

Consumers gain entry to the Marketplace through an online portal. The first step is to create an account. Next, users must supply the information requested by an interactive online application. The online portal electronically verifies information relevant to eligibility for Marketplace programs by matching the information applicants enter with information on the applicant's income, and citizenship/immigration status that is already stored in federal and state data bases. Whenever possible, the portal will provide applicants with eligibility determinations in "real-time." ***Further information about the online application process is provided in Section 1 of this toolkit.***

Once the information submitted has been electronically verified, the portal runs a series of eligibility rules for different programs against the information, as follows:

- The portal looks at eligibility for Medicaid, New York's public insurance program for low-income individuals and families first. Those who are determined to be Medicaid eligible will not be screened for any other programs, as federal law prohibits Medicaid eligible individuals from receiving new insurance affordability subsidies from the federal government. ***Further information about New York State Medicaid is available in Section 2 of this toolkit.***
- If the applicant is determined ineligible for Medicaid, the portal will look at eligibility for other public insurance programs.
  - Immigrants who are income-eligible for Medicaid but cannot meet the program's immigration status requirements, will be screened for eligibility for Emergency Medicaid. ***Further information about Emergency Medicaid is provided in Section 3 of this toolkit as well.***
  - Children who are over-income or ineligible for Medicaid for other reasons (including immigration status) will be screened for eligibility for Child Health Plus (CHP), New York's

public insurance program for children. **Information about Child Health Plus is available in Section 4 of this toolkit.**

- Next, the portal will assess eligibility for federal subsidies to help those over-income, or otherwise ineligible for Medicaid and Child Health Plus, afford private insurance products available in the Marketplace. Federal subsidies include premium assistance and cost sharing reductions, which help with co-pays and deductibles. **Further information about federal subsidies is available in Section 5 of this toolkit.**
- Finally, for those not applying for financial assistance, the portal will assess eligibility for purchasing private health insurance coverage in the Marketplace at full price.
- The Marketplace will eventually provide information on free or low-cost care available through hospital financial assistance programs and Federally Qualified Health Centers (FQHCs) for those who do not qualify for public programs or federal subsidies and cannot afford private coverage. **Further information about hospital charity care is provided in Section 7 of this toolkit.**

Eligibility rules for public programs and federal subsidies for private health insurance are particularly complex for immigrant applicants. **Further information about immigrants and the Marketplace is available in Section 6 of this toolkit.**

Some consumers, notably those who are elderly or eligible for Medicare, may not benefit from applying for health insurance through New York's Marketplace. These consumers can apply for Medicaid and other public programs that provide assistance with Medicare's cost-sharing through county departments of social services. **More information about assisting elderly and disabled applicants is available in Section 8 of this toolkit.**

## SECTION 1: APPLYING FOR HEALTH COVERAGE THROUGH THE MARKETPLACE

Consumers can apply for health coverage in the Marketplace in various ways. Informational campaigns direct consumers to the New York State of Health website. See [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov). Consumers can apply four different ways: online, telephone, in-person or via paper. Very few consumers are expected to apply through the paper application process.

### **ASSISTANCE FOR PATIENTS AND CONSUMERS**

Telephone assistance is provided by the Consumer Support Center, which is a new state entity staffed by workers from a private contractor and complimented by staff from the New York State Department of Health (NYSDOH). Consumer Support Center staff is physically located in both Albany and New York City. Staff sits at computers and can electronically access the applications that callers have started or will start as they work with the Center staff over the phone.

Consumer Support Center staff does not provide in-person assistance to consumers who want to use the Marketplace. Instead, NYSDOH has created a large, community workforce to provide in- person assistance. There are three types of in-person assistors for Marketplace enrollment:

- **Navigators.** Navigators, usually community based organizations, receive funding from the state to help consumers apply for coverage in the Marketplace. Navigators are trained by NYSDOH and Customer Service staff for three days before they are certified and can begin assisting consumers in both the Individual and Small Business Health Options Program, or SHOP Marketplace.
- **Licensed brokers.** Brokers must take one of the approved trainings offered by DOH and pass an exam before applying for certification to assist small businesses with accessing coverage through the SHOP or to assist individuals and families in the Individual Marketplace.
- **Certified application counselors.** Agencies with certified application counselors are not funded by the state, but their workers receive the same training as the navigators and are certified to help consumers apply for programs and purchase insurance products in the Individual Marketplace. Local social services districts, social services agencies and health care providers are all expected to have staff trained as certified application counselors.

Consumers or patients who want in-person assistance can access a list of navigators, brokers and certified application counselors through a zip code driven search function on the New York State of Health website.

### **THE ONLINE APPLICATION PROCESS**

Applicants who sit down with a navigator or application counselor, or initiate the process at home with or without telephone assistance from the Consumer Support Center, will enter information into an online application available through the Marketplace portal on the New York State of Health website. Information submitted on the application will be electronically verified by comparing it to existing information stored in a new federal data hub, which compiles information from data sources such as the

IRS, the Social Security Administration, and the Department of Homeland Security through its SAVE immigration data system and state data sources such as the Department of Tax and Finance and the Department of Labor.

The online application process involves five basic steps, each of which requires the applicant to enter information on several different computer screens:

- The first step is to create a user ID and password on NY.gov so that the applicant can access the NY State of Health website.
- The second step is to create an account and provide identity information. During this step, the applicant provides contact and identity related information: legal name, mailing address, phone number, preferred language, email address, preferred method of contact (regular mail or email) gender, date of birth and social security number, if they have one. The portal electronically verifies this information by checking it against the federal data hub. If found by the hub, the applicant is then presented with 4 security questions. If answered correctly, their identity verification will be complete..
  - People who are transient, homeless or migrant can provide the address of a shelter, case management office or a post office box.
  - People who do not have social security numbers will be asked to explain why. Accepted explanations include different I.D. numbers for immigrants in place of social security numbers and religious objections.
  - People whose identity cannot be electronically verified will be instructed to submit identity documents, either by fax or computer scan. Many applicants without a social security number will have to submit identity documents. ***For more information about verifying identity without a social security number, see Section 6 of this toolkit.***
- The third step is to build a household by entering demographic information about all household members, including applicants, spouses, children and anyone else included on the applicant's federal tax return as a dependent, whether or not they are residing with the applicant.
  - The online application will ask whether the applicant seeks help paying for health coverage and request household information on age, gender, whether they need health insurance, residence, marital status, pregnancy, disability, student/foster care status, citizenship/immigration status, race/ethnicity for each household member and household relationships. Household members who are ineligible for insurance through the Marketplace because of immigration status are not required to provide immigration information. ***For more information on immigrants and the Marketplace, see Section 6.***
  - At this stage, low income applicants who have indicated they have a certified disability, a need for waiver or institutional long term care, or the need for help with existing medical bills may be referred to the local social services district for Medicaid eligibility processing. ***For more information about the local social services district application process, see Section 7 of this toolkit.***
- The fourth step is to build income by entering information about income amounts and sources for each member of the household, including the applicant. The portal will attempt to verify the income

amounts submitted with information accessed through the federal hub and state data bases, and will accept variations of 10% or less as reasonably compatible.

- If income information submitted is not reasonably compatible with information accessed during verification, applicants will be asked for an explanation and may be asked for documentation.
- The fifth step involves supplying information about other health insurance coverage for the entire household. The application will ask for information about public health insurance coverage, like Medicare, as well as employer-related coverage.
- If employer coverage that meets minimum standards of coverage and affordability is available, it may affect eligibility for federal subsidies.
  - Medicare will affect eligibility for federal subsidies but not necessarily eligibility for Medicaid – although those with Medicare will likely be referred to their local social services district for Medicaid application processing.

***(At this point the applicant should receive an eligibility determination for each member of the household. If not all relevant information can be electronically verified, applicants will be instructed to submit additional documents within 15 days (for Medicaid or Child Health Plus) or 90 days (for federal subsidies for private insurance coverage).***

- The sixth step calls for applicants who have received a favorable eligibility determination from the Marketplace (for either Medicaid, Child Health Plus, federal subsidies for private insurance coverage, or full price private insurance coverage) to select a health plan. Customer Service, navigators, brokers and certified application counselors are all trained to explain the different choices consumers will have. All will be able to help applicants compare provider networks, prescription drug formularies, quality ratings and cost, and assist the consumer in selecting a health plan based on his or her individual needs or priorities. Customer Service Center staff, navigators and certified application counselors are prohibited from steering applicants to a specific plan.

Once a health plan has been selected, the portal will forward enrollment information to the plan. Coverage begins on the first of the month following the month of application for those who select a plan prior to the 15<sup>th</sup> of the month of application. For those who select a plan after the 15<sup>th</sup> of the month of application, coverage will begin on the 1<sup>st</sup> of the second month following the month of application.

Consumers can apply for Medicaid and Child Health Plus through the Marketplace all year. Enrollment in private health insurance coverage through the Marketplace is restricted to open enrollment periods. Federal regulations established open enrollment of October 15 through December 7 every year, although in 2013-2014 it began October 1 and extends through March 31<sup>st</sup> (this is the program's longer, "initial enrollment period"). HHS has also modified open enrollment for 2015. Open enrollment for next year runs from November 15 through January 15, 2015. Exceptions will be made when people have a special qualifying life event, which entitles them to a special enrollment period. Qualifying life events include the birth of a child, marriage, death of a family member and divorce.

## SECTION 2: MEDICAID IN THE MARKETPLACE

New York's Medicaid program, also known as Medical Assistance, is a public health insurance program for low income individuals and families. Beginning on January 1, 2014, most applicants for Medicaid will benefit from expanded income levels and the new application technology available through the Marketplace.

### **WHAT ARE THE INCOME LIMITS?**

As part of the Affordable Care Act, income levels for Medicaid have been expanded for most applicants and recipients. In order to benefit from expanded eligibility levels, patients or consumers have to fit into one of the following categories:

- Pregnant women and infants up to one year of age
- Children up to age 19 or 19 and 20, if a full time student
- Parents and relative caretakers of any age
- Childless adults between ages 21 and 64 without Medicare.

The group of people who fit these categories is referred to as **MAGI**, which stands for Modified Adjusted Gross Income. They are called MAGI because the rules for counting their income are drawn from the IRS rules for *Modified Adjusted Gross Income*, with a 5% disregard of income across the board.

Pregnant women and infants qualify for Medicaid up to 224% of the federal poverty level (FPL). Children qualify for Medicaid up to 154% of FPL. Parents, caretakers and single adults between 21 and 64 without Medicare qualify for Medicaid up to 138% of FPL.

Medicaid applicants who do not benefit from the expanded income levels or the new budgeting rules are referred to as the **non-MAGI**. This group is composed of primarily elderly and disabled persons, but also includes those who qualify for Medicaid automatically because they are eligible for other government programs like Temporary Assistance for Needy Families or foster care, also those residing in adult homes, treatment centers and Office for Mental Health facilities, as well as those in special Medicaid programs like spend down, Medicaid Buy in For Working People with Disabilities, the Medicare Savings Programs and Cancer treatment programs.

The non-MAGI group does not benefit from expanded income levels and continues to qualify for Medicaid at the existing level, approximately 87% of FPL. Some non-MAGI applicants are also subject to a resource test (\$14,550 for a single elderly/disabled applicant, \$21,450 for an elderly/disabled couple). Those who need long term care in an institutional setting will be subject to a look-back period of 5 years and a penalty period, during which they will not be eligible for institutional Medicaid if a transfer was made during the look-back period for less than fair market value.

Non-MAGI applicants who are 65 years of age or older or are parents or are disabled can qualify for Medicaid, even if their income or resources are above the medically needy level, if they spend down their income or resources on medical expenses. ***Section 8 on assistance for elderly and disabled individuals provides more information on spend down.***



## ***HOW LONG DOES THE MEDICAID APPLICATION PROCESS TAKE?***

MAGI groups can apply for Medicaid through the new Health Plan Marketplace. Applications through the Marketplace will receive eligibility determinations in real-time, unless documentation is required. However, even in these instances, the expectation is that the Marketplace applications will be completed much more quickly than paper applications filed with local districts. MAGI groups will also benefit from the new telephone assistance available through the Customer Support Center, as well as in-person assistance from navigators and certified application counselors. ***Section 1 of this toolkit provides more information on the eligibility and enrollment process in the Marketplace.***

Non-MAGI Medicaid applicants and recipients cannot receive eligibility determinations through the new Marketplace unless they are also eligible under a MAGI category. If these “non-MAGI-only” applicants try to use the portal, they will be referred to their local social services district where applications are still filed on paper.

Applications filed with local districts must be completed by the 45<sup>th</sup> day following the date of the application, unless a disability determination is required in which case 90 days is allowed. State law requires that applications by pregnant women and children be completed within 30 days of the application. Medicaid applicants who are waiting beyond the prescribed time period, or who are denied Medicaid eligibility can request a fair hearing. Technically, these timelines are true within the Marketplace too, though the turnaround time is usually much faster.

Once Medicaid is approved for either MAGI or non-MAGI applicants, the program will pay for necessary medical services provided up to three months prior to the date of application, as long as the applicant was eligible during the month the services were provided.

Applicants need to recertify for Medicaid every year. Some non-MAGI applicants will need to complete paperwork at recertification, although more and more of these recipients, particularly those on fixed incomes, will be renewed automatically. MAGI applicants will be able to renew online. Navigators will be able to help MAGI recipients with recertification.

## ***WHAT SERVICES DOES MEDICAID COVER?***

The benefit package in New York’s Medicaid program is comprehensive. There are no premiums for Medicaid and co-payments are minimal, with a cap of \$200 in co-payments annually. The following services are covered:

- Hospital care
- Lab tests and x-rays
- Vision, speech and hearing services
- Rehabilitation and habilitation services (with some limits)
- Durable medical equipment
- Emergency room and ambulance services
- Behavioral health and chemical dependence services (with some limits)

- Diabetic supplies and equipment
- Hospice care
- Radiation therapy, chemotherapy and hemodialysis
- Dental services (with limits and only if they are offered by the plan the patient selects)
- Prescription drugs
- Family planning and reproductive services
- Home health care and nursing home care
- For children, Early & Periodic Screening, Diagnosis and Treatment (EPSDT)

Some special Medicaid programs, like the Medicaid Cancer Treatment Program and the Family Planning Benefit Program, are more limited in scope, but allow applicants to have higher income levels. For further information about these specialized programs, visit the NYSDOH website at [http://www.health.state.ny.us/health\\_care/medicaid/index.htm](http://www.health.state.ny.us/health_care/medicaid/index.htm)

Both MAGI and non-MAGI patients and consumers will receive health care services through a managed care plan, which means they must satisfy prior authorization requirements and use in-network providers.

### ***HOW DO PEOPLE APPEAL MEDICAID DENIALS?***

Applicants who are found *ineligible for Medicaid* by the Marketplace can file an appeal with the Marketplace. The eligibility appeal process for Medicaid denials in the Marketplace is the same as it is for a Marketplace denial of Child Health Plus or federal subsidies and commercial coverage. Applicants have 60 days following the date of the denial to file an appeal. A consumer can file an appeal by phone, fax, or mail. In the future, requests will also be available through online accounts. The consumer should receive notice that their appeal has been received, along with an explanation of an informal dispute resolution process which can be used while appeals are pending. In a few weeks, the consumer should receive another notice with a date for a hearing.

Hearings for eligibility denials in the Marketplace are held by telephone, although an in-person option will be available on request in the future. The hearing is held by an impartial hearing officer. Interpreters and assistance for disabled applicants will be available upon request.

Non-MAGI Medicaid applicants cannot file appeals of eligibility determinations through the Marketplace, and must continue to use the fair hearing process available through the Office of Temporary and Disability Assistance (contact information below).

*Appeals of service denials* by Medicaid cannot be filed with the Marketplace, even if the enrollee enrolled in Medicaid through the Marketplace. Both MAGI and non-MAGI Medicaid enrollees must use the existing fair hearings process to appeal service denials. They can also file an appeal with the plan itself, or file for a fair hearing and a review by the plan at the same time.

No matter where the appeal is filed, if the request for a fair hearing is made within 10 days of receiving notice of a reduction or termination of existing services, consumers should receive aid continuing while waiting for their fair hearing.

Medicaid recipients can request fair hearings for service denials from the Office of Temporary and Disability Assistance by phone (800-342-3334), by fax (518-473-6735), online ([www.otda.state.ny.us/oah/forms.asap](http://www.otda.state.ny.us/oah/forms.asap)), or by mail by writing to:

Fair Hearings Section  
NYS Office of Temporary and Disability Assistance  
P.O. Box 1930  
Albany, NY 12201

Patients who file appeals of service denials with the Medicaid plan itself can request an external review with the New York State Department of Financial Services if the plan continues to deny the service. You can get more information about appealing a service denial by a qualified health plan at the Department of Financial Services website (<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>). Empire Justice Center may be able to provide advice, and sometimes representation, on service denials outside of New York City. Clients or patients who already have a fair hearing date may also be able to get help from their local legal services program. For contact information for legal services programs that help with Medicaid related problems in different counties across the state, visit LawHelp at <http://www.lawhelpny.org/>.

## SECTION 3: EMERGENCY MEDICAID

Emergency Medicaid is a special program for those who would qualify for Medicaid in New York, but for their immigration status. Emergency Medicaid covers only those services considered to be emergency services by the federal government.

### ***WHAT KINDS OF SERVICES ARE CONSIDERED EMERGENCY SERVICES?***

The federal government has defined emergency services as those that manifest by acute symptoms (including pain) such that absence of immediate medical attention could put the patient in serious jeopardy, seriously impair bodily functions, or cause serious dysfunction to an organ or body part. New York provides coverage under Emergency Medicaid for chemotherapy and radiation treatment associated with a cancer diagnosis. Coverage should include prescription medications as long as they are associated with stabilization and treatment of the diagnosis that constituted the medical emergency.

Certain services are specifically excluded from Emergency Medicaid coverage, including organ transplants, nursing facility services, home care services, hospital stays billed as “alternate level of care” and rehabilitation services (PT, OT and speech therapy).

### ***HOW DO IMMIGRANTS APPLY FOR EMERGENCY MEDICAID?***

Immigrants who fit into the MAGI groups can apply for Emergency Medicaid through the Marketplace. ***Section 2 of this toolkit provides a list of the MAGI groups – Section 1 describes the screening process for Emergency Medicaid in the Marketplace.***

Immigrants who are non-MAGI can apply for Emergency Medicaid through their local social services district. They will need to submit the standard Medicaid application, and if they are found eligible for Medicaid except for their immigration status, the local district should issue them a Benefit Identification Card and authorize Emergency Medicaid coverage for a 12 month period.

Emergency Medicaid must be renewed every year, just like standard Medicaid. Spend down may be used to qualify for Emergency Medicaid for immigrants in groups who are spend down eligible. ***Section 7 of this toolkit provides more information on spend down and the groups eligible to use it to qualify for Medicaid.***

Payment will be made for services provided under Emergency Medicaid only when the physician who provided the services enters an emergency admission type in the provider claim data base (eMedNY).

## SECTION 4: CHILD HEALTH PLUS

Child Health Plus (CHP) is a public health insurance program for children under the age of 19 without health care coverage who do not qualify for Medicaid. The Marketplace portal will automatically evaluate children for CHP eligibility if they do not qualify for Medicaid.

### ***DO ALL CHILDREN QUALIFY FOR CHP, EVEN IF THEY COULD GET EMPLOYER SPONSORED COVERAGE?***

Children without health care coverage will qualify for CHP even if their parent could obtain family coverage through an employer. The only children who will not qualify for CHP are:

- those who are already enrolled in other coverage
- those who have access to NYSHIP (the New York State Health Insurance Program for state and local government employees) and
- those who recently dropped coverage. Children who have dropped coverage may be subject to a waiting period of three months before they can enroll in CHP, unless they fit one of several exceptions, including parental loss of employment.

Immigrant children will qualify for CHP, even if they are undocumented, as long as they are residents of New York.

### ***WHAT SERVICES DOES CHP COVER?***

CHP provides comprehensive services, including:

- Well-child care
- Physical exams and immunizations
- Diagnosis and treatment of illness and injury
- Lab tests and x-rays
- Outpatient surgery
- Emergency care
- Prescription and non-prescription drugs
- Inpatient hospital medical or surgical care
- Short term therapeutic outpatient services (chemotherapy, hemodialysis)
- Limited inpatient & outpatient treatment for alcoholism, substance abuse, mental health
- Dental care
- Vision, speech and hearing services
- Durable medical equipment
- Emergency ambulance services
- Hospice care

Unlike Medicaid, CHP does not cover long term care services.

## ***WHAT ARE THE PREMIUM LEVELS FOR CHP?***

There are no premiums for families under 160% of the federal poverty level (FPL). Monthly premiums apply above that level as follows:

- \$9 per child (\$27 max.) for families with income above 160 and below 201% of FPL
- \$15 per child (\$45 max.) for families with income above 200 and below 251% of FPL
- \$30 per child (\$90 max.) for families with income above 250 and below 301% of FPL
- \$45 per child (\$135 max.) for families with income above 300 and below 351% of FPL
- \$60 per child (\$180 max.) for families with income above 350 and below 401% of FPL
- Full premium for families with income above 400% of FPL.

The amount of a full premium varies by plan, but remains considerably lower than anything available on the private market.

## ***HOW DO FAMILIES APPEAL CHP DENIALS?***

Applicants who are found *ineligible for Child Health Plus* by the Marketplace can file an appeal with the Marketplace. The eligibility appeal process for Medicaid denials in the Marketplace is the same as it is for a Marketplace denial of Medicaid or federal subsidies and commercial coverage. Applicants have 60 days following the date of the denial to file an appeal. A consumer can file an appeal by phone, fax, or mail. Online requests will be accepted in the future. The consumer should receive notice that their appeal has been received, along with an explanation of an informal dispute resolution process which can be used while appeals are pending. In a few weeks, the consumer should receive another notice with a date for a hearing.

Hearings for Child Health Plus eligibility denials in the Marketplace are held by telephone. In-person hearings will be available on request in the future. The hearing is held by an impartial hearing officer. Interpreters and assistance for disabled applicants will be provided upon request.

Unlike Medicaid, CHP members do not have the right to request a fair hearing or obtain aid continuing if services are reduced or denied. CHP members who are unable to get services they need should pursue appeals within their plan and contact the NYS Health Department's Bureau of CHP Enrollment at 518-474-6965. If the CHP plan denies the appeal, consumers can request an external review with the New York State Department of Financial Services. You can get more information about the external review process at the Department of Financial Services website (<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>).

## SECTION 5: FEDERAL SUBSIDIES FOR COMMERCIAL COVERAGE

The Affordable Care Act (ACA) creates new health coverage options for those with incomes over Medicaid eligibility levels. The ACA establishes Health Benefit Exchanges, run either by states or by the federal government, which serve as marketplaces for the purchase of commercial health insurance products offered by qualified health plans. Applicants with income under 400% of the federal poverty level are eligible to receive federal subsidies to help make the coverage more affordable.

Premiums for individuals and families seeking commercial coverage in New York's Marketplace are significantly lower than comparable coverage outside the Marketplace, due to competition among health insurance plans for the new market of uninsured New Yorkers who face penalties if they do not enroll. Even with price reductions, however, federal subsidies play a critical role in making commercial coverage truly affordable to many uninsured New Yorkers.

### *WHAT ARE THE FEDERAL SUBSIDIES AND WHO IS ELIGIBLE?*

There are two types of federal subsidies available in the Marketplace. Eligibility is different for the two types of assistance.

- **Advance Premium Tax Credits.** Advance premium tax credits help families with income below 400% of the federal poverty level afford the premiums associated with commercial insurance coverage. The size of the credit is adjusted for each applicant, taking into account the taxpayer's income.
- **Cost-sharing Credits.** Cost-sharing credits help reduce out of pocket costs for families with income below 250% of the federal poverty level. The size of the cost-sharing credits is also adjusted by income. In order to obtain cost-sharing credits, taxpayers must select a plan that covers 70% of medical costs before cost-sharing credits are applied. Plans that cover 70% of medical costs are referred to as having a 70% actuarial value and are classified in the Marketplace as silver level coverage.

### *HOW ARE THE SUBSIDIES APPLIED?*

Individuals and families who are found eligible for premium tax credits can choose how their premium credit is applied. The taxpayer can take the premium credit in advance and elect to have it paid directly to the insurance plan he or she selects in order to lower the monthly cost of having insurance.

Taxpayers can also wait until they file taxes and receive the credit all at once at the end of the year. A third alternative is to split the tax credits and receive some each month and some at the end of the year.

Applicants who take the tax credit in advance need to report changes in income during the year so that the amount of the credit can be adjusted. Otherwise, if income increases and they do not report it, they could end up owing money to the IRS at the end of the year through a process called reconciliation. Changes in income or family size can be reported online, through the customer support center or with the help of a navigator, broker or certified application counselor.

Cost-sharing reductions work differently. Cost-sharing reductions can only be applied to out of pocket costs in a silver level plan. If a patient or consumer who is eligible for cost-sharing reductions chooses a silver level plan, the reduction will automatically be applied to lower the deductible and co-pays. If a patient or consumer eligible for cost-sharing reductions does not choose a silver level plan, the reductions will not be applied.

Unlike the premium tax credit, there is no reconciliation process for cost-sharing reductions at the end of the year. As long as the applicant stays with the same silver level plan, the cost-sharing reduction will not change or be charged back at the end of the year, even if income or family size change.

### ***WHAT KIND OF COMMERCIAL HEALTH INSURANCE IS AVAILABLE IN THE MARKETPLACE?***

All commercial health insurance offered in the Marketplace will be provided by qualified health plans, plans that have been approved and certified by the New York Marketplace. All qualified health plans must provide comprehensive coverage, follow limits on out of pocket expenses and have adequate networks of providers.

There are two types of qualified health plans, standard and non-standard. Standard plans must offer exactly the same benefits and cost-sharing; only their prescription formularies can vary. Non-standard plans can offer additional benefits, make a limited number of benefit substitutions and have different cost-sharing. All qualified health plans will have quality ratings and provider directories that consumers can compare when making plan selections.

Each qualified health plan must offer a standard plan at each of four metal levels: bronze, silver, gold or platinum. The difference between the metal levels is the difference in the average percentage of medical costs the plan pays. The percentage of costs that the plan pays is referred to as the plan's actuarial value (AV). Plans increase in actuarial value from bronze (60% AV), to silver (70% AV), to gold (80% AV) and finally, platinum (90% AV). As actuarial value and the percentage of expenses paid by the plan increases, so does the premium.

Customer support center staff, navigators, brokers and certified application counselors are trained to explain the different choices consumers will have. All will be able to help applicants compare provider networks, prescription drug formularies, quality ratings and cost, and assist the consumer in selecting a health plan based on his or her individual needs or priorities. Customer support center staff, navigators and certified application counselors are prohibited from steering applicants to specific plans.

### ***WHAT SERVICES DOES COMMERCIAL INSURANCE IN THE MARKETPLACE COVER?***

Every qualified health plan participating in New York's Marketplace, standard and non-standard, must cover 10 essential health services, regardless of metal level. The ten essential services are:

- Care at a doctor's office
- Prescription drugs
- Hospital care



- Pregnant mother and baby care
- Mental health and addiction treatment
- Emergency services
- Prevention and wellness services
- Rehabilitation and skill development services and devices
- Laboratory services
- Chronic disease management
- Dental and vision care for children.

### ***DOES THE MARKETPLACE OFFER CATASTROPHIC COVERAGE?***

The Marketplace does offer catastrophic coverage, but the only patients or consumers who are eligible to buy it are young adults under 30 and those who are exempt from the individual mandate for coverage because they are unable to afford minimum essential coverage or are eligible for a hardship exemption.

Catastrophic coverage is designed to protect against catastrophic events. Premiums are lower than they are for the lowest metal tier, the bronze plans, and out of pocket costs are higher. Catastrophic plans cover three primary care visits before the deductible is reached. Other essential health benefits are not covered until the deductible has been met. Advance premium tax credits cannot be used to lower premiums for catastrophic coverage and cost-sharing reductions cannot be used to lower out of pocket costs.

In January, HHS created a special hardship exemption process allowing individuals whose health coverage was cancelled and cannot afford to purchase coverage through the Marketplace to purchase catastrophic coverage directly from Marketplace plans without completing an application through the Marketplace. Information about this special exemption can be found on [healthcare.gov](http://healthcare.gov).

### ***WHEN CAN PEOPLE ENROLL IN COMMERCIAL INSURANCE THROUGH THE MARKETPLACE?***

Unlike public health insurance, which patients and consumers can apply for all year round, commercial insurance and federal subsidies in the Marketplace have specific enrollment periods. The initial enrollment period is the kickoff for the new program and takes place from October 1, 2013, when the Marketplace officially opened and runs through March 31, 2014.

Next year, HHS has established a two month open enrollment which begins November 15, 2014 and ends January 15, 2015. After the 2015 enrollment period, consumers and patients will only be able to enroll in commercial insurance and apply for federal subsidies during annual open enrollment periods which run from October 15 through December 7 of every year.

There is an exception for people who have a special qualifying life event. These individuals can enroll or make changes outside of the annual open enrollment period through a “special enrollment period.” Qualifying life events include the birth of a child, marriage, death of a family member and divorce.

### ***WHEN DOES COVERAGE START?***

The date a patient or consumer enrolls in commercial insurance determines the start date of coverage. Generally, patients who enroll between the 1<sup>st</sup> and the 15<sup>th</sup> of the month should have coverage effective the first day of the following month. Patients who enroll between the 16<sup>th</sup> and the last day of the month should have coverage effective the 1<sup>st</sup> day of the second month following their enrollment.

### ***HOW DO YOU APPEAL DECISIONS ABOUT FEDERAL SUBSIDIES?***

If a patient or consumer is denied eligibility for federal subsidies, either the premium tax credit or cost-sharing reductions, he or she can appeal that denial. Likewise, if a patient or consumer is found ineligible to buy commercial coverage even without federal subsidies, that decision can be appealed.

The eligibility appeal process for federal subsidies and commercial coverage in the Marketplace is the same as it is for a Medicaid or Child Health Plus eligibility determination made by the Marketplace. Applicants have 60 days following the date of the denial to file an appeal. A consumer can file an appeal by phone, fax, or mail. Online submissions will be available in the future. The consumer should receive notice that their appeal has been received, along with an explanation of an informal dispute resolution process which can be used while appeals are pending. In a few weeks, the consumer should receive another notice with a date for a hearing.

Hearings for eligibility denials in the Marketplace are held by telephone. An in-person option should be available in the future. The hearing is held by an impartial hearing officer. Interpreters and assistance for disabled applicants will be provided upon request it.

Appeals about service denials by health insurance plans are handled differently and cannot be filed with the Marketplace. An appeal about a service denial with a qualified health plan must be filed first with the health plan itself. If the health plan continues to deny the requested service, consumers can request an external review with the New York State Department of Financial Services. You can get more information about appealing a service denial by a qualified health plan at the Department of Financial Services website (<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>).

## SECTION 6: IMMIGRANTS AND THE MARKETPLACE

### *THE ELIGIBILITY OF NONCITIZENS TO APPLY FOR HEALTH INSURANCE IN THE MARKETPLACE*

U.S. citizens, nationals and noncitizens who are “lawfully present” in the U.S. and are New York State residents are eligible to apply for both public and private health insurance through New York’s Marketplace. Citizens include both those born in the U.S. and noncitizens who have naturalized. People born in Puerto Rico or the U.S. Virgin Islands are also U.S. citizens. The term “U.S. national” refers to U.S. citizens and people born in American Samoa and Swains Island.

Noncitizens are considered “lawfully present” if they are:

- Lawful permanent residents,
- Asylees or refugees,
- Cuban/Haitian Entrants,
- Noncitizens paroled into the U.S.,
- Battered noncitizen spouses, children or parents of a U.S. citizen or LPR in the process of self-petitioning under the Violence Against Women Act,
- Trafficking victims and their spouses, children, parents or siblings with T visas or T nonimmigrant status or certification from the Office of Refugee Resettlement,
- Persons granted withholding of deportation or removal or deportation,
- Persons in a nonimmigrant status (including those with work, student or other nonimmigrant visas and citizens of Micronesia, the Marshall Islands and Palau),
- Residents of Samoa,
- Noncitizens with Temporary Protected Status (TPS),
- Person with Deferred Enforced Departure (DED),
- Person with Deferred Action unless granted under the Deferred Action for Childhood Arrivals program (DACA)<sup>1</sup> (they are however eligible for state funded Medicaid),
- Members of a federally recognized Indian tribe or an American Indian born in Canada,
- Lawful temporary residents, or
- Granted an administrative stay of removal by the Department of Homeland Security.

Applicants for certain immigration benefit whose applications are pending are also considered “lawfully present”, including applicants for:

- Special Immigrant Juvenile Status,
- Adjustment to permanent resident status with an approved visa petition,
- Applicants for T nonimmigrant status,
- Asylum, if they have employment authorization or, if they are under 14 years old, have had an application for asylum pending for at least 180 days, or

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<sup>1</sup> They are however eligible for state funded Medicaid since they are considered to be PRUCOL like all other people with deferred action status.

- Applicants who are in removal proceedings and have an application pending for withholding of removal and have been granted employment authorization or, if they are under 14, have an application pending for withholding of removal for at least 180 days.

The following noncitizens are considered “lawfully present” only if they have currently valid employment authorization:

- A registry applicant (noncitizen with an application for lawful permanent residence based on his continuous residence in the U.S. since before January 1, 1972),
- A noncitizen under an Order of Supervision (usually a person who has been ordered removed but whose removal has not been effectuated),
- An applicant for Cancellation of Removal (someone in removal proceedings who has a defense against removal under the immigration laws),
- An applicant for TPS, or
- An applicant for legalization under the LIFE Act.

Appendix 1 contains Empire Justice’s “Health Coverage Crosswalk: Eligibility by Immigration Status,” a tool that links each of the immigration statuses listed here with an indication of whether an individual in that status is eligible to purchase private insurance in the Marketplace, with or without subsidies, or is eligible for one of the public insurance programs, including federal or state funded Medicaid, CHP, ADAP or Emergency Medicaid. The Crosswalk also shows, by way of colored vertical bands along the side of the chart, in which benefits-related immigrant eligibility classification a particular immigration status falls. The classifications are:

- “qualified alien,” the benefits related classification established under the welfare reform law of 1996 (PRWORA), that enumerates the immigration statuses of noncitizens eligible for federal public benefits after the enactment of the law,
- “lawfully present,” the healthcare related classification established by the ACA (which includes but is much larger than the group defined as “qualified aliens”) that enumerates the immigration statuses of noncitizens eligible to apply for health insurance in the Marketplace,
- PRUCOL (permanently residing under color of law), a New York state defined immigrant eligibility category.

As can be seen from the Crosswalk, there is some overlap between the immigration statuses that make up New York’s PRUCOL classification and those included in the ACA’s “lawfully residing” category. However, the overlap is not complete, the state’s PRUCOL category being more inclusive. This is largely because, to be considered PRUCOL and eligible for New York’s public health insurance programs, it is not required that the person have employment authorization.

Because immigration law is complicated and the terms unfamiliar to many working in the health care field, the Crosswalk contains a glossary (“Explaining the Terms”) that explains what these immigration statuses mean.

## ***VERIFYING IMMIGRANT/NONIMMIGRANT STATUS***

The biggest challenge facing noncitizen applicants and those who assist them in applying for health insurance in the Marketplace is to correctly identify an applicant's immigration status. In order to do this, familiarity with immigration documents is essential. Providing the information on these documents is what will allow the applicant's immigration status to be verified through the matching of that information with data contained in the data systems of the U.S. Department of Homeland Security. The data matching is done through a system called Systematic Alien Verification for Entitlements (SAVE). It is a document driven system and requires the input of particular numbers that are listed on the applicant's immigration document. New York's online application will not allow you to proceed if the required numbers are not provided from the document on which the applicant is relying to verify eligible status.

A guide to the most common immigration documents published by the United States Citizenship and Customs Enforcement can be found at the USCIS website at:

<https://e-verify.uscis.gov/esp/media/resourcesContents/TravelDocGuide2.pdf>

The Guide includes explanations of the documents and as well as pictures of earlier documents that may still be in use.

## ***DOCUMENTS VERIFYING IMMIGRATION STATUS***

### ➤ Permanent Resident Card (I-551)

Perhaps the most well-known immigration document is the permanent resident card, also known as the "green card." Lawful permanent residents (LPR), most of who come to the U.S. through family based petitions, can live and work in the U.S. for as long as they wish and travel abroad. They can also petition for a spouse, a minor child and unmarried adult children. For purpose of the Marketplace, both the "A" number and the card number must be provided.

The "A" number is the alien registration number that identifies and keeps track of individuals who have had contact with the immigration process. It is assigned at the first such contact, for example when an individual applies for an immigration benefit or gets picked up by the immigration enforcement service. It consists of eight or nine digits and belongs to the person for life, much like a SSN.

The permanent resident card contains other identifying information about the person, including a birthdate, when he or she first became a lawful permanent resident and a category or code. The latter identifies through what channel the individual gained permanent status, whether through a family petition, by coming to the U.S. as a refugee, through an employer's petition, as an asylee, and so on.

A very recently arriving immigrant may not yet have his green card but may have an I-551 stamp in their passport as temporary evidence of permanent resident status. This is acceptable as a document verifying LPR status.

An example of a permanent resident card and how to read the information it contains is attached as Appendix 2.

➤ **Employment Authorization Card (I-766)**

Other than permanent residents, most noncitizens who are lawfully here must apply for authorization to work and only if their status allows it. The EAD must generally be renewed every year or two. The period of validity is found at the bottom front of the card. However, even an expired EAD will give a clue to the status of its holder, which may still be current even if the work authorization is not.

A sample EAD card is attached as Appendix 3 and is annotated to indicate where the numbers that must be provided for the Marketplace application are to be found. Three numbers must be provided, the “A” number, the card number and the category code.

The category code signifies the immigrant or nonimmigrant status of the holder that allows him or her to obtain employment authorization. It is contained in the middle of the card, under the word “category” and is made up of a letter and a number. Appendix 4 contains a list of the most commonly seen codes on EADs and identifies the immigration status to which the code applies.

➤ **The I-94 Arrival/Departure Record**

The I-94 Arrival/Departure Record is a record made by Customs and Border Patrol when a nonimmigrant enters the U.S. at a port of entry, such as an international airport. These records used to be stapled onto the individual’s passport, but they are no longer issued on paper. For anyone entering after 2012, the I-94 will be available for download at [www.cbp.gov/i94](http://www.cbp.gov/i94). When verifying status in the Marketplace through an I-94, usually the I-94 number is needed as well as the foreign passport number, the country of issuance and the expiration date if available.

A sample of the paper form I-94, which many people are still likely to have, is contained in Appendix 5. In addition to the “admission number” in the upper left hand corner, the I-94 contains the name of the nonimmigrant, the date of birth and his or her country of citizenship. It also contains a code that identifies the nonimmigrant category in which the individual entered the country. The sample I-94 in Appendix 5 is coded L-1, the code for an individual who was transferred by his company to work in the U.S. in an executive or management position. The I-94 also shows how long the person is authorized to stay in the U.S. In the case of our sample, the period of authorization is from May 12, 2010 to September 30, 2012. Failure to depart on this date means the person is an “overstay,” and is therefore no longer lawfully residing in the U.S.

➤ **The I-797 “Notice of Action”**

The I-797 Notice of Action is the form commonly used by USCIS to communicate with an individual about an immigration benefit for which he or she has applied. If an I-797 is used to verify status, the “A” number will have to be provided.

The I-797 is used by USCIS for many different purposes, including, among others:

- as a notice of receipt of an application
- to schedule an appearance for the taking of fingerprints
- to notify the applicant whether the application has been approved or denied.

An actual I-797 with identifying information redacted is at Appendix 6. This particular notice was sent to an applicant for employment authorization and notified her that the application was approved. The I-797 contains a receipt number in the upper left hand corner and, on the upper right, the type of application involved, the “A” number of the applicant and the category under which the employment authorization was issued, which in this case is C14. That code applies to an authorization granted to an individual who is in Deferred Action status. (See Appendix 4.)

#### ➤ Other Documents

The documents listed above are the most common, but by no means all the documents an individual may have explaining his immigration related circumstances. Some of these documents will contain an “A” number but others may not. Here is a partial list:

- Certificate of Eligibility for Nonimmigrant Student Status or Exchange Visitor Status, both of which contain a Student and Exchange Visitor Information System (SEVIS) number which can be used for verification of status
- Refugee Travel Document, which will have an “A” number
- Visa in Foreign Passport, which will have the individual’s name, date of birth and nationality, the date the visa was issued, the foreign passport number and the visa classification (for example “B-2” for a visitor)
- Order of Supervision, which will have an “A” number, and means that the individual has been ordered removed but the removal cannot be effectuated, for example, because the person is Cuban and the U.S. has no diplomatic relations with Cuba
- Immigration Court Orders indicating that “Withholding of Removal” or asylum has been granted, both of which will contain the person’s name and “A” number
- Documents or certifications from the Office of Refugee Resettlement, usually in connection with a trafficking case.

## **VERIFYING US CITIZENSHIP STATUS**

Generally U.S. citizenship status is verified through the individual’s Social Security number (SSN). However, the citizenship status of someone who was naturalized or who acquired citizenship through a parent may not be verifiable through the person’s SSN simply because the Social Security Administration does not have a record that the person has naturalized or derived citizenship through a parent.

In the case of naturalization, the person will have been issued a Certificate of Naturalization at the time he or she naturalized, which contains a number. The online application asks for this number. A person who has lost this certificate and cannot otherwise provide that number or an “A” number will be unable to complete the online application. The same is true for U.S. citizens who have lost their “Certificate of

Citizenship,” a document that confirms that they derived citizenship automatically through a parent. Since someone who is naturalized or derives citizenship through a parent is in fact a U.S. citizen, a possible workaround, which would allow the application to be completed, is for the applicant to check that he or she is a U.S. citizen. If SSA does not verify the applicant’s citizenship status, he or she will have the opportunity to resolve the inconsistency.

Resolving an inconsistency means providing other information that confirms your status. A list of documents that can be provided to verify citizenship status can be found at <https://healthcare.gov/help/how-do-i-resolve-an-inconsistency/>. For example, to verify U.S. citizenship, the applicant can upload a copy of a U.S. passport. The website provides a variety of alternative verification documents, not just to verify citizenship but also to verify eligible immigration status.

### ***APPLYING FOR REPLACEMENT OF LOST OR STOLEN DOCUMENTS***

Most of the primary documents used to verify immigration status in the Marketplace, including a Certificate of Citizenship or Naturalization, a green card, an I-94 or an employment authorization document card are replaceable if they have been lost or stolen. Proof that an application to USCIS for a replacement document has been made may be helpful in resolving inconsistencies.

The applications for replacement of immigration documents can be found on the USCIS website under “Forms.” To obtain a replacement Certificate of Citizenship or Naturalization, Form N-565 must be filed. Form I-765 is filed to apply for a new EAD card, a renewal of the card or a replacement if it has been lost or stolen. Form I-102 is filed for replacement of a lost I-94 card, although the information needed may also be available electronically on the Customs and Border Control website at [www.cbp.gov/I94](http://www.cbp.gov/I94). Form I-90 is used to apply for replacement of a permanent resident card. A word of caution is necessary here. An applicant for replacement documents will be asked to provide fingerprints once the application is received. That should not pose a problem for people who are seeking Certificates to verify citizenship, since they are not removable for criminal convictions, but it may raise problems for people who are not yet citizens and who have had dealings with law enforcement. They should be advised to consult an immigration attorney before applying for replacement documents.

A request for fee waiver is available for people of low income who would have trouble paying the filing fee for these applications. The form, I-912, is available on the USCIS website and should be filed with the replacement application.

### ***CONCERNS OF NONCITIZENS APPLYING FOR HEALTH INSURANCE THROUGH THE MARKETPLACE***

Applicants for health insurance through the Marketplace, especially subsidized health insurance, may have concerns that U.S. citizens will not have. The household may have members who cannot provide verification of lawful status, including the person who is actually filling out the application. Even applicants with lawful status may be concerned that getting publicly subsidized health insurance will make them a “public charge” and ruin their chance of becoming lawful permanent residents or U.S. citizens or could even lead to their deportation as a public charge.



### ➤ Concerns About Confidentiality

The ACA requires that all information about applicants and non-applicant household members can only be used to determine eligibility for health insurance. This requirement extends to all involved in the application, eligibility determination and enrollment process. Personally identifying information may not be disclosed to anyone not authorized to have the information.

Members of the household who cannot provide verification of a lawful status are not required to provide any immigration related information. Household members who do not have SSNs and are not eligible for one are not required to provide it. Applicants without proof of lawful status may still be found eligible for Emergency Medicaid or, if pregnant, full Medicaid, or CHP if they are children.

Most recently, ICE issued a memorandum that confirmed that any information obtained about applicants or members of their household to determine their eligibility for health insurance will not be used by ICE for civil immigration enforcement purposes. The ICE memo is attached as Appendix 7.

### ➤ Public Charge

More than a decade ago, soon after the passage of PROWORA, the Immigration and Naturalization Service (INS), as the immigration agency was then called, issued guidelines about what it means to be considered a “public charge.” This was necessary because many noncitizens were afraid to apply for any public benefit. INS clarified that the receipt of Medicaid, among other non-cash benefits, would not make a person a “public charge.”<sup>2</sup> The only exception is if Medicaid is used to pay for long term institutional care since such support is the equivalent of complete dependence on the government for subsistence and is the definition of what it means to be a public charge. More recently, in connection with the Marketplace, the government confirmed that the receipt of insurance subsidies available on the Marketplace, including APTC and cost-sharing, does not raise the risk of being considered a public charge.

The receipt of any public benefit, including long term institutional care paid for by Medicaid, is not a barrier to naturalizing. Unlike the application for permanent residence, the citizenship application has no questions that ask whether the applicant has ever received public assistance.

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<sup>2</sup> Someone who is found to be a “public charge” may not be able to adjust status to permanent resident.

## SECTION 7: HOSPITAL CHARITY CARE

In New York, charity care refers to financial assistance that hospitals must make available to low income, uninsured or under-insured patients to help them with their medical bills.

New York law requires all hospitals to have financial assistance policies that help low-income patients with their bills. Hospitals with emergency rooms are required to notify patients that financial assistance is available during intake and on bills. They are also required to post information about financial assistance in languages their patients understand.

Financial assistance policies are different in each hospital but the law requires that at a minimum, all hospitals must reduce charges for patients that are eligible for financial assistance as follows:

- Patients with income below 100% of the Federal Poverty Level (FPL) cannot be charged anything more than a very small, token amount
- Patients with income above 100% and below 150% of FPL cannot be charged more than 20% of their income
- Patients with income between 150% and 250% of FPL are entitled to reductions on a sliding scale
- Patients with income up to 300% of FPL are protected from charges that are any higher than what the hospital has negotiated with insurers

### *HOW DO PEOPLE GET CHARITY CARE OR FINANCIAL ASSISTANCE FROM A HOSPITAL?*

People who are uninsured need to get an application from the hospital where they received the services. Patients should be able to get an application in advance, even for non-emergent care, if they reside within the hospital's service area.

The application must be available in all languages that 5% or more of the hospital's patients speak.

The application will ask for information about income and family size, and request copies of income stubs. Most applications will also ask whether the applicant has applied for Medicaid to cover the bill they need help with and ask for proof of denials.

Some applications will also ask for information about savings. Hospitals are allowed to deny help to patients that have significant savings or assets, but they cannot consider the applicant's home, retirement account, savings for children's college expenses or cars that are in regular use by a family member.

The hospital must give applicants at least 90 days after the date of services to submit an application for financial assistance. The hospital must make a decision about your application within 30 days. If the application is denied, the notice must provide information about how to appeal the denial.

If the deadline has passed for applying for charity care, it is worth contacting the hospital anyway. Hospitals should allow late applications if a patient failed to receive notice of the hospital's financial assistance policy or did not get notice in a language the patient could understand.

***DOES THE LAW PROVIDE ANY PROTECTION AGAINST COLLECTION ACTIONS FROM THE HOSPITAL?***

New York law requires hospitals to be fair and reasonable when they try to collect against patients with outstanding bills:

- Hospitals cannot force sales of patients' homes to collect debts
- Hospitals cannot sue patients who were Medicaid eligible for the services they received
- Hospitals cannot send accounts to collection if a patient has applied for financial assistance
- Hospitals have to offer installment plans with monthly payments of no more than 10% of income
- Interest rates on installment plans cannot be any higher than the 90 day security rate
- Missed payments on installment plans cannot trigger higher interest rates.

## **SECTION 8: ASSISTING ELDERLY AND DISABLED APPLICANTS**

As Section 2 on Medicaid explains, most elderly and disabled patients and consumers fall into the non-MAGI category and cannot use the Marketplace to apply for Medicaid. Exceptions include disabled persons under age 65, who are in the waiting period for Medicare or will not qualify for Medicare. These applicants can apply in the Marketplace for MAGI Medicaid or apply on the basis of disability, in which case they are considered non-MAGI and will be referred to their local social services district.

Non-MAGI applicants who apply for Medicaid with their local social services district will be determined eligible for Medicaid according to existing income and resource levels and budgeting rules. Spousal refusal can be used to help one member of a couple qualify for Medicaid at the local district when he or she would otherwise be over income for Medicaid. Disabled and elderly applicants can also use the spend down program to qualify for Medicaid. The Medicare Savings Program, a special type of Medicaid benefit, can help disabled or elderly Medicare recipients pay for Medicare-related costs. Disabled applicants are eligible to use pooled trusts to eliminate their spend down. Each of these important tools for helping elderly and disabled applicants qualify for Medicaid is explained below.

### ***SPOUSAL REFUSAL***

Spousal refusal is a legal term for the situation when one spouse refuses to make his or her income and resources available to pay for the medical needs of his or her spouse. Generally, the income of both the husband and the wife is counted in determining Medicaid eligibility for both members of a married couple. However, when a spouse's income is not available to a Medicaid applicant because the spouse has refused to provide assistance with medical care, New York's Medicaid program will not count the spouse's income. Therefore, if one spouse needs medical care but cannot qualify for Medicaid because of the other spouse's income, spousal refusal can help the spouse without income (or with lower income) qualify.

The refusing spouse will need to submit documentation of his or her refusal and will have to provide information about his or her income and resources to the local district. Also, the refusing spouse will not be able to apply for Medicaid themselves as long as he or she is refusing to make income or resources available to a Medicaid recipient.

The refusing spouse is legally liable for the costs of providing care to the Medicaid applicant. The county can sue the refusing spouse for the amount Medicaid has spent caring for the non-refusing spouse. The circumstances under which counties will pursue recovery actions against refusing spouses vary by county. Many times the county will ask for a contribution from the refusing spouse in exchange for not pursuing recovery for the Medicaid expenses.

A parent living with a child that needs Medicaid services can submit the same kind of refusal document that a refusing spouse submits. The local district will then evaluate the child's eligibility for Medicaid without considering the parent's income. The refusing parent will have to disclose income and asset

information just as the refusing spouse does, and the parent will also be liable for the costs of the child's medical treatment, if the county sues the parent.

### ***SPEND DOWN***

Some patients who are not eligible for Medicaid because they have too much income or too many resources may be able to use current or even past medical expenses to bring their income or resources down to the Medicaid level. The amounts of income or resources that must be spent in order to bring income or resources down to the Medicaid level is referred to as excess income or spend down.

Only patients who are parents or caretakers of children under 21, or aged (65 or older) or disabled are eligible to use spend down to qualify for Medicaid. MAGI Medicaid applicants who apply for Medicaid at the expanded income levels through the Marketplace cannot use spend down.

A patient who is determined to be eligible for Medicaid with a monthly spend down amount should receive a notice from the local social services district telling him or her the amount of the spend down or excess income. Spend down amounts must be satisfied each month before the person's Medicaid card will be activated. There are two ways to satisfy spend down:

- The patient can pay the spend down amount to the local district at the beginning of each month, or
- The patient can collect receipts totaling the excess amount (or more) each month and supply them to the district. A bill does not have to be paid to count toward the spend down; it only has to be incurred. A bill is incurred on the date the liability for the expense arises (usually date of service).

Inpatient hospitalization bills are treated differently from other bills. If a patient is hospitalized, Medicaid will only become active and pay for the costs after six months' worth of spend down has been satisfied. The patient will then have Medicaid activated going forward without needing to satisfy spend down again for six months.

Example: Lisa is hospitalized for one night in September and is billed \$2,000.00. She applies for Medicaid and is found eligible with a spend down of \$50.00. Medicaid will pay the hospital bill amount above \$300.00 (50 X 6) and Lisa won't need to satisfy her spend down amount again until March.

### ***WHAT KIND OF BILLS CAN BE USED TO MEET SPEND DOWN?***

Patients can use bills for medical expenses for any member of the applicant's household who applied for Medicaid or any legally responsible relatives, even if they are not applying for Medicaid. Legally responsible relatives include spouses and children under age 21.

Spend down can even be used for the costs of medical care or drugs paid for by a state or local program other than Medicaid, like the AIDS Drug Assistance Program (ADAP) or Elderly Pharmaceutical Insurance Coverage (EPIC). This is the best way to help a patient meet spend down because nothing is actually

billed to the patient. Spend down can also be used for premiums, deductibles and co-pays for Medicare, or private health insurance can be used to meet spend down.

Paid bills can be used as long as the medical services were provided within 3 calendar months of the month of application. Unpaid bills can be much older. Unpaid bills can be used as long as they are still “viable,” which means that the provider could still try to collect for the amount owed.

Medicaid will not pay the bill for a medical expense that is used to meet a patient’s spend down. The amount of the bill will be credited against the patient’s spend down, but whether or not the patient pays the bill is between the patient and the provider. Medicaid will pay any portion of the bill that is over and above the spend down amount and it will also pay for other bills that were incurred that same month.

Thus, in order to maximize Medicaid payment on services that are covered under the Medicaid program, it is always a good idea to satisfy spend down amounts by first using expenses that Medicaid will not pay for, or expenses paid by a state program like EPIC or ADAP.

If a patient fails to satisfy his or her spend down for three consecutive months, most local districts will close the Medicaid case, in which case a new application must be filed.

### ***MEDICARE SAVINGS PROGRAM***

The Medicare Savings Program (MSP) is the generic “catch-all” term for three special Medicaid programs that pick up the cost of the monthly Medicare Part B premiums. In 2014, the standard monthly Part B premium costs \$104.90.

Receipt of MSP also automatically qualifies a person for the Medicare Part D (prescription drug) low income subsidy (LIS, also called “Extra Help”), which helps pay for prescription drugs.

MSPs can assist individuals with incomes up to 135% of the federal poverty level (FPL). There is no resource test in New York State for any of the MSPs.

One of the MSPs, the Qualified Medicare Beneficiary (QMB) program, covers ALL Medicare Part A and Part B cost sharing (premiums, deductibles and co-insurance). QMB has an income limit of 100% FPL.

The Specified Low Income Beneficiary Program (SLMB) helps individuals with incomes between 100-120% FPL. The Qualified Individual (QI) program covers those between 120-135% FPL.

MSP is a non-MAGI program, so you apply through your local department of social services – NOT through the Marketplace. There is a simple two page application form for the MSP. You can also use the Medicaid (Access NY) application. The Department of Health posts a handy description of the various MSPs as well as the simplified MSP application form on their website. (See

[http://www.health.ny.gov/health\\_care/medicaid/program/update/savingsprogram/medicaresavingsprogram.htm](http://www.health.ny.gov/health_care/medicaid/program/update/savingsprogram/medicaresavingsprogram.htm).)

There is another way to apply for MSP. If you apply for the Part D Extra Help subsidy through the Social Security Administration, that Extra Help application will be treated as an MSP application as well.

Some individuals are eligible for both MSP and Medicaid together. You can't get both QI and Medicaid spend down – you have to choose between one or the other. But you can have QMB with or without Medicaid, and SLMB with or without Medicaid.

### ***POOLED TRUSTS***

Pooled trusts are an extremely valuable tool for disabled Medicaid applicants who would otherwise have a spend down. Pooled trusts are special forms of Supplemental Needs Trusts (SNTs), which are legal documents that set up accounts for the benefit of disabled persons. SNTs allow disabled individuals to keep their income or assets and still qualify for governmental benefits such as Medicaid.

A pooled trust is a SNT run by an organization for the benefit of many disabled members. The members' funds are pooled for administrative and investment purposes, but each member has a sub-account with a separate trust agreement. Generally, an attorney's help is necessary to establish or create an individual SNT, but disabled persons do not need an attorney to join a pooled trust.

Income or resources that are sent to a pooled trust are treated as invisible for Medicaid eligibility purposes, just as they would be in an individual SNT created by an attorney. Thus, individuals who would have a spend down can join a pooled trust in order to eliminate their spend down amount. They can send their excess income to the pooled trust and direct the trust to use it to pay expenses like rent, utilities, mortgage, even credit card bills.

Only persons with certified disabilities can join pooled trusts. While only persons under age 65 can set up individual SNTs, persons with certified disabilities of any age can join pooled trusts. People who need nursing home level care in a waiver program or in an institution will not benefit from using a pooled trust because the state uses different budgeting rules to determine spend down for these services.

### ***HOW DO PEOPLE JOIN POOLED TRUSTS?***

The first step is to pick a trust – several different non-profit agencies run pooled trusts, most are available statewide. Each trust has a "joinder agreement," which is several pages long and requires a notarized signature. Most trusts have staff that will help walk patients or consumers through the joinder agreement.

Fees can be significant. The Center for Disability Rights (CDR) has the lowest fees at this time. CDR has a non-refundable start-up fee of \$200 and a monthly fee of \$20. NYSARC currently administers the largest pooled trust in New York State. NYSARC has a \$200 non-refundable start-up fee and monthly fees that range from \$30 to \$140, depending on the size of monthly deposits. In addition, NYSARC requires \$100 plus twice the monthly deposit as an upfront deposit in the account.

Once an applicant is approved, the organization sponsoring the trust will sign the agreement and send it back along with a packet that instructs the new trust member on how to make monthly deposits and

submit monthly bills. NYSARC's Joinder Agreement is available on line at [http://onlineresources.wnylc.net/healthcare/docs/NYSARC\\_Joinder\\_Agreement.pdf](http://onlineresources.wnylc.net/healthcare/docs/NYSARC_Joinder_Agreement.pdf)

Individuals certified as disabled can join a pooled trust either before applying for Medicaid or after.

After joining a pooled trust, the individual deposits the amount of his or her spend down with the trust each month, and submits bills for the trust to pay each month. For people already enrolled in Medicaid with a spend down, once the trust documents are signed and the local Medicaid program approves enrollment in the trust, Medicaid will change the individual's Medicaid budget to eliminate any spend down. For those joining a trust before applying for Medicaid, individuals can submit the documents with the application, or wait for approval with spend down and then submit the trust documents.

Technically, membership in a pooled trust is not revocable unless a member dies or enters a nursing home. Money left in the trust when a member dies or enters a nursing home stays in the trust for the benefit of the other disabled members.

If pooled trust members enter a nursing home or need equivalent care from a waiver program, their Medicaid budgets will no longer treat monthly deposits as invisible for spend down purposes (see "Pooled Trusts," above). People can submit bills to use up the remainder of any money in the trust, but there is no longer any benefit to making deposits of excess income.

Practically speaking, even people not needing nursing home care can leave pooled trusts by stopping their monthly deposits, but their spend down amounts will go up.

Empire Justice Center can provide advice about using spousal refusal, spend down, Medicare Savings Program and pooled trusts. Clients or patients may also be able to get help from their local legal services program. For contact information for legal services programs that help with Medicaid related problems in different counties across the state, visit LawHelp New York at <http://www.lawhelpny.org/>.

The LawHelp New York website also provides a link to list of organizations that sponsor pooled trusts. Most of these organizations have staff that can help walk consumers through the process for filling out joinder agreements and joining pooled trusts. You can get to the list at <http://wnylc.com/health/entry/4/>.



# HEALTH COVERAGE CROSSWALK: ELIGIBILITY BY IMMIGRATION STATUS



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Benefit Related Immigration Classifications	Immigration Status	HEALTH COVERAGE OPTIONS					
		EXCHANGE (BHP) <sup>1</sup>	FEDERAL MEDICAID	NYS MEDICAID/ FHPlus <sup>2</sup>	ADAP CHIP <sup>3</sup> (<19)	EMERGENCY MEDICAID <sup>4</sup>	
<b>Lawfully Present<sup>5</sup></b>	<b>Qualified Aliens</b>	<a href="#">Lawful Permanent Resident (LPRs)</a>	Yes	5 year bar unless pregnant or child<21	Yes	Yes	Only while subject to 5 year bar for Fed Med
		<a href="#">Refugees and Asylees<sup>7</sup></a>	Yes	Yes	Yes	Yes	No
		<a href="#">Granted withholding of removal under the INA</a>	Yes	Yes	Yes	Yes	No
		<a href="#">Battered Spouses / children of U.S. citizens or LPR w/ pending VAWA or family petition</a>	Yes	5 year bar unless pregnant or child<21	Yes	Yes	Only while subject to 5 year bar for Fed Med
		<a href="#">Cuban/Haitian Entrant</a>	Yes	Yes	Yes	Yes	No
		<a href="#">Paroled for period of one year or more</a>	Yes	5 year bar unless pregnant or child< 21	Yes	Yes	Only while subject to 5 year bar for Fed Med
		Lawfully residing armed services connected noncitizens and their dependents <sup>8</sup>	Yes	Yes	Yes	Yes	No
		<a href="#">Iraq / Afghan SIV<sup>9</sup></a>	Yes	Yes	Yes	Yes	No
		Canadian born Native Americans <sup>10</sup>	Yes	Yes	Yes	Yes	No
		<a href="#">Amerasians</a>	Yes	Yes	Yes	Yes	No
		<a href="#">T Visa Holders and Certified Victims of Trafficking<sup>11</sup></a>	Yes	Yes	Yes	Yes	No
	<a href="#">In valid nonimmigrant status<sup>12</sup></a>	Yes, if state resident	Only if pregnant or child <21 and state resident	Only if pregnant or child <21 and state resident	Yes, if state resident	Yes, unless eligible for Fed Medicaid <sup>13</sup>	
	<b>PRUCOL<sup>6</sup></b>	<a href="#">U, K3 / K4, V, and S visa holders</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
<a href="#">Approved Visa and Pending I-485</a>		Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid	
<a href="#">Granted withholding of removal under CAT</a>		Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid	

This Crosswalk and Status Explanation originally appeared as appendices to a report supported by the United Hospital Fund entitled, “New York’s Exchange Portal: A Gateway to Coverage for Immigrants.”

Benefit Related Immigration Classifications	Immigration Status	HEALTH COVERAGE OPTIONS					
		EXCHANGE <sup>1</sup> (BHP)	FEDERAL MEDICAID	NYS MEDICAID/ FHPlus <sup>2</sup>	ADAP CHIP <sup>3</sup> (<19)	EMERGENCY MEDICAID <sup>4</sup>	
Lawfully Present <sup>5</sup>	PRUCOL <sup>6</sup>	<a href="#">Paroled for less than 1 year</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Temporary Protected Status (TPS)</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">(non DACA) Deferred Action</a> <sup>14</sup>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Order of Supervision</a>	<b>Only with EAD</b>	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Deferred Enforced Departure</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Granted stays of deportation or removal</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes
		Noncitizens Lawfully Present in American Samoa Under its Immigration Laws <sup>15</sup>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Temporary resident INA 210 / 245A</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Family Unity Beneficiary</a>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<b>APPLICANTS FOR:</b>					
		<a href="#">Special Immigrant Juvenile Status</a>	Yes	Yes	Yes	Yes	No
		<a href="#">Asylum / Withholding Under INA or CAT</a>	<b>Only w EAD or, if child ≤ 14, 180 days after app</b>	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Cancellation of Removal</a>	<b>Only w/ EAD</b>	Only with EAD AND pregnant or child <21	Yes	Yes	Only with EAD AND pregnant or child <21
		<a href="#">Temporary Protected Status (TPS)</a>	<b>Only w/ EAD</b>	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid

Benefit Related Immigration Classifications	Immigration Status	HEALTH COVERAGE OPTIONS					
		EXCHANGE <sup>1</sup> (BHP)	FEDERAL MEDICAID	NYS MEDICAID/ FHPlus <sup>2</sup>	ADAP CHIP <sup>3</sup> (<19)	EMERGENCY MEDICAID <sup>4</sup>	
<b>Lawfully Present<sup>5</sup></b>	<b>PRUCOL<sup>6</sup></b>	<a href="#">For Record of Admission Under 249 (registry alien)</a>	Only w/ EAD	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Adjustment Under LIFE Act</a>	Only w/ EAD	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<a href="#">Legalization Apps Under SAW and IRCA</a>	Only w/ EAD	Only with EAD AND pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
		<b>PRUCOL ONLY</b>					
		<a href="#">Noncitizens who can show continuous residence since on or before 1/1/1972 (registry aliens)</a>	No	No	Yes	Yes	Yes
		<a href="#">Immediate Relatives with approved I-130</a>	No	No	Yes	Yes	Yes
		<a href="#">Deferred Action under DACA (including applicants)<sup>16</sup></a>	No	No	Yes	Yes	Yes
		<a href="#">Request for Deferred Action (non DACA cases) pending for 6 months or more and not denied<sup>17</sup></a>	No	No	Yes	Yes	Yes
		Citizens of Micronesia, Paula and Marshall Islands <sup>18</sup>	Yes	Only if pregnant or child <21	Yes	Yes	Yes, unless eligible for Fed Medicaid
<b>Out of Status</b>	Entry across border without inspection (EWIS) and Visa Overstays	No	No	No, unless pregnant	Yes	Yes	

## ENDNOTES

<sup>1</sup>Exchange eligibility for the various immigration statuses refers to: Eligibility to purchase private insurance in the Exchange, Eligibility for Exchange related financial assistance (advance premium tax credits and assistance with cost-sharing), and Eligibility for the Basic Health Plan (BHP), which New York may choose to create

<sup>2</sup>New York State's Medicaid program (including Family Health Plus) provides assistance to noncitizens for whom it receives federal reimbursement as well as for those who are ineligible for the federal Medicaid programs. This includes most noncitizens who are "lawfully present" but not qualified aliens as well as noncitizens who meet the definition of PRUCOL.

<sup>3</sup>Federal reimbursement for CHIP is only available for qualified alien and lawfully residing children <19.

<sup>4</sup>The state can seek federal reimbursement through the federal Emergency Medicaid program for qualifying services provided to noncitizens ineligible for Federal Medicaid but in receipt of Medicaid using only state funds. This is a "back end" process that does not require the noncitizen in the state's Medicaid program to actually apply for Emergency Medicaid.

<sup>5</sup>The ACA's category of "lawfully present" is for all practical purposes identical to the 2009 CHIP category "lawfully residing" because the ACA requires that to be eligible for the Healthcare Exchange, a "lawfully present" noncitizen must meet the Medicaid state residency rules.

<sup>6</sup>Permanently Residing Under Color of Law (PRUCOL).

<sup>7</sup>Even if a refugee or asylee adjusts to permanent resident status, their exemption from the 5 year bar is not lost.

<sup>8</sup>This category includes active duty service members and honorably discharged veterans not only who are in the "qualified alien" classifications but also those in the "lawfully present" categories. They are not subject to the 5 year bar but may be subject to sponsor deeming and liability.

<sup>9</sup>Treated as refugees for benefits purposes as required by the legislation that created the status.

<sup>10</sup>Must have tribal membership documents. Do not have to apply for LPR status to be eligible.

<sup>11</sup>NYS DOH includes T-visa holders in the "qualified alien" category because they are treated like refugees for benefits purposes. However, under the recently published federal rules, they are defined as "lawfully present."

<sup>12</sup>In its recently published Proposed Rule, HHS removed the phrase "who have not violated their status" inasmuch as that determination is not within the jurisdiction of the Medicaid agency to make. *Medicaid, Children's Health Insurance Programs and Exchanges: Essential Health Benefits in the Alternative Benefit Plans, Eligibility Notices, Fair Hearings and Appeals Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid and Premiums and Cost Sharing*, Proposed Rule, 78 Fed.Reg. 4594, at 4613 (January 23, 2013).

<sup>13</sup>In other words, all immigrants in these and the following categories are eligible for Emergency Medicaid except pregnant women and children <21, who are eligible for Federal Medicaid and therefore ineligible for Emergency Medicaid.

<sup>14</sup>HHS issued clarification at the end of August 2012 that noncitizens granted deferred action under the Deferred Action for Childhood Arrivals (DACA) program are **not** eligible for Federal Medicaid or for the Exchange.

<sup>15</sup>Added by 1/23/2013 Proposed Rule, which also eliminated the category of those lawfully present in Micronesia, Paula and the Marshall Islands from the "lawfully present" list on the ground that they were included in other categories.

<sup>16</sup>See endnote 14. The code on the work authorization of DACA beneficiaries will be (c)(33), which distinguishes them from other noncitizens with Deferred Action, whose work authorization code is (c)(14) and who are eligible for the Exchange.

<sup>17</sup>NYS DOH Policy Guidance memo 08 OHIP/INF-4 at:

[www.health.ny.gov/health\\_care/medicaid/publications/docs/inf/08inf-4.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/08inf-4.pdf).

<sup>18</sup>See endnote 15.

# IMMIGRATION STATUS: EXPLAINING THE TERMS

## “QUALIFIED ALIENS” UNDER PRWORA AND “LAWFULLY PRESENT<sup>1</sup>” UNDER THE ACA:

### **1. Lawful Permanent Resident (LPRs):**

Lawful permanent residents are foreign nationals who immigrate to the United States to live here permanently. Most noncitizens become permanent residents through a family petition filed by their U.S. citizen or lawful permanent resident spouse or parent. Once granted LPR status, they have permission to work and live in the U.S., travel abroad, petition for certain of their family members to come to the U.S. and, after a few years, apply for citizenship. In addition to family based immigration, another path to LPR status is through employment, when an employer files an immigration petition on behalf of an employee, generally one with special skills. Refugee and asylees are eligible to apply for LPR status one year after being granted status. An LPR can apply for citizenship after five years in LPR status, three if the immigrant is married to a U.S. citizen.

### **2. Refugees and Asylees:**

A refugee is a noncitizen who, while outside the U.S. and their home country, has been granted permission to enter and live in the U.S. because of a well-founded fear of persecution based on their nationality, religion, race, political opinion or membership in a particular social group. Asylees are noncitizens who have come into the U.S. in some other way and are already here when they apply for, and are granted, refugee status. Both refugees and asylees can apply for LPR status.

### **3. Granted withholding of deportation or removal under the Immigration and Nationality Act (INA):**

A status similar to asylum, it is granted to noncitizens who are in removal proceedings and who prove that their life or freedom would be threatened based on one of the five protected grounds listed above if they were to be returned to their home country. To be granted this relief, the individual must meet a higher evidentiary standard than for asylum. It is generally granted to someone who, because of their past actions, does not qualify for asylum. A person granted withholding could be removed to a third country if there is one that will accept him. There is no path to permanent residence from a grant of withholding.

### **4. Spouses and children of U.S. citizens or LPRs subjected to “battery or extreme cruelty”:**

Noncitizen spouses and children of U.S. citizens or lawful permanent residents who have been subjected to battery and abuse may petition on their own behalf (self-petition) for lawful permanent residence under the Violence Against Women Act (VAWA). Under PRWORA, they are eligible for Medicaid and other public benefits while they are waiting for the immigration process to be completed and before they adjust to LPR status. In order to be classified as a qualified alien for

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<sup>1</sup> The “lawfully present” immigrant eligibility classification of the ACA is identical to the “lawfully residing” immigrant classification established under the Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Because the ACA requires that, in order to be eligible to utilize the Health Care Exchange, a “lawfully present” noncitizen must meet the Medicaid state residency rules; there is no difference between these two classifications.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

benefit purposes, the individual can no longer be living with the abuser and must also show that (s)he has begun the immigration process by providing evidence that:

- a. her/his VAWA self-petition has been approved or is pending and (s)he has received a “prima facie case determination” from USCIS, or
- b. (s)he has an approved or pending visa application filed by the abusive U.S. citizen or lawful permanent resident spouse or parent and the benefit agency finds that (s)he has presented credible evidence of abuse, or
- c. (s)he has an application pending for cancellation of removal or suspension of deportation under VAWA based on the battery and abuse of her/his US citizen or LPR spouse or parent.

### 5. Cuban/Haitian Entrants as defined by the Refugee Education Assistance Act (REEA)<sup>2</sup>:

The classification Cuban/Haitian Entrant has its historical roots in the time of the Mariel boatlift and the influx of Cuban and Haitian nationals in 1980, when, between April and October, about 125,000 Cubans and 40,000 Haitians entered the U.S. This massive influx occurred just after Congress passed the 1980 Refugee Act. However, the Refugee Act was directed toward the admittance and resettlement of refugees arriving from abroad, not for individuals arriving directly into the U.S. Furthermore, the Cubans and Haitians entering the U.S. fit somewhere between refugees fleeing persecution and immigrants seeking better lives<sup>3</sup>. In June of 1980, the federal government used the Attorney General’s parole authority to create a new immigrant category, “Cuban/Haitian Entrant (Status Pending).” In October of 1980, the Refugee Education Assistance Act was passed, which authorized the provision of refugee benefits to Cuban and Haitian entrants.

A CUBAN/HAITIAN ENTRANT IS DEFINED UNDER SECTION 501(E) OF THE REEA AS:

1. any individual granted parole status as a Cuban/Haitian Entrant (Status Pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, **regardless of the status of the individual at the time assistance or services are provided** (emphasis added); and
2. any other national of Cuba or Haiti –
  - A. who-
    - i. was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act;
    - ii. is the subject of removal proceedings under the Immigration and Nationality Act; or
    - iii. has an application for asylum pending with the Immigration and Naturalization Service and
  - B. with respect to whom a final, nonappealable, and legally enforceable order of removal has not been entered.

<sup>2</sup> P.L. 96-42, 94 Stat. 1799 (1980)

<sup>3</sup> Hemenway, Rohani and King, *Cuban, Haitian, and Bosnian Refugees in Florida: Problems and Obstacles in Resettlement*, Florida Department of Children and Families, Refugee Programs Administration, June 1999, available at: [www.cala.fsu.edu/files/refugee\\_lit\\_review.pdf](http://www.cala.fsu.edu/files/refugee_lit_review.pdf).

## IMMIGRATION STATUS: EXPLAINING THE TERMS

The years since the Mariel boatlift have seen periodic waves of both Cuban and Haitian migrations. Many of the later arrivals were simply given parole status, without any special designation. A rule published in the Federal Register in the late 1990's by INS clarified that a national of Cuba or Haiti who is paroled into the U.S. at any point after October of 1980 is considered to have been paroled in the "special status" referred to in the REAA.<sup>4</sup> Thus, for example, Haitians who came to the U.S. in parole status after the massive earthquake of three years ago are Cuban/Haitian Entrants and therefore qualified aliens with respect to Medicaid and other benefits.

Even an order of removal does not terminate the Cuban/Haitian Entrant status for the purpose of determining the individual's eligibility for Medicaid or other benefits. This applies primarily to Cubans who were initially granted parole status and then, at some later point, were placed in removal proceedings and ordered deported. Because they cannot legally be returned to Cuba while the Communist government is in power, the Office of Refugee Resettlement, in a 2001 clarification to State Refugee Coordinators, instructed that they be treated as Cuban/Haitian Entrants for benefit purposes if they had been granted parole status at any point after October of 1980.<sup>5</sup>

### **3. Paroled into the U.S. for a period of one year or more:**

Noncitizens "paroled" into the U.S. are foreign nationals who have been given permission to enter the U.S. on humanitarian grounds or because it is in the public interest of the U.S. to allow them into the country even though they do not have a visa or lawful status. It is not an immigration status and, with some exceptions, notably Cuban and Haitian parolees, it does not provide a path to permanent residence. If the period of parole granted is one year or more, the person is both a "qualified alien" and "lawfully present." If the period of parole granted is less than one year, the individual is not considered a "qualified alien" but is "lawfully present."

### **4. Noncitizens from Iraq and Afghanistan with Special Immigrant Visas:**

Under various programs enacted by Congress over the last six or so years, a specified number of nationals of Iraq and Afghanistan who have worked with the U.S. in their home country, as translators and in certain other capacities, are permitted to come to the U.S. with special immigrant visas (SIV) each year. Though they enter as lawful permanent residents, they are treated for Medicaid and other public benefit purposes as if they were refugees. Consequently they are not barred for the first five years from qualifying for these benefits.

These special visas are currently limited to 1500 a year through the year 2013 for Afghan nationals who worked with the U.S. and 50 a year for Afghan and Iraqi nationals who acted as translators. From fiscal years 2008 through 2012, there was an annual allocation of 5,000 visas a year for Iraqi nationals who worked for the U.S. but that ended this federal fiscal year. Spouses and children accompanying the principal visa holders do not count towards these limits.

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<sup>4</sup> Final Rule, *Effect of Parole of Cuban and Haitian Nationals on Resettlement Assistance Eligibility*, 63 Fed. Reg. 31895 (June 11, 1998).

<sup>5</sup> However, in New York, Cubans who have a deportation order and are under an Order of Supervision at the time they apply for benefits, even if they were initially granted parole status, are classified as PRUCOL rather than as Cuban/Haitian Entrants. Consequently, the state receives no federal reimbursement for medical assistance provided to them and they are denied food stamps.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

### 5. Amerasians:

Amerasians are noncitizens from Vietnam who are admitted to the U.S. as immigrants (LPRs) pursuant to legislation enacted by Congress in 1988. The term Amerasians refers to Vietnamese children born to U.S. citizen fathers between 1962 and 1976 and their children, spouses and mothers, guardians or next of kin. Because of the passage of time this is likely to be a relatively rarely encountered immigration classification.

### 6. T Visa Holders and Certified Victims of Trafficking:

Trafficking victims with a T visa or a prima facie case determination on a T visa application are “lawfully present” under federal immigration law.

T visa holders are treated like refugees in qualifying for Medicaid and other public benefits. Noncitizens who are victims of human trafficking but not yet in possession of a T visa are also eligible for benefits as if they were refugees if the Office of Refugee Resettlement (ORR) has certified them. To be certified, the individual must be a victim of human trafficking as defined by the Trafficking Victims protection Act of 2000, be willing to assist with the investigation and prosecution of trafficking cases and have completed a bona fide application for a T visa or have received “continuous presence” status from the Department of Homeland Security Immigration and Custom Enforcement (ICE). Children (under 18) who are victims of human trafficking do not have to be certified to be eligible for benefits. Rather, ORR will issue an eligibility letter stating that the child is such a victim.

NYS DOH classifies this group as “qualified aliens” because they are treated as refugees for benefit purposes. T visa holders are eligible to apply for permanent resident status after three years.

### **NONCITIZENS WHO ARE “LAWFULLY PRESENT” AND RESIDING IN THE STATE BUT WHO ARE NOT “QUALIFIED ALIENS” OR PRUCOL**

#### **In Valid Nonimmigrant Status:**

Most noncitizens in a valid nonimmigrant status, for example students or foreign workers, are classified as “lawfully residing.” They are not classified as PRUCOL because historically, nonimmigrants were never, and are still not, eligible for welfare or food stamps or federal housing programs and the like, programs in which the concept of PRUCOL developed. The January 23, 2013 Proposed Rule eliminated the earlier phrase “who have not violated their status” since benefit agencies are not capable of making that determination. Whether an individual violated the conditions of their nonimmigrant status is a determination to be made only by immigration agencies. (An example of a violation of status would be a student who takes a job even though he is not authorized to work.)



# IMMIGRATION STATUS: EXPLAINING THE TERMS

## NONCITIZENS WHO ARE “LAWFULLY PRESENT” AND PRUCOL

### **7. K3/K4, “U”, “S”, and “V” visa holders--nonimmigrants that are eligible to adjust to LPR status<sup>6</sup>:**

- a. A victim of crime who can obtain certification from a state or federal law enforcement agency or a state or federal court that s/he has been, or is willing to be, helpful to the agency or court in the investigation or prosecution of the crime is eligible to apply for a “U” visa. It is a visa designed to encourage noncitizens without legal status to come forward to report crimes without fear that they will be placed in removal proceedings if they do so. The spouse, parent, child(ren), and in some cases, the unmarried siblings, of the crime victim may be eligible for U visas as derivatives. U visa holders are eligible to apply for work authorization and, after 3 years, can apply to adjust to permanent resident status. There is a 10,000 annual cap in the number of U visas that can be granted.
- b. K3 and K4 visas are granted to the spouse of a U.S. citizen, and to his/her children, who are the beneficiaries of a family based petition. This allows them to enter the U.S. and live and work here until they are eligible to adjust to permanent resident status.
- c. A “V” visa is one that is granted to the spouse and children of a lawful permanent resident who are the beneficiaries of a family based petition filed on or before December 21, 2000. The petition must either have been pending for 3 years or more or, if it was granted, the spouse and his or her children are not yet eligible to adjust status. Long delays are endemic to the immigration of the spouses and children of lawful permanent residents because of the annual cap on the number of such relatives who may enter the U.S. in any given year. However, because this was a time limited remedy, no one who is a beneficiary of a petition filed by an LPR after December of 2001 is eligible for the visa. Since most of the spouses and children of LPRs with petitions filed before then have already adjusted status, it is unlikely that there are many, if any, noncitizens left who currently have a “V” visa.
- d. The “S” visa is very rare. It is not a benefit that the noncitizen can apply for on his or her own behalf. Rather, it must be applied for by Attorney General on behalf of a noncitizen who is determined to possess critical information about a criminal organization or enterprise that s/he is willing to supply to law enforcement authorities. Like “U” visa holders, “S” visa holders are eligible to work and to apply for adjustment to permanent resident status after 3 years and may obtain visas for his or her immediate family members.

### **5. Noncitizens with an Approved Visa Petition and a Pending Application for Permanent Resident Status:**

This category refers to noncitizens who are the beneficiaries of an approved immigrant visa petition under which they are now eligible to adjust to permanent resident status. If they have filed the application for adjustment and are now simply waiting for their application to be processed by USCIS, they are considered to be lawfully present.

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<sup>6</sup> Nonimmigrants generally are noncitizens with temporary visas that, by definition, do not have an intention to remain in the U.S. permanently. These specific visa holders are the exception to that rule.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

### **6. Granted withholding of deportation/removal under the Convention Against Torture (CAT):**

The Convention Against Torture is an international treaty to which the U.S. is signatory and it prohibits the return of individuals to their home country who have substantial grounds for believing that they would be at risk of being subjected to torture. As with withholding of removal under the INA, there is no path to permanent residence from a grant of withholding of removal under CAT.

### **7. Persons paroled for a period of less than one year:**

Noncitizens paroled for humanitarian or public interest reasons for a period of less than one year are not included in the definition of “qualified aliens” but are included in the “lawfully present” and PRUCOL classifications. Whether they meet the definition of “lawfully residing” and are thereby eligible to participate in the Exchange will depend on the length of the period for which parole was granted, i.e. whether they can meet the residence requirement of Medicaid and the ACA.

### **8. Noncitizens Granted Temporary Protected Status (TPS):**

Temporary protected status is granted to nationals of certain countries who are residing in the U.S. when their country suffers a severe natural disaster or is experiencing serious civil strife. The Secretary of Homeland Security designates the countries whose nationals are eligible for TPS. For example, in 2010, Haitians who had been living in the U.S. when the earthquake struck were made eligible to apply for TPS. TPS beneficiaries are eligible to remain in the U.S. for specified periods that can be, and routinely are, renewed, often for many years. Individuals applying for TPS must apply for employment authorization at the same time, regardless of age. Once employment authorization is granted, even if it is prior to the grant of TPS, the noncitizen is considered to be lawfully present.

### **9. Noncitizens Granted Deferred Action:**

Immigration officers can exercise “prosecutorial discretion” by granting “deferred action” to a noncitizen who is otherwise removable. There are no statutory or regulatory provisions for this exercise of discretion and generally it is granted on a case-by-case basis on humanitarian grounds. However, there are certain instances where it is granted to certain classifications as a whole, for example VAWA self-petitioners whose petition has been granted but who have not yet adjusted to permanent resident status may be granted deferred action. It has also been granted to U visa applicants whose application has been granted but where the cap on U visas for the year has already been reached.

Most recently, young people who came to the U.S. before reaching the age of 16 and who meet certain requirements have been made eligible for deferred action as “childhood arrivals.” However, they have been excluded from ACA eligibility.

Noncitizens granted deferred action are eligible to apply for employment authorization.

### **10. Noncitizens Granted Orders of Supervision:**

A noncitizen who has been ordered removed or deported by the Immigration Court but where it is unlikely that the removal can be effectuated is usually placed under an order of supervision.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

This would happen for example with a Cuban national who cannot be removed because the U.S. has no diplomatic relationship with Cuba or when someone is ordered removed to a country without a functioning government that can issue travel documents. Orders of supervision require the noncitizen to report to the local immigration officer on a regular basis and permit the individual to apply for employment authorization.

### **11. Noncitizens Granted Deferred Enforced Departure:**

Deferred Enforced Departure (DED) is much like TPS. It is in the President's discretion to authorize and in the past has been granted to nationals of Haiti, El Salvador and the People's Republic of China. Currently only nationals from Liberia are covered under DED. Like TPS, DED is granted for a specified period of time, which can be renewed, and people under DED can apply for employment authorization.

### **12. Noncitizen Granted Stay of Removal:**

Under certain circumstances, ICE may grant a stay of removal to a noncitizen who has a final Order of Removal. This not often granted and almost always involves overwhelming humanitarian considerations.

### **13. Temporary Residents and Applicants for Adjustment under INA Sections 210 and 245A:**

The Immigration Reform and Immigrant Control Act of 1986 included a legalization program for two groups of noncitizens who were without legal status. One was a general legalization program for those who had lived in the U.S. without status since prior to January 1, 1982. The other program was for "special agricultural workers" (SAW), noncitizens who had done agricultural work for a specific period of time. Under the legalization program, individuals were first granted temporary resident status. They were then required to apply for permanent status within a certain time frame.

SAW noncitizens became lawful permanent residents automatically after residing in temporary resident status after 3 to 4 years. Because of the automatic conversion to permanent resident status for SAW noncitizens and the requirement for legalization applicants to apply for permanent status within a certain period of time after being granted temporary resident status, there are unlikely to be few if any noncitizens left who fall into this category.

### **14. Family Unity Beneficiaries:**

Family Unity status provides protection from removal for the children and spouses of noncitizens who legalized under the 1986 legalization program. To be eligible, the person must have been the spouse or child of the legalized immigrant as of May 5, 1988 and must have been continuously living in the U.S. since that time. In 2000, Congress extended Family Unity protection to the spouses and unmarried minor children of noncitizens eligible to apply for permanent resident status under the Legal Immigration Family Equity (LIFE) Act "late amnesty" legalization program.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

### APPLICANTS FOR IMMIGRATION BENEFITS WHO ARE LAWFULLY PRESENT AND PRUCOL:

#### 15. Applicants for Special Immigrant Juvenile Status (SIJ):

This category refers to young noncitizens under the age of 21 who have come under the jurisdiction of the Family Court and who have been abandoned or abused by at least one parent and have an application for SIJ status pending. To be eligible for SIJ the individual must have a court order with special findings, including a finding that it is not in the best interest of the child to be returned to his or her home country.

#### 16. Noncitizens with Employment Authorization<sup>7</sup> who are:

- a. applicants for asylum or withholding of removal under the INA or CAT – if the applicant is a child under 18 years old, there is no requirement that s/he have employment authorization to be considered “lawfully present” but the application for asylum or withholding has to have been pending for at least 180 days;
- b. applicants for cancellation of removal – noncitizens without legal status who have been living in the U.S. for at least 10 years and who are placed in removal proceedings who are of good moral character and who have a U.S. citizen or LPR child, spouse or parent who would suffer severe and extreme hardship if the noncitizen were ordered removed are eligible to apply for cancellation of removal;
- c. applicants for TPS - note that the application for TPS must be accompanied by an application for employment authorization;
- d. applicants for a “record of admission” under INA 249 (“registry alien”) – a noncitizen of “good moral character” who has been continuously residing in the United States since before January 1, 1972 is eligible to apply for permanent resident status solely based on their length of residence and is also eligible to apply for employment authorization while his or her application for adjustment is pending;
- e. applicants for adjustment under the LIFE Act – the LIFE Act of 2000 authorizes class members of one of three class actions that challenged the INS’ implementation of the legalization program under the 1986 Immigration Reform and Immigrant Control Act (IRCA) to file for adjustment of status. In order to be eligible, the individual must show that they were continuously physically present in the U.S. during the period between November 6, 1986 and May 4, 1988 and that they applied for membership in the class before October 1, 2000. The filing period for adjustment applications under LIFE ended May 31, 2002, so it is unlikely that any applications remain pending currently.
- f. and applicants for legalization under 1986 IRCA - the filing period has long been closed, even for those applying under LIFE’s late amnesty program. Because it has been closed for a long time, there is unlikely to be anyone left with an application still pending.

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<sup>7</sup> For benefit eligibility under the **PRUCOL** category, there is **no requirement** that the applicants have employment authorization. In the January 23, 2013 Proposed Rule, HHS proposes to eliminate this long list and simply include all noncitizens with employment authorization under 8 C.F.R. § 273.12(c) in the category of “lawfully present.”

## IMMIGRATION STATUS: EXPLAINING THE TERMS

### **NONCITIZENS WHO ARE PRUCOL BUT NOT CLASSIFIED AS LAWFULLY PRESENT UNDER THE ACA<sup>8</sup>**

#### **17. Registry Aliens with evidence of continuous residence:**

These are noncitizens who are authorized to apply for permanent resident status if they can show that they entered the U.S. before January 1, 1972 and have evidence of continuous residence since then. In contrast to the ACA classification of “lawful presence”, to be considered PRUCOL, the individual doesn’t need to have an application for adjustment pending. Rather, to establish PRUCOL eligibility the individual need only provide the benefit agency with proof that s/he has been living in the U.S. since before January 1, 1972.

#### **18. Immediate relatives with an approved I-130 petition:**

Noncitizen spouses and children of U.S. citizens who are beneficiaries of an approved family petition are considered PRUCOL without meeting the ACA’s “lawfully present” requirement of having an application for adjustment pending with USCIS.

#### **19. Requests for Deferred Action pending for a period of 6 months that have not been denied:**

Unlike the deferred action program for childhood arrivals, which has a formal application procedure, most requests for deferred action are made by letter on behalf of noncitizens who, usually because of their health or other exigent circumstances, are requesting that they be granted deferred action on humanitarian grounds. Because these requests sometimes go unanswered by ICE, NYS DOH has developed a policy that if the request has been pending for at least 6 months without a denial by ICE, the person will be considered PRUCOL as someone who is known by the government to be in the country but where the government appears to have no intention of enforcing their departure.<sup>9</sup>

This policy does not apply to applicants for Deferred Action by Childhood Arrivals, who are treated like all other applicants for an immigration benefit or status under NYS DOH’s PRUCOL rules.<sup>10</sup> This means that they are immediately eligible for Medicaid upon proof that the application has been filed.

#### **20. Applicants for various immigration benefits who do not have employment authorization.**

With the exception of applicants for Special Immigrant Juvenile Status, to be considered lawfully present and eligible for the Exchange, applicants for most other immigration benefits must also have an employment authorization document (EAD) in addition to the pending application. In

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<sup>8</sup> These are individuals who are only eligible for public health insurance under New York’s state funded Medicaid/Family Health Plus programs.

<sup>9</sup> NYS DOH Informational Letter 08 OHIP/INF-4, *Clarification of PRUCOL Status* (August 4, 2008) available at: [www.health.ny.gov/health\\_care/medicaid/publications/docs/inf/08inf-4.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/08inf-4.pdf)

<sup>10</sup> For the purpose of eligibility for public assistance, the NYS Office of Temporary and Disability Assistance does not treat a noncitizen applicant for lawful status as PRUCOL. In order to be considered eligible for cash assistance the individual must actually have the status.

## IMMIGRATION STATUS: EXPLAINING THE TERMS

New York, these applicants are considered PRUCOL regardless of whether they have an EAD or not. Included in the list of PRUCOL eligible noncitizens are applicants for:

- a. Special immigrant Juvenile Status (also considered lawfully present even without an EAD);
- b. Asylum or withholding of Removal under the INA or CAT;
- c. Cancellation of Removal;
- d. Temporary Protected Status;
- e. Record of Admission under Section 249 of the Immigration and Nationality Act (INA);
- f. Adjustment under the LIFE Act, and
- g. Legalization under SAW and IRCA.

Each of these immigration benefits is described in paragraph 13 above, under the section “Applicants for Immigration Benefits who are Lawfully Present and PRUCOL.”

# Reading a Permanent Resident Card

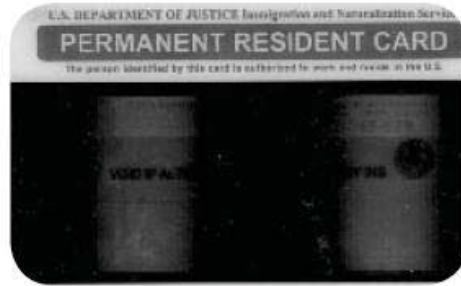
Front

"A-number"



Date you became a Permanent Resident  
(January 1, 1980)

Back

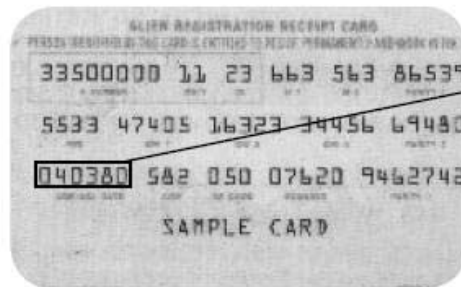


This card does not have Port-of-Entry on it.

"A-number"

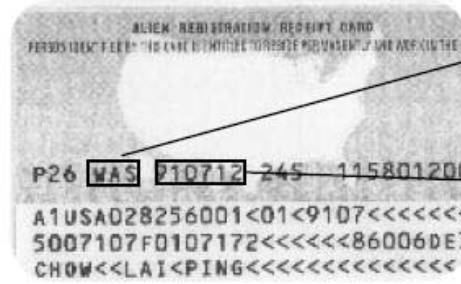


Port-of-Entry or office where you were granted adjustment of status



Date you became a Permanent Resident  
(April 3, 1980)

"A-number"



Port-of-Entry or office where you were granted adjustment of status

Date you became a Permanent Resident  
(July 12, 1991)

NOTE: The "A-number" is the Alien Registration Number

Category Code



United States Permanent Resident Card (green card) (May 2010)

Most of the information on the card is self-evident. The computer and human readable signature at the bottom is not. The format is (digit range: expected data (information contained)):





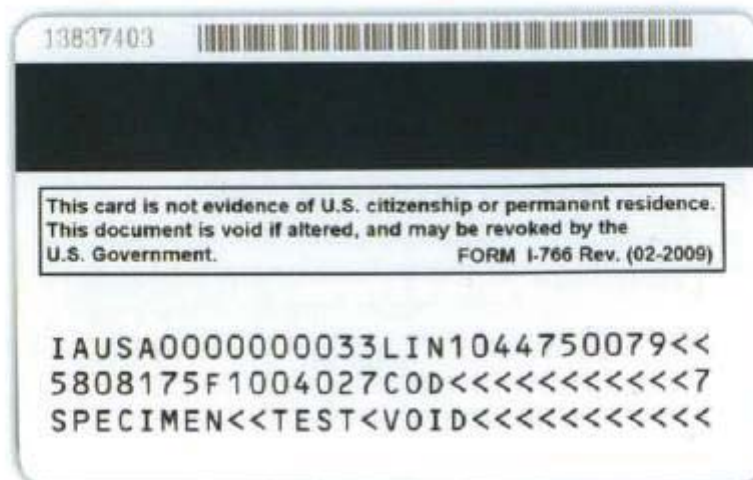
# EMPLOYMENT AUTHORIZATION CARD

USCIS began issuing a modified version of Form I-766 in 2010. The face of the card remains unchanged from the previous version. The reverse features three lines of machine-readable coding instead of a two-dimensional bar code.

The card may have different notations that may allow the bearer to travel internationally. Many cards are “NOT VALID FOR REENTRY” and are used solely for employment, but others may show “VALID FOR REENTRY” or “SERVES AS I-512 ADVANCE PAROLE” and may be used as travel documents.



Form I-766 (February 2009 Revision)



# KEY TO EAD CODES

The chart below contains the most common entries on the front of the EAD card for “category” or “provision of law” and indicates the basis on which the person was granted work authorization. The codes correspond to the work authorization provisions of 8 C.F.R. § 274.12. The following list is not exhaustive. For this reason and because new categories are established from time to time, reference to the regulation itself is advisable to determine the meaning of codes not on the following list. The “(a)” category are non-citizens whose authority to work is inherent in their status; the “(b)” category are non-citizens authorized to work for a particular employer and the “(c)” category are those non-citizens who must apply for work authorization. (Updated 0/18/2013 by Barbara Weiner, the Empire Justice Center, New York: [bweiner@empirejustice.org](mailto:bweiner@empirejustice.org).)

CODE	STATUS
(a)(3)	Refugee
(a)(4)	Paroled as refugee
(a)(5)	Granted asylum
(a)(6)	Fiancé(e) of U.S. citizen or dependent of fiancé(e)
(a)(8)	Citizen of Federated States of Micronesia or Marshall Islands
(a)(9)	Spouse of USC admitted with K3 visa (and K-4 dependent)
(a)(10)	Granted withholding of removal
(a)(11)	Granted Extended Voluntary or Deferred Enforced Departure
(a)(12)	Granted TPS (temporary protected status)
(a)(13)	Granted voluntary departure under Family Unity (IMM Act 1990)
(a)(14)	Granted Family Unity under LIFE Act
(a)(15)	Spouse/child of LPR granted V non-immigrant status
(a)(16)	Person admitted as victim of trafficking (T status)
(a)(19)	Victim of crime admitted with U visa
(a)(20)	Derivative relatives of U visa holder (U2-U5 status)
(b)(6)	Foreign students in on-campus employment
(b)(9)	Temporary worker or trainee (H-1, H-2A, H-2B or H-3 status)
(b)(11)	Exchange visitor (J-1 status)
(b)(16)	Religious worker (R status)
(c)(3)(i)-(iii)	Foreign Student (F-1) permitted to work under certain conditions
(c)(5)	Non-citizen spouse or minor child of exchange visitor (J-2 status)
(c)(6)	Foreign student seeking employment for practical training (M-1 status)
(c)(8)	Applicant for asylum (150 days after filing of completed application)
(c)(9)	Applicant for adjustment to permanent status
(c)(10)	NACARA applicants and applicants for cancellation of removal
(c)(11)	Non-citizen paroled into U.S. for reasons of public interest (PIP)
(c)(14)	Non-citizen granted deferred action
(c)(16)	Registry applicant (resided in U.S. since before 1/1/1972)
(c)(17)(i)-(iii)	Certain domestic workers and airline employees (B-1 status)
(c)(18)	Person under Order of Supervision
(c)(19)	Applicant for Temporary Protected Status
(c)(24)	Applicant for legalization under the LIFE Act Legalization Program
(c)(25)	Immediate family members of T visa holder (T-2 through T-4 visa)
(c)(31)	VAWA self-petitioners
(c)(33)	Deferred Action for Childhood Arrivals

# I-94

When granted admission by a U.S. Customs and Border Protection (CBP) officer at an authorized port of entry, an alien is issued an **ARRIVAL/DEPARTURE RECORD** (Form I-94), the bottom portion of which is stapled to a page in the alien's passport. This document shows how long the bearer may remain in the U.S. and the terms of admission. The I-94, not the non-immigrant visa, serves as evidence of legal presence.

Nationals of some countries may enter the U.S. without a visa under the Visa Waiver Program. They are permitted to remain up to 90 days but are not eligible for employment. They may have either an endorsed green I-94W or a passport endorsed with a CBP stamp to show evidence of legal presence.

DEPARTMENT OF HOMELAND SECURITY  
U.S. Customs and Border Protection

OSBI No. 1051-0111

Departure Record

Admission Number  
**132280125 22**

**MAY 12 2010**  
**L-1**  
*September 30, 2012*

18. Family Name  
**VOID**

19. First (Given) Name  
**VOID**

20. Birth Date (DD/MM/YY)  
**010165**

21. Country of Citizenship  
**INDIA**

DEPARTMENT OF HOMELAND SECURITY  
U.S. Customs and Border Protection

OSBI No. 1051-0111

Admission Number  
**472600079 21**

**MAY 12 2010**  
**WB**  
*Aug 11, 2010*

Departure Record  
**VISA WAIVER**

20. Family Name  
**VOID**

21. First (Given) Name  
**VOID**

22. Birth Date (DD/MM/YY)  
**121255**

23. Country of Citizenship  
**JAPAN**

See Other Side

CBP Form I-94W (05/08)  
STAPLE HERE

# I-797

Department of Homeland Security  
U.S. Citizenship and Immigration Services

RECEIVED DEC 15 2013

I-797, Notice of Action



RECEIPT NUMBER EAC- <i>receipt number</i>		CASE TYPE: I-765 APPLICATION FOR EMPLOYMENT AUTHORIZATION
RECEIPT DATE October 9, 2013	PRIORITY DATE	APPLICANT: <i>"A" Number Name</i>
NOTICE DATE December 10, 2013	PAGE 1 of 1	
BARBARA ELISABETH WEINER EMPIRE JUSTICE CENTER 119 WASHINGTON AVE. FLR 2 ALBANY NY 12210		Notice Type: <i>Approval Notice</i> Class: <i>CA4</i>

Your application for employment authorization has been approved. The Form I-766, Employment Authorization Document, was sent under separate cover to the beneficiary.

This card authorizes your employment in the United States. Show this card to your employer to verify authorization to work during the dates on the card.

If any information on the card is incorrect, please write the address listed below. Include your Employment Authorization Document, I-766, a photocopy of this notice, and evidence to support the necessary corrections.

THIS APPROVAL NOTICE IS NOT A VISA OR EVIDENCE OF EMPLOYMENT AUTHORIZATION, NOR MAY IT BE USED IN PLACE OF A VISA OR FORM I-766.

As a reminder, you may request to change employers under INA 204(j) if your Form I-485 Adjustment application has been pending for at least 180 days and your underlying Form I-20 has approved or is still pending. In order to do so, you should supplement the Form I-485 record of proceeding with documentation relating to the new job offer that forms the basis of the INA 204(j) portability request. For more information on how to request to change employers and what information is required to supplement the Form I-485, please visit [www.uscis.gov](http://www.uscis.gov).

THIS FORM IS NOT A VISA NOR MAY IT BE USED IN PLACE OF A VISA.

NOTICE: Although this application/petition has been approved, USCIS and the U.S. Department of Homeland Security reserve the right to verify the information submitted in this application, petition, and/or supporting documentation to ensure conformity with applicable laws, rules, regulations, and other authorities. Methods used for verifying information may include, but are not limited to, the review of public information and records, contact by correspondence, the internet, or telephone, and site inspections of businesses and residences. Information obtained during the course of verification will be used to determine whether revocation, rescission, and/or removal proceedings are appropriate. Applicants, petitioners, and representatives of record will be provided an opportunity to address derogatory information before any formal proceeding is initiated.

*EAD application approval*

*classification*

Please see the additional information on the back. You will be notified separately about any other cases you filed.  
U.S. CITIZENSHIP & IMMIGRATION SVCS  
VERMONT SERVICE CENTER  
75 LOWER WELDEN STREET  
SAINT ALBANS VT 05479-0001  
Customer Service Telephone: (800) 375-5283



# ICE MEMO

Office of the Director  
U.S. Department of Homeland Security  
500 12<sup>th</sup> Street SW  
Washington, DC 20536



**U.S. Immigration  
and Customs  
Enforcement**

Oct. 25, 2013

## **Clarification of Existing Practices Related to Certain Health Care Information**

### Purpose

The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 224, and the Social Security Act (SSA) require that individuals<sup>1</sup> seeking coverage under a qualified health plan offered on a Health Insurance Marketplace or through an insurance affordability program (i.e., premium tax credits, cost sharing reductions, Medicaid, Children’s Health Insurance Program, or Basic Health Program) provide information regarding their immigration status and certain information about their household members to determine eligibility for such coverage. This memorandum sets forth U.S. Immigration and Customs Enforcement (ICE) civil immigration enforcement policy regarding information concerning such individuals and their household members obtained during the eligibility determination process for such coverage.

### Background

The ACA, the SSA, and implementing regulations outline procedures for determining eligibility for coverage under a qualified health plan offered on a Marketplace or through an insurance affordability program. Under the laws and implementing regulations, information provided by individuals for such coverage may not be used for purposes other than ensuring the efficient operation of the Marketplace or administering the program, or making or verifying certain eligibility determinations, including verifying the immigration status of such individuals.

### Agency Policy

Consistent with the ACA’s, the SSA’s, and implementing regulations’ limitations on the use of information provided by individuals for such coverage, and in line with ICE’s operational focus, ICE does not use information about such individuals or members of their household that is obtained for purposes of determining eligibility for such coverage as the basis for pursuing a civil immigration enforcement action against such individuals or members of their household, whether that information is provided by a federal agency to the Department of Homeland Security for purposes of verifying immigration status information or whether the information is provided to ICE by another source.

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<sup>1</sup> For purposes of this statement, “individuals” means certain applicants for, beneficiaries of, and enrollees in coverage under a qualified health plan offered on a Health Insurance Marketplace or through an insurance affordability program.

# ICE MEMO

SUBJECT: Clarification of Existing Practices Related to Certain Health Care Information  
Page 2 of 2

## No Private Right of Action

This document, which is intended only as internal ICE policy, is not intended to, does not, and may not be relied upon to create any rights or benefits, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.