EFFECT OF THE 1996 WELFARE AND IMMIGRATION REFORM LAWS ON IMMIGRANTS’ ABILITY AND WILLINGNESS TO ACCESS MEDICAID AND HEALTH CARE SERVICES

MAY 2000

SAN DIEGO, CALIFORNIA SITE VISIT REPORT

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This study was supported with funding from The Robert Wood Johnson Foundation.

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Many people contributed to the completion of this study. Most important among them are the numerous county and state officials, safety net providers, representatives of community-based organizations, and the immigrants who gave their time, granted interviews, and furnished materials. The cooperation of the community-based organizations was particularly instrumental in our being able to talk to immigrants about their experiences. We recognize especially the Union of Pan-Asian Communities, Catholic Charities, the Alliance for African Assistance, Alpha of San Diego, San Diego Urban League, Home Start, ACCESS, and Heartland Human Relations. We appreciate the time and assistance from all of these individuals and entities; without their participation this study would not have been possible.

We appreciate very much the support of The Robert Wood Johnson Foundation. We are grateful for the opportunity, which they gave to us, to explore the effect of the welfare and immigration reforms laws of 1996 on immigrants’ ability and willingness to access Medicaid and health care services.

Finally, we note the efforts of Hye Sun Lee, MPH of the Northwestern University Institute for Health Services Research and Policy Studies (IHSRPS). Her work in preparing for the site visit, and participating in interviews, represented an important contribution to completing this study.

Several county and state informants and representatives from safety net providers and community-based organizations reviewed various portions of this report. We appreciate their valuable comments and the report benefited from their review. The opinions expressed in this report belong solely to the authors, however, and we are also responsible for any errors or omissions.
I. INTRODUCTION

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) established new and complex eligibility rules for public benefits for legal immigrants, and made ineligible for most federal public benefits several categories of previously eligible legal immigrants. The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 established certain procedures for determining the admissibility of immigrants and heightened fears that the use of public benefits, even the legitimate use of Medicaid, could jeopardize immigrants’ ability to become legal permanent residents or U.S. citizens. It was anticipated that the combined effects of these two laws would result in a substantial reduction in the use of Medicaid as well as in the use of health care services by immigrants.

This study, funded by The Robert Wood Johnson Foundation, was designed to examine the effects of the 1996 welfare and immigration reform laws on the ability and willingness of immigrants to access Medicaid and health care services. The primary research goals were: (1) to examine how state and local officials have implemented the new Medicaid eligibility requirements for immigrants; (2) to describe how the implementation of these requirements is affecting immigrants’ access to health services; and (3) to explore whether immigrants are discouraged from the legitimate use of Medicaid and other health services. The study used a case study approach and was conducted at four sites: Chicago, Illinois; Metropolitan Washington DC; San Diego, California; and Brownsville, Texas.

Five research questions provide the analytic framework for conducting the research and data analysis: (1) How have the 1996 welfare and immigration laws affected immigrants’ ability to apply for Medicaid? (2) How have the 1996 welfare and immigration laws affected immigrants’ willingness to apply for Medicaid? (3) How have the 1996 welfare and immigration laws affected immigrants’ ability and willingness to seek primary health services? (4) How have the 1996 welfare and immigration laws affected immigrants’ ability and willingness to seek emergency health services? and (5) How have the 1996 welfare and immigration laws affected immigrants’ health-related quality of life (vis-à-vis their effects on immigrants’ ability and willingness to apply for Medicaid and/or seek health services)?

A unique aspect of this research involved the extensive use of focus groups and individual interviews with immigrants. This approach allowed us to examine directly immigrant families’: (1) experiences with changing eligibility criteria; (2) perceptions about and experiences with the process of applying for, and getting access to, Medicaid; (3) willingness and ability to seek health care services; (4) willingness and ability to seek Medicaid and health care services for their children; and (5) health-related quality of life associated with changes in access due to the 1996 welfare and immigration reform laws.

This report presents findings from the San Diego, California site visit. First, we discuss the policy and research context for this study, briefly describe the study methods, and present a range of relevant political and sociodemographic information about the sites. Next we present the study findings and their implications. Finally, we conclude with recommendations for improving immigrants’ access to health insurance programs and health services providers following the enactment of the 1996 reform laws.
A. Policy and Research Context

The 1996 Welfare Reform and Immigration Reform Laws

For immigrants, the passage of federal welfare reform meant much more than ending the entitlement to cash assistance. The law restricted noncitizen eligibility for a wide range of public means-tested benefits, including TANF, Food Stamps, Supplemental Security Income, and Medicaid, and gave states broad new authority to set social welfare policy for immigrants. PRWORA essentially bars legal immigrants from means-tested benefits for which they were previously eligible for at least five years. For the first time since welfare was created, legal immigrants are now eligible for significantly fewer benefits than citizens. These reforms thus represent a turning point in the history of U.S. immigration policy.\(^1\)

Essentially the law created a fundamental distinction between legal immigrants who were lawfully present in the U.S. before the law passed (immigrants arriving before August 22, 1996 or pre-enactment immigrants) and those immigrants arriving on or after August 22, 1996 (post-enactment immigrants). States were given the option to bar most pre-enactment immigrants from TANF and nonemergency Medicaid programs; only two states chose to enact this option.\(^2\) States are required to bar most post-enactment immigrants from “federal means-tested benefits” (i.e., nonemergency Medicaid, SSI, Food Stamps, TANF, and the state Children’s Health Insurance Program (CHIP)) for their first five years in the United States. Figure 1 of Volume I illustrates the pathways for immigrant eligibility from which states can choose.

Table 1 of Volume I shows the change in terminology introduced by the law in that legal immigrants are now categorized as qualified, and certain groups of PRUCOLs (persons residing under color of law) and undocumented immigrants are now categorized as not qualified (the term unqualified is also used). With the notable exception of certain PRUCOLs who were, in effect, moved from legal to not qualified groups, all immigrant groups that were formerly legal became qualified.\(^3\) The term ‘qualified’ is used in the law to distinguish among categories of immigrants for the purpose of eligibility for public benefits. However, being a member of a qualified immigrant category does not necessarily mean that eligibility for public benefits is available.

\(3\) Certain PRUCOLs represent a striking example of a group of individuals who lost the most as a result of PRWORA as they were legally residing in the U.S. yet are now in the unqualified category with illegal/undocumented immigrants and are eligible for only emergency Medicaid. The categories of PRUCOLs so affected by these provisions of PRWORA include: indefinite stay of deportation, indefinite voluntary departure, deferred action status, residing under supervision of INS, and suspension of deportation. Little information is available about these PRUCOLs and, to our knowledge, we did not interview any of these PRUCOL immigrants. These immigrants represent a very small group, albeit a group quite adversely affected by the changes created by PRWORA. The majority of PRUCOLs, however, were unaffected.
PRWORA essentially created three groups of qualified immigrants in terms of eligibility for public benefits (See Table 1 of Volume I). For pre-enactment legal permanent residents (LPRs) with fewer than 40 qualifying work quarters, states can decide whether to provide federal benefits; they will receive federal matching funds for these benefits; states must provide benefits to pre-enactment LPRs with 40 qualifying work quarters. Most, but not all post-enactment LPRs (e.g., veterans) are barred from receipt of federal public benefits for the first five years after their arrival. All other categories of qualified immigrants (e.g., refugees, parolees, LPRs with more than 40 work qualifying quarters; see Table 1 of Volume I for the complete list) are eligible for federal public benefits for five to seven years depending upon the program. After the five-year bar, states may opt to provide federally-funded public benefits to post-enactment LPRs although they must provide benefits to those with 40 work quarters. In dealing with these new groups of immigrants, the distinction between being a qualified immigrant and being eligible for public benefits must be clearly understood (i.e., a qualified immigrant is not necessarily an eligible immigrant).

PRWORA represents a substantial and unprecedented shift in (i.e., devolution of) immigration policy from the federal to the state level. State officials now have substantial discretion to determine which types of immigrants will receive which kinds of public benefits. The law also imposes greater financial responsibility on states choosing to extend benefits to noncitizens/legal immigrants who have been barred from receiving federal public benefits by PRWORA. These provisions mean that: (1) there will be variability by state in terms of coverage and access for immigrants/noncitizens arriving in the U.S. on or after August 22, 1996; and (2) assessing the experiences of immigrants will require knowledge about particular choices made by states with respect to eligibility for public benefits.

The provisions of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), enacted by Congress subsequent to the passage of PRWORA, also have implications for access to Medicaid. Briefly, this law, designed to codify practices of the Immigration and Naturalization Services (INS) concerning the admissibility of immigrants, increased the reporting and verification requirements for federal and state agencies that administer public benefits and focused attention on the issue of public charge. In addition, IIRIRA changed the “deeming” law to hold immigrant sponsors legally responsible for new immigrants at a higher income level. This law has heightened concerns among immigrants that any use of public assistance, even a legitimate use of Medicaid, could interfere with an

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4 An alien who is likely at any time to become a "public charge" is ineligible for admission to the U.S. and is ineligible to adjust status to become a legal permanent resident. An alien who has become a public charge can also be deported from the U.S. "Public charge" means an alien who has become (for deportation purposes) or who is likely to become (for admission/adjustment purposes) primarily dependent on the government for subsistence. The INS will consider the receipt of cash benefits for income maintenance purposes and institutionalization for long-term care at government expense in determining dependence on the government for subsistence. In deciding whether an alien is likely to become a public charge, the law requires the INS to take certain factors into account, including the alien's age, health, family status, assets, resources, financial status, education and skills. Government officials examine all of these factors, looking at the “totality of the circumstances” concerning the alien. No single factor will be used as the sole basis for finding that someone is likely to become a public charge.

immigrant’s ability to become an LPR or petition to bring relatives to the U.S.\textsuperscript{5} Just as we began our site visits in the Spring 1999, the INS issued regulations clarifying the grounds for public charge and specifically noting that any use of the Medicaid (except long-term care) and CHIP programs would not by itself subject an immigrant to the risk of being labeled a public charge.

**Immigrants Have Traditionally Faced Barriers to Health Care and Insurance Coverage and Represent a Growing Portion of Low-Income and Vulnerable Population**

Immigrants/noncitizens have traditionally faced barriers to health care coverage and health care services. In 1995, more than one-half of low-income immigrants lacked health insurance and immigrants struggled with language, cultural, and financial barriers to getting health care services.\textsuperscript{6} Analyses of data from 1990 as well as more recent studies show that immigrants, especially those who arrived recently and did not speak English, were far less likely to have seen a doctor or have a usual source of care than similarly situated citizens.\textsuperscript{7} Immigrants’ access to health care services and insurance coverage also highlights the role played by race and ethnicity among low-income and vulnerable populations with respect to inequities in the U.S. health care system. About one-third of all Hispanics in the U.S. are immigrants. Recent studies have shown that Latinos have low rates of insurance coverage and limited use of health care.\textsuperscript{8}

Immigrants now comprise an increasingly large portion of the U.S. population. Immigrants represented 9.5 percent of U.S. residents in 1999, and are projected to grow to 11.2 percent by 2010.\textsuperscript{9} Foreign-born and U.S.-born children of immigrants now make up about 20 percent of children in the U.S.\textsuperscript{10} Immigrants represent a relatively large portion of the low-income and vulnerable population because of their lower average income level and tendency to be isolated due to cultural and linguistic barriers. Immigrants are particularly likely to lack access to employer-sponsored health insurance coverage because they are often working in low-wage, low-benefit jobs in the agricultural and service sectors.\textsuperscript{11}


The provisions of the 1996 welfare and immigration reform laws have the potential to exacerbate these barriers and so contribute to the growing population of uninsured U.S. residents.

II. METHODS

The project used a case study approach to obtain a detailed picture of immigrants’ experiences since the enactment of welfare and immigration reforms. Four sites (Chicago, IL; San Diego, CA; Brownsville, TX; and the Washington D.C. metropolitan area) were selected based on criteria identified to ensure that certain fundamental issues are examined, including whether substantial numbers of various immigrant populations are represented, the nature of state and local decisions about what services to continue to make available to which immigrants, the recent history of state and local communities with immigrant populations and issues, the accessibility of the immigrant populations, the availability of safety net providers and community-based organizations, and the recent history of INS-related activity.

The case studies were conducted from March through October 1999. In addition to interviewing state and county officials, representatives of safety net providers, community-based organizations, and advocates, we conducted individual interviews and focus groups with immigrants. At least two focus groups were conducted at each site. Focus groups were conducted in the immigrant’s native language (e.g., Spanish, Cantonese, and Polish). We partnered with community-based organizations to recruit low-income immigrant parents to participate in the focus groups or individual interviews. In some cases a representative of the community-based organization moderated the group discussion and, in other cases, project staff conducted the focus groups. At the end of each focus group, participants were asked to complete a demographic questionnaire. Similarly, we relied on community-based organizations to solicit participation from immigrants to participate in the individual interviews. Except in cases where the immigrant parent was comfortable speaking English, all interviews were conducted in the immigrant’s native language and/or with the assistance of a translator. All participants were assured confidentiality. Each participant was paid a $25 cash incentive to participate in the group discussion or individual interview.

This report presents findings from the site visit to San Diego, California. The case study is based largely on interviews conducted during May and June 1999, supplemented by follow-up telephone calls and background materials collected by project staff or supplied by informants. Expert observers, including health and social service providers and advocates, were contacted prior to and during the site visit. Informants interviewed prior to the site visit provided background information and suggested key contacts. Other informants were interviewed on site. State officials from the California Medi-Cal Policy Division were interviewed. County officials from the San Diego County Health and Human Services Agency also were interviewed. Among those county officials interviewed were six caseworkers at welfare offices, three each at the Kearney Mesa and the South Bay District offices.

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12 A synthesis of the study including findings from all four site visits, as well as the individual site visit reports are available at www.gwu.edu/~chsrp. A separate paper focused on the findings from immigrant interviews and focus groups from each site can also be accessed at the same web page.
Representatives from three community health centers, one not-for-profit hospital, and four community-based organizations also were interviewed.

Six members of the project team conducted the San Diego site visit from June 7 to June 9, 1999. A total of 46 immigrants were interviewed, including 19 immigrants who participated in one of two focus groups and 28 immigrants were interviewed individually (one focus group participant was also interviewed individually).

The focus groups and interviews took place at eight different community-based organizations (CBOs) in San Diego. Both focus groups and most interviews involved at least two team members and one translator when necessary. Two members of the project team speak Spanish and translated interviews when necessary. Contacts at the CBOs recruited participants either by posting a flyer in their facilities explaining the project and how to sign up, or by approaching clients they believed would be interested in participating. The contacts scheduled the interviews, found private settings for the interviews to take place, and arranged for translators when necessary.

Interview and focus group participants were informed that their identity would remain anonymous and their comments would not be connected with them in any way in the future. They were asked to talk about their experiences in seeking health care services and Medi-Cal for themselves and their families, their perceptions of the issues immigrants face when considering accessing health care and Medi-Cal, and their perceptions of the general atmosphere in San Diego for immigrants since the 1996 welfare reform laws.

A. Terminology for Immigrants Used in This Report

We use a range of descriptive terms in this report to identify groups of immigrants. For example, we use the term ‘immigrants’ or ‘refugees’ and not ‘aliens;’ and we use the term ‘undocumented immigrants’ instead of ‘illegal aliens.’ We use immigrant and non-citizen interchangeably. While the 1996 laws introduced the term ‘qualified immigrants’ and, thus, ‘not qualified’ or ‘unqualified immigrants’ primarily to distinguish among groups of immigrants with respect to their eligibility for public benefits, these terms are currently not commonly used and are somewhat confusing. Instead, we frequently use other terms such as ‘post-enactment LPRs’ (i.e., legal permanent residents arriving after August 22, 1996) or ‘pre-enactment LPRs’ (i.e., legal permanent residents arriving before August 22, 1996) or undocumented immigrants instead of not qualified immigrants. Although the 1996 law does not indicate a preferred term between unqualified or not qualified, we chose to use ‘not qualified’ as this term embodies a more precise meaning in this context than ‘unqualified.’

We use qualified and not qualified infrequently because these terms include more than one distinct type of non-citizen in terms of eligibility for public benefits. For example, pre-enactment LPRs,

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13 We understand that many people who immigrated to the U.S. and have since become citizens may still refer to/see themselves as immigrants – in other words, in the common vernacular, these terms are often not understood as mutually exclusive. However, for this research and report, our focus concerns only immigrants who are not citizens, and so the terms immigrants and noncitizens are used interchangeably, and the terms immigrant and citizen are seen as mutually exclusive.
who are qualified immigrants, are eligible for Medicaid while most post-enactment LPRs, who are also qualified immigrants, are effectively barred from Medicaid for five years. We instead use post-enactment LPRs to refer to the largest group of “qualified” non-citizens most commonly facing substantial constraints on access to public benefits due to PRWORA. We prefer the terms ‘pre-enactment LPRs’ and ‘post-enactment LPRs’ as these categories capture more clearly the key distinction in terms of non-citizen eligibility for Medicaid. While redundant, we note again that it is essential to bear in mind the distinction between being a qualified immigrant and being an immigrant eligible for public benefits (i.e., a qualified immigrant is not necessarily an eligible immigrant as certain qualified immigrants are barred from receiving federally-funded public benefits for five years).

III. BACKGROUND (See Tables 3 and 4 of Volume I)

A. Characteristics of Immigrants Living in California

California has the largest foreign-born population in the U.S., accounting for one-third of the nation’s total. About 5.8 million immigrants were counted in California in the last decade, an estimated 2.2 percent of the U.S. population. Immigrants now constitute more than half of the growth of the state’s population and labor force. More than 11 percent of the foreign citizens are legal permanent residents of which over seven percent are eligible to apply for naturalization. Almost half of California’s recent immigrants come from Mexico and Central America and another third come from Asia. Forty-three percent of all immigrants to California settle in Los Angeles county followed by Orange, San Diego, Santa Clara, and San Francisco.14

California also has the largest and greatest concentration of undocumented residents. An estimated 1.5 to 2 million undocumented immigrants lived in California in 1996, representing approximately five to six percent of the state’s population and 40 percent of the total number of undocumented immigrants living in the U.S.15 The majority of the undocumented immigrants come from Mexico and reside in Los Angeles, San Diego, Fresno, and Orange counties.16

San Diego County’s population is nearly 2.5 million, of which 17.2 percent is foreign-born. San Diego has a large Latino population because it shares the border with Mexico. As such, San Diego County is among the most immigrant-impacted localities and is projected to remain California’s second most immigrant-populated county after Los Angeles.17

15Geen et al., Income Support and Social Services for Low-Income People in California. The Urban Institute, 1997.
17Census Bureau data: www.fairus.org/msas. (Background on San Diego County: www.co.san-Diego.ca.us/cnty)
### B. Immigrant Participation in Medi-Cal and CHIP

**Eligibility Criteria for Medi-Cal and Healthy Families**

The 1996 federal welfare law transferred the authority to determine which benefits immigrants are eligible for from the federal government to the states. For Medicaid, states have three options: (1) whether to continue or deny federally-funded Medicaid coverage to qualified immigrants who arrived in the U.S. prior to 8/22/96; (2) whether to substitute state dollars for federal dollars for Medicaid coverage for qualified immigrants who arrived in the U.S. on or after 8/22/96; and (3) whether to provide state-funded Medicaid coverage to not qualified immigrants (e.g., certain PRUCOLs, undocumented persons).

Despite a protracted public legal battle (described later) to limit benefits to undocumented persons during Governor Wilson’s Administration, California continues federally-funded nonemergency Medi-Cal coverage to qualified immigrants who entered the U.S. prior to August 22, 1996, and provides state-funded Medi-Cal assistance for undocumented resident pregnant women and post 8-22-96 entrants.\(^\text{18}\) In other words, Medi-Cal eligibility policy has not changed due to enactment of federal welfare reform or due to passage of ballot initiatives (described later). Otherwise eligible immigrants in California (regardless of in which county they reside) are eligible for nonemergency Medi-Cal benefits regardless of date of entry. California continues to provide Medi-Cal to all qualified immigrants (including PRUCOLs) who arrived in the U.S. prior to 8/22/96. California also provides Medi-Cal coverage to qualified immigrants who arrived post 8/22/96. In addition, California provides Medi-Cal pre-natal care to undocumented resident women. California uses state funds for benefits not approved to receive federal matching funds. In effect, all immigrants who were eligible for Medi-Cal prior to 8/22/96 continue to be eligible; for some immigrants (i.e., post 8/22/96 entrants and undocumented immigrants), Medi-Cal benefits are entirely state-funded. No changes were made to emergency Medicaid.\(^\text{19}\)

States have choices in determining eligibility for immigrants under their CHIP programs. States that opt to expand benefits to low-income children using their state Medicaid programs must follow the Medicaid rules described above. States that choose to provide coverage through a separate state program (as in the case of California) may decide independently whether to extend coverage to qualified or not qualified immigrant children. To date, California’s CHIP program, called Healthy Families, covers both pre- and post-enactment “otherwise eligible” qualified immigrant children.\(^\text{20,21}\)

\(^{18}\)To qualify for Medi-Cal immigrants must be “otherwise eligible” for Medicaid (Medi-Cal): Immigrants must meet other federal and state eligibility requirements (e.g., income, deprivation requirements) for Medicaid as well as emergency Medicaid in order to be eligible for state-funded benefits. Undocumented immigrants also must be federally eligible for emergency Medicaid before receiving state-funded prenatal benefits.

\(^{19}\)Emergency services include labor and delivery and kidney dialysis.

\(^{20}\)According to the Healthy Families Program Handbook, children who arrived in the U.S. after 8-22-96 are enrolled in Healthy Families for one year. Continued enrollment in Healthy Families will depend on yearly funding by the state of California.

\(^{21}\)Post enactment children were added during Governor Davis’s administration. During the previous administration, Governor Wilson had vetoed a bill that would have extended Healthy Families to cover post 8/22/96 entrants. At the time the expansion reportedly would have added 35,000 children to the 580,000 that are expected to be eligible for Healthy Families.
Politics of Immigration

California’s Medicaid eligibility policy for undocumented immigrants has been shaped, in part, by previous ballot initiatives and lawsuits. Proposition 187, an initiative passed in 1994, denied public benefits to undocumented immigrants in California. However, its implementation was blocked in court in 1995 and during Governor Wilson’s administration there was a court battle over its legality. In November 1997, a federal court ruled that Proposition 187 is unconstitutional because PRWORA prohibits states from designing legislation concerning immigrant eligibility for public benefits. Also in 1997, Wilson attempted to bar undocumented women from prenatal care by another route, claiming that PRWORA dictated public benefits be eliminated for undocumented immigrants.

Despite attempts to restrict Medicaid coverage to undocumented resident pregnant women, California continued to provide benefits for undocumented resident pregnant women continuously despite lacking explicit enabling legislation. As an interim measure, in January 1999, Governor Davis included $63.8 million for prenatal care for undocumented women in the 1999-2000 state budget. In prior years, such care was paid for out of general state funds. The state legislature during the 1999-2000 session resolved the dispute by affirmatively re-authorizing pre-natal benefits for undocumented resident women. (PRWORA requires states to re-enact legislation specifically designating that services be extended to undocumented immigrants.)

The current Medi-Cal eligibility policies that have resulted in California conflicted with the public efforts to restrict benefits for undocumented immigrants. Yet, in spite of public battles to restrict Medi-Cal eligibility for undocumented immigrants, California is now championed as having one of the most generous state Medi-Cal eligibility policies for legal immigrants and undocumented pregnant women.

Medi-Cal Enrollment

According to a recent study conducted by the Urban Institute, “among the 15 largest states, California has the highest proportion of families on Medicaid – one in six.” The study states that “the impact of the immigrant restrictions on welfare reform will be felt more strongly in California than in any other state. California not only has far more immigrants than any other state, but its immigrants are poorer and have higher rates of welfare use. More than half of California poor families with children under 18 contain a foreign-born person, compared with 19 percent for the U.S. as a whole.” Non-citizens enrollment in Medi-Cal, California’s Medicaid program, on a statewide basis before August 1996 was 1.3 million and expenditures totaled $3.3 million. California non-citizens used a greater

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22 The use of this heading was inspired by a recent report released by The Urban Institute. See Zimmermann and Tumlin, Patchwork Policies: State Assistance for Immigrants under Welfare Reform. May 1999.
23 Three lawsuits maintained prenatal care between December 1, 1996 and July 1999, when the state legislature re-authorized the program: Carmen Doe v Wilson, Milagro Doe V DHS, and Yvette Doe v. Belshé. Personal communication with John Affeldt, Latino Coalition for a Healthy California, April 20, 2000.
percentage of Medicaid than the rest of the country’s immigrant population. This is mostly because undocumented immigrants in California may enroll in Medi-Cal at the welfare office, and receive Medi-Cal cards that permit coverage of limited benefits (i.e., emergency services, prenatal care). In most states Medicaid covers undocumented immigrants (who are otherwise eligible) only after they have an emergency.

The number of legal immigrants enrolled in Medi-Cal has remained relatively constant in San Diego County since welfare reform. When federal welfare reform was enacted in August 1996, there were 9,695 legal non-citizen immigrants enrolled in Medi-Cal, and in April 1999, 11,042 were enrolled, representing a 14 percent increase. However, the number of undocumented immigrants enrolled in Medi-Cal has decreased precipitously from 11,187 in August 1996 to 7,157 in April 1999, a decrease of more than one third. There is no reason to suspect that the number of undocumented immigrants in San Diego is declining proportionately. Over this same time period, the number of citizens enrolled in Medi-Cal in San Diego County increased approximately 15 percent from 58,068 in August 1996 to 66,650 in April 1999.25

CHIP Enrollment

The Healthy Families Program is California’s Children’s Health Insurance Program (CHIP) for low-income children. The program took effect in July 1998. The CHIP program covers families whose incomes are above the threshold to qualify for Medi-Cal but do not have health insurance through their employers and cannot afford to buy their own. Families who earn up to 200 percent above the poverty level are eligible. An estimated 30,000 children in San Diego County are eligible for CHIP; as of April 2000, 20,274 children were enrolled.26

C. Health Care Providers and Community-Based Organizations that Serve Immigrants

Representatives from three health centers (Logan Heights Family Health Center, North County Health Service Corporation, and Vista Community Clinic) and one hospital (University of California at San Diego) were interviewed. Additionally, representatives from several San Diego community-based organizations were interviewed, including: the San Diego Urban League, the Union of Pan Asian Communities, Catholic Charities, the Alliance for African Assistance, Legal Aid Society of San Diego, and the Border Health Initiative of Project Concern International.

Safety Net Providers (SNPs)

Hospitals. There are no public hospitals in San Diego County; San Diego sold its public hospital to the University of California in the 1970s. Consequently, the University of California at San


Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center
Diego (UCSD) Hillcrest Hospital serves as the de facto local safety net hospital. The county contracts for indigent health care services through the university hospital and other private-sector providers. A recent study by the San Diego Regional Health Care Advisory Council reported that San Diego county funding for safety net health care services has been declining steadily as public health facilities are privatized.\textsuperscript{27} The county government contributed only about one percent of total hospital revenues to indigent care.\textsuperscript{28} UCSD Hillcrest Hospital served approximately one half of the indigent non-Medi-Cal patients in San Diego, many of whom are immigrants.\textsuperscript{29} Local non-profit hospitals, including Mercy, Villa View, Kaiser Permanente, and Children’s Hospitals, also served immigrant communities and provided regular and emergency care.

*Community Health Clinics (CHCs).* There are 23 community clinics in San Diego, serving 350,000 patients annually. There is a substantial network of health centers that provides care to immigrants. These clinics typically offer care in the immigrants’ native languages and are located in immigrants’ communities.

Representatives from three community health centers were interviewed for this study. They provided in-depth information about the number and characteristics of the patients they serve and the services they provide. Whether (and to what extent) health centers conducted Medicaid outstationed enrollment also was ascertained.

Logan Heights Family Health Center includes 13 clinic sites that are FQHCs. The main location has functioned as a health care site for nearly 100 years and officially became a community health center 30 years ago. Logan Heights is the largest clinic organization in San Diego County, and the Logan Heights clinics do the “lion’s share” of safety-net care in San Diego. Across all 13 sites there are over 400 clinical and administrative staff members, and the clinics had a total annual budget of $20 million in 1998. In 1998 the clinics served over 60,000 patients at approximately 220,000 visits. The payer mix across the clinics was roughly 40 percent Medi-Cal, and 40 percent uninsured. The patient population was approximately 65 percent Latino (55-60 percent of whom are monolingual in Spanish or strongly prefer to speak Spanish), and the remaining 35 percent were mostly Caucasians, some African Americans, and few Pan-Asians. Information on immigration status is not collected from patients. As a result, it is not possible to track the number or characteristics of immigrants who seek health care services. Limited Medicaid outstationed enrollment is available at Logan Heights. Clinic staff reported that eight applications are taken per day.

The North County Health Service Corporation is a collection of five (soon to be six) clinics in the north and semi-rural areas of San Diego County (mainly in Oceanside). The five clinics were founded 26 years ago, and all are federally qualified health centers (FQHCs). North County clinics served over 42,000 users in 1998 for a total of 117,000 health visits. The clinics provide primary health care services and also administer the Women, Infants, and Children program (WIC), HIV case

\textsuperscript{27}San Diego County Regional Health Care Advisory Council, “Partners in Health,” February 1998.


\textsuperscript{29}San Diego County Regional Health Care Advisory Council, “Partners in Health,” February 1998.
management services, and newly added obstetric care services. The clinics have a $13 million budget with about 250 clinical and administrative staff across the five clinics. In 1998 the payer mix was approximately 29 percent Medi-Cal, 22 percent supported by state and county primary care programs, 46 percent uninsured, 2 percent private insurance, 1 percent Medicare. The two largest North County clinics offer outstationed Medicaid enrollment. Two county workers and two clinic workers assist patients with applying for Medi-Cal. Thirty applications are taken each week and clinic staff report that approximately 80 percent are approved.

Vista Community Clinic has two locations, one in Oceanside, North of San Diego, and another at the U.S./Mexico border. The clinic provides primary care services as well as a number of special programs including family planning and outreach, women’s and children’s health, breast cancer awareness and screening, and farm workers’ health. Vista has a $12 million annual budget and is staffed by 265 clinical and administrative workers. Vista had 35,000 patients in 1998 and 110,000 patient visits. Sixty percent of the visits were pediatric patients. Approximately 30 percent of Vista’s patients are Medi-Cal recipients, 30 percent are self-pay/uninsured, and programs such as the Children’s Wellness Program underwrite the rest. Almost 90 percent of all prenatal patients are enrolled in Medi-Cal and the rest are self-pay/uninsured. Sixty-seventy percent of Vista’s patients are Hispanic, of which approximately 45 percent are Spanish-only speakers and 40 percent are non-citizen immigrants. County workers are taking Medi-Cal applications at Vista clinic three times weekly. A clinic representative reported that there are 24 interview appointments each week and most applications are approved. Applications are taken primarily from undocumented persons who are applying for emergency or prenatal coverage.

**Community-Based Organizations (CBOs)**

Representatives from four community-based organizations provided information about the services they provide to the immigrant and refugee population. Catholic Charities operates two programs for immigrants and refugees: the refugee and immigrant services program and the welfare and immigration reform program. The refugee and immigrant services program operates four offices in the San Diego area for immigrant resettlement, and has administered the county Refugee Health Screening Program for 19 years. The agency serves about 1,500 to 3,000 refugees per year and about 15,000 immigrants per year, and assists immigrants with sponsorship, citizenship, visa petitions, status adjustment, and other immigration issues. The welfare reform program is responsible for administering one of six San Diego county regions’ CalWORKS programs.

With a start-up grant from the United Way, Catholic Charities founded the San Diego Language Bank (SDLB) in 1997 to train health care interpreters to help give limited English-speaking people equal access to health care. Currently the SDLB employs translators in 20+ languages. SDLB provides culturally- and linguistically-competent services to many San Diego area health plans, hospitals, and other service providers, such as Children’s Hospital and UCSD Health Care, one of six HMOs serving the Medi-Cal population, and participates in the California Health care Interpreters Association, an association attempting to standardize the licensing of health care interpreters. The SDLB is sustained by a grant from the United Way and through fees for services provided to various service providers.
The Alliance for African Assistance was established in 1989 in response to an “outcry from African people in San Diego that no services were targeting them,” according to an agency representative. The Alliance works primarily with refugees but also with immigrants. In 1998 it served 19,000 people. Its services include English as a Second Language (ESL) classes, citizenship classes, HIV/AIDS education, community building, mental health, and a health care providers referral program that also helps clients understand how to navigate the health system. This program also assists refugees applying for Medi-Cal. The Alliance became a resettlement agency in 1995.

Because there are no health clinics in San Diego operated by Africans, the Alliance plans on establishing a health clinic to provide culturally sensitive health care for Africans. The Alliance’s Board has approved the idea, and the Alliance is now seeking funding. To date, it is not clear whether the clinic will be operated as a free clinic or will also serve Medi-Cal or other insured patients.

The San Diego Urban League mainly serves newly-arrived African immigrants, but also works to mobilize the entire African and African American communities in San Diego. In 1998 the Urban League served approximately 2,000 people. For the past two years the Urban League’s New American Health care Initiative has been funded by the Alliance Health care Foundation to encourage members of the African community, primarily immigrants, to utilize available health care services. Community members have been employed as outreach workers to increase Medi-Cal and Healthy Start enrollment.

The Union of Pan Asian Communities (UPAC) is the largest human services agency for Asian, Pacific Islander, and other ethnic communities, serving more than 30,000 people annually. UPAC employs 104 bilingual and bicultural staff representing 27 languages and dialects. The health services programs UPAC provides include alcohol, drug and disease (cancer, heart disease, and HIV/AIDS) prevention programs, mental health services, and nutrition programs.

D. Characteristics of Immigrants Interviewed for this Study

Forty-six immigrants participated in focus groups or individual interviews during the San Diego site visit (see Table 2 of Volume I for complete participant demographics). Nineteen immigrants participated in focus groups and 28 immigrants participated in individual interviews. One focus group, comprised of six female immigrants from Mexico and one female from Guatemala, was conducted in Spanish by project staff. The second focus group, comprised of six females and six males who immigrated as refugees from Vietnam, was conducted in English by project staff and translated simultaneously in Vietnamese with the help of an interpreter from a community-based organization. Twelve individual interviews were conducted in English while the remaining 16 interviews were either translated in Spanish by project team members or in other languages with translators.

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30One immigrant was discovered to have participated in both a focus group and individual interview. She is not double counted in the total.
Sixteen females and one male came to the United States from Mexico,\textsuperscript{31} of whom ten immigrants entered the U.S. illegally and two have since become LPRs; three immigrants came as LPRs and one has naturalized; three immigrants came with temporary permission and one has become an LPR; and one immigrant was actually born in the U.S. but has lived in Mexico for long periods of time. Furthermore, there were seven female refugees and seven male refugees from Vietnam—nine of the Vietnamese participants are now LPRs and two have naturalized. From Somalia there were four participants: one female participant who entered the U.S. as an asylee and later attained refugee status, one female who had a temporary residence status that would change to LPR status after one year, and two male refugees. Four female refugees from Laos were interviewed—two of whom have since become LPRs. There were two females from China—one of whom was a refugee who later attained citizenship, and one who entered the U.S. as an LPR. Also included in the set of participants were two female refugees from Cambodia who have each attained LPR status, two male refugees from Sudan who have each attained LPR status, and one female parolee from Guatemala.

All participants in San Diego had received Medi-Cal benefits at some point in the past, except one male immigrant who had private insurance and is now covered by Medicare. Thirty immigrants reported that they and at least one of their children currently receive Medi-Cal, while two participants had private insurance for themselves and their children. Six of the 14 currently uninsured participants reported that only their children receive Medi-Cal, two reported that their children are covered by Healthy Families (California’s State Child Health Insurance Program), and two reported that their children were covered through a county-run program known as CHDP. Three participants reported that they recently lost Medi-Cal benefits for themselves and their children due to ineligibility or incorrect paperwork, and one participant applied for Medi-Cal for her children but was denied due to ineligibility.

Only six of the 47 participants reported being currently employed. Of these, three immigrants reported being involved in job training or skills classes, and ten female immigrants mentioned that their husbands are working.

IV. FINDINGS

A. Immigrants’ Ability to Apply for Medi-Cal

At the start of our research, we anticipated that immigrants’ ability to apply for Medicaid would be negatively affected by the enactment of the welfare and immigration reform laws of 1996. We quickly learned that the ability to apply for Medicaid is more complex and reflects, in part the particular state’s Medicaid eligibility policies adopted since the enactment of these 1996 laws and how these new policies are implemented. Our findings suggest three sets of issues affecting immigrants’ ability to apply for Medi-Cal in California: (1) the conditions of the coverage options for pre- and post-enactment immigrants chosen by California; (2) the implementation of the new Medi-Cal policies and the lack of

\textsuperscript{31}One married couple from Mexico was interviewed together—only the female is counted here.
outreach or education conducted by the state or county; and (3) the circumstances and conditions of the Medi-Cal application process that were affected by these changes.

As discussed previously, PRWORA transferred substantial authority to states to determine the public benefits for which immigrant groups are eligible. California stands as one of the few states opting for the most generous coverage for immigrants post-1996. In addition to continuing federally-funded Medi-Cal coverage to pre-enactment LPRs, California provides state-funded nonemergency Medi-Cal coverage to all post-enactment LPRs. California also has continued its practice of providing state-funded prenatal care for undocumented pregnant immigrants. In other words, Medi-Cal eligibility policies for immigrants have not changed due to the enactment of the 1996 laws: all legal immigrants in California remain eligible for Medi-Cal benefits regardless of their date of entry.32

As stated above, immigrants’ and refugees’ ability to apply for Medicaid or other health benefits is a function of a state’s Medicaid/CHIP eligibility policies largely adopted since enactment of the 1996 federal welfare law. Our findings suggest that other factors play a role in immigrants’ ability to apply, such as the Medicaid (Medi-Cal) and CHIP (Healthy Families) application process and caseworkers’ knowledge about Medi-Cal and Healthy Families eligibility. Thus, we found that some factors may be attributed directly to changes in the 1996 welfare and immigration laws and some factors are not a result of the 1996 laws. Each of these factors is discussed below.

Application Process

Steps Required in Determining Medi-Cal Eligibility

The actual steps required to determine eligibility for immigrants and refugees are identical to those required for citizens, except for proof of immigrant/refugee status. All applicants must first complete a pre-application screening process with clerical staff. Once the application is “cleared,” an appointment is scheduled with an intake worker. During the intake process the caseworker must verify income, property, housing, bank accounts, etc. Immigrant/refugee applicants must provide documentation verifying that they have a “green card,” I-94 for refugees/asylees with notice of action from the INS, rental contract for undocumented, or border crossing/Mexican visa. County officials reported that Medi-Cal fraud investigators conduct fact-finding investigations to determine residency. Following the investigations, fraud investigators give the information to the caseworkers (i.e., eligibility technicians) along with an eligibility recommendation. The caseworker is ultimately responsible for determining if residency requirements are met by evaluating the evidence, which includes information from the investigations. Some caseworkers commented that they would rather err on the side of caution by not denying the application based on questionable residency. Moreover, they added that the burden is on the Department of Social Services to prove non-residency of an applicant.

Applications taken from citizens and immigrants are automated. A computer provides prompts for completing the information and is updated with regulations and rules regarding eligibility. Unlike

32 California recently expanded funding for its CHIP program, Healthy Families, to extend coverage to LPR immigrant children regardless of their date of entry. This expansion apparently does not cover PRUCOL children, however.
applications taken from citizens or immigrants, refugee applications are processed manually. Caseworkers must determine eligibility manually by calculating, for example, the value of the applicant’s assets rather than rely on the computer to process eligibility automatically. County officials reported the refugee case error rate over the past two years is 12.8 percent.

**Language/Interpreter Services**

Availability of applications in languages other than English may impact on whether an immigrant is aware of Medi-Cal benefits for herself and her family and/or is able to complete a Medi-Cal application. Any negative impact may be mitigated by the automated processing of the Medi-Cal application, which aids the caseworker in completing the application with computer prompts.

In all counties of California, the Medi-Cal application is available only in Spanish and English. Additional materials about health care options (most probably choice of health plans) are provided in Lao, Spanish, Vietnamese, and Cambodian. The Healthy Families application is available in 13 languages.

Interviews are scheduled in consideration of the interpreters’ availability. The Kearney Mesa district office, for example, employs workers who speak more than 30 languages.

**Complexity of Medi-Cal and CHIP Applications**  

Despite outreach and training efforts, informants noted that the Healthy Families application process itself discourages citizens and noncitizens alike from applying for benefits. Even though the Healthy Families materials and application is translated into 13 languages countywide (including Spanish, Vietnamese, Laotian, and Farsi), many advocates believed the application for Healthy Families dissuades people from applying. Some commented that the Healthy Families application is far “too complex,” “confusing,” and a “dismal failure.” They reported that the complexity fuels immigrants’ fears about information being used to compromise their immigrant status. Also, as a consequence, it is believed that many applicants, including immigrants, are unaware that they qualify for Healthy Families after they complete the application since it is so complicated.

On the other hand, state and county officials emphasized that they have undertaken several efforts to reduce the complexity of application process for Medi-Cal and Healthy Families for all applicants, immigrants and citizens alike. For example, the state developed a mail-in application for pregnant women and children applying for Healthy Families. In addition, pursuant to legislation, the California Department of Health Services (DHS) is currently developing a mail-in application for the entire Medi-Cal population. The legislative initiative directs the DHS to implement the mail-in application

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33 County officials emphasized that the state—not the county—is responsible for developing applications in languages other than Spanish and English and providing applications to the counties. San Diego County does not have the authority to make any changes or modifications (which includes making available the application in other languages) to the Medi-Cal applications.

34 County officials clarified that the Healthy Families program is administered by the state—not by the counties. The County does not have the authority to make any recommended changes.
by the end of 2000. A state DHS official also noted that in addition to a focus on mail-in applications that the state has streamlined the application process in other important ways, such as simplifying requirements and eliminating questions wherever possible. Furthermore, San Diego County is working to streamline the Medi-Cal eligibility and enrollment processes. Toward this end, county officials noted the development of outreach activities to improve enrollment in Medi-Cal of persons (citizens and noncitizens) eligible for—but not yet enrolled in—Medi-Cal. These efforts include a collaboration between the County and health plans to conduct outreach to assist families in completing the Medi-Cal application. County officials also noted ongoing efforts to simplify eligibility processes, forms and notices to make it easier for families to obtain and retain Medi-Cal benefits. For example, the County encourages caseworkers to make phone contact with families during the re-determination process.

**Assistance in Applying for Benefits**

Resettlement agencies (i.e., Voluntary agencies or “VolAgs”) routinely assist refugees with the Medi-Cal application process. It is customary that a VolAg will schedule an appointment on behalf of the refugee and his/her family for an initial screening and intake. (A refugee who simply “walks in” to the office is referred to one of the VolAgs.)

Unlike refugees, immigrants must rely on help for applying for benefits from family members, friends, staff from community-based organizations and SNPs, or staff from district offices. Many Mexican immigrants felt that San Diego County caseworkers were often unfriendly and did not assist applicants to correct mistakes on their forms.

**Caseworker Workload and Attitudes**

Caseworker workload (i.e., caseload) and attitude also were acknowledged by caseworkers as factors that may impact applicants’ (citizens and noncitizens) actual receipt of Medi-Cal. One caseworker stressed that workload often dictates whether a caseworker will encourage applicants to apply for Medi-Cal. According to one caseworker, some caseworkers have the attitude, “I’m not here to sell these programs.” He added, “it is difficult to be compassionate if you are backlogged.” “A lot” depends on the individual caseworker.

**Where Immigrants Apply for Medi-Cal**

All immigrants in California, except refugees and asylees, use the same avenues to apply for Medi-Cal that citizens use. Non-refugees apply for Medi-Cal at one of 11 district offices located across San Diego County where citizens also apply. Refugees apply for Medi-Cal and other public benefits at a centralized location (called Kearney Mesa) in San Diego County described by one caseworker as the “United Nations” welfare office. Refugee intake was centralized in order to make efficient use of interpreters. It was reported that 37 percent of all granted cases at the Kearney Mesa district office are from immigrants who are non English-speaking. The annual number of Medi-Cal cases taken at this office is approximately 4,000 and, according to its welfare administrator, has remained “about the same” since enactment of federal welfare reform.
Factors Related to Federal Welfare and Immigration Laws

In addition to changes in Medi-Cal eligibility (discussed previously), caseworkers’ awareness of and knowledge about any changes in Medi-Cal eligibility for immigrants as a result of the 1996 laws would likely impact immigrants’ ability to receive the benefits to which they are entitled. Caseworkers may be informed about any changes in eligibility through training sessions, and issuance of guidance, rules or other memoranda. A lack of understanding (or misunderstanding) about eligibility would likely jeopardize immigrants’ ability to apply for benefits.

Eligibility Staff and Caseworker Knowledge of Reforms

Caseworkers’ awareness of and knowledge about any changes in Medi-Cal eligibility has improved since enactment of federal welfare and immigration reforms. Several caseworkers stated that following federal welfare reform there was an initial period of confusion and uncertainty about Medi-Cal eligibility policy but workers now have access to information to know whether to grant or reject an application. Caseworkers noted that they held on longer to Medi-Cal applications during the period immediately following enactment of federal welfare reform to ensure proper determination of benefits.

Generally, though, caseworkers reported receiving little training about Medi-Cal eligibility following welfare reform because California did not change its Medi-Cal eligibility policy. “Immigration status is simply not an issue in determining eligibility for Medi-Cal,” stated one caseworker. While caseworkers must participate in mandatory training sessions once each year, caseworkers apparently may choose from among various sessions; only the training in fraud prevention is required.

Factors Not Related to Federal Welfare and Immigration Laws

Several factors unrelated to the 1996 welfare and immigration laws impact immigrants’ ability to apply for Medicaid. These factors are considered unrelated to the laws because they either predated the enactment of the federal legislation or their impact is not limited only to immigrants. The discussion below underscores the importance of considering longstanding barriers to the Medi-Cal application process in addition to the restrictions imposed by the 1996 laws on eligibility for benefits. Moreover, it is not sufficient to consider only changes in eligibility or implementation of changes in the 1996 laws when assessing immigrants’ ability to apply for Medicaid.

Summary of Findings

Immigrants’ ability to apply for Medi-Cal in California is a measure of what eligibility options the state has adopted since enactment of the 1996 welfare and immigration laws. Additionally, immigrants’ ability to apply for Medi-Cal is affected by multiple factors that are not directly attributable to changes in the 1996 laws: language/interpreter services available during the application process, complexity of the application process, assistance in applying for benefits, and caseworker workload. In California, factors
unrelated to the laws largely account for any negative impact on eligibility since California elected to continue providing Medi-Cal to pre- and post-enactment LPRs and also has elected to continue its state-funded program for pre-natal benefits for undocumented pregnant women. In response to federal restrictions that limit immigrants’ ability to apply for Medicaid, California has opted to ensure that immigrants’ eligibility for Medi-Cal was unchanged by the 1996 laws. California continues Medi-Cal coverage for immigrants pre- and post- 8-22-96 and to undocumented resident pregnant women. In other words, eligibility itself is not a barrier to enrollment. Thus, it is important to consider factors not related to the 1996 laws when assessing the impact of the 1996 laws on immigrants’ ability to apply for Medi-Cal.

Despite continued eligibility, Medi-Cal enrollment has declined sharply for undocumented persons since enactment of federal welfare reform. Medi-Cal enrollment for undocumented persons has decreased by more than one third since August 1996.

Despite California’s options under the 1996 laws, Medi-Cal enrollment for legal immigrants has failed to keep pace with growth in caseload among citizens. Medi-Cal enrollment for legal immigrants has increased by 29 percent while enrollment for citizens has grown by 36 percent from May 1996 to April 1999.

While the experiences of refugees in San Diego in applying for Medi-Cal vary significantly, their disparate treatment is not a byproduct of changes in the 1996 laws. Public assistance for refugees (unlike other immigrant groups) is centralized. In addition, refugees have a built-in support network through the charitable organizations that resettle refugees. These organizations are actively involved in assisting refugees to apply for public benefits. The personal circumstances of refugees also differ from immigrants. They come to the United States with few possessions and money, making the eligibility process easier to complete. Thus, when considering the impact of the 1996 laws on immigrants it is important to distinguish between categories of immigrants because different eligibility rules apply to different classes of immigrants and the process of applying for benefits is vastly different. Refugees’ ability to apply for Medicaid is arguably made easier by having a centralized location where they apply for Medi-Cal and by having access to community organizations that assist them in the application process. Refugees, in comparison to other immigrant groups, seemed to have better access to Medi-Cal and greater knowledge of Medi-Cal. Refugees were almost without exception shepherded by community agencies through the entire Medi-Cal application process. Therefore, they tended to be more well-informed and knowledgeable.

B. Immigrants’ Willingness to Apply for Medi-Cal

The previous section focused on the factors underlying an immigrants’ ability to apply for Medi-Cal following enactment of the 1996 welfare and immigration law vis-à-vis the state’s Medi-Cal eligibility criteria and the Medi-Cal application process. This section explores the behavioral and environmental factors that may impact immigrants’ willingness to apply for the Medi-Cal benefits to which they are eligible.
Informants reported a number of factors affecting immigrants’ willingness to apply for Medi-Cal. Some of these factors are directly associated with welfare reform and some are independent factors. Factors associated with welfare reform and immigration reform include fear of public charge, fear of the INS, and misinformation about the 1996 laws. Independent factors include language barriers, transportation or childcare difficulties, inability to pay for care, and limited availability of Medicaid outstationed locations.

**Difficulty in Attributing Changes in Medi-Cal Caseload to Changes in Immigrants’ Willingness to Apply for Medi-Cal Benefits**

There is a difference in opinion among informants interviewed for this study whether immigrants’ willingness to apply for Medi-Cal has been impacted by federal welfare and immigration reforms. Data to support or dispute the impact of the welfare and immigration laws on immigrants’ willingness to apply for Medi-Cal is inconclusive, but suggests that immigrants’ willingness to apply for Medi-Cal may have declined slightly or, perhaps substantially, following enactment of the 1996 laws. Citing county data showing that immigrant and citizen enrollment in Medi-Cal since enactment (August 1996) of the welfare and immigration laws, (i.e., 14 percent increase for legal immigrants and 15 percent increase for citizens), one county welfare official suggested that welfare reform has not impacted immigrants’ willingness to apply for Medi-Cal benefits. A closer examination of the data, however, showed that the percentage change in enrollment is sensitive to the date range of analysis. Adjusting the time period of analysis over which changes in enrollment have occurred produced a different result. For example, selecting a date prior to enactment (e.g., May 1996) rather than August 1996 revealed that legal immigrants’ enrollment in Medi-Cal increased by 29 percent, while citizen’s enrollment over the same period increased by 36 percent. This seven-percentage point discrepancy might suggest an adverse impact of welfare and immigration reform on legal immigrants’ willingness to apply for Medi-Cal benefits.

Unlike the data on legal immigrants, the data on receipt of Medicaid by undocumented persons showed a clear and consistent pattern. In the months immediately preceding passage of the 1996 welfare and immigration laws, the number of undocumented persons enrolled in Medi-Cal increased each month, albeit by a small increase (two to three percent). Beginning in August 1996, the number of undocumented persons enrolled in Medi-Cal began to decline, and has declined in each subsequent month. Overall, undocumented immigrants’ enrollment in Medicaid has declined by more than one third. At the same time there is no evidence to suggest that the declining caseload is due to a corresponding decline in the number of undocumented immigrants living in San Diego.

There are limited data collected on immigrants’ receipt of Medi-Cal from other sources, thus making it difficult to attribute changes in the 1996 laws to changes in immigrants’ willingness to apply for Medi-Cal benefits. Health care providers, such as health centers and hospitals, do not ask patients about their immigration status in order to protect themselves from the reporting requirements in the 1996 law, which requires the reporting of persons who are known to be unlawfully residing in the U.S. to the INS. Health care providers rely instead on their aggregate patient payor mix or anecdotal experiences as indicators for the effects in changes in law on immigrants’ willingness to apply for Medi-Cal.
Anti-Immigrant Public Sentiment

Before describing the factors that affected immigrants’ willingness to apply for Medi-Cal it is important to consider the local environment in which the 1996 laws were implemented. Local factors that pre-date enactment of federal welfare and immigration laws are important to consider because they create an environment that may either promote or discourage participation in public benefits among immigrants.

Arguably, anti-immigrant sentiment across the nation—which was most visible in California—contributed to the federal retrenchment in public assistance to immigrants under the 1996 laws. While anti-immigrant sentiment was present before enactment of the laws it is inexorably tied to the 1996 laws. Moreover, anti-immigrant sentiment continued after enactment, but has since abated considerably.

Two years before the federal debate over welfare and immigration reform Californians were engaged in a public debate over what public benefits should be granted to undocumented persons. California’s anti-immigrant public sentiment might explain, at least in part, why Medi-Cal caseloads among undocumented persons in particular began to decline, even though Medi-Cal eligibility for undocumented persons did not change over this period.

Most representatives of community agencies and safety net providers believed that during Governor Wilson’s administration, anti-immigrant sentiment in California was a factor that discouraged some immigrants from obtaining public benefits; some informants reported that they believed anti-immigrant sentiment was worse in San Diego than in other parts of the state. However, some noted that in the past year the attitude toward immigrants has improved, perhaps due to the change in administration. An example given of the changing attitude is that Kosovar refugees are being greeted kindly, and that the Deputy Mayor recently said San Diego is proud of its diversity. One representative from a community-based organization believed that recent articles about immigrants in the media have been less numerous and more positive. These are signs of changing times, he said. He characterized the recent changes as a “drastic swing” toward acceptance of immigrants.

In addition, anti-immigrant sentiment was heightened by stories circulating that individuals are receiving costly procedures, such as heart transplants, at the expense of U.S. citizens. Whether due to a growing economy or the new political administration, advocates generally agreed that now the San Diego County Board of Supervisors had become “less militant” about Medi-Cal fraud and were trying to be more “user-friendly.” This, they reported, was helping to ease the anti-immigrant sentiment that immigrants experience.

Factors Related to Federal Welfare and Immigration Reform Laws

Factors related to the 1996 laws include Medi-Cal fraud investigation efforts, efforts to discourage undocumented persons from applying for public assistance, fear, and misinformation about the laws.
Medi-Cal Fraud Investigation Efforts

Several anti-fraud activities implemented during the Wilson Administration were challenged in court: the Border Crossing Project, and the Port of Entry Detection (PED) and California Airport Residency Review (CARR) operations. In the Border Crossing Project the California Department of Health Services teamed with INS agents and targeted Hispanic women who were pregnant or had small children and were crossing into the U.S. from Mexico. Agents checked the women for Medi-Cal cards and border crossing cards, which allow people to cross the border for 72 hours at a time. The agents used a border crossing card as evidence that the women were not residents of the U.S. and, therefore, were not eligible for Medi-Cal. The women were reportedly asked to sign a declaration of non-residence, which effectively made them ineligible fore Medicaid.

A lawsuit was filed challenging the Border Crossing Project. In the case, Latino Coalition for a Healthy California v. Belshé, advocates challenged a state DHS unpublished regulation which said that immigrants who had border crossing cards had to be denied Medi-Cal as non-residents of California, even if they could provide that they did reside in California. The Latino Coalition was successful in overturning the policy that denied Medi-Cal to resident immigrants who possessed border crossing cards. (As was discussed previously, certain persons who are in California illegally are eligible for some Medi-Cal benefits (e.g. prenatal and emergency benefits).  

In the PED/CARR projects, agents targeted immigrants for interviews after they arrived at the San Diego U.S. Mexico borders and at the Los Angeles and San Francisco airports. Information from the interviews was gathered to uncover Medi-Cal fraud and to require repayment of benefits received wrongly. According to one informant, the immigrants also were sometimes denied entry and/or had their immigration documents (e.g., border crossing cards or green cards) confiscated.

The San Diego Friends of Legal Aid filed suit in federal court, Rocio R. v. Belshé, over the repayment policy. The case was settled. Under the settlement agreement the California Department of Health Services is refunding payments made after March 19, 1996. To date, DHS has repaid over $2 million of the $4 million the state unlawfully collected. The PED/CARR operations ceased on April 1, 1999, following a California State Auditor report, which found that the programs were not cost effective.  

From 1996 until recently Medi-Cal fraud investigators conducted investigations of Medi-Cal applicants’ homes as part of state efforts to decrease Medi-Cal fraud. According to a state investigator,

35 A contempt order was issued against the Department of Health Services for failure to comply with the order to restore prenatal and emergency care to undocumented immigrants. According to a Latino Coalition press release, DHS was required to notify all counties to reverse the policy of denying Medi-Cal to holders of border crossing cards; direct counties to restore benefits; and publicize the case and the availability of benefits. The court order compelled immediate compliance. “Court finds state in contempt for failing to correct Wilson-era policy affecting 5,000 undocumented immigrants,” Press release, Latino Coalition for a Healthy California, 1999.

the project began as a pilot in 1996 at the El Cajon district office of the San Diego County Department of Social Services. The pilot was conducted to determine, if prior to granting a Medi-Cal application for benefits, that the information on the application was correct and verifiable. A DSS eligibility supervisor randomly selected one out of every five new intake applications in which no fraud was suspected. Field investigators received the random referrals and conducted field investigations to look for discrepancies. A state investigator reports that over 50 percent of the random referrals contained discrepancies and 30 percent had discrepancies that resulted in total ineligibility. The pilot was conducted for approximately one year and expanded to three additional DSS district offices. The investigators found that nonresidency, unreported assets and unreported DSS district offices were major issues in each of the district offices.

There are conflicting reports about the investigators and the scope of their investigations. A clinic administrator called the Medi-Cal investigators a “huge army… who intimidate people, go in their homes… carry guns and show badges.” She said that the investigators were reportedly worse in the central area of San Diego County and in the South Bay. But, she added, the horror stories reach the northern communities and deter immigrants all over San Diego from applying for Medi-Cal. A state investigator countered these claims, however, reporting that there are only 22 investigators covering two counties; of these, 10 investigators are assigned to fraud prevention and make routine homecalls. Moreover, according to a state investigator, 60 percent of the investigators are female and predominantly Hispanic. The project was terminated in April 1999 due to staffing shortages.

Welfare Office Posters

Following passage of federal welfare and immigration reform, San Diego responded aggressively and visibly to discourage undocumented persons from applying for public benefits. Posters intended to discourage undocumented persons from applying for public benefits appeared in welfare offices across San Diego County after passage of federal welfare reform. County officials reported that the intent of the posters was “to inform the public based on the expectation in the welfare reform law that the county do so.” Several informants justified the presence of the posters precisely because of federal welfare reform. These posters were perhaps a reflection of the anti-immigrant public sentiment in California. No other county in California adopted such visible measures.

San Diego County placed posters at county welfare offices to alert immigrants that the county is authorized to give information to the INS. The first version of the poster did not specify the programs for which the county reserves the right to give information to the INS. It read:

“Federal law now permits confidential information to be released to the INS by Government agencies providing federal benefits. The law allows the name, address and other identifying information of any person known to be unlawfully in the U.S. to be given to the INS. Information about persons unlawfully in the U.S. can be given to the INS at least four times a year or whenever requested by the INS.”

County officials reported that the previous version of the poster had recently been changed when the County changed its policy in accord with state policy not to report information to the INS.
from Medi-Cal applications. The warning about giving information to the INS applies to cash aid and food stamps only. Medi-Cal is exempt from disclosure to the INS. The revised poster read:

“The Federal law now authorizes the county to give immigration status information about public benefit programs to the INS. If you or your family members are receiving benefits from the CalWORKS, Food Stamp, or General Relief programs or apply for benefits from these programs, immigration status information for undocumented adults living in your home may be given to the INS. Persons who apply for or are receiving Medi-Cal will not be reported to the INS.

The information on the posters was also included on a flyer that is included in the Medi-Cal application materials provided to an applicant during the initial screening.

The posters were again replaced in February 2000. The new poster encourages the public to apply for Medi-Cal and Healthy Families, confirms that all information is confidential, and clarifies that receiving Medi-Cal or Healthy Families does not make recipients a public charge with the INS. The new poster states:

Children and their families who live in San Diego County may be eligible for free or low cost health care. You may apply here for Healthy Families or Medi-Cal. By State law, information about people who apply for Healthy Families or Medi-Cal for themselves or their children is confidential. Healthy Families or Medi-Cal will not ask you to pay back benefits for which you are eligible. There is a new rule on “public charge.” Now, getting Healthy Families or Medi-Cal will not make you a public charge with the Immigration and Naturalization Service (“INS”), unless you receive long term care (this means being in a nursing home or hospital for a long time).

The existence of warning posters was widely recognized by California Medi-Cal officials and San Diego advocates to discourage immigrants from applying for public benefits, including Medi-Cal, despite the addition of the Medi-Cal exception. One community agency administrator said that the fraud investigators reflect the “vigilant and conservative” nature of San Diego County officials and their commitment to restricting Medi-Cal use. Caseworkers noted that undocumented immigrants from Mexico have questioned the posters and the caseworkers have advised the immigrants to seek counsel from their immigration lawyers. Caseworkers reported that some immigrants have not completed the application because of the implications of their status and some have taken the benefits regardless. Furthermore, many informants viewed the posters to be misleading because unless they are read carefully it is difficult to understand county policy not to report Medi-Cal applicants’ information to the INS. Despite the warning posters and flyers, caseworkers and administrators said that they have not reported any immigrants to the INS. 37

Fear

37 The observations made by informants about the posters refer only to the first two versions. The most current version of the poster was developed after the site visit.
An undercurrent of fear was evident among immigrants, particularly undocumented immigrants, in San Diego. They fear INS agents, anti-fraud investigators, and becoming a public charge. Given San Diego’s proximity to Mexico, the presence of INS agents is not a new phenomenon. However, some representatives of safety-net providers believed there was a stronger presence of INS agents in San Diego County since passage of the 1996 welfare reform and immigration laws. San Diego intensified its anti-fraud efforts following the 1996 laws. Medi-Cal anti-fraud investigators (who carry guns) became an additional visible threat to undocumented immigrants. Fear of public charge was uniquely a by-product of federal welfare reform. Most representatives from safety-net providers and community-based organizations attributed immigrants’ reluctance to apply for Medi-Cal to a fear of becoming a public charge.

Many immigrants were misinformed or confused about the issue of public charge and were discouraged from applying for Medi-Cal for themselves or their children because of the fear of having to pay back benefits, or being denied changes in immigration status because of the use of Medi-Cal. At least two immigrants had been advised by their lawyers not to apply for Medi-Cal for their citizen children because of the threat of public charge. One participant whose children had recently been dropped from Medi-Cal due to her failure to submit required paperwork commented that she does not plan to reapply. She stated that although she does not fear the INS or deportation when considering to apply for Medi-Cal, she does fear that applying for Medi-Cal for her children would jeopardize her hopes of attaining LPR status.

Many informants believed INS activity was a deterrent for legal and undocumented immigrants to seek Medi-Cal benefits. One advocate reported that there are immigrants who believe the INS will detain anyone who does not have their papers with them when they are approached. Another informant reported that many citizens who have undocumented family members are fearful to access services because of the threat of investigation into their homes. One administrator described that she herself, as an American-born Hispanic person with two Master’s degrees, feels nervous if she is dressed casually in airports or around INS activity because she is fearful of being approached and not having the papers to convince INS agents of her citizenship.

Similarly, it was reported that after welfare reform Medi-Cal fraud investigators would occasionally visit clinics wired with hidden recording devices to monitor clinic staff and what they tell patients about their immigration status or their potential eligibility for Medi-Cal. It was also reported that clinic patients who applied for Medi-Cal at some clinics were often “grilled heavily” by fraud investigators and intimidated. Fraud investigators are separate from INS agents, but providers and community workers frequently do not distinguish the two groups. Clinic staff viewed both activities as creating an environment suspicious of immigrants which immigrants try to avoid. Some safety net

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38 A state investigator was careful to note that the mission of the INS is “totally different” than that of California Department of Health Services (CDHS) investigators. The role of CDHS investigators is to investigate fraud and abuse in the Medi-Cal program. The INS is focused on alien smuggling and identification of imposters.

39 A state investigator points out that CDHS investigators wear business/business casual attire and carry concealed weapons, a badge and credential to identify themselves. CDHS investigators are sworn peace officers and must meet rigid standards as mandated by Peace Officers Standards and Training.
providers reported that intimidation on the part of Medi-Cal fraud investigators and INS agents is a big factor in immigrants’ willingness to apply for Medicaid in San Diego.

In response to the above characterization, a state investigator reported that “certain clinic and hospital employees have coached nonresidents into making false statements in order to be eligible for Medi-Cal…” In one such case in the 1990s, the coaching of a clinic employee was tape recorded. After the incident CDHS investigators relayed that this type of coaching was unacceptable. The CDHS investigations unit provides training to address fraud concerns and what constitutes coaching. Since 1997 the CDHS has assisted in the training of more than 1100 hospital personnel. A state investigator attributed a reduction of coaching complaints to ongoing training and education efforts.

Providers believed immigrants are fearful of the public charge issue and stated that although the California court overturned the rule demanding that immigrants pay back their benefits, concerns over public charge and INS activity along with media attention on these issues combine to confuse the public about Medi-Cal eligibility. One informant stated, “we ourselves are not 100 percent sure of what is and what isn’t public charge.”

Some representatives of community-based organizations that arranged interviews with immigrants for this research project reported that many immigrants were simply not willing to speak about Medi-Cal. In some cases they claimed they wanted to avoid trouble with the government and were concerned about losing their benefits. Most informants agreed that for some these fears discourage immigrants from applying for benefits. For others, their need for health care benefits takes precedence over their fear of government reprisals.

While most Mexican immigrants interviewed were not generally intimidated by the INS or the threat of deportation, many commented that the application process for Medi-Cal was more difficult to complete now than in the years prior to 1996, and the addition of more questions about immigration status made them uncomfortable to apply even for their citizen children. One woman described, “I have a friend… She tried to get the Medi-Cal for her children but on the application there is a statement that says that the information given will be reported to the INS, so she didn’t finish. Before, her children would automatically get Medi-Cal, but when she went to renew and saw that statement, she didn’t anymore. Now they’re all without Medi-Cal.”

**Misinformation about the 1996 Welfare and Immigration Laws**

Representatives of safety net providers and community-based organizations believed that there is not a clear understanding in the San Diego community about how Medi-Cal eligibility and immigration policy were impacted by the 1996 welfare and immigration laws. Many informants reported that the main reason immigrants do not take advantage of public benefits is misinformation. They reported that steady educational efforts in communities have offset the initial effects of changes in law. However, while some agencies believed immigrants were made aware of their entitlements, most believed that misinformation is still a major cause of immigrants not applying for benefits.
Immigrants’ method of communication may offer a possible explanation for continued misunderstanding and the spread of misinformation about Medi-Cal eligibility. Most Mexican immigrants reported that the main source of information about Medi-Cal and immigration-related issues is “word of mouth” and “friends and family.” One immigrant whose children had lost Medi-Cal reported that she was reluctant to re-apply because of the possible threat to her immigration status, even though her social worker at the community-based organization had tried repeatedly to reassure her that it was okay for her to access Medi-Cal for her children. The rumors she had heard about public charge issues were more convincing to her than the advice of the social worker.

Many representatives of community based agencies and safety net providers noted INS activity was a factor that deters immigrants from seeking Medi-Cal and health care services. Some said the INS is very active and visible and cited that they are present at bus stops, in the parking lots of clinics, at airports, and even in local shops. Clinic administrators reported immigrants skipping appointments at the clinic and later explaining that they saw an INS agent near the clinic or on the way to the clinic. Some reported that INS public visibility is, in part, due to the fact that it now performs tasks it previously allowed non-government agencies to perform, like fingerprinting as part of citizenship applications.

In most cases, aside from the two examples cited above, the Mexican immigrants interviewed were willing to apply for Medi-Cal for their citizen children regardless of their own immigration status. Participants commented that although they feared the public charge issue and problems with being reported to the INS, they would not compromise the health of their children. Also, most female Mexican interviewees had received Medi-Cal coverage during their pregnancies and immigration status or fear of public charge did not affect their willingness to apply for the special coverage.

Factors Not Related to the 1996 Welfare and Immigration Laws

While health and social service providers identified public charge as the most important factor in discouraging immigrants from applying for Medi-Cal, immigrants and others serving immigrant populations identified other factors that are not related to federal welfare and immigration reforms. These include inability or limited ability to speak English, childcare and transportation, limited availability of Medicaid outstationed locations, and inability to pay for Medi-Cal benefits. These barriers are not restricted to immigrants but are common barriers (well documented in the literature) for low-income persons generally.

Language Barriers

Nearly everyone interviewed who works with immigrants believed that the inability (or limited ability) to speak English affects immigrants’ willingness to apply for Medi-Cal and seek needed health care services. Most stressed that the use of a good translator is imperative for an immigrant to succeed in negotiating the Medi-Cal application process and understanding how to use Medi-Cal services. Advocates reported that, generally, immigrants who do not speak English or Spanish experience language as a barrier.
The Kearney Mesa welfare office is the preferred welfare office recommended by people who work with immigrants because it has translators in many languages on staff and is accustomed to working with people who cannot speak English well.

Many refugees interviewed commented that problems with the language were the biggest barriers to accessing Medi-Cal. Although some forms were available in other languages, the translations were often confusing or incomplete, and refugees did not feel there were enough staff available at Medi-Cal offices to help them in languages other than Spanish.

Language was not a barrier reported for most Mexican immigrants interviewed in San Diego because participants stated that Medi-Cal materials were available in Spanish and there were caseworkers who spoke Spanish as well. However, some participants reported that there were caseworkers who frowned upon immigrants who could not speak English and many times immigrants are intimidated and “are afraid to ask questions and don’t know there are people who speak Spanish.” One woman explained that because she is illiterate in both Spanish and English and does not speak English, it is very difficult for her to navigate the Medi-Cal application process for her citizen child. She used to live in Los Angeles where she said caseworkers would help her with her forms, but she said county workers in San Diego were unwilling to help her and told her she should learn English.

Transportation and Childcare Barriers

Some informants believed that it is difficult for immigrants to apply for Medi-Cal because welfare offices are often a great distance from most immigrants’ homes. Transportation must be arranged, and community agencies reported sometimes providing transportation. Those working with immigrants believed immigrants generally have friends and relatives take them to the welfare office. One representative of a community agency said that childcare is an issue because immigrants cannot afford to pay to have their children taken care of while they travel to a welfare office. The same difficulties were mentioned when informants discussed immigrants’ difficulties accessing health care services (described later).
Limited Availability of Medicaid Outstationed Locations

Alternative locations where immigrants and citizens may apply for Medi-Cal in San Diego are limited. For example, one eligibility worker from the Kearney Mesa District Office spends a half-day per week at each of four clinics, including the Linda Vista clinic and the AIDS and Drug Assistance Program of the Department of Health. In addition, at Logan Heights, the largest safety net provider in San Diego, the amount of outstationing varies by site from no outstationing at some sites up to two half-day visits per week by Medi-Cal eligibility workers at other clinic sites. Staff from several San Diego area clinics indicated that they would like to do more outstationing and believe the need is great. However, clinic representatives reported San Diego County is unwilling to contribute the necessary resources to provide more extensive outstationing.

Providers, community agencies, and county officials agreed that more extensive outstationed enrollment would be beneficial for immigrant Medi-Cal enrollment. One caseworker who processes Medicaid applications at both a welfare office and one day each week at a clinic remarked that the outstationed site is “friendlier” and “less intimidating” than the local welfare office.

Inability to Pay

Certain Medi-Cal recipients with sufficient income pay a share of costs before Medi-Cal covers their yearly health care expenditures. A couple of immigrants interviewed reported that they do not use their Medi-Cal coverage when they access health care services because they cannot pay their share of costs. Instead they seek free treatment or pay sliding-scale fees. These people were recent refugees and feel they are being treated unfairly.

Summary of Findings

Immigrants’ willingness to apply for Medi-Cal is likely due to a combination of factors rather than only to the most often cited reason: fear of public charge. Anti-immigrant public sentiment in San Diego clearly played a role. Anti-fraud efforts were far-reaching and highly visible: at homes, in airports, at border crossings, and in welfare offices. While these initiatives have since been terminated, they illustrated the public mood during the time prior to and nearly two years following federal welfare and immigration reforms. It is reasonable to conclude that the federal welfare and immigration laws contributed to—and perhaps intensified—anti-immigrant sentiment in San Diego.

Other factors independent of the federal welfare and immigration reform laws also play a role in immigrants’ willingness to apply for Medi-Cal. These factors include: language barriers, difficulties in arranging transportation and childcare to apply for benefits, and inability to pay share of costs. While these factors should not be overlooked, immigrants in California appeared to be influenced more negatively by factors associated with the 1996 welfare and immigration laws. As these negative factors

40 California’s share-of-cost program is a component of its medically needy and medically indigent programs. Under the share-of-cost program, an individual must pay for his/her medical expenses until the amount of medical expenses meets a certain amount, determined by the individual’s income. Greater income requires a greater share of cost.
dissipate, however, greater attention ought to be focused on the factors that are not related to the welfare and immigration laws but that nonetheless present formidable barriers to applying for Medi-Cal or other public benefit programs.

It is difficult to disentangle direct effects of welfare and immigration reform from other environmental factors (most notably anti-immigrant public sentiment) on immigrants’ willingness to apply for Medi-Cal. The ballot initiatives that preceded welfare reform (i.e., Prop 187 and 209) which restricted access to public benefits and limit affirmative action in public schools illustrated the anti-immigrant public sentiment characteristic of the Wilson administration. Most informants noted that anti-immigrant public sentiment has dissipated with the election of Governor Davis.

Immigrants’ were reluctant to apply for Medi-Cal because of fear. Immigrants feared becoming a public charge and the INS. Many immigrants expressed concerns about the government and their immigration status. Additionally, most informants interviewed for the study cited public charge as the single most significant deterrent to applying for Medi-Cal.

Aggressive anti-fraud measures adopted by state and county officials discouraged immigrants from applying for Medi-Cal. There is widespread agreement that the Medi-Cal fraud investigators in operation until April 1999 were likely mistaken for INS agents and, as a result, deterred immigrants from applying for benefits. Furthermore, posters and flyers distributed at welfare offices notifying applicants that they (or their family members) may be reported to the INS were likely discouraging applications from families with undocumented household members.

There is consensus among representatives of safety net providers that people feel most comfortable applying for Medi-Cal at community health centers. San Diego offers immigrants limited opportunities to apply for Medi-Cal at locations other than local welfare offices. Clinics are more convenient, and immigrants can avoid the unease they feel in government spaces, including welfare offices.

C. Immigrants’ Ability and Willingness to Seek Primary Health Services

This section explores whether immigrants’ behavior changed in seeking health care services in the aftermath of welfare and immigration reform. The discussion focuses on whether immigrants have changed their patterns of health care seeking behavior (i.e., where and how often they seek primary care) and the reasons why. Informants and immigrants identified several reasons why immigrants might not seek primary care. Some of these factors are attributable directly to the 1996 welfare and immigration laws (e.g., fear of public charge) and some of the factors are unrelated (e.g., undervalue regular health care, difficulty in navigating Medicaid managed care). On the other hand, cultural and language competency on the part of providers appears to positively impact immigrants’ willingness to seek primary care services. Some factors that might appear to be unrelated to welfare and immigration reform (e.g., inability to pay for care) may be an indirect consequence of the 1996 laws. Immigrants’ ability and willingness to seek primary health services is, at least in part, related to their ability and willingness to enroll in Medi-Cal.
Patterns in Primary Care Seeking Behavior

Health care providers did not report any knowledge about immigrants changing where they seek health care. Some providers did note that their third party payments have shifted slightly away from Medi-Cal to uninsured/self payment. This could mean that in some cases patients may be less likely to be enrolled in Medi-Cal but are still using their same physicians. Providers have insufficient data to conclude whether the increase in uninsured patients is attributable to an immigrant population who may be eligible—but unwilling—to apply for Medi-Cal coverage because health care providers do not know the immigration status of their patients. Thus, while it appears that immigrants have not changed where they go for primary care their frequency of seeking primary care may have been negatively impacted by changes in the 1996 laws or other factors.

Factors Related to the 1996 Welfare and Immigration Laws

Three factors related directly to welfare and immigration reform emerged as possible explanations why immigrants do not seek primary health care: fear of public charge, presence of the INS at clinic sites, and misunderstanding about the 1996 laws. A fourth barrier, inability to pay, could also be a consequence of welfare and immigration reform.

Fear

Health care providers believed public charge is the foremost deterrent to accessing primary care services. Fear of public charge was noted by two Mexican immigrants as the particular reason for not applying for Medi-Cal, but did not discuss whether public charge prevented them from seeking health care. Other immigrants interviewed for the study did not identify fear of public charge as an issue.

One clinic administrator reported that immigrants are aware through word of mouth about which clinics will continue to see them and not report their immigration status to the INS.

Some informants reported the presence of the INS at clinics frequented by immigrants, especially by undocumented persons. Informants noted that frequently there is INS presence near a clinic known to serve undocumented persons and that this dissuades immigrants from using the clinic. There are reports that immigrants who are already inside the clinic have gone without care once they realized the presence of the INS.

Misunderstanding of 1996 Laws

One representative of a community-based agency believes immigrants’ use of primary care services in San Diego decreased immediately after federal welfare law passed because of a lack of understanding of the law. However, it is this informant’s belief that since then the use of primary care services has improved due to the educational efforts of community agencies.
**Inability to Pay for Health Care**

Although most immigrant parents were willing to seek primary care services for their children regardless of any external factors, they were less willing to go to doctors for themselves. The most frequently reported deterrent to seeking primary care reported by immigrants was the inability to pay for care. One Mexican immigrant who was undocumented commented that she has not needed to see a doctor recently, however, “I don’t know what I’m going to do the day I need one because we still can’t go to Tijuana for a doctor, so we would have to go here to a hospital and pay. I had to be operated on four years ago for my gall bladder and I am still paying for it today.” This could, in part, be attributed to the lack of access to Medi-Cal coverage, either because of ineligibility or reluctance to apply, which in turn likely affects their ability to pay for health care services.

**Factors Not Related to the 1996 Welfare and Immigration Laws**

We identified four factors unrelated to welfare and immigration reforms that offer possible explanations why immigrants do not seek primary care: (1) undervaluing preventive care, (2) using alternative sources of care, such as use of home remedies, or traveling to Mexico for care; (3) cost of care; and (4) difficulty in navigating Medicaid managed care. In contrast, perceived cultural and language competence of providers appeared to positively affect immigrants’ willingness to seek primary care.

Informants stressed that immigrants believe health care access is a high priority. This sentiment was echoed by welfare office caseworkers, who agreed that at welfare offices immigrants were most interested in applying for health care benefits.

**Undervaluing Preventive Care**

Notwithstanding immigrants’ expressed interest in access to health care, health care providers and advocates believed also that immigrants as a whole do not uniformly value primary and preventive care, with the possible exception of prenatal care. There is the impression that immigrants are just trying to get by in the U.S. and need encouragement to seek preventive health care services. The Women, Infant and Children’s program (WIC) and other similar programs have served as springboards for immigrants to access health care. Some believed that most immigrants only seek care if they really need it. It is believed that immigrants wait for something to happen before they go to the hospital.

**Cost of Care/Inability to Pay**

Providers and immigrants also noted that immigrants do not seek care because of the cost of primary and preventive health care services.

**Seeking Health Care in Mexico**
As an alternative to seeking health care in the U.S., it is reported that each month 250,000 Mexican immigrants in the San Diego area cross the border back to Mexico for medical care, dental care, and pharmaceuticals. Many Seasonal Agricultural Workers (SAWs), for example, travel back and forth to Mexico because their citizenship status allows them greater mobility. A clinic administrator in San Diego said more immigrants would return to Mexico for health care if they could. She said immigrants like to return to Mexico because they feel safer there, but also because they can access less expensive care to which they are culturally accustomed. One informant noted that her elderly American-born Mexican-American aunt travels 800 miles by bus to visit the dentist and a spiritual healer in Mexico.

Many immigrants from various countries of origin discussed alternatives to seeking primary care services in San Diego, such as the use of home remedies for illnesses or travelling to Mexico for care. Southeast Asian participants spoke about using traditional herbal treatments that they often preferred to try before seeking primary care services. For Mexican participants, the use of home remedies was less an issue of preference, but more due to the inability to pay for care. Many immigrants from Mexico described how a common practice is to go to Mexico for medical care or for pharmaceuticals that can be obtained in Mexico without prescriptions. In cases where one’s immigration status does not allow permission to leave the U.S., interviewees noted that people often send for medications from Mexico to be delivered by others who have permission to cross the border. It is not clear, however, whether immigrants’ use of home remedies or travelling to Mexico has increased since welfare and immigration reforms.

**Difficulty in Navigating Medicaid Managed Care**

Many refugees and also other immigrants who received Medi-Cal complained about the hassles of Medi-Cal managed care, and felt that the new program was too restrictive. Many immigrants reported changing doctors and traveling long distances to access primary care services with network providers. The increased amount of paperwork, lack of freedom to switch providers, and general hassles of managed care reportedly hindered the ability of the participants to access primary care and specialty services.

**Cultural and Language Competency**

Unlike the previous examples that illustrate factors that act to discourage immigrants from seeking primary care services, provider competencies in culture and language appeared to positively influence immigrants’ willingness to seek primary care services. Providers interviewed believed immigrants use physicians with whom they can communicate and that are located in immigrant communities. Ostensibly, providers in immigrant communities can both speak the language and provide culturally-appropriate services.

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41 [www.sandag.cog.ca.us](http://www.sandag.cog.ca.us)

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Providers explained also that immigrants use physicians recommended by others in their community; they are providers who are trusted in the community. Clinic representatives believe that many immigrants prefer to frequent local private practice doctors instead of clinics because they are less comfortable in institutional settings.

**Summary of Findings**

Multiple factors related and unrelated to welfare reform influence whether immigrants seek primary health care services. Factors not associated with the 1996 laws may, in fact, more negatively impact immigrants’ willingness to seek primary care services. Parents may be the group most at risk for not receiving the primary and preventive health care services they need.

General access barriers, especially language, are prominent barriers to immigrants’ receipt of health care. Immigrants rely heavily on translators to apply for Medi-Cal and communicate with health care providers. Perceived quality of care and use of health care varies with immigrants’ ability to overcome common general access barriers.

Ability to seek specialty care is impaired by a perceived lack of specialty providers who speak in the immigrants’ native languages. Several immigrants, most notably among nonEnglish/nonSpanish-speaking immigrants, reported significant barriers to specialty care. They reported great difficulty in accessing specialty care (e.g., making appointments, communicating with a physician) because of the inability of the specialty provider to communicate in the immigrant’s native language.

Cultural and language competence of providers appears to positively influence immigrants’ willingness to seek primary care services. Providers interviewed believed immigrants use physicians with whom they can communicate and that are located in immigrant communities. Moreover, these are trusted sources of care.

**D. Immigrants’ Ability and Willingness to Seek Emergency Health Services**

The 1996 welfare and immigration laws did not alter immigrants’ eligibility for emergency services. Immigrants who are federally ineligible for nonemergency services may nonetheless be eligible for emergency Medicaid if they are otherwise eligible (i.e., they meet federal/state guidelines for eligibility, such as income, deprivation requirements, etc.); simply being an immigrant does not qualify an individual for emergency Medicaid. This section discusses factors related and unrelated to the 1996 laws that impacted immigrants’ ability and willingness to seek emergency services.

**Factors Related to 1996 Welfare and Immigration Laws**

**Fear**

Some Mexican residents reported delaying seeking emergency care services for themselves because of a reluctance to face questions about immigration status. One undocumented immigrant from
Mexico described how two months ago she had become ill and went to the emergency room after much hesitation because she was afraid of encountering the INS. She stated, “I had a problem. I had to go to the hospital but I didn’t want to go… I didn’t even have any money to go to the clinic… I didn’t want to go, I just wanted to feel better. The fear that I had, it went away because I was so sick.” Mexican immigrants stated that hospital emergency rooms tended to ask more questions about immigration status than community-based clinics and this was a disincentive for seeking emergency care. Overall, while fear delayed emergency treatment, immigrants eventually sought emergency care.

According to one clinic administrator, the 1996 welfare and immigration laws, coupled with anti-immigrant sentiment and increased INS presence, had an adverse impact on the number of pregnant women seeking prenatal care shortly after the laws were implemented. A hospital administrator stated that after welfare reform the number of “no care” pregnant women rose dramatically and more immigrant women delivered babies in emergency care settings than before. She said that at one point following the 1996 welfare reform laws, there were 80 women per month delivering babies in the emergency room. This number dropped to approximately 15 emergency deliveries per month and then rose again to almost 30 per month. As of Spring 1999, the number at this facility was about 10 emergency deliveries per month. The administrator attributed the changes to the fact that initially after Proposition 187 and then after welfare reform in 1996, the INS was threatening that immigrants would have to repay the amount of any benefits used. However, there is the opinion now that the vigilance of the INS has receded on this issue and that women feel safer accessing prenatal care.

According to immigrants interviewed nearly two years after enactment of the welfare and immigration reforms, the 1996 welfare and immigration reform laws did not impact their willingness to seek emergency care services when they feel it is an emergency. Most immigrants’ comments resonated with the words of one Mexican immigrant who stated, “An emergency is an emergency no matter where you’re from or what your status is.” Moreover, most immigrants stated that they would seek emergency treatment, as one immigrant said, “if I really had to.”

Factors Not Related to 1996 Welfare and Immigration Laws

Language Barriers

Language was identified as a barrier to seeking emergency services. The biggest barrier to emergency care reported by refugees was language and the difficulty in accessing appropriate translation in an emergency.

Summary of Findings

Factors related and unrelated to the 1996 laws impacted immigrants’ willingness to seek emergency services. There are conflicting reports about immigrants’ utilization of emergency services. Providers reported beliefs that immigrants were not accessing emergency treatment. Discussion with immigrants, on the other hand, indicated that immigrants sought emergency treatment when conditions
were deemed urgent. While fear is palpable for some immigrants, this fear appears to become a secondary consideration in the face of an emergency.

Immigrants’ initial reluctance to seek emergency services appears to have subsided. As vigilance of the INS has receded and the public sentiment toward immigrants has improved, immigrants may feel safer seeking emergency services.

Immigrants faced difficulty in accessing appropriate translation services in emergencies. Language barriers make it difficult for immigrants to communicate effectively with physicians about treatment.

E. Impact on Immigrants’ Health-Related Quality of Life

Representatives of community agencies and providers could not assess whether welfare and immigration reform has had an effect on immigrants’ health. There was insufficient data to attribute changes in the 1996 laws to changes in immigrants’ health outcomes.

Some informants believed that different ethnic communities have been able to deal with changes in health care access better than others. Moreover, those persons with better health care access are likely to exhibit better health outcomes.

There was a difference in the impact of the 1996 welfare reform laws for the refugees interviewed as compared with legal permanent residents and undocumented immigrants. Refugees were well-connected in the welfare and Medi-Cal systems and had access to community-based organizations that served to facilitate their enrollment into Medi-Cal and access to health care. While many participants experienced difficulties due to language barriers and complications of Medicaid managed care, the 1996 welfare reform laws did not appear to hinder the refugees’ health-related quality of life. Refugee participants were grateful for the Medi-Cal benefits and as one Vietnamese woman stated, “I really like Medi-Cal. It’s nice of the government to give the poor people a way to take care of their health.”

In contrast, for the Mexican immigrants interviewed—who were mainly legal permanent residents and undocumented immigrants with families of mixed eligibility—the 1996 welfare reform laws did limit access to Medi-Cal coverage and health care services. Limited health care access potentially could have serious implications on participants’ health-related quality of life. There were at least two examples of participants who were unwilling to apply for Medi-Cal for their citizen children because of the threat of public charge and problems with immigration status of the parents. Also the practice of delaying care or utilizing home remedies could easily result in complicated illnesses and serious health risks for the interviewees and their children.

Summary of Findings
We anticipated that the effects of the 1996 laws could be demonstrated by adverse outcomes related to health care access. There is insufficient data to draw any conclusions about the effects of the law on immigrants’ health-related quality of life. Our study findings suggest, however, that legal permanent residents and families with mixed eligibility who may have more limited health care access may also be more vulnerable to poor health outcomes than refugees, who appeared better able to navigate the Medi-Cal eligibility process.

V. CONCLUSIONS AND IMPLICATIONS

Certainly the 1996 laws have impacted recent immigrants’ access to health care and Medi-Cal. Our findings suggest that the impact of the 1996 laws are largely a result of changes in immigrants’ willingness to apply for Medi-Cal and seek health care services, as opposed to immigrants’ ability to apply for Medi-Cal, since California opted to continue providing Medi-Cal benefits to all immigrants who were eligible prior to enactment of the laws.

It is difficult to quantify the precise impact the new laws have had, and to attribute specific outcomes as a result of the laws’ enactment. We did not expect to see a large decrease (or a decrease in the rate of growth) in the overall number of immigrants receiving Medi-Cal since the laws were enacted, since California did not change immigrants’ eligibility for Medi-Cal. We found, however, that Medi-Cal enrollment for undocumented persons decreased by more than one third since August 1996. Moreover, Medi-Cal enrollment for legal immigrants failed to keep pace with growth in caseload among citizens. This finding suggests that factors other than eligibility have contributed to immigrants’ reluctance to apply for Medicaid.

In addition, it is difficult to determine the law’s precise impact on immigrants’ access to primary and emergency services. Our findings indicate a mixed picture: some informants provided evidence that indicates the laws have had little effect on immigrant behavior, while others reported that the laws have created substantial barriers to Medicaid and health care services.

Although it is difficult to quantify the exact impact the laws have had on immigrants and their ability to access Medicaid and/or health care services, we have identified many factors that do play a role in immigrants’ ability and willingness to access these services. These factors fall into two categories: 1) those that are directly related to the 1996 laws; and 2) those experienced by all vulnerable populations, and not just immigrants. We report the factors in both categories since it is essential to understand all the reasons immigrants face challenges accessing Medicaid and health care services. Factors not related to immigration status (e.g., poverty, geographic isolation, language barriers) must be addressed when attempting to ameliorate the barriers immigrants face in attempting to obtain health care or Medicaid. Policy makers and program administrators should understand that factors unrelated to the 1996 laws may pose greater problems for immigrants than those specifically related to their immigrant status. Both sets of factors should be considered when making policy and program decisions that seek to address immigrants’ health care needs.
Below we discuss our findings and their implications for immigrants seeking Medicaid and/or health care services in San Diego, California.

A. Immigrants’ Ability to Apply for Medi-Cal

Immigrants’ ability to apply for Medi-Cal in California is a measure of what eligibility options the state has adopted since enactment of the 1996 welfare and immigration laws. Additionally, immigrants’ ability to apply for Medi-Cal is affected by multiple factors that are not directly attributable to changes in the 1996 laws: language/interpreter services available during the application process, complexity of the application process, assistance in applying for benefits, and caseworker workload. In California, factors unrelated to the laws largely account for any negative impact on eligibility since California elected to continue providing Medi-Cal to pre- and post-enactment LPRs and also has elected to continue its state-funded program for pre-natal benefits for undocumented pregnant women. Eligibility itself is not a barrier to enrollment. Thus, it is important to consider factors not related to the 1996 laws when assessing the impact of the 1996 laws on immigrants’ ability to apply for Medi-Cal.

Despite continued eligibility, Medi-Cal enrollment has declined sharply for undocumented persons since enactment of federal welfare reform. Medi-Cal enrollment for undocumented persons has decreased by more than one third since August 1996. Similarly, despite California’s options under the 1996 laws, Medi-Cal enrollment for legal immigrants has failed to keep pace with growth in caseload among citizens. Medi-Cal enrollment for legal immigrants has increased by 29 percent while enrollment for citizens has grown by 36 percent from May 1996 to April 1999.

While the experiences of refugees in San Diego in applying for Medi-Cal vary significantly, their disparate treatment is not a byproduct of changes in the 1996 laws. Refugees’ ability to apply for Medicaid is arguably made easier by having a centralized location where they apply for Medi-Cal and by having access to community organizations that assist them in the application process. Refugees, in comparison to other immigrant groups, seemed to have better access to Medi-Cal and greater knowledge of Medi-Cal. Refugees were almost without exception shepherded by community agencies through the entire Medi-Cal application process. Therefore, they tended to be more well-informed and knowledgeable.

B. Immigrants’ Willingness to Apply for Medi-Cal

Factors wholly independent of welfare and immigration reform influence immigrants’ willingness to apply for Medi-Cal. The extent to which they account for immigrants’ reluctance or apply for Medi-Cal compared with other factors associated directly with the provisions of the 1996 welfare and immigration laws is not known and cannot be easily quantified. Therefore, any approaches to overcome barriers to applying for Medi-Cal must not be concerned solely with the welfare-driven issues (e.g., public charge). A comprehensive strategy is needed and is addressed in more detail in the discussion of recommendations.

C. Immigrants’ Ability and Willingness to Seek Primary Care Services
Informants and immigrants identified multiple factors why they may not seek primary health care services. Public charge and misinformation about the 1996 laws are clearly factors related to welfare and immigration reform. These factors may have an adverse impact on immigrants’ ability and willingness to seek primary care services. Based on interviews with immigrants, it is likely that the parents—rather than the children—may bear the brunt of any negative consequences of welfare and immigration reform. Other factors unrelated to welfare appear to influence immigrants’ willingness to seek out primary care, such as their attitude toward preventive care. Finally, whether linked to welfare and immigration reform or not, ability to pay seems to be the crucial factor in determining whether immigrants receive needed primary care services. It is not possible to draw definitive conclusions about the impact of welfare and immigration reform on immigrants’ ability and willingness to seek primary care services.

D. Immigrants Ability and Willingness to Seek Emergency Services

Perceptions about immigrants’ ability and willingness to seek emergency health services differ from the experiences shared by immigrants for this study. This difference may be due to an initial increased reluctance to seek emergency services shortly after the 1996 laws were enacted that has since subsided. Generally, immigrants reported that in emergency situations that they sought emergency care. Immigrants faced difficulty in accessing appropriate translation services in emergencies. Language barriers made it difficult for immigrants to communicate effectively with physicians about treatment.

E. Impact of the 1996 Welfare and Immigration Laws on Immigrants’ Health-Related Quality of Life

It is too soon to draw conclusions about the impact of the 1996 welfare and immigration laws on immigrants’ health-related quality of life. Some informants believed that different ethnic communities have been able to deal with changes in health care access better than others. Moreover, those persons are likely to exhibit better health outcomes. Our findings suggest that legal permanent residents and families with mixed eligibility may be more vulnerable to poor health outcomes than refugees, who appeared better able to navigate the Medi-Cal eligibility process.

In the absence of definitive conclusions, there remains important areas where monitoring immigrant health is essential. For example, the 35 percent decline in undocumented persons’ enrollment in Medi-Cal may suggest that some pregnant undocumented women may not be receiving prenatal care. Lack of prenatal care may lead to increased maternal or infant mortality, low birthweight, or increased costs for caring for infants in a neo-natal intensive care unit. Other conditions, such as tuberculosis, that could be prevented, contained, and treated with early diagnosis and treatment, should also be monitored closely. Other ambulatory sensitive conditions, such as hospitalization for asthma, might also be used as markers for inadequate access to primary and preventive care.
F. Limitations

Our findings based on the immigrant interviews and focus groups are not presented as representative of the entire immigrant population in these sites. There is substantial potential for selection bias among our immigrant informants/sample. These immigrants not only self-selected for participation, but, for the most part, were already connected to resources, such as community health clinics and Medicaid. It is possible that these immigrants were less likely to be fearful about public charge or INS activities, and that these immigrants would have more accurate knowledge about Medicaid and how to access health care services. This bias could mean that we may have underestimated the effects of immigrant-related barriers to Medicaid and health care services, and that our findings about the relative weight of the two sets of barriers may be skewed. Notwithstanding these limitations, however, the reports of the immigrants provided rich and detailed picture of these immigrants’ personal experiences in accessing Medicaid and health care services prior to and since the 1996 laws. Moreover, the potential presence of bias does not change our findings regarding two sets of barriers—both immigrant-related and nonimmigrant-related, and one could suppose that these immigrant informants who were already connected to services have had less trouble with the non-immigrant barriers than would other less-connected immigrants.

VI. RECOMMENDATIONS

Findings from the site visit elicit several recommendations about ways to increase participation in Medi-Cal and CHIP and how to improve access to health care services among the immigrant and refugee population. Concerns about non welfare and immigration reform factors, such as limited or no ability to speak English, inability to pay for services, and complexity of the Medi-Cal application process, among many others, appear to be at least as important—if not more important—than those factors that are directly attributable to welfare reform, such as fear of public charge and anti-immigrant public sentiment.

A. Immigrants’ Ability to Apply for Medi-Cal

- Efforts to simplify the Medi-Cal eligibility and redetermination process should continue. Many immigrants reported that the paperwork requirements discouraged them from applying for (or continuing) Medi-Cal coverage. To address concerns about the complexity of the application process, California has implemented a mail-in application for the Healthy Families program and is in the process of developing a mail-in application for the Medi-Cal program for the entire population. Additionally, California has made efforts to streamline the application process, such as eliminating questions and simplifying regulations. Similarly, the County also has developed outreach activities to improve initial and continued enrollment in Medi-Cal.
Provide funding for the development and distribution of brochures in multiple languages about immigrant eligibility for Medi-Cal, clarification of public charge, and how to navigate the Medi-Cal application process. The Medi-Cal application and brochures describing the Medi-Cal program should be made available in languages other than English and Spanish. While the Medi-Cal application process is largely automated, written materials in more languages may better inform immigrants about the Medi-Cal program, such as documentation requirements, redetermination of eligibility, and eligibility for benefits once a job is found.

B. Immigrants’ Willingness to Apply for Medi-Cal

Increase outreach funding for organizations serving immigrant populations so that they may identify immigrants who are eligible for —but not enrolled in— Medi-Cal.

San Diego County has few Medicaid outstationed enrollment sites and should expand their use. Medicaid outstationed enrollment may help to overcome some of the most prominent barriers to Medi-Cal enrollment— trust, fear, and transportation. More than one county official agreed that increased Medicaid outstationed enrollment would be helpful and said that internal reports have acknowledged that it is a need.

Increased training of community-based organizations and safety-net providers about Medi-Cal and CHIP eligibility is needed to improve outreach to immigrant communities and diffuse misinformation and general reluctance to enroll in Medi-Cal or CHIP. There was a striking lack of awareness about Healthy Families among immigrants who may be eligible for the program and among workers from community service agencies who provide services to immigrants. Community-based organizations and safety-net providers who deliver services to immigrants are poised to spread the word and dispel myths about eligibility for Medi-Cal and Healthy Families, especially in light of the recent clarifications in public charge. CBOs and safety-net providers are trusted, but perhaps underutilized, sources for information about programs and services.

Eligibility workers should receive additional sensitivity training about assimilation issues. Several immigrants reported being mistreated by their caseworkers.

C. Immigrants’ Willingness to Seek Primary Care Services

Provide additional funding to safety-net providers so that they can help their patients (especially those who are non-English speaking) navigate the health care system more effectively. Helping patients navigate the health care system will likely

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42 County officials noted that caseworkers (i.e., eligibility technicians) receive regular training on cultural awareness and diversity issues.
increase enrollment in managed care systems, ensure patient compliance, actively connect them with referral sources, such as specialists, and increase the patient’s satisfaction with the health care system.

- **Safety-net providers should emphasize the value of receiving regular, preventive care, regardless of insurance status.** One health center reported, for example, that children enrolled in CHIP have not used any services. Immigrants may be more accustomed to receiving only episodic care, perhaps because of their experiences in their native countries of origin or perhaps simply because of their insurance status and inability to pay for needed health care services. Whatever the underlying reason, improved education about the value of preventive care and the U.S. health care system may help to increase immigrants’ use of routine, primary care in the U.S. rather than seeking care from across the border, using traditional therapies at home, or forgoing treatment until conditions become emergent.

- **A comprehensive strategy is needed to improve access to care for immigrants.** Strategies to improve access to health care services and Medi-Cal should not only address the barriers created by welfare reform (e.g., public charge) but must also consider traditional access barriers, such as transportation and childcare, inability to pay for services, and the difficulty in navigating the health care delivery system, experienced by low-income and uninsured persons.

- **Increased emphasis should be placed on outreach to undocumented persons.** The precipitous decline in Medi-Cal enrollment for undocumented persons is alarming, especially since eligibility for Medi-Cal has continued and covers only prenatal care and emergency services.

**D. Immigrants’ Willingness to Seek Emergency Services**

- **Improve the quality and availability of translation services for non-English speaking patients who are seeking treatment at emergency rooms.**

**E. Impact of the 1996 Welfare and Immigration Laws on Immigrants’ Health-Related Quality of Life**

- **Rates of deliveries to women without prenatal care, tuberculosis, and other ambulatory-sensitive conditions, such as asthma, among immigrant communities, should be monitored closely.** Systematic and coordinated monitoring of immigrants’ health is needed but new ways of collecting data that will not harm immigrants or the providers that serve them must be generated. Monitoring of immigrants’ health is made difficult by providers’ lack of knowledge about the immigration status of their patients.