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

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Synthesis Report

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FINDINGS FROM FOUR METROPOLITAN SITES

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 US 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 a synthesis of the findings from all four site visits. 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.

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 US immigration policy.

Essentially the law created a fundamental distinction between legal immigrants who were lawfully present in the US 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.\(^3\) 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 illustrates the pathways for immigrant eligibility from which states can choose.

Table 1 also 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, all immigrant groups that were formerly legal became qualified.\(^4\) 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.

PRWORA essentially created three groups of qualified immigrants in terms of eligibility for public benefits (See Table 1). 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 (e.g., veterans), post-enactment LPRs 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 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

\(^3\) Alabama opted not to provide TANF benefits to pre-enactment eligible immigrants and Wyoming opted not to provide pre-enactment eligible immigrants nonemergency Medicaid. See Zimmerman and Tumlin, (1999). *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform*, Urban Institute, May, p. 22.

\(^4\) 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 US 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.
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 US 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 immigrant’s ability to become an LPR or petition to bring relatives to the U.S. 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.

\[5\] 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 US. “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. [www.ins.usdoj.gov/graphics/publicaffairs/questsans/public_cqa.htm](http://www.ins.usdoj.gov/graphics/publicaffairs/questsans/public_cqa.htm) [accessed 4-18-00].


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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. 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. 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 US health care system. About one-third of all Hispanics in the US are immigrants. Recent studies have shown that Latinos have low rates of insurance coverage and limited use of health care.

Immigrants now comprise an increasingly large portion of the US population. Immigrants represented 9.5 percent of US residents in 1999, and are projected to grow to 11.2 percent by 2010. Foreign-born and US-born children of immigrants now make up about 20 percent of children in the US. 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.

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 US residents.

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Methods

The project used a case study approach to obtain a detailed picture of the experiences of primarily immigrant families since the enactment of welfare and immigration reforms. Four sites (Chicago, Illinois; Metropolitan Washington DC; San Diego, California; and Brownsville, Texas) were selected based on criteria identified to ensure that issues key to addressing the research questions were examined. These criteria included: whether substantial numbers of various immigrant populations were 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. We interviewed state and county officials, representatives of safety net providers, community-based organizations, and advocates; reviewed Medicaid enrollment data; and conducted individual interviews and focus groups with primarily immigrant heads of households or parents. At least two focus groups were conducted at each site.\textsuperscript{13} We partnered with community-based organizations (CBOs) 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. Except in cases where the immigrant parent/head of household preferred speaking English, all interviews and focus groups were conducted in the immigrants’ native languages (e.g., Spanish, Cantonese, and Polish) 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 focus group or individual interview. Table 2 provides the demographic characteristics for all immigrant informants.

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

\textsuperscript{13} Summaries of the findings from the immigrant focus groups and individual interviews are contained in Appendix.
‘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 also 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, 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).

II. CHARACTERISTICS OF STUDY SITES

Sociodemographic Characteristics

The four sites, which encompass six states and four urban areas, represent a range of sociodemographic attributes relevant to our inquiry about immigrants and access to Medicaid.
and primary health care services. Our study sites include states that differ with regard to the generosity of their Medicaid programs, the diversity of their populations, their proximity to a national border, and the strength of their economies and well-being as measured by the poverty rate in each state. All states except Maryland show substantial declines in Medicaid enrollment during the period just after the 1996 laws. Tables 3 and 4 present selected characteristics of the states and their Medicaid programs. Table 4 shows that, for the most part, non-citizen or immigrant use of public benefits in 1996 was well below the overall use rate for citizens and non-citizens combined.

In these tables, we show the three states that cover the area comprising Metropolitan Washington DC: the District of Columbia, three counties in Virginia (Alexandria, Arlington, and Fairfax), and two counties in Maryland (Prince George’s and Montgomery). Many immigrants in Metropolitan DC live and work in different states, and it is not uncommon for immigrants to have lived in each state over the course of several years. While we anticipated that there might be differences among these three jurisdictions of Metropolitan DC relevant to our findings, as will be discussed in the following sections, we did not find salient differences in terms of our study questions and goals. Thus, while we present background data for the District, Maryland, and Virginia in Tables 3 and 4, our findings presented in Tables 5 through 10, and our discussion in this paper combine the three jurisdictions into one area — Metropolitan DC.

Our sites also represent a range of other characteristics such as type of immigrant groups, presence of strong welfare and immigrants rights organizations, and presence of community-based organizations. Chicago and Brownsville both have a well-developed and strong network of community-based organizations and immigrants’ rights activists. Immigrants in Metropolitan DC reportedly relied heavily on community-based organizations and safety net providers (SNPs) for information and assistance in seeking services. In general, immigrants placed great trust in these organizations, and many CBOs were willing to recruit immigrants for focus groups and individual interviews. As illustrated by Table 2, the nationalities of these immigrant informants were diverse and ranged from Chinese to Polish to Latin American to African.

The availability of community health clinics, public hospitals and the strength of the safety net for immigrants also varied by site. A large and well-organized network of safety-net providers serves the many immigrant communities in Chicago, and Cook County Hospital provides substantial public hospital access. In San Diego, there are no public hospitals; the
network of community health clinics and safety-net providers were reportedly quite stressed with long waits and crowded facilities. The safety net in the District of Columbia is unique to other cities in that a large number of free clinics exist to serve the uninsured. The Maryland and Virginia counties do not have the same volume of free clinics and many immigrants reported crossing over to the District of Columbia for their care. The safety net in Brownsville is also under serious stress as immigrants reported long waits and limited appointments at the two health centers/clinics.

The level and history of recent anti-immigrant public sentiment was fairly similar across all sites except for San Diego. There has been little anti-immigrant sentiment in Brownsville as most residents of the city are either descendents of immigrants or immigrants themselves, and Brownsville is so close geographically to its sister city, Matamoros Mexico, that residents move back and forth freely and without much concern. Chicago’s lack of anti-immigrant sentiment is probably attributable to the activism and visibility of advocates that predated the 1996 laws. In Metropolitan DC, while occasional episodes of INS activity have caused alarm, the visibility of anti-immigrant sentiment generally continues to be quite low. In San Diego, however, proximity to the border, the anti-immigrant policies proposed by the prior governor of California, and the widely acknowledged conservative county board of supervisors has created a tense and sometimes hostile atmosphere with respect to immigrants. Several years of protracted public battles to limit benefits to undocumented persons during the former governor’s administration only served to heighten these tensions. Although the election of a new governor and less inflammatory public rhetoric have eased tensions, San Diego’s recent history still creates unease among immigrants.

State Choices under PRWORA – Discretion to Determine Medicaid Eligibility

The 1996 welfare reform law transferred substantial authority to the states to determine the federally- and state-funded public benefits for which immigrants are eligible. For Medicaid, states have three options to consider: (1) whether to continue or deny federally-funded Medicaid coverage to qualified immigrants who arrived in the U.S. prior to August 22, 1996; (2) whether to provide state-funded Medicaid coverage for qualified immigrants who arrive in the U.S. on or after August 22, 1996; and (3) whether to provide state- or county-funded medical coverage to not qualified immigrants (i.e., certain PRUCOLs and undocumented immigrants).
All US states but one, Wyoming, have opted to continue to provide Medicaid coverage to legal immigrants who arrived prior to August 22, 1996 (i.e., pre-enactment LPRs). Only a very few states provided more than the federally-required emergency Medicaid to undocumented immigrants prior to 1996 – usually in the form of prenatal care services – and this situation continues post-1996. To the extent that states do not choose to use state funds to extend Medicaid coverage, most post-enactment LPRs, like the undocumented immigrants, will potentially be eligible only for emergency Medicaid services for at least five years. While there is some variability among the states regarding the extent to which states have opted to cover post-enactment LPRs, in most states the majority of these immigrants are not eligible for nonemergency Medicaid coverage. States choosing to extend state-funded coverage are frequently focused on covering pregnant women and LPR children. Just fourteen states chose to provide state-funded Medicaid coverage for post-enactment LPRs and only ten of these states provide full coverage for adults as well as children. Table 5 shows the choices made by these six study sites/states as portions of Maryland and Virginia are included in Metropolitan Washington DC.

**California – Scope of Medi-Cal and CHIP Coverage for Immigrants**

California stands as one of the few states opting for the most generous coverage for immigrants following the 1996 reform laws. In addition to continuing federally-funded Medi-Cal coverage to pre-enactment LPRs, California provides state-funded Medi-Cal coverage to all post-enactment LPRs. California has also 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 full nonemergency Medi-Cal benefits regardless of their date of entry.

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15 In order to be eligible for emergency Medicaid, post-enactment LPRs must be* otherwise eligible* for Medicaid, that is, they meet all the financial and family composition requirements for Medicaid and essentially be Medicaid eligible except for their immigrant status. States have the option to provide federally-funded Medicaid to these immigrants after they have resided in the US for five years. The extent to which states will consider providing federally-funded Medicaid coverage for these immigrants after the five year bar was beyond scope of this paper. It is also probably too soon to tell with certainty what the states’ decisions on this issue will be.

Illinois – Scope of Medicaid and CHIP Coverage for Immigrants

In addition to continuing Medicaid coverage for pre-enactment qualified immigrants, Illinois has opted to provide state-funded medical assistance under Medicaid or the state’s CHIP program, to all pregnant women and children up to age 19, except undocumented children, who are Illinois residents and meet the income requirements, regardless of immigration status and date of entry. Thus, post-enactment LPR children, certain PRUCOLs, and post-enactment and undocumented pregnant women are eligible for state-funded Medicaid or medical coverage.  

Metropolitan Washington DC - Scope of Medicaid and CHIP Coverage for Immigrants

Unlike California and Illinois, the District of Columbia has chosen not to provide state-funded Medicaid coverage to post-enactment immigrants. The District has never provided district-funded prenatal care to undocumented immigrants and does not currently provide funds for prenatal care for any category of post-enactment immigrants not otherwise eligible for Medicaid. Otherwise eligible immigrants can get emergency Medicaid for labor and delivery.

Maryland has chosen to provide state-funded Medicaid coverage to limited groups of post-enactment LPRs: children under the age of 18, full-time students expected to complete high school before the end of the calendar year, and pregnant women. Maryland also provides state funding to make prenatal care services and certain pharmacy benefits available to PRUCOLs and undocumented immigrants.

Virginia opted to provide state-funded Medicaid coverage to two groups: post-enactment LPR children under the age of 19, and immigrants who were receiving Medicaid and living in long-term care facilities on June 30, 1997, which could include some post-enactment LPRs. Virginia has never provided state-funded prenatal care services to immigrants either pre- or post-enactment of the 1996 laws.

Texas – Scope of Medicaid and CHIP Coverage for Immigrants

While opting to continue providing federally-funded Medicaid coverage to pre-enactment LPRs, Texas has not chosen to provide any state-funded Medicaid benefits to post-enactment

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17 California recently expanded funding for its CHIP program, Healthy Families, to extend coverage to LPR immigrant children regardless of their date of entry.
18 Since 1990, Illinois has provided stated-funded medical coverage comparable to Medicaid to all low-income undocumented pregnant women who are residents of the state.
LPRs. While Texas offers no state-funded prenatal care or medical services programs for post-enactment LPRs, PRUCOLs, or undocumented immigrants, some counties offer county-funded prenatal care programs to women regardless of immigrant status. The situation in Texas may be improving for post-enactment LPR children, however. During the 1999 legislative session, the legislature voted to cover children under the age of 19, including post-enactment LPRs, who are not eligible for CHIP and Medicaid under a state-funded health insurance program. The program will reportedly be fully implemented in April 2000.

Concluding Comments

Our four study sites substantially represent the range of state options for Medicaid and CHIP coverage for post-enactment immigrants. In California, post-enactment legal immigrants have complete access to state-funded Medi-Cal, and undocumented immigrants and PRUCOLs continue to have access to prenatal care in addition to emergency Medicaid. While post-enactment adult LPRs in Illinois have no access to Medicaid, the state did opt to provide state-funded Medicaid or medical coverage to post-enactment LPR children up to the age of 19 and to all pregnant women regardless of their date of entry. In Texas and Metropolitan Washington DC, most post-enactment LPRs have no access to Medicaid and few provisions have been made to make prenatal care available to LPRs or undocumented immigrants with two exceptions: Virginia has opted to provide state-funded Medicaid to LPR children, and Maryland provides state-funded Medicaid to LPR children and pregnant women, and provides prenatal care to undocumented immigrants and PRUCOLs.

Consequently, except for California, post-enactment LPR adults/parents and certain categories of PRUCOLs, and to a lesser extent children, face the greatest restrictions on access to (i.e., their ability to apply for) Medicaid due to the 1996 laws in our study sites. Except for certain relatively small groups of immigrants (i.e., refugees, asylees, parolees), these immigrants are potentially eligible only for emergency Medicaid – as long as they are otherwise eligible for Medicaid (i.e., they meet all the financial and family composition eligibility criteria for Medicaid). This is essentially the same very limited access to Medicaid that has traditionally been afforded to undocumented immigrants.
III. Findings

Introduction

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 care services? (4) How have the 1996 welfare and immigration laws affected immigrants’ ability and willingness to seek emergency health care services? and (5) How have the 1996 welfare and immigration laws affected immigrants’ health-related quality of life? These questions also provide the structure for presenting and discussing our findings.

These research questions represent our assessment of the major effects on immigrant access to health care services due to the 1996 laws. These effects encompass both Medicaid coverage and ability to obtain health care services. We felt that it was important and useful to attempt to distinguish between immigrants’ ability and immigrants’ willingness to seek benefits or services given the pressures and other intangible factors created by a confluence of heightened anti-immigrant sentiments and the welfare and immigrant reform laws in 1996. For example, eligible immigrants might be dissuaded from applying due to INS or public charge fears. Consequently, while an immigrant’s ability to apply for Medicaid is primarily an objective assessment (i.e., what are the eligibility criteria), an immigrant’s willingness to apply, although requiring a more subjective assessment, is an equally important consideration. Frequently, the same factors (e.g., adequacy of information about eligibility criteria) will affect both dynamics and our analyses account for this overlap.

With respect to accessing primary care and emergency services, we anticipated an ability to access these services based on the existence of safety net providers (SNPs) and considered that access would largely be a function of willingness to deal with barriers such as cost, language, or transportation. However, the distinction between ability and willingness is not always a clear one and our assessments of willingness frequently bear equally on ability. We anticipated that the effects of these laws on immigrants’ quality of life could be assessed by investigating recent changes in certain outcomes related to access to health services and health status. For example,
we asked provider informants about issues such as primary care service use, incidence of communicable disease, evidence of delayed care, and use of prenatal care. We asked immigrant informants about frequency of illness in their families, loss of work or absence from school due to illness, frequency of delayed care, and change in health status. We did not, however, expect that immigrants would necessarily be able to attribute their experiences to the 1996 laws; rather we asked them about changes or differences in their experiences during the past two or three years, the period since the enactment of the 1996 reform laws.

First, we provide a brief overview of these findings and then a more detailed discussion.

**Overview of Findings**

We found evidence that immigrants’ ability and willingness to access Medicaid and health care services have been adversely affected since the enactment of the 1996 welfare and immigration reform laws. We identified numerous specific barriers, although not all of these barriers were associated with the 1996 laws. It was also difficult to quantify the size of these effects due to data limitations. Tables 6 through 10 present these findings in more detail by site.

♦ **Ability to Apply for Medicaid** – Factors affecting immigrants’ ability to apply fell into two categories: barriers related to immigrant status and the 1996 laws, and longstanding barriers related to vulnerable and low-income population status. Immigrants’ ability to apply seemed to be affected equally by these two types of barriers. Data-based evidence of impacts/effects attributable to the 1996 laws (i.e., more eligible but not enrolled immigrants post-enactment) was difficult to develop due to: (1) lack of relevant data, (2) overall declining trends in Medicaid enrollment; and (3) inability to disentangle potential effects of the two sets of barriers.

♦ **Willingness to Apply for Medicaid** – Factors affecting immigrants’ willingness to apply fell into the same two categories. Our findings suggest that the barriers related to vulnerable and low-income population status exerted a greater negative effect on willingness than barriers related to immigrant status and the 1996 laws. Immigrant parents reported that they were less likely to be discouraged from applying when the circumstances involved their children needing care.
Ability and Willingness to Access Primary Care – Several factors affected immigrants’ willingness and ability to access primary care. We found that these factors and barriers were primarily related to their low-income and vulnerable population status and that the barriers related to immigrant status and the 1996 laws had very little effect. When immigrants reported that they were less willing to seek care, adults were more affected than children.

Ability and Willingness to Access Emergency Care – Immigrants reported that they were generally willing and able to access emergency care when necessary although concerns about language barriers, and costly bills were common. Uninsured immigrants reported that they were delaying care and using emergency rooms as a substitute for primary care.

Impact on Health-Related Quality of Life – Although we found evidence of delayed and limited access to care, the data on relevant outcomes were lacking and it is probably too soon to discern these effects. Community and provider informants frequently reported concerns, however, that short-term outcomes will soon be evident in the form of increases in communicable diseases, decreases in the use of prenatal and preventive care, compromised health status due to delayed care and lack of preventive/primary care, and complications from chronic conditions that are unattended.

How Has Immigrants’ Ability to Apply for Medicaid Been Affected?

Immigrants’ ability to apply for Medicaid is primarily a function of three factors: 1) whether and how the states have chosen to provide Medicaid/CHIP coverage to immigrants and how these choices are reflected in the states’ eligibility policies; 2) how well the states have implemented their new Medicaid/CHIP eligibility policies for immigrants (e.g., do caseworkers understand the new eligibility policies); and 3) what is actually required of immigrants in order to initiate and complete the application process for Medicaid (e.g., accessibility of locations where immigrants may apply for benefits). The first two factors are exclusively a function of the changes created by the 1996 welfare and immigration reform laws. The third factor, however, involves issues that are relevant to both citizens and noncitizens in that questions about the accessibility of the Medicaid application process raise longstanding concerns about the ability of
poor and vulnerable populations to access health care services and the fact that many eligible persons/families are not enrolled in Medicaid. Table 6 summarizes our findings on this issue.

State Medicaid and CHIP Eligibility Criteria for Post-Enactment Immigrants

As illustrated by Table 5 and the foregoing discussion of the coverage options selected by our four study sites, these sites represent the full scope of state Medicaid coverage options ranging from Metropolitan Washington DC, where relatively more post-enactment LPRs are not eligible for nonemergency state-funded Medicaid to California where all post-enactment LPRs remain eligible for all Medi-Cal benefits, albeit state-funded. While certain other categories of post-enactment immigrants are eligible for federally-funded nonemergency Medicaid, these categories represent a relatively small number of immigrants compared to the growing population of post-enactment legal immigrants who are and will be barred from federally-funded Medicaid for at least five years. Thus, state choices to extend coverage to certain portions of the post-enactment immigrants can mean that substantially more of these immigrants are eligible for Medicaid. Illinois has extended coverage to post-enactment LPR children and all pregnant women, and Texas has extended coverage to certain groups of post-enactment LPR children and pregnant women. California and Illinois have extended CHIP coverage to post-enactment LPR children.

Consequently, simply by virtue of these states’ choices about eligibility criteria, fewer numbers of legal immigrants are eligible for Medicaid in all sites but California with post-enactment LPR adults/parents facing the greatest restrictions on eligibility. These immigrants remain eligible for only emergency Medicaid as long as they are otherwise eligible for Medicaid in their state of residence (i.e., they meet all the financial and family composition eligibility criteria for Medicaid).

It is also important to note here that eligibility for Medicaid has historically varied substantially across the states as each state can determine its own financial eligibility criteria under Federal minimum guidelines. As discussed above, these four states also reflect that variability, as California and Illinois cover approximately 60 percent of people with incomes below 100 percent of the federal poverty level (FPL), while Virginia and Texas cover just 45 percent of people with incomes below 100 percent of the FPL.

As noted in Table 1, the complete list includes refugees, asylees and persons granted withholding of deportation during their first five years in the country, parolees, veterans, Cuban, Haitian and Amerasian entrants, LPRs with more than 40 qualifying working quarters, certain PRUCOLs, and certain battered spouses and children.
percent of people with incomes below 100 percent FPL. Because of less generous eligibility criteria that apply to all applicants, both citizens and noncitizens, relatively fewer immigrants will be eligible in Texas and Virginia as compared with California and Illinois.

**Implementation of New Eligibility Criteria for Immigrants**

In general, informants across all sites noted that there was initial confusion among caseworkers about the new eligibility policies and how to apply them to immigrants applying for Medicaid. Although initial confusion is predictable when implementing changes in policies and procedures, there were differences across the sites with respect to how quickly and successfully the states ameliorated this confusion. California and Illinois provided training for their workers although the availability and quality of these trainings reportedly varied. Caseworkers in San Diego and Chicago reported that they had become fairly comfortable with the eligibility policies, and community and immigrant informants at these sites confirmed that caseworkers seem to be knowledgeable. At the time of our site visit, Chicago was reportedly planning to train a small group of caseworkers as immigration specialists to improve administration of public benefits programs and to target assistance to post-enactment immigrants.

Texas provided no formal training but did provide regular updates and bulletins to the county offices about the policy changes. Although caseworkers in Brownsville generally reported that they felt knowledgeable, a few noted continuing confusion about whether and how to assess immigrant Medicaid applicants for 40 quarters of work; community informants confirmed that some confusion and frustration does continue although immigrant informants in Brownsville reported few problems. We were unable to collect substantial data about the implementation of changes in immigrant eligibility in Metropolitan DC although limited information suggested that training for caseworkers was generally poor and inadequate. Immigrant and community informants reported that caseworkers in the District and in Maryland were frequently uninformed or confused about eligibility policies for immigrants. The District has recently updated its manual with a chapter on immigrant eligibility for public benefits.

The study sites also varied with respect to their efforts to inform the community about exactly which immigrant groups remained eligible for what Medicaid benefits as a result of the 1996 reform laws. With the exception of San Diego, the sites did no outreach directly to the immigrant communities. Instead, all four sites relied to varying degrees on community-based
organizations (CBOs), safety net providers (SNPs), and immigrant advocacy groups to inform immigrants about who remained eligible for Medicaid. Chicago and the District of Columbia supported outreach with additional financial resources by contracting with CBOs and SNPs to perform this function. Community and immigrant informants in Brownsville reported that, without formal state support, the informal networks of CBOs, SNPs, and immigrants were somewhat effective in providing information about Medicaid eligibility but these networks also resulted in substantial misinformation.

It is difficult to assess the level of immigrant awareness about their own Medicaid eligibility created by outreach efforts in these four communities, as well as the significance of differing levels of awareness on ability to apply both within each study and across the sites. Community informants in Brownsville specifically noted their belief that many potential eligibles did not apply for Medicaid due to the confusion about eligibility. To the extent that lack of knowledge bears on ability to apply, eligible immigrants in Brownsville, and to a lesser degree in Metropolitan DC, may be not applying for Medicaid. In general, less effective state and county efforts at outreach and education could be resulting in fewer eligible immigrants applying for Medicaid. Community and immigrant understanding of the new eligibility policies is also discussed in more detail in the next section as the level and quality of knowledge about Medicaid eligibility also bears on immigrants’ willingness to apply for Medicaid.

**Application Process**

We considered several aspects of the Medicaid application process to assess whether the requirements of this process adversely and uniquely affected immigrants’ ability to apply for Medicaid. In general, immigrants apply at the same locations as citizens – the local welfare offices. The availability of outstationed Medicaid enrollment sites for applying that are separate from the state or county offices probably has greater significance for immigrants’ ability to apply as informants across the sites uniformly reported high levels of government mistrust among immigrants. In all four sites, informants reported that outstationed sites – usually located in community health centers and safety net hospitals – were available and widely used by immigrants. To the extent that immigrants reported having difficulty getting to the welfare office due to transportation problems or limited hours, outstationed sites provide some relief. Community informants in both Brownsville and San Diego reported, however, that there was a
need for increased state support for outstationed locations and that expanded outstationed locations would benefit immigrants. Community informants in Chicago also noted this need. Immigrant informants in the District reported that it was “nicer” to apply for Medicaid at the hospitals than at the welfare offices.

In general, immigrants complete the same Medicaid application required for citizens although immigrants must provide verification of their immigrant status and additional financial information for sponsors when applicable. To the extent that states have not chosen to simplify their Medicaid application, immigrants experience challenges similar to those for citizens. For example, the District and Maryland have simplified their Medicaid application while Virginia has retained a more complex form. Community and immigrant informants at all sites, however, reported immigrant-specific difficulties in completing the application. For example, in Chicago, confusing documentation requirements reportedly meant that immigrants repeatedly return to the welfare offices, whereas county officials in Brownsville and immigrants alike reported that the process is now very cumbersome with more documentation required for immigrants, and in the two counties in Maryland, immigrant and SNP informants described the application process as especially intimidating for immigrants. County informants in Brownsville and District of Columbia officials did assert, however, that they have simplified their forms and improved the availability of forms in Spanish.

In addition to immigrant-specific requirements, language and literacy were reported as the major barriers to applying for Medicaid. Although language and literacy issues have long been associated with challenges in enrolling vulnerable populations in Medicaid, because immigrants likely have higher levels of language and literacy problems, these barriers will likely affect them more than citizens. Community advocates in Chicago stated that language was the number one problem for immigrants applying for public benefits. Community informants in Metropolitan DC and Chicago reported that CBOs and SNPs frequently assist immigrants with their applications and will accompany them to the welfare offices in order to provide translation services and ensure that the applications are properly processed. Immigrant informants in Brownsville, San Diego, and Metropolitan DC reported experiencing substantial hostility from caseworkers, immigrants in the District and Maryland noted a lack of support for languages other than Spanish, and immigrants in San Diego reported a lack of support for the Vietnamese language. Caseworkers in San Diego and Chicago, on the other hand, reported that an array of
interpreter services were becoming increasingly available to accommodate a wider range of languages. It is clear that community-based and immigrant advocacy groups play an essential role in assisting immigrant applicants for Medicaid and mitigating the effects of language/literacy and caseworker barriers.

The overall accessibility of the application process for immigrants varied across the four study sites, and reflects a combination of factors and barriers that are related to being an immigrant and related to the requirements of the application process for Medicaid. For example, informants in the District noted that language and literacy are longstanding barriers that predate the 1996 laws. Chicago received relatively high remarks from community informants for their efforts to provide help on literacy and language issues, train caseworker as immigrant specialists, and partner with CBOs for outreach. On the other hand, immigrants in the District and Brownsville reported that the Medicaid application process has become more difficult for immigrants in the past few years notwithstanding the assistance provided by SNPs and CBOs networks. These issues are discussed in greater detail in the following section on willingness to apply as concerns about caseworkers’ attitudes and burdensome application requirements are equally relevant to a consideration of immigrants’ willingness to apply for Medicaid.

**Conclusion – Two Types of Barriers Affect Ability to Apply But Lack of Data-Based Evidence Make It Difficult to Discern, Disentangle and Attribute Effects**

Fewer immigrants are now eligible for Medicaid and CHIP coverage, and this reality constrains immigrants’ ability to apply. Other factors associated with different Medicaid eligibility criteria for immigrants, however, might adversely affect their ability to apply resulting in fewer eligible immigrants enrolling in Medicaid. For example, the consequences of poor implementation (i.e., lack of knowledge in community about eligibility, caseworkers not applying eligibility criteria properly for immigrants or additional application requirements for immigrants) could likely be main contributors to reduced enrollment of eligible immigrants. On the other hand, longstanding barriers to applying for Medicaid such as cumbersome procedures and hard-to-reach welfare offices could affect the enrollment of noncitizens as well as citizens.

We found sites with poor implementation and outreach regarding immigrant eligibility for Medicaid, and sites with more complicated application procedures for both immigrants and citizens; in all our sites, community and immigrant informants reported barriers to applying for
Medicaid. These findings highlight the importance of distinguishing between barriers directly related to immigrants’ post-enactment status such as additional process requirements or incorrect application of eligibility criteria, and factors that have traditionally affected any person’s ability to apply for Medicaid such as complicated forms and transportation problems.

Our findings suggest that these two sets of barriers contribute equally to effects on immigrants’ ability to apply for Medicaid. Given the interaction between these two sets of barriers, it is difficult to attribute particular effects to immigrant-related barriers.

It is also difficult to determine whether there are substantial numbers of eligible but not enrolled immigrants in the wake of the 1996 laws. Clear data-based evidence is not available because: (1) data on noncitizens enrolled in Medicaid are limited; and (2) speculation is required about how many noncitizens would have been enrolled but for the 1996 laws. For example, California officials reported that noncitizen enrollment in Medi-Cal increased 14 percent between 1996 and 1999 suggesting little impact. On the other hand, San Diego County officials reported that, while Medi-Cal enrollment for citizens increased by 36 percent between May 1996 to April 1999, enrollment for noncitizens increased by 29 percent for the same period report suggesting some impact. Texas officials reported an overall drop of 16 percent in legal immigrant enrollment in Medicaid with the largest decrease in cash assistance category between 1996 and 1999, and Virginia officials reported a 2.4 percent drop between 1996 and 1998. In Illinois, the number of noncitizens receiving cash assistance and Medicaid declined by 60 percent as compared with a 44 percent decline for citizens between April 1996 and April 1999. During the same period, the number of noncitizens receiving Medicaid and no cash increased by only 12 percent as compared with a 65 percent increase for citizens. These numbers suggested a greater overall loss of Medicaid coverage for noncitizens although state officials could not confirm this. No data were available for Maryland or the District, but, county informants in Maryland and the District suggested that legal immigrant enrollment in Medicaid was increasing.

The fact that enrollment in Medicaid has been declining across the country must be considered as part of the context for assessing reduced enrollment of eligible immigrants. For example, between 1996 and 1998, Medicaid enrollment dropped by 6.5 percent in Illinois, by 16 percent in California, by 9.9 percent in DC, by 26.8 percent in Virginia, by 2 percent in Maryland, and by .7 percent in Texas. Texas shows the widest gap between overall reduction in Medicaid enrollment and reduction in immigrant enrollment (i.e., -.7 percent versus -16 percent).
while California shows a large reduction in overall Medi-Cal enrollment and a large increase in immigrant enrollment (i.e., -16 percent versus 14 percent). These numbers could be attributable to the fact that California chose the most generous Medicaid coverage for immigrants while Texas chose to provide the least generous coverage rather than to barriers specific to immigrants that differ between the two sites. Virginia may provide a better contrast to Texas in that overall Medicaid enrollment dropped by 26.8 percent and immigrant enrollment dropped by 2.4 percent.

Although estimates based on credible data are difficult to make, given our findings about the range of adverse effects on ability to apply, it is likely that there are eligible but unenrolled immigrants for reasons related to both their status and the requirements of the Medicaid application process. Steps taken by state and local officials to address at least the barriers posed by requirements of the application process will benefit all potential eligibles.

**Are Immigrants As Willing to Apply for Medicaid?**

We proposed that immigrants’ willingness to apply for Medicaid, in contrast to ability to apply, would be affected primarily by a set of more subjective factors such as anti-immigrant public sentiment, fears about INS activity and public charge concerns, and mistrust of government institutions. Although there is overlap, we believed that an independent consideration of the factors affecting willingness provide more nuanced and informative findings about immigrants’ access to Medicaid post-enactment. Table 7 summarizes our findings on this issue. We found, as with ability to apply, that the factors affecting willingness to apply for Medicaid fell into two categories: (1) factors specifically related to immigrant status and thus also related to the changes created by the 1996 laws, and (2) factors related more generally related to vulnerable, marginalized, and low-income population status.

**Factors Related to Immigrant Status and 1996 Laws**

*Public Sentiment/Anti-Immigrant Atmosphere*

As discussed above in the section on characteristics of the study sites, anti-immigrant public sentiment was most pronounced in California during the period following the enactment of the 1996 laws. The series of ballot initiatives and other steps taken by the administration of the former governor inflamed an anti-immigrant atmosphere that was already present in many California counties. Community and immigrant informants in San Diego reported that these
public attitudes made immigrants very reluctant to seek public benefits. San Diego County officials reported substantial reductions in undocumented immigrants enrolled for prenatal care during the height of the anti-immigrant sentiment. Participation by undocumented immigrants in prenatal care programs is now reportedly increasing and these officials attribute this increase to reduced anti-immigrant public sentiments and a more positive tone set by the new governor.

Community informants in Chicago reported that the public rhetoric around welfare and immigration reform laws contributed to an increased sense of distrust among immigrants about all government programs. However, the strong presence of numerous CBOs and advocacy groups focused on supporting services for immigrants mitigated this effect somewhat and immigrants did not generally report that they were unwilling to apply for benefits because of public sentiments. In Brownsville and Metropolitan DC, informants said very little about anti-immigrant public sentiments – this issue appeared to have little effect on immigrants’ willingness to apply for Medicaid.

Fear of Public Charge

As discussed above in the introduction to this paper, the provisions of the 1996 immigration reform law (IIRIRA) codified certain longstanding practices of the INS concerning the admissibility of immigrants and focused attention on the issue of public charge. Concerns were heightened among the immigrant advocates that any use of public assistance, even a legitimate use of Medicaid, could interfere with an immigrant’s status. The INS regulations issued in May 1999, which clarified the grounds for public charge and specifically excluded use of noninstitutional Medicaid, were not widely disseminated and/or were greeted with skepticism during our site visits. Indeed, community and immigrant advocate informants asserted that immigrants might still be subjected to public charge questions, and reported that lawyers were continuing to advise their immigrant clients not to use any public benefit while a change in status petition was pending and to be wary of the new presidential administration in 2000.

Although advocates and CBOs across all sites were quite concerned about the public charge issue, and asserted that immigrants’ fears about public charge had a strong negative effect on their willingness to apply for Medicaid, few immigrant informants voiced these concerns. Mexican immigrants in San Diego were quite concerned about how public charge might affect their immigration status and their ability to gain citizenship, but, they were unique among other immigrant informants in San Diego and across the sites. For example, immigrant informants in
Brownsville evidenced quite specific knowledge about this issue and understood that their use of Medicaid was not a threat to their status. It is possible that our immigrant informants self-selected themselves in such a way that immigrants with greater fears about their status chose not to participate in our study. Thus we may have a biased finding about the level of immigrant concern regarding public charge. It is also possible that other issues such as anti-immigrant public sentiment or level of INS activity represented more tangible concerns to these immigrants.

**Fear of INS**

The findings about whether fears of INS activity had a negative effect on immigrants’ willingness to apply for Medicaid are similarly variable and mixed. Once again, concerns were highest among Mexican immigrants in San Diego as these immigrants reported being fearful of confronting INS agents in the welfare offices or being subjected to an investigation of their homes as part of the Medicaid application process. Hispanic immigrants in Metropolitan DC reported that fears of INS activity discouraged them from investigating the availability of public benefits, and African immigrants reported being concerned about giving information that might be reported to the INS. On the other hand, informants in Chicago reported that the INS does not have a strong presence there and so immigrants are not concerned. Immigrant informants in Brownsville again evidenced specific knowledge about INS activity and noted that information given at the welfare office cannot be given to the INS – consequently, they too reported few concerns about applying for Medicaid related to threats from the INS.

The restrictions on Medicaid eligibility for post-enactment LPRs have also meant substantial growth in “mixed families” – families where some members are eligible for Medicaid (i.e., citizen children) and others are not (i.e., LPR parents). Although immigrant parents reported that they are generally quite willing to apply for Medicaid or CHIP for their children, we found evidence that parents might delay seeking these benefits because they are concerned about potential exposure for noncitizen family members. This growing phenomenon of “mixed families” may adversely affect access to Medicaid for the eligible children in these families.

**Factors Related to Vulnerable and Low-Income Population Status**

**Accessibility and Requirements of the Medicaid Application Process**

Across all of the sites, immigrants and other community informants described a range of problems with, and concerns about, the application process. These concerns are common to the
experiences routinely reported by persons applying for Medicaid and include: inability to get to the welfare office due to transportation problems or lack of child care, inability to miss work to complete an application, wait-times that are long and demeaning in the welfare office, and frustrations with onerous paperwork and verification requirements. Safety net informants in Chicago noted that immigrants would frequently not return for follow-up appointments. Safety net informants and county officials in Brownsville noted that certain practices such as reporting absentee parent requirements had a particularly negative effect on immigrants.

Immigrant and community informants noted that San Diego County’s aggressive anti-fraud campaign, developed in the mid-1990s, had a particularly negative effect on immigrants. The notable additional requirement for determining eligibility associated with this campaign was a policy of conducting home visits for all applicants. Immigrant informants reported hearing that Medi-Cal anti-fraud investigators frequently came to homes carrying guns. County officials in charge of the fraud investigation unit asserted that their efforts were not aimed at immigrants, and insisted that reports of investigators coming to homes in uniforms with guns were entirely inaccurate and just rumors. Nonetheless, immigrants were reportedly very frightened by the home visits, confused these investigators with INS agents, and concerned that county caseworkers were giving information to the INS.

*Misinformation, Mistrust, and Language Barriers*

Informants in all sites but Brownsville reported that misinformation about Medicaid eligibility was widespread among immigrants. Language barriers compounded this lack of accurate information with the type of immigrant group most affected varying by site (e.g., Asian immigrants were most affected in San Diego and in Metropolitan DC). Bilingual caseworkers and translation services were reportedly inadequate in all sites except Brownsville. Because it is a border town, Brownsville is largely a bilingual community (Spanish/English) and thus language barriers are rarely an issue. It is notable that Brownsville informants reported the lowest level of problems with fears about INS and public charge and with understanding Medicaid eligibility criteria and the application process.

State and county officials in all four sites reportedly had made few concerted efforts to inform immigrants about the availability of Medicaid and CHIP, and preferred to rely on CBO and SNP networks. Immigrant informants frequently reported that they were more comfortable working with CBOs and SNPs to figure out how to apply for Medicaid. However, these informal
networks did not always compensate for lack of accurate information. Immigrants often reported that they were confused about Medicaid requirements and concerned that there would be copayments and other costs. In San Diego, large and somewhat misleading posters in the welfare offices reportedly spurred immigrant beliefs that using Medi-Cal could endanger their status.

**Caseworker Attitudes**

While immigrants and other community informants reported rude caseworker behavior and mistreatment in all four sites, immigrants and community informants reported the worst treatment by caseworkers in the District of Columbia, two Maryland counties and Texas; this treatment was particularly directed at non-English speaking applicants. Immigrants reported that these experiences made them reluctant to go to the welfare offices. Ironically, informants in Brownsville also noted similar very rude behavior by caseworkers – even though Spanish is widely spoken by caseworkers, applicants/clients are apparently expected to use English.

**Conclusion – Two Sets of Barriers with Greater Effects due to Non-Immigrant Factors**

Our findings suggest that immigrants are generally willing to apply for Medicaid across all four sites notwithstanding a range of barriers; their willingness is particularly strong when they seek services for their children. On the other hand, our findings also indicate that a sizeable number of immigrants have been unwilling to attempt to access Medicaid as a result of these barriers, particularly when the potential beneficiary is the adult parent.

We found that immigrants’ willingness was relatively higher (i.e., less affected) in Brownsville and Metropolitan DC, and relatively lower in Chicago and San Diego. Of the two categories of barriers or factors affecting willingness, factors related to immigrant status and the effects of the 1996 laws showed the most variability across the sites. For example, concerns and fears about public charge and the INS were notable among a few subgroups by site but were consistently prevalent at only one site, San Diego. That the site with the most generous Medicaid coverage for immigrants should also evidence the strongest barriers related to immigrant status and the effects of the 1996 laws illustrates the importance of understanding the particular history and dynamics of each site when assessing the relative effects of these laws.

Barriers related to vulnerable and low-income population status were more consistently reported across all the sites and probably posed the greater negative effect on immigrants’
willingness to apply. Problems with transportation, time-consuming application procedures, and rude caseworkers were uniformly reported. Hispanic immigrants in Chicago, Brownsville, and Metropolitan DC talked about their reluctance to participate in Medicaid due to the cultural values against receiving public benefits. Community informants as well as immigrants frequently talked about a lack of trust in government institutions. In so many ways, these immigrants express concerns that are identical to low-income and vulnerable citizens (especially non-English-speaking citizens) with respect to their experiences in applying for public benefits and willingness to continue to seek access.

Are Immigrants Willing and Able to Access Primary Care Services?

Several factors reportedly affected immigrants’ willingness and ability to access primary care services. We found that these factors or barriers were primarily a function of these immigrants’ low-income and vulnerable population status, and that factors specifically related to their immigrant status and the 1996 reform laws seemed to have very little effect. Our findings suggest that many immigrants, although willing, must deal with certain barriers to be able to access primary care services. Table 8 summarizes our findings.

Factors Related to Immigrant Status and 1996 Laws

Although factors related to immigrant status and the 1996 laws were not widely reported by immigrants or community informants as affecting access to primary care, two notable points about the immigrant-related effects did emerge from our findings. First, undocumented immigrants were most likely to report being deterred from seeking health care services due to fears about being deported. This was particularly true in San Diego where there had been increased Medi-cal fraud investigations and the presence of INS agents reported at or near clinics. Although the 1996 laws did not change what the risks of deportment have always been for undocumented immigrants, it is possible that increased INS activity as well as increased public scrutiny of immigrant issues created a more fearful atmosphere for these immigrants in San Diego post 1996. As noted earlier, county informants reported that their data showed the use of prenatal care by undocumented immigrants decreasing substantially during the period 1996 to 1998, and that use was just beginning to increase in 1999.
Second, the restrictions on Medicaid eligibility for post-enactment LPRs have meant substantial growth in “mixed families” – families where some members are eligible for Medicaid (i.e., citizen children) and others are not (i.e., LPR parents). Although immigrants parents were generally quite willing to seek primary care services for their children, we found evidence that parents might hesitate or delay seeking care because (1) they are concerned about exposure for noncitizen family members, or (2) different insurance status for different family members created additional burdens on seeking care because family members had to get services at different locations.

Factors Related to Low-Income and Vulnerable Population Status

Immigrant informants frequently reported the kinds of problems with seeking primary care services that are frequently reported by low-income, vulnerable and uninsured citizens. These problems include: long waits to get appointments; crowded waiting rooms with long waits; transportation difficulties; and inability to pay. Although immigrants generally had presumptive access to safety net providers (i.e., community clinics and public hospitals), reports of their experiences reflect the reality of seeking care from the overburdened safety net. That Asian and Hispanic immigrants in Chicago, and Chinese immigrants in the District reported preferring home remedies in order to avoid long waits at clinics, and that Hispanic immigrants in San Diego and Brownsville reported frequent trips across the border to access cheaper and quicker care, reflect choices and frustrations of persons trying to access an overloaded safety net system or being unable to pay. Moreover, SNP informants in Brownsville reported that home remedies and care received in Mexico often make the medical conditions worse and complicate subsequent medical treatment.

On the other hand, culture and language issues also influenced immigrants’ behavior in seeking primary care in a more affirmative manner. Not unlike groups of citizens with cultural values and preferences (i.e., rural Appalachians or Native Americans), immigrants reported that they sought primary care in venues where they felt comfortable including: providers who speak their language, curanderas with their home remedies, and trips across the border. The availability and use of these alternative venues may be a function of preferences (i.e., what traditionally has been done and worked) as much as of need (i.e., inability to access or pay for clinic care). Immigrants’ willingness and ability to have a regular provider and routinely use
primary care may also be affected by cultural values as much as by socioeconomic circumstances. For example, community and immigrant informants commonly reported that the cultural values of many immigrant groups, especially Hispanic immigrants, did not promote the use of primary or preventive care.

Conclusions: Post-Enactment Immigrants’ Experiences Are More Like Vulnerable Low-Income Citizens As Increasing Numbers of Them Are Uninsured

At first blush, our findings indicate that the major problems associated with accessing primary care are related to factors involving socioeconomic conditions and vulnerable population status and not to immigrant status. The immigrant groups most vulnerable to impaired access are LPR adults, frequently parents, who were willing to seek care for their citizen and/or insured children but not for themselves. In three out of four sites, community and immigrants informants reported that adults routinely delayed care.

However, our findings suggest that the 1996 welfare and immigration reforms have resulted in growing numbers of uninsured immigrants (i.e., post-enactment LPRs who are barred from federally-funded Medicaid coverage), and have exacerbated the likelihood that eligible immigrants may be less willing to apply for Medicaid/CHIP. Consequently, given that being uninsured makes it more difficult to access primary care services from an overburdened safety net, then our findings also suggest that the 1996 laws have indirectly affected immigrants’ ability and willingness to access primary care services.

Are Immigrants Willing and Able to Access Emergency Services?

Emergency Services Are Accessible But Often Primary Care of Last Resort for Uninsured

In general, immigrants at all four sites reported that they were willing and able to access emergency services when necessary. To the extent that barriers were occasionally reported, they primarily involved fears about costly bills and the inadequacy of interpreter services. Barriers related to immigrant status (i.e., INS presence at hospitals) were rarely reported except in San Diego. SNP informants confirmed these reports about few barriers and reported that, in general, immigrants were able to access emergency care without difficulty. Although immigrant informants emphasized their concerns about costly medical bills and frustrations with language
problems, our findings suggest that these concerns did not prevent them from seeking and accessing emergency care. Table 9 summarizes these findings.

While otherwise eligible immigrants were generally able to access emergency care, the fact that many immigrants reported that they delayed primary or preventive care and waited for an emergency in hopes of getting Medicaid coverage for the bill raises issues about appropriateness and quality of care actually accessible to immigrants. A range of informants reported their experiences with crowded waiting areas, long waits in emergency rooms, frustrations with getting Medicaid coverage for emergency services, and the burdens of paying emergency room bills. Although addressing concerns about the quality and appropriateness of care for immigrants in emergency rooms is well beyond the scope of this study, circumstances that encourage people to use emergency rooms as substitutes for primary/preventive care are generally viewed as undesirable for both patients/consumers and for providers/our health care system. Again, to the extent that growing numbers of immigrants are uninsured as a result of the 1996 reform laws, increased demands on emergency rooms by immigrants who cannot afford access to primary care can be seen as a likely indirect effect of these laws.

What Has Been the Effect of 1996 Laws on Immigrants’ Health-Related Quality of Life?

As noted in the introduction to this section, we anticipated that the effects of these laws could be assessed by considering recent changes in outcomes related to access to health services and health status with data from provider/SNP informants such as the incidence of communicable disease, evidence of delayed care, and appropriate use of prenatal care and primary care. We asked immigrant informants about absences from work or school due to illness, delayed care, and frequency of illness in their families.

We found that state, county, and community-based informants generally reported that it was too soon and/or not feasible to assess definitively the effects of the 1996 welfare and immigrant reform laws on immigrants’ health-related quality of life. They cited many reasons for this position including: (1) an overall lack of relevant data; (2) a lack of provider capacity to collect these data, particularly because providers do not ask about immigrant status; (3) a lack of focus on post-enactment immigrants to facilitate tracking these issues; and (4) that adverse changes/trends in health status and disease incidence take longer to emerge in a generally healthy population.
Immigrant informants generally reported that their health was good. Although they recounted their difficulties with accessing Medicaid and/or primary care services, for the most part these immigrants did not attribute any recent changes or increases in health-related problems to these difficulties. While the occasional anecdote was reported about a family member or friend with a serious problem, these immigrants noted that they and their children were rarely sick and generally in good health, and that sick children were routinely taken to the doctor. The only exception to this involved reports from immigrant informants in Brownsville who specifically talked about the 1996 laws and attributed changes such as more difficult application procedures and increased difficulty in accessing services to these laws.

Both provider and community informants, however, frequently expressed concerns about the longer-terms effect of immigrants’ inability to access primary and preventive health care, citing concerns about impending increases in communicable diseases like tuberculosis or sexually transmitted diseases. These informants also noted the potential effects of not getting regular access to care on children, such as lack of immunizations or increases in the incidence of hospitalizations due to asthma. They predicted that these health problems from the cumulative effects of lack of access would soon begin to emerge, and emphasized that the current lack of data only pointed out the critical need for establishing data collection and tracking mechanisms focused on these immigrants as part of the low-income and vulnerable population.

IV. CONCLUSIONS AND IMPLICATIONS

We found evidence that immigrants’ ability and willingness to access Medicaid and health care services have been adversely affected since the enactment of the 1996 welfare and immigration reform laws. We identified numerous instances of two types of barriers: (1) those related to immigrant status and the 1996 laws such as fear of the INS, concerns about public charge, and changed eligibility criteria; and (2) those related to vulnerable and low-income population status such as culture and language, inaccessible locations for applying, complex application procedures, and inability to pay for health care services. The relative effects of these barriers varied; this suggests that efforts to ameliorate these effects must be tailored accordingly.
**Immigrants Face Immigrant and Non-Immigrant Related Barriers**

The welfare reform law of 1996 made ineligible for Medicaid several categories of previously eligible legal immigrants, primarily post-enactment LPRs. The immigration reform law focused attention on the admissibility of immigrants and heightened fears among immigrants that using Medicaid or accessing health services might jeopardize their status. We anticipated that the combined effects of these two laws would be reductions in the use of Medicaid and the use of needed health services by immigrants. While our findings provide evidence of the effects of these two laws, we also found evidence of more complex and longstanding dynamics that suggest that immigrants’ access to Medicaid and use of health services are equally affected by barriers related to their low-income and vulnerable population status and by barriers related to their immigrant status. These results have important implications for how federal and state officials and policymakers can address the health care access problems faced by immigrants.

**Access to Medicaid Affected By Both Barriers**

States have the option to ameliorate the fact that post-enactment LPRs are barred from receiving federally-funded Medicaid by extending state-funded Medicaid coverage. Our six states illustrate the range of state choices from the most generous state, California, to the least generous state, Texas. California’s generosity is not the norm among the states, however, and our findings confirm that, overall, fewer immigrants are now eligible for Medicaid. Substantial variability exists in state coverage for post-enactment immigrants some states with more generous coverage offer state-funded Medicaid or state- or county-funded medical coverage to pregnant women of any immigrant status and LPR children. Notwithstanding the extended coverage provided by some states, we found that eligible immigrants still faced barriers in their ability to apply for Medicaid, such as poorly implemented changes in immigrant eligibility criteria for Medicaid or additional application requirements for immigrants. In addition, we found that immigrants applying for Medicaid also faced the same barriers as have been traditionally reported by citizens applying for Medicaid (e.g., burdensome application procedures and paperwork, difficult caseworkers, and hard to reach welfare offices).

We found that immigrants’ willingness to apply for Medicaid was also affected by these two sets of barriers. The traditional barriers to Medicaid (i.e., those related to low-income and vulnerable population status), however, seemed to play a greater role in discouraging immigrants
from applying than did the barriers related to immigrant status and the 1996 laws. The notable exception to this point involve the phenomenon of “mixed families” where immigrant family members (usually parents) are often afraid and reluctant to apply for Medicaid/CHIP for citizen members (usually children) out of fear of jeopardizing immigrant family members or relatives. Although definitive data-based evidence was not available to quantify these effects, informant interviews and available data strongly suggest that there are substantial numbers of eligible but unenrolled immigrants, particularly among citizen children of immigrant parents, and that these unenrolled immigrants are being prevented or discouraged from enrolling in Medicaid as a result of these barriers, especially those related to low-income and vulnerable population status.

Access to Primary/Emergency Care Primarily Affected by Non-Immigrant-Related Barriers

We found the same results with respect to immigrants’ willingness/ability to access primary care and emergency services. Both sets of barriers affected access but here the traditional low-income and vulnerable population status barriers seemed to have a much greater effect than the immigrant status-related barriers. It is not surprising that uninsured low-income immigrants would face the same barriers to care as low-income uninsured citizens (e.g., long waits to get appointments, transportation problems, concerns about inability to pay) and that these barriers would be far more troublesome than immigrant-related barriers (e.g., fear of INS). Again, the notable exception to this point involves mixed immigrant families where parents are afraid/reluctant to access services for citizen family members out of fear of endangering immigrant family members or relatives.

Implementation of 1996 Laws Increased the Uninsured Population, Exacerbated Demands on the Safety Net, and Heightened Fears About Using Medicaid

The 1996 welfare law effectively created more uninsured people by denying access to Medicaid to heretofore eligible post-enactment LPRs. These uninsured immigrants – largely comprising LPR adults – are now members of the growing population of uninsured in US. To the extent that the 1996 welfare and immigration reform laws have lead to greater numbers of uninsured immigrants in this country, then the indirect effects of the laws have been to place additional strains on the safety net, and to make access to care more difficult for all groups of uninsured, citizens and immigrants alike. Moreover, these uninsured immigrants will very likely
include greater numbers of Medicaid-eligible but unenrolled immigrants due to heightened fears about using Medicaid. Despite the federal clarification about public charge (i.e., that use of Medicaid will not by itself subject an immigrant to the risk of being labeled a public charge), we frequently heard reports that immigration lawyers, still uncertain about how INS will implement this clarification, continue to advise their clients not to use Medicaid in order to avoid any possible risk of problems. Notably, the Clinton Administration has recently proposed in its FY2001 budget that states should be allowed to provide Medicaid benefits for legal immigrants families regardless of their date of entry and restore Medicaid to legal but disabled immigrants.

**Our Findings Are Consistent with the Results of Other Recent Studies**

Our primarily qualitative findings are consistent with the primarily quantitative results of other recent studies examining immigrants’ access to health care post-welfare reform. Recent analyses of data from the National Survey of America’s Families indicate that noncitizens and their children continue to face multiple barriers to accessing Medicaid, health insurance and health care services. Trend data analyses indicate that insurance coverage of noncitizens has fallen since 1995, particularly Medicaid coverage. Data-based evidence shows the low insurance coverage and greater declines in coverage for citizen children of noncitizen parents as compared to citizen children of citizen parents. These researchers’ conclusions, noting the well-established relationship between health insurance coverage and use of health care services, that immigrants’ access to and use of health care services have fallen due to declining access to health insurance coverage are also borne out by our findings here.

**Efforts to Improve Access Must Address Both Sets of Barriers in Tandem**

These findings indicate that efforts to improve access to Medicaid and health care services to immigrants, and to ameliorate the effects of the 1996 laws must be tailored to each of these findings. It is evident that both sets of barriers must be addressed in tandem to each other. For example, continuing and concerted efforts to clarify that immigrant use of Medicaid does not

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present a public charge issue must be accompanied/complemented by efforts to make the
Medicaid application process more accessible to immigrants (e.g., simplify application
procedures, expand outstationed locations). Otherwise, immigrants will still be unable or
unwilling to apply for Medicaid.

Similarly, efforts to encourage immigrants to use preventive and primary care services
must be accompanied by efforts to reduce the barriers to accessing these services. Again, just
addressing immigrant-related barriers (e.g., fears about INS activity or the risk of deportation for
using services) will clearly not suffice as the primary barriers to access cited by immigrants
involve the traditional barriers faced by low-income, uninsured and vulnerable populations (i.e.,
long waits to get an appointments, transportation problems, concerns about inability to pay
sliding fees). Efforts in this regard must involve steps to reduce the number of uninsured
immigrants (i.e., extend state-funded Medicaid/CHIP) restore federally-funded Medicaid,
establish state or county-funded medical services programs), and to improve the capacity of
safety net providers with increased resources and support.

**Need to Establish Mechanisms to Monitor Health Status and Outcomes for Immigrants**

Our findings do not provide definitive evidence of the adverse effects on immigrants’
health-related quality of life that we anticipated to be the result of reduced/impaired access to
Medicaid and primary care services (i.e., consequences of delayed care, increases in
communicable disease, increased frequency of illness). These effects are not unique to
immigrants and would be anticipated in any group with limited or impaired access to routine and
preventive primary care. However, because these trends can be difficult to observe in their
initial stages, systematic efforts to monitor immigrant health status, complemented by
comprehensive data collection, must be established as part of efforts to monitor the health status
and health services needs of low-income, uninsured and vulnerable populations.

**Limitations of this Study**

Case study methods are designed to produce in-depth examinations of individual “cases.”
Thus, these studies usually create unique findings that reflect the particular circumstances of the
case. To ensure the applicability of our findings to other states, we selected four different
cases/sites, and developed an analytic framework to guide our investigation with common
protocols, and systematic data collection and analyses. Our cross-site analyses do provide the basis for practical recommendations for addressing barriers for immigrant access to Medicaid and health services that are applicable both to our four sites and to other sites.

Our findings based on the immigrant interviews and focus groups are not presented as representative of the entire immigrant population in these sites. We note substantial potential for selection bias among our sample of immigrant informants. Immigrants self-selected for participation and, 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. However, the reports of the immigrants provided rich and detailed pictures of these immigrants’ personal experiences in accessing Medicaid and health care services prior to and since the 1996 laws. Moreover, the potential effect of this bias does not change our findings regarding presence of two sets of barriers: immigrant-related and nonimmigrant-related. One could suppose that these immigrant informants who were already connected to services have had less trouble with the nonimmigrant barriers than would other less well-connected immigrants.

V. RECOMMENDATIONS

We propose recommendations for federal, state, and local officials and policymakers to ameliorate the effects of these barriers on immigrant access to Medicaid and health services; these appear in each site visit report and are specific to particular conditions for that site. Table 10 presents the recommendations organized by site and by research question.

Table 10 also shows the variability and commonalties among the recommendations, notwithstanding the unique characteristics and circumstances relevant to immigrant access to Medicaid and health care services by site visits. The major recommendations common across all sites include: (1) expand outstationed enrollment locations; (2) simplify application procedures; (3) improve outreach about who is eligible for Medicaid; (4) provide more support and financial
assistance to safety net providers; (5) provide more support for public health outreach and education; and (6) improve efforts to clarify scope of public charge. It is notable that most of these recommendations are not unique to immigrants but would be part of strategies to improve Medicaid enrollment and/or expand access to health care for citizens as well.

These major recommendations are summarized according to research question as follows:

**Immigrants’ Ability to Apply for Medicaid**

- Expand outstationed enrollment sites and expand eligibility determinations at these sites.
- Improve training for caseworkers to deal with immigrants’ special needs in applying.
- Simplify the Medicaid eligibility and redetermination process.
- Make the Medicaid application and brochures available in languages other than English and Spanish.
- Invest in outreach and education efforts directed at immigrant families and include both Medicaid and CHIP programs.
- Hire bilingual caseworkers to provide services to non-English speaking applicants.

**Immigrants’ Willingness to Apply for Medicaid**

- Increase training of community-based organizations and safety-net providers about Medicaid and CHIP eligibility to improve outreach to immigrant communities and diffuse misinformation and general reluctance to enroll in Medicaid or CHIP.
- Remove posters and flyers in the welfare offices informing any category of immigrants that they may be reported to the INS if they use certain public benefits.
- Institute programs for eligibility workers for sensitivity training about assimilation issues with a particular focus on immigrants’ frequent fears and distrust of government institutions.
- Articulate widely and clearly that immigrants should not have fears about public charge and Medicaid use with a special emphasis to educate/train INS staff at all levels and concerted efforts to assuage the lingering concerns of the immigration attorneys/bar.
Immigrants’ Ability and Willingness to Seek Primary Care Services

- Use safety-net providers and community-based organizations to emphasize the value of receiving regular, preventive and primary care, regardless of insurance and immigrant status at every opportunity.
- Establish comprehensive strategies to improve access to primary care for immigrants that account for the multiple barriers that discourage immigrants from seeking such care.
- Promote increased outreach and education about the public charge clarification.
- Use promotoras and their equivalents (i.e., lay community health workers) to educate immigrants.

Immigrants’ Ability and Willingness to Seek Emergency Services

- Assure immigrants that hospitals do not report immigration status to the INS.
- Increase the capability of hospitals to provide translators for non-English speaking emergency care patients.
- Educate immigrants about payment options and emergency Medicaid eligibility so that the inability to pay for care does not prevent immigrants from accessing emergency care.

Effect of the 1996 Laws on Immigrants’ Health-Related Quality of Life

- Institute careful monitoring of rates of infectious diseases, such as tuberculosis, and other ambulatory care-sensitive conditions, such as asthma, among immigrant communities.
- Establish capacities to collect more accurate data (e.g., epidemiological data classified by immigration status) that can be used to document and describe the effect of the 1996 laws on immigrants’ health-related quality of life.
- Continue and increase support to safety-net providers who are caring for the uninsured immigrant population.
- Improve the capacity of appropriate health and public health institutions to collect systematically information about immigrants’ health-related quality of life.