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

BROWNSVILLE, TEXAS SITE VISIT REPORT
EXECUTIVE SUMMARY

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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.

PRWORA also 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. For Medicaid, states have three options: (1) whether to continue or deny federally-funded Medicaid coverage to qualified immigrants who arrived in the US prior to August 22, 1996; (2) whether to provide state-funded Medicaid coverage for qualified immigrants who arrive in the US 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).

The law imposes greater financial responsibility on states choosing to extend Medicaid to noncitizens/legal immigrants who have been barred from receiving federally-funded Medicaid by PROWRA. These provisions mean that (1) there will be variability by state in 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 Medicaid and medical other coverage.

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. This research used a
case study approach and was conducted at four sites: Chicago, Illinois; Metropolitan Washington DC; San Diego, California; and Brownsville, Texas.

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 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.

Major findings from Brownsville include:

♦ **Immigrants’ Ability to Apply for Medicaid** – In general, immigrants have not been discouraged from applying for Medicaid for their citizen children. However, this is not always the case for themselves. Our findings suggest three sets of issues affecting immigrants’ ability to apply for Medicaid in Brownsville, Texas: the conditions of the coverage options for pre- and post-enactment immigrants chosen by Texas; the level of misinformation and lack of outreach offered by the state of Texas for CBOs, SNPs, and the immigrant community, and; the circumstances and conditions of the Medicaid application process (e.g., where immigrants are required to apply for Medicaid, and the accessibility of outstationed enrollment sites; the perceived increase in difficulty in applying for Medicaid; and the level of immigrants’ language and literacy skills).

♦ **Immigrants’ Willingness to Apply for Medicaid** – In general, immigrants in Brownsville reported that they were willing to apply for Medicaid for themselves and their children, but several barriers do exist. Two sets of barriers exist: those related to the 1996 laws (i.e., misinformation, fear of public charge, or of the INS); and factors that are not caused by the laws, but are related to, or made worse by, the changes in policies (i.e., mistreatment by caseworkers, and immigrants’ unwillingness to supply necessary information on absentee parents).

♦ **Immigrants’ Ability and Willingness to Seek Primary Care Services** – Generally, immigrants were willing to seek primary care for their children, but not as willing for themselves. Factors affecting immigrants’ ability and willingness to were primarily related to their vulnerable population status: the high cost of health care, and inability to pay; seeking health care and pharmaceuticals in Mexico; use of traditional medicine; long waits to see a provider, loss of time from work, and lack of transportation; mistreatment by providers and discrimination; undervaluing preventive care; and reluctance to accept public benefits. Some factors, related to the 1996 laws have also impacted immigrants’ ability to seek primary care services: confusion about the laws; fear of the public charge; and fear of the INS “police state.”
Immigrants’ Ability and Willingness to Seek Emergency Health Services – In general, the practice of immigrants seeking emergency health care has not been affected by the implementation of the 1996 welfare and immigration reform laws. However, emergency Medicaid coverage can be difficult to obtain for immigrants experiencing non-pregnancy related conditions. Factors unrelated to the new laws, including inability to pay for health care and fear of the INS, continue to impact immigrants’ decision to seek emergency care (especially for undocumented immigrants, except in cases related to childbirth).

Impact on Immigrants’ Health-Related Quality of Life – It is too soon to draw conclusions about the impact of the 1996 laws on immigrants' health-related quality of life, however immigrants and CBO and SNP informants do believe that the laws have had an adverse effect on the overall health status of the immigrant community in Brownsville and on the SNPs that care for this community. Fewer immigrants are eligible for Medicaid since the enactment of PRWORA. Texas has chosen mainly the least generous options within its discretion under PRWORA. Medicaid benefits were continued for pre-enactment LPRs but the state has not provided any substitute coverage for post-enactment adult LPRs who are barred from receiving Medicaid benefits for five years. As noted above, the legislature voted to cover citizen children as well as legal immigrant children who do not qualify for Medicaid or CHIP under a state-funded health insurance program. This program covers post-enactment LPR children 0-19 years old and up to 200 percent FPL with benefits that are similar to the CHIP benefits package.

It is difficult to quantify the precise impact the new laws have had, and to attribute specific outcomes as a result of the laws’ enactment. It is difficult to identify particular data-based evidence to these new policies. Therefore, it is not clear whether immigrants have been more adversely affected than have non-immigrants. However, our findings do suggest that some immigrants who are both qualified and eligible for Medicaid have been dissuaded from doing so due to factors related and unrelated to their immigrant status.

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

Limitations

Our findings are based on interviews and focus groups with 54 immigrants and representatives from 14 community-based organizations and safety net providers. These findings are not presented as representative of the entire immigrant population in these sites. Our findings may not accurately depict the true level of immigrants’ knowledge of the laws. There is substantial potential for selection bias among our immigrant informants/sample because: 1) immigrants self-selected for participation; and 2) were already connected to resources such as community health clinics and Medicaid. Immigrant informants were recruited by safety net providers, community-based organizations, and caseworkers and already had some
understanding of how to navigate the health care delivery and/or Medicaid system in Brownsville, Texas. These immigrants may have been less fearful about public charge or INS activities; and may have had more accurate knowledge about Medicaid and how to access healthcare services. We may have underestimated the effects of immigrant-related barriers to Medicaid and healthcare services, and our findings about the relative weight of the two sets of barriers (immigrant-related and nonimmigrant-related) may be skewed. However, immigrants’ reports provided a rich and detailed picture of their personal experiences in accessing Medicaid and healthcare services prior to and since the 1996 laws.

Recommendations

Our 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 one or the other of these two types of barriers: 1) barriers related to immigrant status and the 1996 laws; and 2) barriers related to vulnerable and low-income population status. It is also evident that both sets of barriers must be addressed in tandem.

Our findings suggest the following recommendations: 1) Texas should invest in outreach and education efforts to keep immigrants informed about which services they qualify for and how to apply; 2) expand the use of Medicaid outstationed enrollment sites; 3) articulate that immigrants should no longer fear public charge, and increase outreach about the public charge clarification; 4) require sensitivity training for caseworkers, particularly regarding treatment of non-/limited English speaking immigrants; 5) use Promotoras to educate immigrants about how to apply for Medicaid and obtain health services; 6) emphasize the importance of primary care; 7) increase immigrants’ access to primary care; 8) focus resources on prevention programs and outreach to mitigate the burden on hospitals caring for patients who may have delayed seeking health care services. 9) inform immigrants about their eligibility for emergency medical assistance under the TP-30 program; 10) assure immigrants that hospitals do not report immigration status to the INS; and 11) collect epidemiological data classified by immigration status (e.g., for conditions such as drop-in child delivery, tuberculosis, diabetes, and asthma).