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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BROWNSVILLE, TEXAS SITE VISIT REPORT

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Many people contributed to the completion of this study. Most important among them are the numerous state officials, safety net providers, representatives of community-based organizations, and the immigrants who gave their time, granted interviews, and furnished materials. The cooperation of the community-based organizations was particularly instrumental in our being able to talk to immigrants about their experiences. We appreciate the time and assistance from all of these individuals and entities; without their participation this study would not have been possible.

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

Finally, we note the efforts of additional project staff from The George Washington University Center for Health Services Research and Policy: Takisha Galaor, MPH, and Carol Tumaylle, MPH. Their work in preparing for site visits, arranging interviews and travel, and participating in site visits, represented an important contribution to completing this study.

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

The 1996 Welfare Reform and Immigration Reform Laws

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

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.² States are required to bar most post-enactment immigrants from “federal means-tested benefits” (i.e., nonemergency Medicaid, SSI, Food Stamps, TANF, and the state Children’s Health Insurance Program (CHIP)) for their first five years in the United States. Figure 1 of Volume I illustrates the pathways for immigrant eligibility from which states can choose.

Table 1 of Volume I 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.³ The term ‘qualified’ is used in the law to distinguish among categories of immigrants for the purpose of eligibility for public benefits. However, being a member of a qualified immigrant category does not necessarily mean that eligibility for public benefits is available.

PRWORA essentially created three groups of qualified immigrants in terms of eligibility for public benefits (See Table 1, Volume I). For pre-enactment legal permanent residents (LPRs) with fewer than 40 qualifying work quarters, states can decide whether to provide federal

³ Certain PRUCOLs represent a striking example of a group of individuals who lost the most as a result of PRWORA as they were legally residing in the 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.
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, Volume I for the complete list) are eligible for federal public benefits for five to seven years depending upon the program. After the five-year bar, states may opt to provide federally-funded public benefits to post-enactment LPRs although they must provide benefits to those with 40 work quarters. In dealing with these new groups of immigrants, the distinction between being a qualified immigrant and being eligible for public benefits must be clearly understood (i.e., a qualified immigrant is not necessarily an eligible immigrant).

PRWORA represents a substantial and unprecedented shift in (i.e., devolution of) immigration policy from the federal to the state level. State officials now have substantial discretion to determine which types of immigrants will receive which kinds of public benefits. The law also imposes greater financial responsibility on states choosing to extend benefits to noncitizens/legal immigrants who have been barred from receiving federal public benefits by PRWORA. These provisions mean that: (1) there will be variability by state in terms of coverage and access for immigrants/noncitizens arriving in the 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.

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4 An alien who is likely at any time to become a "public charge" is ineligible for admission to the U.S. and is ineligible to adjust status to become a legal permanent resident. An alien who has become a public charge can also be deported from the 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 [accessed 4-18-00]

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.

II. METHODS

The project used a case study approach to obtain a detailed picture of immigrants’ experiences since the enactment of welfare and immigration reforms. As noted above, four sites (Chicago, IL; Metropolitan Washington DC; San Diego, CA; and Brownsville, TX) 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 are represented; the nature of state and local decisions about what services to continue to make available to which immigrants; the recent history of state and local communities with immigrant populations and issues; the accessibility of the immigrant populations; the availability of safety net providers (SNPs) and community-based organizations (CBOs); and the recent history of INS-related activity.

The case studies were conducted from March through October 1999. In addition to interviewing state and county officials, representatives of safety net providers, community-based organizations, and advocates, we conducted individual interviews and focus groups with immigrants. At least two focus groups were conducted at each site. We partnered with CBOs and SNPs to recruit low-income immigrant parents to participate in the focus groups or individual interviews. In most cases project staff conducted the interview and group discussions while in some cases a representative of the host organization moderated the group discussion. Except in cases where the immigrant was comfortable speaking English, all interviews were conducted in the immigrants’ native language and/or with the assistance of a translator.

This case study is based largely on interviews conducted during July 1999, supplemented by follow-up phone calls and background materials collected by project staff or supplied by informants. Expert observers including Texas state officials, and representatives of CBOs and SNPs were contacted prior to and during the site visit. Altogether, more than 96 informants participated in the study.

This report presents findings from the site visit to Brownsville Texas. The site visit was conducted during March and April 1999.12

A. Terminology for Immigrants Used in This Report

We use a range of descriptive terms in this report to identify groups of immigrants. For example, we use the term “immigrants” or “refugees” and not “aliens;” and we use the term “undocumented immigrants” instead of “illegal aliens.” We use immigrant and non-citizen interchangeably. While the 1996 laws introduced the terms “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 choose 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 term of eligibility for public benefits. For example, pre-enactment LPRs, who are qualified immigrants, are eligible for Medicaid while most post-

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12 A synthesis of the study including findings from all four site visits, as well as the individual site visit reports are available at www.gwu.edu/~chsrp. A separate paper focused on the findings from immigrant interviews and focus groups from each site can also be accessed at the same web page.
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 these terms pre-enactment LPR and post-enactment LPR 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).

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

A. Characteristics Of Immigrants Living In Texas

Texas has one of the largest populations of immigrants in the United States with an estimated 825,000 legal permanent residents (about 7.8 percent of the state’s population). Texas also has an estimated 700,000 undocumented immigrants, one of the largest populations of such immigrants in the U.S. Consequently the state absorbs high costs for social services used by both legal and undocumented immigrants. The state’s foreign-born population grew by 78 percent between 1980 and 1990 and accounted for 25 percent of Texas’ overall population growth. Undocumented immigrants emigrate primarily from Mexico. Hispanics currently make up 28 percent of the state’s population. In 1998, 15 percent of the Texas population was living in poverty, and non-citizens accounted for 13 percent of that number. During that same period, 25 percent of Texas citizens were uninsured; it is estimated that as many as 1.4 million Texas children may be uninsured, which accounts for nearly 10 percent of all uninsured children in the U.S.

Brownsville is located in Cameron County, which has a population of 322,220; the population of Brownsville is 135,000. Brownsville’s poverty rate of more than 8 percent is more than twice that of the U.S.

B. Immigrant Participation in Medicaid and the Children’s Health Insurance Program

Texas Options for Health Care Coverage for Immigrants post-1996 Reform Laws

The 1996 welfare reform law transferred the authority to determine for which public benefits immigrants are eligible from the federal government to the states. 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-substitute coverage for qualified immigrants who arrived in the

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14 Immigration and Texas: http://www.fairus.org
15 Illegal Resident Population: www.ins.usdoj.gov/illegalalien/index
16 http://govinfo.kerr.orsa.edu/cgi-bin
17 http://relo-texas.cm/brownsville
U.S. on or after August 22, 1996; and (3) whether to provide state- or county-funded coverage to not qualified immigrants (e.g., some categories of PRUCOLs and undocumented immigrants).

Texas has opted to continue providing federally-funded Medicaid coverage to pre-enactment LPRs.\textsuperscript{18} The state has not chosen to provide any state-funded Medicaid benefits to post-enactment adult LPRs who are ineligible for federally-funded Medicaid benefits for five years. Consequently, post-enactment adult LPRs, (except refugees, asylees, LPRs with 40 qualifying quarters) and not qualified immigrants are eligible only for emergency Medicaid. While Texas offers no prenatal care programs for post-enactment LPRs or undocumented immigrants, emergency Medicaid benefits will cover a hospital admission for labor and delivery.\textsuperscript{19}

Table 1 below illustrates the types of programs for which immigrants in Texas are eligible and their eligibility criteria.

### Table 1.
Medicaid and Chip Eligibility for Immigrant Children

<table>
<thead>
<tr>
<th>Programs</th>
<th>Immigrant Category</th>
<th>Age</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Pre-enactment</td>
<td>0-1</td>
<td>185% FPL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-5</td>
<td>133% FPL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6-19</td>
<td>100% FPL</td>
</tr>
<tr>
<td>CHIP</td>
<td>Pre-enactment</td>
<td>0-18</td>
<td>200% FPL</td>
</tr>
<tr>
<td>TP30</td>
<td>All immigrants</td>
<td>Any</td>
<td>Unqualified immigrants with children who otherwise would qualify for Medicaid but for their immigration status</td>
</tr>
<tr>
<td>State–Funded Childrens Health Insurance Program</td>
<td>Post-enactment</td>
<td>0-19</td>
<td>200% FPL</td>
</tr>
</tbody>
</table>

Source: Texas Department of Health and Human Services

The State has currently implemented Phase I of its SCHIP program which expands Medicaid eligibility to adolescents between the ages of 15-19 with incomes at or below 100 percent FPL. Pre-enactment LPR children who are eligible for CHIP are covered. Texas’ SCHIP program currently covers nearly 35,000 children. Phase II is a separate state program that covers children 0-19 years old between 100-200 percent FPL. Children enrolled in the freestanding program are subject to copayments and/or premiums according to their income.

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

\textsuperscript{19} Some county health departments provide family planning and prenatal care through grant funds. For example, Cameron County (where Brownsville is located) has such funding and also operates an indigent care program that covers 60 percent of the cost of major medical expenses for eligible families. Eligibility for this program is severely limited, however, since only those who earn less than 15 percent federal poverty level (FPL) qualify.
levels. The program will be fully implemented in May, 2000, and is expected to cover more than 420,000 uninsured children.

While post-enactment LPR children are not qualified to receive federally-matched CHIP benefits, during the last legislative session, the legislature voted to cover children who are not eligible for CHIP and Medicaid under a state-funded health insurance program. The 1999 Legislature has approved the to help low-income residents under the age of 19, including post-enactment LPR children.

**Medicaid Caseloads**

The Texas Department of Human Services data show a decline of more than 16 percent in the Medical Assistance rolls for LPRs since PRWORA was enacted in August 1996. Table 2 below illustrates the enrollment for all program types. These data do not include the immigrants who received emergency Medicaid benefits (which are covered under the TP30 program).

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>July 1996</th>
<th>April 1999</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFDC $ and medical</td>
<td>18314</td>
<td>8325</td>
<td>-54.54%</td>
</tr>
<tr>
<td>Medical Assistance Only (MAO) grant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under $10</td>
<td>40</td>
<td>29</td>
<td>-27.50%</td>
</tr>
<tr>
<td>MAO 12 months post-earn</td>
<td>2649</td>
<td>2650</td>
<td>0.04%</td>
</tr>
<tr>
<td>MAO 4 months post-child support</td>
<td>80</td>
<td>42</td>
<td>-47.50%</td>
</tr>
<tr>
<td>Transitional MAO – time limits denial</td>
<td>0</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>MAO 12 months post-disregard</td>
<td>336</td>
<td>306</td>
<td>-8.93%</td>
</tr>
<tr>
<td>Pregnant-single and 2 parent household</td>
<td>5939</td>
<td>5695</td>
<td>-4.11%</td>
</tr>
<tr>
<td>Pregnant, presumed eligible</td>
<td>31</td>
<td>12</td>
<td>-61.29%</td>
</tr>
<tr>
<td>Child over 6 at 100% FPL</td>
<td>5721</td>
<td>8559</td>
<td>49.61%</td>
</tr>
<tr>
<td>Ribicoff children</td>
<td>301</td>
<td>2</td>
<td>-99.34%</td>
</tr>
<tr>
<td>Stepparent-grandparent income</td>
<td>54</td>
<td>14</td>
<td>-74.07%</td>
</tr>
<tr>
<td>Children under 6 at 133% FPL</td>
<td>1258</td>
<td>561</td>
<td>-55.41%</td>
</tr>
<tr>
<td>Medically needy</td>
<td>814</td>
<td>2386</td>
<td>193.12%</td>
</tr>
<tr>
<td>Up $ and Medical</td>
<td>1551</td>
<td>2436</td>
<td>57.06%</td>
</tr>
<tr>
<td>MAO UP grant under $10</td>
<td>2</td>
<td>11</td>
<td>450.00%</td>
</tr>
<tr>
<td>UP Transitional MAO</td>
<td>62</td>
<td>0</td>
<td>-100.00%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>37,152</td>
<td>31,131</td>
<td>-16.21%</td>
</tr>
</tbody>
</table>

Note: Children over 6 at 100% includes children receiving Medicaid under the CHIP program.
Source: Legally Admitted Aliens Participating in CSS Medical Programs by Type of Program - Program Budget and Statistics, Office of Programs, Texas Department of Human Services, October 26, 1999.

This table does not include the number of immigrants covered under emergency Medicaid, which is the primary financing vehicle covering post-enactment immigrant

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20 Texas Office of Immigration and Refugees Affairs, September 14, 1999
Significant declines in enrollment can be seen among the following populations: AFDC $ & Medical (55 percent decline); pregnant women presumed eligible (61 percent decline). State officials reported that nearly all the drop in Medicaid is due to the delinking of Medicaid from Temporary Aid to Needy Families (TANF). They also noted that the 55 percent decrease in children under age six at 133 percent FPL has likely been mitigated by the 193 percent increase in the Medically Needy category.

It is interesting to note that while the overall numbers of Medicaid recipients in Texas has decreased by 16 percent from July 1996 to April 1999, many informants in Brownsville reported an increase in Medicaid applications. For example, case workers in Brownsville and Cameron county officials reported a steady increase in the number of Medicaid applications filed, although they could not document the magnitude of the increase. A significant number of these applications are from families with mixed citizenship status (usually families with at least one undocumented parent, but citizen or LPR children who arrived prior to August 22, 1996). Officials at two area hospitals and the health department also reported an increase in Medicaid applications at their outstationed enrollment sites, as well as the number of Medicaid enrollees. This increase in Medicaid applications could be attributed to the high rate of unemployment in Brownsville (currently 8 percent) and the resulting lack of health insurance and poverty.

We received reports that the number of application denials has begun to increase as well. One hospital estimated that as many as 30 percent of immigrant Medicaid applications are denied because patients’ medical conditions were not considered an emergency. Cameron County officials have also reported seeing an increase in the number of immigrant applicants who are denied Medicaid coverage, but could not comment on the exact figures. However, Medicaid officials provided data showing that from June – August 1999, 89 percent of all TP-30 applications were certified. Of the 84 TP-30 applications that were denied (of a total of 747), 54 were denied because the applicant refused to furnish the necessary information to complete the application.

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

The study team interviewed representatives from nearly every SNP and CBO in Brownsville. Informants came from the following organizations: Valley Baptist Medical Center, Valley Regional Medical Center, and the Brownsville Medical Center (all hospitals), and two health centers, Su Clinica Familiar, and Brownsville Community Health Center. Representatives from several CBOs were also interviewed: Catholic Social Services, Texas Rural Legal Aid, the Family Crisis Center, Texas Immigrant and Refugee Coalition, and South Texas Immigration Policy.
Safety Net Providers (SNPs)

Hospitals: By law hospitals that accept Medicaid cannot turn away patients in need of emergency care, regardless of their ability to pay. Brownsville does not have a public hospital; the closest county hospital to Brownsville, South Texas Hospital, is located 26 miles north in Harlingen and is almost entirely devoted to indigent care. By state law, counties are responsible for funding indigent care for residents not served by a hospital district. However, the state provides matching funds for counties that spend more than 10 percent of their gross revenue tax levies on indigent care. Cameron County, which includes Brownsville, was among six counties qualifying for state matching funds. Indigent patients faced with severe diseases have to travel nearly 400 miles to the University of Texas Medical Branch in Galveston, the closest medical facility delivering specialty care for indigent patients. There are local for-profit hospitals such as the Valley Regional Medical Center and the Brownsville Medical Center, both in Brownsville, which provide emergency and regular care.

- **Valley Regional Medical Center** is a 173-bed facility with three senior and two primary care clinics. Ninety-five percent of its patients are Hispanic, reflecting the make-up of the Brownsville community. The hospital has contracted with a private company, which operates in-house doing outstationed enrollment.

- **The Brownsville Medical Center** is located downtown and two miles from the Texas-Mexico border. Informants said that this hospital is “immigrant friendly” because of its proximity to the border and to downtown Brownsville. The Center has 217 beds; between June 1998 and February 1999 it served an average of 1,000 patients per month in in-patient care, and 2,000 patients a month in the emergency department.

- **The Valley Baptist Medical Center**, the only not-for-profit hospital in Brownsville/Harlingen is a 450-bed facility. Most of the beds are occupied during the winter; only half of the beds are used in the summertime.

Primary Care Centers Serving the Indigent: There are two primary care centers in the Brownsville/Harlingen area available to the underserved, *Su Clinica Familiar* and the Brownsville Community Health Center. All of the clinics serve immigrants in their native language. The Cameron County Health Department is also a preventative health care provider.

- In 1998, *Su Clinica Familiar* served over 24,000 patients in 92,000 visits. The center employs 240 healthcare workers across four sites located in Harlingen, Brownsville and a neighboring rural town. Its clientele is 95 percent Hispanic of which approximately 40 percent are monolingual Spanish speakers. *Su Clinica* is an outstationed enrollment site. Staff work with state enrollment workers to schedule appointments with patients and help with their applications. Although the clinic does not ask about immigration status, they estimate that 10 percent of patients are legal immigrants and 10 percent are undocumented. *Su Clinica’s* physicians have admitting privileges at Valley Baptist Medical Center.
Brownsville Community Health Center (BCHC) was founded approximately 50 years ago to provide healthcare services to low income residents in the county. BCHC is a federally designated community health center, receiving approximately 39 percent of its operational budget from the federal government, it employs 133 workers. BCHC served 18,107 patients in 81,332 encounters in 1998. Nine-five percent of the users are Hispanic and 80 percent of them are bilingual English/Spanish. The center has three outstationed enrollment sites in three area schools (elementary, middle and high). BCHC physicians admit patients to the Valley Regional Medical Center.

The Cameron County Health Department (CCHD) provides health care services through an indigent health care program and a WIC program. CCHD provides prenatal care but does not provide primary care services. The department has four CCHD/WIC sites and an additional nine WIC-only sites that also provide immunization services on a part-time basis. Outstationed enrollment occurs at two of the four CCHD sites—one in Brownsville and one in Harlingen. In 1999, CCHD provided maternity care by family nurse practitioners to approximately 1,400 women in Brownsville and Harlingen across all four sites. There were 494 family planning visits, 220 child health visits, 2,329 immunizations, 44 positive TB tests, and 46 STD-related visits. The 12 WIC clinics served over 27,000 people in January 1999, alone. It is estimated that 75 percent of the CCHD program users in Brownsville are immigrants for whom it is guessed that 60 percent are undocumented. Physicians at CCHD admit patients to the Valley Regional Medical Center.

Community-Based Organizations (CBOs)

Representatives from four community-based organizations were interviewed via telephone prior to our site visit about the services they provide to immigrants, Texas Rural Legal Aid (TRLA); Catholic Social Services (CSS); Family Crisis Center (FCC); and the South Texas Immigration Council (STIC).

Texas Rural Legal Aid (TRLA) is a non-profit organization funded by federal grants and private donations. It has 10 offices throughout Texas’ rural areas; due to funding constraints the Brownsville office was closed. The Harlingen office covers a large area from Cameron County to Corpus Christi. The agency handles many civil issues such as family law, consumer protection, Medicaid, and other public benefits. They don’t, however, assist undocumented immigrants except when it involves abused women. The organization conducts 21 interviews a day, three days a week to determine eligibility of applications for all public benefits. TRLA serves a large number of immigrants, approximately half of the population they serve. The other half are U.S. citizen.

Catholic Social Services (CSS) has two offices in San Juan and Brownsville. The Catholic Church, the State of Texas, and foundation grants fund CSS. The agency provides marital and individual counseling as well as a wide array of emergency services such as finding shelter for abused women, supplying food and obtaining prescriptions. About 400 families are serviced monthly. CSS estimates that about one third of its
clientele is undocumented immigrants and the clientele is about 80 percent monolingual Spanish speakers.

- **Family Crisis Center (FCC)** provides services to battered women and their children. The Center houses 150 women a year, and has an outreach and a sexual assault program that serves 300 women. It has a grant from the Texas Council of Housing, which includes funding for healthcare for the women at the shelter. FCC estimates that half of the immigrants they serve are undocumented.

- **South Texas Immigration Council (STIC)** is a private non-profit organization which has three offices operated by 15-18 staff members each, located in Brownsville. The Council provides board-certified presentation, direct services in visa processing, ESL classes, and community outreach to keep immigrants abreast of the current laws. In 1998, the three sites collectively served 14,000 immigrants, both documented and undocumented, of which 96 percent are of Hispanic origin. A substantial portion of their clientele are families with mixed citizenship status.

In addition to these organizations, we interviewed the following CBOs during our site visit to Brownsville: 1) **Centro Cultural**, a community center that houses several service providers who serve LPRs and undocumented immigrants; 2) **Majico Arco Iris** community center is a not-for-profit organization made up of parents and community volunteers to educate Mexican-American children about their heritage, and also provides day care at the center; 3) **Ozanam Center**, a temporary homeless shelter for newly-arrived undocumented immigrants; and 4) **Brownsville Family Center** is a homeless shelter for legal immigrants and U.S. Citizens. Ozanam Center and the Brownsville Family Center are sister organizations.

D. **Characteristics of Immigrants Interviewed for this Study**

Five members of the project team conducted the Brownsville, Texas site visit from July 26 to July 28, 1999. The focus groups and interviews took place at different locations in Brownsville including four CBOs, one community health center, and the Texas Department of Human Services office. The focus groups and interviews involved at least two project team members. Contacts at the site visit locations recruited immigrants to participate in the study either by posting a flyer in their facilities explaining the project and how to sign up, or by approaching clients they believed would be interested in participating. The contacts scheduled the focus groups, found private settings for the meetings to take place, and arranged for refreshments.

The results of interviews and focus groups are rarely generalizeable and our findings based on these immigrant interviews are not presented as representative of the entire Brownsville immigrant population. Also noteworthy is the particular selection bias of our immigrant sample. These immigrants not only self-selected for participation and thus were probably less likely to be fearful about immigrant-related repercussions, but they were also connected to resources such as community-based organizations or clinics and therefore probably more likely to have knowledge about Medicaid, and about how and where to access health care in Brownsville. Despite these limitations, however, the findings provide a rich and detailed picture of these immigrants’
personal experiences with respect to accessing Medicaid and health care services prior to and
since the immigration and welfare reform laws, and suggest valuable insights regarding the
factors affecting immigrants’ ability and willingness to access Medicaid and health care services.

A total of 73 immigrants were interviewed (see Table 2, Volume I for complete
demographics of participants)— 65 immigrants were interviewed in groups ranging from two to
eight participants while the remaining eight immigrants were interviewed
individually. At one of the community-based organizations where focus groups were held, the
immigrants recruited had not been in the U.S. longer than a few days and were not able to inform
us about immigrants’ access to health care or Medicaid in the U.S. These 19 immigrants were
interviewed about their expectations for seeking health care and public benefits in the U.S., and
while their comments were interesting, they are not relevant to this study and are not included in
this report.

Findings presented here are based on reports of 54 immigrants. There were 46 females
and eight males. All immigrants came to the United States from Mexico. Most immigrants had
been in the U.S. over ten years and only two been in the U.S. less than three years.
Approximately half of the immigrants interviewed are pre-enactment Legal Permanent Residents
(LPRs) who obtained their residency before the 1996 laws were implemented. Close to half of
the participants originally entered the U.S. without documents, and approximately one third of all
the immigrants are currently undocumented. Four of the remaining immigrants are now U.S.
citizens.

Nineteen of the 54 immigrants had received Medicaid in the past, primarily for child
delivery and labor under the emergency Medicaid assistance program. Seven immigrants
currently have Medicaid and six are covered by Medicaid and SSI; the remaining 41 immigrants
are uninsured. The children of 24 immigrants are covered by Medicaid while the Medicaid
status of the children for 19 immigrants is mixed—at least one child in these 19 families has
Medicaid, while others are not eligible due to immigration or age requirements. Of the
remaining 11 immigrants, two do not have children and the children in nine immigrants’ families
are uninsured.

Nineteen of the 54 immigrants reported being currently employed, and many females
mentioned that their husbands were working.

IV. FINDINGS

A. Immigrants’ Ability to Apply for Medicaid

The ability to apply for Medicaid is, in part, a function of the particular state’s Medicaid
eligibility policies adopted since the enactment of these 1996 laws and how these new policies
were implemented. Our findings suggest three sets of issues affecting immigrants’ ability to
apply for Medicaid in Brownsville, Texas: 1) the conditions of the coverage options for pre- and
post-enactment immigrants chosen by Texas; 2) the level of misinformation and lack of outreach
offered by the state of Texas for CBOs, SNPs, and the immigrant community, and; 3) the circumstances and conditions of the Medicaid application process.

**Texas Options for Health Care Coverage for Immigrants Post-PRWORA**

As discussed above, PRWORA transferred substantial authority to states to determine the public benefits for which immigrant groups are eligible. 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 has been reported by other researchers and by informants to this study that Texas is undecided about whether it will provide Medicaid to post-enactment LPRs following the five year bar. Informants suggested that Texas legislators were not anxious to provide Medicaid benefits to post-enactment LPRs and did not have ample time to address the issue during the 1999 legislative session on the one hand, but were willing to consider dropping the five year bar and establishing public benefits for these immigrants during the next legislative session in 2001. This signifies that there is at least an interest, if not a commitment, to securing more benefits for legal immigrants in Texas based on more consideration by the Texas legislature.

**Implementation of These New Immigrant Medicaid Eligibility Policies**

There was a great deal of confusion surrounding PRWORA’s enactment in August 1996 that affected the implementation of the new eligibility policies for non-citizens. Caseworkers uniformly reported they were frustrated because the state’s welfare reform policy changed on a daily basis. The state was unsure of how it would interpret the new law, and subsequently was unable to provide caseworkers with formal training quickly to acclimate them to the new procedures. Caseworkers would frequently receive policy statements from the state and then notices would arrive the following week that either clarified or amended the previous notice. Managers were constantly briefing caseworkers on the new policies pertaining to Medicaid, food stamps, and cash assistance for all types of applicants including immigrants.

Further confusion has resulted from a new procedure required for food stamp eligibility that caseworkers often apply erroneously for Medicaid eligibility determination. The 1996 laws stipulated that all legal immigrant food stamp applicants would only be eligible if they had a history of 40 or more work quarters. Counting work quarters is an additional responsibility for caseworkers in assuring that legal immigrant applicants could qualify for food stamps, however, caseworkers often count and report work quarters for Medicaid applicants as well. This new procedure is complicated and caseworkers were confused about how these quarters should be...

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correctly counted, and whether and how quarters could be borrowed from spouses or parents of applicants.

Caseworkers and managers reported that it took a full year before they were comfortable with the new requirements and policies for immigrant applicants resulting from the enactment of PRWORA. Caseworkers never received formal training from the state, but were constantly updated with bulletins and notices. At the time of our site visit, some case workers were still confused about some policies. For example, case workers reported that some other case workers erroneously count work quarters when determining an immigrant’s Medicaid eligibility; work quarters should only be counted when determining food stamp eligibility.

**Misinformation/ Lack of Outreach about New Medicaid Eligibility Policies**

Several informants reported that employees of CBOs and SNPs were initially misinformed about the new law and its impact on immigrants. For example, some CBOs discouraged eligible immigrants from applying for Medicaid because they misunderstood laws and were unclear about which services would subject immigrants to being labeled public charges. Representatives of SNPs claimed that the only information they had about PRWORA came from immigrant patients themselves.

Because of CBOs’ and SNPs’ lack of understanding of the 1996 laws, many immigrants received incorrect or conflicting information about their ability to apply for and receive Medicaid. While the state did occasionally send out briefing information on the new law and eligibility criteria, these notices did not give thorough explanations or information about the new policies and their implications. It is likely that clients and patients who were otherwise eligible were not encouraged to apply for Medicaid or referred to the Medicaid office because CBO and SNP staff misunderstood the new laws and new procedures. It appears from our interviews that both CBOs and SNPs now understand the law and Medicaid eligibility requirements. This awareness is due in part to several town meetings conducted by advocate organizations in coordination with Medicaid officials to clarify the law and to explain who was eligible for each public benefit. One Medicaid official pointed out that the states does not have the budget or responsibility to conduct outreach and education for CBO and SNP staff members.

One factor contributing to the misunderstanding and confusion described above is the lack of outreach and education by the state of Texas to inform immigrants directly about their ability to apply for Medicaid. The state does not set aside funding to operate an outreach or education program. Instead, local Medicaid officials reported that they work with CBOs and SNPs in Brownsville to inform them about the law and who is eligible for Medicaid so that these entities can in turn inform immigrants. In addition *promotoras*, or lay health educators/ workers, that are primarily grant funded through SNPs and CBOs are heavily relied upon in the community to inform immigrants about not only preventive health and other public health concerns, but also about the availability of public benefits and the eligibility criteria.
Application Process

Several aspects of the application process affect the ability of immigrants in Brownsville to apply for Medicaid. These factors include: where they 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.

Where to Apply

Immigrants can apply for Medicaid at either the Medicaid office or at one-stop centers operated by TDHS, as well as at outstationed enrollment locations in area hospitals and clinics. When applying at the Medicaid office, applicants must go to the zone office that serves their zip code, other offices will take their application and forward it to the appropriate office. Many would-be applicants are referred by SNPs and CBOs to the Medicaid office to enroll, but do not go because it is inconvenient to travel to the zone offices or other locations, or because the process is so time-consuming. Many immigrants reported that the application process for Medicaid is cumbersome and not worthwhile unless they are faced with paying an expensive bill, or anticipate having to deal with serious illness or injury.

The two Brownsville hospitals and one primary care clinic provide outstationed enrollment services to process applications for patients for regular and emergency Medicaid assistance. The hospitals have enrollment offices that are continually available to patients and have also contracted with a private contractor to process Medicaid applications for more difficult cases (e.g., applications that are missing information). The private contractors are able to follow-up on applications that are not complete due to false information given on the application forms, for example, or in situations where applicants have trouble gathering necessary paperwork to fulfill the process. These private contractors handle approximately 55 cases per month and receive a percentage of the Medicaid revenue collected by the hospital as a result of their efforts.

A county caseworker visits one of the Brownsville primary care clinics regularly to take Medicaid applications on-site. As a result many applications are approved at the clinic and applicants avoid the hassle of going to one of the Medicaid offices; other SNPs in Brownsville have been unable to make this arrangement because they do not have the space or resources in their facilities to accommodate an outstationed enrollment worker.

Immigrants’ complaints about the cumbersome nature of applying for Medicaid predates the enactment of PRWORA and IIIRA in 1996. This factor applies not only to immigrants but to all applicants since all are required to submit applications at official sites. Short of funding additional outstationed enrollment sites or implementing a mail-in application process, limitations on locations to apply for Medicaid is likely to be a perennial issue for Medicaid applicants.

Difficulty Applying for Medicaid

Immigrants generally reported that the process of applying for Medicaid is more difficult since the implementation of the welfare and immigration reform laws in 1996. Nearly all
immigrants reported that the requirements for receiving benefits are stricter, caseworkers ask for more information, and it takes longer to receive benefits that it did prior to August 1996. Overall immigrants agreed that caseworkers required more documentation, and verify more information at each step in the process than before PRWORA was enacted. For example, immigrants noted that caseworkers ask probing questions about immigration status, income, and living conditions. Immigrants also reported being required to supply more information than before including: immunization records, income verification, birth certificates, social security numbers of parents applying for children, and affidavits from neighbors attesting that applicants have lived in the country for several years. Others have had to supply their utility bills, repeatedly verify how many children live in the household, and show a caseworker how they allocate their money. Adult applicants are also expected to comply with the state’s “finger imaging” requirement and those who refuse this requirement lose their benefits. This increased emphasis on eligibility verification discourages many immigrants and intimidates them from applying.

One state Medicaid official contradicted the claims levied by immigrants. For example, the official stated that federal Medicaid requirements are not new and did not change with the new laws. The finger imaging only applies to those applicants applying for Food Stamps or TANF, and not Medicaid. Furthermore, immigrants are not required to submit immunization records or utility bills, although they may be required for TANF or Food Stamps recipients. Social security numbers are requested but are not required from parents who are applying for Medicaid on behalf of their children.

When interviewed, caseworkers reported that there are new application procedures that are more time consuming to implement. They acknowledged that they are required to collect more information from Medicaid applicants which can also take more time. In addition, caseworkers routinely check each other’s work, and it is not unusual for caseworkers to complete an applicant’s paperwork several times before a client—immigrant or citizen, can be found eligible. Both caseworkers and immigrants reported that the application process is further complicated by the fact that beneficiaries must renew their applications every six months.

The additional information requirements lead some immigrants to supply incorrect or fraudulent information to ensure their children’s eligibility for Medicaid. For example, many immigrants reported that they supply incorrect social security numbers, or claim they are undocumented immigrants when they are actually legal immigrants in order to ensure that their immigration status will not be compromised as a result of applying for their children’s benefits. One LPR stated, “Sometimes you have to lie [and say you’re undocumented] just so that they can leave you alone and give you the Medicaid for the children. It’s not for me, it’s for the children. They do that a lot now, they ask too many questions. It’s easier if you just say you’re illegal, they know there’s nothing else to know.” The 1996 laws heightened immigrant parents’ fears about public charge, and consequently have encouraged them to lie about their immigration status in order to secure health insurance for their children.

State and local officials disagreed that the Medicaid application process had become more difficult. In fact, state officials asserted that the new laws have made the Medicaid application process easier by streamlining and condensing the application. They acknowledged
that obtaining verification information can be difficult for some applicants, but since Medicaid is a means tested public benefit, this verification is necessary.

Language vs. Literacy Barrier

In general, informants and immigrants reported that language was not a barrier to applying for Medicaid in Brownsville, however low literacy proficiency in either Spanish or English posed more of a problem for immigrants applying for Medicaid. Applications are available in Spanish and nearly all caseworkers speak Spanish. In most cases, caseworkers conduct interviews with clients in Spanish, although, as will be discussed below under Section B, some caseworkers reportedly mistreat those immigrants who cannot speak English. Immigrants reported that they felt pressured to speak English, even to bilingual case workers. In addition, illiterate applicants need assistance in filling out forms and can not always supply the necessary eligibility verification documents. This factor is not uncommon among vulnerable populations and is not limited to immigrants and predates the 1996 PRWORA enactment.

Summary of Findings

Subsequent to the 1996 welfare and immigration reform laws, immigrants’ ability to apply for Medicaid in Brownsville was impaired by the implementation options chosen by the state of Texas; the extent of misinformation and lack of communication about the policy changes to community leaders, providers and immigrants; and characteristics of the Medicaid application process that were created by or exacerbated by the new laws. Findings in these areas include:

- **Decreased numbers of immigrants are eligible for Medicaid.** Immigrants’ arriving prior to August 22, 1996 are able to apply for Medicaid without incident; however, newly arrived immigrants are unable to obtain the benefit. State data confirm that immigrants receiving Medicaid have declined significantly since July 1996.

- **Immigrants have not been discouraged from applying for Medicaid for their citizen children.** Immigrants reported that they are able to apply for Medicaid (sometimes with difficulty) on behalf of their citizen children. Families with mixed citizenship status faced difficulties securing insurance and health care for family members/children who are unqualified.

- **Lack of state initiated outreach and education fueled misinformation and confusion, initially reducing immigrants’ ability to apply for Medicaid.** Caseworkers did not receive training on the new law and the new procedures for quite some time and many were unclear about who could qualify for Medicaid. The lack of a state funded outreach and education program for CBOs, SNPs, or directly to immigrants led many stakeholders and immigrants to misunderstand the law and its consequences and many immigrants were discouraged from applying for Medicaid when the laws were initially enacted.

- **A shortage of outstationed enrollment locations hampers immigrants’ ability to apply for Medicaid.**
More challenging application process. Immigrants reported that applying for Medicaid seems to be more difficult since the 1996 change in the federal welfare reform and immigration laws due to increased requirements and documentation. State officials and caseworkers disputed this, however, and contended that applying for Medicaid is actually easier now since forms have been streamlined and are available in Spanish.

Bilingual caseworkers and Spanish Medicaid forms facilitate immigrants’ ability to apply for Medicaid.

B. 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. Post-enactment LPRs, undocumented immigrants, as well as immigrants who are ineligible for Medicaid due to income requirements or other circumstances, all reported that they do not hesitate to pursue Medicaid coverage for their citizen children to secure them coverage. These immigrants also reported that they were willing to apply for emergency Medicaid when faced with a sudden serious illness or condition.

Although immigrants’ willingness to apply for Medicaid was seemingly strong and unaffected by the 1996 welfare and immigration reform laws; immigrant, CBO, and SNP informants cited numerous barriers that led some immigrants to be either less inclined, or unwilling to apply for Medicaid. These informants described cases where immigrants were unwilling to apply for Medicaid for either themselves or their children. Two sets of barriers exist: 1) those related to the 1996 laws (i.e., misinformation, fear of public charge, or of the INS); and 2) 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).

It is important to note that our findings may overestimate the true level of immigrants’ willingness to apply for Medicaid. As noted above, our immigrant informants were recruited by CBOs, SNPs, and caseworkers, and therefore already had some understanding of how to navigate the health care delivery and/or Medicaid system in Brownsville. In addition, the immigrant informants volunteered to participate in the study and may have agreed to participate because Medicaid was a topic they were knowledgeable about and felt comfortable discussing.

Factors Related to Federal Welfare and Immigration Reform Laws

Awareness Among Immigrants about New Medicaid Eligibility Policies

The majority of immigrants, whether undocumented or legal, reported that they are currently very knowledgeable about for which benefits they or their children can apply, and are not hesitant to apply for them. However, many CBO and SNP informants, and immigrants reported that immigrants were initially misinformed about the new laws and their impact. However, this misinformation and confusion has subsided over time in Brownsville. Immigrants reported that because there is no official outreach or education program conducted by state or local officials regarding the changes in eligibility policies, the most common source of
information about the welfare and immigration reform laws and receipt of public programs is through word-of-mouth from friends, neighbors and family. Immigrants reported that they also trust CBO and SNP workers for information but, as CBO and SNP informants admitted, often the organizations and providers are confused about eligibility policies. The next largest source of information for immigrants is through Spanish television or radio. These media outlets run stories about changes in the law and eligibility for services. In general CBO, SNP, and Medicaid informants reported that these stories have been factual, but a few claimed that unique stories of problems or injustices were magnified and misled the immigrant community.

While caseworkers and state officials were confident that eligible immigrants have sought and accessed Medicaid, it is impossible to determine how many eligible immigrants have actually chosen not to pursue Medicaid coverage because they were misinformed about the law. One CBO representative described the misinformation that still exists among Brownsville immigrants that affects their ability to apply for Medicaid. According to this informant, some immigrants believe that they are ineligible for benefits and will be deported if they apply; others believe that state agencies share information with the INS; and some believe that if an immigrant has used a public benefit for even a few hours they will have to repay the government. According to the CBO informant, these misperceptions spread quickly through the immigrant community because word-of-mouth is the primary trusted source for information about Medicaid eligibility and immigration concerns.

**Fear of Public Charge**

Since the passage of IIIRA, concerns and fears have heightened about whether immigrants’ receipt of public benefits could be used as grounds for deportation, held against them when applying to convert their citizenship status, or affect their ability to sponsor other immigrants to enter the U.S. All SNP and CBO informants reported that the public charge issue has affected many immigrants’ decision to apply for Medicaid. Most immigrants interviewed for this study did not echo this sentiment from their own perspectives or experiences, but many related stories of friends or relatives that were in fact fearful of the public charge issue, and the INS because of the new immigration reform laws.

In May 1999, the INS issued a statement clarifying that only the receipt of income maintenance benefits such as temporary assistance for needy families (TANF), and others such as, supplemental security income (SSI) for long term care for an illness or condition sustained prior to entering into the U.S., could be held against an immigrant when adjusting their status. The clarification made it clear that receipt of non-cash benefits such as Medicaid, Food Stamps, WIC, housing assistance, SSI for short term rehabilitation, or long term care for conditions occurring after arriving in the U.S., etc. can not be counted against immigrants seeking to adjust their status.

At the time of our site visit to Brownsville in July 1999, most informants were unaware of the public charge clarification. For example, caseworkers had not received notice from the state that a clarification had been issued\(^23\), and many immigrants, CBOs and SNPs were equally

\(^{23}\) As of November 1999 state representatives confirmed that state caseworkers had been informed that the public charge issue had been clarified.
unaware that any decisions had been made on the issue. Immigration attorneys were aware of the clarification; however, many were skeptical that the order would "stand the test of time." These attorneys continue to advise clients not to apply for any public benefits. One attorney reported that while she informs clients that receiving Medicaid should not count against immigrants when applying for citizenship, there is no guarantee that it won’t come back to harm them in the future. One SNP received letters from immigration attorneys stating they did not want the clinic to force their clients to apply for Medicaid because of public charge. Medicaid caseworkers reported that some clients seeking adjustment of their status asked to withdraw from public benefit programs on advice from their attorneys.

Awareness of the public charge clarification is crucial in the decision for many immigrants to apply for Medicaid, but knowledge of the clarification alone does not guarantee that immigrants will feel comfortable applying for Medicaid. One provider reported that clients who understand that receiving Medicaid cannot affect their adjustment of status, still do not apply for the benefit. Becoming a citizen is very important to these immigrants and takes considerable time and money to complete; often immigrants are unwilling to jeopardize their chances especially in the midst of confusing policy changes, and therefore choose not to apply.

This fear of public charge has also impacted families with mixed citizenship status. Some parents of citizen children have apparently been frightened from applying for Medicaid and other public benefits for their eligible children. This is largely due to the fact that there has been little outreach and education to inform immigrants that obtaining public benefits for citizen children can not be counted against parents’ status adjustment.

Immigrants’ understanding of the public charge issue is fueled mostly by information obtained through word-of-mouth, and therefore, is subject to confusion and misunderstanding. For example, many immigrants believed incorrectly that the Medicaid office was reporting beneficiaries’ information to the INS, and that they would be required to pay back the cost of their benefits later. One state official reported that immigrants contacted the State’s Office of Immigration to request information on the cost of the public benefits they received, and to determine how much they would have to pay back. The Office of Immigration dealt with the requests confidentially and informed immigrants that the use of non-cash benefits would not be held against them in regard to changes in their immigration status.

Fear of INS - Mixed Reports

Impressions of the impact of the INS presence in Brownsville varied widely across informants. Most informants described the valley in which Brownsville is located as militarized and thick with INS activity; the INS has set up roadblocks, bicycle patrols, and checkpoints in the colonias.24 Due to “Project Rio Grande” a border patrol initiative, there is now one border control officer every 1,000 feet along the border. Some CBO and SNP informants reported that fear of the INS and increased activity subsequent to the 1996 welfare and immigration reform

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24 A colonia is a neighborhood in which many Hispanic immigrants live. Although the colonia is part of the city of Brownsville and most immigrants living there own their small tracts of property, the city takes almost no responsibility for maintaining the neighborhood. As a consequence some colonias do not have paved roads, running water, electricity, or sewage. The largest colonia, Cameron Park, recently obtained many of these amenities as a result of community action.

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laws has led some immigrants to avoid applying for Medicaid and other services. However, caseworkers disagreed and reported that the INS was not viewed as a threat in the community, and that immigrants do not seem to be bothered by the INS’ presence. One SNP representative explained that the community of Brownsville frowns on INS activity because undocumented immigrants are a vital part of the economy and society of Brownsville. This informant stated that the INS activity is tempered by the sentiment of acceptance and support for undocumented immigrants in Brownsville. Immigrants reported that, in large part, only undocumented or newly arrived LPRs fear the INS, and that immigrants who obtained their LPR status or citizenship prior to August 22, 1996 are not fearful. Immigration attorneys claimed that undocumented or recent LPRs parents are discouraged from applying for their citizen children due to fear of the increased INS presence.

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

*Mistreatment by Caseworkers*

Immigrants as well as SNP and CBO informants cited mistreatment by caseworkers as a major factor affecting immigrants’ willingness to apply for Medicaid. Immigrants felt that caseworkers discriminated against them based on their appearance, immigration status, and inability to speak English. Informants agreed that immigrants seem to receive the most mistreatment by caseworkers, and are therefore more likely to be unwilling to apply for benefits on behalf of their citizen children. Several immigrants reported that had considered going without needed health care coverage to be spared being humiliated and disrespected by caseworkers.

Immigrants reported that caseworkers are often rude and try to restrict applicants’ ability to obtain services. For example, some reported that caseworkers act as if they are personally in charge of doling out each public benefit and, as one pre-enactment LPR whose citizen children receive Medicaid benefits claimed, “act as if the money is coming out of their own pockets.” Others believed that a caseworker’s role was not to help applicants to receive benefits, but to discourage them and keep them off the public rolls. Others believed that some caseworkers deny immigrants benefits because immigrants are ignorant about the policies and have no recourse to challenge the denial. Immigrants also expressed dismay that Hispanic (bilingual) caseworkers were especially unsympathetic with non-English speaking applicants and reported that caseworkers were less helpful to those applicants who could not speak English.

Although some informants claimed that caseworkers in general acted negatively towards immigrants, others claimed that such mistreatment depended upon an individual caseworker and her/his mood. Interestingly, immigrants reported that higher ranking social service employees treated them better and with more respect than the front line caseworkers. Immigrants complained that female Hispanic caseworkers seemed to be more disrespectful than other caseworkers.

Whether mistreatment of immigrants by caseworkers is a direct result of the changes in federal welfare and immigration laws is difficult to determine. Immigrants believed that discrimination from caseworkers had increased with the enactment of welfare reform and the
implementation of stricter eligibility requirements; however, they reported that many issues between caseworkers and immigrants have existed for many years. In addition, the new regulations that resulted from the change in the welfare laws were imposed on all applicants, not just immigrants. However, immigrants may experience further obstacles than other applicants because of their inability to speak English and because of discrimination from Hispanic caseworkers that existed prior to the changes in law. Medicaid officials maintained that they have made it easier for immigrants and other applicants to apply for Medicaid by streamlining the Medicaid application process, supplying application forms in Spanish, and by employing bilingual caseworkers. Caseworkers denied that they are disrespectful towards immigrants and maintained that they assist their clients to obtain Medicaid if they qualify.

Unwillingness to Supply Information on Absentee Parents

Local officials, CBO representatives, and immigrants reported that some immigrants are unwilling to apply for Medicaid because they are required to identify the name of their children’s father. This requirement applies to all applicants for public benefits and therefore is not specific to immigrants. However the impact is worse for some immigrants whose children’s fathers are undocumented immigrants whom the mothers do not want to incriminate. In addition, local officials reported that some immigrants incorrectly believe that the state Attorney General’s initiative to prosecute absentee parents can affect an immigrant’s ability to adjust citizenship status, and therefore could lead immigrant parents to be unwilling to apply for Medicaid in order to protect the absentee parent’s interest in adjusting status.

Summary of Findings

Although we found that in general immigrants are willing to apply for Medicaid for themselves and their children, several barriers do exist that potentially impact their willingness to apply. Immigrants can be easily misinformed, are concerned about the effect of the public charge issue, and can be intimidated by the increased INS presence in Brownsville. In addition, mistreatment by caseworkers, and reticence to identify absentee parents reportedly play a role in immigrants’ hesitance to apply for Medicaid.

- Immigrants are willing to apply for Medicaid. In general immigrants are willing to apply for Medicaid for themselves and their children. Willingness to apply has not been significantly affected by the 1996 laws. Immigrants including post-enactment LPRs and undocumented immigrants are willing to apply for Medicaid for their eligible children.

- Fear of public charge impacts some immigrants’ willingness to apply for Medicaid. Despite the recent clarification of the public charge issue, some immigrants are concerned that receiving Medicaid could impact their ability to adjust their citizenship status.

- Undocumented immigrants are affected by the increased INS presence.

- Mistreatment by caseworkers discourages immigrants from applying for Medicaid.
Requiring applicants to identify absentee parents can dissuade immigrants’ from applying for Medicaid for their children. Several informants assert that immigrants are unwilling to apply for benefits because they do not want to jeopardize the immigration status of the absentee parent.

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

The discussion in this section focuses on how accessible primary health care is to immigrants in Brownsville, and whether anything has changed concerning the willingness and frequency with which immigrants seek health services as a result of the implementation of the 1996 laws. We found substantial differences between how non-citizen adults and children are affected by these laws with respect to primary care services.

Where and How Often Immigrants Seek Primary Health Care Services

According to most of our informants, immigrants do not hesitate to seek primary care for their children. Immigrants access services from the two clinics in Brownsville as well as the Cameron County Health Department. Immigrants also take their U.S. citizen children covered by Medicaid to the Brownsville Pediatric Center, a private physician practice that accepts Medicaid, and where obtaining an appointment is much faster than at the clinics. When it comes to seeking care for themselves, immigrants are more reluctant to do so because of the high cost of care, and the fear of being deemed public charge. Other immigrants delay seeking care because they do not place a high value on preventive care and often put off receiving care until their condition becomes an emergency. Many immigrants interviewed for this study claimed they do not have to go to a doctor because they are never sick.

Gaining access to some primary care providers can also be challenging. Some clinics have experienced an increase in uninsured patients and therefore have more difficulty covering the cost of seeing additional uninsured people; however they reported they have not turned away any patients. Some immigrants contradicted this by reporting that clinics have turned away a certain proportion of patients. In addition, immigrants have complained about very long waiting periods for appointments (as long as three months), although it is not known if the waiting periods apply both to new and regular patients. Furthermore, the long waiting periods do not only apply to immigrants but to all patients.

Immigrants have difficulty accessing specialty services for more serious conditions. As discussed earlier, immigrants go the University of Texas Medical Branch in Galveston, which is about 400 miles from Brownsville, for treatment of chronic and long-term illnesses. Health care at UTMB used to be free but is no longer. The fee for specialty care is $300, which presents a significant barrier to low-income immigrants. Moreover, immigrants who cannot afford to pay for care at the SNPs in Brownsville or Galveston, often seek treatment in Mexico or use traditional medicine.
Factors Related to the 1996 Welfare and Immigration Reform Laws

Informants and immigrants reported several reasons that prevent adult immigrants from seeking primary health care services for themselves as opposed to their children. Some factors are related to the new 1996 laws, and some are not. Those resulting from the change in the law include: 1) confusion about the laws; 2) fear of the public charge; and 3) fear of the INS “police state.” Other unrelated factors include: 1) the high cost of health care, and inability to pay; 2) seeking health care and pharmaceuticals in Mexico; 3) use of traditional medicine; 4) long waits to see a provider, loss of time from work, and lack of transportation; 5) mistreatment by providers and discrimination; 6) undervaluing preventive care; and 7) reluctance to accept public benefits. These factors are not directly related to the change in welfare and immigration laws and are common among underserved populations.

Confusion About the 1996 Laws

Many immigrants reportedly do not seek primary health care because they have been misinformed about the new laws. For example some immigrants believed that “SNPs and CBOs will report them to the INS;” and they “also will have to pay back the government for their benefits later.” One SNP informant described a patient who would not accept immunizations for her child because she had heard on a Spanish television station that an immigrant was charged for previous immunizations.

Fear of Public Charge

Most immigrants feared that by receiving public benefits they will be deemed “public charges.” They do not understand or believe that receiving non-cash benefits cannot be held against them when seeking adjustment of their status. Some immigrants believed that seeking health care can also lead to being labeled a public charge and therefore avoid care until the condition becomes life threatening.

Fear of the INS

In general, we found that the INS does not deter immigrants from seeking primary health care. However, some informants have reported that many immigrants avoid seeking primary health care services because they are “afraid there is some kind of police state” and the hospital or doctors will report suspected illegal immigrants to the INS, although there is no INS presence at the hospital. Informants cited isolated incidents that support this view. For example, in a neighboring county hospital, security guards wore uniforms similar to those worn by the INS border patrol members. Immigrants saw these uniforms and were frightened; when this fact was publicized, the hospital changed the guards’ uniforms.

Factors Unrelated to the 1996 Welfare and Immigration Reform Laws

While the following factors affect immigrants’ ability and willingness to access health care benefits, they existed before the new laws were enacted in 1996. In addition, they are not
isolated to immigrants, but impact vulnerable populations in general. However, the 1996 laws have exacerbated these factors for immigrants.

*High cost of Health Care and the Inability to Pay.*

Immigrants, CBO and SNP informants reported that immigrants delay seeking health care services because of their inability to pay for care until their problems become an emergency. Paying for care fee-for-service can be very expensive. For example, an informant described an instance where a child was taken to the emergency room with a broken leg where it went untreated because the parents did not have the money to pay (and it was not considered a life threatening emergency). In a similar situation a male LPR had a broken arm but could not pay to have it set, so an immigration attorney intervened to pay for his care. One immigrant woman told us, “I can’t go to the doctor normally because it is so expensive;” another one said, “I would go to the hospital if I had to…but I can’t go to a doctor normally because it’s so expensive.” Immigrants very often go to Mexico for health care and medicine because it is cheaper.

*Seeking Cheaper Health Care and Pharmaceuticals in Mexico*

It is common for LPRs to go to Mexico to see a doctor and for pharmaceuticals because of their inability to pay for expensive healthcare services in the U.S. Undocumented immigrants do not cross the border to receive care in Mexico because they would face great difficulties trying to return to the U.S. Pharmacies in Matamoros, Mexico advertise their lower prescription drug prices in Brownsville newspapers. According to immigrant informants, the quality of healthcare in Mexico is not as good as the care that can be obtained here. Although the cost of care in Mexico is relatively expensive for low-income immigrants, it is cheaper than that available in the U.S. For example, a doctors visit in Matamoros costs $25.00. LPRs feel it is worth traveling to Mexico for health care services because the care provided is culturally familiar to them, waiting times are shorter (or non-existent), and medicines are cheaper and easier to access. However, these drugs are unregulated and thus could be less safe than the drugs available in the United States.

*Using Traditional Medicine*

Besides going to Mexico, many immigrants also use traditional healers and non-western medicine to treat illnesses rather than seek care from doctors in Brownsville. Informants said that this practice has exacerbated many health problems among immigrants because often the drugs from Mexico are either ineffective for their specific problem or make the condition worse. There are dangerous implications especially for chronic conditions.

*Long Waits to See a Provider, Loss of Time from Work, and Lack of Transportation*

Immigrants said that local clinics are very difficult to access because they are overwhelmed with patients. Many informants reported long waits for appointments, for example, one stated, “to get an appointment for a physical you have to make it six month ahead—if you are sick, it is three months.” Additionally, once they arrive at the clinic, the waiting time is very long. One immigrant said, “when my husband gets sick, there were times
when we’ve been there from 8 a.m. and we get out sometimes at 5 p.m.… Sometimes he can’t miss work so he has to go to Matamoros to get the medicines, otherwise it take all day to go to the clinic and get the appointment.” Transportation to the local clinics is very difficult. Most safety-net providers are located far from the immigrants’ residences and it is expensive and time consuming to commute to these clinics and hospitals.

*Mistreatment by Providers and Discrimination*

Some immigrants reported that they refuse to visit certain safety-net providers in Brownsville because they feel mistreated by the workers in these clinics. Many immigrants reported that discrimination is worse now than before the passage of the 1996 welfare and immigration reform laws because now “they kick you out of the hospital after three days…before they didn’t discriminate like that. People who pay or have private insurance get treated first.”

*Undervaluing Preventive Care and Stigma*

Informants reported that seeking preventive care is not a priority; however many do pursue prenatal care through the county health department. As discussed above some, immigrants feel they don’t have to go to the doctors because they are never sick and therefore neglect preventive health care they perceive that such services are not essential. Immigrants reported that preventive care is “one Tylenol” or “traditional medicine.”

*Reluctance to Accept Public Benefits*

Immigrants reported being less inclined to seek free or low-cost health care because of the stigma involved. Many would rather forego receiving needed health care than accept these services.

*Summary of Findings*

As discussed above, adult immigrants will access primary care for their children but will delay seeking primary care for themselves. This is due to some factors that existed before the 1996 laws that impact vulnerable populations in general, but have been exacerbated for immigrants by the new laws. But some factors resulted directly from the new laws. In summary, the study team found that:

- **Immigrants reported being willing to seek primary health care services for their children, but not for themselves.**

- **Many adult immigrants do not seek primary health care because they have been misinformed** about the new law and believe that they will have to pay the government for their benefits later and/or that SNPs will report them to the INS.

- **Many immigrants seek cheaper health care in Mexico.**

- **Many immigrants turn to traditional, non-western medicines.**
• Accessing primary health care in Brownsville is difficult due to long wait times and diminishing indigent care slots. Local clinics are very difficult to access because they are overwhelmed with patients. Getting to these clinics is often difficult due to lack of transportation, the cost of travel, and the loss of time on the job.

• Immigrants feel that preventive care is not a priority and think that they don't have to go to the doctors because they are never sick.

• Many immigrants are reluctant to seek free or low-cost health care due to stigma related to accepting public benefits.

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

The discussion in this section focuses on how accessible emergency health care services are to immigrants in Brownsville, and whether anything has changed concerning the willingness and frequency with which immigrants seek emergency health services as a result of the implementation of the 1996 laws. As noted above, post-enactment LPRs are eligible for TP-30 emergency Medicaid only; undocumented immigrants continue to be eligible for emergency Medicaid as before the 1996 laws. Overall, immigrants and informants reported that the welfare and immigration reform laws did not affect their willingness to seek emergency care, although emergency Medicaid coverage is difficult to obtain for non-pregnancy related conditions. Immigrants and informants also discussed factors unrelated to the 1996 laws that impact immigrants’ decision to seek emergency care, including the inability to pay for health care, and fear of the INS.

Factors Related to the 1996 Welfare and Immigration Reform Laws

General Willingness to Seek Emergency Services Seems Unaffected by 1996 Laws

According to SNP and CBP informants and most immigrants, immigrants in Brownsville are generally willing to seek emergency care services and this willingness has not been affected by the 1996 welfare and immigration reform laws. One hospital informant stated, “there is no hesitation to seek emergency care, regardless of immigration status.” Informants from hospitals, other SNPs, and most immigrants stated that both hospitals in Brownsville and others in the surrounding area were “immigrant friendly” and non-threatening to immigrants in any way. One provider commented that undocumented immigrants often “rotate between hospitals to be on the safe side” in order to avoid calling attention to themselves from frequent use of hospital services, although the informant felt this was an unnecessary precaution.

Local officials and SNPs reported that the rate of drop-in child deliveries at emergency rooms in Brownsville hospitals had decreased substantially in recent years. The drop-in delivery rate had historically been very high because many pregnant women enter the United States to have their children born as U.S. citizens. In response to this epidemic of drop-in childbirths with no pre-natal care, and to the restrictions on eligibility for Medicaid for post-enactment LPRs, informants reported that local providers and clinics have worked with the health department to provide prenatal care to undocumented women as well as to post-enactment LPRs. These new
prenatal care programs allow hospitals, clinics, and providers to identify more high-risk pregnancies and communicate about specific cases to reduce the number of costly and dangerous drop-in deliveries in Brownsville.

Obtaining Medicaid for Emergencies

Many immigrants in Brownsville reported that it is very easy for pregnant women to apply for Medicaid benefits to cover the expense of child delivery under the TP-30 emergency assistance program. Securing Medicaid coverage for non-pregnancy related health emergencies can sometimes prove more difficult. Many immigrants reported that they were suffering from conditions that should be cared for, but they were not severe enough to be deemed an emergency. Some reported being shuffled between hospitals before finding a doctor who would declare the condition an emergency. One woman described an experience her husband had after fracturing his leg. One Brownsville hospital told him it was not an emergency and referred him to the other hospital where he was treated and covered under the TP-30 program. For many immigrants, this issue predates the 1996 welfare and immigration reform laws. Undocumented immigrants who have children and would otherwise qualify for Medicaid, but for their immigration status, have always been eligible for TP-30 Medicaid to cover medical emergencies; they have always faced a challenge in having a (non pregnancy-related) condition deemed an emergency. However, this is a new issue for LPRs arriving in the U.S. post August 22, 1996. These immigrants would have previously been eligible for Medicaid and would not have had to wait until a condition was life threatening before receiving coverage.

Factors Unrelated to the 1996 Welfare and Immigration Reform Laws

Inability to Pay for Health Care

Despite reports from informants and most immigrants that immigrants are generally willing to seek emergency care services, there were some reports of factors unrelated to the 1996 laws that have traditionally discouraged undocumented immigrants from seeking emergency care services. Inability to pay for health care services, and fear of the INS hinders many immigrants from deciding to seek emergency health care.

As discussed above, CBO and SNP informants and immigrants reported that many immigrants delay seeking primary health care until a condition can be declared a life-threatening emergency by providers so that Medicaid will cover the cost of treatment. One immigrant explained that his wife needed a surgery but the hospital was waiting to perform the operation until his wife’s condition escalated to emergency status. Another immigrant stated that she needed gallbladder surgery and was told at one hospital that the condition was not an emergency so she went to another where they agreed to perform the surgery under the TP-30 emergency Medicaid program. In addition, one CBO representative described an example of a young boy who was taken to the hospital because he had broken his leg. According to the informant, the hospital would not set the leg or add a cast because these were not services reimbursable under emergency Medicaid and the child’s parents were unable to pay for the services.
Safety net providers reported that people cross between Brownsville and Mexico to utilize emergency health care services on both sides of the border. Some legal immigrants reported that undocumented immigrants use the emergency room services more than legal immigrants because they are less likely to have a regular source of care and cannot cross the border back to Mexico for health care. Legal immigrants feel the influx of undocumented patients causes the hospitals to be overcrowded with long waiting periods. In response to the influx of undocumented immigrants in Brownsville hospitals, providers explained that legal immigrants often travel to Mexico from the U.S. for faster and more affordable health care services but “end up being admitted to the emergency room over here” because of the perceived poor quality of care in Mexico.

**Fear of the INS**

Another factor in an immigrant’s decision to seek emergency health care is fear of the INS. Immigrants reported that fear of the INS is common among undocumented immigrants. One undocumented immigrant stated that many would rather forego medical care even in an emergency because they do not want to risk being arrested and, “it is too difficult to come here and be deported.” A CBO representative recounted one example of an undocumented immigrant who fell from a ladder and broke his arm, but refused to go to the hospital out of fear of the INS. The CBO representative arranged for him to see a doctor to treat the arm. One immigrant reported that he witnessed a man being arrested by border patrol officers in the waiting room at a hospital emergency department where he was waiting for his wife to deliver a baby. The immigrant believed the man was being arrested because he was undocumented and he suspected that the admitting nurse of the emergency department had reported him to the border patrol. Although this story contradicts reports from SNP informants that hospitals are safe for undocumented immigrants, the example demonstrates the uncertainty about the threat of being deported for many undocumented immigrants.

Several informants from the Brownsville area each recounted the story described earlier about a nearby county hospital where security guards were dressed in uniforms closely resembling those worn by INS agents in 1997. The community interpreted the uniforms as “deliberate” scare tactics to intimidate immigrants from entering the hospital, forcing them to seek services elsewhere. Soon the negative public attention about the uniforms caused the hospital to change them. Overall, informants and immigrants stated that the INS did not generally enter hospitals or monitor hospital activity unless agents were searching for a specific individual.

**Summary of Findings**

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).
• **Immigrants in Brownsville are generally willing to seek emergency care services and this has not been affected by the 1996 welfare and immigration reform laws.** Post-enactment LPRs and undocumented immigrants only qualify for emergency Medicaid under the state’s TP-30 program.

• **Emergency Medicaid is easily obtainable for pregnant women, but can be more difficult for non-pregnancy related conditions.** Undocumented pregnant women easily obtain emergency Medicaid to cover expenses related to their labor and delivery. Securing emergency Medicaid for non-pregnancy related conditions sometimes proves to be more challenging.

• **Inability to pay for health care affects immigrants’ decision to seek emergency health care services.** Many uninsured immigrants delay seeking primary health care because of their inability to pay for care, and are forced to seek emergency care when a condition becomes life threatening. Some immigrants travel to Mexico to avoid paying the expensive bills or to avoid long waits in Brownsville hospitals.

• **Undocumented immigrants can be deterred from seeking emergency health care because of their fear of the INS.**

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

Texas officials, representatives of CBOs and SNPs could not easily determine whether welfare and immigration reform has had an effect on immigrants’ health in Texas. While several CBO and SNP informants related anecdotal evidence that many immigrants’ health-related quality of life was negatively affected by the laws, all informants commented that data was difficult to collect in terms of assessing the overall impact of welfare reform on immigrants. One state official commented, “there are a lot of children and elderly in the community who are not receiving adequate health care” because the laws have made them ineligible for Medicaid. Informants felt the laws had most significant impact on those post-enactment LPRs who were denied access to Medicaid as well as on potentially eligible pre-enactment LPR families who were fearful of public charge. One CBO informant felt program changes would result in long-term negative effects that were impossible to assess after only three years.

Many immigrants reported that their access to health care services was limited by the changed welfare and immigration laws, and therefore the health status of their families had worsened. Enduring a more complicated application process, dividing access to Medicaid and health services for different family members, overcrowded clinics and hospital emergency rooms, and having to overcome discrimination are all factors that affect immigrants’ health-related quality of life, and were exacerbated by the 1996 laws. One pre-enactment LPR discussed how the Medicaid eligibility changes could have a long-term effect on the immigrant community, “On the news they say there’s a lot of sickness among Hispanics… Hispanics die of [diabetes], cholesterol, and heart problems. Well, how are they not going to die if they seek help and it’s denied? As opposed to the American who walks in with their health insurance policy, because that’s the first thing they ask for, insurance. Even if you’re dying, you have to give them your insurance information.”
Informants from CBOs as well as representatives from SNPs in the Brownsville area reported that hospitals are shouldering much of the burden of the effects of welfare and immigration reform. Informants stated that hospitals are receiving uninsured patients whose conditions such as diabetes and hypertension have not been managed and are expensive to care for in advanced stages. One informant stated, “the hospitals get sicker persons who have delayed seeking care and are ultimately more costly to the system.” One CBO informant estimated that 40 percent of the cases presented at emergency rooms in the Brownsville area are results of immigrants’ delaying or not being able to access preventive care.

Summary of Findings

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.

V. CONCLUSIONS AND IMPLICATIONS

Certainly the 1996 laws have impacted immigrants’ access to healthcare and Medicaid. It is clear that the options selected by Texas under PRWORA have left ineligible some immigrants who would have otherwise been eligible to receive Medicaid. As a result of the 1996 laws, most post-enactment LPRs are no longer qualified to receive Medicaid. Hardest hit by the new policies are adult post-enactment LPRs, since post-enactment immigrant children can receive coverage under a state funded health insurance program.

It is difficult to quantify the precise impact the new laws have had, and to attribute specific outcomes as a result of the laws’ enactment. We would expect to see a decrease in the overall number of immigrants receiving Medicaid since the laws were enacted, since fewer immigrants are now eligible to receive the benefit. It is difficult to identify particular data-based evidence to these new policies. For example, although the percentage of immigrants receiving Medicaid has decreased 16 percent statewide since the laws were enacted, this figure does not take into consideration the numbers of immigrants receiving emergency Medicaid (the primary financing vehicle covering post-enactment immigrant hospitalizations). Data on emergency Medicaid usage by immigrants is unavailable from the state. Additionally, declining Medicaid enrollment among the immigrant population mimics the downward trend seen across the United States for all Medicaid enrollees. Therefore, it is not clear whether immigrants have been more adversely affected than have non-immigrants. Finally, it is important to note that eligibility standards for Medicaid are very low in Texas, only the most poor can qualify for the program. Therefore, eligibility for pre-enactment LPRs and post-enactment exempt LPRs is equally limited.

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

Below we discuss our findings and their implications for immigrants seeking Medicaid and/or health care services in Brownsville, Texas.

A. Immigrants’ Ability to Apply for Medicaid

Immigrants’ ability to apply for Medicaid is affected by factors that are both related and unrelated to the 1996 laws. The 1996 laws directly affected immigrants by restricting eligibility for the benefit. In addition confusion and misinformation about the new laws may have contributed to fewer immigrants applying for Medicaid. The Medicaid application process has changed as a result of the new laws; however it is unclear if the changes have adversely affected immigrants more than other Medicaid applicants. Other factors not directly related to the new laws also negatively impacted immigrants’ ability to apply for Medicaid. Factors such as limited application centers and language and literacy issues are longstanding barriers faced by vulnerable populations. While these factors were not caused by the 1996 laws, their effects may be exacerbated by them.

Factors Related to the 1996 Laws

As has been stated earlier, the number of immigrants receiving Medicaid in Texas has declined since the 1996 laws were enacted. Reasons for this decline are difficult to isolate and quantify. It is unclear how much the limited eligibility criteria accounts for the decline in immigrants receiving Medicaid. Other factors clearly seem to play a role. Our findings revealed that caseworkers, CBOs, and SNPs were initially confused about the application process and new eligibility criteria for Medicaid. It is likely that this confusion initially contributed to the declining rolls. Caseworkers may have denied Medicaid to eligible immigrants; and CBOs and SNPs may have dissuaded eligibles from applying because they mistakenly believed they could not qualify. However, overtime the state’s policies have been clarified and caseworkers, CBOs, and SNPs have learned who is eligible for the benefit.

Another factor that may be related to the decline in immigrant Medicaid beneficiaries is the application process. Our findings suggest that some Medicaid eligible immigrants were discouraged from applying because of the perceived difficulty of the application process.
However it is unclear whether the application process is actually more challenging as a result of the 1996 laws. Nearly all immigrants reported that the Medicaid application process is more difficult and entailed since the 1996 laws were enacted. Immigrant informants complained that the process is more time consuming, requirements are stricter, and applicants are required to supply more information. State officials and caseworkers dispute this, however, and contend that applying for Medicaid is actually easier now since forms have been streamlined and are available in Spanish. Bilingual caseworkers and Spanish Medicaid forms facilitate immigrants’ ability to apply for Medicaid. Officials concede that Medicaid applicants are required to supply verification information during the application process. However, this information is required of all Medicaid applicants and not just immigrants.

**Factors Unrelated to the 1996 Laws**

A range of factors unrelated to the application process and new immigrant policies affect immigrants’ ability to apply including: lack of outreach and education, and language and literacy barriers. These factors commonly affect vulnerable populations in their efforts to access Medicaid and other public services, and are not restricted to immigrant populations. Nonetheless, it is important to examine these factors because they do play a predominant role in restricting immigrants’ ability to access Medicaid.

The lack of state funded outreach and education programs led many immigrants and stakeholders to misunderstand the law and its consequences. As a result many mistakenly believed that immigrants should not apply for Medicaid because of a presumed ineligibility or the threat of becoming a public charge. In addition, a shortage of outstationed enrollment locations hampered immigrants’ ability to apply for Medicaid. Many immigrants reported that applying at the Medicaid office is cumbersome and inconvenient. Finally, immigrants are often impeded from applying for Medicaid because of low literacy levels and difficulty with English.

Our findings revealed that all these factors have had some impact on immigrants’ ability to apply for Medicaid in Brownsville, Texas. However, it is not clear how much of the decline in the state’s Medicaid rolls can be attributed to each of these factors individually. It is likely that these factors converge and together have impaired immigrants’ ability to apply for Medicaid since the 1996 laws. However, they do not account for the total decline in immigrant Medicaid beneficiaries. Some of this decline can be attributed to a reduced willingness among immigrants to apply for Medicaid.

**B. Immigrants’ Willingness to Apply for Medicaid**

In general, immigrants are willing to apply for Medicaid for themselves and their children with little apparent effect from the 1996 welfare and immigration reform laws. In addition, the immigrants interviewed reported that their willingness was unaffected by the laws, however they commented that fear of public charge and the INS, mistreatment by caseworkers, hesitation to identify absentee parents and other issues did impact their decision to apply for Medicaid. These factors may be significant limitations for other immigrants who were not interviewed for this study and may, for example, not be connected with a CBO or SNP and feel as confident about their ability to access Medicaid.
The public charge issue is directly related to the 1996 reform laws. Although none of the immigrants interviewed for this study claimed they were unwilling to apply for Medicaid because of the public charge issue, all other informant types reported that large numbers of immigrants choose not to apply for Medicaid because it could impact their ability to become citizens. Despite the recent clarification of the public charge issue, some immigrants are still concerned that receiving Medicaid could impact their ability to adjust their citizenship status. Immigrant attorneys continue to caution immigrants that there is no guarantee that receiving Medicaid will not be charged against them in the future. The INS has a strong presence in Brownsville that has impacted some immigrants’ decision to seek Medicaid. Undocumented and new LPRs are most fearful of the INS and their activities.

Factors unrelated to the 1996 laws have also impacted immigrants’ willingness to apply for Medicaid. Immigrants widely reported being mistreated by caseworkers when applying for Medicaid and other public benefits. Specifically immigrants claim that female Hispanic caseworkers are the most discriminatory towards them, and resent their inability to speak English.

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

According to immigrants and SNPs, immigrants do not hesitate to seek primary care for their children. The cost of health care is the principle barrier impacting immigrants’ ability and willingness to seek primary care for themselves. However, this factor affects many low-income people and is not a direct result of the 1996 welfare and immigration reform laws. Similarly, long waiting times, mistreatment by providers and clinic staff, undervaluing primary care, and stigma effect whether immigrants seek primary care. Other issues related to the new laws such as fear of public charge, lack of knowledge and misinformation, and fear of the INS influence immigrants’ decisions to seek primary health care services.

D. Immigrants’ Ability and Willingness to Seek Emergency Care Services

Immigrants and informants reported that immigrants’ willingness to seek emergency care services had not been changed by the welfare and immigration reform laws. Most immigrants reported that they were comfortable seeking emergency health care and were knowledgeable about their eligibility for TP-30 Medicaid coverage (emergency Medicaid). However, many immigrants did report difficulty receiving TP-30 Medicaid coverage for non-pregnancy related conditions. Other immigrants reported apprehension about seeking care because of the inability to pay or because they fear the INS.

The limitations on eligibility for Medicaid affecting the post-enactment LPRs combined with the inability of many immigrants to pay for health care has most likely resulted in an increase in emergency care use by immigrants. Informants and immigrants reported that immigrants often delay seeking primary health care services but eventually seek emergency health care when a condition escalates. Over time this emphasis on crisis care could result in higher health-related expenses for conditions that could be better controlled or even prevented with improved access to primary care.
E. Impact of the 1996 Welfare and Immigration Reform Laws on Immigrants’ Health-Related Quality of Life

While it is too early to draw empirically-based conclusions about the impact of the 1996 welfare and immigration laws on immigrants’ health-related quality of life, findings suggest that impaired access to routine and preventive care will increasingly lead to sicker children and adults. Because these trends can be difficult to observe in their initial stages, systematic efforts to monitor immigrant health status are essential. Close monitoring of the health of immigrants is essential for the prevention of costly complications of chronic conditions and for the prevention of diseases in border communities where diseases are difficult to track and control.

F. Limitations

It is important to reiterate that our findings are based on interviews with 54 immigrants and representatives from 14 CBOs and SNPs. Our findings based on the immigrant interviews and focus groups are not presented as representative of the entire immigrant population in these sites. We recognize that 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. These immigrants not only self-selected for participation, but, for the most part, were already connected to resources such as community health clinics and Medicaid. Our immigrant informants were recruited by SNPs, CBOs, and caseworkers and therefore already had some understanding of how to navigate the health care delivery and/or Medicaid system in Brownsville. 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 healthcare services. This bias could mean that we may have underestimated the effects of immigrant-related barriers to Medicaid and healthcare services, and that our findings about the relative weight of the two sets of barriers 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. Moreover, the potential presence of bias does not change our findings regarding two sets of barriers – both immigrant-related and nonimmigrant-related, and one could suppose that these immigrant informants who were already connected to services have had less trouble with the non-immigrant barriers than would other less-connected immigrants. These findings also support specific policy recommendations for improvement.

VI. RECOMMENDATIONS

Based on our findings, we present recommendations below that could improve the ability and willingness of immigrants in Brownsville to access Medicaid and health care services. While many of these recommendations apply specifically to the immigrants in Brownsville, others can be applied to other economically or socially vulnerable populations in the community who face some similar barriers to accessing health care coverage and services.
A. Immigrants’ Ability to Apply for Medicaid

- **Texas should invest in outreach and education efforts.** The state does not currently invest in outreach and education efforts to keep immigrants informed about which services they qualify for and how to apply. State caseworkers rely upon the resources of CBOs and SNPs which are already taxed to convey information about the laws.

- **Cameron County has few Medicaid outstationed enrollment sites and should expand their use.** Medicaid outstationed enrollment may make it more convenient for immigrants’ to apply for Medicaid for themselves and their children and therefore increase the number of immigrants who receive the benefit.

B. Immigrants’ Willingness to Apply for Medicaid

- **Articulate that immigrants should no longer fear public charge.** The state should conduct outreach and education to inform caseworkers, SNPs, CBOs, immigrants, and their advocates that receiving non-cash benefits can not be held against them when seeking to adjust their citizen status. The state should work with immigration attorneys to overcome any lingering doubts that inhibit attorneys from recommending that their clients apply for Medicaid and other non-income maintenance benefits.

- **Require sensitivity training for caseworkers.** Many immigrants reported being mistreated by caseworkers because they are reliant on public services. Additionally many immigrants claimed they were made to feel embarrassed because they could not speak English. With so many bilingual caseworkers low English proficiency should not be a problem. Immigrants stated that such mistreatment made them hesitant to apply for Medicaid.

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

- **Increase outreach about the public charge clarification.** Immigrants should be made aware that they can receive free or low-cost health care services without fear of being labeled a public charge. The state should work with advocates, CBOs, and SNPs to educate immigrants about their rights.

- **Promotoras should be utilized to educate immigrants.** Lay health caseworkers and community leaders should be used to disseminate information about Medicaid eligibility, CHIP, immunization, etc. The use of the *promotoras* will generate confidence among the immigrants since they often share the same culture and can relate to their problems.

- **The importance of primary care should be emphasized.** Many immigrants have indicated they don’t seek primary health care because they are never sick. Education efforts should be undertaken to demonstrate how important primary care can be. *Promotoras* could be used more widely to conduct outreach and stress out how vital preventive care is.
- *The state should consider ways to increase immigrants’ access to primary care.*
  Uninsured immigrants have limited access to providers who are willing to care for indigent patients. The state should seek methods of supporting SNPs so they can take on additional uninsured patients, as well as address other access barriers such as language, transportation, and child care.

D. Immigrants’ Ability and Willingness to Seek Emergency Care Services

- *Focus resources on prevention programs and outreach* to mitigate the burden on hospitals caring for patients who may have delayed seeking health care services because of the inability to pay for care. For example, efforts should be undertaken to inform immigrants about their eligibility for emergency medical assistance under the TP-30 program.

- *Assure immigrants that hospitals do not report immigration status to the INS.* Outreach and education efforts should be undertaken to inform immigrants that hospitals (and other SNPs) do not report patients’ immigration status to the INS or border patrol.

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

- *Data are needed to accurately describe the 1996 law’s impact on immigrants.* Collection of epidemiological data classified by immigration status for conditions such as drop-in child delivery, tuberculosis, diabetes, and asthma could help determine the effects of the 1996 laws on immigrants’ health-related quality of life, and could also help identify target areas for prevention programs and outreach