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

EXECUTIVE SUMMARY

Policy Context

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) established new and complex eligibility rules for public benefits for legal immigrants, and made ineligible for most federal public benefits several categories of previously eligible legal immigrants. The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 established certain procedures for determining the admissibility of immigrants and heightened fears that the use of public benefits, even the legitimate use of Medicaid, could jeopardize immigrants' ability to become legal permanent residents or US citizens.

PRWORA also represents a substantial and unprecedented shift in (i.e., devolution of) immigration policy from the federal to the state level. State officials now have substantial discretion to determine which types of immigrants will receive which kinds of public benefits. For Medicaid, states have three options: (1) whether to continue or deny federally-funded Medicaid coverage to qualified immigrants who arrived in the US prior to August 22, 1996; (2) whether to provide state-funded Medicaid coverage for qualified immigrants who arrive in the US on or after August 22, 1996; and (3) whether to provide state- or county-funded medical coverage to not qualified immigrants (i.e., certain PRUCOLs and undocumented immigrants).

The law imposes greater financial responsibility on states choosing to extend Medicaid to noncitizens/legal immigrants who have been barred from receiving federally-funded Medicaid by PROWRA. These provisions mean that (1) there will be variability by state in coverage and access for immigrants/noncitizens arriving in the US on or after August 22, 1996, and (2) assessing the experiences of immigrants will require knowledge about particular choices made by states with respect to eligibility for Medicaid and medical other coverage.

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

Findings

We found evidence that immigrants' ability and willingness to access Medicaid and health care services have been adversely affected since the enactment of the 1996 welfare and

immigration reform laws. We identified numerous instances of two types of barriers: (1) those related to immigrant status and the 1996 laws such as fear of the INS, concerns about public charge, and changed eligibility criteria; and (2) those related to vulnerable and low-income population status such as culture and language, inaccessible locations for applying, complex application procedures, and inability to pay for health care services. The relative effects of these barriers varied; this suggests that efforts to ameliorate these effects must be tailored accordingly.

Major findings include:

- ◆ ***Immigrants' Ability to Apply for Medicaid*** – Factors affecting immigrants' ability to apply included barriers related to immigrant status and the 1996 laws, and longstanding barriers related to vulnerable and low-income population status. Their ability to apply seemed to be affected equally by these two types of barriers. Data-based evidence of effects attributable to the 1996 laws (i.e., more eligible but not enrolled immigrants post-enactment) was difficult to develop due to (1) lack of relevant data, (2) overall declining trends in Medicaid enrollment; and (3) inability to disentangle potential effects of the two sets of barriers.
- ◆ ***Immigrants' Willingness to Apply for Medicaid*** – Factors affecting immigrants' willingness to apply fell into the same two categories. Barriers related to vulnerable and low-income population status exerted a greater negative effect on willingness than barriers related to immigrant status and the 1996 laws. Immigrant parents reported that they were less likely to be discouraged from applying when the circumstances involve their children needing care.
- ◆ ***Immigrants' Ability and Willingness to Access Primary Care*** – Several factors affected immigrants' willingness and ability to access primary care. These barriers were primarily related to their low-income and vulnerable population status; the barriers related to immigrant status and the 1996 laws had very little effect. When immigrants reported that they were less willing to seek care, adults/parents were more affected than children.
- ◆ ***Immigrants' Ability and Willingness to Access Emergency Care*** – Immigrants reported that they were generally willing and able to access emergency care when necessary although concerns about language barriers, and costly bills were common. Uninsured immigrants reported that they were delaying care and using emergency rooms as a substitute for primary care.
- ◆ ***Impact on Immigrants' Health-Related Quality of Life*** – Although there was evidence of delayed and limited access to care, the data on relevant outcomes were lacking and it is probably too soon to discern these effects. Community and provider informants frequently reported concerns, however, that short-term outcomes will soon be evident in the form of increases in communicable diseases, decreases in the use of prenatal and preventive care, compromised health status due to delayed care and lack of preventive/primary care, and complications from chronic conditions that are unattended.

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

The 1996 welfare law effectively created more uninsured people by denying access to Medicaid to heretofore eligible post-enactment legal permanent residents (LPRs). These uninsured immigrants – largely comprising nonpregnant LPR adults – are now members of the growing uninsured population in the US. To the extent that the 1996 welfare and immigration reform laws have led to greater numbers of uninsured immigrants in this country, then the indirect effects of the laws have been to place additional strains on the provider safety net, and to make access to care more difficult for all groups of uninsured, citizens and immigrants alike. Moreover, these uninsured immigrants will very likely include greater numbers of Medicaid-eligible but unenrolled immigrants due to heightened fears about using Medicaid. Despite the federal clarification about public charge, we frequently heard reports that immigration lawyers are still advising their clients not to use Medicaid in order to avoid any risk of problems.

Barriers to Medicaid and Health Care Related to Immigrants' Vulnerable Population Status

We found that immigrants applying for Medicaid also faced the same barriers as have been traditionally reported by citizens applying for Medicaid (e.g., burdensome application procedures and paperwork, difficult caseworkers, and hard to reach welfare offices). Similarly, uninsured low-income immigrants seeking health care services reported the same barriers to care as reported by low-income uninsured citizens (e.g., long waits to get appointments, concerns about inability to pay, transportation problems). The traditional low-income and vulnerable population status barriers frequently seemed to have a greater effect than the immigrant status-related barriers on access to care, with one notable exception. In mixed immigrant families, noncitizen frequently parents reported that they are reluctant to access services for citizen children for fear of jeopardizing themselves or other noncitizen family members.

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

Our findings indicate that efforts to improve access to Medicaid and health care services to immigrants, and to ameliorate the effect of the 1996 laws, must be tailored to one or the other of these two types of barriers: (1) barriers related to immigrant status and the 1996 laws, and (2) barriers related to vulnerable and low-income population status. It is also evident that both sets of barriers must be addressed in tandem. For example, continuing and concerted efforts to clarify that immigrant use of Medicaid does not present a public charge issue must be accompanied by efforts to make the Medicaid application process more accessible to immigrants as members of vulnerable, low-income populations (e.g., simplify application procedures, expand the number of alternative locations where immigrants can apply for Medicaid, improve language assistance).

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

Our findings do not provide definitive evidence of the adverse effects on immigrants' health-related quality of life that we anticipated would be the result of impaired access to Medicaid and primary care services (e.g., consequences of delayed care, increases in communicable disease). These outcomes are not unique to immigrants and would be anticipated

in any group with limited or impaired access to routine and preventive primary care. However, because these trends can be difficult to observe in their initial stages, systematic efforts to monitor immigrant health status over the long term, complemented by comprehensive data collection, must be established as part of efforts to monitor the health status and health services needs of low-income, uninsured and vulnerable populations such as immigrants.

Limitations of the Study

Although case study methods produce in-depth examinations of individual “cases,” we developed an analytic framework to guide our investigation with common protocols, and with systematic data collection and analyses. These cross-site findings and analyses provide the basis for practical recommendations for addressing barriers to immigrants’ access to Medicaid and health care services applicable to other sites as well as to our four sites. However, substantial potential for selection bias exists among our sample of immigrant informants who participated in individual interviews and focus groups. These immigrants self-selected for participation and, for the most part, were already connected to resources such as community health clinics and Medicaid. It is possible that these immigrants were less likely to be fearful about public charge or INS activities, and that these immigrants would have more accurate knowledge about Medicaid and how to access health care services. This bias could mean that we might have underestimated the effects of immigrant-related barriers to Medicaid and health care services. However, the reports of the immigrants provided a rich and detailed picture of these immigrants’ personal experiences in accessing Medicaid and health care services prior to and since the 1996 laws. Moreover, the potential effect of this bias does not change our findings regarding the presence of two sets of barriers: immigrant-related and nonimmigrant-related.

Recommendations – Commonalties Across the Sites Despite Unique Circumstances

We anticipated that the combined effects of the welfare and immigration reform laws would be reductions in the use of Medicaid and the use of health care services by immigrants. While our findings provide evidence of the effect of these two laws, we also found evidence of more complex and longstanding dynamics suggesting that immigrants’ access to Medicaid and use of health care services are affected equally by barriers related to their low-income and vulnerable population status and by barriers related to their immigrant status. These results have important implications for how federal and state officials and policymakers can address the health care access problems faced by immigrants.

Major recommendations based on commonalties across all sites include: (1) expand Medicaid outstationed and alternative enrollment locations; (2) simplify Medicaid application procedures; (3) improve and establish comprehensive and systematic outreach and education efforts about who is eligible for Medicaid; (4) address the cultural and linguistic barriers to accessing Medicaid and health care services; (5) provide more support and financial assistance to safety net providers; (6) provide more support for public health outreach and education to vulnerable populations; and (7) improve outreach and education efforts to clarify scope of public charge, and include a particular focus on INS staff at all levels and immigration attorneys. It is noteworthy that most of these recommendations are not unique to immigrants but would be part of strategies to improve Medicaid enrollment and/or expand access to health care for citizens and noncitizens alike.