

Immigrants and Medicaid After Welfare Reform

Immigrants—who comprise more than one in 10 U.S. residents—historically have faced an array of barriers to obtaining health care, such as poverty, language and cultural differences and, often, resentment. In 1996, Congress added a new impediment to the list when it denied most recent, poor legal immigrants the right to enroll in Medicaid. This policy change has important implications for the nearly nine million foreign-born women of reproductive age residing in the United States and the service providers who are trying to meet their health care needs.

By Rachel Benson Gold

More than 30 million residents of the United States—about 11% of the population—were born in other countries, according to recent estimates from The Urban Institute. Two-thirds of these immigrants are noncitizens, who are more likely than citizens to be poor, even if they work full-time. Although approximately 28% of immigrants are undocumented, either because they entered the country illegally or overstayed their visas, the overwhelming majority are legal U.S. residents.

Eligibility Changes

Historically, legal immigrants—whether citizens or noncitizens—generally were eligible for public benefit programs such as Medicaid on the same basis as were native-born Americans. This changed dramatically in 1996 when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (popularly known as “welfare reform”). The legislation included provisions designed to ensure that most families already enrolled in Medicaid would continue to be covered and to permit additional poor families to enroll in the program even if they did not meet all of the new welfare requirements; however, that was not the case for most immigrants, even if they were in the United States legally.

A year later, Congress enacted the State Children’s Health Insurance Program (SCHIP), modeled on Medicaid. In doing so, it added similar but slightly more

lenient eligibility restrictions for immigrant children—a population generally seen as having greater political appeal than adults. The policy parameters for covering immigrants under Medicaid and SCHIP are outlined in the box on page 7.

For Medicaid, Congress drew a distinction between immigrants who had entered the United States before welfare reform became law in August 1996 and those who arrived later. Welfare reform gave states the option to include individuals already here in 1996 in their Medicaid programs. (Under Medicaid, the federal government and the states share the cost of providing health care for specified groups of poor individuals considered to be unable to afford the cost of necessary medical care.) According to the Center on Budget and Policy Priorities (CBPP), all states except Wyoming have opted to do so.

Most legal immigrants who arrived after August 1996, however, were barred from Medicaid coverage for the first five years of residency, except in emergency situations. Although federal reimbursement is not available for this population, some states—including many that have the largest immigrant populations—have chosen to use their own funds to enroll and serve at least some groups of recent immigrants. According to CBPP, 18 states and the District of Columbia cover pregnant women in their programs; 13 states and the District of Columbia cover people with disabilities, families or seniors; and 17 states and the District of Columbia cover children. States have the option to offer Medicaid coverage to legal immigrants after five years of U.S. residency. All but nine states have chosen to provide coverage to this group, with the costs shared between the states and the federal government.

States have two main options for organizing their SCHIP programs: base their efforts on Medicaid, or design and establish separate programs (“State CHIP Programs Up and Running, But Enrollment Lagging,” *TGR*, October 1999, page 6). For states taking a Medicaid-based approach to their SCHIP efforts, the restrictions on Medicaid coverage for immigrants apply. In contrast, states that design their own SCHIP programs must cover children who arrived before 1996 as well as after they reach the five-year mark. State-designed SCHIP programs are prohibited from using federal funds to cover immigrant children during their first five years of residency; 12 states have opted to use their own funds to cover at least some children in this category.

Federal health programs that are not means-tested—that is, they do not have income-eligibility requirements for individual enrollees—were left untouched by the 1996 welfare reform law. Accordingly, to the extent they are financially able, programs such as Title X, the

maternal and child health block grant and community health centers, as well as state-funded efforts, are legally able to continue providing services to immigrants.

Coverage for Women of Reproductive Age

As seen in the table on page 8, Medicaid is an enormously important source of health insurance coverage for women of reproductive age. Of all women aged 15–44, 10% rely on Medicaid for their care. The program is even more important for poor women; more than a third of reproductive-age women with incomes below poverty depend on the program for their basic health needs. The program pays for a wide range of services critically important to reproductive health, including family planning services and supplies, pregnancy-related care, testing for and treatment of sexually transmitted diseases (including HIV) and cervical cancer.

Despite provisions in the welfare reform legislation designed to maintain Medicaid coverage for most recipients, the proportion of poor women of reproductive age enrolled in the program decreased between 1994 and 2001, from nearly 47% to 35%. One of the most substantial decreases took place among recent immigrants, which was expected given the federal ban on coverage for new immigrants and the limited instances in which states have decided to use their own funds to fill the void. In 1994, 26% of poor women of reproductive age who were recent immigrants were Medicaid enrollees; by 2001, coverage had decreased by almost half to 15%.

Among all poor immigrant women who are not citizens—many of whom explicitly lost eligibility as a result of the 1996 law—the proportion enrolled in Medicaid also fell by almost half, from 36% to 19%. Significantly, coverage dropped just as precipitously among poor, long-standing noncitizen residents as it did among poor, recent arrivals, despite the fact that many states chose to continue to cover the former group.

As would be expected, the extent to which U.S. women were uninsured rose as levels of Medicaid coverage fell, as seen in the table on page 9. Among all women of reproductive age, nearly 19% were uninsured in 2001, a slight increase from 1994. The increase, however, was much sharper among poor women: Just over 40% were uninsured in 2001, up from just over one-third in 1994.

Among all poor women of reproductive age who are noncitizen immigrants—whether long-standing residents or recent arrivals—more than six in 10 were uninsured in 2001. These data are striking in and of themselves, and they raise enormous questions about the access these women have to needed care and the ability of an already-struggling provider community to meet their needs.

Issues of Access

Recent immigrants not eligible for regular Medicaid coverage may obtain care in emergency situations, which according to the *State Medicaid Manual* developed by

IMMIGRANTS' ELIGIBILITY FOR MEDICAID AND SCHIP UNDER WELFARE REFORM LEGISLATION		
	MEDICAID AND MEDICAID SCHIP PROGRAMS	STATE-DESIGNED SCHIP PROGRAMS
THOSE WHO ENTERED THE UNITED STATES BEFORE 1996	Coverage with federal and state funds at state option; covered in all states except Wyoming.	Mandatory coverage with federal and state funds.
THOSE WHO ENTERED THE UNITED STATES AFTER 1996 DURING THE FIRST FIVE YEARS	Coverage with federal funds prohibited except in emergencies. Some states use state funds to cover pregnant women (18 states and DC); families, seniors or the disabled (13 states and DC) or children* (17 states and DC).	Coverage with federal funds prohibited except in emergencies. Covered with state funds in 12 states.*
THOSE WHO ENTERED THE UNITED STATES AFTER 1996 AFTER THE FIRST FIVE YEARS	Coverage with federal and state funds at state option; covered in 41 states and DC.	Mandatory coverage with federal and state funds.
*Some states have taken a combination approach to their SCHIP programs and have both a Medicaid component and a state-designed component to their effort.		
Source: Chin K, Dean S and Patchan K, <i>How Have States Responded to the Eligibility Restrictions on Legal Immigrants in Medicaid and SCHIP?</i> Washington, DC: Center on Budget and Policy Priorities, June 2002.		

the Centers for Medicare and Medicaid Services (CMS), includes labor and delivery. Although the emergency exception allows women to obtain critical reproductive health care when urgently needed, it does not begin to meet these women's full reproductive health needs.

First, emergency coverage does not include prenatal care, even though prenatal care is widely acknowledged to improve birth outcomes for both mother and child. As the Department of Health and Human Services (DHHS) concluded in its 2000 report *Trends in the Well-Being of America's Children and Youth*, "Increasing the percentage of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth." In fact, one of the key goals of DHHS's *Healthy People 2010: Objectives for Improving Health* is to "increase the proportion of pregnant women who receive early and adequate prenatal care."

Second, postpartum care is not covered, despite the fact that the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics consider it an integral part of pregnancy-related care. According to the two medical organizations, failure to obtain adequate postpartum care can jeopardize a woman's health as well as the outcomes of subsequent pregnancies. (This exclusion of postpartum care raises issues similar to those raised by new federal rules that define a fetus as a child for purpose of coverage under the SCHIP program—see "New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women's Expense," *TGR*, December 2002, page 3).

Third, recent immigrants are not eligible for Medicaid-covered family planning services and supplies—one of the few benefits that federal law explicitly requires all state Medicaid programs to cover. Improving access to family planning and reducing unintended pregnancy are also prominent goals of *Healthy People 2010*, and research shows that every public dollar invested in family planning saves three Medicaid dollars in pregnancy-related and newborn care.

In addition, treatment for breast and cervical cancer is available only in emergency situations. Although a letter from CMS to state health officials indicates that some treatment for breast and cervical cancer may qualify as an emergency, it fails to provide any specific guidance beyond an admonition to rely on medical judgment and the facts of a specific case. Moreover, vital screening and diagnosis services would not be covered at all. This omission is most unfortunate in light of new data showing that Hispanic women have a higher incidence of cervical cancer and a greater likelihood of having the disease in its advanced stages than do non-Hispanic women, a development that researchers from the Centers for Disease Control and Prevention say may be the result of the low use of screening services among the Hispanic population.

Outlook

Immigrants face myriad difficulties upon their arrival in the United States. It is, therefore, not surprising that many experience problems in negotiating the complex and confusing health care system. Leighton Ku and Sheetal Matani of The Urban Institute report that "being a non-citizen...reduces access to ambulatory medical care and emergency room care, after factors such as health status, income and race/ethnicity are controlled for." According to their study, the rate at which noncitizens had no ambulatory visits in a year is approximately double the rate for native-born Americans. Data from the Commonwealth Fund Minority Health Survey close the loop by showing that Hispanics who have insurance are more likely than those who do not to enter the health care system and obtain care.

Recent changes in Medicaid eligibility are likely to exacerbate, rather than ameliorate, preexisting problems. The only safety net offered to newly arrived legal immigrants, as well as to immigrants who are here without documentation, is coverage of emergency care. While this gives women access to the medical care that undeniably is needed in childbirth, it provides them no coverage for other important and cost-effective reproductive health services, such as prenatal and postpartum care or family planning.

TRENDS IN PERCENTAGE OF WOMEN 15-44 WHO ARE COVERED BY MEDICAID

	POOR*		TOTAL	
	1994	2001	1994	2001
UNITED STATES (TOTAL)	46.5	35.0	12.6	10.1
NATIVE BORN	48.8	38.9	12.4	10.3
IMMIGRANTS (TOTAL)	36.0	20.6	14.8	9.0
NATURALIZED CITIZENS	35.4	27.6	6.7	7.3
NONCITIZENS (TOTAL)	36.0	19.4	17.1	9.6
LONG-STANDING RESIDENTS**	41.1	23.2	17.3	10.5
RECENT IMMIGRANTS***	25.6	15.3	16.4	8.3

*Women in families with incomes under federal poverty level (\$15,260 for family of three in 2003).
 **Long-standing residents in 1994 were those who had been in the United States prior to 1990; long-standing residents in 2001 were those who had been in the United States prior to 1996.
 ***Recent immigrants in 1994 were those who had arrived in 1992 or later; recent immigrants in 2001 were those who arrived in 1997 or later. *Note:* CPS data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group. *Source:* The Alan Guttmacher Institute, tabulations of data from U.S. Census Bureau Current Population Survey, 1995-2002.

TRENDS IN PERCENTAGE OF WOMEN 15-44 WHO ARE UNINSURED

	POOR*		TOTAL	
	1994	2001	1994	2001
UNITED STATES (TOTAL)	33.6	40.5	17.5	18.7
NATIVE BORN	30.5	35.0	15.4	15.5
IMMIGRANTS (TOTAL)	48.4	61.3	35.0	37.3
NATURALIZED CITIZENS	36.4	47.6	19.8	22.9
NONCITIZENS (TOTAL)	49.5	63.6	39.2	42.9
LONG-STANDING RESIDENTS**	45.9	61.2	35.5	40.6
RECENT IMMIGRANTS***	57.2	66.4	48.1	47.2

See Notes and Source, table on page 8.

Moreover, many advocates contend that the climate of fear and distrust the legislation created is as important an issue as the actual restrictions themselves (“Implications for Family Planning of Post-Welfare Reform Insurance Trends,” *TGR*, December 1999, page 6). According to Lourdes Rivera of the National Health Law Program, many immigrants may be unwilling to apply for Medicaid coverage to which they may be entitled out of a concern that to do so will somehow jeopardize their immigration status or that of family members, despite attempts at both the federal and state levels to make clear that these fears are unfounded.

In the absence of federal reimbursement for recent immigrants, states—already struggling through one of the worst financial crises in recent times—are left using their funds to fill the void. And with no apparent financial relief forthcoming from the federal government, warning clouds are quickly gathering on that front as well. Just about every state has announced some form of cutback to its Medicaid effort, and one state—Colorado—has targeted its funding of care for immigrants. Newly enacted legislation could result in the removal of 3,500 immigrants from that state’s Medicaid program; implementation of the law has been blocked in federal court, at least temporarily.

The removal of coverage does not remove the need for care. It does, however, shift the burden from the Medicaid system to the network of safety-net providers—from family planning clinics to maternal and child health programs to community health centers—who will have to try to stretch their already scarce revenues even farther. Complicating the situation even more, immigrants may be a particularly expensive group to serve, as reflected in the dramatic increases in expenditures for language assistance reported by Title X-funded providers (“Nowhere But Up: Rising Costs for Title X Clinics,” *TGR*, December 2002, page 6).

Despite, or perhaps because of, the fiscal disarray on all sides, several members of Congress have again begun to push for a rollback of at least part of the Medicaid eligibility cuts. In recent weeks, Sens. Bob Graham (D-FL) and Lincoln Chafee (R-RI) along with Reps. Henry Waxman (D-CA) and Lincoln Diaz-Balart (R-FL) have reintroduced the Immigrant Children’s Health Improvement Act, which seeks to restore Medicaid coverage to two specific groups of recent immigrants: pregnant women and children. (Whereas newborns born in the United States would be citizens and eligible for enrollment in their own right, children who immigrated to this country would not be eligible under the current rules.) The measure was included in the welfare reauthorization bill that began to move through the Senate last year, and its sponsors hope that it will be included in whatever welfare reform measure emerges from Congress this year. ☉

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