

# THE MEDICAL SAFETY NET FOR LEGAL IMMIGRANTS IN TEXAS:

## CHALLENGES POSED BY THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

**I**n the past five years, both legislative and extra-legal barriers have been erected to diminish the medical safety net available to legal immigrants in Texas. What began with the congressionally-mandated program cutbacks in 1996 has evolved into a fear so pervasive that legal immigrants are refusing to access essential assistance programs for themselves and/or their eligible children. A General Accounting Office (GAO) study recently reported that almost one-third of Medicaid eligible children who are uninsured live in immigrant families.<sup>1</sup> Despite a slow start, the Texas Legislature has taken positive steps to address the medical needs of this population through state-funded extensions of Medicaid and the new Children's

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Health Insurance Program (CHIP). However, further efforts are essential. The purpose of this paper is three-fold. The first section presents both the numerous and confusing changes in immigrant eligibility mandated by the 1996 "Personal Responsibility and Work Opportunity Reconciliation Act" (PRWORA) and subsequent modifications that also affected immigrant access to benefits. Second, the options that PRWORA left open to the states is outlined, looking specifically at the choices that Texas made in terms of Medicaid and later CHIP. Finally, the barriers still thwarting legal immigrants' access to care is examined, alternatives are discussed, and recommendations for further action at the Texas state government level are offered.

### PRWORA

On August 22, 1996, President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), mandating "the end of welfare as we know it." The justification for this statute was moral and financial: that welfare recipients in general abuse the system, that welfare "hurts" people by encouraging dependency, and above all, that taxpayers should not have to foot the bill for immigrants who view the United States as, according to chairman of the Subcommittee on Immigration and Claims of the House Judiciary Committee Rep. Lamar Smith (R-TX), "nothing more than a taxpayer-funded retirement home." Among the most dramatic changes were those affecting the eligibility of legally present, documented immigrants for federal benefit programs. The original provisions of PRWORA drastically reduced immigrant access to the welfare safety net and gave states much greater power in determining eligibility for that aid. Of the \$60 billion projected savings from the welfare reform, approximately \$24 billion or 44 percent was to come from cuts in social services to immigrants.<sup>2</sup> Eighty-five percent of the savings came from reductions in Supplemental Security Income (SSI), Food Stamps, Aid for Families with Dependent Children (AFDC), and Medicaid.<sup>3</sup> Federal savings from cuts in immigrant access to Medicaid alone were projected to affect 600,000 legal immigrants for a total savings of \$5 billion over seven years.<sup>4</sup>

### BACKGROUND: PRWORA'S IMMIGRANT PROVISIONS

In order to understand PRWORA's impact on legal immigrant access to the medical safety net, it is important to examine the entire array of changes in immigrant eligibility enacted by that law. Immigrant access to health care was affected not only by changes in Medicaid availability, but also by the confusion and fear generated by PRWORA's comprehensive assault on the entire notion of immigrant entitlements.

The immigrant provisions of PRWORA created new categories of distinction among immigrants based not on their legal status, but on their date of arrival and perceived permanence in the U.S. In the past, access to federal benefits was based on the immigrant's legal status and was available as a safety net for any legally admitted immigrant after a period of deeming.<sup>5</sup> Only refugees and asylees were exempt and could apply for benefits upon arrival. After the deeming period expired, legally present immigrants were eligible for most major and minor federal safety net entitlement programs on the same terms as citizens. Undocumented immigrants were excluded from all the major federal assistance programs including SSI, Medicaid, AFDC, and Food Stamps. With the inception of PRWORA, immigrants were recategorized as "qualified" or "unqualified," effectively replacing the "legal" or "illegal" dichotomy as it related to determining benefit entitlement. While the bulk of legal immigrants were deemed "qualified," several categories of legal immigrants suddenly found themselves "unqualified." In terms of eligibility for federal benefits, they were demoted to the same status as the undocumented group, meaning they were denied access, and any benefits they were receiving at the time of the law were terminated.<sup>6</sup> The only exemptions to the ban for both the "unqualified" and undocumented were emergency medical assistance under Medicaid, short term non-cash emergency disaster relief, immunizations, testing for and treatment of communicable diseases, and non-cash, non-means-tested assistance necessary for the protection of life and safety like temporary shelters, soup kitchens, crisis intervention, etc. as specified by the U.S. Attorney General. Although the majority of legal immigrants fell into the "qualified" category, most saw their eligibility for federal safety net programs substantially altered.

A second distinction between legal immigrants under PRWORA was based on their date of arrival in the U.S. The "before" group, or those immigrants

who were legally present in the U.S. before the date PRWORA was signed into law, August 22, 1996, were allowed greater access to welfare benefits than those who arrived on or after that date—the “after” group. States were granted the right to differentiate between the two groups for state programs and those that operate with joint federal and state funds. After January 1, 1997, states had the option of continuing or terminating the participation of “qualified” immigrants in the “before” group for Medicaid and the AFDC replacement, Temporary Assistance for Needy Families (TANF), but were prohibited from using federal dollars to extend these benefits to those in the “after” group. Legal immigrants who arrived or adjusted to legal status after August 22, 1996, had to be barred from all “federal means-tested public benefits”<sup>7</sup> for their first five years in the country except the life and safety provisions outlined above. This bar also prohibited states from using Medicaid funds for public health immunizations and for testing and treatment of communicable disease for “unqualified” and “after” group immigrants. After the five-year waiting period, states would have the option to decide if they would allow legal immigrants to participate in Medicaid and TANF, but only after deeming them “qualified.” Refugees and asylees retained eligibility for full Medicaid and TANF benefits, but were given a time limit of five years after entering or being granted asylum. After five years they would be subject to the same state decisions as other legal immigrants. Additionally, all legal immigrants were to be barred from SSI and food stamps until they naturalized. The only “qualified” immigrants exempted from the bar were those who could prove forty quarters or ten years of Social Security qualified work history,<sup>8</sup> refugees, asylees and those granted withholding to deportation (but only for their first five years in the U.S.), and veterans and active duty military, their spouses and dependent children. Those “qualified” immigrants unable to prove an exemption were to be dropped from the rolls by August 22, 1997.

After the five-year waiting period for those entering the country after August 22, 1996, “qualified” immigrants technically become eligible for federal means-tested benefits, but are then subject to deem-

ing of their sponsor’s income. PRWORA created new restrictions for sponsoring immigrants, requiring that all persons bringing family members to the U.S. demonstrate that they have a household income of more than 125 percent of the poverty level (or \$21,313 for a family of four in 2000).<sup>9</sup> Those legal residents and citizens who do meet the income requirements are required for the first time to sign a legally binding affidavit of support that holds them responsible for supporting the family member until he or she becomes a citizen or obtains forty work quarters.<sup>10</sup> This provision effectively makes “qualified” immigrants in the “after” group ineligible for federal benefit programs until they become

citizens or work forty quarters, because even after the five year period, their sponsor’s income will now be considered as 100 percent available to the immigrant in determining income-based need. Programs exempt from deeming for “qualified” immigrants are: emergency services; public education and educational assistance ranging

from Head Start to student loans; programs offered under the Job Training Partnership Act; and child nutrition programs including school lunches.

New reporting requirements for agencies that administer federal benefits were also outlined in PRWORA. It mandated that these agencies report quarterly to the Immigration and Naturalization Service any persons “known to be unlawfully present” in the U.S. A similar provision makes it illegal for any public entity to adopt an official policy stating that it will not share information regarding immigration status with the Immigration and Naturalization Service (INS). Likewise, no local, state, or federal entity can prohibit employees from sharing this same information. Non-governmental organizations are not included in this requirement of PRWORA and can continue to serve their clients without requiring documentation of legal status.

Since PRWORA was signed into law, there has been a continuous stream of legislation amending it. The pressure for these changes has come from immigrant advocacy groups and from President Clinton himself, who vowed to soften the immigrant provisions of PRWORA even as he signed it. Several significant pieces of legislation, including

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the Balanced Budget Act of 1997 (BBA) and the Agricultural Research, Extension, and Education Reform Act of 1998, served to mitigate the harshest terms of the welfare reform law for the most vulnerable populations. For the most part, however, immigrant access to Medicaid was not affected by these amendments.<sup>11</sup> Of particular importance is that immigrants in the “after” group were not addressed by either law, leaving them subject to individual state decisions, but effectively excluded from Medicaid until naturalization.

### STATE DECISIONS—TEXAS’S CHOICES

PRWORA rendered a major devolution of responsibilities from the federal government to the individual states. For the first time, states were given license to discriminate against non-citizens in their state and locally funded programs. Although PRWORA forbade the use of federal funds to extend coverage to those immigrants whose benefits were terminated, there is no provision preventing or prohibiting states from using their own funds to assist these immigrants or those in the “after” group who face the five-year wait. Most states took some action to make available funds for at least limited assistance programs for authorized immigrants.

Although over 7 percent of qualified immigrants affected by PRWORA live in Texas,<sup>12</sup> the 75<sup>th</sup> Texas Legislature did little to bolster the safety net for them in the immediate aftermath of PRWORA’s passage. The new TANF block grant could have been used to supplement existing state dollars in order to allocate additional funds to health and human services programs assisting legal immigrants affected by PRWORA. Instead of taking advantage of this opportunity to expand services, however, the Legislature used TANF funds to the maximum extent allowable to simply replace existing state spending on health and human services. Bills and resolutions sponsored by Texas State Senators Judith Zaffirini and Carlos Truan and Texas State Representatives Elliot Naishtat and Norma Chavez to help offset the PRWORA changes were filed, but all died in the legislature without much support.<sup>13</sup> Also, a \$1 billion surplus that might have been partially appropriated to assist legal immigrants was instead earmarked in an unwritten consensus to be used to finance an increased property tax homestead deduction.<sup>14</sup>

### MEDICAID

Although minimal, Texas did take a few measures to support specific groups of disintegrated immigrants. Recognizing the reality that without Medicaid coverage, the costs of care for qualified immigrants would shift directly to city and county funded facilities, the Texas Legislature voted to exercise its option to continue using federal funds for “before” group Medicaid recipients who had been cut off from SSI as well as from TANF soon after the passage of PRWORA. Due to a technical barrier, however, Texas’s ability to follow through on this decision was complicated for a large portion of the 101,000 legal immigrants enrolled in Texas Medicaid.<sup>15</sup> Essentially, Texas lacked a special category for the elderly poor and disabled persons who had previously been receiving Medicaid via their SSI eligibility. When SSI was terminated, there was no programmatic home in which to put them. Creating the administrative space, however, would ensure that no legal immigrants in Texas who were receiving Medicaid would lose their benefits and that any “before” group person turning 65 years of age or becoming disabled after August 22, 1996, would still be eligible. After the BBA restored SSI to most “before” group immigrants, Texas dropped its attempt to create the new administrative category. Because the BBA covered only most of the former SSI recipients, however, “before” group legal immigrants who turn 65 years of age in the future but are not disabled will not be eligible for Medicaid. In addition, Texas took no action on the provision of PRWORA that allows states to screen for undocumented children in determining eligibility for Women, Infants and Children (WIC), the Summer Food Service Program, or the Child and Adult Care Food Program. Texas will continue providing child nutrition programs to all poor children without regard to their immigration status.

At the same time as the 75<sup>th</sup> Legislature extended Medicaid coverage to qualified immigrants who were in the U.S. prior to PRWORA, it acknowledged the date of arrival distinction and refused to fill the gap for qualified immigrants who entered after August 22, 1996. Doing so would have required Texas to pay those immigrants’ Medicaid expenses solely with state funds. The Legislature also expressed its intention not to serve the “after” group when the five-year ban is up.<sup>16</sup>

## CHIP

On August 5, 1997, President Clinton signed the federal budget reconciliation act for Fiscal Year (FY) 1998 into law. This, the Balanced Budget Act of 1997, encompassed many important provisions, including the Child Health Block Grant (formally titled the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act). This block grant allocated \$4 billion per year in matching funds for ten years to expand health care coverage for uninsured children whose families cannot afford private insurance, but who earn too much to qualify for Medicaid.<sup>17</sup> Under the federal mandate, CHIP was intended to provide free or reduced cost coverage for children from birth through age 18. Although the funds first became available October 1, 1997, Texas did not begin the federal application process until the 1999 legislative session. Because of this delay, Texas was not able to begin accepting applications from CHIP-eligible children until April 2000.<sup>18</sup>

CHIP targets those children whose family incomes are above the limit for Medicaid, but are less than twice the federal poverty level (\$34,199 in 2000 for a family of four). These children account for a large portion of Texas's uninsured children—both citizen and non-citizen. State officials estimate the population qualifying for CHIP to be 471,000 out of approximately 1.4 million uninsured Texas children in 2001.<sup>19</sup> There are no statistics available as to the proportion of these children who are legal immigrants.

The Texas CHIP program, enacted in 1999, will be paid for with state tobacco settlement funds<sup>20</sup> and matching federal funds.<sup>21</sup> On average, Texas will receive \$423 million per year, or \$2.5 billion in the next five years alone, in federal CHIP dollars.<sup>22</sup> As for the state share, approximately \$1.8 billion in tobacco funds were allocated for the 2000-2001 biennial budget, with just under 10 percent, or \$179.6 million earmarked for CHIP.<sup>23</sup> The state law specifically stipulates, however, that CHIP is not an entitlement program and that it must be reauthorized by the legislature in the event that federal matching funds or tobacco settlement dollars cease to be available in the future. Although there are provisions in the law directing the Texas Health and Human Services Commission to freeze enrollment in the event of inadequate funding, it also protects CHIP from minor fluctuations in the funding stream by granting CHIP "first call" on tobacco settlement funds in all future fiscal years.<sup>24</sup>

By 1999, the Legislature's stance on immigrant benefits had softened sufficiently to extend medical

benefit eligibility to all legal immigrant children, regardless of date of entry. Federal CHIP covers all legal immigrant children who arrived prior to August 22, 1996. Per federal law, however, "after" group children will be subject to the five-year bar and subsequent deeming unless states decide to fill the gap using state funds exclusively. Unexpectedly, the 76<sup>th</sup> Texas Legislature decided to use state-only funds to cover all "qualified" immigrant children at Medicaid or CHIP income level regardless of their date of entry. This means that in Texas, all "qualified" legal immigrant children whose families earn up to 200 percent of the federal poverty level are eligible for CHIP benefits.

## BARRIERS TO CARE

Although many of the institutional barriers to medical care are no longer germane to most legal immigrants in Texas (only "after" group adults still face terms different than citizens), a pervasive fear among the immigrant community, as well as confusion regarding eligibility changes, prevents many from accessing the needed services for which they are eligible. These fears generally stem from the INS/State Department public charge determinations and the INS reporting requirements outlined by PRWORA. Although no Texas-specific studies have been conducted to date, a 1998 Urban Institute study found that approved applications of legal non-citizen families for Medi-Cal and TANF in California fell 71 percent between January 1996 and January 1998 even though there was no change in legal immigrants' eligibility for either program and denial rates in the county were steady during the period.<sup>25</sup> A more recent Urban Institute study found that legal immigrants "accounted for a disproportionately large share of the overall decline in welfare caseloads between 1994 and 1997," with use of means-tested benefits by legal immigrant households falling 35 percent between 1994 and 1997.<sup>26</sup> Citizen household use fell only 14 percent during this same period. Medicaid use followed a similar pattern, dropping 22 percent among legal immigrant households while dropping only 7 percent among citizen households. The difference is even more striking when only households below 200 percent of poverty are examined. Medicaid use among legal immigrant households below 200 percent of the federal poverty level fell 19 percent while the decline among similar citizen households was negligible (less than .01 percent).<sup>27</sup>

Because comparatively few legal immigrants were ineligible for public benefits as of December 1997, it appears that the steeper declines in noncitizens' than citizens' use of welfare, food stamps, and Medicaid owe more to the "chilling effect" of welfare reform and other policy changes than they do to actual eligibility changes. In addition, the fact that welfare [including Medicaid] use among noncitizens dropped as steeply as food stamp use (where new restrictions extended far more broadly) suggests that eligibility in one program may chill noncitizens' use of other programs.<sup>28</sup>

Confusion about eligibility requirements has kept some legal immigrants from accessing benefits to which they are entitled.

Because Texas opted to continue Medicaid eligibility for qualified "before" group immigrants there should have been no break in that group's access to medical care. Erroneously believing that PRWORA had discontinued all benefits to legal immigrants (as was originally the case for SSI and food stamps), however, many legal immigrants dropped off the Medicaid rolls when their food stamps were discontinued.

More worrisome even than the confusion surrounding eligibility, however, is the pervasive fear among immigrants that accessing benefits to which they know they or their children are legally entitled will adversely impact their ability to stay in the U.S. and/or their ability to naturalize. Primarily, the fears stem from concerns about being labeled a "public charge"<sup>29</sup> and from the PRWORA requirement that public agencies report any persons "known to be unlawfully present in the U.S." to the INS.

These fears are not unfounded. Until recently, the "public charge" label could and did occasionally apply to legal immigrants who took advantage of safety net programs. From the passage of PRWORA until its guidelines were clarified in June 1999, the INS and State Department threatened to make public charge determinations based solely on an immigrant's or an immigrant's family's current or past receipt of non-cash public assistance, including Medicaid. Contrary to Medicaid law, the State De-

partment began the Public Charge Lookout System. Under the guise of this program, past Medicaid recipients were detained at the border and denied entry until past benefits were fully repaid. It often took months of separation until family and friends were able to raise the thousands of dollars to remedy the "public charge" problem. INS and State Department personnel clearly told immigrants that utilizing Medicaid or other non-cash health or nutritional benefits would hamper future efforts to adjust immigration status or obtain citizenship. Immigration judges have also coerced immigrants to repay Medicaid benefits that they received legally, threatening adverse rulings for failure to comply.<sup>30</sup>

The INS's June 1999 guidelines on public charge determinations should calm some of these fears.

The guidelines definitively stated that receipt of health care services, including Medicaid and CHIP, nutrition services, including food stamps, WIC and school meals, and other non-cash benefits would not affect an immigrant's ability to get a green card or to naturalize. While this was a very positive step that may

quell fears of being labeled a public charge, it does not address another major barrier to legal immigrants' accessing needed safety net programs—fear of reporting requirements.

The new reporting requirements instituted by PRWORA have profoundly impacted the medical safety net available to legal immigrants. Claudia Schlosberg of the National Health Law Program writes:

Publicity surrounding the welfare law and recent changes in immigration law have generated palpable fear in the immigrant community. A recent poll of Medi-Cal eligibility workers identified fear of INS as the number one barrier faced by persons applying for medical assistance. Providers too are confused and concerned. Increasingly, reports from the field strongly suggest that immigrants entitled to receive emergency health care, public health services and other health care (i.e. under a state-funded program), and citizen children of undocumented parents are 'on the run' medically because they fear being reported to INS.<sup>31</sup>

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Although the reporting requirements exempt public health care providers reporting people to the INS, the agencies where they work are prohibited under PRWORA from having an official policy that they will not share immigrant status information with the INS. Neither can these health care providers forbid employees from sharing that information. Therefore, public hospitals and clinics cannot guarantee protection for undocumented patients. According to the Center for Public Policy Priorities in Texas, "Public health providers report that this is already having a chilling effect on the use of prenatal care, preventative care and primary care."<sup>32</sup>

Fear that undocumented persons will be reported to the INS and subsequently deported hampers the ability of legal immigrants to access medical care for themselves and/or for their legal immigrant and citizen children. Undocumented parents fear exposing themselves or other undocumented family

members to immigration authorities and so avoid accessing medical benefit programs for their eligible children. "Mixed households," in which there is at least one non-citizen family member living with at least one citizen family member, are pervasive. One in five children in the U.S. is either an immigrant or has at least one immigrant parent—many of whom have not become citizens.<sup>33</sup> Moreover, one in ten American children lives in a household where at least one parent is a non-citizen and at least one child is a citizen.<sup>34</sup> In Texas, 1998 Department of Human Services data identified 65,396 mixed households with approximately 9,000 legal immigrant and 144,975 citizen children living in them.<sup>35</sup> Certainly, if mixed households containing at least one undocumented family member were counted the numbers would be far higher. This creates a difficult situation for immigrant families which is reflected in the steep rise in uninsured rates for children in mixed households since welfare reform. Between 1995 and 1997, uninsured rates for non-citizen children rose from 36.4 percent to 43.9 percent, while for citizen children with non-citizen parents, the uninsured rate rose from 23.3 percent to 26.8 percent.<sup>36</sup>

Although health care providers and Medicaid eligibility workers are not required to report their patients'/clients' immigration status to the INS,

TANF eligibility workers are required to do so under PRWORA. Moreover, PRWORA and federal Medicaid guidelines do require federal, state, and local government agencies to determine program eligibility through verification of citizenship and immigration status even though they are not required to share that information with the INS.<sup>37</sup> The crux of the problem is that most states have the same agency responsible for processing both TANF and Medicaid applications—many states even have a single application for the two programs. This causes confusion about reporting obligations and heightens immigrants' apprehensions. Such is the case in Texas, where

TDHS determines eligibility for TANF—which has reporting requirements—as well as Medicaid and food stamps—which have no reporting requirements.<sup>38</sup> The problem is likely to extend to the new Texas CHIP program as well, given

that CHIP and Medicaid now have a common initial application.

Steps have been taken to address these problems. In September of 1998, federal Medicaid officials announced new guidelines that prohibit states from requiring parents, as a condition of either Medicaid or CHIP eligibility, to provide Social Security numbers (SSNs) or any other verification of immigration or citizenship status for themselves or other family members not applying for benefits. This means that states can only require SSNs and verification of status information for the child who will receive the Medicaid or CHIP benefits, and not from any other family members. The guidelines also encouraged states to proactively inform parents that only the applicant child's information will be required.<sup>39</sup>

### THE STATUS QUO: CONSEQUENCES

The federal government's efforts to clarify the "public charge" determinants and to publish guidelines specifically prohibiting states from requiring SSNs and/or citizenship/immigration status information from family members not directly receiving medical benefits represent proactive steps towards bolstering the weakened safety net for legal

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immigrants and citizen children in mixed households. Although there is recognition of this effort, many advocates say that these guidelines do not go far enough in addressing immigrants' fears. The status quo, they contend, continues to support legislative and extra-legal barriers that deny qualified legal immigrants and many citizen children in mixed households fair access to the medical safety net. It is impossible to say how many people in Texas are directly affected by the current atmosphere of fear and confusion, but all Texans may pay the price. Denying people proper health coverage is a liability for all Americans. While immigrants and their children feel the immediate brunt, the consequence of their fears of reporting requirements and of being labeled a "public charge" is increased public health risks to all residents of the U.S., both immigrants and citizens.

The World Health Organization cites a strong correlation between access to health care and infectious disease.<sup>40</sup> In the fight against infectious disease, vaccinations and antibiotics are the most powerful tools, but their effectiveness depends upon timely identification of disease and appropriate treatment. When antibiotics are taken unnecessarily or for a shorter than necessary length of time, drug resistant strains of bacteria appear. Thus, without access to necessary medical care, immigrants pose a danger to themselves and those around them. Bruce M. Bullen, Medicaid Commissioner for the Commonwealth of Massachusetts, calls these barriers to care "a direct threat to the public health of the larger community."<sup>41</sup> For example, since December 1997 the State of New York has been battling the nation's largest rubella outbreak. It started in Westchester County but has since spread to New York City.

The epidemic has been spreading through the Hispanic community among immigrants who have not been vaccinated against the disease. Public health officials acknowledge that one of the problems in fighting the epidemic is that many in the Hispanic community are afraid of the health department because they equate it with the Immigration and Naturalization Service.<sup>42</sup>

Similar outbreaks, including a notable increase in tuberculosis and sexually transmitted diseases, are occurring along the U.S./Mexico border.<sup>43</sup>

Moreover, advocates contend that the federal guidelines do not go far enough in ensuring unfettered access to medical safety net programs. States

are prohibited from *requiring* SSNs, immigration status, or citizenship status information from non-applicants, but they are not prohibited from *asking* for it—and that distinction, they say, makes all the difference. The Center for Budget and Policy Priorities (CBPP) recent publication "Assuring that Child Health Applications Do Not Deter Enrollment Among Eligible Children in Noncitizen Families" reports that the Texas Medicaid application "appears to require SSNs [and information about citizenship status] from parents who are not seeking coverage for themselves" and "appears to require SSNs [and information about citizenship status] from children who are not seeking benefits for themselves."<sup>44</sup> Texas' new CHIP/Medicaid joint application was lauded by program officials and immigrant advocates alike, but remains confusing as to whose information must be provided by requesting information about applicant and non-applicant children in the same section. According to the same CBPP, Medicaid/CHIP applications with ambiguous wording, such as the Texas application, are ineffective because:

[e]fforts to promote enrollment among eligible children in noncitizen families are likely to fall short of their goals if child health applications ask unnecessary questions about citizenship or inappropriately require Social Security numbers from people living in the household who are not applying for benefits for themselves. Such information is not necessary to determine a child's eligibility for health coverage under either Medicaid or a separate CHIP-funded program and is likely to deter families with noncitizen family members from completing the application process.<sup>45</sup>

## POLICY ALTERNATIVES

Several states have taken measures beyond the minimal federal guidelines to ameliorate the fear and confusion surrounding eligibility and public charge concerns. These state actions have centered primarily around clarifying applications and implementing aggressive outreach strategies and public education campaigns.<sup>46</sup>

California and Illinois have gone to lengths to ensure that applicants know that they need only reveal specific information on Medicaid/CHIP applications. California's joint Medi-Cal/Healthy Families (California's CHIP program) application clearly states the information requirements and provides a

clear explanation about the rules regarding SSNs and other status information. There are separate sections in which to list “children under 19 and/or the pregnant women who want health coverage” and other family members who are not applying. SSN and citizenship information are requested in the section for applicant women and children, but in that same section it also clearly states, “Social Security numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.” The section of the application that asks about other family members makes no inquiries about SSNs or citizenship/immigration status. The Illinois KidCare application (Medicaid and CHIP) has a similar approach, asking for information about “all children and pregnant women living with you who want health benefits.” The section does ask for SSNs, but it clearly states within that section that SSNs are optional for pregnant women.<sup>47</sup> Any of these clarifying measures could easily be incorporated into the Texas joint Medicaid/CHIP application.

Outreach and public education are widely viewed as the key to enrolling eligible persons in available medical benefit programs. Legal immigrants and citizen children in mixed households are not the only ones who would benefit from aggressive campaigns to increase awareness and rectify misconceptions. According to a recent Census Bureau report, Texas has the highest rate of uninsured children in the country.<sup>48</sup> Since PRWORA, Texas also has experienced one of the largest drops in qualified low-income kids receiving Medicaid, with 193,400 Texas children—citizen and legal immigrant—or 14.2 percent) falling off the Medicaid rolls in those three years.<sup>49</sup> Many obstacles come between families with uninsured children and the health care coverage for which they are eligible and they are not only impacting legal immigrants. These obstacles include: a lack of information about available programs, confusion regarding eligibility, lengthy and/or complicated application procedures, inaccessible enrollment sites, and reluctance on the part of many families to participate in government programs.<sup>50</sup> Many eligible citizen children have lost their health care coverage because their families were ill-informed that changes in cash benefits under welfare reform were not intended to affect Medicaid eligibility. An aggressive outreach campaign can help clear the confusion for all eligible people.

Funding for such programs is often an issue for the Texas Legislature. Funding is available, however, for outreach and public education regarding Medicaid and CHIP. Federal CHIP law forbids

states from using federal matching funds for CHIP administrative spending (including outreach) exceeding 10 percent of the amount spent on actual health care coverage, but Medicaid administrative funds are available to fund outreach at a 50 percent matching rate. The 76<sup>th</sup> Texas Legislature allocated just \$7 million of CHIP funds for statewide outreach, but as the Medicaid matching funds are uncapped, there is no limit on the allowable amount of outreach. In addition, PRWORA created a special fund called the Medicaid “\$500 million fund” to be allocated among the states to help pay for activities to ensure that children and parents do not lose Medicaid coverage as a result of changes in the welfare system. More specifically, the money was intended to help delink Medicaid eligibility from eligibility for cash assistance.<sup>51</sup> The cost of allowable activities can be reimbursed up to 90 percent. According to the Health Care Financing Administration allowable activities include:

eligibility determinations and redeterminations that arise as a result of delinking; beneficiary educational activities; the production and airing of public service announcements; outstationing, hiring and training eligibility workers; designing, printing and distributing new eligibility forms; . . . assuring access to Medicaid for low-income families who are not eligible for TANF but are eligible for Medicaid. . . .<sup>52</sup> .

Texas must first spend money on Medicaid/CHIP outreach and later submit a claim for the matching funds in order to access the federal matching dollars. The state share of outreach expenditure can come from state revenues, state or local intergovernmental transfers, or private funds, but it may not include federal funds from other programs, including block grants.

## RECOMMENDATIONS

The State of Texas needs to act now to protect the health and well-being of legal immigrants and the citizen children of mixed households—and by extension the health and well-being of all Texans—by breaking down the barriers that prevent these groups from accessing the medical safety net. Relatively few, inexpensive alterations to the current situation would have a large impact. In order to achieve this, the Texas Legislature should take the following measures:

- Delink administration of TANF and Medicaid/CHIP. As TANF is required to report quarterly to the INS while Medicaid and CHIP are not, separation of program administration and location will go a long way in eliminating the fear of inadvertent reporting.
  - Lobby federal lawmakers for an official clarification of INS reporting requirement. There must be an unambiguous policy that guarantees protection to non-applicant family members of qualified applicants who seek medical benefits.
  - Rework the Texas CHIP/Medicaid joint application as well as the Medicaid-only application to eliminate any ambiguous wording that may heighten immigrant fears.
  - Utilize available funds to plan and implement an aggressive public education and outreach campaign. Such efforts will help everyone involved (including health providers, social service agencies, community organizations, and immigrants themselves) to better understand what services remain available to legal immigrants since the passage of PRWORA and to clarify misconceptions about current verification and reporting requirements.
  - Lobby federal lawmakers for an end to the deeming requirement for immigrants entering the U.S. after August 8, 1996. Texas is home to a large number of legal immigrants, and the number is certain to grow in the future. A change in federal law permitting legal "after" group immigrants to qualify for Medicaid after five years of U.S. residence, even if they choose not naturalize, would shift the fiscal responsibility for their care away from Texas state and municipal governments and back to the federal government.
1. Sheri Steisel and Ann Morse, "States, Federal Welfare Reform and Immigrants: The Challenges of the First Year," in *In Defense of the Alien*, Volume XX 1997, ed. Lydio F. Tomasi (New York: Center for Migration Studies, 1998), pp. 23-34.
  2. Joyce Vialet, "Welfare Entitlement: The Congressional View," in *In Defense of the Alien, Volume XX 1997*, ed. Lydio F. Tomasi (New York: Center for Migration Studies, 1998).
  3. The Immigrant Policy Project, *Medical Assistance and Health Benefits* (Washington, D.C.: State and Local Coalition on Immigration, 1997). Online. Available: <http://www.stateserv.hpts.org>. Accessed: March 28, 2000.
  4. During the deeming period, the sponsor's income was also considered when determining the immigrant's eligibility for benefits. The deeming period before PRWORA was three years for Food Stamps and five years for SSI.
  5. The group of newly-unqualified categories of legal immigrants included many people previously designated PRUCOL (Persons Residing Under the Color of Law): Temporary Protective Status; Family Unity Status; "non-immigrants" or temporary residents in the U.S. on time-limited visas to work, study or travel, including temporary agricultural workers.
  6. What constituted "federal means-tested public benefits" was left vague in PRWORA. In August of 1997 they were defined to incorporate only SSI, Food Stamps, Medicaid, and TANF.
  7. The work of a spouse or parent (for the years when the child is under 18) can count towards the forty quarters. To be credited, a person must earn at least the amount established by the Social Security Administration. Beginning December 31, 1996, quarters would not count if a person received federal means-tested benefits during that period.
  8. A sponsor who cannot meet the requirement is allowed to have a joint sponsor. The government will also look at any significant assets that can be counted towards making up the deficit. Those who cannot prove they meet the income requirement will not be allowed to bring over family members, no matter how close the familial relationship.
  9. The only exceptions are widows and widowers applying for immigrant status based on prior marriage to a U.S. citizen and certain battered spouses and children.
  10. Refugee and asylee access to Medicaid eligibility for Medicaid was affected by the Balanced Budget Act. The length of time that refugees, immigrants whose deportation has been withheld, and asylees can collect benefits was extended from five years to seven years. This time change reflects the backlog of cases

healthlaw.org/pubs/19980522publiccharge.html. Accessed: March 28, 2000.

**LBJ**

## NOTES

1. Claudia Schlosberg and Dinah Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (Los Angeles: National Health Law Program, May 22, 1998). Online. Available: <http://>

- at INS offices—sometimes over a year—and was intended to give these groups a fair and realistic time frame in which to naturalize before their benefits were discontinued.
12. Claudia Schlosberg, Trish Nemore, and Josh Bernstein, *Continuing Medicaid Coverage for Qualified Aliens* (Los Angeles: National Health Law Program, November 21, 1996). Online. Available: <http://healthlaw.org/pubs/19961121aliens.html>. Accessed: March 28, 2000.
  13. Center for Public Policy Priorities (CPPP), "Health and Immigrant Benefit Issues Update: Part One," *Policy Page*, no. 52 (July 9, 1997).
  14. Anne Dunkelberg, *Impact on Immigrants* (Austin: The Center for Public Policy Priorities, 1997).
  15. CPPP, "Health and Immigrant Benefit Issues Update: Part One."
  16. Due to extensions and the eventual restoration of SSI and subsequently Medicaid, this program never went into effect. Texas has still not decisively announced how the "after" group will be treated when the ban begins to expire in 2001.
  17. CPPP, "The Balanced Budget Act of 1997: Highlights of Child Health Block Grant and Medicaid Provisions," *Policy Page*, no. 58 (September 24, 1997).
  18. The CHIP program began providing benefits to eligible children in May 2000.
  19. CPPP, "Children's Health Insurance Program Signed into Law," *Policy Page*, no. 90 (July 16, 1999).
  20. In the 2000-2001 budget, approximately \$1.8 billion in tobacco funds were allocated. CHIP was allocated \$179.6 million for the biennium.
  21. The matching rate is 70 percent of the current rate for Medicaid. In Texas this means a 26 percent state matching share for CHIP (Texas will receive \$3 in federal funds for every \$1 it spends on CHIP) compared to 38 percent for Medicaid. The federal program is funded partly by an increase in tobacco taxes.
  22. Texas CHIP Coalition, "CHIP Background," *Texas CHIP Coalition*. Online. Available: <http://www.main.org/txchip>. Accessed: January 27, 2001.
  23. CPPP, "Children's Health Insurance Program Signed into Law."
  24. *Ibid.*
  25. Wendy Zimmerman and Michael Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County*. (Washington D.C.: The Urban Institute, July 1998). Online. Available: <http://www.urban.org/immig/lacounty.html>. Accessed: March 31, 1999.
  26. Michael Fix and Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97* (Washington D.C.: The Urban Institute, 1999). Online. Available: <http://urban.org/immig/trends.html>. Accessed: March 31, 1999.
  27. *Ibid.*
  28. *Ibid.*, p. 6.
  29. The term "public charge" refers to an individual who is found likely to rely on government benefits. Although it has been part of U.S. immigration law for over one hundred years, until recently no guidelines had ever clarified the grounds for a public charge determination.
  30. Schlosberg, Nemore, and Bernstein, *Continuing Medicaid Coverage for Qualified Aliens*.
  31. Claudia Schlosberg, *Not-Qualified Immigrants' Access to Public Health and Emergency Services after Welfare Law* (Los Angeles: National Health Law Program, January 12, 1998), p. 6. Online. Available: <http://healthlaw.org/pubs/19980112immigrant.html>. Accessed: March 28, 2000.
  32. CPPP, "Health and Immigration Issues and the Federal Welfare Act: Texas Update," *Policy Page*, no. 40a (February 18, 1997), p. 8.
  33. Richard E. Brown, Roberta Wyn, and Victoria Ojeda, *Access to Health Insurance and Health Care for Children in Immigrant Families* (Los Angeles: UCLA Center for Health Policy Research, 1999).
  34. Fix and Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits*.
  35. CPPP, "Agriculture Bill Restores Food Stamp Benefits to Some Legal Immigrants."
  36. Brown, Wyn, and Ojeda; *Access to Health Insurance and Health Care for Children in Immigrant Families*.
  37. Schlosberg, *Not-Qualified Immigrants' Access to Public Health and Emergency Services after Welfare Law*.
  38. CPPP, "INS Issues Crucial Guidance on 'Public Charge' Policy," *Policy Page*, no. 91 (July 1, 1999).
  39. *Ibid.*
  40. U.S. Border Health Commission, "Health on the U.S.-Mexico Border: Past, Present and Future. A Report to the United States-Mexico Border Health Commission." (Draft.) Online. Available: [http://www.borderhealth.gov/About/Border\\_Health\\_Report/border\\_health\\_report.html](http://www.borderhealth.gov/About/Border_Health_Report/border_health_report.html). Accessed: March 28, 2000.
  41. Schlosberg and Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care*, p. 2.
  42. *Ibid.*
  43. U.S. Border Health Commission, "Health on the U.S.-Mexico Border: Past, Present and Future. A Report to the United States-Mexico Border Health Commission."
  44. Michelle Cochran and Cindy Mann, *Assuring that Child Health Applications Do Not Deter Enrollment Among Eligible Children in Noncitizen Families* (Wash-

- ington D.C.: Center on Budget and Policy Priorities, December 1999). Online. Available: <http://www.cbpp.org/12-15-99health.htm>. Accessed April 7, 2000. See Table 1.
45. *Ibid.*, p. 1.
46. Health care providers, schools, and community organizations have played important roles as well.
47. Cochran and Mann, *Assuring that Child Health Applications Do Not Deter Enrollment Among Eligible Children in Noncitizen Families*.
48. "Study: Texas Ranks Worst in Keeping Kids on Medicaid," The Center on Public Policy Priorities, October 20, 1999 (press release).
49. Families USA, *One Step Forward, One Step Back: Children's Health Coverage after CHIP and Welfare Reform* (Washington, D.C.: Families USA, October 1999). Online. Available: <http://www.familiesusa.org/pubs/1step.htm>. Accessed: March 28, 2000.
50. Donna Cohen Ross, *Community-Based Organizations: Paving the Way to Children's Health Insurance Coverage* (Washington D.C.: The Center on Budget and Policy Priorities, March 1999).
51. Donna Cohen Ross, *Sources of Federal Funding for Children's Health Insurance Outreach* (Washington D.C.: The Center for Budget and Policy Priorities, 2000).
52. Letter from Timothy M. Westmoreland, Director, Health Care Financing Administration, to State Medicaid Directors, June 6, 2000. Online. Available: <http://www.hcfa.gov/medicaid/wrdl1600.htm>. Accessed: March 28, 2000.
- Health Applications Do Not Deter Enrollment Among Eligible Children in Noncitizen Families. Washington D.C.: Center on Budget and Policy Priorities, December 1999. Online. Available: <http://www.cbpp.org/12-15-99health.htm>. Accessed: April 7, 2000.
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