

**Challenges Associated with Applying for Health Insurance Among  
Latina Mothers in California, Florida and New York  
December 2002**

Tamar Bauer, JD  
Sara Collins, PhD  
James Doyle, MS  
Jennifer Fuld, MA, ABD  
Elena Fuentes-Afflick, MD, MPH\*

\*Department of Pediatrics, University of California, San Francisco

The New York Forum for Child Health  
The New York Academy of Medicine

## Acknowledgements

This research was supported by grants from the Health Resources and Services Administration (HRSA: Grant #R40MC00126), New York Community Trust, William T. Grant Foundation, March of Dimes Birth Defects Foundation/Greater New York Chapter and Maimonides Research Foundation to the State University of New York Health Science Center at Brooklyn; David and Lucile Packard Foundation to the University of California at San Francisco; and the Health Foundation of South Florida to the University of Miami. We would like to specifically acknowledge support from the David and Lucile Packard Foundation for preparation of this policy report and the accompanying brief, and from the Foundation for Child Development for the New York Forum for Child Health.

We greatly appreciate the thoughtful comments provided on the draft report by Linda Schuurmann Baker, M.P.H. of David and Lucile Packard Foundation, Alice Berger of Planned Parenthood of New York City, Gerry Fairbrother, Ph.D. and Alan R. Fleischman, M.D. of The New York Academy of Medicine, Adam Gurvitch of The New York Immigration Coalition, Dana Hughes, Dr.P.H. of Institute for Health Policy Studies, University of California at San Francisco, and Ruth E.K. Stein, M.D. of Albert Einstein College of Medicine, Montefiore Medical Center. In addition, we thank members of the Forum's Committee on Immigrant Health for their comments on initial drafts of the tables, including MaryAnn Chiasson, Ph.D. of Medical and Health Research Association of New York City, Francesca Ganys, M.D. of Task Force on Immigrant Health, Linda Hacker of Mayor's Office on Health Insurance Access, and Lucy Quacinella, J.D., Consultant to Maternal and Child Health Access, Los Angeles. We would also like to thank members of the UCSF Policy Advisory Board. Finally, this report would not have been possible without the experience and leadership of Howard Minkoff, M.D. at Maimonides Medical Center and the Principal Investigator for this study.

A condensed version of the findings from this report is available from the addresses below. For downloadable PDF copies of this and other Forum reports and briefs, see:

<http://www.nyam.org/divisions/healthscience/childhealth/publications.shtml>

or call 212-822-7392

For further information, contact:

Tamar Bauer, JD  
New York Forum for Child Health  
New York Academy of Medicine  
1216 Fifth Avenue  
New York, NY 10029-5293  
tbauer@nyam.org

Elena Fuentes-Afflick, MD, MPH  
Department of Pediatrics  
University of California, San Francisco  
San Francisco General Hospital  
1001 Potrero Avenue, Room 6D37  
San Francisco, CA 94110  
efuentes@sfgHPeds.ucsf.edu

The New York Forum for Child Health is a multi-disciplinary stakeholder body that was established in 1997 to enhance the health of all children in New York State by improving access to health insurance and quality health care services. The Forum seeks to provide a strong and objective voice on child health by serving as a resource for information and analysis, convening key players in the child health community, and advocating for policy reforms. The Forum is run by The New York Academy of Medicine with support from the Foundation for Child Development and other private sources.

Ruth E. K. Stein, MD	Chair
Alan R. Fleischman, MD	Principal Investigator
Tamar A. Bauer, JD	Director
Gerry Fairbrother, PhD	Research Director
Jennifer Fuld, MA, ABD	Research Associate

## Table of Contents

I.	Introduction.....	1
II.	The Policy Context.....	2
III.	About the Survey.....	4
IV.	Characteristics of the Sample.....	5
V.	Medicaid Application Process for Pregnant Women at the Time of the Survey .....	6
VI.	Key Findings.....	8
VII.	Discussion.....	14
	Anti-Immigrant Policies Restrict Access Despite Continuing Eligibility .....	14
	Simplifying the Application Process .....	16
	Mixed Status Families .....	18
	Parent Coverage is Important for Children.....	18
VIII.	Recommendations .....	19
IX.	Appendices.....	21

# **Challenges Associated with Applying For Health Insurance Among Latina Mothers in California, Florida and New York**

## **I. Introduction**

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 fundamentally altered federal law regarding immigrants' eligibility for Medicaid and other public benefits. Before PRWORA, legal immigrants were eligible for Medicaid and other public benefits on the same basis as citizens. Among other provisions, the law imposed new and complex eligibility rules for Medicaid, made ineligible several categories of previously eligible legal immigrants, expanded states' authority to determine legal immigrants' eligibility for Medicaid, and imposed new financial obligations on immigrants' sponsors. For example, formerly eligible legal immigrants who entered the country after August 22, 1996 were barred from receiving Medicaid for at least five years, except for certain categories of individuals, such as refugees and asylees, who are eligible for a limited time. The federal law further restricted immigrant eligibility by delegating to the states the option of providing Medicaid to these immigrants after the 5-year bar. In addition, states were given the option of providing Medicaid to those in this country before enactment.<sup>1</sup> There is concern that both PRWORA and the surrounding political climate have had a negative impact on the willingness of immigrants to apply for Medicaid.

While the evidence that PRWORA has contributed to declines in Medicaid coverage and access to health care among immigrant pregnant women and children is mixed,<sup>2,3,4,5</sup> it is clear that immigrant parents and children in immigrant families are disproportionately uninsured and have reduced access to health care. Recent evidence indicates that 55% of low-income immigrant parents are uninsured, compared to 28% of low-income native-citizen parents. Similarly, low-income immigrant children are more than twice as likely to be uninsured (46%) as citizen children with native-born parents (20%).<sup>6</sup>

There has been little research to date, however, on immigrant women's perceptions about their eligibility for public health insurance programs and the barriers they have encountered in the process of securing health insurance in the years following PRWORA. This policy brief presents findings from a survey of Latina mothers in three states regarding their fears about public health insurance and the problems they experienced in applying for insurance.

Today, one in ten US residents is an immigrant, and one in five children in the US lives in an immigrant family. Latinos are particularly important to study since they currently comprise 12% of the U.S. population but 25% of the uninsured.<sup>7</sup> Latino immigrants are also more likely than any other racial/ethnic group to be uninsured, with 33% lacking insurance.<sup>8</sup>

The challenges reported by women in this survey indicate that the process of applying for Medicaid, the State Children's Health Insurance Program (SCHIP) and other health insurance may be particularly burdensome for immigrant Latina women and may have a negative effect on their willingness and ability to apply. We found that:

- In California, where a series of anti-immigrant policies adopted during the 1990's have contributed to a climate of fear, post-partum Latina immigrants report 6 times as many problems and fears in applying for health insurance as post-partum Latina women in New York (55% vs. 9%);
- Although problems in obtaining health insurance are disproportionately experienced by immigrants, even citizens report difficulties (29.2% in San Francisco, 21.4% in Miami, 2.6% in New York); and
- Problems in obtaining health insurance range from confusion and excessive paperwork to fear of being reported to the INS and concern about providing a Social Security number.

## **II. The Policy Context: Policies Governing Access to Insurance for Pregnant Immigrants in the Three Sites**

**Federal Context.** Among other provisions, PRWORA created new distinctions between legal immigrants who were lawfully present in the US before 8-22-96 (pre-enactment immigrants), and those who arrived on or after that date, significantly restricting Medicaid eligibility for post-enactment immigrants. The law also classified all immigrants as “qualified” or “unqualified.”<sup>9</sup>

Federal Medicaid eligibility was withdrawn from most post-enactment legal immigrants for 5 years, and states were given the option to provide or deny Medicaid (for which federal financial participation is available) to pre-enactment legal immigrants and post-enactment legal immigrants after the 5-year bar. States also had to decide whether to provide state-funded benefits as a substitute for those groups losing federal eligibility for benefits. Access to emergency Medicaid, including labor and delivery services, was not changed by PRWORA and continues to be available without regard to immigration status.<sup>8</sup>

**State Decisions.** After welfare reform, California opted to provide Medi-Cal to all immigrants, including pregnant women, regardless of their date of entry to the US. California is using state funds to cover Medi-Cal for those immigrants who became federally ineligible (post-enactment legal immigrants during their first 5 years and immigrants permanently residing under color of law (PRUCOL)).<sup>8</sup> Most significantly, since 1988, undocumented pregnant immigrants were and continue to be eligible for state-funded prenatal care, despite repeated efforts to eliminate this program.

Florida opted to provide Medicaid to all immigrants, including pregnant women, only where federal matching funds are available. Thus, Florida provides Medicaid to pre-enactment legal immigrants and post-enactment legal immigrants after the 5-year bar. Florida has not created a state-funded program to cover prenatal care services for women who are federally ineligible. Undocumented pregnant immigrants were and continue to be ineligible for Medicaid in Florida.

Pregnant women who are post-enactment legal immigrants (except certain categories including refugees and asylees) during the 5-year bar and PRUCOL immigrants lost Medicaid coverage after PRWORA.

In its 1997 state law implementing PRWORA, New York opted to provide Medicaid to all immigrants, including pregnant women, only where federal matching funds were available, in addition to two groups of PRUCOL immigrants (persons diagnosed with AIDS or residing in certain residential care facilities on 8-22-96.) As a result, most post-enactment legal immigrants lost coverage during the 5-year bar, in addition to most PRUCOLs. In contrast to other immigrants, Medicaid eligibility for all pregnant immigrants in New York remained intact. Due to the long-standing federal court decision in *Lewis v. Grinker*, after PRWORA, all pregnant immigrants in New York, including documented and undocumented women, remained eligible for Medicaid with federal financial participation. When the U.S. Second Circuit Court of Appeals reversed the lower court's decision and withdrew federal Medicaid eligibility for undocumented women in May 2001,<sup>10</sup> New York chose to maintain coverage for this group with state funds.<sup>11</sup>

Two weeks later, in the June 2001 *Aliessa v. Novello* decision, New York's highest court held that the exclusion of legal immigrants (referring to the post-enactment immigrants during the 5-year bar) from full Medicaid coverage violated the New York and U.S. Constitutions.<sup>12</sup> As a result, Medicaid eligibility in New York was restored for post-enactment immigrants and PRUCOLS, using only state funds for non-emergency care because of PRWORA's restrictions on federal funds. Taken together, *Lewis* and *Aliessa* provide full Medicaid coverage for all immigrants except undocumented adults, who are only eligible for emergency and prenatal services.

Nationwide, only Wyoming is denying pre-enactment immigrants access to Medicaid. Fifteen states, including California and New York, are providing state-funded Medicaid during the 5-year bar. Six states reported that they will not provide Medicaid to post-enactment immigrants after the 5-year bar.<sup>13</sup>

**Table 1. Medicaid Eligibility Criteria for Prenatal Care for Immigrants *Before* PRWORA, by State**

	<b>California</b>	<b>Florida</b>	<b>New York</b>
All legal immigrants	Yes, with ffp <sup>1</sup>	Yes, with ffp	Yes, with ffp
Undocumented	Yes, with state funds	No	Yes, with ffp
PRUCOL <sup>2</sup>	Yes, with ffp	Yes, with ffp	Yes, with ffp

**Table 2. Medicaid Eligibility Criteria for Prenatal Care for Immigrants *After* PRWORA, by State**

	<b>California</b>	<b>Florida</b>	<b>New York</b>
In US before 8-22-96	Yes, with ffp <sup>1</sup>	Yes, with ffp	Yes, with ffp
In US after 8-22-96 <sup>3</sup>	Yes, with state funds during 5-yr bar	No, during 5-yr bar	Yes, with state funds during 5-yr bar
Undocumented	Yes, with state funds	No	Yes, with state funds
PRUCOL <sup>2</sup>	Yes, with state funds	No	Yes, with state funds

1. Medicaid with federal financial participation (“ffp”) is available to states that opt to provide Medicaid coverage to qualified immigrants who entered the US *before* 8-22-96.
2. Most PRUCOL immigrants who were eligible for Medicaid before PRWORA were made ineligible by PRWORA. (See endnote 8.)
3. Medicaid with ffp is *not* available to states that opt to provide Medicaid coverage to qualified immigrants who entered the US *after* 8-22-96 during their first 5 years in the US.

### **III. About the Survey**

Our findings are based on a survey of a non-random sample of 2,370 post-partum Latina women in Miami ( $n=781$ ), New York City ( $n=964$ ), and the San Francisco/Bay Area ( $n=625$ ). Investigators recruited women to participate in the study between March 1999 and February 2001 from a sample of 6,211 Latina women who had delivered babies at six study hospitals. The women selected were at least 17 years of age and identified themselves as Latin American or Latin Caribbean, with at least one parent or grandparent of Latin American or Caribbean national or ethnic origin (excluding Puerto Rico and Brazil).<sup>14</sup> Participants were interviewed regarding their immigration status, demographic characteristics, and prenatal care, as well as their knowledge, attitudes and beliefs regarding changes in health insurance and immigration policies.<sup>15</sup> We determined eligibility for Medicaid by an algorithm based on factors including immigration status and state residency (See Appendix 3).

This brief reports on results to the following question: “There are several things that can make it difficult to apply for health insurance. I am going to read a list of possible reasons that may have come up the last time you applied for health insurance. Please tell me if any applied to you.” Women responded yes or no to each of the nine reasons and we created a measure 'any problems or fears' based on women reporting yes to at least one problem or fear. Because only 3% of the sample reported that they used private insurance to pay for prenatal care and 4% reported that they used employer-based insurance to pay for prenatal care, it is reasonable to infer that their responses primarily reflect experiences with Medicaid or SCHIP. Only 2% of the sample was

under eighteen; therefore, we infer that their responses primarily reflect their experiences with Medicaid rather than SCHIP.

Given the circumstances of the study, it was not possible to select a random sample and thus figures reported here cannot necessarily be generalized to the Latina immigrant population in the United States. However, nearly all women in the United States give birth at hospitals<sup>16</sup> and because we included several hospitals in the three cities, we believe the samples offer reasonable approximations of the experiences of post-partum Latina women in those cities.

A more detailed description of study methods is provided in Appendix 2.

#### **IV. Characteristics of the Sample**

**Immigration status.** The majority of the women in the study were immigrants: 30% were legal immigrants, 50% were undocumented and PRUCOL<sup>8</sup> immigrants, 17% were US citizens and 3% had unknown immigration status.

**Eligibility for Medicaid.** Over 50% of the sample was ineligible for Medicaid (except for emergency services) under the federal PRWORA. However, in New York and California, 100% of the women in the study were eligible for Medicaid or Medi-Cal during their pregnancy.<sup>17</sup>

**Enrollment in Medicaid.** Almost 80% of the sample had Medicaid/Medi-Cal at some time during their pregnancy: 87.5% of women in the San Francisco/Bay Area, 69.7% of women in Miami and 82.5% of women in New York City. Overall, 12.4% of the sample lost Medicaid/Medi-Cal at some point during their pregnancy: 8.8% of women in the San Francisco/Bay Area, 27.1% of women in Miami and 4.3% of women in New York City. It is unclear why a small percent of women lost coverage in the San Francisco/Bay Area or New York, since all women remained eligible. In Miami, however, the 27% who lost Medicaid probably were presumptively eligible for an initial period, but ultimately determined ineligible because of their immigration status.

**Country of origin.** About 50% of women in New York and the San Francisco/Bay Area were Latinas of Mexican origin. Substantial numbers of New York respondents were also from the Dominican Republic (18%) while Salvadoran immigrants were well represented in the San Francisco sample (20%). The Miami sample was comprised largely of Latina women of Nicaraguan (20%), Honduran (19%), and Cuban (16%) origins.

See Appendix 1 for additional characteristics of the sample.

## **V. Medicaid Application Process for Pregnant Women at the Time of the Survey**

During the time that this survey was conducted (1999-2001), the Medicaid application process for pregnant women differed in the three states. New York's process was the simplest, only available for pregnant women and notable because the face-to-face interview was done by the provider instead of the Medicaid official, women were allowed to self-attest to their income if other proof was not available, and women were not required to provide information about immigration status. It was essentially the same process that now exists and is explained in greater detail in the Discussion below. In contrast, the process was more complex in both Florida and California. For example, both states required more extensive proof of income and information about immigration status. In Florida, pregnant women had to apply for Medicaid on a joint application form used for all public programs, but they were not required to answer all the questions required of other applicants. In California, a mail-in application form for pregnant women and children was created in 1998, but pregnant women could also apply in person with the standard Medi-Cal application. The process for pregnant women was simpler than the standard process. All three states allowed pregnant women to apply for Medicaid through a presumptive eligibility process, and provided varying degrees of enrollment assistance.<sup>18</sup>

**Table 3. Medicaid Application Process for Pregnant Women in 1999-2000, by State**

	<b>California</b>	<b>California</b>	<b>Florida</b>	<b>New York</b>
Application Requirements	Medi-Cal application for pregnant women & children	Standard Medi-Cal application	Standard Medicaid application	PCAP application for pregnant women <sup>1</sup>
Face-to-face interview		Required	Required	Required, but done by PCAP provider instead of Medicaid official
Mail-in application	Yes	No	No	No <sup>2</sup>
Proof of income	Required	Required	Required	Self-attestation accepted where other proof is unavailable
SSN	Required <sup>3</sup>	Required <sup>3</sup>	Required	
Immigration status	*	Required	Required	
Proof of immigration status	*	Required	Required	
Members of applicant's household		Required <sup>4</sup>	Required	Required

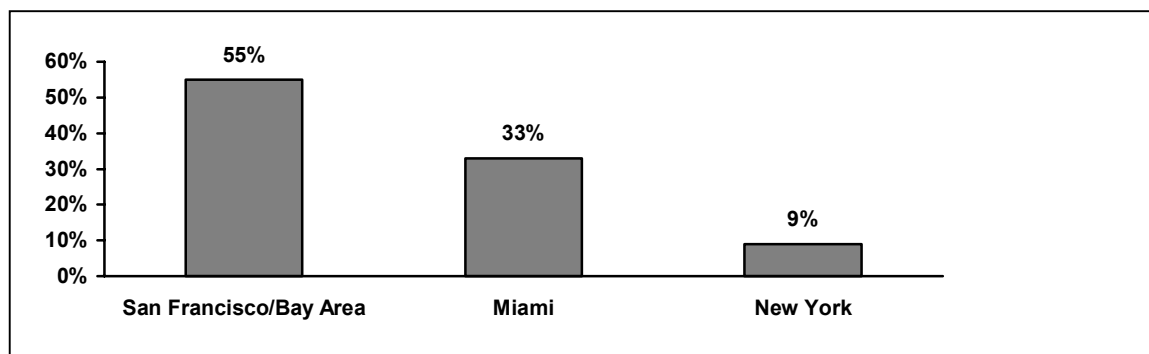
1. Although pregnant women could apply using the standard Medicaid application, most women applied through New York's Medicaid Prenatal Care Assistance Program (PCAP).
  2. Qualified provider forwarded applications to the Medicaid office for the applicant.
  3. SSN is not required if coverage is limited to pregnancy-related care. For full Medi-Cal coverage, SSN is only required for citizens or qualified immigrants over age 1.
  4. Joint MediCal/Food Stamps/TANF form included a question about whether an undocumented person lives in the applicant's household. This question was eliminated in July 1999 after a successful court challenge.
- \* Not required statewide but some counties requested information about immigration status.

## VI. Key Findings

1. *Nearly one-third of surveyed Latina women experienced at least one problem or fear the last time they applied for health insurance. There were substantial differences across cities in the level of reported difficulties.*

The likelihood of citing problems or fears while applying for health insurance varied widely by city. A majority (55%) of San Francisco/Bay Area respondents reported at least one problem or fear, compared to only 9% of New York respondents.

**Table 4. Percentage of Latina Mothers Reporting at Least One Problem/Fear, by Site**



2. *Confusion about the application process, not having the necessary paperwork, and immigration-related fears were the most common difficulties associated with applying for health insurance.*

Latina women living in the San Francisco/Bay Area were the most likely to report problems or fears about applying for health insurance, especially concerns about being asked for a Social Security number (“SSN”) and paying back the cost of their care. Given that California never withdrew coverage of prenatal care for immigrant women who are not eligible for Medicaid under federal law, these high rates of concerns were notable. In Florida, where coverage for some women was withdrawn, and New York, where coverage remained intact, far fewer women cited immigration-related fears about applying for health insurance.

**Table 5. Problems or Fears Associated with Applying for Health Insurance among Postpartum Latina Women, by Study Site**

<b>Problems and Fears, %</b>	<b>San Francisco/ Bay Area</b>	<b>Miami</b>	<b>New York</b>
Any problems or fears reported	55%	33%	9%
1. Confusion about applying*	24.3	14.2	3.7
2. Lacked necessary paperwork*	13	14.1	3.9
3. No one able to explain in Spanish how to apply*	2.9	3.7	0.1
4. Long wait for interview or submission of application*	9.1	4.9	0.6
5. People during process were not helpful*	6.7	5.1	0.3
6. Feared being reported to INS*	11.8	2.6	0.9
7. Was asked to give SSN*	33.8	4.6	0.1
8. Feared applying would make it hard later to become citizen*	16.6	2	0.1
9. Feared would have to someday pay back cost of care*	22.2	2.7	0.3

\* p<.01

**3. *While we found some differences in perceived problems among women based on their country of origin, Latinas' perceptions appeared to be influenced far more by the city in which they live.***

Half the sample of Latinas in both New York and the San Francisco/Bay Area were of Mexican-origin. Despite their shared backgrounds, however, Mexican-origin Latinas in San Francisco were far more likely to report problems or fears than Mexican-origin Latina women in New York.

**Table 6. Problems or Fears Associated with Applying for Health Insurance among Mexican-origin Latina women, by Site**

<b>Problems or Fears, %</b>	<b>San Francisco/ Bay Area</b>	<b>New York</b>
Any problems or fears reported	56.7%	13.4%
1. Confusion about applying*	26.6	6.6
2. Lacked necessary paperwork*	12.5	5.5
3. No one able to explain in Spanish how to apply*	3.1	0.2
6. Feared being reported to INS*	35.1	0.0

\* p<.01

**4. *Immigration-related fears ranked high among both undocumented and legal immigrants in the San Francisco/Bay Area compared to Miami and New York. In all three cities, undocumented immigrants reported the highest rates of problems, followed by legal immigrants and then citizens.***

More than 60% of undocumented<sup>19</sup> immigrants and more than 50% of legal immigrants in the San Francisco/Bay Area reported at least one difficulty in applying for health insurance. Rates of reported problems were somewhat lower in Miami and tended to be largely procedural (i.e., lacked necessary documents) in nature. In contrast, San Francisco/Bay Area respondents reported high rates of procedural problems and very high rates of immigration-related fears.

Even undocumented women in Miami, who were ineligible, reported fewer difficulties than immigrant women in San Francisco, all of whom were eligible. This is somewhat surprising, since it suggests that the climate of fear in California was powerful enough to make the eligible, legal immigrant women in this survey more wary of applying for insurance than ineligible, undocumented women.

Although problems in obtaining health insurance are disproportionately experienced by immigrants, even citizens report difficulties (29% in the San Francisco/Bay Area, 21% in Miami, and 3% in New York). Among citizens, procedural issues and concern about being asked for a SSN ranked highest. Frequencies of types of problems in New York by immigration status were too small to report.

**Table 7. Problems or Fears Associated with Applying for Health Insurance, by Site and Immigration Status**

<b>San Francisco/Bay Area</b>			
<b>Problems or Fears, %</b>	<b>Citizen</b>	<b>Legal Immigrant</b>	<b>Undocumented/ PRUCOL</b>
Any problems or fears reported*	29.2%	53.9%	62.3%
1. Confusion about applying*	6.3	22.4	29.9
2. Lacked necessary paperwork*	3.1	9.9	17.2
3. No one able to explain in Spanish how to apply*	0.0	1.3	4.4
4. Long wait for interview or submission of application	5.2	10.5	9.4
5. People during process were not helpful	5.2	8.6	6.4
6. Feared being reported to INS*	0.0	5.3	18.0
7. Was asked to give SSN*	16.7	30.3	39.6
8. Feared applying would make it hard later to become citizen*	1.0	16.4	21.3
9. Feared would have to someday pay back cost of care*	3.1	17.1	29.6

\*p<.01

<b>Miami</b>			
<b>Problems or Fears, %</b>	<b>Citizen</b>	<b>Legal Immigrant</b>	<b>Undocumented/ PRUCOL</b>
Any problems or fears reported*	21.4%	30.9%	38.1%
1. Confusion about applying <sup>+</sup>	8.7	12.0	18.6
2. Lacked necessary paperwork	6.8	15.2	15.4
3. No one able to explain in Spanish how to apply	0.0	4.0	4.8
4. Long wait for interview or submission of application	5.8	4.9	4.5
5. People during process were not helpful	5.8	4.0	6.4
6. Feared being reported to INS	0.0	2.9	2.9
7. Was asked to give SSN*	1.9	2.6	7.7
8. Feared applying would make it hard later to become citizen	0.0	1.7	2.9
9. Feared would have to someday pay back cost of care	1.9	1.7	3.8

\*p<.01, +p<.05

<b>New York</b>			
<b>Problems or Fears, %</b>	<b>Citizen</b>	<b>Legal Immigrant</b>	<b>Undocumented/ PRUCOL</b>
Any problems or fears reported*	2.6%	6.7%	13.8%

\*p<.01

**5. In the San Francisco/Bay Area, women who had resided in the US less than 10 years were more likely to report problems than women who had lived here longer.**

Length of residence in the US was associated with the level of problems/fears reported in the San Francisco/Bay Area; women who had resided in the US less than 10 years were more likely to report problems than women who had lived here longer. In Miami, differences were not significant and the numbers in New York were too small to report.

**Table 8. Problems or Fears associated with Applying for Health Insurance, by Site and Length of Residence in the United States**

<b>San Francisco/Bay Area</b>			
<b>Problems and Fears, %</b>	<b>Less than 5 Years</b>	<b>5-10 Years</b>	<b>More Than 10 Years</b>
Any problems or fears reported*	62.4%	59.5%	6.7%
1. Confusion about applying*	38.6	21.1	7.3
6. Feared being reported to INS*	20.6	9.5	0.0
7. Was asked to give SSN+	39.2	36.6	23.9
9. Feared would have to someday pay back cost of care*	31.2	20.3	9.2

\*p < .01, +p < .05

<b>Miami</b>			
<b>Problems or Fears, %</b>	<b>Less than 5 Years</b>	<b>5-10 Years</b>	<b>More Than 10 Years</b>
Any problems or fears reported	37.5%	28.6%	29.0%

<b>New York</b>			
<b>Problems or Fears, %</b>	<b>Less than 5 Years</b>	<b>5-10 Years</b>	<b>More Than 10 Years</b>
Any problems or fears reported*	15.4%	6.8%	4.3%

\*p < .01

**6. While more than 60% of San Francisco/Bay Area Latina women who were federally ineligible for Medicaid cited at least one problem or fear related to applying for health insurance, 42% of federally eligible women also cited difficulties. Rates of reported problems among federally eligible women in Miami were also high.**

This finding raises concerns that even women who are eligible for Medicaid under federal law are encountering barriers to enrollment. Frequencies of types of problems in New York by Medicaid eligibility were too small to report.

**Table 9. Problems or Fears associated with Applying for Health Insurance, by Site and Federal Medicaid Eligibility**

<b>San Francisco/Bay Area</b>		
<b>Problems and Fears, %</b>	<b>Federally Ineligible</b>	<b>Federally Eligible</b>
Any problems or fears reported	62.2%	42.4%
1. Confusion about applying*	30.6	15.1
2. Lacked necessary paperwork	16.6	7.5
3. No one able to explain in Spanish how to apply*	4.5	3.2
4. Long wait for interview or submission of application	9.1	9.1
5. People during process were not helpful	6.4	7.1
6. Feared being reported to INS*	17.7	3.2
7. Was asked to give SSN*	38.9	26.2
8. Feared applying would make it hard later to become citizen*	21.2	9.9
9. Feared would have to someday pay back cost of care*	29.8	11.1

\*p < .01

<b>Miami</b>		
<b>Problems and Fears, %</b>	<b>Federally Ineligible</b>	<b>Federally Eligible</b>
Any problems or fears reported	37.5%	28.9%
1. Confusion about applying*	16.0	12.7
2. Lacked necessary paperwork	4.5	3.1
3. No one able to explain in Spanish how to apply	4.6	.4
4. Long wait for interview or submission of application	4.2	5.3
5. People during process were not helpful	6.0	4.4
6. Feared being reported to INS*	2.7	2.4
7. Was asked to give SSN*	7.3	2.7
8. Feared applying would make it hard later to become citizen*	2.7	1.6
9. Feared would have to someday pay back cost of care*	3.6	2.0

\*p < .01

<b>New York</b>		
<b>Problems and Fears, %</b>	<b>Federally Ineligible</b>	<b>Federally Eligible</b>
Any problems or fears reported	13.6%	4.6%

\*p < .01

## **VII. Discussion**

This study examined barriers to enrollment in public health insurance from the perspective of Latina women during the immediate postpartum period. The results demonstrate that more than 1 in 2 (San Francisco/Bay Area), 1 in 3 (Miami) and nearly 1 in 10 (New York City) Latina women reported difficulties applying for health insurance. Difficulties were disproportionately experienced by immigrants, especially the undocumented, but as many as 1 in 3 citizens reported at least one difficulty as well.

The results highlight the importance of simplifying the application process. They also suggest that intensive efforts are needed to educate and build trust among Latina immigrants in California, including clarification of immigration-related concerns from credible sources. These findings have broad implications for designing strategies to expand enrollment in Medicaid and other programs, including SCHIP. They also underscore the importance of restoring Medicaid eligibility to immigrants, which is a necessary but not sufficient condition for creating access to coverage and care.

In each state, and at the national level, there are many opportunities to improve access to coverage and care for both immigrants and citizens. Most recently, in the wake of the attacks of 9/11, New York created a Disaster Relief Medicaid program, which allowed applicants to quickly and simply receive temporary Medicaid coverage, showing only proof of identity. Over 340,000 people signed up in less than four months. "Desperate New Yorkers grabbed the lifeline"<sup>20</sup> the program offered, demonstrating that "there is a huge pent-up demand for health coverage, once you make it simple."<sup>21</sup> Although PRWORA technically de-linked eligibility for Medicaid from eligibility for cash assistance, the process of applying for Medicaid is still characterized by the unfriendly vestiges of the cash assistance world. This study offers evidence that further steps are needed to make it easy for eligible immigrants and citizens to apply for health insurance.

### **Anti-Immigrant Policies Restrict Access Despite Continuing Eligibility**

One of the most important findings from this study is that, among the surveyed new mothers, there were substantial differences across cities in whether Latinas reported problems applying for health insurance. While eligibility for prenatal care was never withdrawn for any immigrants in California, women in California reported barriers to enrollment at rates nearly two times higher than women surveyed in Florida and six times higher than those surveyed in New York.

These high rates of perceived barriers likely stemmed from an antagonistic policy environment towards immigrants in California that existed during the 1990's. This was initiated by Proposition 187 in 1994, and was underscored by aggressive "public charge lookout and antifraud" programs adopted by California shortly thereafter.<sup>22,23</sup>

Proposition 187, a ballot initiative narrowly passed by California voters in 1994, restricted undocumented immigrants' access to most health and social services. Most provisions of the Proposition were never implemented because they were enjoined by the courts immediately after

passage. While the state's appeal to the 9<sup>th</sup> Circuit Court of Appeals was pending, Governor Davis settled with the plaintiffs, leaving in force the District Court decision striking Proposition 187. Also in 1994, California health officials joined with the Immigration and Naturalization Service in anti-fraud "public charge lookout"<sup>24</sup> programs to screen non-residents for use of public benefits including Medicaid. Some immigrants were denied reentry, others were required to repay the costs of benefits they legally received under threat of deportation, and others were forced to disenroll from programs to which they were legally entitled. These programs were disbanded in April 1999 after a lawsuit was settled, and after a Bureau of State Audits report uncovered massive abuses by the state agency. In addition to these initiatives, between 1995-1998, the Wilson Administration repeatedly and unsuccessfully attempted to end state funding for prenatal care for the undocumented.

Although Proposition 187 and California's public charge lookout programs were enjoined and discontinued, and state funding for prenatal care for the undocumented remained intact, these policies likely created a *climate of fear* that exerted a powerful influence on Latinas' perceptions of their access to coverage in this study. California's anti-immigrant policies seem to have a fairly long "tail," lingering to restrict access for some time after the actual policies causing concern were eliminated.

In contrast, low rates of difficulties applying for health insurance were reported by post-partum Latina women in three hospitals in New York City, where eligibility was maintained and the political environment was generally supportive of immigrants, in particular pregnant women. In fact, although legal action to withdraw Medicaid eligibility for undocumented pregnant immigrants was pending during the time of this study, New York City and New York State both opposed the federal government's motion to repeal coverage.<sup>25</sup> Following a decision by the U.S. Second Circuit Court of Appeals that withdrew Medicaid eligibility for undocumented pregnant women,<sup>26</sup> New York chose to maintain coverage with state funds.<sup>27</sup> For populations other than pregnant women and children, however, New York State has been less supportive of immigrants, with bottom-line considerations evidently factoring into State decisions.<sup>28</sup>

New York City's strong immigrant sympathies are reflected in Executive Order 124, which since 1984 has prohibited City employees from reporting any alien to INS unless required by law, or if the alien is suspected of criminal activity. The purpose of the Executive Order is to ensure that immigrants, both legal and illegal, are not discouraged from utilizing city services, including health care.<sup>29</sup>

In addition to this political context, the low rates of difficulties reported in this study by post-partum Latina women in New York also likely reflect the unique effectiveness of the state's Prenatal Care Assistance Program (PCAP), which has combined a simplified application process with a community-based model of care. The simplified features of the PCAP application process are described in the next section. Immigrants applying for other public insurance programs report additional barriers to coverage, including concerns about sponsor liability.

The "sponsor deeming" and "sponsor liability" requirements in PRWORA provide that the income of a legal immigrant's sponsor will be included in determining their eligibility for public benefits, and that a sponsor may be required in the future to pay the government back for the

costs of "means-tested public benefits" (including Medicaid and SCHIP) received by that immigrant.<sup>30</sup> The sponsors are liable even though the immigrants use coverage for which they are eligible. Although women's concerns about these provisions were not directly measured in this survey, they may be reflected in the 22.2% of women in California who indicated fear that they "would have to someday pay back the costs of care." Community groups in all three states report that some legal immigrants are not applying for coverage and not using health services because of concerns about imposing financial burdens on their sponsors in the future. These provisions are both restricting eligibility and deterring immigrants from applying for coverage for which they are eligible. Additional research is needed to examine the impact of these provisions on immigrants' access to coverage and care.

Given that Florida opted to end Medicaid for federally-ineligible immigrants following PRWORA, the lower level of problems or fears reported in Florida compared with California was somewhat surprising. One explanation for this difference may be that Florida's withdrawal of eligibility was primarily driven by budget concerns and was not accompanied by anti-immigrant state government policies. Nonetheless, until halted and declared illegal by a court in 1998, INS offices in Florida had a policy of telling families that if they repaid the costs of Medicaid or other benefits, their applications to adjust their status to legal permanent resident would be granted. These created both a rush to repay and a chill on use of additional benefits. Notably, state and local agencies did not collaborate with INS in these efforts. The higher level of reported problems in Florida compared with New York was expected given the difference in eligibility for immigrants.

### **Simplifying the Application Process**

A problem with assembling the necessary paperwork was reported by 1 in 8 respondents and confusion about the application process by as many as 1 in 4 women in San Francisco and Miami. This is consistent with previous research that has found the complexity of the application process to be a barrier to enrollment.<sup>31, 32, 33</sup> States currently have the authority to streamline the application process. Documentation for Medicaid and SCHIP is left to state discretion, except noncitizens must provide proof of immigration status.<sup>34</sup> On all other matters, self-verification is allowed.<sup>35, 36</sup>

Concerns about being asked for a SSN were extremely high in California (33.8%), and lower in Florida (4.6%). Interestingly, these concerns were reported by both immigrants and citizens, which may reflect both immigration-related and privacy concerns about disclosing this kind of information to a government agency. Federal law only requires applicants for Medicaid to provide this information, but not SCHIP applicants.<sup>37</sup> But federal law does *not* require applicants for emergency Medicaid, including labor and delivery services, to provide a SSN. The high rates of concerns in California are puzzling in part because so few pregnant women in California are required to provide a SSN to apply for Medi-Cal. California does *not* require a SSN for women whose Medicaid coverage is limited to pregnancy-related care ("limited scope" Medi-Cal); only "qualified aliens" (legal immigrants including those with a green card, refugees, asylees and others) and citizens must provide a SSN for Medi-Cal, and only if they are applying for non-emergency coverage, or coverage beyond pregnancy-related care. Yet the highest rates of fears were reported by undocumented women (39.6%), who are not required to provide a SSN. Although this survey does not indicate the cause of these high rates, they appear to reflect either

a continuation of the climate of fear created during the Wilson administration and its policies targeting immigrants on Medi-Cal, or a misunderstanding of program requirements for pregnant women, which could be caused by many factors, such as confusing language on the form, eligibility workers misinforming applicants or poor Spanish translation of the form.

Since the time of this survey, all three states have taken steps to streamline the application process for pregnant women and children. In July 2001, after this survey, Florida adopted a short form for pregnant women applying for Medicaid, and eliminated the requirements that women provide proof of income and have a face-to-face interview as part of the application process. State officials reported a sharp increase in enrollment following this simplification, although not among immigrants. This change had an unexpected impact on immigrants. The simplified application process made it possible for Medicaid eligibility determinations to be made in a matter of days, rather than the weeks or months that were previously common. Consequently, immigrant women who apply for Medicaid through the presumptive eligibility process, and who are ultimately determined ineligible, only receive a few days of coverage while their Medicaid applications are pending.<sup>38</sup>

New York's Medicaid Prenatal Care Assistance Program (PCAP) has offered a streamlined and supportive approach since 1990. Several features of the PCAP model are notable. First, women can apply for Medicaid at their prenatal care provider in lieu of the local Medicaid office. Second, the PCAP provider represents the woman throughout the enrollment process; the provider helps her compile the necessary documents, submits the application to Medicaid, and addresses any concerns about her application that are raised by the local Medicaid office. Third, the PCAP/Medicaid application is short and simple, applicants may *self-attest to their income* where other proof is not available, and do not have to provide a SSN.<sup>39</sup> Fourth, PCAP has an effective model of presumptive eligibility, which allows pregnant women who appear eligible to the provider to begin using health care services upon completion of the application; women complete the Medicaid application in the provider's business office, then go next door for the health care visit. Even if the woman is ultimately found ineligible, the PCAP provider is reimbursed for the services from the time of application until the final determination. PCAP's trouble-shooting function, self-attestation of income where other proof is not available, and blending of service with eligibility are all considered core elements of the program's success. Finally, the decision to call the program PCAP instead of Medicaid for pregnant women has also contributed to easing immigrants' fears about joining a government program. Because of these features, and because PCAP is widely available throughout New York City, immigrants applying for Medicaid through PCAP are likely to report fewer barriers than non-pregnant immigrants applying for insurance in New York. In addition to PCAP, New York's recent experience with a community-based "Facilitated Enrollment" initiative for children, which incorporates some but not all elements of the PCAP model, has shown great promise in helping applicants overcome burdensome application requirements. In one study, nearly half of the families using facilitated enrollment services reported that they had never before applied for a government assistance program (defined as welfare, WIC or food stamps), although some had applied previously for Medicaid or SCHIP.<sup>40</sup>

California has taken many steps to simplify their enrollment process. For example, in 1998, California created a mail-in application for pregnant women and children and began to pay for

“Certified Application Assistants” to help applicants complete the mail-in form. In 1999, the mail-in application was shortened from 28 pages to 8 pages, which is still long compared to other states and includes numerous documentation requirements that are not mandated by federal law.<sup>41, 42</sup> In the summer of 2001, California eliminated the requirement that Medi-Cal applicants have a face-to-face interview. Notwithstanding these and other strategies, enrollment levels remained low until the state adopted continuous eligibility for children, dropped quarterly status reports, funded an intensive community-level outreach campaign and implemented a modest parental Medi-Cal expansion from 77% of poverty to 100%.<sup>43</sup> More recently, California has piloted an internet-based application process in one county, called Health-e-App, which is making the front-end application process less confusing and faster by providing applicants with preliminary determinations of eligibility, automating computations of income and notifying applicants of errors in the application that can be immediately corrected on-line rather than by mail several weeks later. This does not, however, alter the programs’ documentation requirements in any way.<sup>44</sup>

### **Mixed Status Families**

One in 5 US children is either an immigrant or the child of an immigrant.<sup>45</sup> Almost 10% of families with children have a noncitizen parent and a citizen child, a "mixed status" family; 85% of immigrant families include one citizen.<sup>46</sup> Over a quarter of California families with children, and 14% of New York families with children, are mixed status. These so-called "mixed status" families may include a combination of legal immigrants, undocumented immigrants and naturalized citizens. Their status changes frequently, as legal immigrants become citizens and undocumented family members legalize their status. Mixed status families are disproportionately low-income, and account for a substantial share of children without health insurance; 21% of all uninsured children nationwide and over one-half of California's uninsured children live in mixed status families.<sup>47</sup>

In this multi-state study, undocumented immigrants were over 2.5 times and legal immigrants were 1.9 times more likely than citizens to have problems applying for insurance. The high prevalence of mixed status families makes it likely that these immigrant women live with children or adults who are citizens. Yet the concerns and eligibility of some members of a family may define - and restrict - access for all family members. The failure of our health delivery system to provide access to entire families makes it more difficult for eligible individuals to enroll. This has particularly strong implications for current efforts to enroll children living in immigrant families, which may be hampered by the complex immigrant eligibility maze created in PRWORA. Further study is needed to clarify these issues.

### **Parent Coverage is Important for Children**

Studies have shown that insured parents are more likely to have insured children than uninsured parents, and that parents who use health care are more likely to bring their children in for care than parents who don't use care.<sup>48, 49</sup> The policy message is that policies that target children must include their parents. Restoring eligibility only for immigrant children, but not for their parents, may be insufficient to increase enrollment of children. New York has extended public coverage

to parents of eligible children. California’s plan to implement such a program in the near future is currently stalled due to a large budget deficit.<sup>50</sup>

## **VIII. Recommendations**

In this study, three factors contributed to the differences in challenges reported by Latina women across the three sites: the state policy environment, Medicaid eligibility criteria for pregnant women, and the complexity of the application process. Women in New York City reported minimal challenges due to a favorable policy climate for pregnant immigrants, uninterrupted Medicaid eligibility and the simple and supportive PCAP application process. In Miami, women reported more challenges than women in New York, and these differences are likely related to a neutral policy environment, withdrawn eligibility for some immigrants and a complex application process. Latina women in San Francisco reported the greatest number of barriers, by far, due to a policy climate of fear, uninterrupted but threatened Medi-Cal eligibility, and a complex application process. Based on the survey results, the following steps are recommended to reduce barriers to enrollment in public coverage specifically for pregnant Latina women, both immigrants and citizens, and more broadly for immigrant women, their children and families.

### **1. Simplify the Medicaid and SCHIP Application Process**

Each state should take additional steps to simplify the application process for Medicaid and SCHIP. Two important strategies that would encourage immigrants and citizens to apply are reducing the number of documents that applicants have to submit, and eliminating any references to SSN on SCHIP applications or reapplications.<sup>51</sup> Even where a SSN is not required, having a space for it on the application may deter immigrants and citizens from applying. To increase enrollment among both immigrant and citizen families, the federal requirement that a Medicaid applicant provide a SSN should be reconsidered. Until this simplification is adopted at the federal level, it is preferable to have a joint Medicaid/SCHIP application which requires a SSN for some applicants rather than two separate applications, which is likely to deter the largest number of applicants by increasing the complexity of the application process.

To reduce enrollment barriers for pregnant women, California should adopt a simplified “point-of-service” enrollment model that more closely mirrors the simple and supportive PCAP program used so effectively in New York.<sup>52</sup> New York and Florida should make the enrollment process for all immigrants, not just pregnant women, look more like the PCAP model.

Community-based assistance for applicants in completing the application process, internet-based applications, and “express lane eligibility”—where eligibility information is shared between Medicaid/SCHIP, Food Stamps and National School Lunch Programs—may also be important strategies for addressing the barriers reported by Latinas in this study and increasing enrollment among immigrants more broadly. Careful thought, however, is needed to ensure that appropriate privacy safeguards are in place if express lane strategies are adopted, and that applicants are given the choice whether to elect this option.

### **2. Educate and Build Trust Among Immigrants**

Community-level educational campaigns are needed, especially in California, to encourage Latino and other immigrants to apply for public coverage. Immigrant communities should help

design and deliver educational messages which clarify public charge and other immigration-related issues, eligibility criteria and the application process. In addition, federal, state and local governments should widely disseminate consistent and clear messages about the immigration-related consequences of using Medicaid/SCHIP, addressing issues such as public charge, sponsor liability and local agency policies about reporting applicants for public benefits to the INS.

### **3. Anti-Immigrant Policies May Undermine Public Health Objectives**

Policy makers across the US should be cautious before adopting anti-immigrant policies like those adopted in California, given their lasting and negative impact on access for both eligible and ineligible residents. Future policies should be carefully planned to make sure they are consistent with their long-term objectives rather than responsive to a passing political wind. This lesson may have particular relevance today, as new policies and laws are being adopted towards immigrants in response to the events of 9/11.

### **4. Restore Medicaid and SCHIP Eligibility**

Medicaid and SCHIP eligibility should be restored, at a minimum, to all pregnant immigrants who lost coverage as a result of PRWORA. If efforts to restore eligibility at the federal level are not successful, Florida should follow New York and California in using state funds to restore coverage to federally ineligible pregnant women.

To enroll more eligible children in immigrant families, Congress should restore coverage more broadly to all immigrants who lost coverage as a result of PRWORA. Restoring coverage only for immigrant children, but not for their parents, may be insufficient to increase enrollment of eligible children.

### **5. Extend Coverage to Parents in Florida**

To increase access to care for parents and enrollment among eligible but uninsured children, Florida should extend Medicaid or SCHIP coverage to low-income working parents.<sup>53</sup>

## IX. Appendices

### Appendix 1: Characteristics of the Sample

	<b>Total Sample</b>	<b>San Francisco</b>	<b>Miami</b>	<b>New York</b>
<b>Sample Size</b>	2370	625	781	964
<b>Age</b>				
Under 18	2%	1.6%	3.1%	1.5%
18 to 24	38.8%	39.6%	31.4%	44%
25 to 34	47.9%	49.8%	49.2%	45.7%
35 and older	11.3%	9%	16.3%	8.8%
<b>Education</b>				
Less than high school degree	40.3%	50%	33.3%	39.7%
High school degree or equivalent	36.6%	30.1%	35%	41.9%
Some college or higher	23.1%	19.9%	31.7%	18.4%
<b>Monthly Family Income</b>				
Less than \$1000	47%	51.1%	40.8%	49.5%
\$1001-\$2000	41.3%	38.3%	45.7%	39.5%
\$2001 and higher	11.7%	10.6%	13.5%	11%
<b>Marital Status</b>				
Married	41.8%	46.6%	47.4%	34.1%
Separated or Divorced	6.6%	4.4%	9.7%	5.4%
Widowed	0.2%	0	0.4%	0.2%
Living with a partner	32.7%	32.9%	11.9%	49.5%
Never married	18.7%	16.1%	30.6%	10.8%
<b>Employment Status</b>				
Currently Employed	14.5%	17.6%	14.7%	12.2%
Currently Unemployed	85.5%	82.4%	85.3%	87.8%
<b>Country of Origin</b>				
Colombia	3.3%	0.8%	8.3%	0.8%
Cuba	5.2%	0.2%	15.6%	0.1%
Dominican Republic	8.9%	0	6.7%	17.8%
Ecuador	3.2%	0.3%	1%	6.8%
El Salvador	7.6%	19.8%	1%	3.5%
Guatemala	4.1%	7.6%	3.3%	2.4%
Honduras	8.6%	4.2%	19.2%	2.8%
Mexico	34.8%	51.0%	4.4%	48.9%
Nicaragua	8.1%	4.5%	19.7%	1%
Other	16.2%	11.6%	20.8%	15.9%
<b>Years in US</b>				
Less than 5	42.9%	35.7%	43.4%	47.2%
5-10 years	36.3%	43.7%	31.4%	35.7%
More than 10 years	20.8%	20.6%	25.2%	17.1%

## **Appendix 2: Methods**

### **Study Population**

In March 1999, we began a multi-site cohort study of childbearing Latina women who delivered at six hospitals in three cities (3 in New York, 2 in San Francisco, and 1 in Miami). Recruitment took place between March 1999 and February 2001. 6,211 Latina women who had delivered at the study hospitals were approached and underwent a preliminary screening interview to determine if they met eligibility criteria and if they were willing to participate. Those selected were at least 17 years of age at the time of delivery and self-identified as being of Latin American or Latin Caribbean origin. Women who had at least one parent or grandparent of Latin American or Caribbean national or ethnic origin (excluding Puerto Rico and Brazil) were considered eligible for the study. Additionally, eligible participants had to be able to communicate in Spanish and/or English, planned to maintain residence in the area for six months from date of enrollment, and be willing to give informed consent. 3,140 women met these criteria and 2,548 (81.5%) agreed to participate.

Participants were interviewed regarding their immigration status, demographic factors, and prenatal care, as well as their knowledge, attitudes and beliefs regarding changes in health insurance and immigration policies.

### **Variables**

The dependent variables are nine potential barriers to enrollment in public health insurance programs elicited from respondents through the following statement:

- There are several things that can make it difficult to apply for health insurance. I am going to read a list of possible reasons that may have come up the last time you applied for health insurance. Please tell me if any applied to you.

Interviewees selected problems from the following list:

1. You were confused about applying
2. You did not have the necessary paperwork, such as proof of income or address
3. No one was able to explain to you in Spanish how to apply
4. You had to wait a long time for an interview or to hand in the application
5. The people who interviewed you and took your application were not helpful
6. You were afraid they would report you to the INS
7. They asked for your Social Security number
8. You were afraid that applying might make it hard to become a citizen someday
9. You were afraid that someday you would have to pay back the cost of your care

The main predictor variables were immigration status and eligibility for federal Medicaid. We classified respondents as citizens, legal immigrants, and undocumented immigrants, as well as several pertinent sub-categories. A detailed algorithm for determination of federal Medicaid eligibility was developed based on review of the welfare reform law and subsequent legislative changes (see Appendix 2). The algorithm defines which women are eligible for Medicaid as defined under PRWORA, but does not indicate which women are eligible for state-funded Medicaid (California) or federally funded Medicaid due to a court order (New York City).

Federal Medicaid eligibility classifies respondents based on their immigration status and current federal law: ineligible respondents include the undocumented, PRUCOLs, and post-1996 legal immigrants; eligibles include pre-1996 legal immigrants, post-1996 legal immigrants exempt from the five-year bar on benefits, and citizens. A woman's actual eligibility for prenatal care was determined by her state of residence and her immigration status: all women in New York and California were eligible for prenatal care under Medicaid (with federal financial participation in New York and state-funded Medicaid in California), while Florida did not create a state-funded program to cover federally-ineligible women. Other independent variables include site, income, marital status, length of residence in US, education, and country of origin.

### **Statistical Techniques**

We used a combination of descriptive, bivariate and multivariate analyses. We examined the study population across the three sites by immigration category, federal Medicaid eligibility, eligibility for prenatal care, country of origin, income, and education. Using chi-square statistics, we then looked for differences in the rates of difficulties encountered applying for public health insurance across sites, immigration status, federal Medicaid eligibility, income, and education. We also tested country of origin as a predictor of differences alone and across sites.

## **Appendix 3: Algorithm for Determination of Federal Medicaid Eligibility**

### **Eligible for Federal Medicaid as determined by PRWORA:**

- US born citizen
- Naturalized citizen
- Qualified immigrant arriving before 8-22-96
- Qualified immigrant arriving on or after 8-22-96 who is exempt from five year bar on benefits
- Non-qualified immigrant receiving SSI on 8-22-96

### **Ineligible for benefits**

- Qualified immigrant arriving on or after 8-22-96 who is subject to five year bar on benefits
- Non-qualified immigrant, undocumented, permanent resident under color of law (PRUCOL)

### **Qualified Immigrants: Five-year Bar on Federal Medicaid Eligibility**

If an immigrant arrived in the US on or after 8-22-96, they are either subject to or exempt from the five-year bar on federal Medicaid eligibility as noted.

#### **Subject**

- Legal resident, no exemptions
- Alien being paroled into the US for a year or more
- Alien being granted conditional entry into US
- Battered alien

#### **Exempt**

- Refugee or asylee
- Deportation currently being withheld by the INS
- Cuban or Haitian entrant
- Amerasian immigrant
- Veteran, on active military duty or a dependent of someone who is a veteran

<sup>1</sup> Ellwood M, Ku L. Welfare and Immigration Reforms: Unintended Side Effects for Medicaid. *Health Affairs*. 1998; 17(3): 137-151.

<sup>2</sup> A 2002 Urban Institute study found dramatic declines in Medicaid coverage between 1994 and 1999 among low-income working-age adults who are immigrants, especially refugees, with smaller declines for citizens. The study, however, found almost no change in Medicaid coverage among immigrant families with children, perhaps due to the success of policies intended to expand coverage for children under the State Children's Health Insurance Program (SCHIP). Fix M, Passel J. *The Scope and Impact of Welfare Reform's Immigrant Provisions*. Washington, D.C.: The Urban Institute; January 2002.

<sup>3</sup> A 2001 study found a significant drop in the proportion of low-income noncitizen children enrolled in Medicaid between 1995 and 1999 (36% to 28%), with smaller drops for low-income citizen children with native-born parents (45% to 42%). Ku L, Matani, S. Left Out: Immigrants' Access to Health Care and Insurance. *Health Affairs*, 2001; 20(1):247-56.

<sup>4</sup> Further evidence of declines in Medicaid coverage among Latina women with incomes below 200% of poverty dropped from 29% in 1994 to 21% in 1998; Medicaid coverage for women with family incomes under 100% of poverty declined from 41% to 30%. Wyn R, Solis B, Ojeda VD, Pourat N. *Falling Through the Cracks: Health Insurance Coverage of Low-Income Women*. Washington, DC: The Henry J. Kaiser Family Foundation; February 2001.

<sup>5</sup> Two recent studies of Latina mothers in four states found little evidence that prenatal care utilization among immigrant women has fallen in the wake of PRWORA, largely because pregnant immigrants in those states remained eligible for Medicaid. In the one state where coverage was withdrawn, immigrant women who became ineligible for Medicaid had fewer prenatal care visits compared to those who remained eligible. Joyce T, Bauer T, Minkoff H, Kaestner R. Welfare Reform and the Perinatal Health and Health Care Use of Latino Women in California, New York City and Texas. *American Journal of Public Health*; November 2001; 91:1857-1864; Minkoff H, Fuentes-Afflick E, O'Sullivan MJ, Gomez-Lobo V, Bauer T, Joyce T, Holman S, Feldman J. The Relationship of State of Residence to Adequacy of Prenatal Care Among Foreign-and U.S-born Latina Women. *Journal of Immigrant Health*. (submitted for publication)

<sup>6</sup> Ku L, Blaney S. *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage*. Washington, DC: Center on Budget and Policy Priorities; October 2000.

<sup>7</sup> Rhoades J, Chu M. *Health Insurance Status of the Civilian Noninstitutionalized Population: 1999*. Rockville, MD: Agency for Healthcare Research and Quality; 2000. MEPS Research Findings No.14. AHRQ Pub. No. 01-0011.

<sup>8</sup> U.S. Census Bureau, Current Population Survey 2001 Annual Demographic Supplement, expanded sample.

<sup>9</sup> Qualified immigrants are most legal immigrants, including lawful permanent residents and refugees/asylees. Unqualified immigrants are mainly the undocumented, but also include some immigrants who were previously considered legal immigrants, such as immigrants permanently residing under color of law (PRUCOL). PRUCOL is not an official immigration status for purposes of entering the US, but refers to a number of immigrant classifications. Generally, a PRUCOL is a noncitizen residing in the US for an indefinite period of time with the knowledge of the INS and whose departure the INS does not contemplate enforcing.

<sup>10</sup> *Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001), reversing *Lewis v. Grinker*, 965 F.2d 1206 (2d Cir. 1992).

<sup>11</sup> New York State A. 10461/S.6536, March 18, 2002.

<sup>12</sup> *Aliessa v. Novello*, 96 N.Y. 2d 418 (2001).

<sup>13</sup> Tumlin K, Zimmerman W, Ost J. *State Snapshots of Public Benefits for Immigrants: A Supplemental Report to "Patchwork Policies."* Washington, D.C.: The Urban Institute; August 1999.

<sup>14</sup> We excluded Puerto Ricans because they have US citizenship status and Brazilians because they speak Portuguese.

<sup>15</sup> Minkoff H, Fuentes-Afflick E, O'Sullivan MJ, Gomez-Lobo V, Bauer T, Joyce T, Holman S, Feldman J. The Relationship of State of Residence to Adequacy of Prenatal Care Among Foreign-and U.S-born Latina Women. *Journal of Immigrant Health*. (submitted for publication)

<sup>16</sup> In 1999, 99% of births were in hospitals. Ventura SJ, Martin JA, Curtin SC, Menacker F, Hamilton BE. *Births: Final Data for 1999. National Vital Statistics Report*, vol 49, no. 1, Hyattsville, Maryland: National Center for Health Statistics; 2001.

<sup>17</sup> In New York, all pregnant immigrants remained eligible for Medicaid coverage under the holding in *Lewis v. Grinker*. California provided prenatal care to federally ineligible women under a state-funded program.

<sup>18</sup> Presumptive eligibility is an optional Medicaid provision that allows qualified providers to extend immediate, short-term eligibility to pregnant women while their formal Medicaid applications are pending.

<sup>19</sup> Less than 1% (16 women) of the sample reported PRUCOL status. For the sake of simplicity, we use the term “undocumented” in the text to refer to both the undocumented and the PRUCOL women. Both groups are unqualified immigrants under federal law.

<sup>20</sup> Richard N. Gottfried, Chair, New York State Assembly Committee on Health, *Disaster Relief Medicaid: What Have We Learned And Where Do We Go From Here?* New York: December 19, 2001.

<sup>21</sup> Testimony by David Jones, President, Community Service Society, New York State Assembly, Health Committee Hearing, New York: December 3, 2001.

<sup>22</sup> Bauer T. *Welfare Reform and the Perinatal Health of Immigrants: First Year Case Study Findings and Analysis from California, Florida, New York and Texas*. New York: The Research Foundation of the State University of New York; July 1999. Available at <http://www.nyam.org/divisions/healthscience/childhealth/publications.shtml>

<sup>23</sup> Park L, Sarnoff R, Bender C, Korenbrot C. Impact of Recent Welfare and Immigration Reforms on Use of Medicaid for Prenatal Care by Immigrants in California. *Journal of Immigrant Health*. 2000; 2(1); 5-22.

<sup>24</sup> Examples include the Port of Entry Detection Program and the California Airport Residency Review.

<sup>25</sup> *Lewis v. Grinker*, 925 F.2d 1206 (2d Cir.1992); Case Study, supra note 5, pages 29-32.

<sup>26</sup> *Lewis v. Grinker*, 252 F.3d 567 (2d Circuit, 2001).

<sup>27</sup> New York State A. 10461/S.6536, March 18, 2002.

<sup>28</sup> Governor Pataki’s 1997 welfare reform proposals provided Medicaid and other benefits for most immigrants only where federal financial participation was available, and specifically noted that withdrawn coverage would be extended if federal matching funds became available in the future. In June 2001, New York’s highest court ruled in *Aliessa v. Novello* that providing state-funded coverage to some but not all federally-ineligible immigrants violated the New York and US constitutions. As a result, Medicaid and Family Health Plus eligibility was restored to post-96 legal immigrants and PRUCOL immigrants.

<sup>29</sup> On the heels of PRWORA’s enactment, Mayor Giuliani and New York City filed suit against the Federal government in *New York v. U.S.*, Civil Action No. 96 Civ. 7758, (United States District Court, Southern District of New York, Oct. 25, 1996), challenging the legality of Section 434 of PRWORA, also known as the communication provision. Section 434 prohibits states and localities from restricting state government officials from communicating directly with the INS about the immigration status of any alien in the US, notwithstanding any other provision of federal, state or local law. Although the City lost this challenge, the court did not invalidate New York’s Executive Order 124, which remains in effect.

<sup>30</sup> In addition to the federal requirement, New York’s 1997 welfare law included this sponsor liability language, which can be applied retroactively.

<sup>31</sup> Hughes D. *Parents’ Experiences in Obtaining Public Health Insurance for Their Children in California*. California: Institute for Health Policy Studies. University of California, San Francisco; December 2000.

<sup>32</sup> Andrus D, Bauer T, Hopkins S. *Voices for Children’s Health in New York State: Community Roundtables on Increasing Enrollment in Medicaid and Child Health Plus Enrollment*. New York: New York Forum for Child Health, The New York Academy of Medicine; February 1999. Available at <http://www.nyam.org/publications/online/childinsurance/Round.pdf>

<sup>33</sup> Ross DC, Cox L. *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; October 2000.

<sup>34</sup> In addition to this one federal requirement regarding documentation provided by families, states must have the Income and Eligibility Verification System in place to perform post-eligibility verification for Medicaid.

<sup>35</sup> Ross DC, Cox L. *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; October 2000.

<sup>36</sup> Personal communication with Candice Hall, Health Care Financing Administration, Washington, DC; March 9, 2001.

<sup>37</sup> Health Care Financing Administration. *Fact Sheet: CHIP and Child Support Enforcement (CSE)*. Washington, DC; January 12, 1999.

<sup>38</sup> Personal communication with Linda Ginn, Department of Children and Families, Tallahassee, Florida; February 26, 2002.

<sup>39</sup> A joint application form recently developed for PCAP, children’s Medicaid, Child Health Plus, and WIC is longer than the PCAP form, given the additional requirements of the other programs.

<sup>40</sup> Dutton M, Fairbrother G. *Barriers to Enrollment in Child Health Insurance Programs: Report from the Baseline, Update 6*. New York: New York Forum for Child Health, The New York Academy of Medicine; October 2001. Available at <http://www.nyam.org/publications/newsletters/childhealth/nyfchissue6.pdf>

<sup>41</sup> Long P. *Local Efforts to Increase Health Insurance Coverage among Children in California*. California: Medi-Cal Policy Institute; February 2002.

<sup>42</sup> Medi-Cal Policy Institute, *Children's Medi-Cal & Healthy Families Program*. California: Medi-Cal Facts, Number 11; April 2001.

<sup>43</sup> This is distinct from what California is now considering, a SCHIP waiver expansion for parents/relative caregivers with income over 100%.

<sup>44</sup> Long P. *Local Efforts to Increase Health Insurance Coverage among Children in California*. California: Medi-Cal Policy Institute, February 2002.

<sup>45</sup> Hernandez DJ, Charney E. eds. *From Generation to Generation: The Health and Well-Being of Children in Immigrant Families*. Washington, DC: National Academy Press; 1998.

<sup>46</sup> Fix M, Zimmerman W. *All Under One Roof: Mixed-Status Families in an Era of Reform*. Washington, DC: Urban Institute; June 1999.

<sup>47</sup> Ibid.

<sup>48</sup> Lambrew J. *Health Insurance: A Family Affair – A National Profile and State-by-State Analysis of Uninsured Parents and Their Children*. New York: The Commonwealth Fund; May 2001.

<sup>49</sup> Hanson KL. Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Use Revisited. *Inquiry*. 1998; 35:294-302.

<sup>50</sup> Ornstein C. States Cut Back Coverage for Poor. *The Los Angeles Times*. February 25, 2002; Section A, p1.

<sup>51</sup> Examples of additional steps each state could take: Although not required by federal law, California requires Medi-Cal and Healthy Families applicants to submit proof of income. Florida requires children over 5 to reapply for Medicaid and Healthy Kids (their SCHIP program) every 6 months. New York requires Medicaid applicants to have a face-to-face Medicaid interview, and Medicaid and CHIP applicants to submit extensive documentation of income. GAO Report to the Ranking Minority Member, Committee on Energy and Commerce, House of Representatives, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*. (GAO-01-883). Washington, DC; September 2001.

<sup>52</sup> California's "point-of-service" enrollment systems for the Medicaid Breast and Cervical Cancer Screening and Treatment Program and the Family PACT Medicaid waiver program are enrollment models that would improve access for pregnant women, although they only include some of the key PCAP features.

<sup>53</sup> States can use Section 1931(b) to expand Medicaid coverage to parents and relative caregivers to any percent of the federal poverty level. Unlike SCHIP, the Medicaid expansion can be done at state option without a waiver from the federal government.