WELFARE REFORM AND THE PERINATAL HEALTH OF IMMIGRANTS:

Executive Summary
First Year Case Study Findings and Analysis from California, Florida, New York and Texas

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EXECUTIVE SUMMARY

FIRST YEAR CASE STUDY FINDINGS AND ANALYSIS

I. Introduction

After years of intense debate over the costs of public benefits used by immigrants, the 104th Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. This law ends the guarantee of cash welfare assistance to all eligible families and replaces it with a block grant to states to provide time-limited support for low-income families who comply with work requirements. PRWORA also fundamentally altered the legal structure for providing Medicaid and other public benefits to immigrants, while maintaining the Federal entitlement to health insurance under Medicaid for all citizens. The legislation imposed new restrictions on legal immigrants' eligibility for Medicaid and created additional barriers to undocumented immigrants' eligibility for state and local benefits. No exceptions to these restrictions were made for pregnant women; as a result, many immigrants became ineligible for Medicaid coverage of prenatal care, although labor and delivery services remain Medicaid-reimbursable as an emergency medical service. The purpose of our research is to utilize vital data analysis, case studies and client interviews and follow-up to assess the relationship between PRWORA, the different means by which it is applied, and the maternal-newborn health of immigrants.

This report is an executive summary of the first year case study findings and analysis. It is based on a survey of key informants and a review of relevant documents in four states: California, Florida, New York and Texas. The objective of this summary is to catalog each state's methods for implementing the components of welfare reform that directly relate to prenatal care for immigrants. In addition to state action, the full first year case study documents implementation at selected municipal and hospital levels. This perinatal case study provides the contextual information that will be needed to interpret the vital data and the client level interviews. A summary of key findings, description of research methodology, overview of relevant changes in federal law, case studies for the four states, and conclusions are provided below.

Note on recent changes: This field is undergoing continuous change, with reforms contemplated and underway at the federal, state and local levels in all three branches of government: executive, legislative and judicial. **Prior to dissemination but following completion** of this first year report, four noteworthy changes occurred. While a full description will be incorporated into the second year update, a summary is provided below.

- On May 25, 1999, new federal guidance was issued to define "public charge" for the first time. (See discussion of public charge on page 11 below.) The guidance "states which benefits a non-citizen may receive without concern for negative immigration consequences." Benefits that may NOT be considered in a determination of whether an immigrant is, or is likely to become, a public charge include Medicaid, SCHIP, Food Stamps, WIC and other non-cash benefits.

- On May 20, 1999, a New York State judge ruled that restrictions on immigrants' access to state-funded Medicaid violates the equal protection clauses of the United States and State Constitutions. In addition, the restrictions were found to violate the "care of the needy" provision of the State's Constitution. The state law, passed in 1997, incorporated the federally-required 5-year bar on Medicaid for post-enactment legal immigrants. The law granted exemptions for immigrants living in nursing homes or suffering from AIDS as of September 1997. It was this difference in treatment that the court found illegal. The court's ruling restores state-funded medical assistance to individual immigrants who were denied medical assistance because they are PRUCOL, or are lawful permanent residents who entered the country after August 22, 1996.[1]

- The Second Circuit recently affirmed the District Court's decision, which denied New York City's challenge to the legality of the new federal reporting requirements. Mayor Giuliani plans to file for review by the Supreme Court of the United States.[2] Pending a decision by the Supreme Court, the City maintains that Executive Order 124 is still in effect and will be enforced. Since 1984, Executive Order 124 of the City of New York 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. The Order, however, only applies to city agencies and has no bearing on actions by state or federal officials.

- California's Governor Davis has discontinued a Medi-Cal anti-fraud program begun under former Governor Wilson that "pressed immigrants for repayment of state health insurance benefits under the threat of deportation."[3] Among 12, 000 travelers per month, many poor Latinas were questioned about past receipt of Medi-Cal benefits, particularly for childbirth. The state will return about $4 million it collected from legal immigrants.

Key Findings

With the introduction of multiple new variables into the Medicaid eligibility equation as a result of welfare reform, a chilling effect was predicted. The indirect consequences of welfare reform, it is argued, were likely to create new and unintended barriers to prenatal care. Both the terms of the new laws and people's beliefs about what they provide could affect the way that pregnant women obtain health care and other needed services.

To date, New York and California have maintained Medicaid coverage for prenatal care for all pregnant immigrants, each for distinct reasons. Federal enactment of welfare reform unquestionably re-inspired California's Governor Wilson to seek immediate repeal of the state's funding for prenatal care for undocumented immigrants. It also triggered the federal government's challenge to the protective order in Lewis v. Grinker in New York State. Notwithstanding these effects, coverage remains unchanged at this time.

Thus, to the extent there have been declines in prenatal care use by immigrants in New York and California, as suggested by limited data and anecdotal evidence, these declines have not stemmed from eligibility changes but from the *mentality* of welfare reform, including attempted withdrawals of eligibility, the aura of lost access and public charge concerns. In addition, attempts to curb prenatal care in California -- Wilson's attempted repeal of state funding which languishes in the courts -- and New York-- the federal government's motion to vacate the existing order in Lewis, may by themselves have increased fears among immigrants about seeking prenatal care. While it is difficult to quantify the impact of attempted withdrawals of eligibility, public charge concerns, and the aura of lost access, it is clear that eligibility alone does not define access.

In contrast to New York and California, Florida and Texas have withdrawn Medicaid eligibility for post-enactment qualified immigrants for 5 years. Neither state is replacing lost federal Medicaid funds with a state program. Moreover, Texas has indicated that Medicaid may not be restored after the 5-year bar. In both states, notably, other programs exist to at least partially replace the lost Medicaid coverage for pregnant immigrants. In Texas, pregnant women remain eligible for Title V-funded prenatal care services without regard to documentation status. For those women who identify a Title V-funded source of prenatal care, there is no actual decrease in the benefit provided. In Florida, all pregnant immigrants continue to be eligible for Medicaid through the presumptive eligibility process for 45 days of the prenatal period. In contrast to Texas, this coverage does not come close to fully replacing the lost Medicaid coverage.

Contrary to what might be expected, based on anecdotes and the limited data available, there is no greater evidence of decreased access to prenatal care in Florida and Texas, where Medicaid eligibility has been withdrawn, than in New York and California, where eligibility remains unchanged. In all four states, the *mentality* of welfare reform and confusion surrounding public charge issues appear to have been the primary factors leading to whatever decrease occurred in access to prenatal care among immigrant women.

A. Description of Case Study Research Methodology

The first hypothesis of this study is that the welfare act will affect immigrants' maternal-newborn health. The second hypothesis is that maternal-newborn outcomes will vary according to the Medicaid policies of the state in which women reside. In order to explore these hypotheses, the following questions are addressed in each case study:

- How have each state's decisions surrounding implementation of welfare reform affected eligibility for and funding of Medicaid and other health benefits by pregnant immigrants;

- Where there was no change in eligibility for Medicaid and other health benefits for pregnant immigrants, did the *mentality* of welfare reform create an aura of lost eligibility and decreased access;

- In turn, if either of the two conditions outlined above did occur, what local decisions by counties and hospitals have been made to address the health care needs of pregnant immigrants; and

- What is the actual or anticipated impact of these changes on access to services and the perinatal health of immigrants?

The strength of the case study approach is its ability to take into account a broad range of evidence, including documents, interviews and observations, as described by Yin.[4] It is valuable in illuminating a set of decisions surrounding pregnant immigrants' access to Medicaid as a result of welfare reform: why they were taken, how they were implemented and with what result.

Interviews were conducted with ten to twenty key informants in each state, including the state and local Commissioners of Health and Social Services, the CEO or CFO of sentinel hospitals, i.e. hospitals with high percentages of immigrant and indigent women, Chairs of Obstetrics, and policy analysts or advocates. Through interviews with key informants and review of relevant documents, the report traces new policies from their design by executive and/or legislative branches of government through their application at the levels of state and local health departments, hospitals and finally, departments of obstetrics in sentinel hospitals. Legislative changes are followed as they evolve, and responses catalogued at the different levels of inquiry.

B. National Context - A Moving Target

PRWORA Provisions

Enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) in August 1996 ended the guarantee of cash welfare assistance to all eligible families and replaced it with a block grant to states to provide time-limited support for low-income families who comply with work requirements. One of the most contentious elements of the welfare debate concerned the future of the Medicaid program. While the law does not repeal the Federal entitlement to health insurance under the Medicaid program for citizens, it severely curtails immigrants' eligibility. The mandates and options afforded to states under PRWORA are attached as Appendix A. The law divides all immigrants into two new categories: qualified and nonqualified aliens.[5] Qualified aliens is a category that includes only certain legal immigrants, and nonqualified aliens is a category that includes both undocumented immigrants and certain legal immigrants. Throughout this paper, the word "immigrant" and the more technical government term "alien" are used interchangeably.

With the exception of certain groups of refugees and asylees, the law creates a 5-year bar on benefits for immigrants entering the county after the date of enactment, provides benefits for these immigrants after the 5-year bar at state option, requires sponsor-to-alien deeming of income after the 5-year bar for those states that opt to restore federal benefits, and provides benefits to those in this country before enactment at state option. Access to emergency medical services only was not changed by PRWORA and continues to be available without regard to immigration status.

Prior to enactment of PRWORA, legal immigrants were eligible for public benefits on essentially the same terms as US-born citizens. The law draws new distinctions between citizens and legal immigrants, denying benefits to undocumented and recent legal immigrants alike.

Other Laws

Since enactment of PRWORA, there have been a number of other federal health, welfare and immigration policy decisions that either reverse or complement the immigration restrictions in PRWORA. For example, The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, which intersects with PRWORA in relation to the designation of immigration status, included provisions that resulted in harsher treatment of immigrants with fewer opportunities for review of decisions by individual INS officials. The Balanced Budget Agreement of 1997 reversed several major provisions of the PRWORA, restoring eligibility for Supplemental Security Income (SSI) and derivative Medicaid to legal immigrants residing in the United States prior to August 22, 1996, and to those who become disabled in the future. In addition, under PRWORA, refugees and certain other immigrants were given time-limited exceptions to the eligibility restrictions on Medicaid and other benefits; the Balanced Budget Act extended the time period from 5 to 7 years for Medicaid, and to three additional immigrant groups - Cubans, Haitians and Amerasian immigrants. The Agricultural Research Act of 1998 restored Food Stamps for legal immigrant children, senior citizens and people with disabilities who entered the United States before August 22, 1996.

On August 4, 1998, the Department of Health and Human Services issued proposed regulations interpreting "Federal public benefit" as used in PRWORA. The interpretation states that included benefits are those that must be provided to an individual household or family, rather than those that are targeted to broad populations. The interpretation specifically excludes those benefits that are targeted to certain populations based on their characteristics, such as a benefit provided under the Title V Maternal and Child Health Services Block Grant, which provides health services to women and children.[6] Thus, Title V benefits are not subject to PRWORA's restrictions on provision of federal public benefits to immigrants.

On February 1, President Clinton released his FY2000 Budget, which included $1.3 billion over five years to restore additional benefits to legal immigrants, including restoration of SSI and Medicaid to legal immigrants who entered the country after the PRWORA was enacted if they have been in the country for five years and became disabled after entering, restoration of Food Stamp eligibility to legal immigrants in the country on August 22, 1996 who later reached age 65 to be eligible for Food Stamps. In addition, the budget proposal would provide states the option to provide Medicaid coverage for prenatal care to qualified immigrant women who entered the country after August 22, 1996, and the option to provide Medicaid and/or CHIP coverage to qualified immigrant children who entered the country after August 22, 1996.

In April, New York's Senator Moynihan introduced legislation that would represent the largest

restoration to date of immigrant health benefits lost under PRWORA. It would extend Food Stamp eligibility to legal immigrant adults, and Medicaid and SCHIP benefits at state option to certain legal immigrants who entered the country after 1996.[7]

Finally, on May 25, the federal government issued new guidance to define "public charge" for the first time. (See discussion of public charge on page 11 below.) The guidance "states which benefits a non-citizen may receive without concern for negative immigration consequence."[8] Benefits that may NOT be considered in a determination of whether an immigrant is, or is likely to become, a public charge include Medicaid (except for long-term care), SCHIP, Food Stamps, WIC and other non-cash benefits. The proposed rule establishes "clear standards governing whether an alien is inadmissible to the United States, ineligible to adjust immigration status, or has become deportable on the grounds that he or she is likely to be or is a 'public charge.'"[9] Subject to effective implementation and dissemination of this clarification, concerns about public charge should become less of a barrier to use of public benefits by immigrants.

While most of these changes do not reverse those provisions of PRWORA that restricted Medicaid eligibility for immigrants, with the notable exception of proposals currently pending before Congress, they are likely to contribute to a sense of confusion about Medicaid eligibility. As noted in a recent briefing on welfare reform, a District Court opinion from 18 years ago described Medicaid eligibility rules as "an aggravated assault on the English language, resistant to attempts to understand it."[10] This opinion was written before introduction of the recent complexities. Thus, ascertaining the impact of welfare reform on perinatal health is made more complicated by the ongoing changes that continue to evolve at the federal level.

II. CALIFORNIA

A. State Political Environment

Welfare reform arrived in California in the wake of previous initiatives designed to restrict services for immigrants. California's Proposition 187, a ballot initiative passed by voters in 1994 by a 59 to 41 percent margin, attempted to restrict undocumented immigrants' access to a wide array of state-funded health and social services, including prenatal care. Although most of its provisions were immediately stalled in litigation, passage of the initiative led to confusion about eligibility and fear among immigrants about using services. In March 1998, the Federal District Court in Los Angeles struck down virtually all remaining provisions of Proposition 187, finding that the measure unconstitutionally usurped Federal authority over immigration policy. Judge Pfaelzer wrote that when President Clinton signed PRWORA into law, "he effectively ended any further debate about what states could do in this field."[11] Only provisions for criminal penalties for the manufacture, sale and use of false documents to conceal a person's immigrant status remain in force. While a full discussion is beyond the scope of this paper, passage of Proposition 187 intensified public debate about state and local governments' responsibility to fund health care for undocumented immigrants. The fear and confusion in immigrant communities that was triggered by the initiative marked the onset of new and major barriers to

immigrants' access to health services.

Shortly after passage of Proposition 187, the California Department of Health Services began a joint project with the federal Immigration and Naturalization Service (INS) to screen non-residents returning to the country for use of public benefits, including Medi-Cal, as part of an anti-fraud initiative. Some immigrants currently enrolled in public benefits were denied re-entry, others were required to repay the costs of benefits they legally received, and others were forced to disenroll from programs to which they were legally entitled. Officials justified these practices on the basis of public charge provisions, discussed in further detail above, but in fact these practices were unlawful. INS and HHS directives subsequently clarified that repayment policies were generally unlawful. Legal challenges led to elimination of these public charge lookout programs in March 1998, but these policies raised widespread concerns among immigrants about the wisdom of using Medi-Cal.

Welfare reform thus arrived in a context of heightened concern and confusion in California about immigrants' eligibility for public benefits, and the potentially adverse consequences of using such benefits. While the policies discussed above were declared invalid and discontinued, they have contributed to a sense in immigrant communities that it may be wise to stay away from Medi-Cal.

B. State Decisions Regarding PRWORA

PRWORA requires states to make a host of legislative and policy decisions with respect to the various federal, state and public benefits that immigrants receive. This section summarizes the applicable federal laws, regulations or policies and outlines the decisions made by California that directly effect health care for pregnant immigrants.

Medi-Cal Eligibility

PRWORA gave states the option of providing Medicaid to qualified immigrants who entered the United States by August 22, 1996. It barred qualified immigrants who enter the country after that date from receiving any federally-funded Medicaid for their first five years in the country. California opted to provide Medi-Cal to immigrants in the United States regardless of date of entry.[12] California is using state funds to pay for Medi-Cal to newly entering immigrants during the five year bar. California has not implemented new Medi-Cal eligibility restrictions on certain immigrants who were formerly considered permanently residing under color of law, or PRUCOL. Most significantly, undocumented pregnant immigrants were and continue to be eligible for state-funded prenatal care under Medicaid. Finally, all immigrants continue to be eligible for emergency medical services including labor and delivery. Medi-Cal eligibility for pregnant women and infants up to one year remains at 200 percent of poverty.

Thus, California has not enacted a state law changing Medi-Cal eligibility after PRWORA. Instead, existing programs were changed to conform to federal requirements by replacing federally matched Medi-Cal with state-only funded Medi-Cal where required.

State-Only Funding for Prenatal Care for Undocumented Women

Despite the Wilson Administration's repeated attempts between 1995-1998 to eliminate state-only funding for prenatal care for undocumented women, the program remains intact. The California Legislature has appropriated funds to this program since 1988, which provides care to approximately 70,000 women each year. The most recent attempt to eliminate the program was enjoined by a California court in the Milagro case in 1998, with a trial date postponed until after the November election. The injunction was granted based upon the theory, yet to be proven in court, that denial of prenatal care would violate the public health assistance and communicable disease provisions of PRWORA, which allow states to provide public health assistance to nonqualified aliens for immunizations and for testing and treatment of symptoms of communicable diseases. While states are prohibited from using Medicaid funds with federal financial participation to provide these services to nonqualified aliens, California's program is funded with state-only dollars. The court in Milagro found, on a preliminary basis, that denying prenatal care to undocumented women in effect denied them the opportunity to receive public health assistance in the form of testing for tuberculosis and other communicable diseases.

While the jury is still out, the election of Governor Gray Davis could represent a dramatic shift in immigration policy from his Republican predecessor, Pete Wilson, who celebrated federal welfare reform as a long-awaited victory in the state's efforts to eliminate aid to illegal immigrants. Governor Davis's proposed budget allocates $60 million for prenatal care for undocumented women, although the new administration downplayed the shift by noting that funding was provided in response to an existing court order.[13] Legislative support for Davis' shift is strong but not unanimous. Clarification of the motivation behind Davis' budget proposal will be provided shortly when the administration reveals its plans for proceeding with the ongoing court challenges to Wilson's proposed elimination of this state program.

Healthy Families

PRWORA's restrictions on immigrant eligibility for Medicaid generally also apply to the new State Children's Health Insurance Program (SCHIP). The only difference is that while Medicaid coverage for qualified immigrants in the country before August 22, 1996 is at state option, SCHIP coverage is mandatory. Federal law requires that SCHIP coverage be available to legal immigrant pre-enactment children on the same terms as citizen children. Children who arrived after that date are subject to the 5-year bar from SCHIP, after which federal law once again requires states to include them. Those immigrants who are not subject to the 5-year bar on Medicaid (refugees, asylees, etc.) are also not subject to a 5-year bar on SCHIP. Undocumented immigrants and other non-qualified aliens are barred from Medicaid and SCHIP alike, except for emergency medical services.

California's SCHIP program is called Healthy Families. It provides coverage for children 1-18 years between 100-200 percent of poverty. California is not providing Healthy Families to new immigrant children during the 5-year bar, as required by federal law; in addition, it will not provide coverage to these children using state funds alone. The SCHIP plan also expands the Assistance for

Infants and Mothers (AIM) Program, which covers pregnant women and infants up to age one from 200 to 250 percent of poverty.

Application Forms

There has been no change to the Medi-Cal application form as a result of welfare reform. The same pre-PRWORA immigrant categories are still used, and while some new information is obtained, it is considered transparent to the applicant. For at least five years prior to welfare reform, a state statute has required proof of immigration status for all Medi-Cal applicants; the "MC13: Medi-Cal Statement of Citizenship, Alienage and Immigration Status", still in use today, has been in effect since 1992. Although the application remains essentially unchanged, hospital eligibility workers indicate that Medi-Cal officials are now pressing for documents more than in previous years.

A joint Healthy Families/Medi-Cal form, introduced in spring 1997, remains essentially unchanged. Faced with low enrollment and growing criticism, California officials have requested that the 28-page application booklet, which included a 6-page application form, be reduced to 5 pages. A separate issue for Healthy Families concerns the state's interpretation of date of entry. While PRWORA defines date of entry as physical not legal entry, California is presuming that a Healthy Families applicant arrived after August 22, 1996 if no INS document can be produced as proof. Some consider this approach as evidence of California's hostile environment for immigrants. Medi-Cal applicants are still permitted to use the longer Medi-Cal form. For pregnant women and children only, no face-to-face interview with Medi-Cal officials is required.

A joint TANF/Medi-Cal/Food Stamps form, sometimes used by pregnant women, now includes a chilling question about whether any undocumented persons reside in the applicant's household. A court challenge seeks removal of this question from the joint form.

Sponsor Deeming, Affidavits of Support

Under sponsor deeming, the income and resources of the sponsor and his or her spouse count as the immigrant's income in determining the immigrant's eligibility for public benefits.
The sponsor is the person who signed an affidavit of support on behalf of the immigrant so that the immigrant could obtain legal permanent resident status. Only legal permanent residents are subject to sponsor deeming. Prior to PRWORA, sponsor deeming did not apply to Medicaid.

Now, for the first time, PRWORA requires states to deem all federal means-tested programs including Medicaid for new immigrants, and makes it optional for state and local benefits. Pre-enactment immigrants do not appear to be subject to the new sponsor deeming requirements. Newly arriving immigrants are subject first to the 5-year bar on Medicaid, and then deeming applies. Deeming lasts until the sponsored immigrant becomes a naturalized citizen, has worked for 10 years or the death of the sponsor. Prior to PRWORA, sponsor deeming only applied to cash assistance, Supplemental Security Income and Food Stamps and it only lasted three years. PRWORA expanded both the number of programs and the duration of sponsor deeming.

Implementation of sponsor deeming for federal programs awaits HCFA guidance on the methodology for counting the income of sponsors. Sponsor deeming does not apply to emergency medical assistance. California is not imposing sponsor deeming for state and local programs, including state-funded assistance during the 5-year bar.

Beginning in 1998, most immigrants seeking to become permanent residents and rejoin their families in the United States must have an affidavit of support from their sponsor. PRWORA creates new requirements for sponsorship; sponsors must now be citizens, nationals or lawful permanent residents; 18 years or over; US resident; and have an income which is at least 125 percent of the Federal Poverty Level. Sponsors must also now sign an affidavit of support, now a legally enforceable document, agreeing to financially assist the immigrant.[14] California has not enacted legislation to permit recovery of expenses from sponsors, unlike New York, and is not expected to do so under the Davis Administration.

Presumptive Eligibility

Presumptive eligibility, enacted as part of OBRA 1986, 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. Providers are reimbursed for prenatal care services during the 45-day presumptive period or until a final determination of eligibility, without regard to the ultimate outcome.

Questions have been raised about the effect of PRWORA on the continued ability of qualified providers to offer undocumented women presumptive eligibility. Although Medicaid law does not require states to determine lawful immigration status for presumptive eligibility determinations, PRWORA may supercede Medicaid law and place presumptive eligibility in the category of proscribed federal public benefits.

No changes are reported to use of presumptive eligibility, implemented in California in 1995, with continuous eligibility for pregnancy through 60 days postpartum for women up to 200 percent of the Federal Poverty Level. Although a question about the applicant's social security number was added to the presumptive eligibility application in 1996, it is considered optional and unrelated to welfare reform.

Reporting Requirements

PRWORA requires agencies that administer SSI, housing assistance or TANF to report quarterly to the INS the names and addresses of individuals they know are unlawfully in the US. California officials are waiting for implementing guidance from HCFA to act on this provision, but the lack of consensus around reporting requirements has stalled even introduction of new legislation in this area, unlike other states. An outstanding question that could be decided at the state level concerns the definition of "individuals they know are unlawfully in the US."

California has made no changes to pre-PRWORA reporting by Medi-Cal. The Medi-Cal policy continues to be that information can only be used to deport an applicant in cases of fraud, based upon information provided by the Systematic Alien Verification for Entitlements (SAVE) Program, an intergovernmental information-sharing service for agencies to determine a noncitizen's immigration status that has been used by Medi-Cal since 1988. Advocates question whether the generally hostile environment might lead INS to jump too quickly to the conclusion of fraud in cases of other error. California is not using the SAVE system for its SCHIP program.

The communication provision of PRWORA (Section 434) prohibits states and localities from restricting state governmental officials from communicating directly with the Immigration and Naturalization Service (INS) about the immigration status of any alien in the United States, notwithstanding any other provision of federal, state or local law. This in effect provides whistle blower protection for state officials. According to state sources, however, HCFA has provided written instruction that preserves the confidentiality of information provided to Medi-Cal. Despite assertions of confidentiality, this provision ensures that government officials who seek to violate the confidentiality rules cannot be restrained.

"Public Charge" Issues

"Public charge" is a term used in immigration law. When immigrants apply to become legal permanent residents, or when they seek to enter or re-enter the country after traveling abroad, they are evaluated by the INS and/or the State Department. One factor in this evaluation is whether or not they are likely to be able to support themselves, their spouses, and other dependents, or whether they are, or are likely to become, a "public charge" by depending for their support on public assistance programs. This doctrine has been part of US immigration law for more than 100 years. Recent immigration and welfare reforms have contributed to growing confusion and concern about eligibility and the potentially adverse immigration consequences of using public benefits.

On May 25, 1999, in response to strong pressure from some state governments and advocates, the federal government issued new guidance that defines "public charge" for the first time. The guidance "states which benefits a non-citizen may receive without concern for negative immigration consequences."[15] Benefits that may NOT be considered in a determination of whether an immigrant is, or is likely to become, a public charge include Medicaid (except for long-term care), SCHIP, Food Stamps, WIC and other non-cash benefits. Current, past or future use of non-cash benefits by the immigrant or by a family member will not be considered. The proposed rule establishes "clear standards governing whether an alien is inadmissible to the United States, ineligible to adjust immigration status, or has become deportable on the grounds that he or she is likely to be or is a 'public charge.'"[16] Subject to effective implementation and dissemination of this clarification, concerns about public charge should become less of a barrier to use of public benefits by immigrants.

The public charge doctrine does not apply to refugees or aliens seeking asylum, nor does it

apply to legal permanent residents seeking to naturalize.[17] Potential consequences of being found a public charge include delay or denial of changes in immigration status or re-entry after traveling abroad, or in rare cases deportation.[18] Under narrowly circumscribed circumstances, the INS can deport an alien on public charge grounds if he or she fails to meet a demand for repayment of the costs of certain benefits unlawfully received.[19] Factors including age, health, assets, resources, family status, education, skills, financial status and past receipt of benefits are all considered in evaluating the "totality of circumstances" required in making a public charge determination.

Between 1997 and May 25, 1999, California officials repeatedly requested written clarification from INS regarding the public charge policy as it relates to health benefits including Medicaid and SCHIP. While INS had informed the Department of Health Services that citizen children's enrollment in Healthy Families would not create a public charge liability for their parents, it had not clarified the implications of immigrant children's enrollment. In California, public charge policies generally were not applied to citizen children unless the receipt of benefits was their sole source of support. Concerns about public charge issues, both accurate and unfounded, are widely considered the single largest deterrent to use of Medi-Cal and SCHIP. Public charge policies, in turn, have fed a growing industry of unlicensed health care providers in immigrant communities, operating out of offices, storefronts and homes, sometimes with disastrous consequences.[20]

A number of programs related to public charge issues have been started in California since 1994, declared invalid and terminated. Shortly after passage of Proposition 187, the California Department of Health Services began a joint project with the federal Immigration and Naturalization Service to screen non-residents returning to the country for use of public benefits, including Medicaid. Some immigrants currently enrolled in public benefits were denied reentry, others were required to repay the costs of benefits they legally received, and others were forced to disenroll from programs to which they were legally entitled. Officials justified these practices on the grounds that use of Medi-Cal justified a de facto "public charge" determination which warranted action by border patrols, but in fact these practices were unlawful. As cited in a report by the Center for Immigration Research, a May 22, 1997 cable from the State Department described the Public Charge Lookout System(PCLS) and its usefulness in screening out "public charges" who had received health services in California:

> Several posts are conducting in excess of 1200 PCLS checks per month with reported hit rates of 20 percent to 35 percent. Tijuana has been engaged in successful pilot programs working closely with INS border posts and California Dept. of Health Services to identify likely public charge cases. Ciudad Juarez also has conducted a pilot program with California, submitting names of large numbers of IV (immigrant visa) applicants and petitioners/sponsors for PCLS checks (Interpreter Releases 1997).[21]

INS and HHS directives subsequently clarified that repayment policies were generally unlawful. Legal challenges led to a court order prohibiting these public charge lookout programs in March 1998, but community advocates report that these policies raised widespread concerns among immigrants about

the wisdom of using Medi-Cal. Hospital eligibility workers and advocates report that in 1997 and 1998, lawyers in California were advising clients to stay away from public services due to public charge concerns.

Recently, a state audit found that the policies continued after March 1998 despite federal directives and the court order. In response to the findings of the state audit, California's Medi-Cal will return to immigrant families an estimated $4 million in unlawfully obtained repayments.[22] Coverage for prenatal care was often the subject of requested repayment policies by Medi-Cal. A state audit revealed that state officials questioned more than 13,000 travelers per month, mostly poor Latinas, about past receipt of Medi-Cal benefits, particularly for childbirth.

IIRIRA

At the same time that PRWORA created new restrictions on immigrants' eligibility for benefits, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 has significantly changed treatment of immigrants in numerous ways. The law creates new restrictions on immigrant rights and benefits and increases the enforcement authority of INS, especially along the United States-Mexico border. IRRIRA also greatly expands the definition of criminal aliens and the crimes for which they can be deported. The law represents a shift away from interior and benefits-based enforcement to border enforcement.

Other Benefits for Pregnant Women - Public Health Assistance, TANF

Under PRWORA, all immigrants continue to be eligible for public health assistance for immunizations and for the testing and treatment of communicable diseases, whether or not the symptoms are ultimately caused by such disease. Medicaid funds may not be used for this purpose. In California, the Title V Maternal and Child Health Block Grant primarily funds local maternal and child health infrastructure rather than direct services, with some exceptions including outreach and special case management services. Wherever possible, the state sought to maximize the number of services that could be classified as public health assistance.

California's TANF program exempts from work requirements pregnant women for whom the pregnancy impairs the ability to work, parents for 12 weeks after the birth of a child, teen mothers who live at home and victims of domestic violence.

III. FLORIDA

A. State Political Environment

The election of Governor Jeb Bush in November 1998 to succeed Democratic Governor Chiles is a dramatic shift to a Republican controlled government after more than 120 years of Democratic control. As Governor from 1990 to 1998, Lawton Chiles was widely recognized as a champion of pregnant women and children. He created the Lawton and Rhea Chiles Center for Healthy Mothers and Babies and established the state-funded Healthy Start program in an effort to reduce infant mortality

rates. Prior to his death in December 1998, former Governor Chiles was working closely with the White House to seek restoration of Medicaid to immigrants. Despite the sympathies of the Chiles administration, and primarily due to fiscal concerns, Florida did not opt to use state funds to replace withdrawn federal funds for newly ineligible immigrants.

Governor Bush is perceived to be supportive of health and immigrant issues, and is seeking restoration of Medicaid for immigrants at the federal level. At this time, Florida is also considering allocating state funds to provide coverage for all immigrant children in KidCare, an umbrella of four insurance programs including Medicaid and Healthy Kids, who are not eligible for federal funds. At the leadership level, most state agencies are considered sympathetic to the needs of immigrants, seeking to interpret the new federal restrictions as liberally as possible, or to delay their implementation as much as possible. Local implementation of new policies, however, is considered inconsistent, with wide variations among individual offices and workers.

Notwithstanding the sympathetic agency leadership, there is a perception that politicians and voters alike don't want to make it " too easy" for Floridians to receive Medicaid or cash assistance, in part due to fear of attracting more foreigners to their state. Statewide, there is generally stronger support for the large Cuban immigrant population than for the far smaller Haitian immigrant community. The Cuban community has used its voting power to influence government policies.

At the legislative level, the Republicans are in charge of both houses for the third year in a row; control shifted from Democrats to Republicans in the House while Chiles was still Governor. Only selected members of the Dade County/Miami delegation to Tallahassee and the Congressional delegation in Washington have been vocal on immigrant issues.

As summarized by one state official, "Florida waxes and wanes in its feelings towards immigrants. It has some milk of human kindness, but ...."

Florida enacted an aggressive state welfare reform program called WAGES in the spring of 1996 just before enactment of PRWORA. WAGES was implemented in October 1996. The state law included no new restrictions for immigrants and provided that immigrants are eligible for benefits to the extent permitted by federal law. Florida officials consider WAGES a success; the welfare rolls have fallen more than 50 percent statewide since implementation, with lower declines in Dade County due to higher poverty and unemployment rates. Dade County officials observe that there is little data collected on what happens to people once they leave cash assistance, and have concerns that privatization of the WAGES program may compromise the needs of welfare clients. State officials report that evaluations of people leaving cash assistance have found that most are employed and that some, but not many, are facing hardships. Use of child care and Medicaid among people leaving the welfare rolls is low.

B. State Decisions Regarding PRWORA (Note: Where not provided below, the applicable federal law, regulation or policy is summarized above in the California case study.)

Medicaid Eligibility

Florida opted to provide Medicaid where federal matching funds are available. Thus, Florida opted to provide Medicaid to qualified immigrants in the United States by August 22, 1996, and to restore Medicaid to post-enactment immigrants after the 5-year bar. Florida has not created a state-funded Medicaid program to provide coverage where federal funds are not available. Undocumented pregnant immigrants have received no special treatment in Medicaid in Florida: all undocumented immigrants were and continue to be ineligible for Medicaid, with the exception of emergency medical services. Medicaid eligibility for pregnant women and infants up to one year remains at 185 percent of poverty. PRWORA's immigration restrictions were implemented in Florida effective July 1, 1997.[23]

SCHIP/KidCare

Florida is using federal SCHIP funds to expand Medicaid eligibility for children ages 15 through 18 up to 100 percent of poverty and to subsidize premiums for children above age 5 below 185 percent of poverty in a program called Healthy Kids. Florida has combined these two programs with two additional programs into one program called KidCare, which extends health insurance coverage to more uninsured children.[24] Children from 0-1 year are eligible for Medicaid up to 185 percent of poverty and for MediKids up to 200 percent of poverty.

A child must be a US citizen or a qualified alien to participate in KidCare. No documentation is required of the applicant's statement of their status; self-attestation is satisfactory proof except for the Medicaid programs within KidCare.

Prior to enactment of SCHIP, Florida did not ask applicants for Healthy Kids about their immigration status. Florida is continuing to use state funds to pay for coverage of children ineligible for SCHIP who were enrolled in Healthy Kids prior to Florida's implementation of the new federal initiative (April 1, 1998). No state funds, however, have been allocated to provide coverage for unqualified immigrant children or qualified immigrant children who arrive in the United States on or after August 22, 1996. Proposals to use state funds to cover all immigrant children are currently under review by the Bush administration..

Pregnant young adults are only covered by Florida's SCHIP program if they are living with a responsible adult.

Healthy Start

Florida's Healthy Start program receives support from federal Title V (the Maternal and Child Health Block Services Grant) and state general revenue funds. Healthy Start provides prenatal care and wrap-around services to pregnant women at risk for poor birth outcomes. All pregnant women and infants in the state are screened to assess their service needs, including prenatal care, care coordination, parenting education, child care, etc. Women and infants who receive a risk score above "4" are accepted into the program.

Women are eligible without regard to documentation status or income — eligibility is based

solely on an assessment of health and social risk status. There has been no change in eligibility since welfare reform. Demand for Healthy Start services exceeds the funding available. Healthy Start is a payer of last resort, paying for services and care coordination where no other reimbursement is available. Healthy Start's annual budget has been level for several years around $40 million. The program is funded at 46 percent of need; over $80 million would be required to provide the optimum level of services needed by the population currently eligible. Funds flow from the State Health Department through 33 local Healthy Start coalitions. Healthy Start dollars are applied differently by each coalition at the local level.

State health officials are concerned about the limited resources in Healthy Start, and about potential increases in demand for the services as a result of welfare reform. While some local coalitions fund prenatal care services, most rely on Medicaid to reimburse for services and offer wrap-around services through Healthy Start. State officials are concerned that local coalitions may not be aware of the new restrictions on Medicaid eligibility for immigrants, and the need to use their local Healthy Start funds for prenatal care services for these women. On other hand, while data are not available, some advocates believe that Healthy Start is primarily used by non-immigrant populations because program staff are not required to speak languages other than English and program materials are not translated.

Application Forms

There has been no change to the Medicaid application form as a result of welfare reform. As a result of an integrated eligibility system adopted in 1992, there is a one page joint application form (the Request for Assistance or RFA) for Medicaid, WAGES (cash assistance) and Food Stamps that is processed by one agency. Applicants are asked for information about citizenship status.

A new one page mail-in application form for pregnant women is being piloted in two counties beginning July 1, 1999. This application is for Medicaid alone, and does not require a face-to-face interview.

The new KidCare application asks whether the child is a US citizen or qualified alien, and requests a social security number for the child, although applications will be processed even where no social security number is provided. It does not ask about the immigration status of the parents. Prior to 1996, the Healthy Kids application did not ask for information about citizenship.

WIC applications are processed separately by the WIC offices, or through presumptive eligibility providers. In the 1998 federal reauthorization of the WIC program, a provision was added to require proof of local residence, such as an electric bill. Although the program always had a local residency requirement, proof has not been required. WIC officials are concerned that immigrants may be deterred by this requirement.

Sponsor Deeming, Affidavits of Support

Florida adopted sponsor deeming in October 1998 for Medicaid for post-enactment

immigrants, although implementation awaits HCFA guidance on the methodology for counting the income of sponsors. Sponsor-deeming does not apply to state and local programs in Florida at this time.

Presumptive Eligibility

Pregnant women are eligible for presumptive eligibility in Medicaid. There has been no change to the application form as a result of welfare reform.

When a pregnant woman applies for Medicaid, the standard one page joint RFA application is used but two shortcuts are allowed: first, the citizenship box does not have to be completed; and second, the application is processed without any supporting documentation based on verbal information from the patient alone. An authorized presumptive eligibility provider is required to forward the presumptive application to the Office of Children and Families within 10 days, and a final determination of eligibility is required within 45 days of the initial application with the presumptive eligibility provider. The presumptive eligibility application triggers an application for all benefits, including cash assistance and Food Stamps. Upon receipt of the application, the Department of Children and Families then contacts the applicant to set a date for a standard Medicaid interview, at which time proof of income, residence and immigration status are required.

At the interview, if the applicant presents valid proof of immigration status, the agency confirms the information with the SAVE system and the application goes forward. Where an applicant's immigration document is expired, the state has directed that the *document* should be considered expired, but not the *status*. Local officials report that this step represents the state's effort to provide some protection to immigrants with invalid documents. This procedure is used with all Medicaid applicants, not only pregnant women. The SAVE system is then checked to determine if the applicant has any valid status that is current. If not, the Department of Children and Families is supposed to refer the applicant to INS. As noted below, however, the Dade County Office has a policy of not referring anyone to INS. Undocumented applicants are denied at the interview stage, except for emergency medical services.

Where a determination is not reached within 45 days, the presumptive status is sometimes maintained and providers may continue to receive reimbursement. Officials report of recent state pressure on local agencies to reach determinations within 45 days.

Although there is no provision for presumptive eligibility in KidCare, pregnant women may pre-apply to KidCare for an un-born child to facilitate the newborn's coverage at birth.

Reporting Requirements

The only time that an agency in Florida is required to report someone to INS is if the worker knows the person is "not lawfully present," as required by PRWORA. Absent issuance of federal regulations implementing this requirement, Florida is interpreting this provision to mean that the

person is under a final order of deportation. Despite fears of rogue workers reporting to INS under the communication provision of PRWORA, there are no reported cases. Dade County reports no pressure from Tallahassee to increase reporting to INS since 1996.

Public Charge Issues

Concerns and confusion about public charge were reported by all informants to be significant in Florida, especially in Dade County with its large immigrant population.

Florida state officials actively sought clarification from the White House regarding the public charge policies, similar to California officials. In late 1996 and 1997, state Medicaid and WIC officials report that INS was aggressively advising both professionals and consumers that use of Medicaid, WIC and other benefits would be used in public charge determinations. On the advice of private immigration attorneys, applicants were seeking to repay benefits but such payments were not accepted by any agencies in Florida. In different regions of the state, advocates report that INS 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 significant chill on use of additional benefits.

The Dade County Department of Children and Families was opposed to providing any information to INS. Nonetheless, where immigration judges were demanding repayment of benefits received as a condition of granting an adjustment of status, upon request by the client, the Department did provide records of benefits received to the judge.[25]

A 1998 court order halted all repayment programs, declaring them to be illegal.

In November 1997, Florida's central WIC agency issued a memorandum to local WIC agencies with interim advice from the United States Department of Agriculture stating that participation in WIC would not be considered in public charge determinations, and that no reimbursement of WIC benefits is required. State officials report that confusion around WIC participation still exists, but has declined since 1998.

In Orlando, advocates report that INS recently raided a county-sponsored SCHIP outreach session for families. Men without immigration papers were taken away by the INS, while women and children were left behind. According to providers, advocates and agency officials, periodic sweeps by INS appear to have lasting repercussions on immigrants' willingness to apply for public benefits or to seek non-emergency health care.

Other Relevant Provisions for Pregnant Women - WAGES, WIC

Florida's 1996 welfare law allows the state to provide services to immigrants to the extent permitted by federal law. Florida's welfare program, WAGES, includes a two-year continuous limit and four-year lifetime limit on cash assistance. Parents of infants up to 3 months are allowed to defer work

requirements. Prior to welfare reform, this exemption existed for parents of children under 3 years. The exemption was sharply reduced apparently based on the rationale that middle class women often return to work at 3 months. Florida introduced a family cap in the WAGES program; cash assistance is increased by 50 percent for the first child conceived while the mother is on cash assistance, but subsequent children warrant no further increases.

Women continue to be eligible for WIC without regard to documentation status.

Affirmative State Legislation Regarding Benefits for Undocumented

Florida imposes no alienage restrictions on state and local benefits, but, as in the other study states, no affirmative legislation has been enacted to expressly affirm Florida's intent to continue benefits for the undocumented, as required by PRWORA.

IV. NEW YORK

A. State Political Environment

Welfare reform arrived in New York State as an unprecedented restriction on immigrants' eligibility for Medicaid and other benefits. Since the beginning of the decade, New York State has provided reimbursement for health care to undocumented pregnant women and children through Medicaid and Child Health Plus, albeit with little advertising due to fears that upstate Republican Senators would seek repeal if they fully grasped the programs' scope.

Despite this persistent concern, support for immigrants often transcends partisan politics and geography. Mayor Giuliani and, to a lesser degree, Governor Pataki are both protective of immigrants' access to public benefits in general and strongly support Medicaid coverage to provide prenatal care for all immigrants. In fact, earlier this year, the State and City joined the plaintiffs' brief opposing the Federal government's motion to vacate the holding of Lewis v. Grinker, which provides Medicaid coverage for prenatal care without regard to immigration status, discussed further below. In addition, both the former Democratic Governor and the current Republican Governor have championed the availability of Child Health Plus coverage for all children without regard to immigration status. New York City's strong immigrant sympathies are reflected in Executive Order 124, discussed further below, which prohibits reporting of aliens to INS by city employees.

Bottom-line considerations evidently factor into City and State support of immigrants, as do political considerations. Governor Pataki's welfare reform proposals provided benefits for 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. Interestingly, while California overall is more hostile to immigrants, California's welfare reform bill is more generous to immigrants and, unlike New York's law, maintains pre-welfare reform Medi-Cal coverage by using state-only funds to replace withdrawn federal funds. Although Republican Governor Pete Wilson proposed restricting eligibility based on the rules for federal matching, the legislature rejected his proposals and enacted more progressive coverage.

New York State legislative sympathies divide along partisan lines and also reflect an upstate-downstate political gap on immigrant issues. In the 1998 Legislative Session, the New York State Assembly restored Medicaid to PRUCOL and future legal immigrants who had lost eligibility in the State's welfare reform act, but the Senate failed to act on the bill and it died. In the current session, the Assembly once again restored Medicaid in their Budget Resolution and allocated $12 million to fund the restoration. While this is likely to be an inadequate allocation, the Senate has shown no indication of support so the issue may be moot.

Several lawsuits have been filed challenging the new restrictions on immigrants' eligibility for benefits. On May 20, 1999, a New York State judge ruled that restrictions on immigrants' access to state-funded Medicaid violates the equal protection clauses of the United States and State Constitutions. In addition, the restrictions were found to violate the "care of the needy" provision of the State's Constitution. The state law, passed in 1997, incorporated the federally-required 5-year bar on Medicaid for post-enactment qualified immigrants. The law granted exemptions for immigrants living in nursing homes or suffering from AIDS as of September 1997. It was this difference in treatment that the court found illegal. The court's ruling restores state-funded medical assistance to individual immigrants who were denied medical assistance because they are PRUCOL, or are lawful permanent residents who entered the country after August 22, 1996.

New York politicians in Washington have been outspoken advocates of restoring Federal benefits to all immigrants. Senator D'Amato and Representative King (R) introduced a bill to extend the Food Stamps and SSI cutoff date in 1997. Most recently, outgoing Senator Moynihan introduced legislation that would represent the largest restoration to date of immigrant health benefits lost under PRWORA. It would give states the option to restore Medicaid benefits to legal immigrants who entered the country after 1996 and Food Stamp eligibility to legal immigrant adults. Governor Pataki, Mayor Guiliani and State and Federal Congressmen have all actively lobbied Congress to repeal the anti-immigrant provisions of the welfare law.

Overall, except for pockets of largely upstate and Republican legislators, New York State is far more supportive of immigrants than California in many ways. There is little chance that anti-immigrant initiatives like California's Proposition 187 would ever muster in New York the centrist support found in California. This is particular true in New York City.

B. State Decisions Regarding PRWORA (Note: Where not provided below, the applicable federal law, regulation or policy is summarized in the California case study.)

Medicaid

New York opted to provide Medicaid to qualified immigrants in the United States before August 22, 1996, which is available with federal financial participation. Qualified immigrants who enter the United States after the date of enactment are subject to the federally imposed 5-year bar on

Medicaid. During the federal 5-year bar, new immigrants are eligible only for emergency medical services, unless federal financial participation becomes available. Nonqualified immigrants, including those who were formerly considered permanently residing under color of law, or PRUCOL, are eligible only for emergency medical services. Refugees, asylees and other protected categories are exempt from the 5-year bar on new arrivals and are eligible for Medicaid in accordance with federal law, which requires coverage for seven years.

Due to the long-standing federal court decision of Lewis v. Grinker, Medicaid eligibility for all pregnant women remains intact, with income levels set at 185 percent of poverty (or 222 percent gross). The state welfare reform law, in fact, references the holding in Lewis v. Grinker. By its terms, PRWORA does not repeal the federal entitlement to health insurance under the Medicaid program for low-income citizens. All non-citizen pregnant women in New York continue to be eligible for Medicaid without regard to documentation status under the holding of the U.S. Second Circuit Court of Appeals in Lewis v. Grinker, 965 F.2d 1206 (2d Cir. 1992). On February 26,1997, the Federal government filed a motion to vacate the existing order. After procedural delays, oral argument was heard on the motion in March, 1999. No decision has been released to date.

The Second Circuit's decision in 1992 was based on its reading of the Congressional intent behind the Medicaid statute. It never reached the constitutional "equal protection" argument, that it would be irrational to distinguish between infants, in utero, who are all US citizens, based upon the alienage of their mothers. The Federal government's motion in 1997 contends that the original order in Lewis must be vacated because the welfare act makes it clear that Congress now intends to deny Medicaid coverage for non-emergency prenatal care to undocumented aliens. The plaintiff's opposing motion asserts first that the Government's reading of Congressional intent is unfounded, that Congress did not intend to overrule the Second Circuit or "to inflict needless lifelong disability and suffering on US citizen children by denying prenatal care to their immigrant mothers." Part of this line of argument is based on the legal premise that Congress -- well aware of Lewis -- would have needed to express its intention to overturn Lewis in order to accomplish that result. The motion's second argument is that "the denial of prenatal care to nonqualified immigrant women who will bear US citizen children violates equal protection."[26] [27]

If the order in Lewis is vacated, New York is likely to continue providing Medicaid coverage for all pregnant immigrants with state funds. During the 1997 state budget negotiations, the New York State Assembly requested a written commitment from the Governor's office stating their support for continued coverage with state funds. While reaffirming the Executive's support for maintaining current eligibility standards for prenatal care, no written assurances have been provided. In the unlikely event that state funds are not made available, newly arrived qualified immigrants will be subject to the 5-year bar on Medicaid, plus sponsor-deeming, and all undocumented immigrants will lose Medicaid eligibility. Coverage for emergency medical services, which includes labor and delivery but not prenatal care, remains available for all immigrants.

Conclusion

Senior officials with the State Health Department indicate that no contingency plans have been developed to respond to the potential withdrawal of federal funds should the order in Lewis be vacated. They are proceeding with business as usual, and anticipate continued coverage, while recognizing that total funds are likely to be reduced if the court case is lost.

Child Health Plus

As described in the California section, PRWORA's restrictions on immigrant eligibility for Medicaid generally also apply to the new State Children's Health Insurance Program (SCHIP), which was implemented through Medicaid and Child Health Plus in New York State.

New York State has provided coverage under Child Health Plus since its creation in 1990 for all income-eligible children without regard to immigration status. New York State plans to continue providing coverage for all children, but will use state-only funds for those children ineligible for federal matching funds. Eligibility for Child Health Plus is at 230 percent of poverty based on gross income, with an increase to 250 percent in the year 2000.

Application Forms

There has been no change to the actual Medicaid application form for New York State as a result of PRWORA, although applicants are now asked for more detailed information to verify their "satisfactory immigration status." The New York State welfare law passed on August 4, 1997. Field training was conducted in the fall, and new systems were up statewide by November 1997, and in New York City by January 1998. Prior to welfare reform, applicants were asked for more general information to establish their status as legal permanent residents or PRUCOL. The proof now required to establish status as a qualified alien in many cases is more detailed.

As part of SCHIP, a joint Medicaid/WIC/Child Health Plus form is being piloted in select regions statewide. This application does request information about immigration status to comply with PRWORA and SCHIP requirements.

Sponsor Deeming, Affidavits of Support

Sponsor deeming, as required by PRWORA for *new* immigrants on Medicaid and other federal benefits, will first take effect in 2001 and implementing guidance from HCFA has yet to be issued. Sponsor deeming does not apply to emergency medical assistance. PRWORA also creates new requirements for sponsorship; sponsors must now be citizens, nationals or lawful permanent residents; 18 years or over; US resident; and have an income which is at least 125 percent of the Federal Poverty Level. Sponsors must also now sign an affidavit of support, now a legally enforceable document, agreeing to financially assist the immigrant.[28]

New York did not opt to require sponsor deeming for state and local benefits, including Child Health Plus, but did enact legislation to permit recovery of expenses from sponsors. The State's welfare law includes a provision establishing sponsor liability. Social services districts can now attempt to

recover any assistance paid to the immigrant by suing the sponsor. The district shall request reimbursement from the sponsor and may commence legal proceedings against any sponsor who within 45 days has not indicated a willingness to make reimbursement payments.

Although not directly on point, an 1992 decision by the New York Court of Appeals in a related context is illuminating. Under federal law, an immigrant sponsor's income was deemed available for three years. The Court held that the New York State Constitution governed, not federal deeming rules, and that if the person was still needy by New York's definition, then New York was required to provide assistance through its state-funded Home Relief program instead of AFDC. Article XVII of the New York State Constitution provides the following:

> The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine (Section 1).
>
> The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine (Section 3).

Courts in the future are likely to continue relying on the New York State Constitution to hold New York to a higher standard of aid than that provided by the Federal Government.

Presumptive Eligibility

No changes to use of presumptive eligibility for Medicaid in New York have occurred as a result of welfare reform. The form continues to make no reference to the immigration status of applicants, nor does it request social security numbers. Presumptive eligibility as implemented by Prenatal Care Assistance Providers is considered a critical access point for pregnant immigrants and other women.

Reporting Requirements

PRWORA requires agencies that administer SSI, housing assistance or TANF to report quarterly to the INS the names and addresses of individuals who are "known to be not lawfully present." It is still unclear how this provision will be implemented, but the language of the law appears to be subject to interpretation at the state level in ways that could preserve some confidentiality. For example, Florida is interpreting this provision to only refer to immigrants under a final order of deportation. New York officials are waiting for HCFA guidance on this issue.

New York State's welfare law requires local social service districts to report to the state Office of Temporary and Disability Assistance (formerly DSS) the name, address and other identifying information concerning individuals known to be undocumented immigrants in the United States. A public assistance administrative directive, 97ADM-23, from the State to local social services districts, dated October 30, 1997, implements the provisions of state welfare reform. Among other provisions, it

requires monthly reporting from local districts to the State, and indicates that information provided to the State will be forwarded to the Federal government.

To date, the State has informed counties that no reporting of Medicaid applicants is required. While the Medicaid administrative directive on the alien provisions of welfare reform has not yet been issued, information on Medicaid implications of welfare reform is included in the public assistance ADM and provides that "alien status is never a factor of eligibility for pregnant women."[29]

Note: Discussion of PRWORA's communication provision and New York City's Executive Order 124 is presented below in the section under "Local Implementation Decisions."

Public Charge Issues

The issue of public charge has received less attention in New York than in California, but is still a factor that has deterred immigrants. Several years ago, the United States Department of State asked New York for assistance in identifying immigrants who had received public assistance in a program called "Embassy Match." According to state officials, names of individuals were only provided in cases of fraud, or where recipients were deemed ineligible due to improper reporting of assets. The program was eliminated this year.

Other programs include apparently small scale efforts by the Justice Department to recoup payment from immigrants. New York State's position has been that prenatal care is not subject to repayment if enrollees are otherwise eligible, but the State acknowledges one case of recoupment from a pregnant client of a Prenatal Care Assistance Program. The State is currently withholding issuance of the Medicaid administrative directive outlining the alien-related provisions of welfare reform pending clarification from the Federal government about public charge issues.

Other Relevant Provisions for Pregnant Women - TANF, WIC

All TANF recipients in New York State are required to work within two years of receiving benefits, except parents of infants under three months and pregnant women in their ninth month. New York State did not impose a cut in benefits (a family cap) for children born into public assistance households, opted to continue WIC without regard to documentation status, requires single teen parents without a high school diploma to seek one, and exempts domestic violence victims from work and other requirements. Families of drug users who fail to participate in mandatory screening, including children, lose TANF cash benefits but continue to be eligible for Medicaid and non-cash safety net assistance.

V. TEXAS

A. State Political Environment

The social service safety net in Texas is one of the weakest nationwide, with stronger political support for health care than welfare. In recent years, Texas has experienced little of the heated and divisive debate that surrounded enactment of Proposition 187 in California. Governor Bush is

considered a moderate on immigrant issues, and most statements by the state's political leadership have favored legal immigrants.[30] Political support for immigrants is generally perceived to be stronger where budget impacts are minimal.[31] Texas, like most other states, opted to continue federal benefits for immigrants in the country before 1996, and Governor Bush, State Senators and others lobbied Congress to restore federal benefits for legal immigrants who lost eligibility in PRWORA. At the same time, however, it remains unclear whether Texas will provide Medicaid benefits to post-enactment immigrants after the 5-year bar, despite the availability of federal matching funds. Public expressions of support, thus, are tempered by quiet adoption of anti-immigrant policies in some cases.

California's Proposition 187 had a big impact on immigrants' perceptions of their eligibility for services in Texas, but little impact on government policy. Despite lobbying by California Medi-Cal officials, Texas declined to undertake collaborative public charge lookout policies with INS. The Mexican-American legislative caucus is increasingly "flexing its political muscle," according to one policy analyst; in San Antonio, for example, they helped defeat an initiative to eliminate subsidies for health care for the undocumented. It is considered politically risky to oppose low cost pro-immigrant initiatives since state and local political power is increasingly held by Mexican-Americans.

An Austin-based observer of the political process states that "you cannot underestimate the political significance of having a Governor who is running for President, and his desire to take on certain symbolic positions. At the same time, you cannot underestimate the Governor's desire to keep his fingerprints off of everything except tax breaks." As a result, there is little overt leadership from the Governor's Office today on health or other issues. This may help explain, in part, why Texas did not take a higher profile in the area of public charge - as a matter of state policy, Texas contrasts with California because it did not formally adopt a public charge lookout program, nor did it aggressively seek clarification of federal policy to halt abuses. The limited evidence available suggests that the chilling effects associated loosely with welfare reform were less significant in Texas than in California or Florida. At the same time that immigrants enjoy moderate political support in Texas today, the treatment of immigrants in Texas has become significantly harsher by the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996, as explained further below.

Finally, prenatal care is described by advocates as having little political visibility in Texas today. Few individuals or organizations are available to champion the needs of low-income pregnant women, especially immigrants. In contrast, support for prenatal care was strong enough to establish Medicaid eligibility at the surprisingly high level of 185 percent in 1990-1991, under the leadership of the last Lieutenant Governor, Bill Hobby, who was viewed as having a commitment to health and human services. The expansion was not enacted with legislation at that time, but funds were simply inserted in the appropriations bill. Providers are the strongest base of support for prenatal care, and the cost-effectiveness of prenatal care is an accepted rationale. The proposed SCHIP legislation in the 1999 session excluded reproductive health care including prenatal care. According to advocates, prenatal care may have been too quickly sacrificed on the altar of building support for CHIP among powerful pro-life conservatives opposed to inclusion of any reproductive health services. The bill was amended in

the final hours "to exclude reproductive services other than prenatal care and care related to diseases or abnormalities of the reproductive system."[32] Coverage of delivery services remains unclear, but family planning benefits and abortion are excluded in all cases.

B. State Decisions Regarding PRWORA (Note: Where not provided below, the applicable federal law, regulation or policy is summarized in the California case study.)

Texas expeditiously implemented PRWORA's restrictions on Medicaid eligibility for immigrants in the month following enactment, September 1996. The three other study states implemented these provisions between one and two years later.

Medicaid

Like all states except Wyoming, Texas opted to provide Medicaid to pre-enactment qualified immigrants.[33] Texas is one of only six states that, to date, has opted to extend the ban on Medicaid for post-enactment qualified immigrants until citizenship, rather than limiting it to the five years after entry into the United States.[34] This decision is contained in the State's TANF Plan submitted to HCFA, was not approved by the Legislature, and may be revisited by Health and Human Services Commissioner Don Gilbert, who was appointed by Governor Bush after the Plan was filed. Proponents of a permanent ban suggest that new immigrants came to Texas knowing they would not be eligible for any benefits and so none are owed to them. It is unclear whether Commissioner Gilbert will succeed in convincing the Administration to join the majority of states and restore benefits after the 5-year bar.

Texas has not created a state-funded Medicaid or other health program to replace Medicaid for post-enactment qualified immigrants and pre-enactment PRUCOLs, who lost eligibility in PRWORA. Undocumented immigrants were and continue to be ineligible for Medicaid, except for emergency medical services including labor and delivery. Medicaid eligibility for pregnant women and infants up to one year of age is at 185 percent of poverty without any resource test, in contrast to the low eligibility level of 25 percent of poverty for other adults.

Title V

Texas continues to provide prenatal care to all women below 185 percent of poverty without regard to immigration status through Title V, the Maternal and Child Health Services Block Grant. As noted in Section I(B) above, Title V benefits are not subject to PRWORA's immigration restrictions. Although Title V is used by many states for infrastructure support, in Texas it supports direct services including prenatal care. Applicants simply are required to be residents of Texas, and the Title V Policy Manual for Texas states that self-attestation of all requirements is satisfactory proof. Delivery services are not covered by Title V. In Austin, however, application requirements for Title V programs are stricter than required by Title V due to an integrated eligibility system, as explained in section C below.

In 1990, Title V prenatal clinics began preparing emergency Medicaid applications for their

clients 30 days before the expected date of delivery to assist hospitals obtain Medicaid reimbursement for deliveries.

SCHIP

The Texas State SCHIP Plan, submitted in March 1998, expands Medicaid eligibility for children ages 15-18 up to 100 percent of poverty. Currently, Medicaid covers children ages 15-18 up to 25 percent of poverty, ages 6-14 up to 100 percent of poverty, ages 1-5 up to 133 percent of poverty, and pregnant women and infants under 1 year of age up to 185 percent of poverty.

On May 28, Governor Bush signed SB 445, Texas' new SCHIP law. The new program will be available to uninsured non-Medicaid-eligible children in families up to 200 percent of poverty. The program includes all legal immigrant children, using state tobacco settlement funds for those excluded from federal funding. As noted above, Federal law requires that SCHIP coverage be available to legal immigrant pre-enactment children on the same terms as citizen children. Children who arrived after that date are subject to the 5-year bar from SCHIP, after which federal law once again requires states to include them. Only legal immigrant children who are in the 5-year bar period are excluded from federally-funded SCHIP and covered with state funds in Texas.

The state law further provides that if Congress gives states the option to lift the 5-year bar on Medicaid and CHIP for post-enactment legal immigrants, Texas will exercise that option and draw down the usual federal matching funds for these children. According to advocates, this provision was included because the Governor is not expected to support such benefits for immigrants in the event that federal law is changed. In the Texas legislature, however, federal matching funds create sufficient incentive to overcome anti-immigrant concerns; there is a 74-26 percent federal/state match for SCHIP in Texas. The law allows deductions from income for child care and work-related expenses and allows the Texas Health and Human Services Commission to adopt 12-months continuous eligibility.

Family planning and prenatal care services were excluded in the State's SCHIP Plan and the proposed SCHIP legislation. Reproductive health care was seen as a stalking horse for the right. In order to increase political support for the SCHIP bill, reproductive health services were eliminated by making it clear that the bill was not about helping kids have abortions or babies. Somewhat surprisingly, however, the bill was amended in the final hours to provide that primary and preventive benefits may not include reproductive services *other than prenatal care* and care related to diseases or abnormalities of the reproductive system. Family planning benefits and abortion are excluded, and it is not clear whether delivery services are covered, since the restriction is limited to "primary and preventive benefits."

Application Forms

There has been no change to the Texas Medicaid application form as a result of welfare reform. However, when legal immigrants are asked for a document to establish their status, as was done prior to welfare reform, the date of their entry is obtained and used to determine eligibility under the new guidelines. A joint Medicaid, TANF, Food Stamps 4-page form continues to be used for pregnant

women, who are not required to answer some questions, including those about eligibility for Food Stamps and AFDC, and other resources. Applicants are asked for information about their immigration status and social security number, and for such information about anyone who lives with them.

Sponsor Deeming, Affidavits of Support

As required by PRWORA, Texas will require sponsor deeming for new immigrants who apply for Medicaid. As in Florida, this decision has had little impact to date; implementation of deeming awaits HCFA guidance and most immigrants will not be subject to sponsor deeming until 2001, when the first five-year Medicaid bar expires. While considered unlikely by state and local officials, it remains unclear whether sponsor deeming will be adopted for the few state and local benefits that do exist, such as the County Indigent Health Care Program.

Presumptive Eligibility

Although presumptive eligibility was adopted in the early 90s, it is not used in Texas for reasons that are not entirely clear. Before Medicaid managed care, all presumptive eligibility providers were safety net providers. They had little incentive to comply with additional requirements, such as special provider numbers required to be approved presumptive eligibility providers, since Texas provides for three months of retroactive eligibility in Medicaid. However, this retroactive eligibility does not ensure reimbursement for women who are ultimately determined to be ineligible. For pregnant women, presumptive eligibility is less valuable than, for example, in New York, since a face-to-face interview with Medicaid is still required.

Reporting Requirements

State officials report that PRWORA's requirements that TANF agencies report "individuals they know are unlawfully in the US" is being interpreted by Texas to refer only to aliens under a final order of deportation. For years, Texas has used this standard to interpret immigrant eligibility for Food Stamps. IRRIRA requires new verification of the immigration status of all applicants for benefits, but implementing regulations have not yet been issued. Statewide, there are no reported changes in reporting requirements at the state level by any agency regarding immigration status, and no new requirements to verify the immigration status of applicants for federal, state or local benefits.

Texas state policy continues to be that reporting to INS will only occur in cases of welfare or Medicaid fraud, based upon information provided by SAVE. Individual cases of DHS caseworkers improperly threatening Medicaid applicants occasionally surface, but the extent of the problem remains unclear.

Public Charge

In contrast with California, Texas officials have been less aggressive about both seeking repayment of benefits from returning immigrants, and urging the federal government to clarify the standards for public charge. The issue came to a head during 1997, when the Office of Program Integrity in the Department of Human Services (DHS) was most active in investigating alleged cases of

fraud, and urged DHS to share lists of people receiving benefits with INS. During that year, representatives from California's Medi-Cal fraud office came to urge Texas' DHS to collaborate with INS as California was doing with their Public Charge Lookout Program. DHS requested clarification from Washington and determined that confidentiality rules precluded sharing information with INS and consulates. While Texas was in discussions with INS about participating in the Public Charge Lookout Program, there was never an official state policy in Texas to request repayment at the borders.

In 1997, individual consular officials at the Mexican border were detaining Mexican immigrants returning to Texas and demanding repayment of benefits they had legally received. State officials report the following case: a doctoral student and his wife, when asked by the consulate whether they had ever used public benefits, truthfully replied that Medicaid had paid for the delivery. They were detained at the border until they repaid the costs of the delivery, which they were able to borrow from the student's professor. This kind of enforcement was most prevalent at the Juarez consulate, which is at the border across from El Paso. During this time period, Texas' DHS received many phone calls from clients asking how they could repay their Medicaid benefits. DHS asked clients to submit their requests in writing, and provided the requested information but refused to accept any payments from clients.

These policies were halted in December 1997 when federal guidance was issued that no state was permitted to ask legal permanent residents for repayment of benefits used, and that no questions were supposed to be asked about their use of public benefits if they were out of the country for less than 180 days.

As described in further detail in the section on hospitals below, a handful of border hospitals have gone to the extreme measure of sharing information about patients with INS and contracting with collection agencies in Mexico in an attempt to slow their declining Medicaid revenues, which have resulted in part from welfare reform. Other health care-related enforcement efforts are found in the Rio Grande Valley, where most residents are referred to Galveston for needed medical care. Intensified INS patrols on the one road connecting the Valley with Galveston have barriers to health care, according to health care providers and advocates.

Stories about requested repayments in California and the individual incidents in Texas have spread quickly through immigrant communities. All study informants believe that concern about public charge continues to be the most significant deterrent to use of health and other benefits. An outreach worker at a community health clinic reported that Adriana Luzon, a pregnant woman previously seen at the clinic, is *currently* refusing to seek treatment for vaginal bleeding because she does not want to jeopardize her pending application for citizenship. (In fact, the public charge test applies to applications for permanent legal residence but does not apply to naturalization applications.) She is married to a US citizen, and applied for citizenship over 12 months ago.

With the new and long-awaited federal clarification of public charge, immigrant communities are likely to be more willing to access benefits. Follow-up interviews will examine the impact of this new

policy on immigrant health-seeking behavior.

IIRIRA

The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 imposes new restrictions on immigrants, increases the enforcement authority of INS, and significantly expands the definition of criminal aliens and the crimes for which they can be deported. The law represents a shift away from interior and benefits-based enforcement to border enforcement, as demonstrated by the following statistics; the number of illegal immigrants apprehended at work sites in Texas dropped from 311 in June 1997 to only 17 in June 1998.[35] At the same time, more people are being deported, with the majority from El Paso and San Diego; in 1998, 171,154 people were deported, an increase of 50 percent from 1997.[36]

In a study conducted by the Center for Immigration Research, four provisions of IRRIRA were found to have had a major impact on immigrant communities in Texas border communities: first, the expanded definition of "criminal aliens" and "aggravated felonies" for which immigrants may be deported; second, the new limitations on appeals for people accused of committing immigration-related crimes; third, mandated detention of asylum seekers, criminal aliens and those accused of immigration-related crimes; and fourth, the strengthened sponsorship requirements for family-based immigration, including the requirement that sponsors sign a legally-enforceable affidavit of support.[37] These provisions have resulted in harsher treatment of immigrants with fewer opportunities for review of decisions by individual INS officials. The study finds that "immigration officials have quietly begun denying entry to, deporting, and detaining thousands of people with few checks and balances on their decisions."[38]

Other Relevant Provisions for Pregnant Women - TANF, Medicaid Managed Care

Texas enacted welfare reform in 1995 with slightly less restrictive provisions than PRWORA, and no restrictions on immigrants' eligibility, which only became federally permissible in 1996. Pregnant and parenting women are subject to TANF work requirements, unless they apply when they have a child under the age of four. Texas has not adopted a family cap on cash assistance, so benefits increase with the birth of a child.

An unintended but significant consequence of Medicaid managed care in Texas is an 8-10 week delay in entry into prenatal care; pregnant women have to go through the process of applying for Medicaid, enrolling in managed care, selecting or being assigned to a plan, and then selecting or being assigned to a primary care provider. This delay is partially due to incompatibility between Medicaid and managed care systems. Pending legislation would force a fix by requiring the first prenatal care visit within 30 days of applying for Medicaid. Similar problems exist with enrollment of newborns, particularly for infants of undocumented mothers.

VI. Conclusions

KEY FINDINGS

With the introduction of multiple new variables into the Medicaid eligibility equation as a result of welfare reform, a chilling effect was predicted. The indirect consequences of welfare reform, it is argued, were likely to create new and unintended barriers to prenatal care. Both the terms of the new laws and people's beliefs about what they provide could affect the way that pregnant women obtain health care and other needed services. Results from the first year of case studies both affirm these predictions and add new dimension. Key findings, as described below, are that eligibility alone does not define access; that other programs have at least partially replaced Medicaid coverage where it was withdrawn; that the mentality of welfare reform created barriers to care beyond statutory changes in eligibility; and that the complexity of welfare reform's restrictions on immigrant eligibility may in fact exceed the doable.

Eligibility Alone Does Not Equal Access

To date, New York and California have maintained Medicaid coverage for prenatal care for all pregnant immigrants, each for distinct reasons. Federal enactment of welfare reform unquestionably re-inspired California's Governor Wilson to seek immediate repeal of the state's funding for prenatal care for undocumented immigrants. It also triggered the federal government's challenge to the protective order in Lewis v. Grinker in New York State. Notwithstanding these effects, coverage remains unchanged at this time.

Thus, to the extent there have been declines in prenatal care use by immigrants in New York and California, as suggested by limited data and anecdotal evidence, these declines have not stemmed from eligibility changes but from the *mentality* of welfare reform, including attempted withdrawals of eligibility, the aura of lost access and public charge policies. In addition, attempts to curb prenatal care in California -- Wilson's attempted repeal of state funding which languishes in the courts -- and New York-- the federal government's motion to vacate the existing order in Lewis, may by themselves have increased fears among immigrants about seeking prenatal care. In California, the long and tortuous path of attempts to eliminate the state's prenatal care program for undocumented women received significant attention. In New York, the drawn out litigation in Lewis was not covered by the media but communities were nonetheless informed of challenges to the court's decision.

While it is difficult to quantify the impact of attempted withdrawals of eligibility, public charge concerns, and the aura of lost access, it is clear that eligibility alone does not define access. Rather, access to care is the product of multiple factors, none of which exist in isolation. Changes in eligibility at the statutory level, unsuccessful efforts to change eligibility, facilitated enrollment processes like presumptive eligibility, media coverage of INS raids -- are all relevant factors that influence access.

"Replacement Benefits" Vary in Scope

In contrast to New York and California, Florida and Texas did not opt to use state funds to replace federally withdrawn Medicaid eligibility for post-enactment legal immigrants for 5 years. Moreover, Texas has indicated that Medicaid may not be restored after the 5-year bar.

In both states, notably, other programs exist to at least partially replace the lost Medicaid coverage for pregnant immigrants. In Texas, pregnant women remain eligible for Title V-funded prenatal care services without regard to documentation status. For those women who identify a Title V-funded source of prenatal care, there is no actual decrease in the benefit provided. In fact, the application process for Title V is easier to complete than the Medicaid process. Title V is not, however, an entitlement like Medicaid and Title V funds are reported to be inadequate to meet current demands. If demand increases when immigrants newly ineligible for Medicaid show up on the Title V doorstep, women may have to be turned away.

In Florida, all pregnant immigrants continue to be eligible for Medicaid through the presumptive eligibility process for 45 days of the prenatal period. Presumptive eligibility, in effect, is a loophole which diminishes to some extent the impact of welfare reform's restrictions on immigrants' eligibility for Medicaid. Nonetheless, although some women remain on the Medicaid rolls for longer than 45 days due to system inefficiencies, this time-limited coverage does not come close to fully replacing the lost Medicaid coverage. Other pieces of the safety net available to pregnant immigrants in Florida are equally limited in scope due primarily to funding limitations. Public health department clinics, where they continue to provide prenatal care, and federally qualified health centers, where they exist, have long waiting lists. Likewise, demand for Healthy Start services exceeds funding available. To a greater degree in Texas than in Florida, replacement benefits have the potential to absorb some but not all of the withdrawn benefit.

The Mentality of Welfare Reform

Contrary to what might be expected, based on anecdotes and the limited data available, there is no greater evidence of decreased access to prenatal care in Florida and Texas, where Medicaid eligibility has been withdrawn, than in New York and California, where eligibility remains unchanged. In all four states, the *mentality* of welfare reform and confusion surrounding public charge issues appear to have been the primary factors leading to whatever decrease occurred in access to prenatal care among immigrant women. Shifting sands and patchwork policies have contributed to a climate of uncertainty among immigrants and service providers alike.

Lost in the Web: Implementation Challenges

Some of the lessons that emerge from this case study relate to the process of creating public policy. The withdrawal of Medicaid and other benefits from selected immigrant groups in welfare reform and the incremental restoration of benefits through multiple acts has created a complex and fluid eligibility web. This web is difficult to understand, limiting the ability of patients, providers and government officials to effectively navigate the system. Dividing patients into qualified, super qualified, nonqualified, post-enactment, etc., may be stretching beyond what is understandable or practical.

A common theme expressed by some informants in each category from all states is that the complexity of welfare reform may exceed the doable. As noted by a high-ranking state official,

"Complexity frustrates the intention of the (welfare reform) law. It is too hard to follow." As a result, the eligibility and other provisions are neither well understood nor applied evenly. On the other hand, a more cynical perspective expressed by one health policy expert suggests that the underlying, albeit rarely stated, intent of many legislators in enacting PRWORA was exactly that — to reduce the number of people receiving public benefits by creating a complex web of eligibility that few could successfully navigate.

Or is welfare reform simply one example among many of the transformations that occur between enactment and implementation of any piece of legislation? In the words of a seasoned state health analyst, "Legislation never has the intended effect, especially where it is targeted at poor people and health. Legislating is an imprecise business, an imperfect science...They know what we know, you can't trust the government."

OTHER FINDINGS

In addition to the conclusions above, the following observations emerge from the first year case studies.

Cost Shift to States and Counties

Overall, there is consensus that PRWORA's reduction of federal responsibility for immigrants will result in an unprecedented cost shift to the states. The costs of new restrictions on Medicaid eligibility of immigrants will initially be absorbed by states, counties or providers. Some states will transfer liability for the costs to localities, which may shift liability onto public hospitals and other safety net providers. In California, state decisions on Medicaid eligibility suggest that the state is likely to absorb much of the cost shift, given recent indications of Governor Davis' support for prenatal care for the undocumented. However, due to public charge issues and perceptions of ineligibility, some of the costs will in turn be shifted onto counties and providers for those patients unwilling to apply for Medi-Cal. A similar cost shift onto counties and providers is likely to occur in Florida for these same reasons and due to the withdrawal of Medicaid eligibility.

The Federal government's efforts to vacate Lewis, if successful, will result in a cost shift from the federal government to the state or local districts for post-enactment qualified and all undocumented pregnant immigrants. Most deliveries, however, will remain eligible for emergency Medicaid coverage, with the exception of scheduled caesarean section deliveries. It is thus primarily the costs of prenatal care that will be shifted onto the state, counties or individual providers.

In Texas, however, if newly ineligible Medicaid patients access Title V services for prenatal care, this will result in a cost shift from the federal government to the state for the following reason. In Texas, Title V draws a lower federal match rate than Medicaid, which has a 62/38 percent federal-state match for direct services. In contrast, the baseline Title V required match is a 58/42 percent federal-state match; in addition, the state is required to maintain 1989 funding levels which results in a higher allocation of state dollars in relation to federal funds.

Confounding Variables - Managed Care, Shifting Sands

Immigrants' reluctance to use Medi-Cal in recent years, documented in recent reports from The Urban Institute, has been described as inspired by the *mentality* of welfare reform but not the *terms* of the law, which maintained eligibility for most immigrants by using state funds to replace withdrawn federal funds. Beginning with Proposition 187 in 1994 and continuing with border repayment programs, it is difficult to isolate the impact of welfare reform from other factors. Federal laws and state implementation of them are a moving target, with new provisions under consideration at most times. Ongoing and multiple court challenges to state policies contribute to confusion. For example, Wilson's efforts to repeal the state-funded pool for prenatal care for undocumented immigrants created a thick paper trail from the state to the counties, with memorandums alerting counties to the elimination of the program, followed by clarifying letters notifying them of the injunction. In turn, consumers have been informed of the shifting sands by advocates, providers and county health departments in some cases.

In addition, the increasing penetration of managed care is identified as a major force in all four states, with consequences that can amplify or mask the impact of welfare reform. For example, the unexpected increase in unreimbursed deliveries in Miami's public hospital in the year following welfare reform apparently was caused by one or all of the following factors: an increase in immigrants ineligible for Medicaid; an increasing reluctance on the part of immigrants to apply for Medicaid due to public charge; or an increase in out-of-network deliveries denied reimbursement by managed care plans.

In this environment, it may not be possible to distinguish the impact of welfare reform from other related forces. Fewer variables are at play in the other states, but the same challenges exist given the complexities of welfare reform itself and the fluid federal statutory and regulatory framework regarding public benefits for immigrants.

Reaching Communities

Many credit effective outreach by advocates and providers with pregnant immigrants' apparent willingness to seek health care. An ever-changing set of eligibility and program rules has led to heightened confusion and fear during different times over the past five years, after which most sources reported a return to prior levels of utilization. For example, community health workers in Texas report that immigrants stay behind shut doors in the weeks and months following an INS raid. After some time, they again become willing to seek help from community workers, and with time, some seek government support as well. In California, hospital eligibility workers and advocates report that lawyers advised clients to stay away from public services in 1997 due to public charge concerns. After some time, some advocates and providers report that concerns abated and patients were again willing to apply for Medi-Cal. As rules regarding immigrants' eligibility for public benefits become more complex and fluid, there is an ever-growing need for advocates who can translate the rules for the communities affected by them. Invigorated funding for health-based advocacy is critically needed to ensure patients' access to care.

Independent Silos

Despite widespread reports that immigrants are staying away from prenatal care and other health care due to concerns about public charge issues or fears of new reporting requirements to INS, there is little quantitative evidence to date regarding maternity care. This not to say that data prove that welfare reform had no impact on maternity care, but that few analyzes have been undertaken. To some extent, the four categories of informants -- state and local health and social service commissioners, hospital CFO, chairs of obstetrics, and policy analysts/advocates -- exist as independent silos, with different sources of information contributing to different perceptions of the issues. This underscores both the limitations and strengths of qualitative data in capturing the complexities of any reality.

Public Charge

It is safe to say that less change than was expected has occurred as a direct result of welfare reform, and more change has resulted from the invigorated and often illegal application of public charge policies in the years immediately following welfare reform. Although the two are distinct initiatives driven by separate forces, welfare reform is described as having provided a new "platform" for public charge policies. In all four states, public charge concerns are uniformly identified as the single most important deterrent to immigrants' use of benefits and health care.

Application of the public charge policies has varied greatly both within and across states. Individual officials have "quietly denied entry to, deported, detained and requested repayment from thousands of people with few checks and balances to their decisions."[39] Some immigrant communities have gone underground, fearful of accessing services to which they may be legally entitled. California is notable for being the only state to establish formal and widespread public charge payback programs with one hand and, at the same time, to aggressively seek federal clarification with the other hand. Advocates and providers report of a "spill-over" effect from California's policies onto immigrants in the other states, especially Texas. Reports of incidents in California spread quickly to create fears in other states. Neither Texas nor Florida engaged in collaborative ventures with INS, although in both states, there were widespread misinformation campaigns by INS and nearby consular offices. In New York, application of the public charge doctrine appears to have been the least prevalent, although community concerns were reportedly high nonetheless. Collaborations between Medi-Cal and INS raise important concerns about how to ensure the safety of using public benefits in the future.

With the recent and long overdue federal clarification of public charge policies, immigrant communities are expected to enroll in larger numbers in public benefit programs including Medicaid. It remains to be seen whether the new policy will be implemented uniformly and effectively by the various government agencies responsible for its implementation. Other questions, however, remain regarding verification requirements under illegal immigration reform that may compromise the confidentiality of immigrants' use of a wide range of services.

Greater Impact on Immigrants in Mixed Families or Those Seeking Legal Status

Both PRWORA and the climate of welfare reform appear to have had a greater impact on immigrants seeking legal status than on illegal immigrants. Medicaid eligibility has been newly withdrawn from legal immigrants alone in Florida and Texas, the two states where changes were made. In contrast, Medicaid eligibility of undocumented immigrants remained unchanged in those states. In all four states, public charge policies by definition only applied to immigrants seeking legal status. As a result of welfare reform and its climate, these legal immigrants face new barriers to care while the undocumented continue to access prenatal care through specific clinics or programs that were and are available for the uninsured and/or undocumented immigrants. For example, the Urban Institute's Los Angeles study found a smaller decline in Medi-Cal enrollment among citizen children of undocumented parents than among citizen children with legal immigrant parents.[40] Similarly, in El Paso, where large numbers of pregnant immigrants were already operating outside the established health care system, welfare reform had little if any impact on their access to and use of lay midwifery services.

Is Pregnancy Different?

One question for further analysis is whether use of health services by immigrants is likely to be different during pregnancy than at other times. Do immigrant women have different motivations to overcome public charge and other barriers during pregnancy than at other times? Does the knowledge that they will deliver in a hospital create a willingness to have earlier contact with the health care system? Do special programs for pregnant women like presumptive eligibility and outreach programs actually work and increase women's willingness to enter care? Answers to such questions may be needed to determine the relevance to pregnant immigrants of lessons learned from broader national studies on immigrants' use of public benefits in the years following welfare reform.

Parallels and Divergences

Nationwide, about 7.5 percent of Medicaid enrollees were noncitizen immigrants in 1994, compared with 12.6 percent in New York, 24.9 percent in California, 6.8 percent in Florida and 5.5 percent in Texas.[41] Nationwide, use of Medicaid among noncitizen households fell more sharply (22 percent) between 1994 and 1997 than among citizen households (7 percent).[42] Between 1995-1996, AFDC/Medicaid participation by nondisabled adults and children declined in all four states: 3.2 percent decline in California, 4.4 percent decline in New York, 7.4 percent decline in Florida and a 7.9 percent decline in Texas. Declines in noncash-related Medicaid groups were much smaller. Welfare caseloads fell much further in 1997, and Medicaid rolls are expected to follow.[43]

California and New York - Given the high percentage of Medicaid enrollees who were noncitizens in 1994, California and New York are likely to be disproportionately affected by PRWORA's immigration changes. The impact will appear slowly, as immigrants newly entering the US will be ineligible for benefits. If immigration continues at past rates, then a large portion of new entrants will be uninsured and ineligible for Medicaid, which could impose large costs on the states and localities in which they reside as well as on the immigrants themselves.

As noted above, Medicaid eligibility for pregnant immigrants has remained intact in both

California and New York, and in both states, eligibility is the subject of ongoing litigation. The social and political context, however, is markedly different in each state. In California, Proposition 187, active public charge payback border programs and an anti-immigrant former Governor have all contributed to a hostile environment, with documented and dramatic drops in immigrant enrollment in Medi-Cal and TANF. In New York, welfare reform was the first and only anti-immigrant initiative; all elected leaders have been outspoken opponents of the new immigrant restrictions.

The question now, then, is whether a state's social and political sentiments towards immigrants affect pregnant immigrant's access to and use of services? Reports from advocates and providers indicate that women were scared away in both states, but more so in California due to public charge issues, and presumably the generally hostile context. In both states, however, outreach efforts appear to have been successful at bringing women back for prenatal care and delivery services, with the most intensive efforts undertaken in California, although additional quantitative and qualitative data are needed to definitively draw this conclusion.

Texas and New York - In both states, benefits are "quietly" being provided to the undocumented through Child Health Plus and PCAP in New York, and through Title V in Texas. In both states, there is little if any broadcasting of undocumented immigrants' eligibility for fear of alerting legislators who might revoke eligibility if they became fully aware of existing provisions. These policies are contributing to public and professional uncertainty regarding immigrant eligibility for the programs involved. Absent a better alternative, immigrants and those who serve them in Texas and New York continue, with varying degrees of success, to rely on informal channels of communication.

California and Texas - The political environment toward immigrants is significantly different in Texas and California, with more support for immigrant health issues at the political level in Texas than in California. This difference is partially explained through the following statistics: Latinos represent a majority in only 1 out of 58 counties in California, but in 32 out of 254 counties in Texas. These counties are concentrated in Southern Texas. This difference can also explained by the political culture of Texas; the Lone Star state identifies with an independent "live and let live" spirit. Significant linkages between the economies of Mexico and Texas also make aggressive anti-immigrant positions like those held by former Governor Wilson less likely to prevail in Texas.

ENDNOTES

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1. "Judge Overturns State Law Limiting Medicaid Benefits for Needy Immigrants," The New York Times, May 19, 1999.

2. Angelica O. Tang, Executive Director, NYC Mayor's Office of Immigrant Affairs & Language Services, presentation at Children's Health Insurance for Immigrant Families Conference, Children's Defense Fund, June 25, 1999, New York City.

3. "California Governor Ends Fraud Program Targeting Immigrants," Los Angeles Times, May 4, 1999.

4.Yin R 1989. Case Study Research: Design and Methods. Beverly Hills, Calif.:Sage.

5. "Qualified aliens" are permanent residents, asylees, refugees, parolees, people whose deportation is withheld and people granted conditional entry. A subgroup of qualified aliens are not subject to

PRWORA's restrictions on eligibility for federal aid; these are refugees, asylees, veterans and their immediate families, and those with forty quarters of Social Security eligible employment. Most people will not qualify under this subgroup. All other non-citizens fall into a "nonqualified" class which makes them ineligible for Medicaid (except emergency care), TANF, and most federal means-tested benefits.

6. August 4, 1998 Federal Register, Vol. 63, pages 41567-41661.

7. "Immigrant Care: A Renewed Push to Restore Benefits,"American Health Line, April 14, 1999.

8. "Public Charge" Fact Sheet, INS Field Guidance, May 25, 1999.

9. "Definition of Public Charge in Immigration Laws," Notice of Proposed Rulemaking, Department of Justice, Federal Register, May 26, 1999.

10. "Welfare Reform and Its Impact on Medicaid: An Update," Issue Brief No. 732, National Health Policy Forum, The George Washington University, Washington D.C., February 1999.

11. "Judge Nullifies Most of California Immigrant Law," The New York Times, March 19, 1998.

12. Only one state opted not to provide Medicaid to pre-enactment immigrants, while six states indicated that they would not provide Meicaid to post0-enactment im igrants after the five-year bar (Virginia, Oregon, Ohio, Idaho, Mississippi and Wyoming). Wendy Zimmermann and Karen Tumlin, "Patchwork Policies: State Assistance for Immigrants under Welfare Reform." Occasional Paper Number 24, page 25, The Urban Institute, 1999.

13. "Governor Davis Wants $60 Million for Prenatal Care," Los Angeles Times, March 1999.

14. Lynda Flowers-Bowie, "America's Newcomers: Access to Prenatal Care for Unauthorized Immigrants. Challenges for States." National Conference of State Legislatures, May 1997.

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17. "Public Charge." National Immigration Law Center, July 1997.

18. Claudia Schlosberg and Dina Wiley, "The Impact of Public Charge Determinations on Immigrant Access to Health Care." National Health Law Program and National Immigration Law Center, May 22, 1998.

19. "Public Charge" Fact Sheet, INS Field Guidance, May 25, 1999.

20. “Makeshift Pharmacies Are Dispensing Death,” The New York Times, March 29, 1999.

21. Jacqueline Hagan, Nestor Rodriguez and Randy Capps, “Effects of the 1996 Immigration and welfare Reform Acts on Communities in Texas and Mexico.” Center for Immigration Research, University of Houston, January 21, 1999.

22. “Governor Ends Fraud Program Targeting Immigrants,” Los Angeles Times, May 4, 1999.

23. “Noncitizen Policy for Temporary Cash Assistance and Medicaid, Including SSI-Related Medicaid,” Transmittal No. Policy 97-06-00003, Linda G. Dilworth, Assistant Secretary for Economic Self-Sufficiency Services, Florida Department of Children and Families, June 17, 1997.

27. KidCare consists of the following components:

- MediKids, a Medicaid managed care program for up to $15 per household, for children from birth through age 4 up to 200 percent of poverty;
- Florida Healthy Kids serves children ages 5 through 18 years up to 200 percent of poverty through a public/private partnership with fewer benefits than Medicaid, and school-based enrollment that was expanded to all counties in 1998;
- Medicaid for children from birth through 20 at staggered eligibility from 100-185 percent of poverty (eligibility for children ages 0-1 is up to 185 percent); and
- Children’s Medical Services Network for children through 18 who have special health care needs up to 200 percent of poverty.

25. Interview with Anita Bock, District Administrator, Florida Department of Children and Families, February 1999.

26. Lewis v. Grinker, Civil Action No. CV 79-1740, Memorandum of Law in Opposition to the Federal Defendant’s Motion for a Judgment on the Pleadings, (EDNY 1999).

27. H. Minkoff, T. Bauer and T. Joyce, “Welfare Reform and the Obstetrical Care of Immigrants and Their Newborns.” The New England Journal of Medicine, Volume 337, Number 10, 705-707 (Sept. 1997).

28. Lynda Flowers-Bowie, “America’s Newcomers: Access to Prenatal Care for Unauthorized Immigrants. Challenges for States.” National Conference of State Legislatures, May 1997.

37. “Public Assistance Changes Resulting from the Welfare Reform Act of 1997,” Administrative Directive 97ADM-23, pp 35-36, New York State Office of Temporary and Disability Assistance, Albany, New York, October 30, 1997.

46. Jacqueline Hagan, Nestor Rodriguez and Randy Capps, “Effects of the 1996 Immigration and welfare Reform Acts on Communities in Texas and Mexico.” Center for Immigration Research,

University of Houston, January 21, 1999.

31. Joshua Weiner, et al, "Health Policy for Low-income People in Texas." The Urban Institute, 1997.

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33. Wendy Zimmerman and Karen C. Tumlin, "Patchwork Policies: State Assistance for Immigrants under Welfare Reform." Occasional Paper Number 24, The Urban Institute, 1999.

34. *Ibid.*

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