

## EXECUTIVE SUMMARY

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted access to Medicaid for low-income immigrants in the United States. Before the 1996 PRWORA, or welfare reform, lawful permanent residents (LPR's) were eligible for Medicaid on the same basis as citizens. Following welfare reform, legal residents and their citizen children like Alicia Garcia and her family were required to wait five-years before they would be eligible for federal or state funded medical coverage. This rationing of publicly funded health care based on citizenship status has had consequences on immigrant families as well as the financial viability of the states and safety nets<sup>1</sup> that serve them.

Research provides many examples of how the new Medicaid restrictions have exacerbated the pre-existing barriers in accessing health care (language, fear, and discrimination) for immigrants especially for citizen children of mixed-status<sup>2</sup> families (households where one or more parents are a noncitizen and one or more children are a citizen). In addition to the language barriers, it is common for working immigrant parents, like Alicia Garcia, who cannot afford to pay out-of-pocket for health to sporadically seek preventive medicine from Mexico. Access barriers result in delayed care, irregular care and/or limited access to preventive medicine and ultimately, diminish health outcomes for immigrants, including pregnant women and U.S. citizen children. Increased access barriers also jeopardize the health of the public because of lower childhood immunizations and limited screenings for tuberculosis, sexually transmitted diseases and HIV.

Another major consequence of welfare reform was the transfer of decision making and administrative and fiscal responsibility to the states and local governments. The devolution of authority gave states flexibility in deciding which types of immigrants will receive which kind of public benefits. The 1996 welfare law allowed states the option to offer or deny federal and/or state covered benefits for legal immigrants arriving before or after August 22, 1996. Federal matching funds for Medicaid are no longer provided to the states for certain categories of immigrants who arrive after 1996. As a result, the immigrant provisions and changes have placed increased financial burdens to the states and local governments, which in turn, have created significant variation in the funding and delivery of health care to immigrants by the safety net system.

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<sup>1</sup> Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients (2000, IOM committee). Core Safety Net Providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

<sup>2</sup> According to the literature, many immigrant children live in "mixed status" households in which one or more parents are a noncitizen and one or more children are a citizen. This variation in eligibility within family results in higher uninsurance rates, increased health access barriers, decreased use of public benefits, and increased emergency medical utilization.

Underlying the policy changes is a political debate over the obligation of federal, state and local governments in financing health services to immigrants (documented and undocumented). The ongoing debate of “who will pay” for immigrant health care is rooted in tensions and conflicting ideas regarding immigrants that are a reflection of social, economic, and political values. How these tensions manifest and influence the translation of welfare policy into practice is of significant importance at the state and local levels where the distribution of funds and services have a direct impact on the health and well-being of immigrant parents and their children.

## **A. RESEARCH DESIGN**

Using a qualitative research design, this study addressed one overarching question: What are *the local consequences of the 1996 PRWORA (welfare reform) on the funding and provision of health services to immigrants?* This local level investigation provides policy makers with an understanding of how the 1996 PRWORA has resulted in variation in local policies and in the responses (decision-making and practices) of safety net providers to these changes.

### ***The three study aims analyzed:***

Aim 1: The responses of the state, counties and safety-net providers to the eligibility and benefits changes in the 1996 PRWORA (i.e. Medicaid, sponsor-deeming, five-year bar) pertinent to the funding and provision of health services to immigrants.

Aim 2: The impact of welfare reform on the willingness and ability of the safety-net providers (government and private) in New Mexico to serve immigrants.

Aim 3: New Mexico’s policies regarding the funding and provision of health services to immigrants in comparison to those of other border states (Arizona, Texas, and California).

The objectives were addressed by using a qualitative research design according to standard scientific practice (Bernard, 2000; Creswell, 2003; Denzin, 2000; Emerson, 1995; Lofland, 1995; Maxwell, 1996b; Miles, 1994; Miller, 2002). Triangulation of the data was executed by gathering from various sources and by using different methods (Maxwell, 1996b). Data was collected at the state, county and local levels. Levels of analysis include: state, county, and safety net. Semi-structured interviews with 55 key-informants served as the main data collection method, augmented by documents collection of eligibility and benefits policies and reports on the financing of immigrant health care and field notes. Community advisors were invited to contribute to the research design and assist in developing policy recommendations from the findings.

*The following are the research questions that correspond with study aims:*

Aim 1: Analyze the responses of the state, counties and safety net providers to the eligibility and benefits changes in the 1996 PRWORA (i.e. Medicaid, sponsor-deeming, five-year bar) pertinent to the funding and provision of health services to immigrants.

- Question 1: What were the policies regarding eligibility and the provision of public benefits to immigrants at the state, county and local levels before and after the 1996 Personal Responsibility and Work Opportunity Reconciliation Act?
- Question 2: How are state and county officials, safety-net providers, and community advocates responding to federal and local policy changes that restrict immigrant eligibility and benefits?
- Question 3: How do local actors interpret, adapt and arrive at decisions regarding the welfare reform provisions of health services pertinent to immigrants?

Aim 2: Analyze the impact of welfare reform on the willingness and ability of the safety-net providers (government and private) in New Mexico to serve immigrants.

- Question 4: How has the willingness and ability of the state, counties, and safety net to finance uncompensated care to immigrants changed after the 1996 PRWORA?

Aim 3: Analyze New Mexico's policies regarding the funding and provision of health services to immigrants in comparison to those of other border states (Arizona, Texas, and California).

- Question 5: How does New Mexico's policies regarding the funding and provision of health services to immigrants compare to those of other border states (California, Texas, and Arizona)?

## **B. SIGNIFICANCE**

The unique contribution this study makes to the literature is the focus on the role of counties and local safety-net providers and the factors shaping local policies and behaviors regarding the funding and provision of health care to immigrants. This study provides a critical contribution not only to the literature but also to the recent legislative efforts at the state level to restore immigrant eligibility for public benefits. No other study utilizes a multi-level qualitative analysis uniquely focused on New Mexico

populations and the local impact of the 1996 PRWORA on government localities, and the safety net. In addition, the research questions, study aims and design have been developed by soliciting input from local health leaders that participated in a pilot study conducted in 2001 for the NM Legislature (Cacari Stone, 2001).

### **C. PRELIMINARY STUDIES**

During Forty-Fifth Legislature, First Session, 2001, the New Mexico State Senate and House of Representatives enacted Senate Joint Memorial 52 (SJM 52) requesting “the Department of Health (DOH), the Health Policy Commission (HPC) and Human Services Department (HSD) to evaluate the provision of health care to immigrants, especially those documented immigrants in the United States for fewer than five years and undocumented immigrants (Cacari Stone, 2001).” A statewide work group was assigned to discuss and identify research questions and frame areas of inquiry and policy strategies. The purpose of the work group was to produce a written report to be presented to the NM State Legislature in December 2001.

Sixty-five work group members were recruited and selected by the New Mexico Department Health, Health Policy Commission, and Human Services Department in July 2001. As a result of the SJM 52 mandate, the three agencies generated a list of key informants and stakeholders regarding immigrant health provision in New Mexico. Participants were selected based on their common experience in the provision of health and social services to immigrants. The first meeting was held in July and at that time participants recommended other members to participate in the subsequent meetings in August and October.

The SJM 52 study findings were presented to the NM Legislative Health and Human Services Committee in December 2001. Due to the concerns outlined by the study, a new piece of legislation was proposed in January 2002, Senate Joint Memorial 70 (SJM 70) but never passed committee. As a result of the findings in SJM 52, the SJM 70 requested further examination of the core issues inhibiting the University of New Mexico Hospital (UNMH) from providing complete medical services to undocumented immigrants and considers the appropriate use of county indigent funds to ensure equitable use of all available revenue sources. In December 2002, the American Civil Liberties Union and the Community Health Partnership requested the Legislative Health and Human Services Committee (LHSC) to consider legislation that would restore the option for local governments to provide health care and other benefits (derived from state and local tax dollars) to immigrants of all statuses. The LHSC debated and voted not to pursue drafting any bills requesting further study to be introduced in the 2003 legislative session. To date, there remains a need for a research investigation of local variability of the funding and provision of immigrant health in New Mexico.

Thus, the SJM 52 study provided critical groundwork and the impetus for this more systematic investigation. The preliminary policy study served to: (1) to build trust and

gain entry into the community and policy circles in New Mexico; (2) to prioritize areas regarding immigrant health access after the implementation of the 1996 PRWORA; (3) to conduct key-informant interviews with providers, elected officials, and health advocates; (4) to pilot an interview guide with key-informants and immigrants (in Spanish); and (5) to draw on the collective knowledge of community stakeholders from throughout New Mexico familiar with the challenges providing health care to immigrants.

## **D. FINDINGS**

The following findings are based on analyses of written documents, key informant interviews, and field observations and are organized into three major sections which include the corresponding research aims and questions: (1) response of state and localities in New Mexico; (2) willingness and ability of safety-net providers to serve immigrants; and (3) border state comparisons. A summary of the findings proceeds as follows.

### **1. Response of State and Counties**

- Interview data across counties demonstrate that state and county officials and safety-net providers have had variable responses to the federal policy changes that restrict eligibility and benefits for legal immigrants arriving after 1996.
- UNM Hospital (located in Bernalillo County) has implemented the most restrictive eligibility policies following welfare reform. In response, political advocacy efforts have been more prevalent in that county and have spurred a state legislation mandating a study and statewide task force to address immigrant health access barriers following welfare reform.
- Local economic forces appear influential in shaping variable county responses to the health care needs of uninsured residents, both legal and undocumented.
- The financing and community context of local health care safety net systems seem to account for the variation of responses of the funding and provision of health care to immigrants following welfare reform.
- The federal rationing of resources based on citizenship, a rise in the number of uninsured in New Mexico, increased demand on local budgets, and resentment influence the lack of “political will” to publicly dialogue and address on-going public health issues related to immigration.
- In absence of a united political will to challenge the welfare reform changes and related policies pertinent to immigrants, local advocacy

groups have sporadically managed to place pressure on the state, counties, and local safety net providers to address the public health needs of uninsured immigrants.

- The majority of respondents confirmed that complicated welfare reform policies and regulations have created a climate of chronic confusion and ambiguity among state and county officials, health administrators, providers, advocates, and immigrant communities.
- This ambiguity has increased front-line discretion, which in turn has created variable interpretation of policies and provider practices.
- The collective narrative implies that ambiguity, confusion, and discretionary decision-making have magnified the pre-existing barriers and challenges of providing care to immigrants.

## 2. Willingness and Ability of Providers

- Administrators, elected officials and providers reported that the costs of providing health care to immigrants were a smaller part of the growing financial pressures such as state Medicaid cuts, health system infrastructure changes such as conversions of county funded hospitals to for-profit companies, and the rising number of uninsured.
- Despite an increased uncompensated care burden and administrative complications, counties and safety-net providers expressed a willingness to continue serving immigrants and in some counties, innovative efforts were being made to outreach to newcomers.

## 3. Border States Comparison

- New Mexico, California, Texas and Arizona have responded differently both in policy changes and interpretation. Among the most salient issues relevant to New Mexico are: state elected coverage for qualified immigrants; interpretation of county coverage for immigrants; and interpretation of the “definition” of emergency.
- Compared to other border states, New Mexico has the largest percent of immigrants who live in poverty. Like Arizona and California, New Mexico provides post-enactment qualified immigrants after the five-year bar with federally matched Medicaid benefits, but unlike California and Texas, does not provide state-funded medical assistance for immigrant children during the five-year bar.

## **E. STUDY LIMITATIONS**

It is important to note the strengths and limitations of this study based on the availability and suitability of the data. In terms of strengths, this study contributes to the literature by providing a wealth of evidence of the dynamic social, political and economic circumstances that contribute to variation in policy implementation. It also provides a deeper understanding of the role of counties, as an understudied unit of analysis, in setting local policies, and funding and providing health care to uninsured persons, especially immigrants. The sampling included a diverse array of informants across rural and urban counties/communities from local health educators to elected county and state officials.

The greatest shortcoming to the study is the lack of the perspective of the immigrant community. Focus groups and individual interviews with families would have been a valuable source of data in understanding the impact of welfare reform on the targets of that policy, immigrants. Second, the scope of this study is narrow and limited to New Mexico with comparisons to other border states (California, Texas, and Arizona). Secondly, this study relies on local informants in order to best define the context and impact of the 1996 PRWORA on access to health care for immigrants. Qualitative data (key informant interviews, field notes and observations) are subject to bias of various types.

## **F. POLICY IMPLICATIONS**

The goal of the research was to analyze the response of the state of New Mexico and its' localities to the immigrant provisions of welfare reform and compare that response to other border states. The application of the findings include clarifying the problems related to the implementation of welfare reform that warrant public intervention either at the state, county, organizational and/or community levels. Secondly, the findings provide evidence of which solutions are favorable to an array of actors such as front-line workers, program directors and administrators, health providers, immigrant advocates, and elected officials.

Five policy recommendations are offered to address local administrative and fiscal burdens and public health issues. First, under the welfare reform, New Mexico has the option to create its own eligibility rules through formal state legislative enactment regarding eligibility for immigrants for state and county funded services. If enacted, this would eliminate the argument that UNM Hospital has adopted that the organization is just following the law. This would also prevent any further confusion, litigation or ambiguity by other counties regarding their limitations to provide health care to post-enactment legal residents, as has occurred in Texas.

Second, the federal government through legislation enacted by Congress could strike the provision to TANF that prohibits state and local governments from spending

their own money on undocumented immigrants unless an emergency or could reinstate federal benefits for legal immigrant children and pregnant women. State legislatures, county commissioners and local health advocates could support Congressional action in order to increase a federal funding source to localities to provide health services to the most vulnerable populations impacted by the current law.

Third, ambiguities and interpretations of current eligibility policies could be clarified by implementing a standard training curriculum to Medicaid eligibility workers, ISD offices, county indigent staff, and other providers and advocates. The training could be adapted from the existing curriculum on “Immigrants and Public Benefits” which is currently implemented by the National Immigration Law Center. Initiatives to “train-the-trainers” could be supported by state and county funds.

Fourth, further investigation is needed on intergovernmental approaches to financing and providing primary health care to immigrants, especially between counties and states in the U.S.-Mexico border area. The health care system in New Mexico is extremely under-funded. Increasing health status disparities between Native Americans, native-born Hispanics, immigrants, other minority groups and White, non-Hispanics, need to be linked to the lack of publicly and privately financed health coverage to New Mexico’s uninsured population. A more comprehensive health care financing plan, which is long-term and involves many levels of government and private contributors is the only promise to securing the health of families living in New Mexico.

Finally, local leaders, governments, and advocacy groups play a significant role in shaping policy and diffusing anti-immigrant sentiment and attitudes by encouraging public debate and efforts to address the public health of residents (documented and undocumented). A town hall meeting that gathers key health care leaders from around the state could be implemented to dialogue and debate key issues and identify solutions regarding the funding and provision of health care of immigrant families and their children. As one legislature eloquently stated, “there are more borders in New Mexico than the ones in the south with Mexico. We have internal borders between people and the health care system that we need to address in order to tend to the health care needs of our communities and their children.”

## **G. RECOMMENDATIONS FOR FURTHER RESEARCH**

Future research is needed on the expectations and experiences of immigrants themselves regarding accessing the U.S. health care system. Baseline data is sorely needed on the actual costs of providing care to immigrants. Even though safety net providers reported they don’t ask immigrants their status because they are mandated not to ask, estimates of the number of immigrants served based on census population figures in every county could be made. Secondly, evidence of the costs of health care immigrants could be validated rather than having providers and policy makers rely on “perception.” This baseline collection of costs and even current and projected immigrant

population size and health care needs by county would be invaluable for long-term planning with local resources.

Research that educates the public with accurate information regarding the contributions that immigrants make to New Mexico is needed. Immigrants (legal and undocumented) are a vital force to New Mexico's economy by paying taxes and working in labor and agricultural industries, and domestic and service jobs. They also contribute to the social and cultural diversity of communities by sending their children to local schools, promoting tourism, and enhancing the language, custom and traditions. Information derived from the research could be disseminated to the public through the education system (K-12 and higher education) as well as through local radio, television and Internet.

Finally, on a broader scale, Mexico faces similar access issues as does the United States. In the Mexican case, most of this is attributed to fragmentation in the offerings and financing of coverage. Unlike the United States they do, indeed, consider access to health care and coverage a basic human right. However, the challenge is in really making it accessible to all. We face similar challenges regarding resources and distribution regarding preventive and primary care. There may be opportunities here for joint collaboration in the border area. There are lessons and practices that we must be implementing with regard to how to better work with Mexican immigrants. The borders between policies and people may shift, but the geographic proximity of Mexico to New Mexico and the other border states will never change.