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The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care

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Throughout its history, the United States has gone through cycles of anti-immigrant fervor. Such times are marked by claims that immigrants—because of excessive numbers, lack of skills and resources, or cultural isolation and differences—are a danger to the country and a drain on its resources. One particularly persistent complaint is that immigrants, regardless of their legal status, take advantage of the nation's safety-net system of government assistance.

The mid-1990s was a crest of one such cycle. During that time, California voters approved Proposition 187, which prohibited illegal immigrants from receiving virtually all public benefits, including public health coverage and primary and secondary education. For its part, Congress attributed almost half of the expected savings from its so-called welfare reform legislation in 1996 to those to be achieved by establishing years-long waiting periods for legal noncitizens to join such government programs as welfare, food stamps and Medicaid—or excluding them entirely unless and until they gain citizenship.

The anti-immigration wave soon ebbed. Proposition 187 was enjoined by a federal court as unconstitutional; Congress backtracked on some of its most extreme restrictions, such as the restriction on legal immigrants' receipt of food stamps; and where Congress remained unmoved, many states stepped in to provide benefits with their own resources. President Bush was elected to office in 2000 touting his proposal for a guest-worker program and courting Hispanics for the Republican Party. Merely a decade later, however, the debate over immigration has intensified once again. This may not be surprising in light of the numbers: According to federal statistics, the country gained over 1.1 million legal immigrants in 2005, an increase of more than 20% from the mid-1990s peak. In addition, the Department of Homeland Security estimates that the population of immigrants who arrived illegally is increasing by 400,000 per year.

Throughout 2005 and 2006, conservatives—combining anti-immigration sentiment with post-9/11 security fears—championed a House proposal to enhance border enforcement and impose punitive measures against illegal immigrants and their employers. More moderate members of Congress offered competing proposals to address the issue of immigration—both legal and illegal—more comprehensively. In the end, Congress was only able to enact a new law authorizing 700 miles of fence along large swaths of the U.S.-Mexican border. During the same years, the states were assertive in forging new policy, particularly on the subject of government benefits. According to the National Conference of State Legislatures, at least 14 new laws were enacted in 11 states in 2006 restricting or expanding immigrants' eligibility for public education, health care or other public benefits. This trend has continued in 2007: By mid-January, at least nine states had introduced bills restricting immigrants' access to public benefits. Virginia alone has considered dozens of measures this year related to immigration, including one that could force charities and other groups receiving state and local funding to verify that a client is in the country legally before providing services.

Medicaid and Immigrants: Changing the Rules

For advocates and providers of sexual and reproductive health services, the most direct and severe consequence of anti-immigration policymaking has been its deleterious and, to a large extent, unintended impact on Medicaid enrollment. Medicaid and its smaller companion program, the State Children's Health Insurance Program (SCHIP), are enormously important as sources of coverage for sexual and reproductive health services, including family planning services and supplies, pregnancy-related care, and testing for and treatment of HIV, other STIs and cervical cancer.

Historically, American citizens and legal noncitizen immigrants have had equal eligibility for most public benefit programs, including Medicaid. In the 1996 welfare reform legislation, however, Congress drew a distinction between recent and long-standing legal noncitizens (related article, May 2003, page 6). Since then, legal immigrants have not been eligible for federally reimbursed Medicaid and SCHIP coverage until they have lived in the United States for five years, except in emergencies (which include labor and delivery).

This change in federal policy has had a substantial impact, but not only in the way Congress intended. Although enrollment dropped considerably between 1994 and 2005 among the recent immigrants targeted by the change (from 26% to 17%, among poor reproductive-age women; see table), enrollment fell just as much (from 41% to 22%) among long-standing legal residents, who should not have been affected. Long-standing residents, who are fully entitled to Medicaid coverage under federal law, are now only half as likely as U.S.-born citizens to have such coverage. (There was also a smaller but still considerable drop in coverage, from 49% to 40%, among poor, native-born Americans—the program's core constituency. That development was likely related to the failures of another aspect of welfare reform, which was supposed to maintain eligibility for Medicaid for many Americans even as the new law pushed them off of the welfare rolls.)

These trends in Medicaid coverage, along with declines in employer-sponsored health insurance, have led to across-the-board increases in the proportion of poor women who are uninsured, particularly among noncitizens. And with their only limited enrollment in Medicaid, noncitizens—regardless of how long they have been in the country—are now about 70% more likely than their native-born peers to be uninsured.

State-level policymakers, meanwhile, have exercised their power to enhance or mitigate the harm of the federal policy. States have the option of being more restrictive than the federal government, by denying Medicaid coverage to long-standing legal residents unless or until they become citizens, and a few states have done so. On the other hand, states are also allowed to use their own funds to provide coverage to some or all immigrants ineligible for federally funded care. According to the Center on Budget and Policy Priorities (CBPP), as of May 2004, 21 states and the District of Columbia are providing prenatal care to recent legal immigrants, and 13 of those to immigrants in the country illegally. (Seven of those states were taking advantage of another federal policy allowing them to provide SCHIP coverage for the fetus, regardless of the pregnant women's own immigration status; related article, December 2002, page 3.)

BAD MEDICINE

The 1996 legislation that limited Medicaid coverage for recent immigrants had just as severe an impact on Medicaid coverage, and insurance coverage more broadly, among long-standing residents.

	% of poor* women 15–44					
	Covered by Medicaid			Uninsured		
	1994	2001	2005	1994	2001	2005
Total	46.5	35.0	36.4	33.6	40.5	41.2
Native-born	48.8	38.9	40.0	30.5	35.0	36.4
Immigrants	36.0	20.6	22.6	48.4	61.3	59.6
Naturalized citizens	35.4	27.6	31.8	36.4	47.6	41.3
Noncitizens	36.0	19.4	20.6	49.5	63.6	63.4
Long-standing residents†	41.1	23.2	22.4	45.9	61.2	63.0
Recent immigrants‡	25.6	15.3	17.0	57.2	66.4	61.6

*Women in families with incomes under the federal poverty level ($17,170 for a family of three in 2007). †Long-standing residents are those who had been in the United States prior to 1990 for the 1994 data; prior to 1996 for the 2001 data; and prior to 2000 for the 2005 data. ‡Recent immigrants are those who had arrived in 1992 or later for the 1994 data; in 1998 or later for the 2001 data; and in 2002 or later for the 2005 data. *Notes:* Data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group. Data from 1994, 2001 and 2005 are not entirely comparable because of changes to the survey methodology. *Source:* Guttmacher Institute tabulations from Current Population Survey, 1995, 2002 and 2006.

Requiring Proof of Citizenship

It has always been clear that illegal immigrants are ineligible for federally funded Medicaid; however, some lawmakers suspected that states' protections against this "theft of Medicaid benefits" were not strong enough, even though there was little indication that Medicaid faced any significant problem. In fact, a July 2005 report by the Department of Health and Human Services Office of Inspector General (OIG) looked at the then-current practice of allowing applicants to simply self-declare their citizenship, under the penalty of perjury, and although it made recommendations to enhance safeguards in the process, it did not identify major flaws or recommend requiring documentation. In its response to the OIG report, the Centers for Medicare and Medicaid Services (CMS) noted that it "does not find particular problems regarding false allegations of citizenship, nor are we aware of any."

Nevertheless, in 2006, conservatives pushed through a new law requiring states to ensure that Medicaid enrollees who claim to be citizens provide documentary proof. (Immigrants eligible for Medicaid had already been required to document their status.) As implemented by CMS, the new requirement stipulates a tiered list of documentation that states must request of both new applicants and recipients renewing their enrollment to prove citizenship and identity. Passports top the list, even though many low-income Americans do not possess one. Presenting a birth certificate along with a driver's license or similar photo identification would qualify as second-tier documentation. CMS limited the use of nongovernmental documents and affidavits, but did give states the option of using data matches with government agencies as documentation—for example, checking the computer records of the state's vital statistics agency in lieu of obtaining a birth certificate.

Health care advocates and many state officials are worried that millions of low-income American citizens—between 1.2 million and 2.3 million, according to CBPP estimates—could be forced to delay needed care or even lose Medicaid coverage because of the time, expense and difficulty of obtaining acceptable documentation. And, although no comprehensive data are yet available on the law's impact, initial reports indicate that citizens—not immigrants—are the ones at risk of lost or delayed coverage and care, including the full range of sexual and reproductive health care provided by Medicaid. A February 2007 report by CBPP highlights problems in 11 states, including unexpected enrollment declines (running counter to rising caseloads for food stamps), backlogs in processing applications and significant administrative costs. As one Iowa official put it, "There is no evidence that the [enrollment] decline is due to undocumented aliens leaving the program. Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity."

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Because of the time-sensitive nature of prenatal care, delays in receiving services are especially problematic for pregnant women. As of July 2006, 30 states and the District of Columbia allow presumptive eligibility for pregnant women—granting them access to services without having to wait for documentation of citizenship or even income. In the other 20 states, all pregnant women are required to first provide documentation of citizenship, which can significantly delay their initial prenatal care visits, which in turn could impact the health of both the mothers and the children. In a further snub to the health of newborns, the CMS regulations break the long-standing axiom that a child born to a woman receiving Medicaid is to be automatically enrolled in Medicaid, thereby ensuring immedi-

ate access to preventive care. Instead, states must now require an application and proof of citizenship for some infants born in U.S. hospitals—those born to immigrant women, here legally or illegally, who are only eligible for emergency Medicaid coverage for the delivery—despite the fact that any child born in the United States is, by definition, a U.S. citizen.

In addition, the new documentation requirement may be a hindrance to providing family planning services under Medicaid. Obtaining the proper documents may be a particular burden to young, extremely poor mothers—the typical recipients of family planning services in most states. With states' income-eligibility ceilings for parents averaging only two-thirds of the federal poverty level (childless adults are typically excluded from Medicaid entirely), a fee of perhaps $20 for a new birth certificate or nearly $100 for a U.S. passport may be daunting—not to mention additional expenses such as lost wages, transportation and child care that may accompany a trip to a government office. Furthermore, documentation may be an obstacle for teenagers looking to obtain coverage confidentially.

These problems may be particularly relevant in states that have obtained approval from CMS to broadly expand eligibility for family planning services under Medicaid. As of February 2007, 17 states have approval to provide family planning benefits to individuals if their income is under a specific limit—typically, at or near 200% of poverty. These expansion programs have served millions of women and men and, moreover, have been proven to save tens of millions of dollars for individual states and the federal government (related article, Summer 2006, page 2). Yet, these expansions, which are far less expensive per client than the broader Medicaid program, may become substantially less attractive from a financial standpoint in the face of increasing enrollment expenses.

Misguided Policy

The Medicaid citizenship documentation requirement, along with the 1996 welfare reform law before it, have had negative consequences, however unintended they may be, for American citizens and long-standing legal residents who are unquestionably entitled to the program's benefits. However, even if these policies had done only what their supporters asserted they would do—withhold Medicaid services from illegal immigrants and legal immigrants for their first five years in the country—there would still be reason to question their wisdom, particularly regarding vital sexual and reproductive health services. To be sure, Medicaid, like all programs, is governed by a set of rules and regulations, and its trustees and administrators have a legitimate interest in seeing that those rules and regulations are followed. Yet, at the same time, one must ask: Is it really in the national interest to deny prenatal and postpartum care to immigrant women whose babies will be U.S. citizens? Who benefits from withholding voluntary family planning services from immigrant women who themselves do not want to become pregnant? What is gained by denying immigrants services for communicable diseases such as HIV and other STIs?

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In addition to their potentially devastating impact on individual people and their families, it should be noted that these anti-immigrant policies pose a serious problem for the nation's safety-net providers. Federal health programs beyond Medicaid that do not restrict participation based on income were left unaffected by the 1996 welfare legislation. Thus, Title X family planning providers, maternal and child health clinics, and community and migrant health centers remain available to serve immigrants, regardless of legal status. Yet, the rising tide of uninsured clients,

both citizen and noncitizen, is a significant strain on their resources (related articles, pages 2 and 24). Citizenship documentation, too, poses financial and logistical difficulties: The more that states and providers must spend on the administrative costs of processing Medicaid applications and renewals, and on helping patients navigate the process, the less money they have to spend on actual health care.

Some policymakers, providers and advocates have recognized these problems and have fought to maintain residents' access to at least some vital services, regardless of immigration status. For example, both Colorado and Georgia passed laws in 2006 limiting illegal immigrants' access to a broad range of public benefits; however, each identified several exceptions, including prenatal care and services related to communicable diseases such as STIs. And when then-Gov. Robert Ehrlich (R) in 2005 eliminated for fiscal reasons Maryland's state-funded Medicaid coverage for children and pregnant women who are legal recent immigrants, the state legislature and a lawsuit filed by advocates on behalf of the immigrants forced him to reverse course the following year.

Such piecemeal efforts may be the most that are possible for the time being, at least until Congress undertakes comprehensive reform of the nation's immigration and immigrant policy. Immigration reform remains a high priority for President Bush, and many observers believe that it is one of the few potential area of agreement between the president and the new Democratic leadership in Congress. However, anti-immigration sentiment remains strong among many policymakers and their constituents, and there is ample potential for new restrictions on immigrants at the federal and the state levels. When Congress does renew its debate over immigration, it should resist the compulsion to cater to this sentiment and reassess the wisdom of denying immigrants access to critical health care services, including those related to sexual and reproductive health. www.guttmacher.org