BEYOND OUTREACH & INFORMING

By Claudia Schlosberg

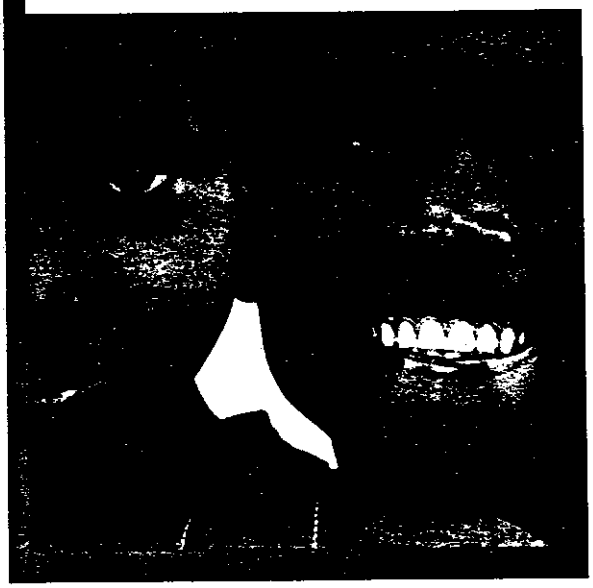
Getting Serious About Covering Uninsured Children in Immigrant Families

There are an estimated 10 million to 11 million uninsured children in the United States, and between 3 million and 4 million of these are eligible for, but not enrolled in, Medicaid (Seldon, Banthin & Cohen, 1998; U.S. Agency for Health Care Policy, 1996; Levander, 1998). Not surprisingly, children without health insurance get less health care. They have fewer visits to the doctor, are less likely to be appropriately immunized, less likely to receive well-child checkups and preventive care, and less likely to receive treatment when they are sick (Levander, 1998).

Not having health insurance means that children do not receive treatment for preventable diseases or delay treatment until symptoms worsen. Several studies have found that low-income and uninsured children are more likely to be hospitalized for conditions that could have

been managed with appropriate outpatient care (Levander, 1998). For a poor child, having no health insurance and lacking access to health care can mean a lifetime of ill health, low productivity, and even early death (Perkins & Zinn, 1995).

In response to the crisis of children's health access, states and the federal government have implemented aggressive outreach campaigns to identify uninsured children, screen them for eligibility, and enroll them in either Medicaid or the newly created $24 billion Children's Health Insurance Program (CHIP).[1] The Clinton Administration is spearheading a national children's health outreach initiative. By executive memorandum, the president has directed eight federal departments (Treasury, Agriculture, Education, Labor, Housing and Urban Development, Health and Human Services, Interior, and the Social Security Administration) to develop agency-specific, action-oriented plans to encourage full participation in Medicaid and CHIP. Congress is also doing its share, having approved enhanced federal matching funds for outreach activities in both the Medicaid program and CHIP.[2,3] By September 1998, the Health Care Financing Administration (HCFA) had approved 40 CHIP plans and sent out dozens of letters to encourage states to simplify and streamline their application processes for both Medicaid and CHIP. Foundations also are helping with major new initiatives to foster public/private partnerships and innovative strategies to get children covered.[4]



[1] *CHIP, enacted as part of the Balanced Budget Act of 1997, allocates $24 billion over five years to extend health care coverage to uninsured children through state-designed programs, subject to approval by the Health Care Financing Administration.*

[2] *In enacting the Personal Responsibility and Work Opportunity Reconciliation Act of 1997, Congress established a $500 million fund to assist state Medicaid agencies with additional Medicaid administrative expenditures incurred as a result of delinking Medicaid eligibility from eligibility for cash assistance. State agencies may claim federal financial participation (FFP) at a 90 percent enhanced match rate for outreach and other allowable activities against the state's allocation. Outreach activities are also reimbursable as routine administrative expenses under a state's regular Medicaid match rate.*

CHIP outreach activities are treated as administrative expenses and are reimbursable at an enhanced federal match rate. Reimbursable, non-benefit expenditures, including administrative costs, however, cannot exceed 10 percent of the state's total CHIP expenditures.

[4] *"Covering Kids," an initiative of the Robert Wood Johnson Foundation, is providing $3 million in funding to states for innovative outreach programs that identify and enroll eligible low-income children in Medicaid and state CHIP programs.*

It is still too early to draw conclusions about the success of this unprecedented campaign to reach out to low-income children. The early experiences of California and other states with high immigrant populations, however, suggest that outreach alone will not be enough to overcome enrollment barriers for significant numbers of uninsured children who live in immigrant families. Evidence is mounting that immigrants are avoiding health and health-related publicly funded benefits because of concerns that receipt of such benefits will adversely affect their immigration status, resulting in family separation and possible deportation.

Health care providers and staff at immigration rights organizations reported these and other stories to the National Health Law Program and the National Immigration Law Center. Unfortunately, the fears expressed by parents in these families are not unfounded. Yet, if we are serious about covering uninsured children in immigrant families, we must focus on the current conflict between public health and immigration policy, and its impact on children's health.

- In (Yakima County) Washington, a citizen child, whose father is a permanent resident and whose mother has applied for a visa, did not receive any medical care for six ear infections he had in 1997. The parents were afraid that if they applied for assistance for the child, the mother would not receive an immigrant visa.
- In Massachusetts, a legal permanent resident refused to apply for Medicaid benefits for her four citizen children. She was aware that her children needed health care and food. But she feared that if she applied for public benefits for her children, the INS would deport her and the children would have to return to their father.
- A citizen child in Massachusetts was rushed to the hospital by ambulance because the child went into convulsions. Subsequently, it was determined that the child needed ongoing treatment. The child's mother, however, refused to complete a Medicaid application on behalf of her child because she feared she would not be permitted to adjust her immigration status if her child received Medicaid. Without Medicaid, the hospital cannot be paid for the care it provided and the child is unable to access medical treatment for his ongoing health condition.

DEMOGRAPHICS OF UNINSURED CHILDREN

The number of uninsured children who live in immigrant families—defined for purposes of this article as households where one or both parents are noncitizens—is significant. Nationwide, while 9 out of 10 uninsured Medicaid-eligible children are U.S.-born, over one-third live in immigrant families (U.S. General Accounting Office, 1998). Among all major racial and ethnic groups, Hispanic children are most likely not to be insured. In 1996, 29 percent of Hispanic children had no health insurance. Yet, 73 percent of Hispanic children live in families with incomes below 200 percent of the federal poverty level, and are potentially eligible for Medicaid or CHIP (DeParle, 1998).

In states with large immigrant populations, such as California and New York, the success of efforts to insure children will depend in large part on the state's ability to enroll children living in immigrant households. In California, with an estimated 666,500 uninsured Medicaid-eligible children, the number of uninsured children living in immigrant families is estimat-

ed to be as high as 73 percent (Wallace, Yu, Mendez & Brown, 1998a; U.S. General Accounting Office, 1998; Zimmerman & Fix, 1998). Children who live in families where at least one parent is a noncitizen also make up a significant portion of the population targeted for coverage under CHIP. California's CHIP program, called Healthy Families, is targeting uninsured children in families whose earned incomes fall between 100-200 percent of the federal poverty level. Statewide, the adjusted estimate of eligible children is 400,300 (Wallace et al., 1998b). In Los Angeles County, where about 152,114 of these children live, 63 percent of children in the targeted income bracket have at least one noncitizen parent (Wallace et al., 1998b; Zimmerman & Fix, 1998).

INEFFECTIVE OUTREACH

Current outreach efforts, however, are not translating into greater participation by children in immigrant families. In Los Angeles County, California, where over 424,000 children qualify for Healthy Families' coverage, less than 2,000 children enrolled during the first month (*Inland Valley Daily Bulletin*, 1998). In addition to low enrollment in the state's CHIP program, there has been a precipitous drop in Medicaid participation for immigrant families. According to a recent study by the Urban Institute, since January 1996, applications for CalWORKS (the state's Temporary Assistance for Needy Families [TANF] program) and Medi-Cal (the state's Medicaid program) benefits fell by 52 percent among households headed by noncitizens, even though there has been no actual change in immigrant eligibility for public assistance in California, with the exception of food stamps (Zimmerman & Fix, 1998). Moreover, in the same two-year period, the Urban Institute study found that the number of newly approved applications for TANF and Medicaid for citizen children in immigrant families dropped by 48 percent (Zimmerman & Fix, 1998).

The Urban Institute study confirmed what California health officials already knew: immigrants are avoiding Medicaid and other publicly funded health care benefits because of heightened fears about immigration enforcement policies. Lynn W. Bayer, director of the Los Angeles County Department of Public Social Services, noted that the findings are "consistent with our experience in the Child Medi-Cal Enrollment Project (CMEP). We believe many immigrant parents have been unwilling to enroll their children, most of whom are U.S. citizens, in Medi-Cal for fear that such enrollment could adversely impact the parent's immigration status or ability to naturalize" (L. Bayer, personal communication, July 28, 1998).

Angie Medina, director of the Los Angeles County CHIP Outreach Program, called fear of adverse immigration consequences "significant, the biggest problem we have." Frontline Medi-Cal eligibility workers agree. Based on a survey about barriers faced by people applying for Medi-Cal, Ruben Mejia, acting director of the Medi-Cal Long Term Care District, noted that "overwhelmingly, the fear of INS was identified as the number one barrier" (R. Mejia, personal communication, December 26, 1997).

Immigrant avoidance of health care benefits is not limited to California. In Massachusetts, health care providers have reported that they are increasingly unable to provide essential preventive and follow-up services to immigrants who refuse to apply for MassHealth because of their fear of the potential effect on their immigration

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status. According to Bruce Bullen, Massachusetts' Medicaid commissioner, the state has not been able "to address the very real and growing fear within the immigrant community that receipt of MassHealth or similar health care benefits will bar their ability to adjust their immigration status with INS or to return to the United States after a temporary absence" (B. Bullen, personal communication, April 23, 1998).

In Dade County, Florida, a door-to-door survey of 87 immigrant households identified 85 in which there was one or more children eligible for, but not enrolled in, Medicaid. Ten percent of the surveyed parents specifically identified Immigration and Naturalization Service (INS) policies and practices as the reason for not enrolling their children in Medicaid. At the East Coast Migrant Health Headstart Center, 300 children (roughly one-third of the center's enrollment) were identified as eligible for but not enrolled in Medicaid. The most common reason cited by the parents for not enrolling their children was fear that receipt of Medicaid would adversely affect their immigration status (M. Harmatz, personal communication, July 31, 1998).

Florida health officials "have become acutely concerned regarding inclusion of Medicaid benefits in the 'public charge' determinations" (J.T. Howell, personal communication, July 9, 1998). According to James T. Howell, Florida's secretary of public health,

> "[i]t is our growing experience in Florida that the inclusion of Medicaid benefits in determining immigration status serves as a strong deterrent for families who need to access valuable health care for their children. Unfortunately, Immigration and Naturalization Services' inclusion of Medicaid and other health insurance programs in the public charge determination serves as an impediment to increasing health care for uninsured children."

IMMIGRATION POLICY AND AVOIDANCE OF HEALTH CARE

The General Accounting Office also has identified U.S. immigration policies that are a barrier to getting children covered under Medicaid.

Immigration policy and practice are affecting children's enrollment in publicly financed health benefit programs primarily through the application of "public charge" rules. *Public charge* is a term the INS and the U.S. Department of State use to describe immigrants who will receive public benefits. The Immigration and Nationality Act (INA) of 1996 states that an immigrant seeking entry to the United States is inadmissible if he or she is "likely" to become a public charge. The public charge test is applied by the State Department to individuals seeking entry to the United States, by the INS to individuals seeking permanent residency in the United States, and to permanent residents who travel outside the U.S. for more than six months or who have otherwise made a meaningful departure. Under narrow circumstances the INS can also deport or "remove" legal immigrants who become public charges, although this rarely occurs.[5]

[5] *Under standards established by case law, a permanent resident can be removed only if he or she became a public charge within five years after entry, received benefits based on factors that existed before entry, received benefits that created a legal debt, or was asked to repay the debt but refused.*

The INS and the State Department historically have applied slightly different standards in determining who is likely to become a public charge. The State Department applied a poverty guideline income test, which changed slightly in 1996 when Congress required 125 percent of the poverty guideline. In considering the relevance of public benefits received, the State Department has instructed consuls that only receipt of cash assistance raises public charge concerns. Assistance is outside the scope of the public charge exclusion when it is "a program that is essentially supplementary in nature, in the sense of providing training, services, food, etc., to augment the standard of living, rather than to undertake directly the support of the recipients" (U.S. Department of State, 1998).

When the INS makes a public charge determination, under the Immigration and Nationality Act of 1996, it is supposed to examine the "totality of the immigrant's circumstances," including a prospective evaluation of the immigrant's age, health, family status, assets, resources, financial status, education, and skills (D. Meissner, personal communication, September 9, 1998). INS also is supposed to distinguish between programs providing financial support to the needy and "essentially supplementary" benefits directed to the general welfare of the public as a whole.[6]

In the past two years, however, dramatic changes in immigration policy and laws affecting immigrants' eligibility for welfare and health benefits have led to more aggressive application of public charge rules. Both the INS and the State Department have engaged in questionable practices calculated to deter immigrants from receiving public benefits, including Medicaid, to which they are lawfully entitled. The most notorious program was called the Public Charge Lookout System (PCLS), a formal program which provided consular offices with information regarding an immigrant's past receipt of state or federal public benefits when an immigrant applied for a visa (U.S. Department of State, 1997). Although federal law prohibits the disclosure of information about the receipt of Medicaid to agencies such as the INS and State Department, approximately 10 states signed formal memoranda of understanding with consular posts and routinely responded with the requested information.[7]

As this practice spread, consular offices began regularly demanding that an intending immigrant repay in full the amount of past benefits received by family members in the United States,

For immigrants being sponsored by family members, the Illegal Immigration Reform and Immigrant Responsibility Act also requires an annual income threshold of 125 percent of the federal poverty line, to be demonstrated in a binding affidavit of support submitted on behalf of the immigrant by his or her sponsor. When executing an affidavit of support (INS form I-864), sponsors must list any "federal means-tested public benefits" received by them or members of their household, and agree to reimburse the government if the immigrant becomes dependent upon such benefits.

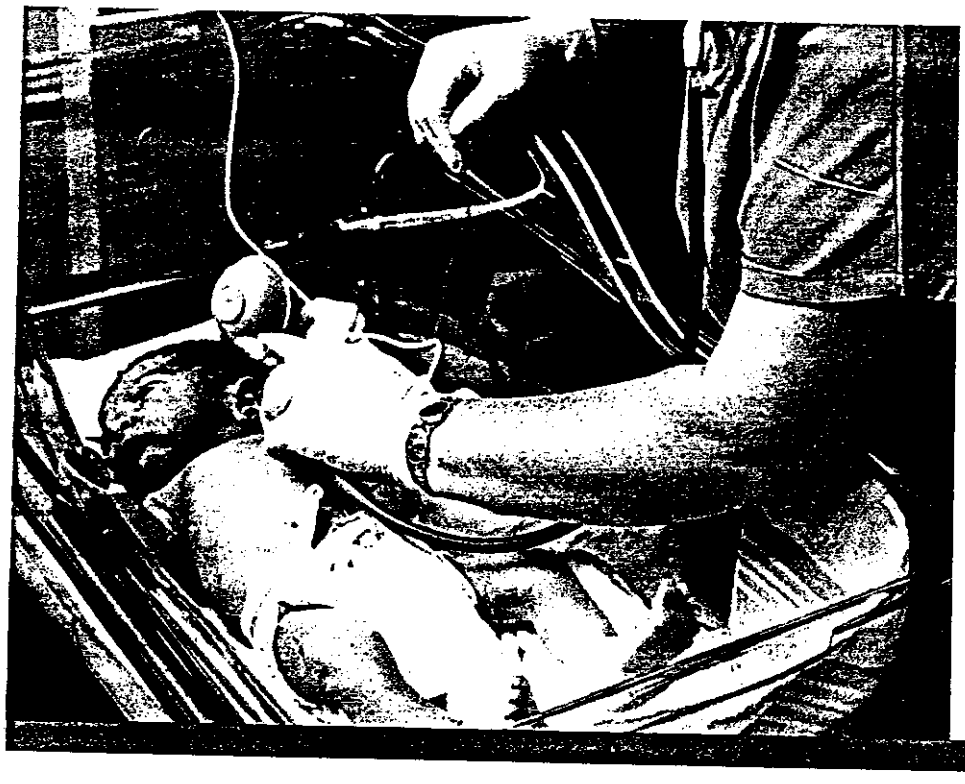
42 U.S.C. Section 1396(a)(7) provides that the use or disclosure of applicant and recipient information be limited to "purposes directly connected with the administration of the [state Medicaid] plan." Such purposes include establishing eligibility, determining appropriate amounts of medical assistance, providing services for recipients, and conducting investigations related to plan administration.

while INS officers began refusing reentry to permanent residents returning from visits abroad until they repaid past benefits received or withdrew from enrollment in programs such as Medicaid or the Women, Infants and Children (WIC) program. In one case, a mother who had traveled to Guatemala for her visa interview was prevented from returning to the United States to care for her U.S.-born seven-year-old-child who has cystic fibrosis because she refused to withdraw her child from the Medicaid program. Even immigration judges have ordered individuals to repay Medicaid benefits to which they were legally entitled, with the implicit threat of adverse rulings in their cases if they did not comply.

Responding to reports about the PCLS, HCFA characterized the forced repayment of Medicaid benefits as a "serious" problem. In a letter to state Medicaid directors, Sally Richardson, HCFA's director of Medicaid and state operations, informed states that "[t]he Medicaid program has no authority to collect repayments of benefits from current or former beneficiaries except in cases where those benefits were fraudulently received or an overpayment has occurred." Richardson noted that,

> "State Medicaid agencies are not authorized to provide information about the receipt of benefits or the dollar amount of these benefits to the INS, the State Department or immigration judges unless the information will assist the State in collecting outstanding debts. Even if the individual requests documentation of the amount of benefits received, this information is not to be released because the disclosure is not directly connected to the administration of the Medicaid State plan."

The Public Charge Lookout System was finally terminated, but only after White House intervention. In December 1997, both the State Department and INS issued memoranda acknowledging that the forced repayment of public benefits, properly received, is illegal. The State Department instructed consular offices that "[u]nder no circumstances should an officer instruct or request an applicant to repay previously received benefits. This is a matter the applicant should address directly to the state." In its policy memorandum, the INS stated as a general rule, "an alien is not required to repay public benefits received in the past in order to avoid being found inadmissible as a public charge. . . . [t]he Service does not have the authority to request as part of the inspections process that aliens (lawful permanent residents or other aliens) repay public benefits."[6]



During the past year, the State Department

[6] *The INS went on to say that repayment of public benefits is relevant to a public charge inadmissibility determination only if at the time of application for admission, the alien has an outstanding debt based on receipt of a public benefit. The test, as outlined in case law, requires that there be a legal obligation to repay the debt, a demand for repayment by the benefit-granting authority, and failure to pay the alien.*

and the INS issued several different directives on what benefits can be considered when making a public charge determination. The State Department issued a public charge update to inform consuls that "reliance on emergency health and supplemental nutrition programs does not constitute public charge." The directive notes that under the welfare reform law, these programs remain available to all immigrants regardless of immigration status and "are supplemental (i.e., not subsistence) non-cash benefits that promote the public good." The directive specifically identified the WIC program as a public nutrition program that provides food supplements to ensure positive, healthy birth outcomes, specifying that "such programs should not be considered when making public charge determinations."

The directive did not, however, clarify the scope of exempt "emergency health" programs and made no reference at all to Medicaid or emergency Medicaid. At least one INS district has ruled that the use of a state's uncompensated care pool is not reason for determining that a prospective immigrant is likely to become a public charge. The district office concluded that "[g]iven the state's aggressive public health posture, it would be imprudent to deny lawful permanent resident status to those applicants who have used the pool to obtain health care" (S.J. Farqunarson, personal communication, April 21, 1997).

Additionally, on July 22, 1998, INS Commissioner Doris Meissner wrote a letter to Gloria Molina of the Los Angeles County Board of Supervisors stating "it has been INS policy for many years that the receipt of benefits by an alien's U.S. citizen child is not attributed to the alien parent or other family members for public charge purposes. The only time this general rule would not apply would be if the family were reliant on the child's benefits as its sole means of support." Though widely circulated, Meissner's letter did little to quell immigrants' fears because it contradicted field operation practices where, routinely, the receipt of Medicaid by a citizen child created a public charge problem for the child's parent.

Fortunately, the Clinton Administration, alarmed by the public health implications and the impact on children's health, has understood the need to clarify federal policy on public charge. As this issue went to press, the White House was on the verge of issuing new public charge guidance that may eliminate any risk to immigrants and their families who lawfully seek and use Medicaid or CHIP benefits. To be effective, the policy not only must be without any ambiguity, it must be effectively communicated to INS and State Department field staff, the immigration bar, health care providers, and immigrant communities.

REMOVING MEDICAID AND OTHER HEALTH RELATED PROGRAM FROM THE PUBLIC CHARGE DETERMINATION

There are several compelling reasons why Medicaid, CHIP, and other health and health-related programs must be removed from the public charge equation.

"reliance on emergency health and supplemental nutrition programs does not constitute public charge."

As a practical matter, the Medicaid program today is no longer a program of assistance only for the destitute. Of an estimated 37 million people who receive Medicaid-funded services, half are children and a majority of children eligible for Medicaid live in families where their parents (or parent) work but do not have sufficient income to purchase private health insurance

(Weigers, Weinick & Cohen, 1998). Nearly 53 percent of children on Medicaid live in a household where one or both parents are employed. With the advent of the TANF program, the extension of transitional Medicaid, and the expansion of state Medicaid programs, increasingly adult, nondisabled recipients of Medicaid are employed or are working toward self-sufficiency. In many states, families with incomes well over 125 percent of the federal poverty line are eligible for some coverage, while many states also have programs that allow applicants to "spend down" their incomes by offsetting their medical expenses.

Of the 40 CHIP programs approved as of September 17, 1998, 35 extend coverage to children in families above 125 percent of the federal poverty level (DeParle, 1998). In most of these families, there are one or more working adults. In short, Medicaid and CHIP clearly are classifiable as noncash, supplementary benefits that augment the standard of living for low-income families. Neither program directly supports its recipients.

More important than the nature of the benefit is the effect of its continued inclusion. So long as Medicaid and CHIP assistance are included in the public charge equation, immigrants will be deterred from enrolling in the programs. This means, quite simply, that children in immigrant families, including significant numbers of U.S.-born children, will remain uninsured.

REPORTING REQUIREMENTS

New reporting requirements are also causing immigrants to fear use of public health benefits. In 1996, Congress enacted two laws, the Personal Responsibility and Work Opportunity Reconciliation Act and the Illegal Immigration Reform and Immigration Responsibility Act, both of which contain provisions intended to preempt "sanctuary ordinances." Sanctuary ordinances ensure confidential communications between immigrants and agencies that protect the public health and safety. They have been adopted by over 20 jurisdictions, including San Francisco, New York, Chicago, and Washington, D.C. The two new provisions prohibit states from enforcing any restriction on communication with the INS, but the prohibition against restricting communications is limited only to information concerning the citizenship or immigration status of any individual.

In addition, Section 404 of the welfare reform law requires agencies that administer social security income, housing assistance programs under Sections 6 and 8 of the Housing Act of 1937, or block grants under the TANF program to make quarterly reports to the INS of the name and other identifying information of any person the agency knows is not lawfully present in the United States. Although this provision does not apply to health programs, in many states the same agency that administers TANF also is responsible for making Medicaid eligibility determinations and 48 states actually use a single or combined application form for TANF and Medicaid. Consequently, while the law clearly does not mandate reporting of immigration status when an immigrant applies for Medicaid or CHIP, it may be difficult for eligible workers to apply different rules to different programs and situations.

These reporting provisions have enormous potential to erode privacy protections that encourage people, regardless of immigration status, to seek health care and benefits. If parents are afraid they will be reported to the INS, then clearly they will be reluctant to enroll their children in Medicaid or CHIP. Indeed, they are likely to be concerned about any contact with the health care system.

While individuals are clearly placed at risk by these policies, the public's health is also endangered. In December 1997, for example, public health officials in Westchester County, New York, battled the nation's largest outbreak of rubella. After the outbreak spread to New York City, officials issued a health alert. According to newspaper accounts, the epidemic spread largely through the Hispanic community among immigrants who had not been vaccinated against the disease. Public health officials acknowledged that one of the problems in fighting the epidemic is that many in the Hispanic community are afraid of the health

department because they equate it with the INS (*The Journal News*, 1998).

For health professionals, public health officials, and politicians concerned with children's health, the deterrent effect of INS public charge determinations and new reporting provisions ought to raise alarm bells. Uninsured children in immigrant families clearly make up a significant portion of children targeted by new outreach strategies. No amount of information, however, will entice these children's parents to enroll them in Medicaid or CHIP if to do so endangers their family's safety and status. If we are serious about covering these children, we must look at policies and practices that place INS enforcement interests over the interests of the public's health. A critical first step is ensuring that the lawful receipt of Medicaid, CHIP, or other health and health-related benefits by a child or any member of his or her family is not used against that family in any immigration proceeding. The next step is ensuring that affected communities are fully informed and reassured that receipt of health benefits will not, under any circumstance, place them or their families at risk. ●

Claudia Schlosberg is staff attorney at the National Health Law Program in Washington, D.C.

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