Resource ID#: 4621

Access to Prenatal Care for Immigrant Women in Georgia

Acce orgia

A report to the State Office of Rural Health and Primary Care
&
Georgia Mutual Assistance Association Consortium
by
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January 1, 1998

It is widely accepted that prenatal care is the most cost effective way to improve birth outcomes and ensure the health of women and infants during pregnancy. Prenatal care reduces the number of infants born at low-birthweight. Infants born at low or very low birthweight are more likely to have serious conditions, including cerebral palsy, deafness, blindness and epilepsy. (NCSL, p. 5) Prenatal care is also important in the early identification of maternal medical complications such as gestational diabetes. Neonatal intensive care unit costs average $31,000-$71,000 per incident, compared with an average cost of $400 for prenatal care. (NCSL, p. 6)

Prenatal care is particularly important for immigrant women, many of whom are poor, live in substandard housing, and often have other unmet health needs. It has been argued that extending public benefits such as prenatal care to undocumented immigrant women increases illegal immigration. However, the cost benefits of providing prenatal care are tremendous. The 14th amendment of the U.S. Constitution provides that infants born in the U.S. are U.S. citizens, and thereby eligible for Medicaid and other public benefits. Proponents for providing prenatal care to undocumented women argue that the health care system can pay the low costs of prenatal care or pay far more for the care of critically ill U.S. citizen infants.

There are many different funding sources, federal, state, and local, that pay for the cost of prenatal care for those women who are uninsured or can not afford to pay (see Attachment C). One of the largest of theses funding sources is the Medicaid Program. Recent changes in federal welfare and immigration reform have made access to Medicaid dollars more difficult for immigrant women. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 divides immigrants into two groups; "qualified" and "not qualified" for federal public benefits. "Not qualified" immigrants include some immigrants who are legally within the U.S. and others who are undocumented. As a result of federal welfare reform, pregnant "not qualified" immigrants are no longer eligible for Medicaid Presumptive Eligibility, which covers prenatal care.

In response to federal welfare reform, on January 11, 1997 the Georgia Department of Medical Assistance (DMA) implemented the use of the Citizenship Declaration Form as part of the application process for Medicaid Presumptive Eligibility. In implementing the citizenship requirement, DMA seeks to assure that only "qualified" immigrants are covered by the program. The form requires applicants to sign a statement swearing that they lawfully live in the United States (see Attachment B). Many "not qualified" immigrant women may now avoid interaction with the health care system because they fear they will be asked for legal documents or reported to the Immigration and Naturalization Service (INS). The purpose of this study is to determine how these reforms have affected access to prenatal care for immigrant women.

Access to prenatal care for immigrant women was examined in several regions in south Georgia. Data were collected in Decatur, Colquitt, and Marion counties. Interviews were conducted with providers of prenatal care and pregnant immigrant women. Most of the immigrants in south Georgia are Hispanic and many have very limited English skills. Fifteen pregnant women, or women who had given birth since May of 1997, were interviewed by a bilingual interviewer. A twenty-two question interview relating to access to prenatal care services was administered (see Attachment A). The interview included questions on demographics, use of prenatal care services, and payment sources for prenatal care. All of the interviews were conducted in Spanish as eleven of the women were from Mexico, three from Guatemala, and one from Honduras. Other interviews were conducted with providers of prenatal care services in the various counties. Providers known to serve immigrant clientele were contacted and interviewed about access to prenatal care in their area for this group of clients.

Decatur County Findings

Decatur County is located in the southwest corner of the state and is a major producer of tomatoes, corn, and other vegetables. It is the county with the greatest number of farmworkers needed to harvest the crops. It has been estimated that more than 10,000 farmworkers and their families are in Decatur County during the peak month of the year (Estimation of Migrant and Seasonal Farmworkers in Georgia, ICAD, 1994). However the numbers of Hispanic clients enrolled in programs such as the Women, Infants, and Children Program (WIC) and the state Perinatal Case Management Program (PCM) are very low.

Decatur County has little infrastructure to assist the immigrant population with access to health care services. There are no bilingual staff, or outreach staff, employed by local health care or social service providers. The health department does not provide primary care services nor does

any provider in the county provide primary care on a sliding fee scale. Transportation is a major barrier to care. Most of the immigrant population live outside of Bainbridge; most health care service providers are located in Bainbridge.

Decatur County Health Department employees began using the Citizenship Declaration Form for enrollment in Medicaid Presumptive Eligibility in early 1997. Prior to the addition of this form to the enrollment process Medicaid Presumptive Eligibility was being used to cover the cost of an initial prenatal care visit for undocumented immigrant women. After the first visit, costs for prenatal care were covered through other state and health district low cost or high risk pregnancy programs. Since January 1997, when a "not qualified" pregnant immigrant woman comes into the health department, the PCM program refers her to a private doctor. The costs for her prenatal care services are covered by funds from the health district's low cost prenatal care package or the state high risk pregnancy program. The PCM program provides prenatal vitamins and iron supplements; however other medications must be paid for by the patient. The employees from the PCM program, neither of whom are bilingual, follow women throughout pregnancy and delivery and help them enroll in programs such as WIC. In Decatur County, Emergency Medicaid is usually applied for at the Department of Family and Children Services (DFCS) after the delivery. According to the PCM program, Emergency Medicaid in Decatur County will cover only "active delivery" which is usually one day. Many women do not come back after delivery to apply for Emergency Medicaid so the hospital is not compensated for the costs incurred. Employees from the PCM program stated that the numbers of pregnant women coming to the health department are lower than last year. The PCM program has about four immigrant women enrolled currently and the county WIC program has only two active Hispanic clients.

Two interviews with immigrant women were conducted in Decatur County. The first interview was with a Mexican woman who has been living with her family in Bainbridge for the past seven years. She has three children and is several months pregnant with a fourth. Two of the children were born in Mexico and one was born in Bainbridge five years ago. She couldn't remember exactly how often she went for prenatal care during her first pregnancy in the U.S. but stated that she first saw a doctor two months into the pregnancy and went to that private doctor about once a month until delivery. She did not pay for the services and remembers going to an office to sign papers several times. For her current pregnancy the PCM program referred her to a private doctor for prenatal care. She stated that she will not pay for care this pregnancy because the health department put her on a low cost program and Medicaid will pay for her delivery. When asked if she were charged $30 per visit for prenatal care what would she do, she responded that she would go for fewer visits, and go only when the family had the money. The family had been

out of work for several weeks at the time of the interview. She said there was a great need for interpreters both for the prenatal visits and for her delivery. Her husband, who spoke some English, would take her to appointments when he could but only if he was not working. The second woman interviewed was from Guatemala and has been living approximately five miles outside of Bainbridge for four years with her family. She had given birth to five children, three in Guatemala and two in the U.S. In Guatemala she gave birth at home with a midwife. For her first pregnancy in Decatur County, the first prenatal visit was at six months. She had a friend that could take her to the appointments and interpret for her. She thought that Medicaid had paid for the perinatal services and remembered going to an office to sign papers every few months. For her latest pregnancy she did not go to a doctor until nine months into the pregnancy. Her reasons included feeling fine during the pregnancy, her inability to speak English, and lack of transportation. She did have two prenatal visits in the ninth month after being referred by the health department to a private doctor. The family did not pay for any costs and they remember filling out paperwork with a man that spoke Spanish. She stated that if she had to pay $30 for prenatal visits she would not go because she's always felt fine during pregnancy and she would need an interpreter and a ride to get to any appointment.

Colquitt County Findings

Colquitt County is also located in the southwest region of the state and is home to many Hispanic immigrants. It is an important region for agriculture and industry. Many vegetables are grown in the county including cabbage, peppers, cucumbers, and tomatoes. Major industries include lumber, mobile home manufacturing, and food processing. The estimated number of farm workers and their families that are in Colquitt County in the peak month of June is 6,303 (ICAD,1994). Many Hispanic immigrants who came to the county originally to work in the fields have now "settled out" of the migrant stream and are finding jobs in other industries. Therefore the total number of Hispanics in the county is significantly larger than that given for farmworkers and is growing rapidly.

One of the Georgia Migrant Health Program sites is located at the Colquitt County Health Department. The health department and the migrant health program employ bilingual interpreters. There is a local OB/GYN physician that provides prenatal care to most of the Hispanic women in the area. The physician has an interpreter available at his office one morning of every week to assist the Hispanic patients. The interpreter is an employee of Colquitt Regional Medical Center where the doctor delivers his patients. Pregnant immigrant women who come to the health department are evaluated for eligibility into several payment programs for the uninsured before

being referred to this private physician for care. Women may be eligible for Medicaid, ongoing Emergency Medicaid, high risk pregnancy, or low cost programs. One of these programs pays for prenatal care costs; Emergency Medicaid, if applied for, covers the cost of the delivery.

The OB/GYN physician agreed to see women referred by the health department on the low cost program. This program, administered by the Albany Health District, reimburses the doctor $500 per pregnancy for all prenatal visits. Prior to January 1997, health department employees were using Medicaid Presumptive Eligibility to obtain reimbursement for providers of prenatal care for immigrant women who were not eligible for Medicaid. Women were repetitively signed up for Medicaid Presumptive Eligibility and thus the provider could get reimbursed for the next month of care. Health department employees began using the Citizenship Declaration Form in early 1997. Staff at the private physician's office feel that Medicaid Presumptive Eligibility is currently not being used as much as it was last year and that the number of immigrant women they are seeing is lower than in previous years. There was a short period between the implementation of the Citizenship Declaration Form in January 1997 and the use of the low cost program for prenatal care for undocumented women in the spring of 1997. During that time, the physician's office had to charge immigrant women $30 per prenatal visit and the number of Hispanic women served by the office dropped to almost none. On the morning of the interview (12/17/97), a slow day according to the staff, the physician saw approximately twenty Hispanic prenatal clients before 12:00 p.m.

Thirteen pregnant immigrant women were interviewed in Colquitt County. Six interviews were conducted at the private doctor's office, two at the Colquitt County Health Department, and five at private homes. All of the women interviewed initiated prenatal care services before the end of the second trimester of pregnancy. Most had been referred to the private OB/GYN by the health department. In general the women did not understand what program paid their prenatal care costs, but they knew that they would not have to pay and that Medicaid would pay for the delivery. Twelve of the thirteen women said that if the doctor charged $30 per visit they could not pay or would come for fewer visits. Five of the women said they have problems accessing care because they need an interpreter and seven said that transportation was a barrier for them.

Marion County Findings

Marion County is located in the central western region of the state between the cities of Columbus and Americus. It is home to several large industries including a Tyson Chicken processing plant and the Baby Dreams factory. Both of these factories are located in the town of

Buena Vista. Many of the workers in these industries are immigrants from Guatemala and Mexico. Approximately 1,000-1,500 Tyson employees (60%) are Hispanic. Marion County has a large number of Guatemalan immigrants that do not speak English or Spanish, but a Mayan language spoken in some regions of Guatemala. There is some local knowledge of two men who are known to go to Guatemala and Mexico and bring back people to work in the factories. In general, the immigrant population in this region of the state has recently arrived. Most of the people have been in Marion County less than three years.

The Marion County Health Department does not provide prenatal care services and does not employ any bilingual outreach or interpreter staff. One day a week, for limited hours, there is a DFCS employee at the health department to enroll women in Medicaid and other reimbursement programs. There are no OB/GYN doctors in the county; however there are two family physicians who provide prenatal care on a fee for service basis.

Columbus Regional Hospital has an outpatient clinic in Buena Vista. The clinic employs an Hispanic medical interpreter who also provides outreach services. Since this employee was hired in June of 1997, the number of Hispanics coming to the clinic has increased dramatically. The clinic is currently seeing 25 immigrant women for prenatal care. All of these women have been in the area less than one year. When a pregnant immigrant woman comes to the clinic she is sent to the health department to enroll in Medicaid or other possible reimbursement programs for the uninsured. If she is eligible for Medicaid she is referred to one of two OB/GYN doctors in Americus. In the past few months, if a woman was not eligible for Medicaid the clinic would provide prenatal care services at no cost to the patient and without being reimbursed. Administrators at the clinic recently learned of a low cost program provided by the Columbus Health District that would reimburse the clinic for prenatal services. If the women can get to the health department to enroll for the program then the clinic could get reimbursed at a rate of $500 for each pregnancy for all prenatal visits. Women also need to apply at the health department for Emergency Medicaid to cover delivery costs. They can apply 45 days before the delivery. Most of the women deliver at Sumter Regional Hospital in Americus because it is the closest hospital to Buena Vista.

There are many barriers to accessing health care for pregnant immigrant women in Marion County. Transportation is a major problem for this population. Many women walk miles for appointments and may miss them if it is raining or cold. Most of the health and social service providers in the county do not employ bilingual staff and have a reputation for being inhospitable and discriminatory toward Hispanic clients. The Tyson plant offers private insurance to

employees; however there are few Hispanics who are enrolled or understand how the insurance works. Employees must undergo a probation for 90 days before they can apply for insurance and then they have a 60 day period to enroll. If they do not sign up before the end of the 60 days, they must wait a year for the opportunity to enroll again. The insurance plan covers 80% of health care costs and prescriptions are available for twelve dollars. However, there is only one pharmacy in Marion County and they do not accept Tyson insurance. Therefore even those employees covered by insurance have to drive to Americus to fill a prescription for the $12 price. Most of the employees do not understand the insurance process or how to fill out the paperwork and therefore do not ever receive insurance through their employer.

All but one of the pregnant women who have come to the Columbus Regional Outpatient Clinic for prenatal care have had uncomplicated pregnancies. In the one case where there was a serious complication, it was suggested that the woman move to a neighboring county where the health department had a program for women with high risk pregnancies. The family moved, enrolled in the program, and travels the distance to the Tyson factory every day to work.

Conclusions and Recommendations

The immigrant population in south Georgia is growing at a rapid rate. Most of the immigrants are Hispanics with very limited English skills. These immigrants are flocking to Georgia to work in the fields and factories to earn an income they can not make at home in Mexico or Central America. Those working as farmworkers and in poultry processing are critical to harvesting and processing over $2 billion dollars of Georgia's agricultural products each year. Despite their significant contributions to Georgia's economy, they are mostly very poor, making an average of $6,000-7,000 a year, and live in substandard housing. In general they are uninsured and do not understand the health care system and the different payment sources for prenatal care. Fourteen of the fifteen women interviewed indicated that they could not pay even $30 a visit for prenatal care.

It is recommended that Georgia fund prenatal care for all immigrants who are no longer eligible for Medicaid Presumptive Eligibility. Prenatal care is a cost effective method of improving birth outcomes and reducing pregnancy complications. Risk factors such as poor nutrition, substandard housing and incomes at or below poverty increase the likelihood that pregnancies among this population will be high risk. According to the NCSL report, "Studies estimate that every dollar spent on prenatal care yields between $1.70 and $3.38 in savings by reducing neonatal complications". (p. 6)

While health districts are trying to cover the costs of prenatal care for "not qualified" immigrants, coverage is not uniform across the state. Low cost packages differ from county to county. Some health districts do not have funds to pay for care for all immigrant women who are now ineligible for Medicaid Presumptive Eligibility because of their immigration status. The Georgia Division of Public Health should examine how other states, such as Illinois, are providing prenatal care for "not qualified" immigrant women.

Health districts should work closely with providers who serve immigrant clientele to maximize reimbursement for perinatal services. The use of low cost programs to fund prenatal care for undocumented women has led to confusion among some providers regarding the availability of funds and procedures for reimbursement. The fact that Medicaid programs are administered through county DFCS offices and low cost and high risk programs are administered through health departments has also led to confusion over where to apply and who is eligible for what program.

Many hospitals are not being reimbursed by Medicaid for the delivery services provided to undocumented women. Applications for Emergency Medicaid should be initiated prior to delivery. Applications can be made up to 45 days before the delivery. Application before delivery would increase the number of women for whom providers are reimbursed since fewer women will "disappear" after delivery without having applied for Emergency Medicaid.

Health departments should familiarize themselves with the immigrant communities in their county and assure that services are accessible to them. Accessibility assumes cultural and linguistic appropriateness and a non threatening environment. The majority of immigrants in south Georgia are Spanish speaking and very few have the English skills required to negotiate the health care system. Bilingual staff are needed to help women fill out paperwork for reimbursement, to interpret at prenatal care appointments and deliveries, and to explain the U.S. health care system to clients. Bilingual staff can also help to alleviate fears that immigrants may have regarding confidentiality and INS reporting. Decatur County is in particular need of bilingual staff as there currently are none employed in the county and there is no link between health care providers and the Hispanic community. The Columbus Health District should help the Marion County Health Department hire bilingual staff and provide cultural sensitivity training for employees.

References

Institute for Community and Area Development (ICAD), *Estimation of Migrant and Seasonal Farmworkers in Georgia*, University of Georgia, Athens, GA, 1994

National Conference of State Legislatures (NCSL), *America's Newcomers: Access to Prenatal Care for Unauthorized Immigrants, Challenges for the States*, Washington D.C., May 1997

Attachment A

Survey of Pregnant Immigrant Women

Survey of Pregnant Immigrant Women
December 1997

ID #_____ Time begin_____

Date_____ Time end_____

We are conducting a survey to look at the impact of welfare reform on pregnant immigrant women. We need to know how women are accessing and paying for prenatal care since changes occurred last year. This information is crucial to making further changes that can gain immigrant women access to the care they need to have healthy babies.

1. Are you pregnant or have you had a baby since June 1997?
   (Esta embarazada o ha tenido un bebe desde junio pasado?)
   1. Yes
   2. No

2. Where are you from?_____
   (De donde es usted?)

3. How long have you been in the US?_____
   (Cuanto tiempo ha estado ud. en los Estados Unidos?)

4. How old are you?_____
   (Cuantos anos tiene ud.?)

5. Do you have other children?
   (Tiene ud. otros hijos?)
   1. Yes
   2. No

If yes, go to #6
If no, go to #14

6. How many?_____
   (Cuantos hijos mas tiene?)

7. Where were they born?_____
   (Donde les fueron nacidos?)
(If any in US, go to #8) _____

(If all another country, go to #14) _____

8. Did you get prenatal care for those born in the US?_____
   (Fue ud. al doctor durante los embarazos de los hijos que fueron nacidos aqui?)
   1. Yes _____
   2. No _____

If yes, go to #10
If no, go to #9

9. Why didn't you get prenatal care?_____
   (Porque no fue al doctor durante el embarazo?)

10. What services did you get and how often? _____
    (Cuantas veces se fue al doctor y que servicios le ofrecieron?)

    _____

    _____

    _____

11. At what time did you first see a doctor (each pregnancy)?_____
    (Cuando fue ud. al doctor por la primera vez en el embarazo? a cuantos meses?)

    _____

    _____

12. How did you pay for the prenatal care (for each kid)?_____
(Como pago ud.por los servicios medicos del embarazo?(menos el parto))

_____

_____

_____

13. Were you eligible for Medicaid for these previous pregnancies? _____
(Estaba ud. elegible por Medicaid durante los embarazos anteriores?)

_____

_____

14. This (latest) pregnancy, are you getting/did you get prenatal care services?
(En este embarazo, va/fue ud. al doctor por servicios medicos del embarazo?)
    1. Yes
    2. No

If yes, go to #16
If no, go to # 15

15. Why aren't/didn't you get prenatal care services?_____
(Porque no va/fue al doctor por servicios medicos del embarazo?)

16. What services and how often? _____
(Que servicios le ofrecen y con que frecuencia?)

17. At what time did you first see a doctor? _____
(Cuando fue ud. al doctor por la primera vez en el embarazo? a cuantos meses?)

18. Where do you/did you get prenatal care services? _____
(A donde va/fue ud. por los servicios medicos del embarazo?)

19. How did you/are you paying for prenatal care services? _____
(Como esta pagando ud. por los servicios medicos del embarazo?)

20. Are/were you eligible for Medicaid? _____
(Esta/estaba elegible por Medicaid?)

21. How much could your family afford to pay for prenatal care (total care for 9 months)?
(Cuanto ud. y su familia pueden pagar por los servicios medicos del embarazo?)

If you were charged $30 a prenatal visit, what would you do?

22. Is there anything else about these pregnancies that you'd like to share with me?
(Hay algo mas que quiere decirme sobre los embarazos y servicios medicos?)

Attachment B

Citizenship Declaration Form

PRESUMPTIVE ELIGIBILITY

DECLARATION OF CITIZENSHIP / LEGAL ALIEN STATUS

I know that the Immigration and Naturalization Service (INS) has to verify my immigration status. Information received from INS could affect my benefits.

1) I, _____, certify under penalty of perjury, that I am a citizen of the United States, born in _____ or naturalized on _____.

Signature _____

2) I, _____, certify under penalty of perjury, that I am a lawfully admitted immigrant that entered the United States before August 22, 1996.

Signature _____

3) I, _____, certify that I am a lawfully admitted immigrant that entered the United States on or after August 22, 1996. However, I certify: a) I have forty quarters (10 years) of employment (under the U.S. Social Security system) and have not received any public benefits during these quarters, b) I am an honorably discharged U.S. military veteran or active duty military personnel or the spouse or unmarried dependent child of a veteran, c) I am a refugee or asylee, d) My deportation has been withheld.

Signature _____

4) Client cannot certify to any of the above.

Signature of Witness (If someone signs with an "x")	Provider Signature	Title
Date of Completion	Qualified Provider Name	Provider Number

-For Office Use Only -

Verification of citizenship / legal immigrant status attached if available.
(Applications are not to be denied or held pending if verification is not present).

☐ Yes ☐ No

Medicaid Identification Number (For Office Use Only)	Patient's Name

Attachment C

Funding Prenatal Care for Unauthorized Immigrants:
Challenges Lie Ahead for States
Executive Summary

National Conference of State Legislatures

AMERICA'S NEWCOMERS

Funding Prenatal Care for Unauthorized Immigrants: *Challenges Lie Ahead for States*

EXECUTIVE SUMMARY

Prenatal care is widely acknowledged as the most cost-effective way to improve the outcome of pregnancy for all women and infants. The care is especially beneficial for undocumented women, many of whom live in poverty, are uninsured, have a number of risk factors for poor birth outcomes and are likely to initiate prenatal care with unmet health needs. States and localities typically combine their own funds with funds from a variety of federal programs to make prenatal care and perinatal nutrition support available to undocumented women. These programs include:

State-Federal Programs

- Emergency Medicaid (labor and delivery services only);
- Medicaid-financed prenatal care (New York only);
- Medicaid presumptive eligibility; and
- The Maternal and Child Health Services Block Grant.

Federal Grant Programs

- Community and Migrant Health Centers;
- The Supplemental Food Program for Women, Infants and Children (WIC); and
- Targeted federal grants.

State Funded Programs

- State and local health department appropriations;
- Special state-funded prenatal care initiatives; and
- Restricted Medical (California only).

Concern about the impact of illegal migration on federal, state and local budgets, coupled with the belief that withholding public benefits is a deterrent to such migration, are prompting policymakers to reconsider the wisdom of providing publicly-funded benefits, including prenatal care, to unauthorized immigrants, even though the Fourteenth Amendment to the U.S. Constitution confers citizenship upon their United States-born children.

The recent enacted federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, has a number of provisions that make it possible for federal, state and local governments to deny prenatal care and nutrition support to undocumented women. Specifically, the law bars all *not qualified aliens*, including unauthorized immigrants, from receiving federal public

benefits with the important exception of benefits designed to meet emergency needs and protect the public health. In addition, the federal law attempts to nullify existing state laws and prohibit state and local governments from providing public benefits, including prenatal care, to *not qualified aliens*. States are permitted to provide their own benefits to undocumented persons *only if* they enact new laws affirming an intent to do so. Finally, states are given the *option* to provide or deny federally funded nutrition support (WIC) to pregnant undocumented women.

The prohibition on federal public benefits may shift the entire burden of providing prenatal care for undocumented women onto states. States in turn are left to decide whether to assume the costs of making this care available and to assess whether provisions of the law or their decisions relative to them will face Constitutional challenges. As state policymakers prepare to make these important .. decisions it is important that they are mindful of the health- and cost-benefits of prenatal care for women, newborns and communities.

Early and continuous prenatal care provides women with opportunities for ongoing assessment for one of the most significant complications of pregnancy -- low birth weight. Low birth weight and very low birth weight which result from a failure of the fetus to fully develop (intrauterine growth retardation), the infant being born too soon (pre-term) or a combination of both, contribute substantially to infant mortality and childhood disabilities. Studies estimate that every dollar spent on prenatal care yields between $1.70 and $3.38 in savings by reducing neonatal complications. The savings increase dramatically when the long-term costs of caring for newborns with physical and developmental disabilities are considered, and are even greater when unforeseen maternal complications are avoided.

In addition to the cost savings associated with prenatal care, such care offers many undocumented women their first exposure to the United States health care system as well as their first opportunity since entering the United States to be screened and treated for communicable diseases. Perinatal identification and effective treatment of communicable diseases, such as TB, chlamydia (a sexually transmitted disease or STD) and HIV, can be lifesaving for both the mother and infant, protect communities from epidemics and save hundreds of thousands of dollars in remedial care. Epidemiologists have found that every dollar spent on prevention care for undocumented women, including prenatal care with screening for STD's , saves over $13; and each prevented case of fetal HIV saves an estimated $400,000 in lifetime costs associated with treating HIV-infected infants.

The primary goals of restricting undocumented immigrant' access to publicly funded health care are to deter illegal migration and reduce federal, state and local costs. The federal welfare reform law leaves it up to state policymakers to ultimately decide whether these objectives can be met by denying prenatal care to undocumented women. Because the U.S. Constitution grants citizenship to all children born in this country regardless of their parent's immigration status, these children are entitled to receive the full range of public benefits, including Medicaid. Thus, the minute the child of an undocumented woman is born -- whether in perfect health or critically ill -- the baby is immediately eligible to have the public pay for its health care.

Undocumented women are currently barred from receiving Medicaid-financed prenatal care (with the exception of undocumented women who live in New York). However, undocumented women are able to receive Medicaid-funded emergency labor and delivery. In addition, Medicaid often funds ongoing care for undocumented women who experience post delivery complications, as well as the care needs of infants born with critical conditions. Thus the financial burden ultimately falls upon federal, state and local governments, each sharing in the cost of care. Although the recent enactment

of federal welfare reform appears to give states the opportunity to deny prenatal care to undocumented women, in the end state policy makers must decide for themselves whether the hope of immediate savings outweigh the long-term costs to the health of women, newborns and communities.

NOTES

The federal welfare reform law divides immigrants into *qualified aliens and not qualified aliens* for purposes of determining eligibility for public benefits. *Qualified* immigrants are: lawful permanent residents; refugees; asylees; persons paroled into the U.S. for a period of at least one year; persons granted withholding of deportation; persons granted conditional entry in the U.S. and certain battered spouses and children. All other immigrant classifictions, including undocumented immigrants, are considered *not qualified* immigrants.

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