

**EFFECTS OF 1996 ON IMMIGRATION AND IMMIGRANT POLICY
REFORMS ON LEGAL PERMANENT RESIDENTS**

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I. INTRODUCTION

In 1996 after decades of study, public pressure and political wrangling, the Congress of The United States approved the most extensive welfare reform legislation since the passage of the New Deal. The movements to stem the deterioration of the welfare family, curtail the cycle of dependency, reduce poverty in America by reaffirming a work ethic, and control the staggering cost of public assistance programs, culminated in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, P.L. 104-193 (PRWORA). One feature of the reform legislation aimed at addressing the demands the growing immigration population placed on the welfare system. Praised by conservatives and moderates alike, the historic welfare legislation amended six decades of social policy and radically overhauled the welfare system in an effort to redefine the government's commitment to federal welfare and entitlement programs. The enormous effort behind the success of these proposals was the desire by conservatives and moderates alike to "end welfare as we know it" through the promotion of work and marriage, a reduction of non-marital births, and the encouragement of the formation and maintenance of two-parent families. The aim was to end the culture of dependence that had infected parts of society. The congressional hearings on the act's proposals attracted widespread attention from both critics and supporters, initiating heated debates, editorials, opinion polls, protest marches, and policy arguments.¹

Essentially, PRWORA promised to decrease welfare spending by \$55 billion over five years, limit welfare receipt to two years after which time recipients must work,

establish a lifetime limit of five years on welfare, and allocate a lump-sum payment (block grant) to states to create state-based welfare programs. This block grant to States became known as Temporary Assistance to Needy Families (TANF) and replaced the Federal cash public assistance program Aid to Families with Dependent Children (AFDC).ⁱⁱ The legislation had a profound and unforeseen impact on post-enactment immigrants. Welfare reform redefined the welcome mat to new immigrants by declaring them unqualified for the public benefits, including non-emergency Medicaid. While the Federal government continued to exercise its control over *immigration policy*, it passed onto State governments the responsibility of *immigrant policy* and shifted the expense of services that supported immigrant integration into society. This paper investigates how the policies, as perceived and modified in the 1996 welfare reform action, affected health care access and related issues of the next generation of immigrants to America.

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II. AN OVERVIEW OF THE POLICY & CLASSIFICATION OF IMMIGRANTS

Though the terminology usage varies widely a uniform categorization of immigrants is essential to an understanding of entitlement since under the law an immigrant's status is used in determining eligibility for public benefit programs. Therefore it is important for the purpose of this paper to briefly define the immigrant classifications that will be used. The Immigration and Naturalization Service defines immigrant as to mean those who are lawfully admitted to the United States for permanent residence. The phrase non-citizen in this paper will refer to foreign-born people who have not become naturalized citizens. Legal (or lawful) permanent residents (LPRs) are foreign-born people who are legally admitted to live permanently in the United States by qualifying for immigrant visas abroad or through an adjustment to permanent resident status once in the U.S. The focus of this paper will center on LPRs. This group of green card holders does not include those who have been admitted for temporary periods for specific purposes like study, business or just as tourists. This group will include refugees and asylum seekers who are in actuality a group of their own, as foreign born people admitted legally to the United States, but since they may and often do adjust to legal permanent resident status after they have been in the United States for a year. LPRs, refugees and asylum seekers may become U.S. citizens through a naturalization process. Typically after five years of residence they qualify for naturalization, though immigrants who marry citizens qualify for US citizenship usually after three years of residence. The

U.S. process of naturalization is a selective feature particularly set by the fact that eligibility for naturalization follows admittance for permanent residence. Other basic criteria for naturalization include good moral character, ability to speak, read, and write English; knowledge of the "fundamentals" of U.S. history and government; attachment to constitutional principles; being "well-disposed to the good order and happiness of the United States"; and an oath expressing allegiance to the United States and renouncing all prior allegiances. Although characterized as an act of Congressional favor, naturalization under the main provisions of the law has always been a matter of statutory entitlement for those who meet the specified criteria.

In the ten years prior to 1996 approximately 9 million immigrants legally attained permanent residence in the United States and approximately 3 million immigrants entered illegallyⁱⁱⁱ. Beyond the surface of this unprecedented growth of the immigrant population, history will see something even more distinctive about the decade. 1996 marked a turning point when a new harder attitude toward immigration took hold in the center of the political spectrum. PRWORA in conjunction with the passage of the Illegal Immigration Reform and Individual Responsibility Act of 1996 were the results of a political system that showed increasing skepticism over the arrival of legal immigrants. Prior to the 1996 there existed few distinctions in federal law between legal permanent residents and citizens, thus legal immigrants were generally eligible for AFDC and Medicaid benefits on the same basis as citizens were eligible depending on the state eligibility requirements. Key immigrant provisions of the law distinguished between

"qualified" and "not qualified" immigrants,¹ and between persons who entered the United States before and after enactment of the 1996 law, in determining eligibility. Almost all of the immigrants who were legally admitted to the United States before August 22, 1996 (when PRWORA was enacted) were still eligible for full Medicaid coverage, if they met income and categorical standards. The legislation banned "not qualified" immigrants from Medicaid assistance (except for emergency Medicaid services), and generally made "qualified" immigrants ineligible for this program for five years after coming to the United States. The law allowed exceptions to these requirements only for refugees, asylum seekers, persons granted withholding of removal during their first five years (subsequently extended to seven years) in the United States, immigrants, who meet the 40-quarter work history test, and current and former military personnel and their spouses and dependents.^{iv}

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A key provision affecting legal immigrants in the Illegal Immigration Reform and Individual Responsibility Act of 1996 was a change to the Immigrant Sponsor requirements.² The minimum household income level for a sponsor of an immigrant was raised to 125 percent of the federal poverty level. It also required sponsors to sign a legally enforceable affidavit pledging to assume financial responsibility for their sponsored immigrants meaning means-tested benefits agencies of state governments may

¹ Qualified Immigrants are (1) Lawful permanent residents (LPRs), (2) refugees, asylees, persons granted withholding of deportation/removal, conditional entry, or paroled into the U.S. for at least one year; (3) Cuban/Haitian entrants; and (4) battered spouses and children with a pending or approved (a) self petition for an immigrant visa, or (b) immigrant filed visa for a spouse or child by a U.S. citizen or LPR, or (c) application for cancellation of removal/suspension of deportation, whose need for benefits has a substantial connection to the battery or cruelty.

² The term Sponsor means an individual who “ (A) is a citizen or national of the United States or an alien who is lawfully admitted to the United States for permanent legal residence; (B) is 18 years of age or over; (c) is domiciled in any of the 50 states of the District of Columbia; and (D) is the person petitioning for the admission of the alien...”²

sue sponsors for failing to provide the support pledged.^v At the end of 1997 the INS began to implement these modifications in the law by issuing a new Affidavit of Support putting the new sponsorship requirements into effect by drafting regulations in which sponsors' income is "deemed available" as a part of the immigrants' income in the determination of eligibility for means tested public benefits, like Medicaid.^{vi} And since most legally admitted immigrants who enter the United States after August 1996 were eligible for full Medicaid coverage after their first five years here, this new provision rendered these immigrants unqualified for Medicaid, because the law required that the income of the persons who sponsored their entry must be "deemed" available to them. Thus, few post-enactment immigrants will appear to be sufficiently poor to qualify. An exception was that refugees and asylum seekers retained full Medicaid coverage for their first seven years in the United States.

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Title IV of PRWORA includes the above provisions on exemptions of public benefits programs based on immigrant status and the increased financial responsibility of citizens for immigrants whose entry they sponsor. Cost reductions were estimated by the Congressional Budget Office to account for almost half of the savings expected to accrue from the legislation. An estimated \$21 to 24 billion was to come from the efforts to curtail benefits to legal immigrants, though the majority of the media coverage did not focus on the provisions throughout the authorization debate. With the legislation's enactment Congress claimed to not want "anyone" to lose Medicaid eligibility as a result of welfare reform, by providing that the law require states to use their old AFDC eligibility requirements in determining eligibility under TANF. On the other hand, as a part of the cost-cutting measure Congress knowingly expected that the new provision of

title IV would cause Medicaid enrollment to decline among immigrants households. Almost all of the immigrants who were legally admitted to the United States before August 22, 1996 were still eligible for full Medicaid coverage, if they continued to meet income and categorical standards. But in contrast, immigrants admitted post-enactment were ineligible and become eligible only if they attain “qualified” immigrant status by five years or more of residence. This amendment to previous law was lauded by some congressional leaders and policy makers who thought that their purpose was “to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy”^{vii} and vehemently protested by other scholars, interest groups spokesmen, and progressive congressional figures. The Los Angeles Immigration Law Center wrote that the immigrant provisions in the law would be the first time “legal immigrants who have lived here for many years will not have equal access to the programs that their taxes fund”.^{viii} Providing health care coverage to all advances the common good of all individuals in a society and through the provision of this good, an equal moral standing for each individual in a society regardless of individual strength, social contribution, money, race, etc. is established.

III. THE WELFARE MAGNET OF THE UNITED STATES AND THE RISE IN DEPENDENCY FOR IMMIGRANTS

The fiscal issue propelling the reform to include immigrants was largely driven by congressional interest in reducing government spending. This is evidenced in that nearly half of the law's projected savings were attributable to the provisions making most legal immigrants ineligible for public benefits, yet this fact alone does not explain the justification of the immigrant provisions as policy. The issues determining the debate behind the enactment went beyond the economic benefits. One policy dispute centered on whether immigrants' access to public benefits should be curtailed in order to discourage people from immigrating to the United States just to gain access to public benefits. Republicans mainly argued that generous Federal benefits draw immigrant to the U.S. and discouraged them working. This negative rhetoric of “welfare magnets” and “welfare dependency” among immigrants dominated the debate though it is a largely unfounded myth. In fact most studies have found that LPRs enter this nation either as a part of family reunification, or for reasons of employment. In her testimony over the immigrant provisions of the Act, Congresswoman Nancy Pelosi stated that according to an INS report on LPRs which found that “fully 64 percent of legal immigrants come to the United States to join family members, 14 percent come because U.S. employers need their skills and 16 percent are fleeing political persecution”^{ix} Those statistics alone account for almost the entire LPR motivation for immigrating and holds the welfare magnet supposition to be fundamentally untrue.

Congresswoman Pelosi further states another finding that “only 3.9 percent of immigrants, who come to the United States to join family members or to work, rely on public assistance, compared to 4.2 percent of native-born residents.” This rebukes the other major dispute over the reform that centered on whether immigrants are more of a contribution to our society or more of a drain of public resources. There has been a growing public perception that the immigration policies of this nation have greatly increased welfare roles and are preventing efforts to reduce the effects of poverty by contributing to the problem. Though extensive research has been done in studying immigrant use of welfare, since there exist no universal definition for what range of public assistance programs are included in welfare, there is widespread disagreement among scholars over the conclusion that can be made, especially in immigrant usage of Medicaid. The impact of the research conclusions has profound impacts on the politics and has greatly shaped the debates and public opinion. Governor Pete Wilson was successful in California the passage of Proposition 187 as a popular statewide referendum, because his rhetoric blamed immigrants’ for the chronic multi-billion dollar budget deficits that California faces as a result of their use of social services. Briggs and Moore find few studies that actually support his claims and found that while studies do exist such as a 1992 study by the Los Angeles County Board of Supervisors sustaining the results that immigrants are greater users of the welfare system these studies have been shown to have severe methodological errors that preclude any validity.^x There are many studies concluded that the changing demographics of the immigrant population to low-skilled labor has produced an increase in the use of public programs by immigrants. Economist and leading immigration expert George Borjas has conducted widely cited

studies that find that unlike a generation ago, today's immigrant households are more likely to receive welfare than native households and states his own speculation as to the consequences this lack of interdependence in policy between *immigrant* and *immigration* policy has brought about. Borjas purports that fact: "the INS did not link the receipt of public assistance and the public charge provision in the immigration law in the 1990's, the number of immigrants receiving public assistance rose rapidly"^{xi} Borjas sites congressional reaction to this trend as the major cause for the provisions that tightly restricted immigrant access to public assistance programs like Medicaid. His analysis supported the republican charge that immigrants, at the time of the debate, had grown in their levels of dependency on benefits. In his findings immigrants were slightly less likely to than natives to receive cash welfare benefits in 1970, but that by 1990 immigrant households were overrepresented among the welfare population posits only a relatively small fraction of 1.7 percent different between the two categories.

In his testimony before congress Michael Fix reported on the Urban Institute's findings that welfare use of immigrants who have arrived in the past ten years is concentrated to a larger extent among refugees. Their augmented need for such safety nets as Medicaid among this group of individuals is understandable. Refugees and asylum-seekers are more often in worse health and this is often due to their circumstances which categorizes them as refugees who have left their country of origin often during times of persecution or political commotion, and have fled to the U.S. in search of safety. In the case of Cubans and Asians, the groups most likely to have received settlement assistance upon arrival, this increased rate of public assistance usage is due to their likelihood of obtaining refugee status the rates of usage did not increase the longer the

time spent in the US, but rather in some instances, declined.^{xii} The 1990 census indicates that when immigrants from refugee sending countries are excluded the welfare usage rates among immigrants who entered in the 1980s were actually lower at 2.3 percent than the native average.^{xiii} Aside from the understandable need for benefits that refugees and asylum seekers need upon arrival to the United States, the claim that legal immigrants abuse welfare is unsubstantiated by the studies. According to Fix during the 1996 congressional hearings on welfare reform, one alleged abuse involved high-income Chinese families who, though they could afford to support their elderly parents, enrolled them in the Supplemental Security Income program anyway. Political and media portrayals of freeloading border-crossing immigrants have created a negatively based stereotype of the immigrant in American's minds today. It is a grossly inaccurate portrayal of the 24.6 million "Americans" or 9.5 percent of the population at the time of the passage of PRWORA who were foreign born, the overwhelming majority of whom are not abusing the welfare system.

The latest studies have refuted both the welfare magnet and dependency theories. According to a report from the Brookings Institution, the 30 least generous states saw strong growth in immigrant populations between 1995 and 2000. The numbers of immigrant families with children increased by 31 percent in these states, four times the rate of the 20 other states. And it's hardly the case that welfare leads to immigrant dependency: Immigrant men 16 years and older have a higher labor market participation rate-79 percent to 74 percent-than native men. In fact, the National Academy of Sciences discovered that the United States nets a \$50 billion surplus from taxes paid by immigrants to all levels of the government.^{xiv}

IV. FEDERALISM ISSUES AND MEDICAID: DEVOLUTION, DELINKING AND THE INCREASE OF THE STATES' BURDEN

Just as the debate over PRWORA was clouded by alleged abuses, including controversy and gross misperceptions, so inherently will the attempts to analyze the justness of the welfare reform acts. In the first year of reform implementation most states opted to maintain the Medicaid program that they had administered previous to 1996. However because of the historical link that state's had made by tying Medicaid to cash assistance, the move from AFDC to TANF affected the participation rates for low income families who may not have realized that they were still eligible for Medicaid coverage with out cash benefits. ^{xv}

Beginning in 1972, Federal statutory and regulatory alien eligibility criteria were established for four major federal assistance programs: AFDC and Medicaid, which were Federal-State matching programs; and SSI and food stamps which are basically Federal programs.” ^{xvi} George Borjas writes that not much has changed in *immigration* policy legislation since the Supreme Court unambiguously granted the federal government the sole authority to control immigration in 1876. The two reforms of 1996 redefined the federal/state balance on immigration policy. The law separated Medicaid from welfare cash assistance. AFDC recipients were automatically eligible for Medicaid, and families leaving AFDC due to employment could qualify for up to a year of transitional Medicaid coverage. But in shifting from AFDC to the block grant TANF, policymakers recognized that such automatic eligibility would be problematic under the new legislation.

By allowing the states to use their own discretion to determine who is eligible for TANF and for how long, the tying of Medicaid eligibility to TANF receipt Congress noted, could result in inappropriate contractions or unintended expansions of Medicaid coverage. To resolve the issue, Congress created a new Medicaid eligibility category.³

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Though Congress claimed to not want individuals to lose Medicaid eligibility as a result of welfare reform, the new law required states to use their old AFDC eligibility requirements in determining eligibility under TANF. But for immigrants this reform was expected to effect eligibility. They anticipated in their cost benefit analysis that the new eligibility requirements would cause Medicaid enrollment to decline. This was due to the payments structure of the Medicaid program ensures that both the federal government and the states share in program financing and setting major program policies such as eligibility. The welfare law gave states the option of continuing to provide Medicaid benefits to most legal immigrants but prohibited states from providing these benefits with federal matching funds to legal immigrants who have been in the United States for less than five years.

Almost all of the immigrants who were legally admitted to the United States before August 22, 1996 are still eligible for full Medicaid coverage, if they meet income and categorical standards. In contrast, most legally admitted immigrants who enter the United States after PRWORA's enactment date are ineligible for Federal matching funds

³ The Government Accounting Office defined the Medicaid population into three categories as determined by the legislation: (1) people who Medicaid eligibility is primarily based on the receipt of cash assistance, (2) people who do not receive cash assistance and (3) people who receive cash assistance, but could qualify for Medicaid under a an alternative eligibility category.³

for Medicaid. Federal laws funding State programs containing eligibility restrictions based on immigration status is where many of the problems in states' fiscal deficits stem from.

Because of Medicaid's historic linkage to cash assistance, choices that states must make regarding eligibility for TANF also affects Medicaid participation rates for low income families. States must choose who will be eligible for TANF and how much income and resources TANF recipients may have. Less generous standards could discourage people from going to welfare offices where they could receive information on Medicaid eligibility. The welfare reform law gives the state's the option to continue using their July 16, 1996 AFDC categorical and financial standards for both program or to develop separate standards for TANF.

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Some states have responded to federal restrictions on immigrant benefits by establishing state-funded substitute programs, but these programs have not filled the gap left from the loss of federal assistance. An Urban Institute study found that, as of May 1999, more than half (28) of all states had created at least one substitute program for immigrants who lost their eligibility for federal assistance under TANF, Medicaid, food stamps, or SSI. "Many states with substitute programs did not extend benefits to all legal immigrants who lost federal eligibility, however, or to post enactment immigrants during their five-year federal ineligibility period. Moreover, participation rates in these substitute programs remain low."^{xviii} The GAO found that in one state they investigated there were approximately 1,700 children who had lost their SSI eligibility based on new reform

criteria but then were inappropriately severed from their Medicaid coverage as well due to administrative oversights.^{xix}

While promoting Medicaid is still a new concept since its' de-linking from welfare following the reform, most states are currently running marketing campaigns to increase immigrant awareness and enrollment in their Medicaid and CHIP programs to those who are eligible. Since most states have extended eligibility to immigrants, but their enrollment remains low, marketing is a crucial tool needed to bring up enrollment and ensure healthier children.

The Kaiser Commission on Medicaid and the Uninsured sponsored the first study on the effects of marketing Medicaid. A key finding in the difference in children's health insurance profiles between two states, New York and California is that the immigrant children are far more likely to have coverage through New York State's Children's Health Insurance Program SCHIP than through California's health insurance program SCHIP (called Healthy Families in California). Both states extend coverage to legal immigrant children in their programs, but since the New York program was established several years earlier than Healthy Families it has a much larger overall enrollment levels that include immigrant children. The length of a program's existence to its effectiveness in enrollment implies often that reform or changes to policy produces confusion and decrease participation.^{xx}

Less efficiency and more bureaucracy is one result of the new responsibilities states have with barriers enacted to the use of Federal funds for health care services to a proportion of its' residents. New administrative positions will be required allowing policy

makers discretion over who is to be covered by public assistance. Despite the largely insignificant need for structural changes due to the 1996 law, some states were troubled that the impact of the change from AFDC requirements to TANF requirements for eligibility would be on management programs. Some states contract with private firms to determine eligibility of applicants and to work with their welfare clients. The anticipated concerns of the Health Care Financing Administration HCFA were that new administrative requirements were associated with the requirement of additional cost obligations. Welfare reform initially provided an additional \$500 million to the states to help respond the new administrative costs of administering their Medicaid programs. HCFA issued regulations allocating these funds in 1997. HCFA's allocations consisted in two parts. A lump sum of \$2 million was given each state plus another stipend that varied by state that was between \$500,000 and 81.7 million depending on the state's AFDC caseload and Medicaid expenditures.^{xxi}

The period of post-enactment of PRWORA found legal permanent residents to be at the mercy of their state legislation to decide if they will extend benefits to them. This cost shift to the states contributed to the reform negative impacts since the states are facing fiscal budget crises and are under funded and overburdened as it is. This is consistent with the testimonies on the "Impact of Immigration on Welfare Programs" heard in hearings before the Subcommittee on Human Resources, House Ways and Means Committee on Nov. 15, 1993. They address the fact that the costs and benefits from immigrants are unequally distributed amongst the states. Theresa Parker, chief deputy Director of the State Department of Finance in California and serving as the undersecretary of Health and Welfare Agency in California before subcommittee on

human resources reported on the effects of immigrant resettlement patterns has created an overwhelming burden on certain states where the immigrant population has been located disproportionately in certain US states. Recent immigration trends have led some states to more acutely feel the financial burden of these shifts in responsibility since according to David Simcox, senior fellow at the Center for Immigration Studies reported that 60 percent of all immigrants settle in the states of California, New York, New Jersey, Massachusetts, and Illinois. All of these states rank in the top 25 percent of the States in terms of generosity of their assistance benefits.^{xxii} Nationally the number of refugees since the 1975 immigration law is about 1.6 million. California has 38 percent or 600,000 of them residing in the state. This geographic phenomenon has meant that federal mandates to provide support to immigrants have caused massive crisis in funding in these states.

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V. EFFECTS ON IMMIGRANT ACCESS TO HEALTH CARE: THE INTENDED AND UNINTENDED CONSEQUENCES

The actual expected decline in enrolled immigrants in Medicaid programs due to the changes on policy as reported by the Congressional Budget Office was substantial. They estimated that as of 2002 as many as 260,000 elderly, 65,000 disabled, 175,000 other adults and 140,000 children who were eligible for Medicaid will not be allowed to receive those benefits under the welfare law.^{xxiii} Though it is hard to quantify the decline of LPRs as a result of the reforms there exists a general consensus among case workers, health care providers, government officials and advocates for the immigrant populations is that there has been a general decline in enrollment among non-citizens in Medicaid programs since the enactment of welfare reform.

According to reports on the studies conducted by the Kaiser Commission on Medicaid and the uninsured, more than half of the low-income (which is set at below 200 percent of poverty line) non-citizen immigrants were uninsured in the United States in 1998 two years following the passage of PRWORA.^{xxiv} Further analyses of the March 2000 Current Population Survey reveals that Medicaid participation among low-income immigrants and their U.S. and foreign born children increased slightly between 1998 and 1999, although levels of participation were still lower than the 1995 figures, indicating that those immigrants were still participating at a level lower than before the enactment of welfare reform.^{xxv}

Participation in Medicaid was found to be lower for non-citizen immigrants and their citizen and non-citizen children when placed in controlled comparison to native-born families. (This was done by statistically taking into account adjustments for differences in income, health status, race/ethnicity, employment and education.)

Los Angeles is the only city with actual documented decline in caseloads; this is due to the fact that the majority of Medicaid data systems at States' social services departments did not document the legal status of enrollees. Even though California retained full Medicaid eligibility for post enactment immigrants the number of non-citizen immigrants and their children applying for Medicaid fell more than fifty percent in LA County following the passage of Federal welfare reform law.

In other cities data were not available as immigration status was not included in Medicaid data systems because it was not an eligibility criterion in earlier times and local agency staff was generally unaware of participation trends since data analysis was not conducted at the local level. Due to the lack of data it is hard to determine if Medicaid participation of non-citizen immigrants changed more in one city than another.

Another study was conducted to explore the relationship that declining Medicaid enrollment was due to immigration status as opposed to other socioeconomic differences related to poverty. Statistical methods controlling for health status, income, race/ethnicity, and other factors that affect insurance status and utilization were used to differentiate trends to ensure that variations in insurance status and usual source of care was related to being an immigrant, as opposed to other social and economic differences, that could affect immigrants' participation Medicaid.

The effects presented in the study are the estimated change in the average probability of having insurance (or a usual source of care), compared with the reference group, controlling for the other factors. For example, the estimate for the likelihood of being uninsured for a citizen child with non-citizen parents is 7.9 percent, meaning that if a child whose parents were citizens had a 20 percent risk of being uninsured, then a similar citizen child with non-citizen parents would have had an 8 percent higher risk, or 28 percent.^{xxvi}

For adults, being a non-citizen was associated with a 2.5 percent reduction in Medicaid coverage, and an overall 8.5 percent increase in the probability of being uninsured, compared with native citizens. Non-citizen adults were less likely to have a usual source of care than native citizens were. Naturalized citizens' insurance status did not significantly differ from that of native citizens after multivariate controls, but they were more likely to lack a usual source of care.^{xxvii}

Non-citizen children had 14 percent less Medicaid, and 16 percent greater risk of being uninsured, compared with children whose parents were citizens. They also were less likely to have a usual source of care. After controlling for the other factors, citizen children whose parents were non-citizens had about 5 percent less Medicaid and 8 percent less job-based insurance and were about 8 percent more likely to be uninsured. They also were more likely than children of citizens were to lack a usual source of care. While citizen children with non-citizen parents were eligible for Medicaid, they were still less likely to participate.^{xxviii}

VI. “PUBLIC CHARGE” AND THE “CHILLING EFFECT” ON IMMIGRANTS’ ENROLLMENT AND ACCESS TO MEDICAID

The evidence suggests that the decline in participation among eligible immigrants reflects a variety of fears. Many eligible immigrants fear that if they receive benefits, they may be considered a "public charge," which disqualifies them from sponsoring relatives who may want to immigrate, or that they may be investigated by the Immigration and Naturalization Service (INS). Despite efforts made by the INS to clarify that getting Medicaid would not affect public charge status under most circumstances, it is not yet clear whether this clarification has improved program participation.^{xxix}

“In a study conducted by the Urban Institute, 3,447 immigrant families (families with at least one foreign born adult) in Los Angeles County and New York City were interviewed to study the status of immigrants following welfare reform. Key findings of the report found that United States citizens make up half of the members of immigrant families and that one third are native citizens.^{4 xxx}

As of early 2000 there were about 123,000 LPRs and refugees who entered the US since August 1996 in LA county and about 210,000 LPRs. The LA sample includes adults born in 75 countries and the New York sample includes adults from 109 countries. In LA county 31 percent of immigrant families are considered poor (that is classified as below 100 percent of the federal poverty level) and 61 percent have low incomes (below

⁴ Immigrant categories for the purpose of the report included all foreign born people but more specifically are relegated to categories of legal permanent residents, refugees, undocumented aliens, other foreign born person, and naturalized citizens.

200 percent of the FPL) In NYC 30 percent are considered poor while 53 percent are considered low income. Legal immigrants who entered the country since 1996 are poorer than those who arrive earlier, despite new policies requiring sponsors to demonstrate incomes over 125 percent of the FPL. The share of legal permanent residents entering after August 1996 with incomes below poverty is 30 percent in LA and 40 percent in NYC, as compared to 27 percent in LA and 33 percent in NYC prior to 1996.^{xxxix}

Various explanations for the changes in immigrants' Medicaid participation were cited by the study and further studies also noted the existence of a "chilling effect", perception rather than policy was responsible for the decline in participation in Medicaid. In all of the cities a common erroneous belief that welfare reform meant that most immigrants were not eligible for benefits anymore further compounded this "chilling effect". One study by the Urban Institute concluded that the "chilling effect" of welfare reform was more responsible for the decline in the participation rate in benefit programs than the actual policy. This finding is evidenced by the fact that as of December 1997 when the study was conducted, only a small amount of legal immigrants actually had lost eligibility for these benefits, meaning the perceived ineligibility cause the decline.^{xxxix}

The factors contributing to the "chilling effect" in non-citizen immigrant participation in Medicaid cannot fully be known or understood by naturalized citizens. In California Proposition 187, the referendum proposed to deny illegal immigrant access to the public benefits including schooling for their children, received 59% of California voter's support. This majority reflects the growing negative public opinion and has undoubtedly affected the social and political climate as well as validating the existence of

an anti-immigrant sentiment. These feelings of resentment towards immigrants viewed as a drain on public services has undoubtedly affected the mentality of some immigrants and induced this fear of applying for benefits such as medical coverage. Immigrants know that often natives determine not only their residency status, but whether or not they can be considered a “public charge” when they apply for citizenship. Under current immigration law a person can be barred from attaining a visa, or adjusting from temporary to permanent status if the INS determines the likelihood of their becoming a public charge.

The federal ruling dates back to 1882 when Congress banned the entry of “any persons unable to take care of himself or herself without becoming a public charge” Section 237 of the Immigration and Nationality Act goes on to state that “Any alien who within five years after the date of entry, has become a public charge from causes not affirmatively shown to have arisen since entry is deportable” evidencing little change in the public charge legislation in the 20th century.^{xxxiii} Though historically Medicaid was not considered a factor as a public charge determinant and the receipt of such non cash benefits were not factors in determining “public charges”, the existence of immigrant lore and stories of public charge deportations are common in high immigrant population areas. These stories often exaggerate the low number of immigrants actually deported as a result of being deemed a “public charge”, but nonetheless well publicized cases in the 1990’s of immigrants who were refused reentry into the United States by the INS unless they paid their debt for their Medicaid benefits no doubt created apprehension amongst immigrant communities.^{xxxiv}

This existence of fear as a factor for not attaining coverage was verified in many of the cases of the Kaiser Commission studied where they found testimony that immigrants were afraid to apply for Medicaid or other public benefits because it might endanger their residency status in the US, cause them to be deported, or require them to repay the government for their medical coverage.^{xxxv} The public charge fears appeared to be the greatest in California where the enforcement activities were most visible.

In 1999 the INS published a regulation that summarized the link between the receipt of public cash assistance and the definition of a public charge in an effort to demonstrate that Medicaid did not enter into the determination of what would define a public charge, but enough damage in public perception had been done and therefore the positive effect of the 1999 issuance of the INS Guidance on the Public charge issue is difficult to quantify.

Community organizations sometimes aided by public agencies conducted public education about the new public charge rules. The education efforts appeared strongest in Los Angeles where the fears were highest but it still remains difficult to assess the effectiveness of education efforts since many immigrants have deeply rooted misgivings about the INS. For example even though Los Angeles county officials held a televised press conference publicizing the new public charge rules, the effectiveness of the outreach has yet to be determined. One immigrant attending said she understood the new rules, but still did not plan to apply for Medicaid explaining, “Why take the risk?”^{xxxvi} The fear and confusion in the immigrant communities engendered by PRWORA has been

widely reported, although the behavioral consequences based on immigrants' perceptions of the programs and their public charge concerns have not yet been assessed.

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VII. COMPLEXITY TO CONFUSION: OTHER BARRIERS TO THE ACCESS OF HEALTH INSURANCE

While immigrants' understanding of the complex rules varies by state almost 40 percent of survey respondents (and 50 percent of low income respondents) gave incorrect answers to the at least two out of three questions about program eligibility and the impact of benefits receipt on their ability to legalize or naturalize. Yet, respondents with wrong answers were slightly less likely to be enrolled in Medicaid. A large proportion of immigrants according to the survey believe that using Medicaid might harm their immigration status these fears and misperceptions in their eligibility status are shown to have only a modest relationship to their likelihood to participate in Medicaid programs. Nevertheless the findings should cause program administrators and community leaders to consider how to reassure the immigrant community and decrease their wariness about benefits use. ^{xxxvii}

Another set of barriers to Medicaid participation related to applying for benefits. Some respondents reported that sometimes immigrants went to welfare offices and were told that they were ineligible or that they should go get a job even though an actual application for eligibility determination was not completed. In some cases a receptionist or security guard turned applicant immigrants away, rather than the caseworker. Some of these policies may be an element of welfare "diversion" policies that were not aimed at immigrants per se, but at discouraging people from welfare programs in general. However, advocates also cited examples in which caseworkers incorrectly denied

eligibility because they misunderstood the complicated immigrant-related eligibility rules. Further, foreign-language applications or interpreters were often lacking, or if available, limited to certain languages. Spanish translations are more common than other translations. There were also problems with rude or intensive caseworkers and excessive documentation requirements; complaints often voiced by native citizen applicant as well.^{xxxviii}

Language barriers can make it even more difficult to understand the complex rules of the new welfare system, further exacerbating immigrant families' confusion about eligibility. Although an executive order issued in August 2000 sought to address concerns about linguistic barriers to programs for non-English speakers, it remains to be seen whether the guidance is implemented locally in ways that ensure meaningful access to programs. A number of organizations whose members would implement the guidance, such as the American Medical Association, opposed the order because of its purported cost, and a bill that would prohibit its implementation was introduced in Congress in March 2001.^{xxxix}

With over three quarters of the adult immigrants in LA (about 1.9 million people) and nearly two thirds in New York 1.1 million are Limited English Proficient (LEP), Limited English proficient immigrants are also poorer than immigrants adults overall: their poverty rate is 33 percent higher in LA and 34 percent higher in NYC. As compared to 13 and 14 percent in the two cities respectively, among English speaking immigrant adults who spoke English well or very well. Immigrants' tend to have lower incomes despite high labor force attachment. Overall labor force participation rates are among immigrant adults are in both New York and LA are comparable to those among native

born adults at 80 percent. But labor force participation among low income immigrants 73 percent in both cities is higher than among a low income native born resident which stands at 64 percent. This is due to the fact that immigrants take low wage jobs; their incomes are generally lower than those of the native citizen labor force.”^{x1}

Another element of the complexity is the categorization of immigrant households. Another key reason for low participation rates is that many immigrant households have mixed status, that is, they include members who are citizens and non citizens, "qualified" and "not qualified," eligible and ineligible. As a result, a substantial number of children who are citizens and fully eligible for federal and state public assistance may not be receiving needed benefits because they live with a non citizen parent or grandparent who is ineligible for various assistance programs under the 1996 law.^{xii}

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Studies have shown that non-citizen children with legal permanent resident parents are more likely to be uninsured than citizen children in LPR families. Immigrants and their children tend to have reported somewhat lower health status than members of native citizen families. In Los Angeles 40 percent of non-citizen children and 22 percent of citizen children in immigrant families are uninsured. In NYC 28 percent of non-citizen children and 8 percent of citizen children in immigrant families are uninsured compared with 6 percent of children in native families that are uninsured.^{xliii}

Debates over welfare reform that centered on whether immigrants are a contribution to our economy or a drain of public resources have dominated the research field and taken away much needed emphasis on the potential drawbacks on of the new

policies' effects on restricting access to LPRs can have on the health of both their citizen and non-citizen children. The receipt of public benefits by immigrant children was low even before welfare reform, and has fallen even lower as a result of restrictions on benefits and the decline in participation among immigrant families. After the 1996 law was enacted, participation rates continued to drop, even though the need among the children of immigrants is well documented, and most of these children are themselves U.S. citizens.

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VIII. THE TWO REFORMS' EFFECTS LIMIT ACCESS TO HEALTH CARE AMONG IMMIGRANTS

Good health is as an important determinant of immigrants' assimilation into society and an important indicator of socioeconomic opportunity is one's access to health care and insurance coverage. Having established that immigrants' children, both citizen and non-citizen are less likely to be insured because of their parents' fears or other perceived barriers previously discussed other studies have been conducted that investigate the effects that lack of insurance coverage has on limiting access to health care show that the Personal Responsibility and Work Opportunity Reconciliation Act and the Illegal Immigration Reform and Individual Responsibility Act of 1996 fundamentally altered the understanding of entitlement to the basic health. . Numerous studies have demonstrated that children who are uninsured- without private insurance, Medicaid, or SCHIP-receive fewer physicians visits overall, fewer visits for care of chronic conditions, and fewer preventative health services than do insured children^{xliii}

This affected the health of unborn citizens as well by barring the LPR mothers of form receiving federal public funding for prenatal care, the period around childbirth, especially the five months before and one month after birth for LRPs there are increased deleterious effects on the perinatal health of babies. All legal immigrants entering the country after August 22, 1996, except those in protected categories that include refugees and asylum seekers were barred from receiving federal public benefits for at least 5 years.

Since states responded differently to the new withdrawal of federal eligibility and funds, immigrants' perceived and actual loss of eligibility varied by state. For example, California chose to use state funds to finance the prenatal care of immigrants who were newly ineligible for federally funded Medicaid; in addition, California continued to use state funds for prenatal care for the undocumented. New York opted not to provide Medicaid to immigrants who entered the United States after August 1996.^{xliv}

One issue that arises from restricting immigrant eligibility is made apparent in that prior to the passage of PRWORA there was already evidence of a problem among immigrants of having a greater likelihood of being uninsured. This would then inevitably be exacerbated by any new legislation, which would further propagate myths that public health coverage was not intended for immigrants even if their children, if they were born *jus soli*, were then qualified. The researchers, led by E. Richard Brown at the Los Angeles Center for Health Policy Research, used U.S. Census and National Health Interview surveys to determine whether U.S. citizen children in immigrant families are at higher risk for being uninsured than those whose parents were born in the United States.

They found that equal proportions of non-citizen, non-Latino white children and non-citizen Mexican American children are covered by Medicaid. For citizen children in immigrant families, those with family incomes between 100 and 199 percent of poverty are more likely to lack coverage. Interestingly, the uninsured rate for citizen children with U.S. born parents is similar for those with incomes fall below the poverty line and between 100 and 199 percent of poverty. These higher or equal rates at 100 and 199 percent of poverty reflect the greater coverage that Medicaid provides to poor children and suggests that that immigrant parents are no more likely to use Medicaid funds than

citizen parents even when their children deserve coverage. The study concludes that immigration and citizenship status dramatically affect the probability of being uninsured.^{xlv}

As a result of PRWORA Medicaid eligibility for immigrants' has a negative impact on the relation to pregnant LPR women became ineligible for Medicaid coverage of prenatal care. In states like California, New York, and Texas, the number of immigrants potentially affected by this bar was significant. In 1995, 44% of all births in California, 43% of all births in New York City, and 25% of all births in Texas were to foreign-born women. In California and New York City, over 60% of births to foreign-born women were financed by Medicaid. In Texas, unlike in California, elected officials chose not to use state funds to replace the funds withdrawn by the federal government for prenatal care of Medicaid-eligible immigrants. This decision was implemented only 1 month after the passage of PRWORA^{xlvi}

Confusion in the immigrant communities engendered by PRWORA has been widely reported, although the behavioral consequences of that concern have not been assessed. How much of the decline in the use of public benefits documented in these reports represents statewide trends is unclear. Moreover, there are few data to demonstrate adverse clinical outcomes among communities most likely to perceive or experience a change in access to primary care following federal or state initiatives.^{xlvii} The study reported in the American Journal of Public Health attempted to discern the effect of the reforms on the perinatal health and health care utilization of Latino women. If welfare reform makes foreign-born women ineligible for, or fearful of seeking,

publicly provided health insurance, then an increase in the percentage of births to foreign born women that are uninsured, results in a decrease in early initiation of prenatal care, and an increase in adverse birth outcomes is expected.⁵ In Texas where the loss of Federal Medicaid financing for prenatal care for unqualified immigrants under PRWORA, these effects were almost immediate. Thus, unlike in California and New York City, confusion as to eligibility for Medicaid benefits in Texas was accompanied by an actual withdrawal of benefits for unqualified immigrants.^{xlviii}

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⁵ To test their hypothesis, birth certificates from California, New York City, and Texas were used to characterize the changes in perinatal outcomes among foreign-born vs US-born Latinas between 1995 and 1998. Specifically, we compared changes in the financing of births (Medicaid and self-pay), prenatal care utilization (early initiation of care and prenatal visits), and birth outcomes (low birthweight, very low birthweight, and preterm delivery) between US-born and foreign-born Latinas from 1995 to 1998.

IX. CONGRESSIONAL DEADLOCK AND THE REAUTHORIZATION

TODAY

On May 2, 2002, a bipartisan group of senators introduced a bill that would expand low-income immigrants' access to health care and thus avoid the aforementioned deleterious effects. Under current law, states can obtain federal Medicaid reimbursement only for emergency medical services (including labor and delivery) provided to immigrants who are ineligible for "full-scope" Medicaid. The denial of preventive and primary health care forces many immigrants to defer treatment for chronic or preventable conditions until they have progressed to the emergency stage. The FRIHA would expand the "emergency Medicaid exception" to provide Medicaid reimbursement for pregnancy-related services, including prenatal and family planning services, and testing and treatment of communicable diseases. The bill would also expand the definition of an emergency to include chemotherapy, dialysis, and services necessary to prevent an emergency. Sponsored by Sens. Jeff Bingaman (D-NM), John McCain (R-AZ), Robert Torricelli (D-NJ), and Jon Corzine (D-NJ), the "Federal Responsibility for Immigrant Health Act" (FRIHA), S. 2449, combines several important proposals that had previously been under consideration, but as of yet the law is still under review.^{xlix}

2002 marked the year that the 1996 passage of PRWORA came up for review. It faced an impasse over the immigrant eligibility issue. The Bush White House opposes any new health or welfare benefits for legal immigrants who have not become citizens.

But Democrats and Hispanic groups insist on some relaxation of the ban on such benefits, adopted as part of the 1996 welfare law.

No one was surprised by the revival of the debate over the landmark 1996 welfare law's reauthorization. On Capitol Hill, where welfare debate was re-engaged over the September 30th expiration date unfortunately the old arguments between the parties. The continued misperceptions of Republicans led the House GOP leadership to drive forward with a bill reauthorizing the Temporary Assistance for Needy Families (TANF) block grants to the states at \$16.5 billion per year while also building on the earlier reforms, advancing from merely moving people off welfare rolls to reducing poverty by fostering responsibility and family.¹ The fact that most children of low-income immigrants live in working, married two-parent families still alludes their understanding of the effects of the immigrant provisions of PRWORA. Citizen and non-citizen children of immigrants and their non-citizen family members are no more immune to crises such as unemployment and economic insecurity than are families headed by U.S. citizens. In fact, many immigrant families are more vulnerable to these pitfalls as they struggle to establish themselves during their first few years in the United States.

Much of the discussion the week of Sept. 16 right before the deadline focused on a last-minute bid to get a floor vote on the welfare reauthorization bill (HR 4737)⁶ approved by the Senate Finance Committee on June 26. The bill, backed by a majority of Democrats, also had the tentative support of nine Republicans and appears to have the

⁶ The text of HR 4737 has not yet been received from GPO Bills are generally sent to the Library of Congress from the Government Printing Office a day or two after they are introduced on the floor of the House or Senate. Delays can occur when there are a large number of bills to prepare or when a very large bill has to be printed.

votes for passage. The House passed its version of the welfare bill in May. That measure, which closely resembles President Bush's proposals, But the Republican welfare bill, which passed the House May 16, does nothing to restore benefits to immigrants. Therefore the focus on the legislation is completely inane in its refusal to address the immigrant provision issue. Instead with its emphasis on promoting marriage and encouraging teens to abstain from sex the bill does put greater importance on the goals for welfare reform as was purported during passage. The reauthorization argument needs to recognize the myths behind the initial reform that lead to the injustice of immigrant exclusion and its impacts.^{li}

A new bi partisan measure is necessary, and it needs to be one that would provide much needed funding for new spending and allow states to use federal money to provide Medicaid to legal immigrants. One solution can be found in Senators Thomas Carper and Evan Bayh's Work and Family Act. With the support from the Democratic Leadership Council it offered the state option to grant TANF benefits for legal immigrants, but goes on to give states the option to grant Medicaid to immigrant children and pregnant women, and provides additional funding. As separate legislation, this idea has strong bipartisan support and was introduced by 12 senators-eight Democrats, three Republicans, and one Independent. Though the legislation has been introduced to restore eligibility to legal immigrants and pregnant immigrant women, currently reauthorization of the law remains at a stalemate and no such legislation had been successful and the barriers still exist unjustly.^{lii}

X. PROPOSALS FOR WELFARE REFORM AND CITIZENSHIP
ELIGIBILITY IMPLICATIONS

Media coverage that reports the success of reform attributes victory to the findings that welfare participation has fallen much more rapidly than has child poverty is not consistent with findings that most families leaving welfare are either entering low-paying jobs or are not working. For those entering low-wage jobs, the need for support services remains high, and the significant concerns that have been raised about the difficulties in ensuring that low-earning immigrant families have access to Medicaid have yet to be addressed.^{liii}

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If an end to “welfare dependency” is measured by number of caseloads, as many analysts have purported, then the success of welfare reform can be applauded. By 1999 the average monthly caseloads stood at less than half the 1994 pre-reform peak for the predecessor AFDC.^{liv} Those who applaud welfare reform’s victories are acutely unaware of this existing crisis in our nations’ Medicaid system, because they are not completely informed about the situational impacts of the immigrant provisions. Those who report that caseloads have decreased indicating a positive impact on work and marriage, reduction of non-marital births and the positive maintenance of two parent families have grossly overlooked the importance of the health care safety net in this nation. One may blame legislators for allowing this blatant injustice toward the legal immigrant population to continue in the states. But can one blame the misinformed social workers, and state officials who have mistakenly cut off eligible immigrants from Medicaid coverage due to

the intricate and confusing laws passed in Congress. Is the unadjusted and bewildered, often LEP immigrant to be placed at fault for a wariness of the law, and a apprehension to seek publicly funded health insurance coverage? No it the policy wonks, congressional legislators, and their staff whose responsibility it is to make sure that their decisions reflect all that is just and fair and constitutional and not what the media will buy, report or and the public will believe and salivate over.

Public policy analysts are certainly torn over what direction should be headed as well. The Urban Institute's National Survey of American Families found that families leaving welfare in 1999 did as well or better economically than 1997 leavers" even though the institution is inherently against the reforms immigrant provisions.^{iv}

Reform of the Illegal Immigration Reform and Individual Responsibility Act of 1996 should focus on liberal revisions to the sponsor program. The policy should not impose a sponsor deeming requirement on legal immigrant pregnant women and children in states that adopt the option to provide Medicaid benefits to immigrants. Few sponsors can reasonably be expected to purchase health insurance for sponsored immigrants, since individual health care policies are often unavailable or unaffordable for most low-income families. According to the U.S. General Accounting Office, the middle-range premium cost of health insurance purchased for a family of four in the non-group market was about \$7,300. Though information is limited information available about the income levels of typical sponsors suggests that costs in this range are prohibitively expensive for most sponsors. Moreover, a substantial portion of sponsors appear to be uninsured themselves. If sponsor deeming requirements were applied to these programs, few of the children and pregnant women whom the state option is intended to assist would be able to obtain

health insurance. As a result, of applying sponsorship deeming for Medicaid coverage for many legal immigrants those who are expectant mothers would go without prenatal care and many legal immigrant children — most of whom will ultimately become U.S. citizens — would not have the opportunity to see a pediatrician and receive treatment before minor illnesses become serious or even life-threatening. Diabetic children would not receive insulin, for example, and children with developmental disabilities would not receive health care to help ensure they are ready for school.^{lvi}

Immigration represents a mutual and reciprocal process. The commission on Immigration reform has reiterated “its call for commitment to the Americanization of new immigrants, which is the cultivation of a shared commitment to the American values of liberty, democracy and equal opportunity.” The Commission report states: immigration presents mutual obligations. Immigrants must accept obligations we impose - to obey our laws, to pay taxes, to respect other cultures and ethnic groups. At the same time, citizens incur obligations to provide an environment in which newcomers can become fully participating members of our society.^{lvii} Therefore “access to welfare and other social benefits should not be conditioned upon citizenship as their withdrawal is more likely to slow than accelerate integration, and then their provision will not diminish the importance of citizenship as a statement of civic engagement on the part of the individual. Presumptive permanence rather than citizenship should suffice for access to most benefits made available under the welfare state.”^{lviii}

The denial of access to a health care system which further exacerbates the vulnerability, powerlessness, and potential for additional differential disadvantages

arising for immigrants from their non-citizen status is wrong. By condoning negative rights construction for immigrant groups, who typically are already underserved by the Medicaid system, the nation is calling into question what is meant by residence on American soil. The fact is clear that immigrants perform a vital role in American society contributing economically, culturally and in countless other ways and they should not be denied access to our social safety net.

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XI. CONCLUSIONS

Recent history, full of its misconceptions and preconceptions, intended and unintended consequences, has taught us that the group that is naturally more likely to be vulnerable in this nation continues to be discriminated against unjustly. Whether we have bought into the irony, are skeptical of the media, or tend to harbor xenophobic feelings, there exist certain policy measures that exemplify why changes are imperative. They should be addressed for the future happiness of our nation and in order for it to live up to the self-proclaimed motto, that in the US, one can achieve “life, liberty and the pursuit of happiness.”

It is of course ludicrous to measure human worth by merely examining contributions or short term receipt of public benefits. By employing only fiscal impact analyses, we ignore some of our main justifications for our current immigration policies which include reunifying families, providing refuge to the persecuted, and ensuring the balanced ethnic diversity.^{lix} By unduly restricting immigrants’ access to federal benefits, we similarly undermine the purpose behind these programs: to assist persons in realizing self sufficiency and realizing their full potential. Since it has been proved that immigration has long term positive socioeconomic benefits to nation as a whole, it is in everyone’s interest to invest in this human capital. Charles Wheeler of the National Immigration Law Center has said that “The results [the reform] have implications that derive from the underappreciated fact that the country’s immigration and immigrant policies are interdependent”^{lx} The nation’s laws, regulations and practices should

positively influence the incorporation processes among immigrants after they arrive, While historically, the immigrant policy of the United States has involved little more than the granting of the opportunity to enter the country, since little more was deemed necessary and indeed, little more may have been required when the economic opportunities for unskilled workers were relatively plentiful, the state of the nation right now makes it clear that we must reinvestigate our approaches. We must be reverent in our commitment to equality of opportunity and recognize that good health is essential in realizing human capability, and in our understanding that access to health care services is especially strategic in achieving improved health status. Providing health care coverage is essential to the advancement of a sound and positively intentioned public, one which all individuals, regardless of the state they reside, or their status is entitled to.

Furthermore citizenship, despite recent legal federal regulations, should not be a precursor of health care entitlement. Though T.H. Marshall's famous writing, *Citizenship, Social Class, and Other Essays*, he decisively linked the concept of citizenship to a welfare state, legal permanent residents in Democratic states are entitled to the "the basic human equality associated with full membership in a community" which he understands to be the importance of in the concept of citizenship. Our Constitution's preamble states "We the people..." not "We the citizens" reflecting a need to respect the equal dignity of persons that entails a commitment to equal access to the means necessary to cope with illnesses, disabilities and the like. As non-citizens LPRs have a lack of political leverage with an inability to vote. This has created a compelling argument that researchers and policy makers have a unique obligation to pay particular attention to their needs in further policy analysis and action.

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- ⁱ Gring-Pemble, L. "'Are we going to now govern by anecdote': Rhetorical constructions of welfare recipients in Congressional hearings, debates, and legislation, 1992-1996." *The Quarterly Journal of Speech*; Annandale: NY; Nov 2001.
- ⁱⁱ Gring-Pemble, L. "'Are we going to now govern by anecdote': Rhetorical constructions of welfare recipients in Congressional hearings, debates, and legislation, 1992-1996." *The Quarterly Journal of Speech*; Annandale: NY; Nov 2001.
- ⁱⁱⁱ Weitzman, M. MD, et al. "Health Care for Children of Immigrant Families." *Pediatrics*, July 1997: 100: 153-156.
- ^{iv} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^v Gimpel, J. and Edwards J. *The Congressional Politics of Immigration Reform*. Allyn and Bacon Needham Heights: MA. 1999
- ^{vi} Ku, L. and Freilich, A. Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{vii} "A Myopic Immigration Reform" Tomasi, Lydio F. 1996 Migration World Magazine
- ^{viii} "A Myopic Immigration Reform" Tomasi, Lydio F. 1996 Migration World Magazine
- ^{ix} Pelosi, N. "Legal Immigration". CONGRESSIONAL RECORD Vol. 141 No. 38 -- House Congresswoman speaking before the Wednesday, March 1, 1995 104th Congress 1st Session on 141 Cong Rec H 2477. Obtained from congressional quarterly on Lexis Nexis.
- ^x Briggs, V. and Moore, S. *Still an Open Door? U.S. Immigration Policy and the American Economy*. Washington, DC: The American University Press. 1994 pp:91-112
- ^{xi} Borjas, G. "Welfare Reform and Immigration." *The New World of Welfare*. 372.
- ^{xii} Bean, F. D. "Impact of Immigration on Welfare Programs" hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. (Y4.W36:103-58).
- ^{xiii} Fix, M. "Impact of Immigration on Welfare Programs." hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. (Y4.W36:103-58)
- ^{xiv} Thrupkaew, N. "No huddled masses need apply." *The American Prospect*. Princeton; Summer 2002.
- ^{xv} "MEDICAID: Early implications of welfare reform for beneficiaries and states". United States General Accounting Office. February 1998. GAO/HEHS-98-62.
- ^{xvi} Vialet, J. C. "Impact of Immigration on Welfare Programs" hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. Library of Congress. (Y4.W36:103-58)
- ^{xvii} "MEDICAID: Early implications of welfare reform for beneficiaries and states". United States General Accounting Office. February 1998. GAO/HEHS-98-62.
- ^{xviii} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^{xix} "MEDICAID: Early implications of welfare reform for beneficiaries and states". United States General Accounting Office. February 1998. GAO/HEHS-98-62.
- ^{xx} Ku, L., Freilich, A. "KFF: Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston". The Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{xxi} "MEDICAID: Early implications of welfare reform for beneficiaries and states". United States General Accounting Office. February 1998. GAO/HEHS-98-62.
- ^{xxii} "Impact of Immigration on Welfare Programs" hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. (Y4.W36:103-58)
- ^{xxiii} Serafini, M. "Welfare: The Benefits of Citizenship." *National Journal* Saturday, Nov. 16, 1996.
- ^{xxiv} Ku, L. and Freilich, A. (2001). "Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{xxv} Ku, L. and Blaney, S. (2000). "Health Coverage for the Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and S-CHIP Coverage," Washington, DC: Center On Budget and Policy Priorities, October 2001.

-
- ^{xxvi} Ku, L. and Matani, S. "Left out: Immigrants' access to health care and insurance." *Health Affairs*. Chevy Chase: Jan/Feb 2001.
- ^{xxvii} Ku, L. and Matani, S. "Left out: Immigrants' access to health care and insurance." *Health Affairs*. Chevy Chase: Jan/Feb 2001.
- ^{xxviii} Ku, L. and Matani, S. "Left out: Immigrants' access to health care and insurance." *Health Affairs*. Chevy Chase: Jan/Feb 2001.
- ^{xxix} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^{xxx} Fix, M. and Passel, J. "Trends in Noncitizens' and Citizens' use of Public Benefits Following Welfare Reform: 1994-1997." Washington: Urban Institute. 1999.
- ^{xxxi} Fix, M. and Passel, J. "Trends in Noncitizens' and Citizens' use of Public Benefits Following Welfare Reform: 1994-1997." Washington: Urban Institute. 1999.
- ^{xxxii} Fix, M. and Passel, J. "Trends in Noncitizens' and Citizens' use of Public Benefits Following Welfare Reform: 1994-1997." Washington: Urban Institute. 1999.
- ^{xxxiii} Borjas, G. "Welfare Reform and Immigration". *The New World of Welfare*. 371.
- ^{xxxiv} Borjas, G. "Welfare Reform and Immigration". *The New World of Welfare*. 375.
- ^{xxxv} Ku, L. and Freilich, A. "Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{xxxvi} Ku, L. and Freilich, A. "Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{xxxvii} Capps, R. Et al. "How are Immigrants Faring After Welfare Reform? Preliminary Evidence form Los Angeles and New York City" The Urban Institute. March 2002.
<http://www.urban.org/Uploadedpdf/410426_final_report.pdf>
- ^{xxxviii} Ku, L. and Freilich, A. "Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February 2001.
- ^{xxxix} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^{xl} Capps, R. Et al. "How are Immigrants Faring After Welfare Reform? Preliminary Evidence form Los Angeles and New York City" The Urban Institute. March 4, 2002.
<http://www.urban.org/Uploadedpdf/410426_final_report.pdf>
- ^{xli} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^{xlii} Capps, R. Et al. "How are Immigrants Faring After Welfare Reform? Preliminary Evidence form Los Angeles and New York City" The Urban Institute. March 4, 2002.
<http://www.urban.org/Uploadedpdf/410426_final_report.pdf>
- ^{xliii} Brown, R. E. et al. "Access to Health Insurance and Health Care for Mexican American Children Immigrant Families." *Crossings: Mexican Immigration in Interdisciplinary Perspectives*. Suarez-Orozco, Marcelo M. ed. Cambridge: Harvard University Press. 1998: 227-249.
- ^{xliv} Joyce, T., Bauer, T., Minkoff, H., Kaestner, R. "Welfare reform and the perinatal health and health care use of Latino women in California, New York City, and Texas." *American Journal of Public Health*. Washington; Nov 2001.
- ^{xliv} Brown, Richard E. et al. "Access to Health Insurance and Health Care for Mexican American Children Immigrant Families." *Crossings: Mexican Immigration in Interdisciplinary Perspective.s* Suarez-Orozco, Marcelo M. ed. Cambridge: Harvard University Press. 1998: 227-249
- ^{xlvi} Joyce, T., Bauer, T., Minkoff, H., Kaestner, R. "Welfare reform and the perinatal health and health care use of Latino women in California, New York City, and Texas." *American Journal of Public Health*. Washington; Nov 2001.
- ^{xlvii} Joyce, T., Bauer, T., Minkoff, H., Kaestner, R. "Welfare reform and the perinatal health and health care use of Latino women in California, New York City, and Texas." *American Journal of Public Health*. Washington; Nov 2001.
- ^{xlviii} Federal Responsibility For Immigrant Health Act Introduced. *Immigrants' Rights Update*, Web Edition, May 10, 2002. <<http://www.nilc.org/immspbs/health/health016.htm>>

-
- ^{xlix} Federal Responsibility For Immigrant Health Act Introduced. *Immigrants' Rights Update*, Web Edition, May 10, 2002. <<http://www.nilc.org/immspbs/health/health016.htm>>
- ^l Hickey, J. G. "Everything old is new again." *Insight on the News*. Washington: 18 (21), 10.
- ^{li} Swindell, B. "Welfare Fight Could Extend Into Next Year." *CQ Weekly*: Sept. 21, 2002, 2458.
- ^{lii} Thrupkaew, N. "No huddled masses need apply." *The American Prospect*. Princeton; Summer 2002
- ^{liii} Greenberg, M. H., Levin-Epstein, J., Hutson, R. and Ooms, T.J. "The 1996 Welfare Law: Key elements and reauthorization issues affecting children." *The Future of Children*; Los Altos; Winter 2002.
- ^{liv} Anonymous. "Welfare Reform impacts in SIPP". *Monthly Labor Review*. Nov 2002.
- ^{lv} Anonymous. "Welfare Reform impacts in SIPP". *Monthly Labor Review* Nov 2002
- ^{lvi} "TANF Reauthorization: One step forward, or two steps back?" The Center for Law and Social Policy. 2002. <http://www.clasp.org/DMS/Documents/1028928846.02/view_html#12>
- ^{lvii} Executive Summary: "Becoming an American: Immigration and Immigrant Policy" U.S. Commission on Immigration Reform. (Washington, DC: Government Printing Office, 1997), 7
- ^{lviii} Fix, M. E. and Laglagaron, L. "Social Rights and Citizenship: An International Comparison." The Urban Institute. May 2001. <<http://www.urban.org/url.cfm?ID=410545>>
- ^{lix} Wheeler, C. "Impact of Immigration on Welfare Programs" hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. (Y4.W36:103-58)
- ^{lx} Wheeler C. "Impact of Immigration on Welfare Programs" hearings before the Subcommittee on Human Resources, House Ways and Means Committee, Nov. 15, 1993. (Y4.W36:103-58)