SENATE JOINT MEMORIAL 52 REPORT: AN EVALUATION OF THE 1996 PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT (PRWORA) ON ACCESS TO HEALTH CARE AND PUBLIC BENEFITS FOR IMMIGRANTS IN NEW MEXICO.

The New Mexico
Department of Health
Health Policy Commission
Human Services Department
& Senate Joint Memorial 52 Workgroup

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EXECUTIVE SUMMARY

BACKGROUND

During the Forty-Fifth Legislature, First Session, 2001, the New Mexico State Senate and House of Representatives enacted SJM 52 (attached as Appendix A) requesting "the Department of Health, the Health Policy Commission and Human Services Department to evaluate the provision of health care to immigrants, especially those documented immigrants in the United States for fewer than five years and undocumented immigrants." A broadly representative SJM 52 Workgroup convened in July, August, and October 2001 to discuss issues, provide direction, and help develop this report to clarify the policy and programmatic issues affecting immigrants who are uninsured and unable to afford heath care in New Mexico (see Appendix B for workgroup membership). The challenges posed to immigrants, advocates, community-based organizations, safety net providers, counties, public hospitals and state government are complex, multi-faceted and require long-term policy and programmatic solutions. Debates and critical policy questions are rooted in diverse beliefs and often competing opinions regarding human rights, financial resources and priorities, legal statutes, nationalism, and ethical values in the provision of "health care for all."

METHODOLOGY

This study assesses the impact of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) on the provision of primarily the public benefit of health care for immigrants living in New Mexico. Of particular interest are those documented immigrants in the United States for fewer than five years and undocumented immigrants who clearly lost access to certain benefits as a result of the PRWORA. Health care in this study is defined comprehensively to include the full range of physical and behavioral health services that promote well-being, and prevent and treat disease.

A literature review was conducted of over 100 articles and reports searching key words such as "welfare and immigration reform, health care access, and immigrant health" from academic and legal journals, policy research organizations such as the National Immigration Law Center and Urban Institute. This literature is mostly from national and cross-state comparative studies. Secondary data was gathered and reviewed from multiple sources including but not limited to the U.S. Census Bureau, National Council of State Legislatures, and local studies and data. Since there is a clear lack of New Mexico specific data, national trends and information are frequently cited.

Qualitative interviews were conducted with over 20 key informants and immigrants throughout New Mexico. These interviews were frequently conducted in Spanish, translated to English, and included in the report. **Various perspectives are captured in the report in order to present the diverse views from state, local, provider and grass-roots levels in a balanced manner. Some are highlighted in dialogue boxes for emphasis and others as "a community voice" to reflect the actual perspective of resident immigrants. They represent personal feelings and experiences and are not presented as verified factual accounts.**

STUDY LIMITATIONS

It is important to note other limitations of this SJM 52 Report. First, there was no funding appropriated to implement a systematic investigation which would produce more extensive evidence of the impact of the PWRORA on immigrants in New Mexico. Secondly, research on immigrants' health access and status is problematic since there is no consistent method to defining "who is immigrant." According to a national assessment of immigration status in health research, methodological issues relating to studying immigrant health include: how immigrant is defined, how immigration status is assessed and how sampling and recruitment strategies of immigrants are conducted.[1] In general, three broad paradigms exist for the definition of immigrant and the determination of immigrant status: social science, immigration law, and public benefit law/entitlement.

> Research on immigrants' health access and status is problematic since there is no consistent method to defining "who is immigrant."

This issue becomes even more confusing at the state, county, and local levels since there is a lack of clarity when discussing who is eligible for public benefits and health care. Even the SJM 52 Workgroup, despite their collective knowledge and expertise, have struggled through the complex language and diverse frameworks for determining who is immigrant: citizens; non-citizens; documented; qualified (i.e. lawful permanent residents, refugees, asylees, aliens paroled, battered aliens); not-qualified (i.e. Persons Residing Under Color of Law PRUCOL, undocumented), etc. (See Appendix C, Glossary of Terms). As a consequence, this study was unable to disaggregate the multiple categories of "immigrant" framed by both the legal and public benefit definitions while having no consistent or quantifiable data available to do so at the state or local levels. In addition, this report does not include quantifiable data, pre and post 1996, to determine the impact of the PRWORA on health utilization and health outcomes for immigrants—it simply does not exist. Health outcomes are not covered in this study although it is recognized that they are critical in determining health status, public health priorities, and their relationship to the socio-economic and legal positioning of immigrants.

It is important to note that the SJM 52 Workgroup gathered and utilized as much local data as available. Since there is a lack of clear and comprehensive data regarding undocumented immigrants health care utilization before and after the 1996 PRWORA, this study relies heavily on national and other state resources and studies in order to best define the context. **Thus, this SJM 52 Report is not able to provide a definitive answer to the questions posed in the memorial. It is more of an attempt to describe the complex issues involved, represent the challenges faced by immigrants, broadly assess the response of the safety net providers in New Mexico, reflect in a balanced manner the diverse perspectives on various issues, and identify possible actions that might best serve as next steps towards improving the current situation.**

A SUMMARY OF THE FINDINGS

Issue 1: How have immigrants been impacted by the 1996 PRWORA?

The PRWORA replaced the AFDC entitlement cash assistance program with the Temporary Assistance for Needy Families (TANF) Program and made citizenship or long-term residency a condition of eligibility for public benefits for most immigrants. In 1996, welfare and immigration laws restricted access to public benefits and health care programs for some immigrants by restricting eligibility. In addition, PRWORA changed Medicaid eligibility policy by eliminating the automatic link between Medicaid and Welfare.

In addition to loss of health benefits, the PRWORA also limited participation in the Supplemental Security Income Program (SSI) to certain qualified immigrants. In fact, most of the national savings from welfare reform derived from barring most non-citizens from SSI. The loss of SSI also threatened the automatic link to Medicaid eligibility for many elderly and disabled immigrants.[2] Many immigrants now face access and coverage disparities because of the PRWORA policy changes.[3] Current policy now treats new and recent legal immigrants differently from both longer term immigrants (greater than 5 years) and citizens when determining eligibility for Medicaid and other public benefits. This creates confusion that can be particularly challenging for non-English speaking families who may face difficulty understanding complex welfare regulations.[4]

Administrative and survey data indicate that Medicaid coverage of immigrants and of their children (who are often U.S. born and therefore citizens) has fallen sharply since 1995.[5] [6] [7] Data from the Current Population Survey (CPS) show that the share of low-income non-citizen immigrants (non-elderly people with incomes below 200 percent of poverty) who had Medicaid fell from 19 percent in 1995 to 15 percent by 1997, reflecting the lack of eligibility for recent legal immigrants.[8]

Because comparatively few legal immigrants became ineligible for public benefits after 1996, it appears that the steeper declines in non-citizens' than citizens' use of welfare, food stamps, and Medicaid owe more to the **"chilling effect"** of welfare reform and other policy changes than they do to actual eligibility changes. National data trend analysis concludes that **eligibility changes in one program may chill non-citizens' use of other programs**. Therefore, some feel that state eligibility changes are critical as most immigrants admitted after August 22, 1996, will be ineligible for most means-tested public benefits for at least five years after their entry into the country.[9]

Historical barriers to health care such as language and fear of being a "public charge", compounded with policies such as the 1996 PRWORA, have increased immigrants' likelihood for being uninsured and have diminished their chances for having a regular source of care, compared to citizens. The long-term policy implications for a state like New Mexico with limited economic resources, among the highest rate of uninsured in the nation, and low wage earnings, could result in diminished health outcomes across generations of immigrant families.

Public Charge is determined by the INS and is used to identify an immigrant who has or is likely to become dependent on the government for subsistence. However, under the 1999 guidance issued by the INS, it is rare that immigrants are deported under this determination.

Source: Health Care Access for Immigrants & Refugees (2000). The Access Project.

Issue 2: Who are the immigrants in New Mexico? How do they contribute to our economy and society?

Over three-fourths (78%) of **all** immigrants admitted to New Mexico are from Mexico. Immigrants admitted to New Mexico also originate from a number of Asian countries, including Vietnam (2.9% of all admitted immigrants), China Mainland (1.5%), Philippines (1.5%), and India (1.4%).[10] **The estimated number of undocumented immigrants in New Mexico in 1996 was 37,000, again, the vast majority presumed to be from Mexico.[11] From 1997-1999, the population distribution by citizenship status in New Mexico was 92.9 % (1,685,640) citizens and 7.1% (129,040) non-citizens as compared to 93.5 % citizens and 6.5 % non-citizens in the U.S.[12]** Compared to the national average and other state estimates, the proportion of undocumented immigrants to total non-citizens living in New Mexico is about average at around 30%.

A recent report by the Institute of Medicine notes that despite the belief that most uninsured are unemployed or recent immigrants, 80% of uninsured Americans "are in working families" and immigrants "make up only a small percentage" of the uninsured population.[13] Despite the fact that immigrants are disproportionately represented in many of the lowest-paying jobs in the services sector, agricultural industry, construction and domestic work,[14] recent immigrants do not drain the welfare budgets and are not responsible for the growth in the number of uninsured.

The Social Security Administration estimates that undocumented workers paid over $20 billion in Social Security taxes from 1990 to 1998 and most likely will never receive any benefits.

The National Research Council reports that "immigration benefits the US economy overall, and has had a small adverse impact on the income and job opportunities of most native-born Americans."[15] The evidence is that immigrants contribute as much as $10 billion to the economy each year. Two-thirds of immigrants who are in non-citizen families are much more likely to be poor and have a full-time worker in their family. The typical immigrant family pays an estimated $80,000 more in taxes over a lifetime, than they receive in local, state, and federal benefits.[16] Finally, the Social Security Administration estimates that undocumented workers paid over $20 billion in Social Security taxes from 1990 to 1998 and most likely will never receive any benefits.[17]

Issue 3: How are the children and families impacted?

Citizen and non-citizen children of immigrant parents are equally at-risk of not being insured and not having a usual source of healthcare.

A recent study utilizing the 1997 National Survey of Americas Families, indicate that non-citizen immigrants and their children are much less likely to have a usual source of health care than citizens and their children and immigrants are more likely to rely on clinics or outpatient departments but less likely to use private doctors' offices or health maintenance organizations (HMOs). For adults, being a non-citizen was associated with a significant reduction in the probability of getting Medicaid or job-based insurance and substantial increase in the probability of being uninsured or of having no usual source of care, compared to citizens. Non-citizen children were also significantly less likely to have Medicaid or job-based insurance coverage and exhibited heightened risk of having no usual source of care, compared to children whose parents are citizens.[18]

Issue 4: How has the NM safety net system responded to the PRWORA?

Despite the growing rate of uninsured and the competitive health care market, the safety net continues to adapt, survive, and absorb the costs and burden of providing uncompensated care. In spite of financial pressures and constraints, most health care providers in New Mexico continue to uphold their ethical values and professional obligations to serving all peoples regardless of nationality, race, religion, party, politics or social standing.

Counties share with state government in the costs of uncompensated health care through the County Indigent Fund (CIF) program and other mechanisms. **Of the 29 counties surveyed in FY 2000 by the NM Health Policy Commission, 27 counties provide indigent health care to qualified legal immigrants. Eighteen counties provide indigent health care to qualified undocumented immigrants.** In a follow-up survey from the DOH in August 2001, all 29 counties now report program eligibility to qualified legal immigrants. Bernalillo County uses a mill levy approach to fund indigent care, as the County Indigent Fund does not apply to a Class A County. We are unable to quantify the amount of county indigent funding that is utilized to support resident immigrant needs, but some counties reported as much as 20-30% of their total dollars for immigrants. It should be noted that Indigent Fund expenditures are understated compared to the true costs of indigent care (including immigrant care), due to the limited categories of eligible providers and the partial payments made by CIF.

Publicly supported primary care clinics are another critical part of the safety net in New Mexico. Supported by fees and a variety of federal, state and local subsidies, primary care clinics track ethnicity and race, but they **do not** make inquiries or eligibility determination based on immigration or citizenship status. **Thus, in New Mexico, the barriers to access to primary care services experienced by uninsured immigrant populations are essentially the same as those experienced by the uninsured population as a whole.** While primary care clinics provide medical services to both legal and undocumented immigrants, the numbers and costs of the services rendered these populations are not quantifiable. **The same is true for Emergency Medical Services (EMS) in New Mexico.** No distinctions are made, no questions are asked regarding immigration status, all "911" callers are provided emergency response and treatment, and medical transportation is provided as appropriate. **The public health system's population-based preventive services (immunizations, sexually transmitted disease, family planning, etc.) are another aspect of the safety net in New Mexico that does not distinguish clients based upon citizenship. The same is true for Department of Health supported behavioral health, substance abuse, and long term care services in New Mexico.**

The critical challenge for hospitals in New Mexico according to the Executive Director of the New Mexico Hospitals and Health Systems Association is "how to stabilize payment for uncompensated health care services when the health care reimbursements to hospitals have been destabilized as a result of the 1991 Balanced Budget Act (BBA). None of the hospitals have dollars to pay for this care; they all have un-reimbursed care that amounts to approximately $160 million a year for all NM hospitals. But this figure includes all care for which there is no expected or known source of payment, so it includes but is not restricted

to the undocumented immigrant category."[19] **Although there have been, and are today, serious planning initiatives to reduce the number of uninsured in New Mexico (like the State Coverage Initiative) none of them would provide coverage for undocumented immigrants.**

There has been much discussion and concern about immigrant access to health care at the **University Hospital and related programs of the Health Sciences Center (UNMHSC),** especially access to emergency services, primary care and specialty care after the 1996 PRWORA. Concerns from some advocates and providers about the UNMHSC policies and practices contributed to the enactment SJM 52. There are seven different financial assistance policies that guide eligibility for and access to care at University Hospital. According to a letter from the UNMHSC administration, "staff make no inquiries regarding immigration status unless an individual applies for financial assistance."[20] Thus, the determination of eligibility for financial assistance is key. It is clearly articulated in the policies how eligibility is determined between "legal and illegal aliens" and what benefits are associated with each group. **UNMHSC points out that undocumented immigrants are now eligible for limited financial assistance specifically for emergency care, diagnosis and care of symptoms of communicable diseases, and immunizations, per federal requirements. They indicated that prior to 1996, these individuals were not eligible for any financial assistance at UNMHSC. For services other than those specified above, undocumented immigrants are considered "self-pay" patients and they must provide at least partial payment prior to receiving non-emergent, non-urgent care, and the remainder is billed to the individual. This is like others in the self-pay category and certainly may be a barrier to care, particularly for people without means.** It should be noted that much of the bad debt is written off and UNMHSC indicates they incurred almost $90 million in uncompensated care this past fiscal year. As the major tertiary care center within New Mexico, UNMHSC is the primary hospital safety net provider, with many immigrants from all over the state referred to or seeking services at UNMHSC for emergency, primary, and specialty care.

UNMHSC indicates that they strive to serve all patients in a fair and equitable manner in keeping with their assessment of eligibility under their policies. **UNMHSC says that "the distinction between legal and undocumented aliens with respect to eligibility for financial assistance is not a distinction based on national origin. Rather, it is based on immigration status, consistent with requirements of federal law."[21]** Further, UNMHSC indicates that they continue to actively review their eligibility and financial assistance policies in a manner that ensures compliance and balances their legal requirements under federal, state and local laws, their financial obligations and constraints, and other relevant considerations.

Finally, the majority of the SJM 52 Workgroup expressed strong concerns about implications of UNMHSC's policies given their role in the training of new health care professionals. **The concern is that current institutional policies and practices that exclude certain groups of patients may not promote the appropriate level of professional responsibility and ethics in the next generation of health care professionals. They felt that the responsibility of health care professionals is to serve all patients in need--regardless of one's immigration status.**

Overall, it appears from this review that most safety-net providers, despite limited resources, serve all immigrants in New Mexico. In fact, safety-net administrators have reported that questions and distinctions regarding immigration status are not asked about or considered, except for financial assistance determinations made by the UNMHSC.

Issue 5: What are the costs and benefits of prevention/primary care vs. emergency care for immigrants?

Despite the fact that immigrants are eligible for basic preventive care through a variety of safety net providers in New Mexico, emergency care remains a regular source of care for many of those who have no regular physician and no health insurance, and they delay care due to real fears of deportation and language and cultural barriers. It should be noted that even under the PRWORA, **all** immigrants are entitled to emergency care and certain public health interventions. However, this reliance on emergency care does not seem to be a reasonable long-term solution given that the emergency medical delivery system is already overcrowded and overburdened with uncompensated care costs. Most members of the SJM 52 Workgroup feel that investing in preventive, primary and secondary care offers an affordable and more humane and responsive policy option.

A California study found that for every $1 spent on prenatal care, $3.33 was saved in the cost of post-natal care and $4.63 was saved in incremental long-term costs (health care, child care, special education, grade repetition).[22] Another California survey of undocumented immigrants seeking care in an emergency room found that[23]:

- 80% reported that lack of funding or insurance was the primary reason;
- 36% stated that they had difficulty getting care elsewhere because of their immigrant status;
- 51% did not know of another source of care; and
- 44% said that only the ER was acceptable as a source of care.

More locally, UNMHSC has initiated a W.K. Kellogg Foundation funded program entitled: Community Voices: Healthcare for the Underserved - A National Demonstration of Local Visionary Models. This model has developed strategies in eight counties which include building and enhancing the safety net network (public hospitals, community health centers, managed care organizations, the department of health), creating a primary care home for uninsured individuals, and enhancing the interdisciplinary services available in these primary care homes to best meet community and individual need. This enhanced, community-based primary care model is called a "health commons." This model builds on the positive experience gained in Bernalillo County from the UNM Care Program, which began enrolling uninsured county residents into a "managed" system, with each individual choosing or being assigned a primary care provider at community-based sites operated by UNM or First Choice Community Health (the local federally qualified health center system). **Data from 1997-2000 demonstrate overall cost savings and improved quality outcomes for this particular enrolled, uninsured population served by the UNM Care Program.**

However, UNMHSC School of Medicine senior leadership offers another view about the relative costs of prevention/primary care versus emergency care from a broader perspective. They feel that improved access to primary care will not lead to decreased overall health care costs by decreasing utilization of emergency services and that actual costs of low acuity care are comparable regardless of the setting in which they are provided. They also indicate that "the demand for specialty care services is directly and positively associated with the use of primary care. While improved access to primary care has the potential of long-term health benefits, it also increases the demand for access to specialty services, with a predictable overall increase in use of specialists' services. There is also a positive correlation with increase in the demands for ancillary services, pharmaceuticals, diagnostics and hospital capacity." [24]

Issue 6: How are New Mexico and other states responding?

Findings from the Urban Institute's study, "Patchwork Policies: State Assistance for Immigrants under Welfare Reform", show that many states have chosen to provide considerable assistance to immigrants, particularly when the costs are shared with the federal government. In fact, nearly every state, including New Mexico, has opted to maintain TANF and Medicaid eligibility for immigrants who were already in the United States when the federal welfare law passed. Over half of the states are spending their own money to cover at least some of the immigrants who are ineligible for federally funded services. State funded substitute benefits for immigrants losing eligibility for federal assistance include the following: a food stamp substitute program; an SSI substitute program; TANF for post-enactment immigrants (i.e. those entering after August 22,19996) who are subject to a five year bar on federally funded assistance; and Medicaid for the same post-enactment group. State provisions for most public benefits are made available through support of their safety net providers, as evidenced in the earlier section regarding New Mexico's safety net programs. Despite these efforts, most state replacement programs do not provide the same level of benefits as federal programs, and funding for many of these programs is temporary and subject to changes in the changing political and financial climates.[25]

Some states have passed laws complying with 8 U.S.C. 1621 (permitting states to pass affirmative legislation authorizing the use of state and local funds for provision of public benefits to income eligible persons regardless of immigrant status) including:

- Massachusetts has passed such a law that permits the provision of public benefits to income eligible persons regardless of immigrant status, subject to appropriation.
- Connecticut permits qualified "aliens" who do not qualify for federally funded cash assistance, other lawfully residing immigrant aliens or aliens who were formerly Persons Residing Under the Color of Law (PRUCOL) to be eligible for state funded services and gives benefits to others, but only until July 1, 2001.
- Colorado passed a bill to study how to provide prenatal care to undocumented immigrants.
- California provides food assistance to "sponsored aliens", each county determines whether or not unqualified immigrants receive Medicaid or TANF.

- Georgia had time limited legislation providing TANF benefits for all immigrants who were income eligible from July 1999 to July 2001.
- New Mexico provides Medicaid, SCHIP and TANF to qualified immigrants after the five-year ban if they are otherwise eligible.

In addition to offering immigrants support through the safety net, New Mexico has implemented initiatives that promote clarification for immigrants on eligibility rules for public benefits and to decrease fear around seeking those benefits. For some period of time, immigrants as well as public officials and the general population have been unclear on whether or not the receipt of Medicaid could cause them to be determined a "public charge," and thus affect their immigration status. Receipt of Medicaid and SCHIP benefits, except for long-term care, is not the basis for a public charge determination. The Department of Justice- Immigration and Naturalization Services published a regulation defining and clarifying public charge policy in May of 1999. **New Mexico, through the Human Services Department and New Mexico Advocates for Children and Families took the initiative to work actively with the Immigration and Naturalization Service to provide education to the public and, specifically, this population.** A Spanish language videotape to allay fears on the public charge issue was aired in a statewide media campaign. Border communities were targeted in this campaign.

Many undocumented immigrants have children who are either United States citizens or qualified immigrants, and who are eligible for public assistance programs, despite their parent(s)' status. **The New Mexico Human Services Department has been proactive in providing policy clarifications and revised application forms emphasizing that citizenship status and Social Security numbers are not required for family members who are not applying for assistance and must not be requested.**

POLICY OPTIONS

The SJM 52 Workgroup has assessed the critical issues impacting immigrant's access to health care and public benefits at the federal, state, county, and community levels. From this study a variety of possible policy options and directions were explored and discussed for New Mexico to consider. **The majority of the SJM 52 Work Group did agree that they share a broad vision and ethical value that "access to basic healthcare is a human right" and that all immigrants should have equal access in regards to health care and other public benefits.**

It became clear in this study that there is no single specific course of action to recommend at this time. No "bottom-line" solutions or quick fixes are offered. Rather, the following policy options that target multiple levels and kinds of interventions are provided for the New Mexico State Legislature to consider:

- Under the PRWORA, New Mexico has the option to create its own eligibility rules through formal state legislative enactment regarding eligibility for immigrants for state funded services. As a matter of principle, the SJM 52 Workgroup agrees that it would be desirable to enact such legislation to deem all residents, including immigrants, eligible for state-funded public benefits as a way to promote equity in

accessing health services and public benefits. **However, given that the study shows that most safety net providers in New Mexico continue to provide services to all in need within available resources, the SJM 52 Workgroup does not recommend this kind of legislative action at this time.** Their concern is that the public discussion that would likely take place to attempt to enact such legislation might be more damaging than the current situation.

- The SJM 52 Workgroup concludes that access to health care and public benefits for immigrants (undocumented and those who have been in the U.S. for less than five years) is a priority issue for the state agenda in trying to influence the 2002 federal reauthorization of PRWORA. **The Work Group recommends that the New Mexico State Legislature consider working with the NM Congressional Delegation to recommend to the U.S. Congress that the denial of public benefits to non-qualified aliens as defined under the current PRWORA should be repealed in the October 1, 2002 reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.**

- **A possible action considered by the Workgroup is to enact another, more broadly written Legislative Memorial requesting a further investigation of these complex issues and involving all key parties in order to better answer several important questions that could not be adequately addressed by SJM 52 effort.** This additional study should be funded if possible.

- Issues affecting immigrants cut across economic, educational, legal, health, and social policies and involve multiple layers of authority including international (i.e. NAFTA), federal, state, county, and local governments. There is currently no central point of contact for immigrant health and welfare issues in New Mexico**. Other states have addressed this by creating a State Office on Immigrant Affairs or a statewide Immigrant Advocacy Coalition. New Mexico may wish to consider creating this kind of capacity somewhere within state government.**

- **In addition, the state legislature could assure that New Mexico complies with the Title VI-Policy Guidance Regarding Inquiries into Citizenship, Immigration Status Social Security Numbers.** Under this law, federally funded programs may not require applicants to provide information about the citizenship or immigration status of non-applicant family or household member or deny benefits to an applicant because a non-applicant family or household member has not disclosed his or her citizenship or immigration status. For example, intake staff would not be allowed to ask immigrant parents about their citizenship or for their social security number when asking about health coverage for their citizen children.

- **The Legislature could request the U.S.-Mexico Border Health Commission to consider these issues of access to healthcare and public benefits for immigrants through a bi-national discussion forum and developing recommendations for state and local actions.**

Other Options:

On a national level, the National Health Law Program[26] recommends that states use a combination of solutions including public policy development, education, monitoring and outreach efforts such as:

- State and local policy must be clarified and administrative processes developed to insure that immigrants seeking health services to which they are entitled can do so without fear of being reported to the INS. States should be urged to pre-certify eligibility for emergency care.
- Public education and outreach campaigns should be expanded to immigrant communities to diminish fears and encourage the use of public health services.
- Federal and state governments must review other policies and rules affecting immigrant access to health care to ensure the public's health is not put in jeopardy by immigrant enforcement concerns.
- Public education should be provided so that health providers, social service agencies, community-based organizations and immigrants, themselves, understand what services remain available and the procedures for verifying and reporting immigration status.

IN CONCLUSION

It is clear from this preliminary study that issues of immigrant health and access to public benefits are critically important to the State of New Mexico. This initial effort at attempting to understand the complex legal, social, economic and health policy issues has demonstrated that more consideration is needed.

It should be acknowledged that the world has changed since September 11, 2001 and the global conflict that now engages our nation's attention has profound impacts on the issues discussed in this report. In the months prior to September, Presidents Bush and Fox were making significant progress in addressing issues of immigration reform that included several proposals for reconsidering, redefining, and "regularizing" the status of undocumented Mexican immigrants residing in the United States. During the late August meeting of the SJM 52 Workgroup there was "cautious optimism" that these complex issues of access to public benefits for recent and undocumented immigrants might resolve, or certainly improve. Clearly that has now changed and "immigration reform" seems to be taking a very different direction. If is unclear when or if the US/Mexico discussions about immigration reform will resume at its previous presidential level**. Nonetheless, the social, economic, public health and ethical challenges posed by resident immigrants in New Mexico will continue to require public discourse and public policy attention.**

INTRODUCTION

BACKGROUND

During the Forty-Fifth Legislature, First Session, 2001, the New Mexico State Senate and House of Representatives enacted SJM 52 (attached as Appendix A) requesting "the Department of Health, the Health Policy Commission and Human Services Department to evaluate the provision of health care to immigrants, especially those documented immigrants in the United States for fewer than five years and undocumented immigrants." A broadly representative SJM 52 Workgroup convened in July, August, and October 2001 to discuss issues, provide direction and help develop this report to clarify the policy and programmatic issues affecting immigrants who are uninsured and unable to afford heath care in New Mexico (see Appendix B for workgroup membership). The challenges posed to immigrants, advocates, community-based organizations, safety net providers, counties, public hospitals and state government are complex, multi-faceted and require long-term policy and programmatic solutions. Debates and critical policy questions are rooted in diverse beliefs and often competing opinions regarding human rights, financial resources and priorities, legal statutes, nationalism, and ethical values in the provision of "health care for all."

METHODOLOGY

This study assesses the impact of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) on the provision of primarily the public benefit of health care for immigrants living in New Mexico. Of particular interest are those documented immigrants in the United States for fewer than five years and undocumented immigrants who clearly lost access to certain benefits as a result of the PRWORA. Health care in this study is defined comprehensively to include the full range of physical and behavioral health services that promote well-being, and prevent and treat disease.

A literature review was conducted of over 100 articles and reports searching key words such as "welfare and immigration reform, health care access, and immigrant health" from academic and legal journals, policy research organizations such as the National Immigration Law Center and Urban Institute. This literature is mostly from national and cross-state comparative studies. Secondary data was gathered and reviewed from multiple sources including but not limited to the U.S. Census Bureau, National Council of State Legislatures, and local studies and data. Since there is a clear lack of New Mexico specific data, national trends and information are frequently cited.

Qualitative interviews were conducted with over 20 key informants and immigrants throughout New Mexico. These interviews with frequently conducted in Spanish, translated to English and included in the report. **Various perspectives are captured in the report in order to present the diverse views from state, local, provider and grass-roots levels in a balanced manner. Some are highlighted in dialogue boxes for emphasis and others as "a community voice" to reflect the actual perspective of resident immigrants. They represent personal feelings and experiences and are not presented**

as verified factual accounts. In addition, documents such as newspaper articles were reviewed and included in sections of the report. Finally, process data such as minutes from the SJM 52 workgroup and correspondence between workgroup members were utilized.

STUDY LIMITATIONS

It is important to note other limitations of the SJM 52 study. First, there was no funding appropriated to implement a systematic investigation which would produce more extensive evidence of the impact of the PWRORA on immigrants in New Mexico. Secondly, research on immigrants' health access and status is problematic since there is no consistent method to defining "who is immigrant." According to a national assessment of immigration status in health research, methodological issues relating to studying immigrant health include: how immigrant is defined, how immigration status is assessed and how sampling and recruitment strategies of immigrants are conducted.[27] In general, three broad paradigms exist for the definition of immigrant and the determination of immigrant status: social science, immigration law, and public benefit law/entitlement.

Research on immigrants' health access and status is problematic since there is no consistent method to defining "who is immigrant."

This issue becomes even more confusing at the state, county, and local levels since there is lack of clarification when discussing who is eligible for public benefits and health care. Even the SJM 52 Workgroup, despite the collective knowledge and expertise, have struggled through the complex language and diverse frameworks for determining who is immigrant: citizens; non-citizens; documented; qualified (i.e. lawful permanent residents, refugees, asylees, aliens paroled, battered aliens); not-qualified (i.e. Persons Residing Under Color of Law PRUCOL, undocumented), etc. (See Appendix C, Glossary of Terms). As a consequence, this study was unable to disaggregate the multiple categories of "immigrant" framed by both the legal and public benefit definitions while having no consistent or quantifiable data available to do so at the state or local levels. In addition, this report does not include quantifiable data, pre and post 1996, to determine the impact of the PRWORA on health utilization and health outcomes for immigrants-it simply does not exist. Health outcomes are not covered in this study although they are important in determining health status, public health priorities, and their relationship to the socio-economic and legal positioning of immigrants.

It is important to note that the SJM 52 Workgroup gathered and utilized as much local data as available. Since there is a lack of clear and comprehensive data regarding undocumented immigrants health care utilization before and after the 1996 PRWORA, this study relies heavily on national and state resources and studies in order to best define the context. **Thus, this SJM 52 Report is not able to provide a definitive answer to the questions posed in the memorial. It is more of an attempt to describe the complex issues involved, represent the challenges faced by immigrants, broadly assess the response of the safety net providers in New Mexico, reflect in a balanced manner the diverse perspectives on various issues, and identify possible actions that might best serve as next steps towards improving the current situation.**

PART ONE: Selected Policy Changes Impacting Immigrants

THE "BIG CHILL": THE 1996 POLICY CONTEXT

The Illegal Immigration Reform and Immigration Responsibility Act of 1996 (IIRIRA) and The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), along with anti-immigrant attitudes, have had a chilling effect on immigrant use of public benefits. Trend analysis of welfare rolls following Welfare Reform concludes that eligibility changes in one program may chill noncitizens' use of other programs. Both Acts worked as a tag team, one cutting benefits (food stamps, SSI and Medicaid) and the other, restraining civil rights (hearing and appeal rights) from immigrants. The overarching goal of both reform policies was to replace civil rights protections with personal responsibility. This goal was successful in making the most vulnerable groups of immigrants who have less social, political and economic capital to draw on for survival more at risk of being uninsured and without benefits.

The PRWORA replaced the AFDC entitlement cash assistance program with the Temporary Assistance for Needy Families TANF Program and made citizenship or long-term residency a condition of eligibility for public benefits for most immigrants. The PRWORA established, for the first time, a bar on immigrants' access to Medicaid. As a result, Medicaid eligibility policy has changed markedly, eliminating the automatic link between Medicaid and Welfare (FIGURE 1).[28]

The law cut $23.8 billion in benefits for legal immigrants, accounting for 44% of the federal savings in the welfare law. These savings were estimated at $5 billion over 7 years, affecting approximately 600,000 immigrants. Most of the national savings from Welfare Reform derived from barring most non-citizens from the Supplemental Security Income Program (SSI). The loss of SSI also threatened the automatic link to Medicaid eligibility for many elderly and disabled immigrants.[29] Immigrants now face access and coverage disparities because of the PRWORA policy changes.[30] Current policy now treats new legal and recent legal immigrants differently from both longer-term immigrants (greater than 5 years) and citizens when determining eligibility for Medicaid and other public benefits. This creates confusion that can be particularly challenging for non-English speaking families who may face difficulty understanding complex welfare regulations.[31]

The de-coupling of Medicaid and welfare eligibility combined with the effects of new rules for coverage of immigrant families appear to be playing a significant role in the reduction of welfare rolls and decline in Medicaid enrollment.[32] The welfare caseload reductions raise significant policy questions of the impact of welfare changes on health insurance coverage for low-income families. Administrative and survey data indicate that Medicaid coverage of immigrants and of their children (who are often U.S. born and therefore citizens) has fallen sharply since 1995.[33] [34] [35] Data from the Current Population Survey (CPS) show that the share of low-income non-citizen immigrants (non-elderly people with incomes below 200 percent of poverty) who had Medicaid fell from 19 percent in 1995 to 15 percent by 1997.[36]

The Urban Institute reported trends from 1994-1997 in noncitizens' and citizens' use of public benefits following Welfare Reform, which reveal a "chilling effect" on immigrants.[37] Principal findings are:

- Use of public benefits among noncitizen households fell more sharply (35 %) between 1994 and 1997 than among citizen households (14 %). These patterns hold for welfare (defined as TANF, SSI, and General Assistance), food stamps, and Medicaid.

- For low-income populations (i.e., with incomes below 200 % of poverty), program usage also fell faster for noncitizen than citizen households.

- Welfare use in noncitizen households with children also fell faster (36%) than in households with children where all adults are citizens (23%).

- One result of these trends is that noncitizens accounted for a disproportionately large share of the overall decline in welfare caseloads that occurred between 1994 and 1997.

- Neither naturalization nor rising incomes accounted for a significant share of noncitizens' exits from public benefit use.

Because comparatively few legal immigrants were ineligible for public benefits after 1996, it appears that the steeper declines in noncitizens' than citizens' use of welfare, food stamps, and Medicaid owe more to the "chilling effect" of welfare reform and other policy changes than they do to actual eligibility changes. In addition, the trend analysis concludes that eligibility changes in one program may chill noncitizens' use of other programs. Therefore, state eligibility changes are critical as most immigrants admitted after August 22, 1996, will be ineligible for most means-tested public benefits for at least five years after their entry into the country.[38]

ELIGIBILITY REQUIREMENTS FOR PUBLIC BENEFITS AND MEDICAID

As a result of PRWORA, state and local governments acquired new responsibilities, increased fiscal pressures and complicated administrative decisions.[39] States are currently making complex decisions regarding federal programs in three areas: (1) immigrant eligibility decisions, i.e. whether immigrants should be covered and which types of immigrants should be covered; (2) the level of benefits to be offered to immigrants; and (3) administrative decisions, i.e. whether to create new state programs or reform current programs to serve immigrants.[40]

What is a public benefit? The PRWORA defines a federal public benefit as any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and Any retirement, welfare, health, disability public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by the United States or by funds of the United States (Appendix C).

How do states determine who's "qualified" under the 1996 PRWORA? To be "qualified" an applicant must have immigration status in one of the following areas [41],[42] (Appendices B & C):

- Naturalized Citizen- an immigrant who has gone through the process of naturalization to become a U.S. citizen. Immigrants that are eligible (in most cases) are legal permanent residents in the U.S. for at least five years and also meet other qualifications such as language, knowledge of the U.S., criminal background check, and are of "good moral character."
- Legal (or lawful) permanent resident (LPR)- a person who has been granted lawful permanent residence status, i.e. someone who is a "Green Card" holder and is entitled to remain in the U.S. indefinitely.
- Refugee- a person who flees his or her country in fear of persecution or with a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.
- Asylee- a person who has been determined to meet the same requirements as a refugee, but who was already present in the U.S. at the time he/she obtained asylum.
- Aliens paroled into the U.S. for at least on year.
- Aliens whose deportations are being withheld.
- Aliens granted conditional entry (prior to April 1, 1980).
- Battered alien spouses, battered alien children, the alien parents of battered children and alien children of battered parents who fit certain criteria.
- Cuban/Haitian entrants

"Qualified Aliens"

- naturalized citizens
- legal/lawful permanent residents
- refugees
- asylees
- persons who have had deportation withheld
- persons granted conditional entry
- battered immigrants

All other documented and undocumented immigrants are considered "non-qualified aliens."

Source: Immigrant Access to Health Benefits: A Resource Manual (2000). The Access Project.

PRUCOLS are any other immigrant living in the U.S. with the knowledge and consent of the INS, and whose departure the INS does not contemplate enforcing.

Source: Health Care Access for Immigrants & Refugees (2000). The Access Project.

Which immigrants are "not qualified"? "Not qualified" immigrants are not eligible for Medicaid, except in emergencies, and include all other non citizens, such as:

1. Persons Residing Under Color of Law (PRUCOL)[1] including Undocumented Alien- an immigrants who are not a U.S. citizen and who have entered (or remained in) the US without the proper documentation and who do not have legal status for immigration purposes [Appendix B]. Some examples include: immigrants with temporary protected status; deferred enforced departure, parolees granted status for less than one year; applicants for asylum or other statuses, registry immigrants.
2. Undocumented immigrants.
3. Nonimmigrants such as students and foreign visitors.

What are effects on Medicaid for immigrants after 1996? Before Welfare Reform, most persons who were legal immigrants and permanent residents were entitled to full Medicaid coverage. FIGURE 1 shows the effects on eligibility rules for Medicaid before and after

[1] This category generally means that INS is aware of the person's presence but has no intent to deport him/her. However, PRUCOL is defined differently in different jurisdictions and for different programs.

1996. Coverage for post 1996 and undocumented immigrants is limited to emergency coverage only, including childbirth, but not prenatal care.

FIGURE 1: Welfare Reform's Effects on Medicaid for Immigrants

Before PRWORA	***After PWORA***
▪ Most persons who are legal immigrants and permanent residents are entitled to full Medicaid coverage. ▪ Coverage for undocumented persons is restricted to emergency coverage only.	▪ Qualified immigrants who enter the country before August 1996 may be denied Medicaid at a state option. ▪ Qualified immigrants (legal permanent residents and others) who enter the country after August 22, 1996 are barred from receiving Medicaid and CHIP for five years. After the five years, the sponsor's income is "deemed" before determining eligibility. States may choose to deny Medicaid or CHIP to these immigrants after the five year ban. ▪ Coverage for post 1996 and undocumented immigrants is limited to emergency coverage only, including childbirth, but not prenatal care. ▪ Refugees/asylees are exempt from these provisions for seven years after receiving their status.

Note: PRWORA is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Source: Rosenbaum, 2000 for the Kaiser Commission on Medicaid and the Uninsured.

With many important exceptions explained in FIGURE 2**,** "Qualified Aliens" are ineligible for Food Stamps and SSI. (See Appendix C For Eligibility, Rules and Exceptions).

FIGURE 2. Welfare Reforms Effect on Federal Public Benefits for Immigrants

"Qualified" Immigrants in the U.S. Before 1996	***"Qualified" Immigrants entering the U.S. on or after 1996***
*Eligible for SSI: • If they were receiving the benefit on 8/22/96; or • If they are or become disabled • Eligible for Food Stamps: • If they were 65 years of age or older as of 8/22/96; • If they are under 18 years of age; • If they are a tribal member or family member of a Hmong or Highland Laotian tribe; OR • If they are a member of specific Indian tribes living along the U.S. border States have the option to determine immigrant eligibility for TANF, Medicaid, and social services block grants (Title XX).	• *Barred from Supplemental Security Income (SSI) and Food Stamps with some exceptions. • Subject to a 5-yar bar on non-emergency Medicaid, the state Child Health Insurance Program (CHIP), and Temporary Assistance for Needy Families (TANF- formerly AFDC). • After 5-year bar, subject to deeming for up to one year except for some battered spouses and children, and those at risk of going hungry or becoming homeless. • After the 5-year bar, states still retain the option to determine immigrant eligibility for TANF, Medicaid, and social services block grants (Title XX).
San Antonio Immigrant & Refugee Rights Coalition, February, 1999. 210-736-1503 *Exceptions are explained by the National Immigration Law Center (NILC) www.nilc.org	

The 1996 IIRIA increased the income requirements of sponsors of immigrants from 100% of the federal poverty level to 125%, clarified that the income of the sponsor is deemed to the immigrant, and stated that the sponsor is financially liable for benefits. Sponsorship is important because as part of the immigration process, many, but not all immigrants will need to have a sponsor. Under the new changes of 1996, greater legal liability is imposed on

sponsors and makes it more difficult for new immigrants to qualify for public benefits even after they have lived in the United States for five years.[43] The law also expanded the grounds for deporting long-term resident immigrants, toughened border enforcement, closed opportunities for undocumented immigrants to adjust their status, and narrowed rules to gain asylum.[44] The new hearings and appeals rights under IIRIA means that immigrants arriving in the U.S. can now be "excluded", i.e. sent back, without a hearing unless they state a "credible fear" of persecution or an intention to apply for asylum.. Undocumented immigrants living in the U.S. can also be "excluded" without a hearing under certain circumstances.

Sponsor –
A person who signs an affidavit of support for a person who is applying to immigrate to the U.S. as a resident. A sponsor must be a U.S. citizen, national, or legal permanent resident, 18 years or older, domiciled in the U.S., and must meet income/assets requirements.

Source: Immigrant Access to Health Benefits: A Resource Manual (2000). The Access Project.

Sponsor deeming of income-
For any federal means-tested public benefits program, such as TANF, SSI, food stamps, CHIP, and Medicaid, the income and resources of a sponsor are added to those of the immigrant when determining eligibility for, and amount of, benefits available under each of the programs.

Source: Immigrant Access to Health Benefits: A Resource Manual (2000). The Access Project.

EXCEPTIONS TO THE PRWORA

The most important exception to restrictions on eligibility for health care is that regardless of immigration status, all immigrants remain eligible for Medicaid-reimbursed emergency health care.[45] In addition, all non-citizens remain eligible for public health programs providing immunizations and/or treatment of communicable disease symptoms.[46] School breakfast and lunch programs also remain open to all children.

Under the PRWORA, emergency Medicaid is available to all aliens, regardless of immigration status. PRWORA, Section 401(b)(1)(A). Hospitals and other providers are not required to and indeed, should not attempt to verify an alien's immigration status as a condition of receipt of emergency services or for any other reason. [47] Emergency Medicaid coverage, however, is limited to medical conditions that meet the definition of an emergency medical condition. An emergency medical condition is defined in the Medicaid statute [42 U.S.C. Section 1396b(v)(3)] and the HCFA State Medicaid Manual (February 1997), Section 3211.11.[48]

Under the Emergency Medical Treatment and Active Labor Act of 1986, 42 USC § 1399 dd, hospitals participating in Medicare, are prohibited from refusing to treat people who need emergency medical assistance but have no health insurance or other means to pay the bill.

Nursing homes and hospitals receiving renovation and construction grant under the Hill-Burton Act are obligated to provide uncompensated care to persons unable to pay 10% of all grants received or 3% of their annual operating budget for up to 20 years from the date of the grant. However, the community service obligation under Hill-Burton prohibits facilities

from discriminating on any ground unrelated to an individual's need for services or the availability of needed services in the facility. Thus, Hill-Burton Hospitals must maintain an open emergency room for everyone in the service area, even those unable to pay.

Federally Qualified Health Centers (FQHCs) are required to serve underserved populations regardless of ability to pay. FQHCs must provide basic health services (i.e. primary care, cancer and other disease screening, immunizations, dental screenings), and offer services that ensure access to basic health and social services (i.e. transportation). Migrant Health Clinics and Rural Health Clinics receiving federal funds must also comply with similar obligations.

The following federally funded programs are also exempt from restrictions under the 1996 PRWORA and IIRIA: Women Infants and Children funded by the United States Department of Agriculture (USDA); Family Planning funded by Title X; and Children's Medical Services and the High Risks Pregnancy Program both funded under Title V.

Other exceptions regardless of immigration status, include: short-term, non-cash, in-kind emergency disaster relief, non-Medicaid funded public health services, and community based programs necessary to protect life and safety such as crisis counseling, shelters, police and fire, and transportation services.[49]

BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA), P.L. 105-33, reversed $11.4 billion of immigrant benefits stripped away by the 1996 welfare reform law. The Act restored SSI to individuals who were receiving SSI benefits on August 22, 1996. Immigrants lawfully residing in the U.S. as of that date who are or become disabled will be eligible for Medicaid and SSI benefits. The BBA also restored SSI and Medicaid to recipients who applied for benefits prior to 1979, the year that the Social Security Administration began asking for proof of citizenship or immigration status. This provision affected many citizens as well as immigrants who were at risk of losing benefits because they had no birth certificates or other documentation proving citizenship or naturalization.[50] As noted above, the federal government reimburses states for the costs of provided emergency medical services to undocumented immigrants. Under the terms of Section 4723 of the 1997 BBA, an additional $25 million per year from 1998-2001 was distributed to 12 states with the largest number of Emergency Medical Services provided to undocumented persons (New Mexico ranks number 14 and thus did not receive these particular fund).

CALIFORNIA'S PROPOSITION 187 IN 1994

Proposition 187's stated purpose is to "provide for cooperation between state and local government agencies, and to establish a system of required notification by and between such agencies, to prevent illegal aliens in the United States from receiving benefits or public services in the State of California." Prop. 187, section. 1 In 1994, that statute, under the leadership of former Governor Pete Wilson represented a dramatic effort to drive out

undocumented aliens and to deter their entry by cutting them off from medical and other public services and depriving their children of an education. The statute was immediately attacked as unconstitutional in several lawsuits.

Proposition 187's provisions required California law enforcement, social services, health care and public personnel to:

- Verify the immigration status of persons with whom they came in contact;
- Notify certain defined persons of their immigration status;
- Report those persons to state and federal officials; and
- Deny those persons social services, health care, and education.

There was strong opposition against Proposition 187 due to its exclusionary tone against immigrants. The implementation was delayed, and California Governor Grey Davis declared in 1999 that the state would not try to implement the policy.[51]

Opponents of California's Proposition 187 argued that it posed serious threats not only to civil rights protections of language and racial minorities, but also to the public's health. The prohibition of prevention and medical care from targeted classes of people's creates serious public health consequences, such as increasing the risk of contagious diseases.

WHAT POLICY PROTECTIONS DO IMMIGRANTS HAVE?

Title VI-Policy Guidance Regarding Inquiries into Citizenship, Immigration Status Social Security Numbers. The new guidelines established by the Immigration and Naturalization Service and U.S. Department of State clarify that under federal law, states are required to establish the citizenship and immigration status of applicants for Medicaid (except for emergency Medicaid), SCHIP, TANF, and Food Stamps. However, states may not require applicants to provide information about the citizenship or immigration status of non-applicant family or household member or deny benefits to an applicant because a non-applicant family or household member has not disclosed his or her citizenship or immigration status. Finally, states must comply with the Privacy Act, 42 USC § 45 when seeking disclosure of an individual's social security number.[52]

Title VI Protections-Language Access Issues. The rights of language minorities are of growing importance because many benefits and privileges of living in and being a citizen of the United States are based on a person's proficiency in English. Legal protection under Title VI of the Civil Rights Act begins to address the structural barriers and discrimination against immigrants based on race, color, and national origin. While Title VI does not provide absolute protection against discrimination in accessing health care, it begins to confront the daily effects of "business as usual" types of practice, which inhibits access to quality health care for mono-lingual immigrants.

> Language is crucial in accessing and receiving quality health care.

Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. Seq., and its' implementing regulation at 45 C.F. R. Part 80 provides that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied benefits of, or subjected to discrimination under any program or

activity receiving Federal financial assistance." In January of 1998, the Office of Civil Rights (OCR) with the United States Department of Health and Human Services (USDHHS) issued policy guidance to all federally funded recipients. "In order to ensure compliance with Title VI, recipient/covered entities must take steps to ensure that persons with Limited English Proficiency (LEP) who are eligible for their programs or services have meaningful access to health and social service benefits that they provide."[53] The four steps include assessment, development of a comprehensive written policy on language access, training of staff, and vigilant monitoring.

Language protection is critical in assuring civil rights. Equally important is that communication with a physician and medical personnel is critical to building trust, developing a patient-provider relationship, and establishing a reliable and regular source of care. Preventive health and treatment can be void or delayed as a result of language barriers for monolingual immigrants. When people finally seek treatment, it is often on an emergency medical basis.[54]

The Office of Civil Rights (US Department of Health and Human Services) reports that over the last 30 years, it has conducted thousands of investigations and reviews involving language differences that impede the access of LEP persons to medical care and social services.[55] Where failure to accommodate language differences discriminates on the basis of national origin, OCR has required recipient/covered entities to provide appropriate language assistance to LEP persons.

A Community Voice

"But I didn't feel comfortable because the doctor didn't speak Spanish well enough. There were no translators. No doctor or nurse made me aware of a translator. I tried with the little English I know, I tried to explain the problem and that's how we communicated—with signs and we both knew."

THE LINK BETWEEN POLICY, HEALTH DISPARITIES AND HEALTH STATUS

Social inequalities in health cannot be explained solely by the inequity in the distribution of health care. Rather, the attainment of health is determined by having access to different forms of capital (financial, social, political, human and cultural).[56] For example, Kawachi et al conducted an extensive review of this literature and concludes that the three pathways by which income distribution affects health are[57]:

1. Access to life opportunities. Education, jobs and medical services are influenced by relative as well as absolute income.
2. Social cohesion. Decreased trust is closely related to strains in the social fabric leading to hostility, suspicion, and social isolation, all of which affect health.
3. Psychosocial explanations. Income inequality affects an individual's social environment but also affects him/her directly, bringing with it hopelessness, lack of control and loss of respect, the underlying mediator being stress.

In the long-term, as difficult as it will be, root causes of health status disparities must be understood and addressed since immigrants are over-represented in the low-paying labor force, are generally the least likely to be offered employer sponsored health benefits, encounter significant legal, language and structural barriers to accessing services, and experience the daily impact and stressors of discrimination and exclusion from multiple segments of society.

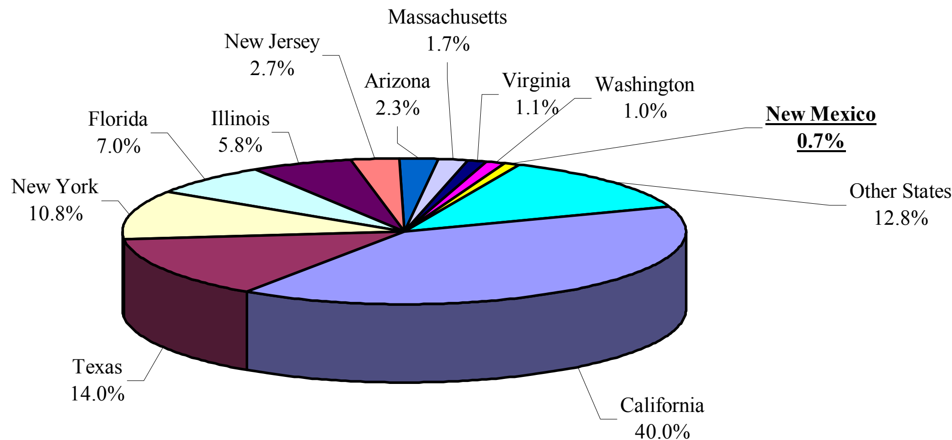
Policy enactments of 1996 such as the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA) and the Immigration Reform and Control Act (IRCA) of 1986 have placed restrictions on who receives public benefits and health care in this country. As a result, an immigrant's likelihood and risks for being uninsured and having a regular source of care have diminished. The long-term policy implications for a state like New Mexico with limited economic resources, among the highest rate of uninsured in the nation, and low wage earnings, could result in diminished health outcomes across generations of immigrant families.

PART TWO: DEMOGRAPHICS

IMMIGRANTS IN THE U.S.

According to the 2000 Current Population Survey (CPS), 11.2 % of the 273 million U.S. population is foreign-born, with the majority being native born at 88.8%. Of the total 30.7 million immigrants in the U.S., undocumented aliens represent only 28% of the immigrant population, 30% are legal permanent residents, 30% naturalized citizens, 5% refugees, non-citizens, 2% refugees, naturalized and 5% others.[58] The INS reports that in Federal FY 96 the top ten countries of birth for the 5,000,000 identified as "illegal aliens" are: Mexico (2,700,000), El Salvador (335,000), Guatemala (165,000), Canada (120,000), Haiti (105,000), Philippines, (95,000), Honduras (90,000), The Bahamas (70,000), Nicaragua (70,000), and Poland (70,000). States with the highest population of "illegal aliens" in 1996 are California (2,000,000), Texas (700,000), New York (540,000), Florida (350,000), Illinois (290,000), New Jersey (135,000), Massachusetts (85,000), Virginia (55,000), and Washington (52,000). Comparatively, New Mexico has a lower population of "illegal aliens" at 37,000 (See FIGURE 3).

FIGURE 3. Geographic Distribution of Illegal Alien Population by State Oct. 1996, INS Data



A recent report by the Institute of Medicine notes that despite the belief that most uninsured are unemployed or recent immigrants, 80% of uninsured Americans "are in working families" and immigrants "make up only a small percentage" of the uninsured population.[59] Although undocumented Latino immigrants have come to the U.S. for economic opportunity, their employment rates were lower than for Latinos nationally**. And despite their coming in search of work, the vast majority of undocumented Latinos had poverty-level incomes.[60] Immigrants are disproportionately represented in many of the lowest-paying jobs in the services sector, agricultural industry, construction and domestic work.[61]**

Recent immigrants do not drain the welfare budgets and are not specifically responsible for the growth in the number of uninsured. Results from a longitudinal study of the California Work Pays Demonstration Project, show that there is weak evidence that foreign-born mothers are more likely to continuously receive AFDC than native-born mothers when comparing persons with similar dependency history, family structure and socioeconomic status.[62] In-person interviews of 973 undocumented persons living in Houston and El Paso (Texas), Fresno and Los Angeles (California) found that undocumented Latino immigrants come to the U.S. primarily for work and less than 1 percent of respondents cited obtaining social services as the most important reason for immigrating.[63] Overall, welfare use by immigrants and native born is similar- in 1994, 6.6% of foreign born (including both naturalized and non-citizens) used AFDC, SSI or general assistance programs.[64] In addition, declining welfare rolls are not necessarily translating into economic self-sufficiency for immigrant families. For eligible immigrants with limited English proficiency and/or limited education or job skills, the only options for work are in low-paying jobs that offer no health insurance or the possibility to lift their families out of poverty.

Although there was a growth in the uninsured from 41 million in 1994 to 44 million in 1998, recent immigrants did not contribute to the growth. In fact, according to a 2000 study by the Kaiser Commission on Medicaid and the Uninsured, uninsured immigrants decreased by 100,000 during this period. Recent immigrants and their children who lacked health insurance coverage (2.3 million) constituted only 5 percent of the 44 million uninsured. Finally, the largest growth in the uninsured occurred among U.S. citizens who made up 2.7 million of 4.2 million increase in the uninsured between 1994 and 1998.

The National Research Council reports that "immigration benefits the US economy overall, and has had a small adverse impact on the income and job opportunities of most native-born Americans."[65] The evidence is that immigrants contribute as much as $10 billion to the economy each year. Two-thirds of immigrants who are in non-citizen families are much more likely to be poor and have a full-time worker in their family. **The typical immigrant family pays an estimated $80,000 more in taxes than they receive in local, state, and federal benefits over a lifetime.[66] The Social Security Administration estimates that undocumented workers paid over $20 billion in Social Security taxes from 1990 to 1998 and most likely will never receive any benefits.[67]**

In summary, immigrants contribute to the economy and despite the fact that they are hard working and hold low-wage earning jobs that do not offer health insurance coverage, they are not responsible for the increased growth rate of the uninsured in the U.S.

IMMIGRANTS IN NEW MEXICO

Over three-fourths (78%) of the immigrants admitted to New Mexico are from Mexico. Immigrants admitted to New Mexico also originate from a number of Asian countries, including Vietnam (2.9% of all admitted immigrants), China Mainland (1.5%), Philippines (1.5%), and India (1.4%).[68] **The estimated number of undocumented immigrants in New Mexico in 1996 was 37,000, the vast majority presumed to be from Mexico[69]**

From 1997-1999, the population distribution by citizenship status in New Mexico was 92.9 % (1,685,640) citizens and 7.1% (129,040) non-citizens as compared to 93.5 % citizens and 6.5 % non-citizens in the U.S.[70]

Even though Hispanics comprise the largest proportion of immigrants in New Mexico, over 90% of Hispanics are native-born. This is higher than the national average, of over 64% of all Hispanics born in the US. The remaining were born outside the U.S. Nationally, families, with a native Hispanic householder have a similar poverty status and income to families with a foreign-born Hispanic householder. In New Mexico, however, families with a foreign-born Hispanic householder are more than twice as likely to be in poverty those with a native-born householder.[71]

In New Mexico, families with a foreign-born Hispanic householder are more than twice as likely to be in poverty those with a native-born householder.

New Mexico does not have accurate data to disaggregate insurance coverage by citizenship status and county; however, local surveys and community-based studies provide a better description of geographic clusters of immigrants and their socio-economic, language, and health care needs.

For example, in a survey of 410 households in La Mesa/Trumbull neighborhoods in Albuquerque[72], 58% of respondents identified countries of origin other than the U.S., with the vast majority (46%) from Mexico, 4% from Cuba, 8 % from other countries including Vietnam, China, Philippines, El Salvador, Panama, and Guatemala. Forty-two percent of the households use Spanish as their main language. With regard to employment the immigrant population appears to be concentrated in construction, retail trade, and the unskilled and semi-skilled service industry (78% immigrant households reported agriculture and 73% report construction) as a main source of income. Both industries are seasonal and unreliable. The vast majority of households identified employment as their primary source of income. Nearly all households identifying Mexico (97%) and Cuba (94%) as their country of origin derive their primary income from employment, compared to 71% of U.S.-born households and 27% households born in other countries. The average monthly income reported by respondents was $1,268, and the average household spends 37% of its monthly income on rent and utility payments.

In 84% of households with at least one child under the age of 18, some form of healthcare coverage covered the children. The most common type of coverage is Medicaid/Salud (75%). In the case of adults, however, just over one half of those who responded have no healthcare coverage, and must rely on their own financial resources to pay for healthcare. Almost one fifth of adults do not access healthcare anywhere. Children access health care at a wide range of facilities, ranging from the local public health offices, First Choice Primary Care Center, the Indian Hospital, neighborhood clinics such as the SE Heights clinic (SEHC), UNMHSC outpatient clinics and hospital emergency rooms.

PART THREE: BARRIERS TO ACCESSING HEALTH CARE

BARRIERS TO ACCESSING HEALTH CARE CONTRIBUTE TO INCREASED HEALTH DISPARITIES

Inequalities in income and occupational segregation significantly impact ones ability to obtain health insurance coverage and health care services. Consequently, adequate access to health care services can significantly influence health outcomes. People of color were disproportionately represented among the nearly 41 million people (15 percent of the total population) without health insurance in 1995. According to the research literature, the top two indicators inhibiting access are:[73] [74] lack of health insurance coverage and lack of or limited linkage to a regular source of care. Multiple barriers like inability to pay for costs and lack of a regular source of care have a devastating impact on the health of families (adults and children) composed of citizens and non-citizens, also known as "mixed status families."

Immigrants more often lack health insurance coverage. The 2000 Census Bureau figures show that people who were not born in the United States were three times as likely as U.S.-born residents to lack insurance. Studies conducted after 1996, report that the majority of non- citizens and their children are at high risks of being uninsured and face serious gaps in receiving health care and public benefits.[75] For example, undocumented Latino immigrants obtain fewer ambulatory physician visits, rates of hospital admission, except hospitalizations related to childbirth, which were comparable between undocumented immigrants and other Latinos.[76] Low-income Mexican and Central Americans, recent immigrant groups, and language minorities are the least likely to have job-based coverage and the most likely to be uninsured.[77] [78] Obtaining employee sponsored insurance is one barrier, but the greatest obstacle for undocumented immigrants is actually maintaining regular work and earning a decent living wage.

A Community Voice

"When I don't have a job, I worry about costs. Since 1996, when they began to fine those businesses that had undocumented workers, my company let many go, I was one of them. Before, I was not worried about not being able to pay for medical care, now I am."

Immigrants more often lack or have limited linkage with a regular source of health care. According to the Medical Expenditure Panel Survey Chartbook [79] one way to measure access to care is to ask whether people have a usual source of care—a person or place they usually go to if they are sick or need advice about their health. Lacking a usual source of care may also have important implications for the quality and continuity of care received. Data from the Current Population Survey indicate that undocumented immigrants are undercounted and less likely than other Hispanics to have insurance coverage. [80] Despite the popular misconception that Americans who lack health insurance get the medical care they need, uninsured Americans tend to forego necessary care until their condition becomes

intolerable and hospital emergency and outpatient departments serve as their "regular source of care".[81]

Problems exist for immigrants with mixed family status. A recent study utilizing the 1997 National Survey of Americas Families, indicate that non-citizen immigrants and their children are much less likely to have a usual source of health care than native citizens, and their children, and immigrants are more likely to rely on clinics or outpatient departments but less likely to use doctors' offices or health maintenance organizations (HMOs). For adults, being a non-citizen was associated with a significant reduction in the probability of getting Medicaid or job-based insurance and substantial increase in the probability of being uninsured or of having no usual source of care, compared to native citizens. Non-citizen children were also significantly less likely to have Medicaid or job-based insurance and exhibited heightened risk of being uninsured or of having no usual source of care, compared to children whose parents are citizens.[82]

OTHER BARRIERS TO ACCESSING HEALTH SERVICES

Across the United States, other barriers to accessing health services include: high cost of services; lack of bilingual/bicultural services; long waiting times between calling for an appointment and the actual visit; long waits once they get to the health facility; the complicated medical forms to be filled out; the fact that services are designed for the convenience of health care providers and not the consumers; discriminatory attitudes and practices by health care providers towards racial, ethnic, immigrant, and low-income patients; fear by immigrants of being a "public charge" or of being reported to the Immigration and Naturalization Service (INS) for deportation; misinformation regarding Medicaid and public benefits eligibility rules; deterrence policies and practices by health systems; and a shortage of physicians and health professionals in areas with a high concentration of immigrants.

Findings from a survey of 533 undocumented Latino immigrants living in Los Angeles and Fresno counties in California explain that [83]:

- Financial barriers were paramount as reasons for inability to obtain care.
- Spanish-speaking medical personnel are important in ensuring access to health care services.
- A large proportion of undocumented Latino immigrants have children who are legal residents, most of whom are likely to be U.S. citizens.

Another study conducted by the Albuquerque Community Health Partnership on children with asthma found that recent immigrant parents of asthmatic children dealt with severe episodes of asthma by delaying care until a time of crisis.[84] Delayed care-seeking behavior patterns were attributed to language barriers and/or confusion in navigating the medical system in the U.S. Most parents described the visit to the clinic/hospital as causing terror and fear because of not knowing how to deal with the medical system and because of the fear and frustration

Most parents described the visit to the clinic/hospital as causing terror and fear because of not knowing how to deal the medical system and because of the fear and frustration due to language barriers.
–Community Health Partnership Study

due to language barriers. These circumstances were further complicated when the families were undocumented.

According to a report by the U.S. General Accounting Office, in El Paso, New York City, and Miami, health administrators consistently reported that the primary barrier to accessing health care was the shortage of physicians serving low-income Hispanic communities in urban and rural areas. For example, in El Paso, only 30 of the city's 800 physicians (4%) maintain practices in the poorest part of the city, an area that houses 170,000 people. [85] Consequently, the lack of primary care centers providing core preventative and treatment services to immigrants exacerbates the void of qualified health professionals, especially physicians. When medical personnel are available, they often lack cultural and language proficiencies.

FEAR OF DEPORTATION AND PUBLIC CHARGE

According to a study conducted by the U.S. Commission on Immigration Reform[86], the Welfare Act has created widespread fear and confusion among immigrants. For low-income immigrants, many who are elderly, disabled, or not fully proficient in English, the technicalities of PRWORA may be incomprehensible. For example, many eligible immigrants have been discouraged from using health and other benefits because of fears that their participation in public programs could cause them to be determined a "public charge" by the Immigration and Naturalization Service, which then leads to a delay or denial of changes in immigration status. Public charge is a term used by the Immigration and Naturalization Service (INS) to identify an immigrant who has or is likely to become primarily dependent on the government for subsistence as demonstrated either by: receipt of public cash assistance for income maintenance; or institutionalization for long-term care at government expense.[87] A person determined to be a public charge under U.S. immigration law, can be excluded from entering or reentering the United States as an immigrant, denied permanent resident status, or, under very limited circumstances, deported.

Fear of public charge determinations remain despite the May 1999 regulation that secures that legal immigrants will not be classified as public charges if they receive Medicaid or CHIP. As a result, immigrants' fear of public charge determinations is having devastating, widespread impact on the ability and willingness of immigrants to access health services and public benefits.[88] According to a report by the National Council of La Raza, "Latinos are inevitably the targets of immigration reform, whether or not they are immigrants."[89] This is significant because most policies that advantage or disadvantage non-citizens are likely to have broad spillover effects on citizen children who live in the great majority of immigrant families with mixed status.[90] Thus, denying health care to parents of U.S. citizen children has implications for the well being of those families and children.

A Community Voice

"When I was processing my documents to become a legal resident, the attorneys that were helping me told me that I could not apply for anything because I would risk my documents not getting processed. And even though my husband is a citizen, I might be denied residency."

PART FOUR:
STATE OPTIONS & RELEVANT COURT CASES

The PRWORA represents a substantial devolution of immigration policy to the states officials who now have substantial discretion to determine which types of immigrants will receive which kind of public benefits. For Medicaid, states have three options: (1) whether to continue or deny federally-funded Medicaid coverage to qualified immigrants who arrived in the U.S. prior to August 22, 1996; (2) whether to provide state-funded Medicaid coverage for qualified immigrants who arrive in the U.S. on or after August 22, 1996: and (3) whether to provide state-or county-funded medical coverage to non qualified immigrants.[91] (See FIGURE 4). There is substantial variability on what other states have opted to implement reflecting a continuum from more generous to more exclusionary "immigrant" policies. National research centers such as the Urban Institute, The National Immigration Law Center, The Health Policy Tracking Service, and The National Center on Policy and Budget Priorities have conducted very extensive cross-state analyses on immigrant policy choices that states are making.

Findings from the Urban Institute's study, "Patchwork Policies: State Assistance for Immigrants under Welfare Reform", show that many states have chosen to provide considerable assistance to immigrants, particularly when the costs are shared with the federal government. **In fact, nearly every state, including New Mexico, has opted to maintain TANF and Medicaid eligibility for immigrants who were already in the United States when the federal welfare law passed.** Over half of the states are spending their own money to cover at least some of the immigrants who are ineligible for federally funded services. State funded substitute benefits for immigrants losing eligibility for federal assistance include the following: a food stamp substitute program; an SSI substitute program; TANF for post-enactment immigrants (i.e. those entering after August 22,19996) who are subject to a five year bar on federally funded assistance; and Medicaid for the same post-enactment group. State provisions for most public benefits are made available through the support of their safety net programs. As reflected in the next section, that is true for New Mexico. Despite these efforts, most state replacement programs do not provide the same level of benefits as federal programs, and funding for many of these programs is temporary and subject to changes in the changing political and financial climates.[92]

Some states have passed laws complying with 8 U.S.C. 1621 (permitting states to pass affirmative legislation authorizing the use of state and local funds for provision of public benefits to income eligible persons regardless of immigrant status) including:

- Massachusetts has passed such a law that permits the provision of public benefits to income eligible persons regardless of immigrant status, subject to appropriation.
- Connecticut permits qualified "aliens" who do not qualify for federally funded cash assistance, other lawfully residing immigrant aliens or aliens who were formerly Persons Residing Under the Color of Law (PRUCOL) to be eligible for state funded services and gives benefits to others, but only until July 1, 2001.
- Colorado passed a bill to study how to provide prenatal care to undocumented immigrants.

- California provides food assistance to "sponsored aliens"; each county determines whether or not unqualified immigrants receive Medicaid or TANF.
- Georgia had time limited legislation providing TANF benefits for all immigrants who were income eligible from July 1999 to July 2001.
- New Mexico provides Medicaid, SCHIP and TANF to qualified immigrants after the five-year ban if they are otherwise eligible.

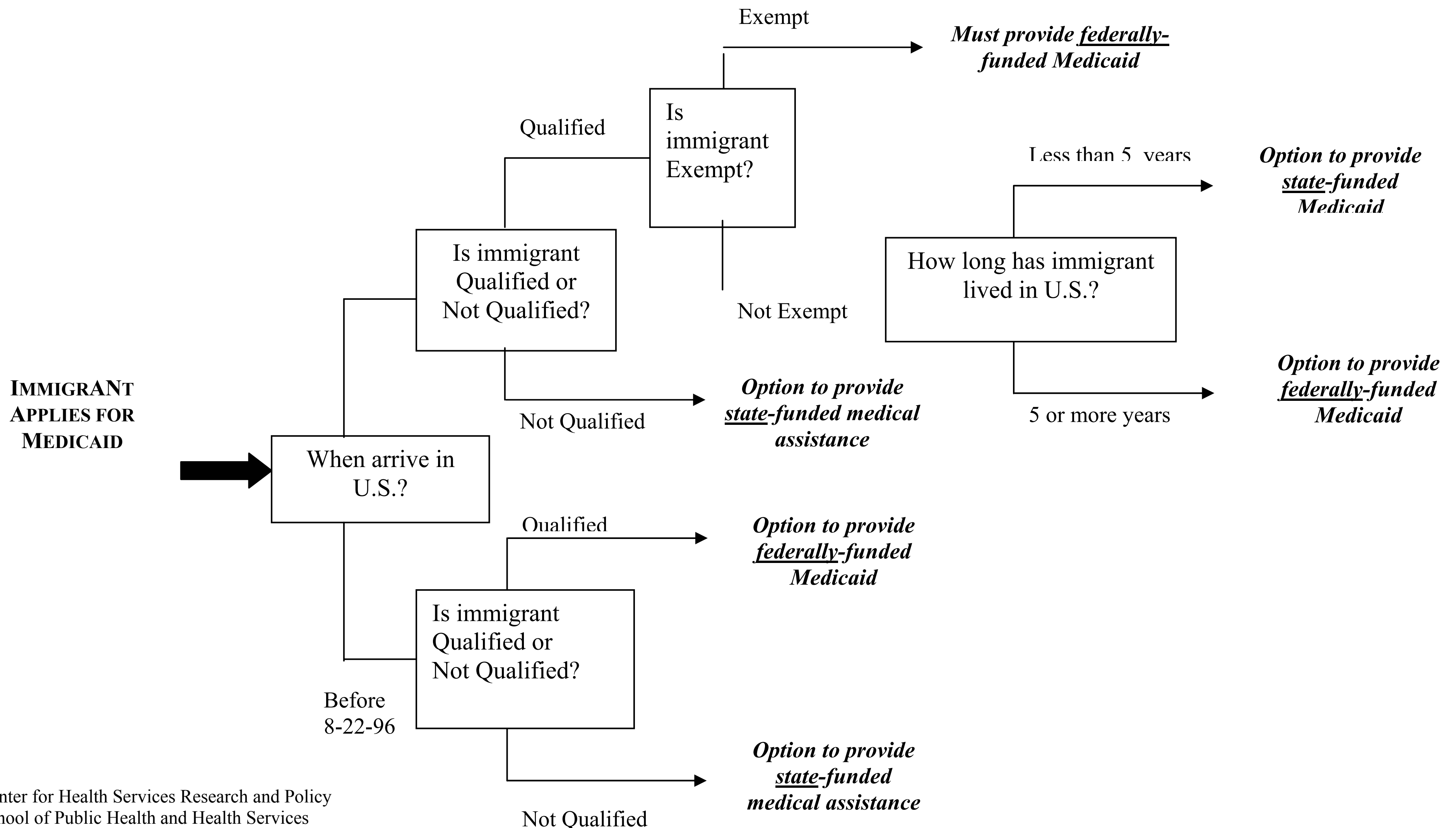
States continue to have to deal with the uncertainties around federal and state level litigation and around federal regulatory activities. In Aliessa v. Novello, NY2d, 2001 NY LEXIS 140 D (N.YCt. App. June 5, 2001) the New York court of appeals held that a NY statute denying Medicaid benefits funded solely by the State to plaintiffs based on their status as legal aliens violated equal protection clauses of NY and US constitutions. N. Koenigsberg with the NM Center on Law and Poverty explains that "this case relies primarily on the New York constitution. In addition, this court also recognized important considerations in the interpretation of federal immigration law." Particularly, this court "recognized that although the Federal government has broad constitutional power to distinguish among aliens in setting the rules for their admission and naturalization, Congress does not have the power to authorize the individual states to violate the equal protection clause," Graham v Richardson, 40 U.S. 365, 382 (1971). Title IV of PRWORA does not impose a uniform immigration rule for states to follow, thus, impermissibly authorizes each state to decide whether to disqualify many otherwise eligible aliens. In Aliessa v. Novello, the court proceeded to strike down the NY law on federal equal protection grounds as well.[93]

Texas passed a constitutional amendment in 1998, creating hospital districts, which are required to provide medical, and hospital care to "needy inhabitants" of a county. Article IX, §4. A Texas Attorney General's opinion states that public funds cannot be spent on undocumented residents unless state legislation has been passed to authorize it.[94] The response from Brownsville Community Health clinic is "when you cut off preventive care to any segment of the population, you are subjecting the entire population to communicable diseases." According to the El Paso County Attorney, "It is my opinion that the El Paso County Hospital District is authorized to continue to provide free or discounted non-emergency health care to eligible residents without regard to the person's citizenship or immigration status."[95]

"In Texas, undocumented immigrants feed the coffers of state and county governments through property taxes & sales taxes."

-Jeffrey Starke, MD, Ben Taub's Chief of Pediatrics

FIGURE 4. STATE OPTIONS TO PROVIDE MEDICAID TO IMMIGRANTS POST-PRWORA



Center for Health Services Research and Policy
School of Public Health and Health Services
The George Washington University Medical Center, Maloy, K.A. et al, May 2000, Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Services, RWJ Foundation.

PART FIVE: THE SAFETY NET IN NEW MEXICO

Although the number of uninsured Americans has dropped for the second year in a row, decreasing from 39.3 million in 1999 to 38.7 million in 2000, the 2000 U.S. Census reports that New Mexico (22.6%) and Texas (22.2 %) are the two states in the nation with the highest uninsurance rate. Despite the growing rate of uninsured and competitive health care market, the safety net continues to adapt, survive, and absorb the costs and burden of providing uncompensated care. Community health centers/primary care clinics, urban and rural public hospitals, state Department of Health programs (behavioral health and long-term services) and public health clinics, community hospitals, county indigent services, teaching hospitals such as UNM, and physician groups constitute our safety net in New Mexico.

Despite the growing rate of uninsured and the competitive health care market, the safety net continues to adapt, survive, and absorb the costs and burden of providing uncompensated care. In spite of financial pressures and constraints, most health care providers in New Mexico continue to uphold their ethical values and professional obligations to serving all peoples regardless of nationality, race, religion, party, politics or social standing.

New Mexico (22.6%) and Texas (22.2 %) are the two states in the nation with the highest uninsurance rate.

HUMAN SERVICES DEPARTMENT

Provision of public benefits to immigrants is mostly offered through the safety net in New Mexico. **The New Mexico Human Services Department provides Medicaid, SCHIP and TANF to qualified immigrants after the five-year ban if they are otherwise eligible.** There are currently 34 eligibility categories within Medicaid. They include: individuals receiving Supplemental Security Income; families in the Temporary Assistance to Needy Families program; poverty level women and children, and persons residing in long term care facilities. However, certain "qualified" and "unqualified" aliens have restricted eligibility as a result of the 1996 PRWORA.

The Human Services Department has clarified the following regulations regarding New Mexico Medicaid coverage for aliens:[96]

- Aliens who meet all criteria for Medicaid under any category but for their undocumented or nonqualified status are potentially eligible only for emergency services, for the duration of the emergency. Natural childbirth is defined (by federal guidelines) as an emergency. Nursing home and dialysis services do not qualify as emergency services.

- Pursuant to federal law (Personal Responsibility and Work Opportunity Reconciliation Act of 1996) legal aliens who enter the country after August of 1996, even with "legal permanent resident" status, are subject to a five-year bar from Medicaid coverage, with some exceptions (i.e., refugees, active military and veterans).

- Aliens who entered the country prior to August of 1996 are subject to the regulations in effect prior to enactment of PRWORA.

- Aliens who meet above criteria are eligible for the same Medicaid package as other eligibles, as appropriate to the category.

In addition to offering immigrants support through the safety net, New Mexico has implemented initiatives that promote clarification for immigrants on eligibility rules for public benefits and to decrease fear around seeking those benefits. For some period of time, immigrants as well as public officials and the general population have been unclear on whether or not the receipt of Medicaid could cause them to be determined a "public charge," and thus affect their immigration status. **Receipt of Medicaid and SCHIP benefits, except for long-term care, is not the basis for a public charge determination.** The Department of Justice- Immigration and Naturalization Services published a regulation defining and clarifying public charge policy in May of 1999. New Mexico, through the Human Services Department and New Mexico Advocates for Children and Families took the initiative to work actively with the Immigration and Naturalization Service to provide education to the public and, specifically, this population. A Spanish language videotape to allay fears on the public charge issue was aired in a statewide media campaign. Border communities were targeted in this campaign.

Many undocumented immigrants have children who are either United States citizens or qualified immigrants, and who are eligible for public assistance programs, despite their parent(s)' status. **The New Mexico Human Services Department has been proactive in providing policy clarifications and revised application forms emphasizing that citizenship status and Social Security numbers are not required for family members who are not applying for assistance and must not be requested.**

COUNTY INDIGENT FUND

Under the Indigent Hospital and County Health Care Act (CIF Act), Section 27-5-1, NMSA 1978 and the County Local Option Gross receipts Tax Act, Section 7-20E-9, NMSA 1978 counties are given great latitude to determine how revenues for the CIF program are to be generated and collected. It should be noted that Bernalillo County uses a mil levy approach to fund indigent care, as the CIF does not apply to a Class A county. Funds for services and capital improvement are collected from gross receipts tax, mill levy, general appropriation and bonds. Under the CIF Act, participating counties are required to appoint a County Indigent and County Health Care Board to, among many duties, administer CIF claims.[97]

There is relative flexibility in how counties appropriate these funds:

- State statute does specify and limit the types of services that can be paid for with CIF money.
- Counties are given leeway in determining which of the services they want to include as a provided service.

- Counties determine the qualifying criteria for indigent services. This includes identifying income requirements, county residency requirements, and immigrant qualifications.

What does this mean for immigrants? Information about statewide indigent health care is collected in the Health Policy Commission's Annual CIF Questionnaire, which requires the county governments to identify their policy towards immigrants with regards to providing indigent healthcare. The Annual CIF Questionnaire asks each county the following: [98]:

- Are legal immigrants eligible for receiving health care from your CIF? and;
- Are undocumented individuals eligible for receiving health care services from your CIF?

Of the 29 of 33 New Mexico counties that provided county funds for indigent health care in FY 2000, 27 counties provide indigent health care to qualified legal immigrants. Eighteen counties provide indigent health care to qualified undocumented immigrants.

How have the New Mexico counties responded to costs? Counties share the costs of uncompensated health care with the state government. However, New Mexico's state government and its counties bear the increasing financial burden of providing emergency medical services to illegal or undocumented immigrants. For example, the burden on border counties due to illegal immigration has increased dramatically since 1994, and the costs incurred on border counties for indigent health care was $933, 273 and emergency medical services, $83,477, which represents 21.6% of total county department/function.[99] These costs do not reflect the providers' actual costs and may be significantly understated. Moreover, those figures do not take into account trauma or specialty care provided at UNMHSC for those patients, which is largely uncompensated by the counties.[100]

According to a Health Policy Commission (HPC), policy analyst conducting the 2000 CIF survey, "counties have expressed some concern about declining gross receipts revenues and increasing health care costs and the impact that this may have on indigent health care. Two counties have already laid-off their indigent fund administrators. With decreasing and limited funds available, some counties may move to restrict some indigent health services by tightening some of the eligibility requirements. **The HPC analyst also stated that "most importantly to immigrants, counties may view their obligation to citizen residents as more vital than obligations to immigrants who are ineligible to vote. This potential change in policy may further inhibit medical care for immigrants."[101]**

NEW MEXICO HOSPITALS AND HEALTH SYSTEMS ASSOCIATION (NMHHSA)

The NMHHSA is working with a national coalition with ten other states who have "unpaid care issues" to try and improve the federal dollars allocated to cover care, at least emergency care, given the federal law and the few dollars now allocated for care for even documented workers.[102]

In a survey of hospitals conducted by the NMHHSA and NM DOH, it was reported that all the hospitals serve immigrants. Other responses in the survey addressed:

1. "What is the estimated annual number of immigrants served?" Of the hospitals who answered, two were unable to estimate, the others in total estimated 1,200 but also stated that they have no way of getting an accurate count since they do not track these numbers as such.

2. "What is the estimated dollar amount in funds, which support care to immigrants?" In response, none of the hospitals have dollars to pay for this care, they all have un-reimbursed care figures regarding costs (approximately $160 million a year for all NM hospitals). This is for all care for which there is no expected or known source of payment so this includes other unreimbursed costs for care provided to patients who are not in the undocumented immigrant category.

It is difficult to estimate the exact numbers of undocumented immigrants served since the annual data collected on discharges and Diagnostic Related Groups (DRG) does not disaggregate utilization by immigration status. The critical challenge for hospitals in New Mexico according to the Executive Director of the NMHHSA is "How to stabilize payment for uncompensated health care services when the health care reimbursements to hospitals have been destabilized as a result of the 1997 Balance Budget Act (BBA)."[103] **Although there have been, and are today, serious planning initiatives to reduce the number of uninsured in New Mexico (like the State Coverage Initiative) none of them would provide coverage for undocumented immigrants.**

UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER (UNMHSC)

During the SJM 52 Workgroup meetings from July to October 2001 a considerable amount of discussion and debate about the perception that some aspects of access to health care, particularly access to specialty care at University Hospital have changed since the PRWORA was implemented. At the August 29, 2001 meeting, Mr. Steve McKernan, CEO of University Hospital provided a brief historical background of University Hospital and an overview of their relevant policies and perspectives on issues of providing health services to undocumented immigrants.

The University Hospital began as the Bernalillo Indian Hospital in 1949. Since 1978, when the New Mexico Legislature passed the Hospital Funding Act, University Hospital has leased the hospital from Bernalillo County. Bernalillo County enacted a mil levy (up to 6.5 mils) that supports the operation and maintenance of the hospital, including the provision of care to indigents. However, it is important to note that this is not an "indigent fund" under the Indigent Hospital Claims Act that covers all other counties. The mil levy must be voted on by Bernalillo County residents every 8 years. It was most recently passed and contributes about $54.6 million in fiscal year 2002, compared to $32.3 million per year for fiscal year 2001 to the overall support of University Hospital.[104]

The lease with Bernalillo County was renewed in 1999, and includes the UNM Hospital and Mental Health Center. At the time that the lease was renewed, all regulations governing the hospital (local, state and federal) were reviewed. The Bernalillo County Board of Commissioners establishes the lease and transfers money to University Hospital, but University Hospital sets all operating policies. At the August workgroup meeting this point was reiterated by Bernalillo County Manager, Juan Vigil. **It was also emphasized by Mr. McKernan that the UNMHSC provides medically necessary care to the medically indigent to the extent of available resources and funds, in conformance with all applicable state and federal laws.** Mr. Vigil reiterated that Bernalillo County expects UNMHSC to provide care for indigent county residents, but not necessarily for undocumented immigrants who may reside in the county.

There are seven different financial assistance policies that guide access to care at University Hospital as illustrated in FIGURE 5. **According to a letter from the UNMHSC administration, "staff make no inquiries regarding immigration status unless an individual applies for financial assistance."**[105] Thus, the determination of eligibility for financial assistance is key. It is clearly articulated in the policies how eligibility is determined between "legal and illegal aliens" and what benefits are associated with each group.

FIGURE 5. ELIGIBILITY OF NON-UNITED STATES CITIZENS FOR FINANCIAL ASSISTANCE AT UNM HEALTH SCIENCES CENTER CLINICAL FACILITIES

	LEGAL ALIENS (in U.S. under color of law)	**ILLEGAL ALIENS** (not in U.S. under color of law)
INDIGENT BERNALILLO COUNTY RESIDENTS	Eligible for Bernalillo County Financial Assistance (including UNM Care)	***Eligible for Limited Financial Assistance; otherwise self-pay.
INDIGENT NEW MEXICO RESIDENTS	Not eligible for Bernalillo County Financial Assistance (including UNM Care); eligible for Out-of-County Indigent fund assistance.	Eligible for Limited Financial Assistance; otherwise self-pay.
INDIGENT RESIDENTS OF OTHER STATES	Self-pay (not eligible for Bernalillo County Financial Assistance (including UNM Care) or Out-of-County Indigent Fund)	Self-Pay (not eligible for Bernalillo County Financial Assistance (including UNM Care) or Out-of-County Indigent fund)
INDIGENT NON-RESIDENTS OF U.S. (E.G., VISITORS)	Self-pay (not eligible for Bernalillo County Financial Assistance (including UNM Care) or Out-of-County Indigent fund)	Self-Pay (not eligible for Bernalillo County Financial Assistance (including UNM Care) or Out-of-County Indigent fund)

***** Eligible for Limited Financial Assistance; otherwise self-pay. Such assistance is for emergency care, diagnosis and care of communicable diseases, and immunizations in conformance with federal requirements.

UNMHSC points out that undocumented immigrants are now eligible for limited financial assistance specifically for emergency care, diagnosis and care of symptoms of communicable

diseases, and immunizations, per federal requirements. **UNMHSC indicates that prior to 1996 (PRWORA), these individuals were not eligible for any financial assistance at UNMHSC. For services other than those specified above, undocumented immigrants are considered "self-pay" patients and they must provide at least partial payment prior to receiving non-emergent, non-urgent care, and the remainder is billed to the individual. This is like others in the self-pay category and certainly may be a barrier to care, particularly for people without means.** It should be noted that much of the bad debt is written off and UNMHSC indicates they incurred almost $90 million in uncompensated care this past fiscal year. As the major tertiary care center within New Mexico, UNMH is the primary hospital safety net provider, with many immigrants from all over the state referred to or seeking services at UNMH for emergency, primary, and specialty care.

In a presentation to the SJM 52 Workgroup (See Appendix G, Minutes from August 29, 2001), Mr. McKernan explained, "in general, the financial assistance policies covering services to immigrants have remained essentially the same for 20 years. University Hospital has always differentiated between legal and illegal immigrants, although the introduction of managed care forced the policies to be more finitely defined." Mr. McKernan also indicated that additional delineation between legal and illegal aliens was made in response to their legal interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1997-98." Mr. McKernan made it clear that final authority on University Hospital policy resides with him as the CEO for operational policies and the Dean of the Medical School if it involves the medical staff. However, many other internal and external groups and individuals, including the medical staff, are involved in developing the policies at University Hospital.

The following are policies submitted by the UNMH outlining the eligibility guidelines for services and financial assistance:

- Medical Services & Financial Assistance for Non-U.S. Citizens (Aliens), Development. Date December, 1999, Revised 6/2000, and Approved 6/15/00 by the HSC Administration.
- Collection of Third Party Coinsurance, Co-payments and Deductibles. Developed 10/00, Approved 10/00.
- Bernalillo County Financial Assistance, Developed 10/86.
- Inter-hospital and Emergency Dept. Transfers to UNMHSC (adheres to the provisions of the Emergency Medical Treatment and Active Labor Act of 1986, 42 USC § 1399 dd, EMTALA). Developed 7/99, Reviewed 6/97, 7/98, 6/00, Approved 8/00.
- Patient Payment. Developed 11/99, Revised 6/2000, Approved, 11/00
- Point-of-Service Collections for Self-Pay Patients, Developed 8/98, Revised 7/99, Reviewed 7/99, Approved 11/00.
- Out-of-County Medically Indigent, Developed November 1999, Revised 6/2000, Approved 11/00.
- Pre-Authorization/Referrals for Non-Urgent and Routine Admissions/Services. Developed 11/99, Revised 5/00, Approved 5/00.

Immigrants residing in and out of Bernalillo County are either referred to or seek services at UNMHSC for emergency and/or specialty care. It was reported during the SJM 52 Workgroup meetings by immigrants themselves and organizations that work with immigrant communities that seeking care and accessing services at UNMHSC has sometimes been problematic, especially for undocumented immigrants. The Community Health Partnership, a community based health advocacy organization, began documenting access problems in 2001, and presented the list of cases to the SJM 52 Workgroup and others. These cases, although not representative of all patients seeking care at UNMHSC, presented a few specific examples of health access and financial problems experienced by undocumented immigrants and legal permanent residents.

UNMHSC indicates that they strive to serve all patients in a fair and equitable manner in keeping with their assessment of eligibility under their policies. **UNMHSC says that "the distinction between legal and undocumented aliens with respect to eligibility for financial assistance is not a distinction based on national origin. Rather, it is based on immigration status, consistent with requirements of federal law."[106]** Further, UNMHSC indicates that they continue to actively review their eligibility and financial assistance policies in a manner that ensures compliance and balances their legal requirements under federal, state and local laws, their financial obligations and constraints, and other relevant considerations.

However, the majority of the SJM 52 Workgroup expressed strong concerns about implications of these policies given the role of UNMHSC in the training of new health care professionals. The concern is that current institutional policies and practices that exclude certain groups of patients may not promote the appropriate level of professional responsibility and ethics in the next generation of health care professionals. Therefore, besides their role to provide services, UNMHSC must consider their responsibilities in preparing the next generation of health care professional; this means the knowledge as well as the values and ethics required to be competent. According to SJM 52 Workgroup member, Norton Kalishman, M.D., "there should be no moral or legal obligation for anyone to ask about immigration status, especially since most medical school graduates take the Oath of Geneva that contains principals for the medical profession"[107] [See FIGURE 6].

FIGURE 6. The Oath of Geneva

" I solemnly pledge myself to consecrate my life
to the service of humanity;
I will give to my teachers the respect and gratitude,
which is their due;
I will practice my profession with
conscience and dignity;
The health of my patient will be
my first consideration;
I will respect the secrets which are confided in me;
I will maintain by all the means in my power the
honor and noble traditions of the medical profession;
My colleagues will be my brothers;
I will not permit considerations of religion,
nationality, race, party, politics, or
social standing to intervene between
my duty and my patient;
I will maintain the utmost respect for human life
from the time of conception;
Even under threat, I will not make use of
my medical knowledge contrary
to the laws of humanity. I make these promises solemnly, freely, and upon my honor."

The Oath of Geneva was adopted by the
World Medical Association in 1948

PRIMARY CARE CENTERS AND OTHER NM SAFETY NET HEALTH CARE PROVIDERS

Publicly supported primary care clinics are another critical part of the safety net in New Mexico. Supported by fees and a variety of federal, state and local subsidies, primary care clinics track ethnicity and race, but they **do not** make inquiries or eligibility determination based on immigration or citizenship status. **Thus, in New Mexico, the barriers to access to primary care services experienced by uninsured immigrant populations are essentially the same as those experienced by the uninsured population as a whole.** While primary care clinics provide medical services to both legal and undocumented immigrants, the numbers and costs of the services rendered these populations are not quantifiable. **The same is true for Emergency Medical Services (EMS) in New Mexico.** No distinctions are made, no questions are asked regarding immigration status, all "911" callers are provided emergency response and treatment, and medical transportation is provided as appropriate. **The public health system's population-based preventive services are another aspect of the safety net in New Mexico that does not distinguish clients based upon citizenship. The same is true for Department of Health supported behavioral health, substance abuse, and long term care services in New Mexico.**

In 2000, primary care clinics provided services to 220,000 New Mexicans, of which 108,381 were uninsured, 28,919 were recipients of traditional Medicaid, and 33,364 were SALUD members. Collectively, primary care clinics in New Mexico spent approximately $40 million to care for the uninsured, about 20% recovered from patients themselves.[108] Of the population served by the Primary Care clinics nearly 1 in 2 patients were uninsured and over 1 in 4 patients were Medicaid recipients. Primary care clinics spent approximately $80 million, or an average of $365 per user, in their provision of health care services. Prorating that expense to the uninsured population, approximately $40 million was spent on care for the uninsured. Approximately 20% of this expense was recovered from the patients themselves. The remainder was funded through Federal, State, and Local/Indigent Care sources. Uninsured populations accessed all types of primary care services, including: General primary medical care, Diagnostic Testing/Lab/X-ray, EMS, HIV Testing, Immunizations, OB/GYN Care, Dental Care, (Preventive, Restorative, and Emergency), Mental Health Care, Pharmacy Services, and Enabling/Case Management services.

> "Primary clinics deliver care to all populations regardless of citizenship or immigration status."
> - David Roddy, ED, New Mexico Primary Care Association

It is the opinion of the New Mexico Primary Care Association and the members that it has contacted, "a practical solution to increasing access to health care services for immigrant populations, in general, would remove the legal barriers that may cause governmental or healthcare organizations to deny services to immigrant populations. Not only would this increase access to services, but also it would be in the best interest of the public health."

New Mexico Department of Health, Children's Medical Services (CMS)

CMS is an umbrella program within the New Mexico Department of Health, Public Health Division. Children's Medical Services (CMS) is funded through Title V and the State General Fund. Under Title V, there is a 4/7 to 3/7 match so that 57% is federal funding and 43% state funds. The Children With Special Health Care Needs Program also receives funding form Title V. The Healthier Kids Fund is also under the CMS umbrella and is funded by general funds through the NM State Legislature and in-kind contributions from the Title V Program, which provides funding for staff salaries of CMS who in turn, provide management and service coordination to the Healthier Kids Fund. As previously mentioned, these programs are exempt from eligibility restrictions towards for undocumented immigrants under the 1996 PRWORA. CMS provides case management, referrals, Medicaid and SCHIP enrollment assistance, and payment for care for children with special health care needs who are uninsured (mostly immigrant children) and those with insurance with a high deductible.

CMS provides payment for healthcare for:

- Children with Special Health Care Needs (CSHCN) who are uninsured (many of whom are immigrant children);
- Young adults (19 to 21 years) who no longer qualify for the Medicaid State Children's Health Insurance Program (SCHIP);

- And Children who have insurance with a high deductible whose family income meet CMS financial guidelines.

All children covered by CMS must meet income and medical eligibility requirements. CMS provides primary care, pharmacy, some dental care and coverage for hospitalization and surgery if needed. ER care is covered if it is directly related to the medical condition that makes a child eligible for CMS.[109] It should be noted that the CMS program has been successful in negotiating favorable contracts with many providers throughout New Mexico. Thus, the actual cost of care for these children is often greater than what CMS pays.

In the last year, CMS served 2,454 children with special health care needs (average cost per child was $593) and 2,949 children through the Healthier Kids Fund, HKF (average cost per child was $306). These numbers include only those children for whom CMS is the only pay source, not those who receive other services such as case management and specialty clinics. The costs are those for covered medical care (primary care/specialty care/dental/ pharmacy/hospital, etc.) to children with special health care needs and primary care up to six dental visits, pharmacy and three specialty visits for the Healthier Kids Fund.

PART SIX: PREVENTION/PRIMARY CARE vs. EMERGENCY MEDICAL CARE

Safety net providers play a critical role in not only increasing access to health care for vulnerable populations but more importantly in managing costs and improving efficiency in a competitive and market-based health care environment. The committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers[110] reports that after Welfare Reform, safety net providers will continue to face greater pressure to provide care for uninsured individuals. "In a recent survey by the National Association of Community Health Centers, CHC directors ranked welfare reform as the number one issue negatively affecting their paying patient base."[111]

Safety net providers in New Mexico cannot afford to continue to pay for the escalating costs of emergency services. In a memorandum to the SJM 52 Workgroup on August 22, 2001, the New Mexico Border Health Advisory Council articulates their philosophy, "Do no harm, as best characterizing their focus on prevention, which provides the foundation for our efforts to maximize the quality of healthy living for every resident." Ethical values in serving "all people regardless of race, creed, language or citizenship status" combined with the drive to manage the health care costs of the uninsured are a convincing argument for investing in prevention, according to the Border Health Advisory Council.

Despite the fact that immigrants are eligible for basic preventive care through a variety of safety net providers in New Mexico, emergency care remains a regular source of care for many of those who have no regular physician and no health insurance, and they delay care due to real fears of deportation and language and cultural barriers. It should be noted that even under the 1996 PRWORA, all immigrants are entitled to emergency care and certain public health interventions. **However, this reliance on emergency care does not seems to be a reasonable long-term solution given that the emergency medical delivery system is already overcrowded and overburdened with uncompensated care costs. Most members of the SKM 52 Workgroup feel that investing in preventive, primary and secondary care offers an affordable and more humane and responsive policy option.**

As an example, in New Mexico, UNMHSC has initiated a W.K. Kellogg Foundation funded program entitled: Community Voices: Healthcare for the Underserved - A National Demonstration of Local Visionary Models. This model has developed strategies in eight counties which include building and enhancing the safety net network (public hospitals, community health centers, managed care organizations, the department of health), creating a primary care home for uninsured individuals, and enhancing the interdisciplinary services available in these primary care homes to best meet community and individual need (primary & preventive medical care, oral health, behavioral health, social and case management services). This enhanced, community-based primary care model is called a "health commons." This model builds on the positive experience gained in Bernalillo County from the UNM Care Program, which began enrolling uninsured county residents into a "managed" system, with each individual choosing or being assigned a primary care provider

at community-based sites operated by UNM or First Choice Community Health (the local federally qualified health center system). Data from 1997-2000 demonstrate overall cost savings and improved quality outcomes for this enrolled, uninsured population served by the UNM Care Program. FIGURE 7 and FIGURE 8 compare the utilization rates for various groups, both public and private including the uninsured, commercial, and Medicaid and Medicare populations.

FIGURE 7: Hospital Days per 1000 Members – NM HMOs vs. U.S. Averages

Payer Population Managed Care Org.	Commercial	Medicaid	Medicare
Lovelace	151	430	1222
Presbyterian	205	394	1206
Cimarron	124	619	1918*
U.S. HMO Averages	210.5	402	1382

*QualMed Medicare Performance
Compiled by: Dan Derksen, M.D., Beth Fingado, Jason Rounds

FIGURE 8: Managing the Uninsured – UNM Care Plan FY'97-99

Event	UNM Care Managed	UNM Self Pay *Unmanaged	U.S. HMO Commercial	U.S. HMO Medicare	U.S. HMO Medicaid
Admission per 1000 Enrollees	**62.1**	197.6	58.4	262.9	115
Hospital Days per 1000 Enrollees	**289.9**	349.9	210.5	1382.5	402
Physician Encounters pypm	**2.99**	4.8	3.9	12.0	4.3

*According to a clarification memo from UNMHSC administration to NM DOH on November 15, 2001, "the UNM Self Pay Unmanaged may be misleading in that the majority of these patients are not receiving primary care at the UNMHSC but are receiving mainly tertiary care (especially trauma care and resulting specialty and inpatient care).
Sources: U.S. HMO – Hoescht Marion Roussel Managed Care Digest 1999
UNM Care Plan – Academic Medicine, 4/00 Kaufman et al

In an article, "Managed Care for Uninsured Patients at an Academic Health Center: A Case Study, Dr. Dan Derksen, et al, conclude, "Managing care of uninsured patients in an academic health center can reduce the cost of care. However, to achieve these favorable outcomes requires the organization of services to meet the unique needs of the uninsured and underserved populations."[112]

However, UNMHSC School of Medicine senior leadership offers another view about the relative costs of prevention/primary care versus emergency care from a different perspective. They feel that improved access to primary care will not lead to decreased overall health care costs by decreasing utilization of emergency services and that actual costs of low acuity care are comparable regardless of the setting in which they are provided. They also indicate that "the demand for specialty care services is directly and positively associated with the use of primary care. While improved access to primary care has the potential of long-term health benefits, it also increases the demand for access to specialty services, with a predictable overall increase in use of specialists' services. There is also a positive correlation

with increase in the demands for ancillary services, pharmaceuticals, diagnostics and hospital capacity." [113]

By contrast, a California study found that for every $1 spent on prenatal care, $3.33 was saved in the cost of post-natal care and $4.63 was saved in incremental long-term costs (health care, child care, special education, grade repetition).[114]

Another California survey of undocumented immigrants seeking care in an ER found that[115]:

- 80% reported lack of funding (uninsurance) as the primary reason;
- 36% stated that they had difficulty getting care elsewhere because of their immigrant status;
- 51% did not know of another source of care; and
- 44% said that only the ER was acceptable as a source of care.

A related study found that eliminating prenatal care for undocumented immigrants would increase the morbidity and costs related to undetected sexually transmitted diseases, which are screened for during prenatal care.[116] Despite the medical and financial arguments, litigation continues to re-hash whether "denying preventive care is unconstitutional." Yet, in Lewis v. T. Thompson, 252 F. 3d 567, (2nd Cir. 2001). upheld the denial of prenatal care to "non-qualified" immigrants, but affirmed that U.S. citizen children born to these women had the same right to Medicaid as children born to U.S. citizen mothers. The decision permits the alien mother to apply for and obtain Medicaid for her U.S. born child during her pregnancy but not for herself.[117]

A Community Voice

"One time I had a very strong migraine. I went to the emergency room- I was there 3 or 4 hours and it cost more than a thousand dollars. We still haven't finished paying. Now we make payments to the hospital rather than continue the insurance. Because of high costs, we don't feel we can get sick anymore."

Elimination of emergency room costs requires a commitment in targeting at-risks persons and vulnerable minority groups such as undocumented immigrants. A study on racial and ethnic differences in preventable hospitalizations across 10 states found that Hispanic children, African American Adults, and elderly patients in both minority groups are most at risk of being hospitalized for preventable conditions than whites. Hispanic children were at greater risks regardless of insurance status, working-age African American adults were at greater risk of being hospitalized for preventable conditions than were working-age white adults with similar insurance status, and minority elderly patients covered by Medicare, were 6-21 percent more likely to be hospitalized for preventable conditions than for a similar white patient.[118]

PART SEVEN:
POLICY OPTIONS & ACTIONS

The SJM 52 Workgroup has assessed the critical issues impacting immigrant's access to health care and public benefits at the federal, state, county, and community levels. From this study a variety of possible policy options and directions were explored and discussed for New Mexico to consider**. The majority of the SJM 52 Work Group did agree that they share a broad vision and ethical value that "access to basic healthcare is a human right" and that all immigrants should have equal access in regards to health care and other public benefits, consistent with a 1999 declaration from a New Mexico First Town Hall on healthcare.** (See FIGURE 9).

It became clear in this study that there is no single specific course of action to recommend at this time. No "bottom-line" solutions or quick fixes are offered. Rather, the following policy options that target multiple levels and kinds of interventions are provided for the New Mexico State Legislature to consider:

- Under the PRWORA, New Mexico has the option to create its own eligibility rules through formal state legislative enactment regarding eligibility for immigrants for state funded services. As a matter of principle, the SJM 52 Workgroup agrees that it would be desirable to enact such legislation to deem all residents, including immigrants, eligible for state-funded public benefits as a way to promote equity in accessing health services and public benefits. **However, given that the study shows that most safety net providers in New Mexico continue to provide services to all in need within available resources, the SJM 52 Workgroup does not recommend this kind of legislative action at this time.** Their concern is that the public discussion that would likely take place to attempt to enact such legislation might be more damaging than the current situation.

- The SJM 52 Workgroup concludes that access to health care and public benefits for immigrants (undocumented and those who have been in the U.S. for less than five years) is a priority issue for the state agenda in trying to influence the 2002 federal reauthorization of PRWORA. **The Work Group recommends that the New Mexico State Legislature consider working with the NM Congressional Delegation to recommend to the U.S. Congress that the denial of public benefits to non-qualified aliens as defined under the current PRWORA should be repealed in the October 1, 2002 reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.**

- **A possible action considered by the Workgroup is to enact another, more broadly written Legislative Memorial requesting a further investigation of these complex issues and involving all key parties in order to better answer several important questions that could not be adequately addressed by SJM 52 effort.** This additional study should be funded if possible.

- Issues affecting immigrants cut across economic, educational, legal, health, and social policies and involve multiple layers of authority including international (i.e. NAFTA), federal, state, county, and local governments. There is currently no central point of contact for immigrant health and welfare issues in New Mexico. **Other states have addressed this by creating a State Office on Immigrant Affairs or a statewide Immigrant Advocacy Coalition. New Mexico may wish to consider creating this kind of capacity somewhere within state government.**

- **In addition, the state legislature could assure that New Mexico complies with the Title VI-Policy Guidance Regarding Inquiries into Citizenship, Immigration Status Social Security Numbers.** Under this law, federally funded programs may not require applicants to provide information about the citizenship or immigration status of non-applicant family or household member or deny benefits to an applicant because a non-applicant family or household member has not disclosed his or her citizenship or immigration status. For example, intake staff would not be allowed to ask immigrant parents about their citizenship or for their social security number when asking about health coverage for their citizen children.

- **The Legislature could request the U.S.-Mexico Border Health Commission to consider these issues of access to healthcare and public benefits for immigrants through a bi-national discussion forum and developing recommendations for state and local actions.**

FIGURE 9.
NEW MEXICO FIRST TOWN HALL: TWENTY FIRST CENTURY HEALTHCARE IN NEW MEXICO: CONSTRUCTING A RATIONAL PLAN

Declaration of Values:

Access to basic healthcare is a human right.
New Mexicans value a system that provides choice.
New Mexicans value a plan that empowers individuals to take responsibility for their own personal health.
Any rational system must take into account New Mexico's unique cultural diversity and be sensitive to traditions of all people: respect and dignity for all.
New Mexicans value optimal health and wellness for New Mexicans.

Report of the Twenty-Third New Mexico First Town Hall, October 21-24, 1999, Las Cruces, New Mexico.
Copyright 1999, New Mexico First, 505-855-6056, townhall@nmfirst.org

Other Options:

On a national level, the National Health Law Program[119]recommends that states use a combination of solutions including public policy development, education, monitoring and outreach efforts such as:

- State and local policy must be clarified and administrative processes developed to insure that immigrants seeking health services to which they are entitled can do so without fear of being reported to the INS. States should be urged to pre-certify eligibility for emergency care.
- Public education and outreach campaigns should be expanded to immigrant communities to diminish fears and encourage the use of public health services.
- Federal and state governments must review other policies and rules affecting immigrant access to health care to ensure the public's health is not put in jeopardy by immigrant enforcement concerns.
- Public education should be provided so that health providers, social service agencies, community-based organizations and immigrants, themselves, understand what services remain available and the procedures for verifying and reporting immigration status.

IN CONCLUSION

In concluding, it is important to recognize that we are a nation of immigrants and that since the nation's founding, more than 55 million immigrants from every continent have settled in the United States. In fact, with the exception of Native Americans, everyone living in this country is either an immigrant or a descendent of voluntary or involuntary immigrants. Yet every wave of immigration has faced fear and hostility, especially during times of economic hardship, political turmoil, war, or terrorism.[120] Thurgood Marshall, the architect of American race relations in the twentieth century, effectively frames the dilemma, "If people of color, as citizens, are still struggling for equality (legal, economic, political, and social), then the inherent position of immigrants will be less."[121]

> "If people of color, as citizens, are still struggling for equality (legal, economic, political, and social), then the inherent position of immigrants will be less."
> -Thurgood Marshall

It is clear from this preliminary study that issues of immigrant health and access to public benefits are critically important to the State of New Mexico. This initial effort at attempting to understand the complex legal, social, economic and health policy issues has demonstrated that more consideration is needed.

It should also be acknowledged that the world has changed since September 11, 2001 and the global conflict that now engages our nation's attention has profound impacts on the issues discussed in this report. In the months prior to September, Presidents Bush and Fox were making significant progress in addressing issues of immigration reform that included several proposals for reconsidering and redefining the status of undocumented Mexican immigrants residing in the United States. During the late August meeting of the SJM 52 Workgroup there was "cautious optimism" that these complex issues of access to public benefits for recent and undocumented immigrants might resolve, or certainly improve. Clearly that has now changed and "immigration reform" is taking a very different direction. If is unclear when or if the US/Mexico discussions about immigration reform will resume in the foreseeable future. **The social, economic, public health and ethical challenges posed by resident immigrants in New Mexico will continue to require public discourse and public policy attention.**

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