

ASPE ISSUE BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BARRIERS TO IMMIGRANTS' ACCESS TO HEALTH AND HUMAN SERVICES PROGRAMS

Project Purpose

The Immigrant Access to Health and Human Services project maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants, major barriers (such as language and family structure) to immigrants' access to health and human services for which they are legally eligible, and innovative or promising practices that can help states manage their programs.

Introduction

Over the past 20 years, the foreign-born population in the United States has doubled from 20 million in 1990 to 40 million in 2010 (U.S. Census Bureau 2011). Immigrant families include nearly 17 million children, more than 15 million of whom are U.S.-born citizens. While foreign-born adults have high employment rates and many do well economically, they are also more likely to work in low-wage jobs and less likely to have health insurance coverage from their employers than native-born adults (Chaudry and Fortuny 2010; Kenney and Huntress 2012).

Several major public programs, including Medicaid and the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF) provide economic, health, and nutritional support to low-income families, including many that work at low wages. Research suggests that these programs reduce hardship, improve health and nutrition (particularly for children), and contribute to stability in families' work and home lives and better outcomes for children (Cohen-Ross and Hill 2003;

ABOUT THIS ISSUE BRIEF

This Issue Brief is one of several under the "Immigrant Access to Health and Human Services" project; for more information see <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/index.shtml>.

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Miller et al. 2008; Mills, Compton, and Golden 2011; Nord and Golla 2009). However, even though immigrant adults may have greater need for these programs as a result of low wages and limited health insurance in comparison to U.S.-born citizens, these low-income, working immigrant families have less access to health and human services programs. This limited access reflects stricter program eligibility requirements, and additional barriers to access that lead eligible immigrants to take up these benefits at lower rates than U.S.-born citizens (Capps and Fortuny 2006; Capps et al. 2004; Chaudry and Fortuny 2010; Fix and Passel 2002; Friedberg and Jaeger 2009).

Based largely on site visits conducted under the Immigrant Access to Health and Human Services project, this brief describes barriers to eligible immigrant families' access to health and human services. First is a review of the federal and state policy contexts for immigrant access, including the eligibility rules for immigrants—because it is important to understand who is in fact eligible for which programs and because the complexity of the eligibility rules turns out to be one factor affecting access—as well as important features of the administration of programs. This is followed by a brief description of the site visits and methods used for this study. The brief then provides a detailed account of the barriers to access identified in our site visits. This brief is one of several products under the Immigrant Access to Health and Human Services project, which includes the previously published “A Comprehensive Review of Immigrant Access to Health and Human Services” (Fortuny and Chaudry 2011a), as well as briefs that discuss promising practices used in states and localities to improve access to health and human services, and the potential impacts for immigrants of new provisions being implemented as part of the Affordable Care Act (ACA).

The Federal and State Policy Context for Immigrants' Access

In an earlier paper under this project, Fortuny and Chaudry (2011a) detail the federal and state eligibility framework for the major national programs that support low-income immigrant families' access to health care (Medicaid/CHIP), nutritional benefits (SNAP), and income support (TANF). For purposes of understanding access, the single most important theme is that immigrant eligibility is complex; may vary for different family members depending on their immigration status, date of immigration, and other factors; varies greatly across states and (in some states) sub-state jurisdictions; and varies among the different programs.

Federal Policies Provide the Framework for State Eligibility Provisions

Before 1996, legal immigrants were eligible for public benefits on similar terms as citizens,¹ while unauthorized immigrants² were mostly ineligible for public benefits. The 1996 welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), restricted access to TANF, Medicaid, and SNAP for many legal immigrants. It established two categories of immigrants for eligibility purposes (qualified and nonqualified immigrants) and restricted eligibility for qualified immigrants based on time of arrival into the United States (pre-enactment versus post-enactment immigrants), and length of U.S. residency (more than five years versus five years or less). Stated most generally, welfare reform allowed benefits for qualified immigrants,³ most of whom are legal permanent residents (LPRs), who arrived in the United States prior to the enactment of PRWORA (on August 22, 1996), and it restricted benefits for most immigrants who arrived after enactment for their first five years of qualified residency in the United States.⁴ As a result of these reforms, eligibility for public benefits can vary within families based on each family member's citizenship, immigration status, time of arrival, and length of residence in the United States (see Fortuny and Chaudry 2011a).⁵

Within this Framework, States Can Choose to Provide Additional Benefits to Some Qualified and Nonqualified Immigrants

In some cases, these optional benefits may be federally funded. In other cases, states must use state-only funds to cover qualified and nonqualified immigrants who can no longer receive federally funded benefits. As discussed in more detail in Fortuny and Chaudry (2011a), states' eligibility provisions for immigrants vary substantially across safety-net programs.

- *Medicaid and CHIP*: As of March 2011, 22 states and the District of Columbia (DC) used a federal option to provide Medicaid and CHIP to immigrant children and/or pregnant women who are lawfully present (i.e., regardless of their date of entry into the United States), with most providing coverage to both children and pregnant women.⁶ Additionally, states may use CHIP to provide prenatal care, labor, and postpartum care to pregnant women without regard to immigration status, and 14 states had adopted this option as of July 2010. Using state-only funds, 14 states and DC provide some public health insurance coverage to selected groups of qualified immigrants during the five-year ban on federally funded benefits. Moreover, 16 states and DC provide some health insurance coverage to select groups of nonqualified immigrants.⁷
- *SNAP*: All qualified immigrant children are eligible for SNAP and not subject to the five-year ban. Seven states also provide state-only funded nutritional assistance to other qualified immigrants not eligible for SNAP due to the five-year ban.⁸
- *TANF*: In all states, qualified immigrants (including children) only become eligible for TANF cash assistance after the five-year ban. In four states, some qualified immigrants remain ineligible even after the five-year ban.⁹ For immigrants ineligible for federal means-tested benefits, 22 states have established state-funded programs for qualified immigrants; in a few states, some nonqualified immigrants are eligible for benefits as well.

States, and Sometimes Counties, Have Substantial Authority in Administering Their Programs

Most public benefit programs are administered at the state level, although with differing levels of consistency or flexibility across the programs (e.g., generally more national standardization in SNAP, and more discretion and flexibility in the other programs). States have broad discretion to design their own eligibility application forms, web portals, outreach materials, and language services. These administrative design decisions can critically influence access to services for immigrants. Several states (including North Carolina among our sites) operate on a "county-administered, state-supervised" model, where counties operate the programs directly and have considerable authority (varying by state) over policy and administration.¹⁰

States and Local Areas Differ Greatly in Their Experience, Infrastructure, and Resources to Serve Immigrant Communities

The population of immigrants in the United States has continued to settle in historical gateway states and cities in the west, southwest, and northeast. But the immigrant population has also dispersed to new destinations in the Midwest and southeast (Fortuny and Chaudry 2011b). Many of these new destinations include rural and suburban areas without established infrastructures to deliver services in languages other than English and without professional providers familiar with the culture, histories, and subsequent needs of the populations being served.

States and Localities Also Differ in the Broader Policy Context on Immigration and Enforcement Activities

In recent years, a handful of states have passed broad and restrictive immigration legislation that seeks to prevent unauthorized immigrants from obtaining driver's licenses, employment, housing, public education, and access to benefit programs. In addition, many states and local jurisdictions have participated in federal enforcement programs, including through 287(g) agreements and the Secure Communities program (see footnote for a fuller description of these programs).¹¹ Although these state policies and enforcement activities are directed at unauthorized immigrants, they can influence the willingness of lawfully present immigrants and immigrants with U.S.-born children to access services. References to these policies do not always clearly distinguish between lawfully present immigrants and unauthorized immigrants. Further, many immigrants live in mixed-status families where at least one person is unauthorized and potentially at risk of deportation (Capps et al. 2004; Capps, Fix, and Henderson 2009).

Study Sites and Methods

To better understand local variations in immigrant access to health and human services, the Urban Institute's research team visited multiple locations within Massachusetts, North Carolina, and Texas between May 2011 and September 2011. Sites in these states were purposively selected to reflect variations in (1) the settlement of immigrants in historical immigrant gateway and new destination states; (2) the size, concentration, and diversity of immigrant populations within states; (3) the eligibility of immigrants for health and human services; (4) immigrants' use of health and human services; and (5) the immigration policy climates and local immigration enforcement activities. Within each state, researchers conducted in-person and phone consultations with key service providers and public officials.

Sites

The selected sites were located in distinct geographical regions of the United States and included two historical immigrant gateways and one emerging immigrant state. Massachusetts, in the northeast, and Texas, in the southwest, are historical gateway states in which the foreign-born comprise 14 and 16 percent, respectively, of the population. North Carolina, on the other hand, is a new destination state and saw a nearly six-fold increase in its immigrant population between 1990 and 2009. As of 2009, 7 percent of the state's total population was foreign born. The share of children in the states who have immigrant parents are much higher across all the states, accounting for 16, 24, and 33 percent, respectively, in North Carolina, Massachusetts, and Texas.

Reflecting the diversity of immigrants across the United States, a majority of immigrants in Texas and North Carolina were of Latin American origin (73 and 57 percent, respectively), while in Massachusetts immigrants had more diverse origins (35 percent from Latin America, 28 percent from Asia, 26 percent from Europe, and 8 percent from Africa). Also, in Massachusetts, 49 percent of the foreign born were naturalized citizens (above the national rate of 40 percent), compared with 31 percent in North Carolina and 32 percent in Texas.

Reflecting the diversity of both state-level policies regarding immigrant eligibility for health and human services and state immigration enforcement activities, we included two states (Texas and Massachusetts) that provide CHIP services to pregnant women regardless of their immigration status and two states (North Carolina and Texas) that have widely implemented 287(g) and Secure Communities programs. All the states we visited provide Medicaid/CHIP to pregnant women and/or children during the five-year ban. None of the states provide SNAP or TANF benefits to qualified immigrant adults during the five-year ban.

There are sizable gaps in service use between immigrant families and families with native-born parents across all programs. For example, analysis of SNAP administrative data shows that the percentage of all eligible individuals who received SNAP in 2009 was 72 percent compared with 56 percent for eligible noncitizens; for all eligible children, 92 percent received SNAP in 2009 compared with 63 percent for citizen children with noncitizen parents (Leftin, Eslami, and Strayer 2011). For children’s participation in Medicaid/CHIP, Kenney and colleagues (2011) found that 86 percent of eligible children with citizen parents participated in these programs in 2009, compared with 83 percent of citizen children with noncitizen parents and 76 percent of noncitizen children with noncitizen parents.

Similarly, when we analyzed reported data from the American Community Survey (ACS) for state-level differences, we found that the usage rates for all major health and human services programs were lower among children of immigrants than children with native-born parents, that the relative gap in use for Medicaid/CHIP for children between immigrant and native-born families was smaller than for the other programs, and that children of immigrants were more likely to participate in Medicaid/CHIP than to receive either SNAP or cash assistance (see Appendix Table 1).¹² Among study states, Massachusetts had the highest overall rates of program use among poor families with children for all programs, and it had the smallest relative usage gaps for these programs between poor immigrant families and those with native-born parents. Program use among poor families with children in Texas was generally the lowest, with the gaps between children in immigrant families and those with native-born parents generally similar in size to the national levels. North Carolina generally had the widest gaps between children in immigrant families and those with native-born parents among the study sites.

Methods

For each state visit, researchers conducted both in-person and phone consultations with state and local *government agencies* including officials from state and local public agencies responsible for administering Medicaid/CHIP, SNAP, and TANF programs, and law enforcement officials. Researchers also spoke with *community-based, nonprofit service providers* including managers of state and local health care organizations (e.g., federally qualified health care organizations) and community-based and faith-based organizations that immigrant families turn to for assistance. Finally, researchers spoke with *advocates* including directors of grassroots and statewide advocacy organizations, local community leaders, and immigration legal aid experts. We did not undertake conversations with immigrants themselves about their experiences accessing health and human services. For one such study, see Yoshikawa (2011).

All consultations conducted before and during the site visits followed a conversation guide designed to elicit information about respondents’ experiences serving immigrant clients and their knowledge of standard practices, barriers, and innovative or promising practices influencing immigrants’ access to health and human services. Where applicable, researchers probed relevant themes to understand the intersection of policy and practice across the primary health and human services programs (SNAP, TANF, Medicaid, and CHIP). Overall, the team received feedback from 104 individuals across 58 different organizations in Massachusetts, North Carolina, and Texas (Table 1).

Table 1. Site Visit Consultations, by Organization Type and Service Area

Services	Type			Service Area	
	Government agency	Nonprofit (CBO) provider organization	Nonprofit advocacy group	State	Local
Health services	8	8	6	12	9
Human services	8	2	0	5	7
Health and human services	7	9	10	15	10
Total	23	19	16	32	26

Findings

Though many immigrants and/or their children may be eligible for health and human services, our consultations revealed that many may never apply for these benefits and others may begin but not complete the application process. Our conversations with state and local public administrators, service providers, and advocates identified several factors that contribute to lower application and take-up rates among eligible immigrants, including: (1) the complexity of the application process and eligibility rules; (2) related administrative burdens; (3) language, literacy, and cultural barriers; (4) transportation and other logistical challenges; and (5) climates of fear and mistrust. We discuss each of these as well as additional challenges that population groups such as mixed-status families and refugees may face.

Complexity of Application, Eligibility Rules, and Verification

The complexity of the states' applications, program rules, and eligibility systems created significant barriers to access. State and local program administrators, service providers, and advocates indicated that the income eligibility and determination guidelines, along with the documentation required to verify employment, income, and immigration status, varied across the programs we studied (Medicaid/CHIP, SNAP, and TANF). Many researchers and policy experts have highlighted the pervasiveness of these challenges across states and the impacts on access for all families (see Rosenbaum and Dean 2011 and Mills et al. 2011 for further discussion). However, these barriers were even more acute for immigrant families, in part because the specific policies and requirements related to immigrant eligibility and verification changed rapidly, differed across programs, and added greatly to an already high level of complexity. State-level legislation frequently allowed or rescinded expansions of eligibility for some immigrant population groups covered by federal program options or state-only funded programs. In one state, program administrators explained that the income verification process for benefits changed annually as part of the legislature's budget negotiations. Over the years, changes in federal laws governing health and human services programs, as well as clarifications in federal rules or guidance, also led to frequent updates in the eligibility of some immigrant populations and required that administrative staff learn to recognize several different types of immigration documents. As a result, program administrators and staff in immigrant-serving community-based organizations had difficulty keeping their knowledge of eligibility rules and required documentation up to date.

Immigrant families had difficulties understanding the applications for benefit programs and rules requiring proof of citizenship and Social Security numbers. Some immigrant families came from countries or regions of the world where public programs do not exist or reach their towns. Others had limited education, language, and computer literacy skills that reduced their abilities to understand applications, which can be over 20 pages long, or to obtain the documentation necessary to verify information in the application. Moreover, seemingly basic questions such as "number of children" or "household size" were difficult to answer for parents who had children living abroad or whose household composition shifted over time.

According to our respondents, questions regarding Social Security numbers (SSNs) and household members' legal status also discouraged eligible families from applying, especially when at least one household member did not have authorization to work in the United States. In some states such as Texas, applications did not clearly indicate that proof of citizenship and Social Security numbers were required only for the applicant beneficiary. Thus, ineligible non-applicant parents incorrectly assumed that they could not apply for benefits even on behalf of an eligible child. In other states such as Massachusetts, where the state had provided clear guidance and training to eligibility workers that the parent's SSN was not required if the parent was only applying for the child, we heard that some local eligibility workers nevertheless pushed non-applicant parents

for their SSNs without realizing that this potentially intimidated parents or created a disincentive for them to apply for the eligible members of their family.

Immigrant families did not always have ready access to all the support documentation needed to submit a complete application and potentially experienced delays (or disruptions) in eligibility determination. First, immigrants were sometimes unable to provide proof of income because they worked irregular or nontraditional jobs (e.g., day laborers, farm laborers, subcontractors), were paid in cash, worked for less than the minimum wage, and did not receive pay stubs or consistent proof of income. Employers are allowed to write support letters indicating the income paid to employees. However, even when assured that these letters would not be used against them in tax or other legal proceedings, employers were reluctant to write them. Second, immigrants had difficulty documenting their state or county residence and demonstrating their intent to remain. Some resided with relatives or were doubled up in a household with another family, but were not on the lease or utility bills. Third, immigrant parents did not always have birth certificates for children born outside the United States and sometimes had difficulty obtaining birth certificates for children born in the United States. In some cases, county administrators asked for proof of identity from immigrant parents before issuing birth certificates to their children with the parents' names, and immigrants sometimes did not have any form of identification recognized by these county officials.

Because immigrant families often did not have regular phone service or understand requests for additional supporting documents, a missing document could result in a delayed or rejected application.

Even when immigrants had secured the required forms and documentation, they sometimes expressed concern about providing the documentation to public agency personnel. The required documents were extremely valuable to them. Thus, they worried about a government agency losing them, and some reported to caseworkers that they had prior experiences with their documents being taken or misplaced.

Immigrants potentially faced long waits to be approved for benefits; in some states, they had to reapply for county-administered benefits if they moved across county lines. Lengthy application processing times were particularly challenging for low-income immigrants who moved around a great deal and had irregular phone service. In Texas, it took 45 days to be approved for Medicaid if applying in person. Community-based organizations (CBOs) in Texas reported that their clients often had to repeat the application process because they missed a prescheduled phone call or had not received some key notice. In North Carolina, where the TANF and Medicaid programs were county administered, one county-level administrator remarked, “ *We actually close a case when [clients] move to a new county....It’s really sad because, we close [the case] here, and then they have to fill out a whole other application [in the next county].*” Similarly, in Massachusetts, SNAP administrators reported that immigrant applicants did not understand notices received about their benefits and, when they did not receive benefits quickly, they gave up on the process.

Once enrolled, the difficulties associated with the application process resurfaced during recertification and often resulted in termination and “churn” (i.e., turnover among families that get terminated and reapply). Medicaid/CHIP, SNAP, and TANF all required recertification of eligibility for benefits—every six months in many states for most programs and participants; for some programs in some states, however, certification periods had been extended to 12 months. Even though this was an issue that affected nearly all participants, program supervisors and outreach workers expressed particular concern that immigrant families did not respond to reminders to recertify to keep their benefits. Given the costs of processing new applications and re-determining eligibility, public agencies were working to reduce the processing period for applications, and to minimize loss of eligibility by participants during recertification. In both North Carolina and Texas, the average processing time for Medicaid applications was 45 days. In general, without dedicated assistance

during re-certification, immigrant families tended to lose benefits at the time of renewal. They subsequently returned to reapply for benefits after the birth of a child, a medical emergency, or a sustained loss of income.

Administrative Burdens and Errors

The long list of immigration documents required caused confusion among caseworkers and supervisors.

Leading the challenges faced by public agencies during application and recertification was the review of immigration documents. Public agency administrators noted the difficulty of comparing physical immigration documents with the descriptions of these documents in their policy manuals. Federal database systems did not always solve this confusion in a straightforward manner, and administrators then had to confer with each other case by case. Relatively recent guidance allowing states to access Social Security databases had somewhat alleviated the problems, but supervisors routinely left cases open while they requested additional guidance to determine legal status for immigrants. These concerns arose even in agencies with ongoing training and an acute awareness of the complicated nature of immigration documents. This suggests the potential for greater barriers in locations with less experience in serving eligible lawfully present immigrants.

Appropriate entry of names and dates created an administrative challenge for caseworkers. Until recently, caseworkers in communities with established immigrant populations could count on little or no guidance on basic questions, such as how to enter two last names in outdated data systems that were not designed to accommodate hyphenated names and other punctuation. To complicate matters, different public agencies and service providers sometimes wrote names in different formats. Thus, they were unable to match the names and coordinate information on clients across agencies. Finally, families themselves did not always follow a single convention when writing down family members' names. This affected Latin American clients as well as clients from other regions (e.g., Asia and the Middle East) with their own naming conventions and punctuation. As public agencies share more data for the purposes of eligibility determination, they may need to revisit current efforts to standardize names.

Similarly, training and standardization may be required to ensure consistent dates (such as birthdates) are used on clients' records. Service providers we spoke with expressed confusion about different international conventions for dates (e.g., month/day/year versus day/month/year). Subtle distinctions easily eluded caseworkers and resulted in data errors and mismatched case records.

Public agency personnel and CBOs expressed great concern about the immense burden associated with the expectation that they do more with less. State and local agency personnel who worked on SNAP and Medicaid enrollment pointed to the sharply rising caseloads alongside increased demands to improve eligibility and recertification processes as well as hiring freezes due to budgetary shortfalls. Long-time public administrators pointed to many instances when staff cuts produced higher caseloads and increased responsibilities. As a result, local staff felt overworked and unable to keep up with the mounting caseloads. In some states, benefits were terminated at the time of renewal simply because staff did not have time to review the required paperwork.

CBO staff provided substantial support to public agencies that helped reduce these burdens. However, as described by some CBO staff, funding to support outreach to immigrant populations had been reduced substantially due to state budgetary pressures. To adjust to these reductions in funding, some immigrant-serving organizations in North Carolina as well as Massachusetts were merging their service areas, pooling resources, and reducing the scope of services offered. Because grants to CBOs typically covered very specific programs or population groups and did not cover overhead, comprehensive services for all immigrant populations were especially difficult to support.

Language, Literacy, and Culture

Language posed barriers for many immigrant families interested in learning about or applying for programs.

Many immigrants do not speak English or do not speak it proficiently. All states made applications and some program materials available in Spanish. As required by law for languages that exceed a 5 percent threshold, some provided applications and materials in other languages as well. Despite these efforts, English dominated online portals and was typically required to navigate public agency web sites in each state. As a result, community, school, or library programs interested in connecting immigrant families to services had few options for referring families to online information. Further, non-English-speaking applicants arriving at local public agencies could not count on multilingual information or signage to help them navigate buildings or find appropriate providers. In all the sites, we also heard that immigrants may not fully comprehend questions about their English skills at the front intake desk and may be erroneously identified as English-speaking.

Across sites, administrators and CBOs expressed an urgent need for more bilingual and bicultural staff to better serve immigrants. In a few cases, respondents indicated that some program offices had recently hired bilingual, bicultural staff and cross-trained them in multiple programs to assist with the intake of Spanish-speaking clients. At the same time, we heard that the level of hiring was not sufficient to keep up with demand. The need for more bilingual, bicultural staff was compounded by the fact that caseloads had increased during the deep recession and states had imposed hiring freezes. The remaining longer-term staff were often least able to provide linguistically appropriate services to the current client population. As a result, immigrant clients typically waited longer to be seen by bilingual staff or chose to rely on family members, including young children, and friends for interpretation services. The need for bilingual, bicultural staff was particularly acute in rural areas and areas with emergent immigrant communities.

The reliance of public agencies and service providers on untrained interpreters such as friends or applicants' own minor children posed risks for clients. Although immigrants' reliance on family and friends for interpretation services was common across the sites, the use of these informal and untrained interpreters made some program staff uncomfortable. In North Carolina, a state attorney and refugee service provider worried about possible confidentiality and HIPAA violations if friends and family members serving as interpreters shared information about a client's medical condition with other family members or friends. In Massachusetts, similar concerns were expressed about the reliability of some informal interpreters, such as school-age children. For this reason, some experienced service providers stressed the importance of hiring interpreters internally and training them extensively.

Public agency reliance on phone-based interpretation potentially reduced the quality of service received to immigrant clients. In the absence of trained bilingual staff or interpreters, staff used phone-based interpretation services, such as the AT&T language line. However, these services relied on personnel who had little or no public program expertise. In addition, many public agency offices did not allow for privacy. As a result, speaker phones could not be used and agency staff had to speak to the interpreter, hand the phone to the client, and get the phone back from the client for interpretation in a three-way conversation. Program staff who had used these services to assist clients, described it as *"cumbersome to go back and forth between the worker, the interpreter, and the client on the phone."* Therefore, all state administrators and staff agreed that whenever possible, in-person interpretation and bilingual staff should be used with immigrant clients, or dedicated space should be provided allowing for confidential interpretation and conversation.

Aside from language barriers, immigrants from less developed countries tended to have minimal formal schooling and limited literacy. Given the often-complex nature of public assistance information, limited literacy or illiteracy can obscure the meaning of applications, notices, and brochures. Illiterate applicants must rely on secondhand interpretation of such documents, which can prove difficult if not written (or translated)

in plain language or paired with visual alerts or information. As a result, eligible families may not fully understand or glean important eligibility or recertification information. Although the state collected language preference data, agencies had few coordinated efforts to identify low-literacy clients and disseminate information to them comprehensibly.

Some immigrants from less developed countries had cultural beliefs and practices that inhibited their interactions with public agency staff and/or caused them discomfort navigating Western medical systems and bureaucracies more generally. Staff in several community-based organizations mentioned that, similar to citizens, most immigrants value hard work, family support, and self-reliance, and therefore felt ashamed to use public benefits. Consequently, they often avoided applying for needed benefits. Other staff spoke of the challenge of knowing how to talk with some immigrant family members about culturally sensitive subjects such as income and disability. One caseworker relayed a story about a Somali family. The wife came to apply for benefits because the husband, the breadwinner of the family, was ashamed to apply. However, the wife did not know anything about her husband's job or income. So, when the caseworker asked her income- and employment-related questions, she did not know the answers. The caseworker thought the wife was lying and withholding information and did not know how to work with her to obtain the necessary data. Caseworkers also had difficulties dealing with issues related to the definition of a family. U.S. public assistance laws are often written with a nuclear family in mind. Workers, therefore, had difficulty applying eligibility rules to cases where immigrants were living together in multi- and extended-family units.

Transportation and Other Logistical Barriers

Even when linguistic and cultural challenges could be overcome, getting to and from a public agency presented complications for immigrants with limited access to transportation. Where states required in-person interviews, immigrants had to be able to get to and from public agencies in order to complete an application or receive services. Not all immigrants had access to a car, could afford to pay for gas regularly, had sufficient literacy to complete a driver's license test, or had the legal documentation necessary to obtain a driver's license. Across all sites, transportation issues were particularly acute for immigrants living in rural and even some urban areas where public transportation systems were poorly developed and taxi rides could be expensive given the geographic size of the community. Thus, immigrants often relied on family, friends, and neighbors for transportation. Yet without dependable public transportation and training in navigating the public transportation system, immigrants were less able to control their day-to-day schedules, keep appointments with caseworkers, and meet work requirements for some public programs.

Work obligations also resulted in logistical barriers to applying for and receiving public assistance services. As one service provider and community advocate commented succinctly, *"When we're open, they're working."* To respond to this type of logistical barrier, some agencies and community organizations that facilitate families' enrollment for Medicaid/CHIP and SNAP provided alternative hours and co-located services in convenient locations, including workplaces with many immigrant employees.

The reliance on word of mouth to inform immigrants about public assistance benefits also potentially reduced enrollment and limited access to benefits. As noted by several state- and county-level program administrators and local service providers, the primary way most immigrants learned about services was through word of mouth. While immigrant groups (e.g., Mexicans) in some areas of Texas, Massachusetts, and North Carolina had access to wide social networks and community organizations that helped facilitate their access to services, others (e.g., Central American, African, and other immigrants who had arrived more recently in the United States) had more limited social networks and much smaller communities that were not necessarily served by community-based organizations. The lack of CBOs and established social networks to

assist these immigrant populations made it more difficult for them to connect with services. This difficulty was recognized by both public agency staff and community organizations.

Climates of Fear and Mistrust

Across all three states, fears of mistreatment and deportation deterred immigrants from seeking public assistance. Despite federal guidance that clarified only those who would be receiving benefits were required to provide Social Security numbers, it appears that some agencies were requesting SSNs from “non-applicant” parents seeking benefits on behalf of their applicant U.S.-citizen children.¹³ When asked for SSNs, these non-applicant immigrant parents feared that showing up at a public agency to apply for benefits on behalf of their U.S.-citizen children would expose them to immigration enforcement authorities and result in deportation. For those who were lawfully present and had a qualified or protected status, the fear remained because many lived in mixed-status families where another family member was unauthorized.

Immigrants’ fears were not entirely unfounded. For example, in North Carolina, newspaper reports that an individual’s medical records were used to prosecute an employee whose legal immigration status had lapsed spread quickly in the immigrant communities and led to sharp declines in the use of public services and applications for public assistance (Collins 2008). Refugees often had more generalized fears, having typically been mistreated and abused by the governments of their home countries in ways that bred mistrust of any government entity.

In all sites, pervasive misconceptions about the “public charge” rules and other myths further deterred immigrants, especially those in mixed-status families, from seeking public assistance. Immigrants aspiring to become U.S. citizens did not want to risk that they or their children might be considered inadmissible, deported, or unable to naturalize because they were considered “public charges.” In 1999, the Department of Justice published guidance that defined a public charge as an alien who has become (for deportation purposes) or is likely to become (for admission or adjustment of status purposes) “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense.” However, not all public programs result in a “public charge” classification. Benefits specifically excluded from public charge consideration include Medicaid (except assistance for institutionalized long-term care), CHIP, SNAP, noncash TANF benefits (such as subsidized child care and transit subsidies), and emergency medical assistance and preventive care (such as prenatal care and immunizations). Yet, similar to previous findings (Fremstad 2000), many immigrants avoided using all public programs because they were unaware of these distinctions and feared the public charge laws would be changed to make them ineligible for citizenship in the future.

Misconceptions about public charge rules were not the only ones reported to reduce participation in public programs. In each of the three states we visited, we also heard that immigrants believed children and youth who receive any federal benefits would eventually have to pay back the state, for example through future military service.

Finally, while most public agencies and CBOs actively worked to provide accurate information and correct these misconceptions, advocates and service providers in each state also noted that some public agency employees promoted these misconceptions to discourage immigrants’ use of public programs. These fears and misconceptions were sometimes promoted by immigration attorneys who advised their clients to “not apply for anything.” By doing so, they helped perpetuate the idea that program benefits were incompatible with successfully applying for permanent residency/citizenship or later sponsoring a relative to immigrate. In addition, these immigration attorneys undermined outreach efforts by state health and human services agencies and partner community-based organizations.

The growth of immigration enforcement programs contributed to the general climate of fear and mistrust, leading some immigrants to avoid all public programs and interactions with public service providers. In Texas and North Carolina, state and local law enforcement were participating in different immigration detention and enforcement programs: reimbursement to local jails that house unauthorized immigrants (State Criminal Alien Assistance Program),¹⁴ local law enforcement partnerships with federal immigration authorities (287(g) agreements), and biometric screening in local jails (the Secure Communities program). Because these programs involved partnerships between local and federal governments, public agency and CBO staff reported that immigrants believed that any interaction with local government officials would result in reports to the federal government about their immigration status or that of other household members. Public agency and CBO staff also reported that these enforcement activities had increased hostilities between local law enforcement and immigrant communities. According to advocates and others, immigrants were inappropriately asked for identification and struggled with anxiety and other mental health concerns after interactions with law enforcement officials. Consequently, immigrants not only avoided seeking needed Medicaid, SNAP, and TANF services, but also reported fewer crimes, avoided driving or leaving their homes, and pulled their children out of schools when enforcement activities in a community were rumored.

Anti-immigrant press combined with state legislation targeting immigrants in the states we visited or nearby states also contributed to the climate of fear and mistrust. According to agency officials and service providers in all states, immigrants were very aware of events across the country, such as the passage of omnibus immigration laws in Arizona, Alabama, Georgia, and Mississippi, which were close to our study sites in North Carolina and Texas. Officials in Houston reported that the presence of immigrants in the city's service centers dropped markedly after the Arizona omnibus law passed, fueled in part by rampant rumors that immigration officers would be scouring the Houston community for undocumented families to deport.

Special Challenges for Mixed-Status Families and Refugees

While many barriers to accessing health and human services affected all immigrants equally, a few more acutely affected mixed-status families and refugees. PRWORA made immigrant eligibility for public assistance programs more complicated. As a result, some legal immigrants (e.g., many of those with less than five years residence in the United States) are not eligible for public assistance benefits but have family members who are. Refugees are generally eligible for all types of benefits but may face more acute barriers to access due to language, literacy, and cultural differences.

Immigrant parents who were not eligible for services often did not realize that their children were eligible or were reluctant to apply for benefits on behalf of their children. Children born in the United States to immigrant parents are citizens, and as such are eligible for health and human services on the same terms as other citizens, while their parents may not be. In addition, some programs (SNAP) and some states may opt to provide benefits to noncitizen children even when their parents are ineligible for coverage. However, as mentioned earlier, applications for benefits do not always clearly indicate that parents only need citizenship information and Social Security numbers for their children, not themselves, when applying for child-only benefits. Moreover, fears about public charge regulations and contact with public officials can be more salient for some unauthorized immigrant parents with U.S.-born children who fear forcible separation from their families if their legal status becomes known.

Immigrant parents were also reluctant to apply for benefits on behalf of some children when other children in the family were not eligible. In many immigrant families, one child is foreign born while another is U.S. born. Thus, one child may be eligible for services while another is not. Staff at CBOs reported that because

immigrant parents worry about showing favoritism for one child, they may not enroll any of their children in public assistance programs.

Refugees had broader eligibility for public benefits and services than most other immigrant groups, but they may have found these benefits and services more difficult to access due to language, literacy, and cultural issues. Across the study sites, few services were available in languages other than English or Spanish. Yet, most refugees spoke neither language. Thus, refugees were especially reliant on refugee-serving organizations in their communities and/or networks of family and friends for assistance with translation and interpretation. Moreover, refugees escaping political violence and wars often had experienced traumas from government officials, agencies, and/or organizations, which made them more wary of government and more reluctant to interact with social service providers. Likewise, social service providers did not always have the knowledge and skills necessary to assist families from newer sending countries and relied on the experience of volunteers and employees from refugee-serving organizations.

Summary and Conclusion

Immigrants face many barriers to accessing health and human services programs across the United States. These multiple barriers fall into several categories, including how the programs are administered, who the immigrants are and how they perceive and understand the programs, and what the general climate toward immigrants is like in a community or state.

Several barriers stem from how programs are administered at the state and local level and the particular challenges for immigrant applicants and caseworkers trying to help families. These challenges pertain to the complexities that occur when trying to overlay intricate eligibility rules related to health and human services systems with an equally complex and confounding immigration system. These challenges often emerge in the documentation process for an applicant's income, residence, and immigration status, which then often lead to more requests for information and longer processing times for immigrant applicants. The issues have also become more burdensome for states since the economic downturn as applications for benefit programs have grown at the same time that state budgets and personnel for administering them are being reduced.

The characteristics, experiences, and circumstances of immigrants add to the challenges created by these administrative barriers. Among low-income immigrants, language and literacy barriers sometimes limit access to health and human services programs. Shortages of multilingual staff or staff who understood potential differences in cultural beliefs and practices that can affect families further exacerbate the difficulty of application processes. Some immigrant parents lack knowledge of health and human services programs or have limited understanding of the eligibility and application process. The level of misinformation about programs among low-income noncitizens deters some families from seeking needed benefits, and immigrants often rely on social networks and word of mouth to learn about programs. This reliance on informal outreach networks can lead to pervasive misperceptions about how programs work and how to access them.

Finally, immigration enforcement policies and practices in the states have become a growing barrier to immigrants' access to programs. There is broad-based fear among immigrant communities of interactions with government. Although such fears have been a long-standing barrier for many immigrants, there is a sense in the sites that it has become more widespread as a result of the sharp growth in state-level immigration enforcement, heated anti-immigrant rhetoric, and restrictive state legislation in many states. The fear resulting from heightened enforcement is thought to be more present for mixed-status families. Consequently, respondents report that immigrant parents, fearing adverse consequences for someone in the household, are unlikely to apply for benefits for their citizen children.

The wide range of barriers that many immigrants face poses challenges for immigrant families' abilities to meet their basic needs and improve their well-being. Overcoming the barriers and improving access for immigrants will likely require sustained attention by program administrators and community leaders, and development of creative solutions. Many program administrators and community leaders are trying to develop this capacity. Often the same respondents who detailed the barriers immigrants faced discussed promising practices that had been designed, planned, and/or implemented to target particular barriers to access (Crosnoe, et al.).

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Appendix Table 1: Share of Children in Poor Families with Reported Receipt of Health and Human Services Programs in the United States and Selected States

	Children of U.S.-born citizens	Children of immigrants	Children of naturalized citizens	Children of noncitizens	All children ^a
<i>% of poor children</i>					
United States	16	23	13	36	18
Massachusetts	10	14	10	22	12
North Carolina	18	29	15	40	20
Texas	18	32	17	46	23
<i>% of poor children in households receiving SNAP^b</i>					
United States	69	45	44	45	61
Massachusetts	73	60	58	62	67
North Carolina	70	38	38	38	62
Texas	67	48	46	48	57
<i>% of poor children in families receiving cash assistance^c</i>					
United States	18	11	10	11	16
Massachusetts	31	23	21	24	27
North Carolina	10	2	2	2	8
Texas	10	7	5	7	9
<i>% of poor children receiving Medicaid/CHIP^d</i>					
United States	77	69	68	69	74
Massachusetts	87	88	88	89	86
North Carolina	79	65	63	65	75
Texas	73	66	66	65	69

Source: Urban Institute analysis of Integrated Public Use Microdata Series datasets drawn from the 2008 and 2009 American Community Survey (ACS).

Notes: Estimates are based on self-reported data in the ACS on benefits receipt. There is significant underreporting of public benefits use in the ACS (as well as other large nationally representative surveys) when reported receipt is compared with administrative data (Meyer, Mok, and Sullivan 2008). The estimates have not been corrected for underreporting of public benefits and aim to provide a sense of the relative use of these programs by population subgroups and across the states.

^a All children include children with unknown parental citizenship.

^b SNAP receipt is for anyone in the household for the past 12 months.

^c Income from welfare includes Temporary Assistance for Needy Families and General Assistance payments received during the past 12 months. Welfare receipt is for anyone in the family.

^d Medicaid receipt includes Medicaid, Medical Assistance, or any other kind of government-assistance plan for those with low incomes or a disability at the time of the survey.

Figure 1. Definitions

Foreign born: Someone born outside the United States and its territories, except those born abroad to U.S.-citizen parents. The foreign born include those who have obtained U.S. citizenship through naturalization and other persons in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to U.S.-citizen parents, are native born.

Immigrant: A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 et seq (similar to the statutory term “alien”). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this paper adheres to the legal definition of immigrant.

Lawful permanent residents (LPRs): People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

Naturalized citizens: LPRs who have become U.S. citizens through the naturalization process. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

Refugees and asylees: Persons granted legal status due to persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum application is approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants: Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants: The term “lawfully present” is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security (DHS) regulations at 8 CFR 103.12(a). The same definition is also used by the U.S. Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid (CMS) issued a guidance to states that further defined “lawfully present” for determining eligibility for Medicaid/CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009 (CMS, “Re: Medicaid and CHIP Coverage of ‘Lawfully Residing’ Children and Pregnant Women,” SHO # 10-006, CHIPRA #17, Center for Medicaid, CHIP, and Survey and Certification, July 1, 2010, <https://www.cms.gov/smdl/downloads/SHO10006.pdf>). Lawfully present immigrants broadly include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period, for work, as students, or because of political disruption or natural disasters in their home countries, and some may seek to adjust their status and may have a status that allows them to remain in the country but do not have the same rights as LPRs.

Qualified immigrants: The following foreign-born persons are considered for eligibility for federal benefits:

- LPRs
- refugees
- asylees
- persons paroled into the United States for at least one year
- persons granted withholding of deportation or removal
- persons granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as

refugees/asylees)

Nonqualified immigrants: Immigrants who do not fall under the qualified immigrant groups, including immigrants formerly considered permanently residing under color of law (PRUCOLs), persons with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban: Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States. Detailed immigrant eligibility criteria for these programs are provided in the discussion and tables of the report.

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¹ Foreign-born persons who are naturalized citizens of the United States have the same eligibility for programs as U.S.-born citizens. In this brief, we use the term "immigrant" to refer only to foreign-born persons who are not U.S. citizens per the Immigration and Nationality Act, Section 101 et seq.

² Unauthorized immigrants are eligible for emergency medical care and a few other programs that benefit mothers and children, such as the Special Supplemental Nutrition Program for Women, Infants, and Children.

³ Qualified immigrants who are eligible for federal means-tested programs include lawful permanent residents (LPRs), refugees, and asylees, as well as some other special groups, such as victims of domestic violence (under the Violence against Women Act). Nonqualified immigrants for public benefits includes all other foreign-born persons including those with temporary protected status, asylum applicants, other lawfully present foreign-born persons (such as students and tourists), and unauthorized immigrants. The welfare reform law also made a distinction between pre-enactment and post-enactment immigrants, with pre-enactment immigrants maintaining eligibility for benefits without the same restrictions placed on post-enactment immigrants. For post-enactment immigrants, it imposed a five-year waiting period for lawfully present immigrants otherwise eligible for Medicaid and TANF.

⁴ Since the enactment of PRWORA, subsequent changes in federal legislation have restored eligibility for some benefits to some categories of lawfully present immigrants. Food stamps (later renamed SNAP) benefits were later restored to certain groups of lawfully present immigrants, particularly children and disabled immigrants regardless of their arrival date and years in the United States. In addition, the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act (ACA) led to further changes in eligibility provisions, with CHIPRA giving states the option to provide Medicaid and CHIP health coverage to lawfully residing children and pregnant women, regardless of their date of entry into the United States. The potential implications of the ACA provisions for immigrant families are discussed in another of the project's issue briefs by Kenney and Huntress (2012).

⁵ For more discussion about the changes that PRWORA and subsequent federal legislation made to immigrants' access to the major health and human services programs, see Fortuny and Chaudry (2011a).

⁶ CHIPRA allowed states to provide these options as part of the federal-state Medicaid and CHIP programs.

⁷ Coverage in these programs varies and is often limited depending on age, immigrant status, and disability status.

⁸ The states are California, Connecticut, Maine, Minnesota, Nebraska, Washington, and Wisconsin. Not all these states cover all qualified immigrants under these state-substitute SNAP programs.

⁹ In Idaho, Mississippi, North Dakota, and Texas, eligibility after the five-year ban is generally limited to qualified immigrants that states are required to cover by federal law: refugees, asylees, and other immigrants exempt on humanitarian grounds during the first five years in qualified status; LPRs with 40 qualifying quarters of work; and members of the military and veterans (and their spouses and children). Texas and Idaho cover battered spouses and children (details on immigrant eligibility provisions in each state are provided in Fortuny and Chaudry 2011a).

¹⁰ Which states have “state-supervised, county-administered” service delivery models can vary by program. For TANF programs, 14 states use this model (AL, CA, CO, MD, MN, MT, NC, NJ, NY, ND, OH, OR, VA, WI), including some of the largest states like California and New York. The extent to which counties are able to make decisions varies among these states. For example, although California’s eligibility criteria and benefit levels are established at the state level, other aspects of the program differ greatly by county. Colorado and North Carolina are also known for having very independent counties. Ohio, on the other hand, tends to have less variation among counties.

¹¹ Section 287(g) agreements are named for the section of the Immigration and Nationality Act (INA) that authorizes the Department of Homeland Security (DHS) Immigration and Customs Enforcement (ICE) agency to enter into agreements with state and local law enforcement agencies for state and local law enforcement officers to allow them to perform immigration enforcement functions (see <http://www.ice.gov/news/library/factsheets/287g.htm> and <http://www.migrationpolicy.org/pubs/287g-divergence.pdf>). Secure Communities is a federal program begun by ICE in March 2008 that works with participating state and local law enforcement to identify unauthorized immigrants through sharing biometric data with federal integrated databases. Secure Communities has been implemented at different times and to different degrees across the states (see http://www.ice.gov/secure_communities and <http://www.immigrationpolicy.org/just-facts/secure-communities-fact-sheet>).

¹² The estimates presented here are based on self-reported data in the ACS on benefits receipt. There is significant underreporting of public benefits use in the ACS (as well as other large nationally representative surveys) when reported receipt is compared with administrative data (Meyer, Mok, and Sullivan 2008). For example, analysis of SNAP administrative data shows that the percentage of all eligible children who receive SNAP in 2009 was 92 percent and the percentage for citizen children with non-citizen parents was 63 percent (Leftin et al. 2011), rates significantly above the 61 percent and 47 percent we found among poor children that was reported in the ACS.

¹³ Department of Health and Human Services, Department of Agriculture. 2003. “Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits,” <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/origin/policyguidanceregardinginquiriesintocitizenshipimmigrationstatus.html>.

¹⁴ The State Criminal Alien Assistance Program is administered by the Bureau of Justice Assistance in conjunction with DHS and provides federal payments to states and localities that incurred personnel costs for incarcerating certain unauthorized immigrants.