

# Law and the Public's Health

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## MEDICAID AND DOCUMENTATION OF LEGAL STATUS: IMPLICATIONS FOR PUBLIC HEALTH PRACTICE AND POLICY

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This installment of *Law and the Public's Health* examines the Medicaid citizenship documentation requirements contained in the Deficit Reduction Act (DRA) of 2005 and their implications for public health policy and practice. Following a brief overview of the relationship between U.S. legal status and eligibility for publicly funded health care services, the DRA Medicaid amendments are described and their potential ramifications for Medicaid coverage and financing considered. The article concludes with a description of states' legal discretion in implementing the amendments and how this legal discretion might be used to either intensify or mitigate the effects of the reforms.

### BACKGROUND AND OVERVIEW

The power to condition the receipt of public benefits on U.S. legal status is a federal one under the United States Constitution.<sup>1</sup> (This fact does not stop state and local governments from routinely attempting to create a broad array of legal status tests related to residency or receipt of services.)<sup>2</sup>

Until the past two decades, U.S. lawmakers did not focus significantly on the relationship between the use of publicly funded health care services and U.S. legal status. Indeed, individuals who could claim “color of law” status (i.e., living here without evidence of a deportation order) were generally considered to be U.S. legal residents for the purposes of public welfare programs such as Medicaid.

This policy approach to U.S. legal status under Medicaid began to shift with the Immigration Reform and Control Act amendments of 1986, which instituted new requirements compelling affirmative proof of legal status rather than the mere absence of a deportation order. Beginning in the mid-1990s, a series of developments—robust immigration, the nationwide dispersion of recent U.S. immigrants (like all immigrant populations before them) away from a few large urban centers, and (in the view of some) the perceived cultural, financial, and labor consequences of these trends—combined to create a widespread immigrant

backlash. This backlash, which includes the erroneous assertion that immigration is driving the growth in the number of uninsured individuals,<sup>3</sup> inevitably came to focus on federal funding of services for immigrant populations. Despite the strong population health considerations that underlie the “assurance” mission of public health agencies, federal health care financing programs for lower income individuals were not spared.

The 1996 welfare reform amendments mark the beginning of the most recent and decisive phase of the modern immigrant backlash era. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)<sup>4</sup> made several important changes in federal health policy. First, the amendments limited access to means-tested federal public benefits. Second, the amendments imposed Medicaid coverage restrictions on most otherwise-eligible noncitizen children and adults who are undocumented persons (defined as lacking clear, affirmative evidence of legal status), do not fall into certain recognized eligibility categories (e.g., individuals granted refugee or asylum status), or have not resided in the U.S. for at least five years.<sup>5</sup> The PRWORA Medicaid amendments also added legal status verification requirements to state Medicaid agencies' ongoing administration responsibilities. Studies suggest that the PRWORA has had a substantial impact on Medicaid coverage, reducing enrollment levels among noncitizen children alone, for example, by 12 percentage points from 1995 to 2001.<sup>6</sup>

States, by and large, implemented the verification requirements of the 1996 legislation through the use of oral affirmation procedures. That is, states accepted oral statements, submitted under penalty of perjury, that Medicaid applicants met the law's legal status requirements. Despite the absence of evidence to suggest widespread problems with oral affirmation techniques, the absence of state requirements for written documentation of legal status took on new force in the summer of 2005. The result was a little-noticed provision in the House of Representatives' FY 2007 deficit reduction bill that required Medicaid applicants and recipients to submit actual written proof of their citizenship or legal status. This House provision was included in the DRA Conference Agreement, whose delayed final enactment<sup>7</sup> came in February 2006, following a contentious debate<sup>8</sup> and a narrow vote for final passage.

## THE DRA'S DOCUMENTATION REQUIREMENTS AND IMPLEMENTING FEDERAL REGULATIONS

The DRA amends the law to condition federal payments to state Medicaid programs on states' ability to demonstrate that they have written proof of citizenship or legal status for all beneficiaries for whom federal payments are sought. Thus, the documentation requirement applies both to individuals receiving Medicaid at the time of enactment of the DRA as well as to all post-enactment applicants. Furthermore, although the requirement is actually written as a condition of federal funding, in practice it operates as an eligibility requirement. This is because under federal law, failure to produce required documentation to verify income and eligibility constitutes a basis for denying coverage to an applicant or recipient.<sup>9</sup>

Once analysts began to focus attention on this provision, the level of concern began to escalate. The amendments were absolute on their face, applying to all citizens and legal residents, including children and individuals lacking legal mental competence. A study released in January 2006 by the Center on Budget and Policy Priorities estimated that from 3.2 million to 4.6 million U.S.-born, low income citizens receiving Medicaid—most of them children—would face serious barriers to continued coverage because they lacked either a birth certificate or a passport, the two basic means for documenting their citizenship.<sup>10</sup>

The potential reach of the statute was subsequently softened somewhat by interim final rules issued by the Centers for Medicare and Medicaid Services in July 2006.<sup>11</sup> The interim final rules (which are expected to become final in 2007 after the agency has been able to respond to public comments) exempted individuals receiving both Medicare and Medicaid, or whose Medicaid coverage is derived from the receipt of Supplemental Security Income (SSI) benefits<sup>12</sup> from these documentation requirements. The basis for this exemption is the proof of citizenship already in the Social Security system. This exemption means, of course, that the impact of the new documentation requirements falls almost completely on families with children, as well as on individuals who receive Medicaid but not SSI—typically extremely disabled residents of long-term care medical institutions. Revised impact estimates issued by the Center on Budget and Policy Priorities conclude that the rule will affect more than 28 million children and 15 million adults, implicating coverage for some 900,000 U.S.-born adults and 2.8 million native-born children who possess neither a birth certificate nor a passport.<sup>13</sup>

The provisions of the interim final rule<sup>12</sup> can be expected to significantly affect both access to coverage

and the ability of publicly funded health care facilities and institutions to ensure the receipt of essential operational financing:

- The rule applies to most applicants and recipients and requires proof of both citizenship *and* identity in cases in which no passport is available. The rule contains no exemptions for children and adults who might be expected to face major difficulties securing documents, such as children in foster care and out-of-home placements, victims of natural disasters, and individuals with severe disabilities who do not receive SSI.
- Individuals who were already receiving Medicaid are to be given a time period to produce needed documentation at the time of redetermination. However, the rule prohibits extension of Medicaid to citizen applicants, even if they are otherwise completely eligible for assistance, unless and until they physically produce the actual documentation required. (Getting copies of documents can take weeks.) Ironically, where the applicant is a legal immigrant, assistance can begin while the receipt of documents is pending.
- Although states must give applicants a reasonable time to secure documents, the term "reasonable time" is not defined. States therefore have the power to close an application if documents are not produced in a relatively short time, thereby forcing applicants to begin the process all over again. In the case of current recipients, coverage can continue until the documents are actually furnished as part of the redetermination process.
- The rule does permit states to put data match systems into place in order to obviate the need for production of birth certificates, but in states that lack such systems individuals will be required to produce originals or copies of required documents.
- The rule narrowly defines permissible documents. The rule identifies passports and naturalization documents as "primary" documents that, taken together, establish both legal status and identity. Secondary documents consist of birth certificates, final adoption records, and official evidence of military service. Beyond these documents, the rules set forth a hierarchy of documents, ranging from the most to least reliable. States may accept a lower level document only if the higher level is not "available" (a key term that is given no definition in the rule). "Fourth level" evidence, to be used "only in the rarest of circumstances" includes medical records and written affidavits.

The two affidavits that must be presented in order to prove citizenship, in those "rarest" of instances in which affidavits are permitted, must come from both relatives and unrelated individuals.

- The rules permit individuals to prove their identity with documents such as driver's licenses or school identification cards containing photos. Such documents, of course, do not exist for preschool children, whose identity depends on the provision of an affidavit by a parent or guardian. Furthermore, although Medicaid provides for automatic Medicaid enrollment for most infants born to Medicaid-enrolled women, federal policy appears to distinguish between infants born to women receiving full benefits and those born to women who, because of their legal status, receive emergency coverage only.<sup>14</sup>

#### IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The DRA citizenship documentation requirements have a number of important implications for public health policy and practice. First, the requirements have the potential to bar enrollment for millions of current and future Medicaid beneficiaries, not because they cannot satisfy the legal status standard, but because they cannot secure the needed documents to prove citizenship and identity. The cost of obtaining certified copies of documents (giving an original document to a welfare office clearly is far too risky in terms of the potential for loss or destruction) can be prohibitive for low income families, and families with unstable residential arrangements clearly face added obstacles in terms of the actual receipt of documents.

Second, the documentation rules make it far more difficult for states to operate streamlined eligibility determination systems in order to speed Medicaid enrollment and maintain it. In recent years, many states have experimented with streamlined enrollment procedures;<sup>15</sup> how these special initiatives fare in the wake of an exponential increase in paperwork obligations for applicants and recipients remains a serious and unanswered question.

Third, as enrollment among families with children falls, the effects can be expected to be felt throughout the system of publicly funded health care for low income families, including health centers, public hospitals, Medicaid managed care systems, and local health agencies that furnish or oversee primary health care services as well as health care services for children with special health care needs.

How deep the projected enrollment reductions turn out to run will not be known for some time, although early anecdotal evidence suggests considerable declines in enrollment, particularly for children. Public health agencies should consider interventions that can ease the burdens of these new requirements, such as data matching between Medicaid enrollment systems and state vital records offices, active assistance to applicants including financial support to pay for the cost of documents, and ensuring that state Medicaid enrollment rules permit applicants to submit the broadest possible array of documents as well as lengthy periods for the production of documents in order to avert case closures during periods when the receipt of documents is pending. Agencies should also collaborate with public health researchers publicly funded health care providers to calculate the impact of the documentation requirement, so that the effects of the requirement will be known.

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