IMMIGRATION POLICY IN FOCUS
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UNEQUAL ACCESS: Immigrants and U.S. Health Care

by Sarita A. Mohanty, M.D., M.P.H.*

EXECUTIVE SUMMARY

Despite the important role that immigrants play in the U.S. economy, they disproportionately lack health insurance and receive fewer health services than native-born Americans. Some policymakers have called for limits on immigrants' access to health insurance, particularly Medicaid, which are even more stringent than those already in place. However, policies that restrict immigrants' access to some health care services lead to the inefficient and costly use of other services (such as emergency room care) and negatively impact public health. The future economic success of the United States depends on a healthy workforce. Therefore, policies must be devised that improve, rather than restrict, immigrants' access to quality health care.

Among the findings of this report:

- In 1998, per capita health care expenditures were 55 percent lower for immigrants than for natives. Although immigrants comprised 10 percent of the U.S. population, they accounted for only 8 percent of U.S. health care costs.

- In 1998, immigrants received about $1,139 per capita in health care, compared to $2,546 for native-born residents.

- Despite the fact that all immigrants are eligible for emergency medical services, they had lower expenditures for emergency room visits, as well as doctor's office visits, outpatient hospital visits, inpatient hospital visits, and prescription drugs.

- Large disparities in health care expenditures between natives and immigrants exist within minority groups. Latino immigrants accounted for $962 in per capita health care expenditures in 1998, compared to $1,870 for native-born Latinos. Black immigrants averaged $1,030 in health care expenditures, compared to $2,524 for native-born blacks. And white immigrants averaged $1,747, compared to $3,117 for native-born whites.

- Immigrant children had 74 percent lower per capita health care expenditures than U.S.-born children in 1998. However, emergency room expenditures were more than three times higher among immigrant children than U.S.-born children despite the fact that immigrant children visited the emergency room less often. This suggests that immigrant children may be sicker when they arrive in the emergency room.

- The primary reason that immigrants are using the health care system less than the native-born is lack of health insurance. According to 2002 data from the Survey of Income and Program Participation (SIPP), foreign-born adults are nearly three times as likely as native-born adults to be uninsured (32 percent vs. 13.4 percent, respectively).

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INTRODUCTION

Despite the important role that immigrants play in the U.S. economy, they disproportionately lack health insurance and receive fewer health services than native-born Americans. Nevertheless, some policymakers have called for limits on immigrants' access to health insurance, particularly Medicaid, which are even more stringent than those already in place. In the absence of a federal solution to the failures of U.S. immigration policy, politicians in states such as New York, California, Texas, Arizona, and Florida have called for removing the access and eligibility of illegal immigrants for publicly supported health, social, and educational services.

However, concerns that immigrants are placing an undue burden on the U.S. health care system as a whole are largely unsubstantiated. Moreover, policies that restrict immigrants' access to some health care services lead to the inefficient and costly use of other services (such as emergency room care) and negatively impact public health. Little attention has been directed toward the development of policies and practices that improve the well-being of immigrants, particularly immigrant children. Policymakers have a responsibility to examine the societal impact of health care restrictions on a group that comprises 15 percent of the U.S. labor force.[1]

IMMIGRANTS CONTRIBUTE TO THE ECONOMY

Many studies have documented that immigrants contribute significantly to the U.S. economy. For example, the National Research Council estimated in 1997 that the average immigrant pays about $1,800 more in taxes than he or she uses in government services. The net tax contribution of an immigrant and his or her children and grandchildren is $80,000.[2] A 2005 report from the National Foundation for American Policy concluded that new legal immigrants to the United States will provide a net benefit of approximately $407 billion in present value to the Social Security system over the next 50 years. The report also affirmed that any significant reduction in legal immigration would worsen the financial status of the Social Security system and make any reforms to the system far more difficult to achieve.[3] In addition, the Social Security system reaps an enormous benefit from the taxes paid by undocumented immigrants. The Social Security Administration (SSA) concluded in 2001 that undocumented immigrants "account for a major portion" of the billions of dollars paid into the Social Security system under names or social security numbers that don't match SSA records and which payees can never draw upon.[4] As of July 2003, these payments totaled $421 billion.[5]

A COMMON MISCONCEPTION

Although immigrants are net contributors to the U.S. economy, the misconception remains that they are a burden to native-born taxpayers. This view has spurred legislative initiatives such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which created a five-year ban on Medicaid eligibility for new legal immigrants and required that the income and resources of a prospective immigrant's sponsor be used in calculating eligibility to immigrate. PRWORA also prevented states from using federal funds to provide Medicaid and State Children's Health Insurance Program (SCHIP) coverage for most legal immigrants who have resided in the United States for less than 5 years. Prior to 1996, all legal permanent residents

[1] Bureau of Labor Statistics, U.S. Department of Labor, News Release: "Foreign-Born Workers: Labor Force Characteristics in 2005," April 14, 2006, p. 1.

[2] James P. Smith & Barry Edmonston, eds., *The New Americans: Economic, Demographic, and Fiscal Effects of Immigration*. Washington, DC: National Research Council, National Academy of Sciences Press, 1997, p. 349-351.

[3] Stuart Anderson, *The Contribution of Legal Immigration to the Social Security System*. Arlington, VA: National Foundation for American Policy, February 2005 (revised March 2005), p. 1.

[4] Office of the Inspector General, Social Security Administration, *Obstacles to Reducing Social Security Number Misuse in the Agriculture Industry* (Report No. A-08-99-41004), January 22, 2001, p. 12.

[5] Testimony of Patrick P. O'Carroll, Assistant Inspector General for Investigations, Social Security Administration, before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Oversight and Subcommittee on Social Security, regarding "Social Security Number and Individual Taxpayer Identification Number Mismatches and Misuse," March 10, 2004.

had the same access to public benefits, including Medicaid, as did U.S. citizens.[6]

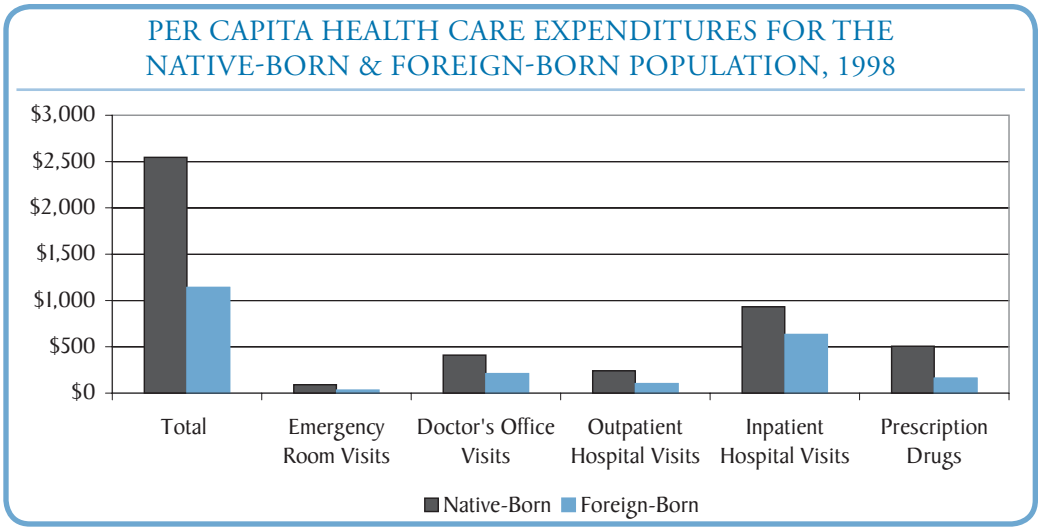
However, research conducted before the passage of PRWORA generally found that immigrants were *less likely* than native-born Americans to use public services.[7] Data suggested that the United States was not a "welfare magnet" for undocumented migrants from Mexico.[8] A 1996 study by the Carnegie Endowment for International Peace and the Urban Institute concluded that "there is no reputable evidence that prospective immigrants are drawn to the U.S. because of its public assistance programs."[9]

IMMIGRANTS CONSUME LESS IN HEALTH CARE THAN NATIVES

Immigrants account for a relatively small share of total U.S. health care costs. According to a 2005 study, per capita health care expenditures were 55 percent lower for immigrants than for natives in 1998, even after adjusting for sociodemographic characteristics. On average, immigrants received about $1,139 in health care, compared with $2,546 for native-born residents. Although immigrants comprised 10 percent of the U.S. population in 1998, they accounted for only 8 percent of U.S. health care costs. Immigrant health care expenditures totaled $39.5 billion in 1998, with about $25 billion reimbursed by private insurers, $11.7 billion reimbursed by government programs, and $2.8 billion paid out of pocket. Despite the fact that all immigrants are eligible for emergency medical services, they had lower expenditures for emergency room visits, as well as doctor's office visits, outpatient hospital visits, inpatient hospital visits, and prescription drugs {Figure 1}.[10]

A 2005 report by the University of California and the Mexican government found that recent immigrants from Mexico are half as likely to use emergency rooms as native-

Figure 1:



Source: 1998 Medical Expenditure Panel Survey & 1996-1997 National Health Interview Survey.

[6] International Migration Policy Program of the Carnegie Endowment for International Peace & the Urban Institute, "Immigrants and Welfare," *Research Perspectives on Migration* 1(1), September/October 1996, p. 8.

[7] George J. Borjas & Lynette Hilton, "Immigration and the Welfare State: Immigrant Participation in Means-Tested Entitlement Programs," *Quarterly Journal of Economics* 111(2), May 1996, p. 575-604.

[8] Douglas S. Massey & Kristin E. Espinosa, "What's Driving Mexico-U.S. Migration? A Theoretical, Empirical, and Policy Analysis," *American Journal of Sociology* 102(4), January 1997, p. 939-999.

[9] International Migration Policy Program & the Urban Institute, 1996, p. 3.

[10] Sarita A. Mohanty, et al., "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis," *American Journal of Public Health* 95(8), August 2005, p. 1431-1438. The study used the 1998 Medical Expenditure Panel Survey linked to the 1996–1997 National Health Interview Survey to analyze data on 18,398 native-born persons and 2,843 immigrants.

born whites and Mexican Americans. Fewer than 10 percent of recent Mexican immigrants (both legal and undocumented) who had been in the United States for fewer than ten years reported using an emergency room in 2000, compared to 20 percent of native-born whites and Mexican Americans. Recent immigrants also were more likely not to have seen a doctor in the previous two years. Despite the fact that immigrants are often in the most risky occupations (e.g. construction), they are not using emergency rooms as often as the native-born.[11] This raises an important question for policymakers: how will immigrants work in their jobs, many of which are physically demanding, without good health?

Large disparities in health care expenditures between natives and immigrants also exist within particular minority groups {Figure 2}. Latino immigrants accounted for $962 in per capita health care expenditures in 1998, compared to $1,870 for native-born Latinos. Black immigrants averaged $1,030 in health care expenditures, compared to $2,524 for native-born blacks. And white immigrants averaged $1,747, compared to $3,117 for native-born whites.[12]

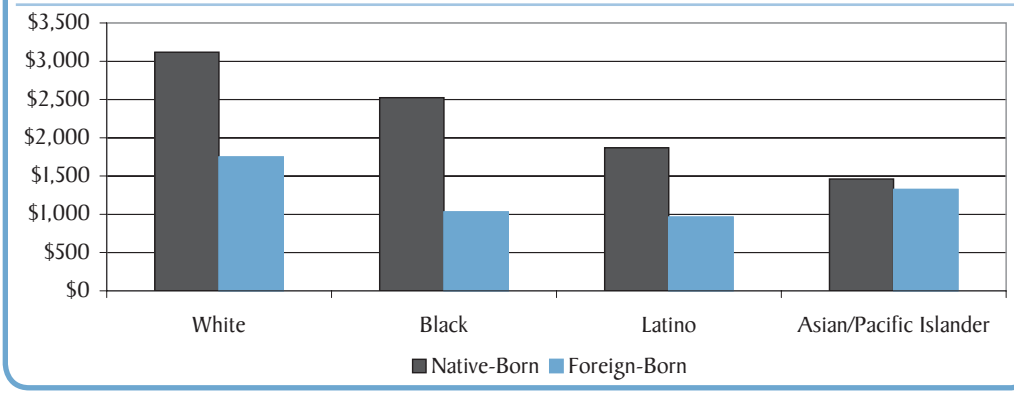
Disparities in health care expenditures are especially pronounced among children. Immigrant children had 74 percent lower per capita health care expenditures than U.S.-born children in 1998. However, emergency room expenditures were more than three times higher among immigrant children than U.S.-born children {Figure 3} despite the fact that immigrant children visited the emergency room less often. This suggests that immigrant children may be sicker when they arrive in the emergency room and probably reflects poor access to primary care.[13] A 2001 study also found that non-citizen children were less likely than citizen children to have made both office-based visits and emergency room visits.[14]

LACK OF HEALTH INSURANCE

The primary reason that immigrants are using the health care system less than the native-born is lack of health insurance.[15] According to 2002 data from the Survey of Income and Program Participation (SIPP), foreign-born adults are nearly three times as likely as native-born adults to be uninsured (32 percent vs. 13.4 percent, respectively).[16]

Figure 2:

PER CAPITA HEALTH CARE EXPENDITURES FOR THE NATIVE-BORN & FOREIGN-BORN POPULATION, BY RACE/ETHNICITY, 1998



Source: 1998 Medical Expenditure Panel Survey & 1996-1997 National Health Interview Survey.

[11] University of California, Los Angeles (UCLA) Center for Health Policy Research and the National Population Council of the Government of Mexico (CONAPO), *Mexico-United States Migration: Health Issues,* October 2005.

[12] Sarita A. Mohanty, et al., 2005.

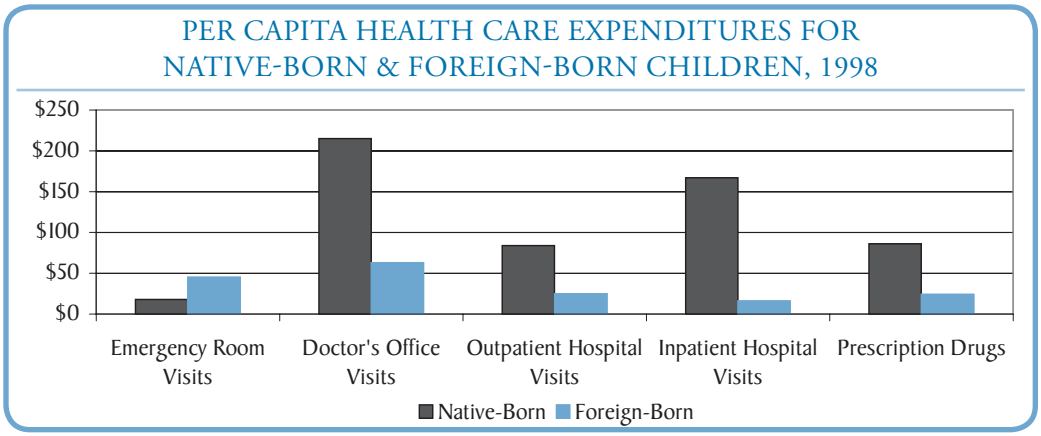
[13] *ibid.*

[14] Leighton Ku & Sheetal Matani, "Left Out: Immigrants' Access To Health Care and Insurance," *Health Affairs* 20(1), January/February 2001, p. 247-56.

[15] Olveen Carrasquillo, et al., "Health insurance coverage of immigrants living in the United States: differences by citizenship status and country of origin," *American Journal of Public Health* 90(6), June 2000, p. 917-23.

[16] Thomas C. Buchmueller, et al., *Immigrants and Employer-Provided Health Insurance.* Ann Arbor, MI: Economic Research Initiative on the Uninsured, University of Michigan, August 2005.

Figure 3:



Source: 1998 Medical Expenditure Panel Survey & 1996-1997 National Health Interview Survey.

Some studies have indicated that even immigrants with higher rates of education and employment are more likely to be without health insurance than their U.S.-born counterparts.[17] Ultimately, these immigrants do not receive quality health care and lack timely preventive services. Instead, they often use health care mostly when they become sick. Due to poorer access to health insurance, many immigrants avoid or delay medical care because of financial burdens.[18]

A 2005 study found that the difference in insurance coverage rates between U.S. natives and immigrants is explained by the types of jobs that immigrants hold, as well as personal characteristics that directly and indirectly affect coverage.[19] A significant proportion of immigrants works in low-paying jobs or jobs with small firms that do not offer health insurance. Non-citizen immigrants in particular are typically younger, less educated, and work in less-skilled jobs, which is also the case with U.S. citizens who lack insurance. Catherine McLaughlin, director of the Economic Research Initiative on the Uninsured at the University of Michigan, points out that "non-citizen immigrants are the 'canary in the mine' for health insurance woes in the U.S. Their lack of access to employment-based coverage is more pronounced than other groups, but signals the vulnerability many face as employment-based coverage becomes more difficult and costly to secure."[20] Policies that improve employment-based access to health insurance are imperative to improving the health and well-being of the U.S. population.

Even among immigrants who are eligible for publicly funded health insurance, such as Medicaid, fear and confusion often create barriers to enrollment and to concern about becoming a "public charge," which would make them ineligible for U.S. citizenship in the future and could result in deportation.[21] These fears persist despite outreach work by community groups at the local level and Department of Justice clarifications reaffirming that Medicaid and SCHIP coverage must not be used in making public charge determinations. A useful model for creating a one-stop shop where immigrants can apply for public insurance without fear is California's Children's Health Initiatives, which has been especially successful in offering a seamless system of coverage for undocumented children and their families.[22]

[17] Achintya N. Dey & Jacqueline Wilson Lucas, "Physical and Mental Health Characteristics of U.S. and Foreign-Born Adults: United States, 1998–2003," *Advance Data* No. 369 (National Center for Health Statistics), March 1, 2006, p. 1-19.

[18] Len M. Nichols, et al., *Ensuring Health Coverage for California's Immigrant Children*. Washington, DC: New America Foundation, Health Policy Program, November 2005.

[19] Thomas C. Buchmueller, et al., 2005.

[20] Economic Research Initiative on the Uninsured (University of Michigan), *Research Highlight* No. 11, March 2006, p. 1.

[21] Marc L. Berk & Claudia L. Schur, "The Effect of Fear on Access to Care Among Undocumented Latino Immigrants," *Journal of Immigrant Health* 3(3), July 2001, p. 151-6.

[22] Len M. Nichols, et al., 2005.

CONSEQUENCES OF POOR HEALTH CARE

Lower rates of insurance coverage among immigrants contribute to lower health care utilization, including lower rates of cancer screening and other types of preventive services.[23] Uninsured children are five times more likely to use the emergency room as their usual source of care than privately insured children.[24] In addition, uninsured children, a majority of whom are immigrants or the children of immigrants, delay needed preventive care such as immunizations, well-child screenings, and management of chronic medical conditions like asthma. Similarly, uninsured individuals are more likely to delay seeking treatment for potentially serious conditions until treatment is more costly and less effective.[25]

California and some other states use state funds to provide Medicaid or SCHIP coverage to legal immigrants who arrived in the United States after the enactment of PRWORA. However, high-immigrant states like California have become vulnerable to cutbacks recently.[26] But limiting access to health care for immigrants by restricting health insurance coverage is likely to have a negative impact on the health and welfare of the immigrant population. A 2000 study found that eliminating public funding for prenatal care for undocumented immigrants in California could result in lower birth weights, more premature births, and higher post-natal health care costs.[27]

DIRECTIONS FOR FUTURE RESEARCH

More research is urgently needed to facilitate greater access to health care for immigrants. Effective health care policies require an understanding of the specific needs and patterns of health care utilization among immigrants. Numerous studies have found that newly-arrived immigrants tend to have healthier lifestyles than native-born individuals, but these advantages diminish over time. Further research is needed on how health behaviors, health status, and insurance coverage change the longer an immigrant resides in the United States.[28]

Research also is needed to identify culturally and linguistically sensitive approaches to encourage immigrants to seek proper preventive health care. Language and cultural differences are major barriers to health care for immigrants. According to the 2000 Census, over 18 percent of the U.S. population speaks a language other than English at home. Immigrants who do not speak English as a primary language experience greater problems accessing the health care system. For example, only a third (36 percent) of non-citizen Spanish-speaking Latino adults had seen a doctor in the previous year.[29] One study at an inner city clinic found that one in nine immigrant parents reported that they had not brought their children in for health care because they felt that the medical staff did not understand Latino culture.[30]

Overcoming these linguistic and cultural barriers requires expanding, and providing timely reimbursement for, interpreter services, and increasing the number of linguistically and culturally competent staff. Often, methods to reduce culture and language barriers must be community-based rather than hospital or clinic-based, since a substantial proportion of immigrants do not enter the health care system

[23] Israel De Alba, et al., "Impact of U.S. Citizenship Status on Cancer Screening Among Immigrant Women," *Journal of General Internal Medicine* 20(3), March 2005, p. 290-296.

[24] Melinda L. Schriver, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk.* Philadelphia, PA: American College of Physicians–American Society of Internal Medicine, March 2000, p. 11.

[25] Committee on the Consequences of Uninsurance, Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America.* Washington, DC: National Academies Press, 2003.

[26] Sylvia Guendelman, et al., "Overcoming the Odds: Access to Care for Immigrant Children in Working Poor Families in California," *Maternal and Child Health Journal* 9(4), December 2005, p. 351-62.

[27] Michael C. Lu, et al., "Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis," *American Journal of Obstetrics and Gynecology* 182(1, pt. 1), 2000, p. 233-239.

[28] Thomas C. Buchmueller, et al., 2005.

[29] Leighton Ku & Timothy Waidmann, *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2003.

[30] Glenn Flores, "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics & Adolescent Medicine* 152(11), November 1998, p. 1119-1125.

regularly. Health care providers serving immigrant communities should work in concert with community groups, as well as with public health, social service, and school systems. For example, health care providers and researchers developed culturally appropriate educational materials and workshops to promote oral health among pregnant women in New York City when they discovered, through surveys, that low-income immigrant women knew very little about oral health.[31] As another example, bilingual and bicultural outreach staff in New York worked with immigrant communities to correct cultural misunderstandings about tuberculosis and lessen the fear of being stigmatized by the disease.[32]

CONCLUSION

The widely held assumption that immigrants consume large amounts of scarce health care resources is invalid. Moreover, the government does not avoid health care costs by limiting immigrants' access to health insurance programs. In fact, using public funds to provide comprehensive health care for low-income immigrants fosters individual and public health and is cost-effective.[33] Comprehensive coverage reduces the unnecessary use of high-cost emergency room care and inpatient hospital visits. Key to health care policy on behalf of immigrants and to public health in general is expanding access to affordable health insurance. The future economic success of the United States depends on a healthy workforce. Therefore, policies must be devised that improve, rather than restrict, immigrants' access to quality health care.

[31] Gustavo D. Cruz, et al., "Community-Based, Culturally Appropriate Oral Health Promotion Program for Immigrant Pregnant Women in New York City," *New York State Dental Journal* 71(7), December 2005, p. 34-38.

[32] Judith E. Sackoff, et al., "Tuberculosis prevention for non–US-born pregnant women," *American Journal of Obstetrics and Gynecology* 194(2), February 2006, p. 451-456.

[33] National Immigration Law Center, *Comprehensive Health Care for Immigrants: A Sound Strategy for Fiscal and Public Health*. Los Angeles, CA: April 2004.

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