



Immigrants in the U.S. Health Care System

Five Myths That Misinform the American Public

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Introduction

Restrictionist politicians and talking heads concur that immigrants in the United States are a burden on our health care system. A decade ago this belief contributed to legislation that limited immigrants' access to the health care system. Today, similar sentiments misinform the current debate over immigration reform.

These myths about documented* and undocumented immigrants' use of U.S. health care services need to be examined in detail if our nation is going to have a true understanding about the immigrants in the U.S. health care system. The five most prevalent of these myths are:

- U.S. public health insurance programs are overburdened with documented and undocumented immigrants.
- Immigrants consume large quantities of limited health care resources.
- Immigrants come to the United States to gain access to health care services.
- Restricting immigrants' access to the health care system will not affect American citizens.
- Undocumented immigrants are “free-riders” in the American health care system.

These misconceptions feed a perception that one of the biggest reasons for our nation's failing health care system is the growth of immigration—and not the lack of insurance and skyrocketing health care costs. As a consequence, these myths have influenced policymaking and sparked federal efforts to preclude immigrants' access to the health care system.

Such an effort culminated in the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act, which put a five-year ban on eligibility for Medicaid and other public benefits programs for recent immigrants. These same eligibility restrictions were also included in the State Children's Health Insurance Program, which was enacted in 1997.

* Unless otherwise noted, “documented immigrant” is defined as legal permanent resident of the United States, but not a citizen.

Then as part of the Deficit Reduction Act of 2005, the law now requires U.S. citizens to provide proof of citizenship when applying for Medicaid benefits, with the intention of preventing immigrants from obtaining Medicaid coverage.

As this paper will demonstrate, these myths perpetuate the marginal status of immigrants—for this paper,

non-citizens—in the U.S. health care system and promote poor policymaking at all levels of government. These myths need to be subjected to the bright light of objective analysis to better inform critical policymaking decisions on health care reform and immigration reform moving forward.

Immigration Patterns

The United States is currently experiencing another increase of immigration. In 2005, the foreign born population was nearing 36 million—35 percent were naturalized citizens, 33 percent were documented immigrants, and 31 percent were undocumented. Just a decade earlier, 24 million people in the U.S. were foreign-born, with 30 percent comprised of naturalized citizens, 47 percent comprised of documented immigrants, and 20 percent comprised of undocumented immigrants.¹

As this trend illustrates, the number of documented immigrants has held steady at roughly 12 million. Yet the number of naturalized citizens has increased by 5.4 million and the undocumented immigrant population has increased from a little less than five million to roughly 12 million.

As of March 2005, the PEW Hispanic Center estimated that children constituted 16 percent of the undocumented population. Nearly two-thirds of the children living in undocumented immigrant families are U.S. citizens by birth, an estimated 3.1 million children in 2005.²

Most immigrants, documented and undocumented are from Mexico: 30 percent of the documented immigrant population and 56 percent of the undocumented population.³ Immigrants from other countries in Latin America comprised

an additional 35 percent of the documented population and another 22 percent of the undocumented population.

Twenty-six percent of the documented immigrant population is from Asia, 14 percent from Western Europe and another 8 percent from Africa and other regions. Another five percent of undocumented immigrants come from South Asia and Southeast Asia. The origin of the remaining 17 percent of undocumented immigrants is unidentified.

Furthermore, immigrants are not only choosing to settle in states that traditionally have had large immigrant populations, such as California, New York, Texas, New Jersey, and Illinois. Over the past 15 years they are also increasingly locating in “new growth” states such as Iowa, North Carolina, Virginia, Utah, and Missouri for job opportunities.

As the immigrant population begins to settle all over the country, not just in demographic pockets, the U.S. will confront important social, cultural, and political change, with one key domestic policy issue being health care. Expectations are that the U.S. population will add 120 million people by 2050, about 80 million of whom are or will be here as the direct or indirect effect of immigration.⁴ Knowing the facts about immigrants and the U.S. health care system is a key first step to dealing with these issues (see main paper).

Myth #1

U.S. public health insurance programs are overburdened with documented and undocumented immigrants.

Seventy-one percent of likely American voters would support a law to STOP the use of taxpayer funds to provide Medicaid...for illegal immigrants.
~McLaughlin & Associates Poll, April 2007

The misinformation supporting the myth that U.S. public health insurance programs are overburdened with documented and undocumented immigrants has percolated into the American psyche for well over a decade. Yet this belief is not substantiated by the facts.

While low-income citizens depend on Medicaid and SCHIP for health coverage, undocumented immigrants and non-permanent documented immigrants, such as individuals with student or temporary work visas, are not eligible for Medicaid, except limited Medicaid coverage for emergency services. Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence.⁵

Prior to this act, permanent documented immigrants had the same access to public benefits such as Medicaid, as did U.S. citizens.⁶ Five years after passage of the law, non-elderly immigrant adults had experienced a 36 percent decline in coverage.⁷ Today, about 40 percent of all documented permanent residents in the United States entered after August 22, 1996 and have been subject to this prohibition.⁸

This same law had a similar effect on immigrant children. Documented and undocumented immigrant children are more likely to be uninsured than citizen children. Roughly 1.5 million of the 6 million uninsured children who are otherwise eligible for Medicaid or SCHIP are excluded from the programs due to their immigration status.⁹

From 1995 to 2005, the uninsured rate for citizen children declined to 15 percent from 19 percent as Medicaid and SCHIP enrollment increased by 17 percent. In contrast, during this same time period the uninsured rate for documented immigrant children increased to 48 percent from 44 percent, while Medicaid and SCHIP coverage declined by 17 percent.¹⁰

Recognizing the importance of providing health coverage to the immigrant population, 21 states and the District of Columbia¹¹ now use state-only funds to offer basic health services to documented children and pregnant women who otherwise would be prohibited from enrolling in a public health insurance program due to the five-year limit.¹² States that traditionally have large populations of immigrants, such as California, New York, and Texas, are among them.

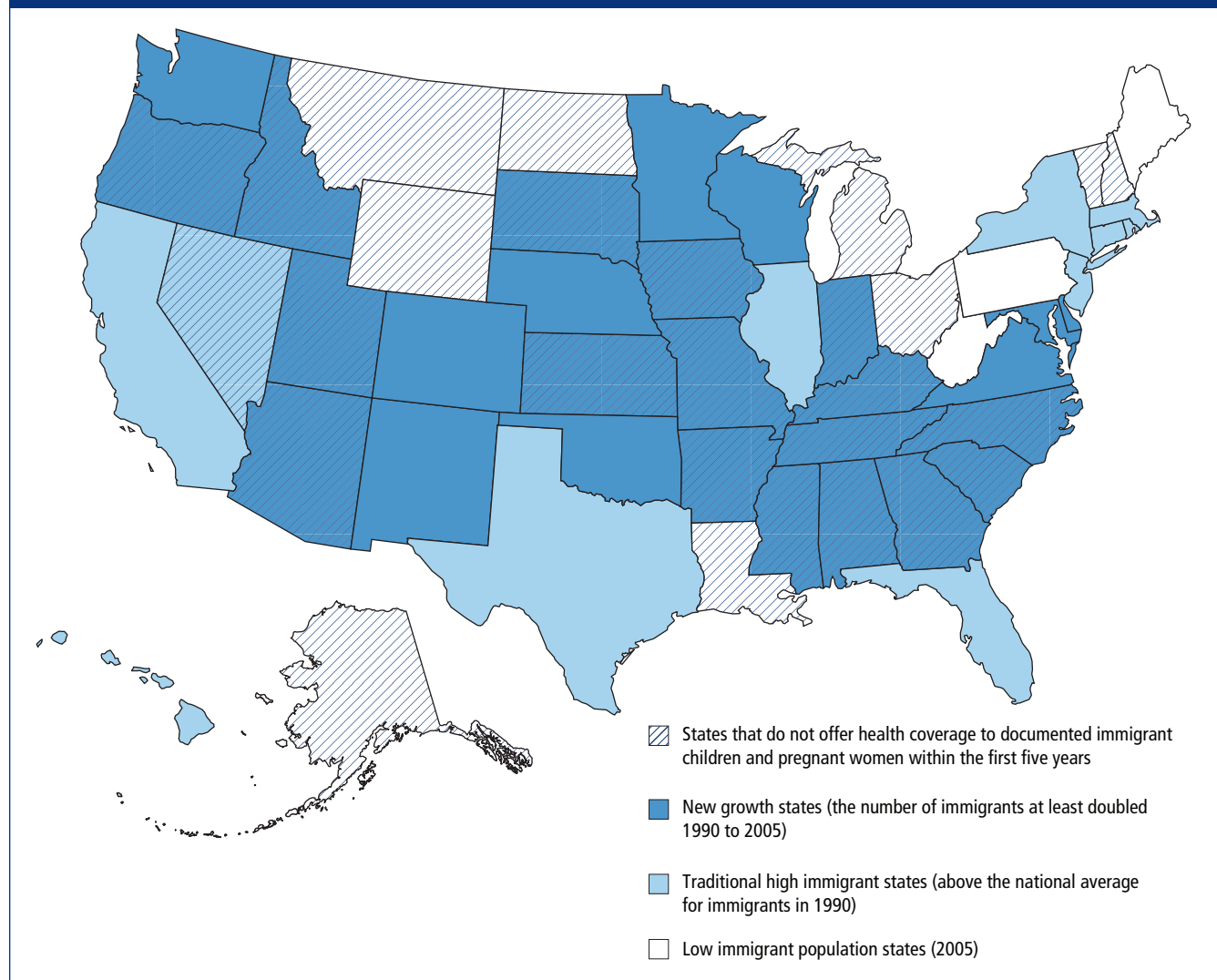
Yet over the past 15 years immigrants are increasingly locating in “new growth” states, such as Arkansas, North Carolina, and Iowa. Most of these states do not offer state-funded coverage to documented immigrant children and pregnant women during their first five years (see Figure 1) and are therefore leaving these populations vulnerable to health risks.¹³

Even with the five-year ban on public benefits eligibility for recent documented immigrants, belief that ineligible documented and undocumented immigrants are enrolling in Medicaid and SCHIP continues. On July 1, 2006 as part of the Deficit Reduction Act of 2005, a federal law was enacted requiring U.S. citizens to present proof of their citizenship and identity, such as a U.S. passport or birth certificate, when they apply for Medicaid coverage or seek to renew their coverage.¹⁴

As a consequence of these restrictions and stipulations, public sector health expenditures are much less

for immigrants enrolled in public health programs such as Medicaid or SCHIP. Twenty-one percent of total medical costs were paid through public sources for native-born citizens, compared to 16 percent for documented and undocumented immigrants.¹⁷ In terms of taxes paid per household, this equates to \$56 for health care for documented immigrants and \$11 for health care (emergency Medicaid services) for the undocumented.¹⁸

FIGURE 1: HEALTH COVERAGE IN IMMIGRANT GROWTH STATES



Source: Center on Budget and Policy Priorities, April 2007.

Myth #2

Immigrants consume large quantities of limited health care resources.

It is a ...widely held assumption that immigrants consume large amounts of scarce health care resources.

~Sarita A. Mohanty, Assistant Professor of Medicine, University of Southern California, Los Angeles

Immigrants are more likely to be uninsured and therefore less likely to consume health care services.¹⁹ Nearly 44 percent of documented immigrants were uninsured in 2005, more than three times the uninsured rate for the native born.²⁰ There is no accurate data on the number of undocumented immigrants who are uninsured, but chances are very high that the percentage is well beyond 44 percent.

One survey of uninsured California farm workers found that only half of the males and one-third of the females had seen a physician in the past two years, even though nearly one in five had an occupational illness or a chronic health problem such as high blood pressure, high cholesterol serum, or obesity.²¹ Chronic diseases account for about 75 percent of health care costs in the United States,²² which demonstrates that if these individuals had health insurance, they would be better able to manage their health and reduce health care costs for everyone.

Documented immigrant children also face a stark reality. For example, uninsured immigrant children are more likely than their citizen counterparts to lack a usual source of care (51 percent compared to 30 percent) or to go more than one year without seeing a health professional (48 percent compared to 38 percent).²³ Additionally, 52 percent of insured immigrant children had a well-child visit in the past year compared to only 30 percent of uninsured immigrant children.²⁴ No wonder medical expenditures for immigrant children were 74 percent lower per capita than those for U.S.-born children.²⁵

Contrary to popular belief, immigrants also rarely use emergency room services.²⁶ Cases in point: the metropolitan areas of Miami-Dade, Phoenix, and Orange County, Calif.—all urban areas with large immigrant populations—have much lower rates of emergency

room use than do areas with smaller immigrant populations, such as Cleveland and Little Rock.²⁷

Additionally, fewer than 10 percent of Mexican immigrants, both documented and undocumented, who had been in the United States for fewer than 10 years reported using an emergency room, compared to 20 percent of native-born whites and Mexican Americans.²⁸ Immigrants' low use of emergency room services reflects a low use of health care services in general—and more specifically reflects fear among immigrants about using the health care system at all.

Lack of insurance means that individuals are more likely to wait for their health problems to worsen before seeking care. And the statistics on immigrant children illustrate this point. While immigrant children visit the emergency room less often than U.S.-born children, because they are often sicker when seeking care their emergency room expenditures are more than three times higher,²⁹ suggesting that access to primary and preventive care could have prevented the illness from worsening and ultimately, reduced medical costs.

In addition to limited access to emergency room care, immigrants have access to health care services through federally funded community health centers, migrant health centers, promotora programs (Hispanic lay health worker programs), federal grant programs for community initiatives, and other local and state efforts. In 2004, for example, migrant health centers served over 675,000 migrant and seasonal farmworkers.³⁰ While these programs are effective in delivering health care services to some immigrants their limited capacity and their dependence on limited federal grants and funds for operation do not meet the needs of a growing, diverse immigrant population.

Myth #3

Immigrants come to the United States to gain access to health care services.

The giant magnet of federal incentives draws foreigners into the country.

~Governor Peter Wilson, California (1991–99)

Job opportunities across the country are the “magnet” that draws immigrants to the country; not federal incentives such as health care coverage and services. Immigrants are most likely to be employed in industries that do not offer health insurance coverage, such as agriculture, construction, food processing, restaurants, and hotel services.³¹ Immigrants are nearly four times more likely to work in the agricultural industry and two times more likely to work in the construction industry.³² Uninsured rates in these industries are over 30 percent for all workers compared to 19 percent for workers across all industries.³³

Work opportunities through guest-worker programs also drive immigration. Yet the guest-worker programs for temporary, unskilled labor (the H-2A program for agriculture workers and the H-2B program for non-agriculture workers) provide limited, if any, health care benefits to the documented immigrants in the programs.³⁴

Immigrants in the H-2A program do have limited legal protections, including employer compensation benefits for medical costs and payment for lost time due to temporary or permanent work injury. But agricultural employers in this program are not required to provide health insurance or other needed services.³⁵ And existing protections are rarely enforced.

Immigrants in the H-2B programs do not even have those limited benefits. Their employers are obligated to offer full-time work and pay the prevailing wage

rate, but there is no regulation requiring any of the benefits afforded H-2A workers.³⁶

And while it may seem that H-2A workers have limited access to the health care system on paper, in practice they often find that they do not. These laborers often toil in two of the most dangerous industries, agriculture and forestry. Fatality rates in these two industries are nearly 10 times the national average.³⁷ Yet both H-2A and H-2B workers often do not have health insurance to cover appropriate care. Even worse, if an injury or illness is severe, immigrant workers in these two programs lose their jobs and therefore their legal status to stay in the United States.³⁸

Immigrant day workers experience a similar fate. A 2003–2004 national survey of predominantly undocumented day workers found a high level of occupational injuries. One-fifth of the day laborers had suffered a work-related injury, but less than half received medical care for their injuries.³⁹

Purchasing health insurance through the private market is an unlikely option for immigrants as well. The unskilled work of many immigrants is often low-wage;⁴⁰ day workers were unlikely to have annual earnings that exceeded \$15,000 and full-time immigrant workers average \$23,000 in annual income in 2003.⁴¹ Yet the average annual premiums cost paid by a worker for individual employer coverage was \$508 and for family coverage was \$2412 that same year.⁴²

Myth #4

Restricting immigrants' access to the health care system will not affect American citizens.

75 percent of Americans would deny illegal immigrants government services such as health care, believing that uninsured immigrants do not affect them.

~Time poll, March 2006

Restricting undocumented and documented immigrants' access to the U.S. health care system threatens our nation's public health. When immigrants arrive in the U.S. they are more likely to be healthier than native born individuals, yet as time goes on, their health deteriorates.

In New York City, for example, immigrants had similar or lower death rates from the 10 leading causes of death in the city compared to U.S. born adults.⁴³ Four or more years later, however, immigrants to New York City have poorer health than more recent arrivals (24 percent versus 17 percent) and they are more likely to be obese (16 percent versus 12 percent).⁴⁴

Some of this difference can be explained by a change in health behaviors, but an equally important factor is the lack of health insurance. Specifically, the lack of coverage for preventive health services during their initial years in the U.S.⁴⁵ is very costly to the nation's overall public health. Additionally, providing preventive services will reduce health care costs in the long run.

Areas with relatively high uninsured rates are likely to have greater instances of vaccine-preventable diseases, communicable diseases, and disability. For example, under-immunization increases a community's vulnerability to outbreaks of diseases such as

measles, flu, and pneumonia.⁴⁶ Furthermore, childhood and adult immunization levels are positively correlated with having either public or private health insurance.⁴⁷

Even though immigrants use health care services less and therefore have low health care expenditures, the cost of the limited resources uninsured immigrants do use are shifted onto federal and state governments, local communities, and American citizens.

Uncompensated health care received by documented and undocumented immigrants in hospitals is reimbursed by the federal government.⁴⁸ State and local governments or charitable entities that are disproportionately affected by uninsurance, such as those delivering health care services in areas with a high density lower-wage and service-sector jobs, often have a smaller tax base with which to address the health care needs of uninsured residents.⁴⁹

Individuals with insurance, citizens or immigrants, also experiences this cost-shift. In 2005, health insurance premiums for a family of four were \$922 higher and individual health insurance premiums were \$341 higher due to the cost of health care for the uninsured.⁵⁰ Cost-shifting is a consequence of the entire uninsured population, not just the uninsured immigrant population.

Myth #5

Undocumented immigrants are “free-riders” in the American health care system.

Undocumented immigrants have a free ride on the backs of legal, lawful immigrants and American citizens.

~Lou Dobbs, CNN

This myth is perhaps the most ardently asserted belief regarding undocumented immigrants and the U.S. health care system. The facts illustrate that undocumented workers contribute more to the revenue stream for U.S. social benefits than they use.

In Texas, for example, nearly seven percent of the state’s population was comprised of undocumented immigrants in 2005. The state’s health care costs for undocumented immigrants that same year were a mere \$58 million. Yet state revenues collected from undocumented immigrants exceeded what the state spent on social services provided to these immigrants such as health care and education by \$424.7 million.⁵¹

Immigrant contributions to social services are similar across the country. The National Research Council concluded that immigrants will pay on average \$80,000 per capita more in taxes than they will use in government services over their lifetimes.⁵²

Additionally, in March 2005, more than seven million undocumented immigrants were in the workforce yet received few public services for their labor and tax contributions. The Social Security Administration, for example, reaps an enormous benefit from the taxes paid by undocumented immigrants. It estimates that workers without valid social security numbers contribute \$7 billion in Social Security tax revenues and roughly \$1.5 billion in Medicare taxes annually, yet elderly immigrants rarely qualify for Medicare or long-term care services provided through Medicaid.⁵³

In 2001, the Social Security Administration concluded that undocumented immigrants “account for a major portion of the billions of dollars paid into social security that don’t match SSA records,” which payees, many of whom are undocumented immigrants, can never draw upon. As of July 2003, these payments totaled \$421 billion.⁵⁴

Conclusion

A close examination of immigrants' actual experience with the U.S. health care system sheds light on the many obstacles immigrants encounter when they seek health insurance and health care. Low-income documented immigrants must wait five years before being eligible for public health insurance. And less than half of the states provide coverage to select documented immigrant populations, such as children and pregnant women.

Furthermore, cumbersome administrative regulations regarding proof of citizenship status dissuade potentially eligible documented immigrants from applying to Medicaid and SCHIP. And although undocumented immigrants contribute to the economy through their labor and taxes, they are barred from federally-matched Medicaid services.

But that is not all. Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance. The reason: the average health insurance premium for a family of four was roughly \$11,500, nearly half of the average annual income of an immigrant worker.

Because of these limitations and restrictions, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardize health and welfare, and create some cost-shifting.

The increase of documented and undocumented immigrants into the U.S. is not the cause of the failing health care system. The health care system is broken in large part because 45 million individuals lack health insurance and health care premiums have nearly doubled over the past six years. [Any effort to reform the American health care system should work to reduce barriers to health insurance coverage for immigrants. And any effort at immigration reform should also be informed by these facts.]

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