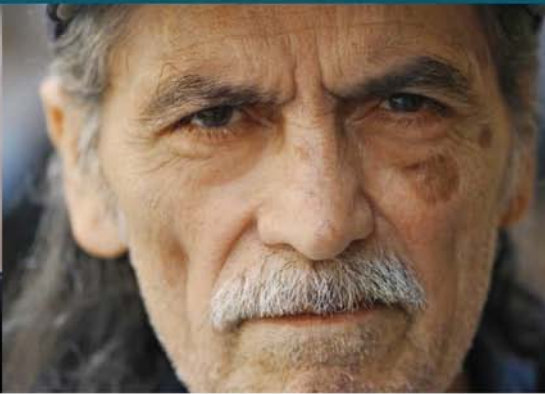




# What Health Care Reform Means For Immigrants



**COFEM**



# What Health Care Reform Means for Immigrants

Raul Hinojosa Ojeda, Max Hadler,  
Paule Cruz Takash

## *Executive Summary*

The Patient Protection and Affordable Care Act, signed into law by President Obama in March 2010 is poised to have a major effect on the United States' health service delivery system. The most important health care reform bill in a generation will increase access to care, mandate coverage for most individuals, regulate the insurance industry, and provide better, more affordable options to consumers. However, it will do so without the participation of a large segment of the immigrant population upon which this country so consistently depends.

Approximately 11 million immigrants in the U.S. are uninsured,<sup>1</sup> representing nearly one quarter of the overall uninsured population. Many of them stand to gain little from the new legislation. Some will lose ground because of it. While expanding coverage and controlling costs are admirable goals, we believe they are not fully achievable without the inclusion of the immigrant community, and especially the increasingly marginalized undocumented immigrant population.

This brief describes, in three sections summarized below, (1) the current health care status of immigrants, (2) the effect of health care reform on immigrants, and (3) the steps necessary to further improve the health care access of immigrants in the U.S.

1) Immigrants are a relatively healthy group that uses health care services at substantially lower rates than the U.S.-born population, even when controlling for immigrants'

unfavorable insurance status. Contrary to popular belief and rhetoric about the burden undocumented immigrants place on the health care system, they use emergency departments relatively infrequently. This is the case despite the fact that emergency care is often their only recourse. Undocumented immigrants' share of health care expenditures is dwarfed by their proportional representation in the population.

2) Health care reform is a step in the right direction. Increased funding for community health centers is a nod toward their critical role in immigrant health. Reform also allows legal immigrants to obtain publicly-funded credits and subsidies to purchase insurance on newly-created exchanges, helping middle-class immigrants comply with new individual coverage mandates.

However, the bill maintains the five-year ban on legal immigrant access to publicly-funded programs such as Medicaid, a mainstay of the Welfare Reform Act of 1996 that jeopardizes the health of low-income immigrants. As Latinos comprise fifty-three percent of all immigrants in the United States, over half of whom are women, Latina immigrants and their families are greatly impacted by the five year ban and the added burden of paying out-of-pocket for vital reproductive health care procedures.<sup>2</sup>

Most dramatically, the reform prohibits undocumented immigrants from participating in the new insurance exchanges even if they are able to purchase coverage with their own funds. The new legislation also retains a complete ban on publicly-funded benefits for undocumented immigrants other than Emergency Medicaid. These measures will cause undocumented immigrants to become an increasingly large proportion of the nation's uninsured population.

3) Immigration reform, tipped as one of the next major items on the Obama administration's agenda, is more urgent than ever given the shortcomings of health care reform. Creating a process through which undocumented immigrants can normalize their status is imperative and is one way to further improve health care access in a system that will improve for many others because of the recent reform.

It is also critical to keep in mind the major economic benefits that comprehensive immigration reform can have on the U.S. economy (estimated at over \$1.5 trillion over 10 years),<sup>3</sup> further strengthening the nation's health care system.

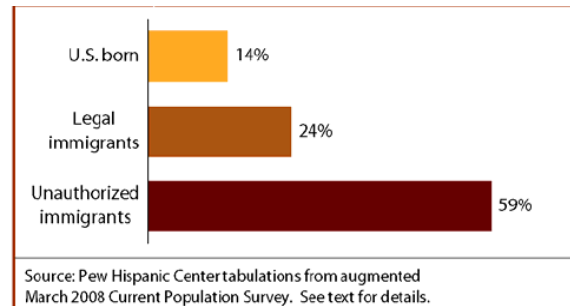
In the interim, the burden of filling gaps in care will continue to fall on governments and organizations at the state and local levels, as they desperately try to maintain state programs such as California's prenatal care initiative in a time of drastic budget cuts. Within the context of increasingly integrated labor markets it therefore becomes even more imperative that cross border health care plans and services also be considered.

## (1) IMMIGRANT HEALTH NOW

### *Current insurance status of immigrants*

Fifty-nine percent of undocumented immigrants and 24 percent of legal immigrants are uninsured.<sup>4</sup> Overall, immigrants represent about one-quarter of the country's uninsured population.

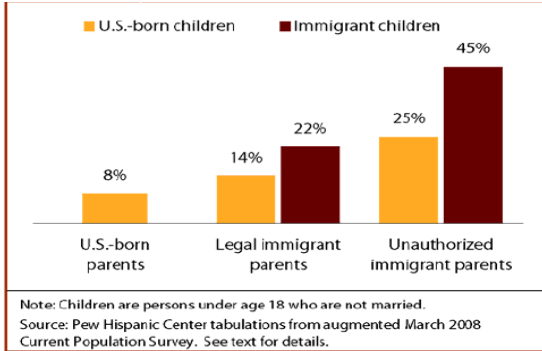
**Figure 1**  
**Share of Adults Without Health Insurance by Status, 2008**  
*(% of adults in status group without health insurance in previous year)*



Many of the uninsured are children. While initiatives such as the Children's Health Insurance Program help expand coverage, immigrant youth and children of immigrants are still extremely vulnerable, often as a result of their parents' immigration status and subsequent relationship to the health care system.

One California study found that U.S.-born children with immigrant parents were twice as likely to be uninsured as their counterparts with U.S.-born parents. Immigrant children with immigrant parents were six times more likely to be uninsured. The study found a strong correlation between lack of insurance and lack of a regular source of care, laying lie to the claim that insurance is not an important indicator of health care access.

**Figure 2**  
**Share of Children Without Health Insurance, By Nativity and Parents' Status, 2008**  
*(% of children in status group without health insurance in previous year)*

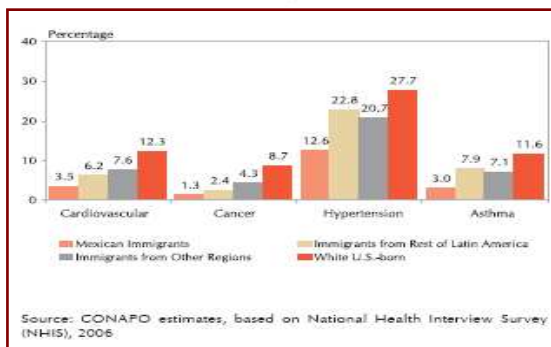


The implications of these numbers are alarming when considering that 85 percent of immigrants live in mixed-status households.<sup>5</sup>

***Latino Immigrants: a healthy, low-cost population***

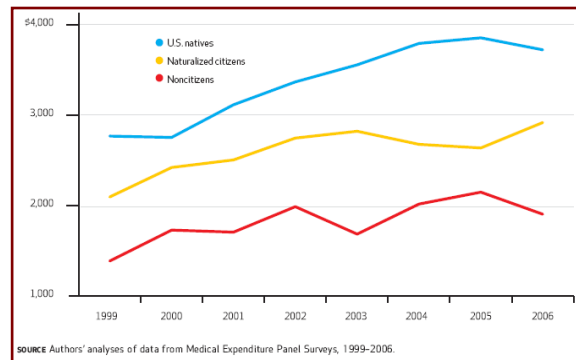
Despite risk factors such as low socio-economic status, education levels and health insurance rates, Latino immigrants are a relatively healthy population, with lower prevalence of cardiovascular disease, cancer and hypertension than the U.S.-born white population.<sup>6</sup>

**Figure 3**  
**Diseases of Immigrant population (from Mexico and other regions) and; White U.S.-born Population Ages 18 and over in United States, 2006.**



Per capita health care spending on immigrants is less than half that of U.S.-born people.<sup>7</sup> In Los Angeles County, undocumented immigrants make up 12 percent of the overall population but account for only six percent of health care spending.<sup>8</sup>

**Figure 4**  
**Age-Adjusted Total Per Capita Health Spending (2008 Dollars) For U.S. Natives, Naturalized Citizens, And Noncitizens, 1999-2006**<sup>9</sup>



Latino immigrants are precisely the demographic that lawmakers should seek out to expand the risk pool and lower costs for all people in the U.S. In excluding much of the immigrant population, health care reform fails to fully take advantage of the productive structural changes of the new system.

**(2) THE IMPACT OF REFORM**

***Increasing Latino health care access, while exacerbating disparities by immigration status***

Health care reform addresses many concerns for Latinos, who at 32 percent are the most uninsured ethnic group in the country.<sup>10</sup> The Congressional Hispanic Caucus estimates that the reform will cover an additional 8.8 million Latinos, or 60 percent of the currently uninsured Latino population.<sup>11</sup> The Congressional Budget

Office estimates that by 2019, five years after many of the reforms take effect, the new policies will help cover 32 million people who would otherwise be uninsured. However, 23 million people would remain uninsured. One-third of these 23 million would be undocumented immigrants,<sup>12</sup> more than doubling their representation in the overall uninsured population from its current 15 percent.

### *Premium credits and subsidies for legal immigrants*

The federal government recognizes that not all individuals and families have the economic means to purchase their own insurance plans, as mandated by the reform. Legal immigrants are included in the mandate and are therefore eligible for premium credits and subsidies to help defray costs and comply with the new law. According to a Migration Policy Institute estimate, 3.4 million legal immigrants who have incomes below 400 percent of the Federal Poverty Level (the cutoff point for credits and subsidies) are uninsured.<sup>13</sup> Many of those on the higher end of the scale who can afford to contribute to their own coverage will benefit from the new subsidies and insurance exchange system.

### *Community Health Centers (CHCs)*

Health care reform increases spending for CHCs by 11 billion dollars over five years starting in 2011.<sup>14</sup> CHCs are a critical cost-saving piece of the reform. They also represent one of the few bright spots for people who are not covered by other parts of health care reform, most notably undocumented immigrants. The National Association of Community Health Centers estimates that CHCs will cover an additional 20 million patients as a result of increased funding.<sup>15</sup> Though the organization does not

provide an estimate of the number of undocumented immigrants that will be served by this increase, expanded CHC capacity is the only real improvement these marginalized immigrants stand to see from health care reform.

Despite this encouraging development, CHC expansion must be placed in the overall health care context. CHCs generally provide little specialty or acute care, meaning access beyond primary care remains perilous for undocumented immigrants.

Furthermore, low-income women of all immigration statuses will have fewer family planning options due to the standing Hyde Amendment that bans federal funding for abortion procedures. In order to gain needed support from Congress for the health care reform bill, President Obama signed an Executive Order on March 24, 2010, that reinforces this ban. Executive Order 13535 also specifically disallows the slated increased funding of CHCs to be used for these reproductive health procedures,<sup>16</sup> curtailing immigrant women's right of choice otherwise guaranteed by the Supreme Court's 1973 ruling in *Roe vs. Wade*.

The Nelson provision of the Patient Protection and Affordable Care Act has created new obstacles for women seeking to obtain coverage for legal abortions by requiring them or their employers to make two separate payments every month for a standard insurance policy bought through the exchange. Women in states that decide to deny all abortion coverage in private policies purchased through the exchange will be further deprived of their right to all family planning choices.<sup>17</sup>

### ***A ban on the most vulnerable legal immigrants***

Health care reform retains a law included in the 1996 Welfare Reform Act that mandates a five-year ban on access to public funding for legal immigrants. Thus, the encouraging Medicaid eligibility expansion to 133 percent of the Federal Poverty Level will not help legal immigrants in this income bracket. While the poorest legal immigrants are eligible for premium credits and subsidies, those who cannot afford to purchase coverage even with incentives will most likely remain uninsured. Immigrants and women of color are disproportionately poor, making it likely that many immigrant women will not be able to afford uninsured reproductive health care and putting them and their families at greater risk.<sup>18</sup>

### ***Restrictions on undocumented immigrants***

For undocumented immigrants, who make up 15 percent of the uninsured population nationally,<sup>19</sup> the new legislation is truly counterproductive. They are to be fully excluded from the insurance exchanges, regardless of their ability to pay. These restrictions are, in part, a response to concerns about the public resources used to provide care for undocumented immigrants. However, undocumented immigrants do not seek care at high rates. A study in North Carolina, a state with one of the fastest-growing immigrant populations in the country, estimated that just five percent of the total undocumented immigrant population used Emergency Medicaid, the only publicly-funded program available to undocumented immigrants. These expenditures represented less than one percent of the total state Medicaid budget.<sup>20</sup>

Among Latinos, undocumented immigrants are the least likely group to use health

services, perhaps in part because they are the most likely to report negative experiences when seeking health care. They are also less likely to seek care in emergency departments despite lower rates of insurance and fewer regular sources of care.<sup>21</sup>

### ***New identification requirements affect all U.S. residents***

To enforce restrictions on undocumented immigrants, the reform bill imposes identification verification requirements that could be detrimental to U.S. citizens and legal residents who do not possess the necessary documentation to prove citizenship. The verification system may seem logical given the legal stipulations of the bill, but enforcement that targets undocumented immigrants is unnecessary and wasteful because there is almost no evidence that immigrants currently try to access public health insurance through fraud.<sup>22</sup> In one egregious example, a watchdog program in Los Angeles County received \$28 million in funding to verify Medi-Cal documents and did not find a single undocumented immigrant with false paperwork among the more than 100,000 recipients the program reviewed.<sup>23</sup>

### **(3) WHERE TO GO FROM HERE**

Federal inaction on immigrant health forces civil society and state and local governments to pick up the slack. While the reform is estimated to provide coverage to as many as 7.3 million uninsured Californians,<sup>24</sup> it does not cover some of the state's most vulnerable residents who as productive members of the US economy have a right and a legitimate claim to health care regardless of immigration status.

A combination of existing and new initiatives provide hope in the prologue to

the next critical piece of the president's agenda – comprehensive immigration reform.

### *Providing care to those who pay into the system*

The exclusion of some legal immigrants and all undocumented immigrants from reform creates a class system in health care based largely on immigration status. This is justified by the argument that immigrants should not reap the benefits of a system into which they do not pay. In fact, immigrants of all statuses pay billions of dollars in payroll taxes that contribute to Social Security and Medicare. Among them are the majority of undocumented immigrants, who under current law will never see a return on their investment.<sup>25</sup>

In the brief period since the health care reform bill was signed into law, articles have appeared suggesting that the reform's generosity and attendant cost make immigration reform impossible because the new health system would collapse under the weight of 11 million additional users. Considering that immigrants already pay into the health care system and indeed comprise a significant portion of the US healthcare workforce, the idea that they should be kept out because of solvency issues suggests, if anything, the need for budget adjustments, not the exclusion of paying residents.

While incorporating health care reform into a new legal immigration system is a challenge that carries significant financial repercussions, it would be unconscionable to turn this challenge into a justification for denying health care to people who have been in the U.S. for many years.

Undocumented immigrants who are provided a path to normalization of immigration status must be given credit for the time they have spent in the U.S. and the financial contributions they have made to public programs, as well as access to the health care system they have a right to but have consistently been denied.

### *Cost savings of providing comprehensive care to all, regardless of immigration status*

Opposition to a California policy that provides prenatal care for all women regardless of immigration status led to a renowned cost-benefit analysis in 2000 that found the state would lose \$136 million if it eliminated coverage for undocumented women. Using risk ratios associated with births by women who did not receive prenatal care and the resultant cost of treatment for low birth weight and preterm infants, the authors calculated it would cost the state \$194 million in additional expenditures, far outweighing the \$58 million saved on reduced prenatal costs.<sup>26</sup>

Such analyses prove the value of state initiatives like Restricted Medi-Cal for pregnancy, which continues to provide prenatal care to all low-income women regardless of immigration status. This cost-benefit perspective should be applied to preventive care generally and would be better served by opening the reform door to all people in the U.S.

### *State programs do not negate the need for federal action*

Through initiatives such as Restricted Medi-Cal, some states with large immigrant populations have in recent decades closed some of the support gap created by federal inaction, with California among the leaders. Nonetheless, the importance of federal

guarantees cannot be understated in light of the vulnerability of these state programs. The current economic situation in California provides sufficient warning, as Governor Arnold Schwarzenegger considers budget cuts to safety-net care for immigrants at the same time that federal reform has missed an opportunity to significantly improve health care access for undocumented immigrants.

### *Immigrants as health care providers*

The U.S.' aging population and the increasing burden of their health care costs on the economy were among the main drivers of health care reform. A recent Georgetown University study shows that immigrants are intimately involved in the long-term care (LTC) industry, filling more than one in every six positions in a field of three million workers.<sup>27</sup> A majority of all LTC providers are direct caregivers for elderly and disabled members of society; 21 percent are foreign-born, of which half are from either the Caribbean (29%) or México and Central America (21%). The Bureau of Labor Statistics anticipates these "front-line" health care jobs will become the second-and-third fastest growing occupations in the United States between 2006-2016.<sup>28</sup>

Any future provider shortage is likely to be offset, at least in part, by increased immigration. Preventing full health care access to the very people who keep the most expensive component of the health care system functioning is not only ironic; it is an illogical move that does not recognize the importance of a healthy, more productive workforce, or the public health need to ensure access to health services for all.

### *US-Mexico binational health care collaboration*

Long before health care reform became a reality, enlightened parties in the U.S. and México floated ideas for a binational health plan that would allow insurance portability to transcend borders, in recognition of the large amount of transnational individuals who split their time between the two countries or, in the case of families, who are split by the border. Initiatives such as *Salud Migrante*, undertaken by México's National Institute of Public Health, were considered previous to the delayed U.S.-based reform because of the pressing reality of migration and the problems it creates for status quo health care access.

The failure of the US health care reform to address the needs of immigrants in the U.S. further underscores the importance of binational health care initiatives and institutional partnerships. Precedents include collaborations started in 2001 between Mexico's Ministry of Health with local, state and federal agencies in the US, the Mexico Ministry of Foreign Affairs, donors and the private sector to provide migrants with better access to health care information and services;<sup>29</sup> and partnerships initiated by the Institute for Mexicans Abroad (*Instituto de los Mexicanos en el Exterior or IME*) with the California Endowment and US-Border Health Commission. The latter has created "health stations" or *Ventanilla* offices located within Mexican consulates that partner with local health care facilities to provide services for Mexican migrants and their families in the US.<sup>30</sup> As the IME has made health care for its compatriots in the US a priority, more and substantive binational health care plans could be realized for uninsured and underserved Mexican nationals with the greater cooperation of the US government.

More serious consideration should be given as to how binational health care plans and services that currently benefit many US citizens should be integrated into health care reform programs.<sup>31</sup> Many Americans cross the U.S.-México border daily for low-cost medicine, routine care and surgery and over one million U.S. citizens now live in México. Many Americans are enrolled in a medical insurance plan offered by the Mexican Social Security Institute (IMSS).<sup>32</sup>

Absent federal action, states are probing additional cost-saving initiatives, including California's cross-border medical HMO plans that provide patients treated in México the same rights as those who receive care in California.<sup>33</sup> The organization Americans for Medicare in México has lobbied Congress to allow Medicare to cover health care in México that the organization claims will save the government program half of what it now spends to provide care in the U.S. Providing more health care services and facilities for U.S. citizens may also contribute to greater job creation in México.

Looking ahead, the absence of any discussion in the health care debate of transnationality or any of the current and proposed binational health care plans highlights the need for these innovations to be brought to the fore by civil society.

### *What's next*

Having further entrenched in law the notion that immigrants do not already contribute to health care in the United States and do not have a right to health care, health care reform has passed the buck to immigration reform. Though expansion of community health centers is a valid (if indirect) recognition of the need to treat people in

non-emergency situations, it is insufficient. Given the improbability of further health care reform in the near future, one way to progress toward a more respectable slate of health rights for immigrants is through a legalization process for people already in the U.S. – one that allows them to eventually gain access to the positive structural changes in the health care system created by the Patient Protection and Affordable Care Act.

### *About the authors*

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Founded in 1995, the NAID Center conducts interdisciplinary research concerning the economic integration process between the United States, Mexico and Canada; and assists communities and governments with projects and policies for sustainable and equitable development across borders. NAID Center activities have followed the trajectory of globalizing trade, capital, migration and remittances flows in the midst of intra- and inter- regional disparities in income and productivity across communities and regions in the United States and Latin America. [www.naid.ucla.edu](http://www.naid.ucla.edu)

### *About COFEM*

The Council of Mexican Federations (COFEM) is a non-profit organization whose mission embraces a community centered approach to promote the advancement of the Latino community through public policy advocacy, educational

and cultural programming, strategic mobilization, community organizing, and binational economic development. The organization forges bridges with communities and institutions interested in the advancement of the Latino immigrant community. The organization fully embraces an immigrant-led bottoms-up oriented model of community organizing that has led to the rapid expansion of Hometown Associations (HTAs) throughout the nation.

COFEM is the largest immigrant led organization in the United States representing over 300 HTAs throughout California, Nevada, Arizona, and Washington. Headquartered in the heart of Los Angeles in Olvera Street, the organization has developed unique programs and services that reach affiliated members throughout the region. [www.cofem.org](http://www.cofem.org)

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