Left Out: Immigrants' Access To Health Care And Insurance

Even when insured, noncitizens and their children have less access to care than insured American citizens have.

by Leighton Ku and Sheetal Matani

ABSTRACT: Recent policy changes have limited immigrants' access to insurance and to health care. Fewer noncitizen immigrants and their children (even U.S.-born) have Medicaid or job-based insurance, and many more are uninsured than is the case with native citizens or children of citizens. Noncitizens and their children also have worse access to both regular ambulatory and emergency care, even when insured. Immigration status is an important component of racial and ethnic disparities in insurance coverage and access to care.

PUBLIC ATTENTION HAS RECENTLY FOCUSED on racial and ethnic disparities in access to health care, and research indicates that Latinos have the highest uninsurance rates among racial/ethnic groups living in the United States.[1] But there has been surprisingly little discussion of the importance of immigration status, although one-third of U.S. Hispanics and two-thirds of U.S. Asians are foreign-born. Immigrants are a large and growing segment of American society and are disproportionately low-income and uninsured.[2] Thus, the status of immigrants has broader implications for national and state efforts to improve access to health care.

The 1996 federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) restricted Medicaid eligibility of immigrants, so that those admitted to the United States after August 1996 cannot receive coverage, except for emergencies, in their first five years in the country.[3] Historically, legally admitted immigrants were eligible for Medicaid and other benefits on the same terms as citizens were, but PRWORA signaled an important change in the social contract. These policies exacerbated immigrants' fears that began after the enactment of California's Proposition 187 and after publicity about the Immigration and Naturalization Service (INS) efforts to apply "public charge" en-

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forcement to Medicaid, asking immigrants to repay the value of Medicaid benefits received or else jeopardize their U.S. residency status.[4] Collectively, these policies signaled that legal immigrants should avoid Medicaid, even if they were uninsured and eligible.

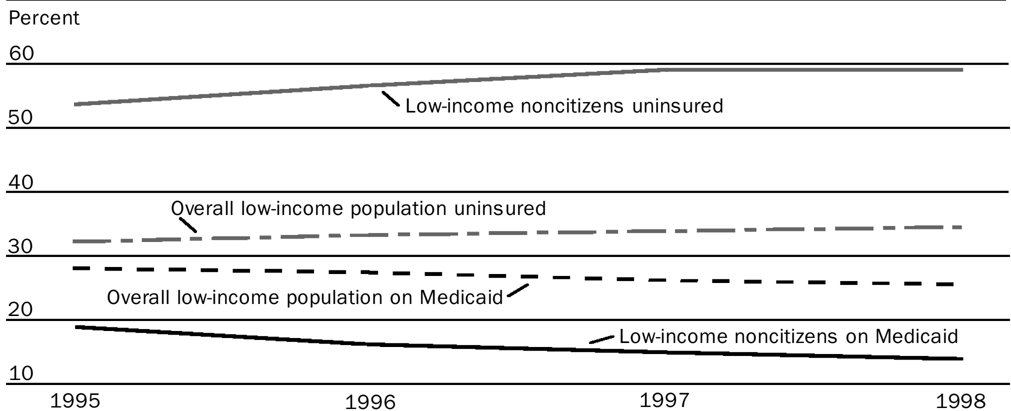
The Medicaid participation of low-income noncitizens fell and uninsurance rates climbed from 1995 to 1998 (Exhibit 1).[5] Since PRWORA changed eligibility for only the fraction of immigrants admitted after 1996, many analysts ascribe these changes to a "chilling effect" that affected immigrants who still were eligible. These fears affected U.S.-born children of immigrants (who are legal citizens), impeding efforts to enroll children in Medicaid and the State Children's Health Insurance Program (SCHIP).[6] About one-fifth of all children in the United States are immigrants (3 percent) or U.S.-born children of immigrants (16 percent).[7]

This paper presents data from the National Survey of America's Families (NSAF) on how immigrant status affects insurance coverage and the use of medical, dental, and mental health services by adults and children. A key advantage of NSAF is that it includes data about citizenship, insurance status, and health care use. By contrast, the Current Population Survey (CPS) lacks information about health care use, while the National Health Interview and Medical Expenditure Panel Surveys do not report citizenship status.

Data And Methods

More detail about the 1997 NSAF is provided elsewhere, but key features are that it has a sample size of 109,992 noninstitutionalized persons under age sixty-five and oversamples the low-income popu-

EXHIBIT 1
Changes In Medicaid And Uninsurance Rates Among Adults And Children With Incomes Under 200 Percent Of Poverty, 1995–1998



SOURCE: 1996–1999 Current Population Surveys.

lation.[8] State-representative samples from thirteen states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin), plus a wraparound sample for the balance of the nation, together comprise a nationally representative sample. Interviews were conducted in English and Spanish. The survey had an overall response rate of 70 percent. All analyses presented are weighted and control for the complex NSAF survey design, using the method of balanced repeated replicates and sixty sets of replicate weights.[9]

Insurance Coverage And Usual Source Of Care

Exhibit 2 compares the insurance coverage of low-income persons—those with family incomes below 200 percent of poverty.[10] Adults were grouped as noncitizen immigrants, naturalized citizens, or native-born citizens. Children were classified based on a combination of their own status and that of their parents. Noncitizens include legal permanent residents (the largest group), refugees, undocumented aliens, and other immigrants who have not been naturalized.

The patterns are stark. More than half of the low-income noncitizen adults and children in the sample were uninsured. Noncitizen adults and their children were much less likely than native-born citizens were to have Medicaid and/or job-based or other insurance and were more likely to be uninsured.[11] Some have claimed that immigrants are more likely than native-born citizens are to use Medicaid but fail to account for their disproportionate poverty.[12]

Noncitizens and their children also were less likely to have a usual source of health care. Given the low level of insurance coverage, it is not surprising that noncitizen families were relatively less

EXHIBIT 2
Current Health Insurance Coverage And Usual Source Of Care For Persons With Incomes Under 200 Percent Of Poverty, By Immigrant Status, 1997

	Adults (ages 18–64)			Children (under age 18)		
Type of coverage	Noncitizen	Naturalized	Native citizen	Noncitizen child/ noncitizen parents	Citizen child/ noncitizen parents	Citizen child/ citizen parents
Medicaid	8.7%***	12.0%**	17.2%	23.0%***	42.2%***	39.6%
Job-based	26.1***	34.3	36.5	20.9***	21.8***	35.2
Other	7.0	12.1	12.6	2.3***	2.8***	6.6
Uninsured	58.2***	41.6**	33.7	53.7***	33.1***	18.5
Source of care						
Doctor's office or HMO	19.7***	31.9***	43.7	25.1***	32.3***	57.9
Clinic or outpatient department	38.5***	32.4	31.5	47.1***	53.4***	33.3
Emergency room	4.4	4.0	5.8	2.0	1.3***	2.8
None	37.4***	31.9***	19.0	25.7***	13.0***	6.0

SOURCE: 1997 National Survey of America's Families.
NOTES: The tests of significance compare immigrant groups with the native citizen or citizen child/citizen parent groups. HMO is health maintenance organization.
** $p < .05$ *** $p < .01$

likely to use private doctors or health maintenance organizations (HMOs). Community clinics and hospital outpatient departments are the most common sources of ambulatory care for immigrants. Very few said that the emergency room was their usual source.

■ **Effect of immigrant status.** To what extent are the differences in insurance status and usual source of care related to being an immigrant, as opposed to other social and economic differences? We used multivariate statistical methods to control for health status, income, race/ethnicity, and other factors that affect insurance status and utilization.[13] Exhibit 3 presents the results for eight logit models of insurance coverage and usual source of care for the full samples of adults and children. We present only the findings related to immigrant status and race/ethnicity. Effects are presented as the estimated change in the average probability of having insurance (or no usual source of care), compared with the reference group, controlling for the other factors. For example, the estimate for uninsurance for a citizen child with noncitizen parents is 7.9 percent, meaning that if a child whose parents were citizens had a 20 percent risk of being uninsured, then a similar citizen child with noncitizen parents would have had an 8 percent higher risk, or 28 percent.

EXHIBIT 3
Effect Of Immigrant Status And Race On Insurance Status And Usual Source Of Care, Based On Logit Models, 1997

	Estimated mean change in probability of having			
Variable	Medicaid	Job-based insurance	No insurance	No usual source of care
Models for adults[a]				
Immigrant status (ref = native citizen)				
Noncitizen	−2.5**	−8.9***	8.5***	7.6***
Naturalized citizen	0.3	−2.6	2.9	4.7***
Race/ethnicity (ref = white, non-Hispanic)				
Hispanic	−1.3	−0.3	3.2	3.7**
Black, non-Hispanic	1.4***	−2.5	1.3	−2.0
Asian	−2.3*	−1.1	−0.8	2.4
Models for children[b]				
Immigrant status (ref = cit. child/cit. parents)				
Noncitizen child/noncitizen parents	−14.1***	−14.7***	15.9***	4.4***
Citizen child/noncitizen parents	−4.8**	−7.7***	7.9***	2.0**
Race/ethnicity (ref = white, non-Hispanic)				
Hispanic	1.5	−14.2**	0.8	2.8
Black, non-Hispanic	8.8***	−7.8***	−2.0*	0.3
Asian	6.7**	−1.3	−2.5	5.4***

SOURCE: 1997 National Survey of America's Families.
NOTES: Effects are presented as the estimated change in the average probability of having insurance (or no usual source of care), compared with the reference group and controlling for the other factors. Tests are two-tailed.
[a] Adult models also control for age, sex, income, employment, education, family structure, health status, work limitations, and state.
[b] Child models also control for age, sex, income, parental employment, parental education, family structure, health status, and state.
* $p < .10$ ** $p < .05$ *** $p < .01$

For adults, being a noncitizen was associated with a 2.5 percent reduction in Medicaid coverage, an 8.9 percent decrease in job-based insurance coverage, and an 8.5 percent increase in the probability of being uninsured, compared with native citizens. Noncitizen adults were less likely to have a usual source of care than native citizens were. Naturalized citizens' insurance status did not significantly differ from that of native citizens after multivariate controls, but they were more likely to lack a usual source of care.

Noncitizen children had 14 percent less Medicaid, 15 percent less job-based insurance, and 16 percent greater risk of being uninsured, compared with children whose parents were citizens. They also were less likely to have a usual source of care. After controlling for the other factors, citizen children whose parents were noncitizens had about 5 percent less Medicaid and 8 percent less job-based insurance and were about 8 percent more likely to be uninsured. They also were more likely than children of citizens were to lack a usual source of care. While citizen children with noncitizen parents were eligible for Medicaid, they were still less likely to participate, perhaps because of their parents' fears or other perceived barriers.

After we controlled for immigrant status and the other factors, the insurance coverage of Hispanics was not significantly different from that of non-Hispanic whites, except for employer-sponsored insurance for children. A major reason for the low insurance coverage of Latinos is that so many are in noncitizen families.

Immigrants And Their Children's Access To Care

How is immigrant status related to access to and use of services? First, we examined what factors determined whether a person had any visits to a doctor/nurse or an emergency room in the past year, as a measure of health care access. Next, we examined how these factors affected the number of visits, among those who had at least one visit, as a measure of the quantity of health care received.

■ **Ambulatory care.** Exhibit 4 indicates that after many other social and economic factors are controlled for, being a noncitizen adult or child was associated with a substantial and significant reduction in access to regular ambulatory health care (visits to a doctor or nurse) and to the emergency room, compared with native citizens or their children. Further, citizen children with noncitizen parents had significantly fewer doctor/nurse and emergency room visits than did children of citizens. Noncitizen adults and children also had fewer emergency room visits, among those with any.

Noncitizen families had less initial access to ambulatory medical and emergency medical care and, even when they had access, often received less care. These data show that immigrants faced serious

EXHIBIT 4
Effect Of Immigrant Status And Race On Visits To Doctor Or Nurse Or To Emergency Room In The Past Twelve Months, 1997

Variable	Estimated mean change in probability of visiting: Doctor or nurse	Estimated mean change in probability of visiting: Emergency room	Estimated change in number of visits, among those with any: Doctor or nurse	Estimated change in number of visits, among those with any: Emergency room
Models for adults[a]				
Immigrant status (ref = native citizen)				
Noncitizen	–6.0***	–9.2***	–0.41	–0.46***
Naturalized citizen	–1.8	–2.4	–0.33	–0.22
Race/ethnicity (ref = white, non-Hispanic)				
Hispanic	–11.9***	–3.5	–1.83**	0.01
Black, non-Hispanic	–1.4	6.3***	–0.11	0.08
Asian	–7.2***	–3.3	–0.48	–0.11
Insurance status (ref = uninsured)				
Medicaid	21.4***	7.3***	2.28**	0.02
Job-based insurance	19.4***	–2.3*	0.52	–0.31*
Other insurance	14.8***	–2.1	0.42	–0.23
Models for children[a]				
Immigrant status (ref = cit. child/cit. parents)				
Noncitizen child/noncitizen parents	–6.4**	–13.3***	–0.53*	–0.53***
Citizen child/noncitizen parents	–3.8	–2.7	–0.73***	–0.51**
Race/ethnicity (ref = white, non-Hispanic)				
Hispanic	–8.0*	–12.7***	–5.35***	–0.37
Black, non-Hispanic	–2.9*	1.3	–0.74**	–0.10
Asian	–4.5	–6.1*	–0.25	–0.12
Insurance status (ref = uninsured)				
Medicaid	15.3***	10.4***	1.38***	0.41***
Job-based insurance	12.2***	1.1	0.33	–0.10
Other insurance	8.9***	6.3**	0.92	0.19

SOURCE: 1997 National Survey of America's Families.
NOTES: Effects are presented as the estimated change in the average probability of visiting a doctor/nurse or emergency room in the past twelve months, and among those with any visits, of having more than one visit.
[a] See Exhibit 3 for covariates.
* $p < .10$ ** $p < .05$ *** $p < .01$

barriers in getting both regular ambulatory care and emergency room care. This is in contrast to the common assumption that people with less access to primary care use emergency rooms more often for routine problems. To help put this in perspective, the extent to which noncitizens and their children had no doctor/nurse or emergency room visits in a year (41 percent for noncitizen adults, 38 percent for noncitizen children, and 21 percent for citizen children with noncitizen parents) was roughly double the rate of native adults (21 percent) and children of citizens (13 percent).

■ **Hispanics' access to care.** Even after immigration status was controlled for, being Hispanic was associated with getting less medical care. Both citizen and noncitizen Latinos had poorer access to care than white citizens had (in contrast to the findings for insurance coverage).

Being Hispanic also modified the relationship of health status to

medical care use. In the NSAF, as in most other surveys, Latinos reported poorer health status than non-Latinos did. It has been speculated that this might be caused by cultural differences in how Hispanics describe their health status, as compared to differences in more clinical or objective measures of health.[14] People who reported fair or poor health status used much more health care, but this relationship was smaller for Hispanics.[15] This is consistent with the view that Latinos report health status differently than non-Latinos do, although an alternative interpretation is that a similar level of impairment leads to less additional medical care for Latinos.

In the models, having health insurance was associated with much better access to regular ambulatory care for immigrants and non-immigrants alike but had relatively little effect (except for Medicaid) on emergency room access.[16] Although insured noncitizens had less access to care than insured citizens did, they have much better access to care than uninsured noncitizens.

■ **General patterns.** Looking across the analyses, general patterns can be inferred. Being a noncitizen adult or the child of noncitizen parents reduces access to ambulatory medical care and emergency room care, after factors such as health status, income, and race/ethnicity are controlled for. For children of noncitizen parents, the access gaps are larger for noncitizen children than for citizen children, but both types of children have less access to medical care than do children of citizens. The health care access of naturalized citizens is generally similar to that of native-born citizens, suggesting that immigrants' health care use increases as they acculturate.

Conclusions And Policy Implications

Noncitizen immigrants and their children have large gaps in their health insurance coverage and access to health care, even when the children are citizens. The disparity in access has two components. First, noncitizens and their children are much more likely to be uninsured. Since insurance strongly increases access to care, uninsurance reduces immigrants' ability to get care. Second, even insured noncitizens and their children have less access to medical care than insured native-born citizens have. Immigrants encounter nonfinancial health care barriers.

From a policy perspective, the insurance gaps for citizen children in immigrant families are distressing, since they are eligible for Medicaid and SCHIP and are a major target of outreach campaigns. The insurance coverage of U.S.-born children of immigrants has fallen in recent years.[17]

Noncitizen families have poor access to both ambulatory medical and emergency room care. The gap in emergency care is particularly

relevant because federal policy lets noncitizen immigrants, including undocumented aliens, receive emergency Medicaid services, even if they are ineligible for full coverage. In principle, this policy should permit more Medicaid emergency room care as a "safety valve" for both patients and providers. Our finding suggests that the current policies are not effective and that states could do more to facilitate emergency Medicaid access for immigrants. An earlier study found that use of emergency Medicaid benefits appeared to be higher in California, which provides a Medicaid card that gives immigrants limited emergency coverage, than in other states that mostly determine Medicaid eligibility only after an emergency occurs.[18]

Even before the welfare reform changes of the mid-1990s, immigrant families had problems with insurance coverage and access to care.[19] Their situation appears to have worsened during the late 1990s. It is hard to disentangle the comparative effects of immigrant eligibility changes under welfare reform, public charge, and other factors, since the policies occurred in roughly the same time period and all sought to discourage immigrants from using public services.[20] Nevertheless, it seems reasonable to conclude that the combined effect was negative.

Some remedial actions have begun or have been proposed. In 1999 the INS clarified that getting Medicaid should not endanger immigrants' legal status under public charge provisions, and the governor of California cancelled efforts to implement Proposition 187. Many states, such as California, Washington, and Massachusetts, have chosen to use state funds to provide Medicaid or SCHIP coverage to postenactment immigrants, supplementing federally funded benefits. Recent congressional proposals would give states the option to restore immigrants' eligibility for Medicaid and SCHIP for children and pregnant women. It also is important to consider strategies to foster private job-based health insurance for immigrant workers and their families. A recent study found that noncitizen workers in California were offered health insurance less often than citizens were, but that their take-up of insurance offers was similar.[21]

Finally, health care systems need to reduce access barriers. Language problems were the leading barrier to child health services cited by Latino parents; they may also increase medical errors because of misdiagnosis and misunderstanding of physicians' orders.[22] Federal policy already states that providers must ensure that people with limited English proficiency can get interpreter services, but problems remain commonplace. Clinics, hospitals, managed care plans, and Medicaid eligibility offices need to provide adequate interpreter and translation services.

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NOTES

1. U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality: Vol. I, The Role of Governmental and Private Health Care Programs and Initiatives* (Washington: U.S. Commission on Civil Rights, 1999); and K. Quinn, *Working without Benefits: The Health Insurance Crisis Facing Hispanic Americans* (Cambridge, Mass.: Abt Associates, 2000).
2. Kaiser Commission on Medicaid and the Uninsured, *Immigrants' Health Care: Coverage and Access* (Washington: Kaiser Family Foundation, August 2000).
3. Under PRWORA, refugees and asylees can receive Medicaid for their first seven years in the country, while other legal permanent residents (the most common legal immigration category) who entered the United States after August 1996 are barred from full Medicaid eligibility for their first five years. Other provisions, such as that the income of sponsors be "deemed available" to immigrants in determining income eligibility, will probably keep most legal permanent residents ineligible even after the five-year bar expires. Undocumented (or illegal) aliens have long been barred from full eligibility.
4. M.L. Berk et al., "Health Care Use among Undocumented Latino Immigrants," *Health Affairs* (July/Aug 2000): 51–64; and C. Schlosberg and D. Wiley, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (Washington: National Health Law Program and National Immigration Law Center, May 1998).
5. Private insurance coverage (not shown) stayed about the same throughout the period, about 25 percent for noncitizens and 36 percent for the overall low-income population.
6. W. Zimmerman and M. Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County* (Washington: Urban Institute, July 1998); E.R. Brown, R. Wyn, and V. Ojeda, *Access to Health Insurance and Health Care for Children in Immigrant Families* (Los Angeles: UCLA Center for Health Policy Research, June 1999); and M. Fix and J. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994–97* (Washington: Urban Institute, March 1999).
7. Unpublished analyses of the Current Population Survey by Jeff Passel of the Urban Institute.
8. P. Brick et al., *Survey Methods and Data Reliability,* Report no. 1, NSAF Methodology Reports (Washington: Urban Institute, July 1999). NSAF was designed by staff of the Urban Institute and Child Trends and was conducted by Westat. More complete information about the survey, including methods and many data analyses, are at <newfederalism.urban.org/nsaf/cpuf/index.htm> (17 August 2000).
9. K. Rust and J.N.K. Rao, "Variance Estimation for Complex Surveys Using Replication Techniques," *Statistical Methods in Medical Research* 5, no. 3 (1996): 282–310.
10. For more detailed results, see L. Ku and S. Matani, "Immigrants' Access to Health Care and Insurance on the Cusp of Welfare Reform," Assessing the New Federalism Discussion Paper no. 00-03 (Washington: Urban Institute,

June 2000).
11. In this paper, insurance groups are not mutually exclusive; a few have both Medicaid and job-based insurance.
12. S. Camarota and J. Edwards, *Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance* (Washington: Center for Immigration Studies, July 2000).
13. Models for both adults and children include the following as control variables: race/Hispanic ethnicity, age, sex, income (family income as a percentage of poverty and a dummy variable for those under 200 percent of poverty), self-reported health status (fair/poor, excellent/very good/good), the interaction of Hispanic and health status, and state of residence (thirteen NSAF states and the rest of the nation). Models for adults also include respondent's employment (full time, part time, none), educational level (less than high school, high school graduate, college graduate), family status (married with children, married without children, single with children, single without children), and having a health condition that limits work. The models for children also include parental employment (full time, part time, none), parental education (below high school, high school graduate, college graduate), and family structure (single- versus two-parent family). In models where health care use is the dependent variable, we also include insurance status variables.
14. S. Shetterly et al., "Self-Rated Health among Hispanic vs. Non-Hispanic White Adults: The San Luis Valley Health and Aging Study," *American Journal of Public Health* 86, no. 12 (1996): 1798–1801; and M. Weigers and S. Drilea, *Health Status and Limitations: A Comparison of Hispanics, Blacks, and Whites, 1996*, MEPS Research Findings no. 10, AHCPR Pub. no. 00-0001 (Rockville, Md.: Agency for Health Care Policy and Research, 1999).

15. The general variable for poor health status had a large positive effect on access and utilization, but the interaction of Hispanic and poor health status was significant and negative.
16. We also tested interactions of immigrant status and insurance coverage variables on access and utilization. Most of the interactions were not significant, and in the few cases where they were significant, they did not alter the general direction of findings. Because of the concerns that insurance coverage is affected by immigrant status and might be subject to endogeneity bias, we also tested models without the insurance variables. When insurance was not included, the magnitudes of the gaps between noncitizens and native citizens were slightly larger and still significant, so the effect is robust.
17. Brown et al., *Access to Health Insurance and Health Care.*
18. L. Ku and B. Kessler, *The Number and Cost of Immigrants on Medicaid: National and State Estimates* (Washington: Urban Institute, December 1997).
19. F. Leclere, L. Jensen, and A. Biddlecom, "Health Care Utilization, Family Context, and Adaptation among Immigrants to the United States," *Journal of Health and Social Behavior* 35, no. 4 (1994): 370–384.
20. Only 5 percent of the foreign-born adults in NSAF entered the United States in 1996 or 1997, indicating that very few should have been ineligible for Medicaid in light of the federal welfare reform changes. Even so, some of the pre-1996 entrants may have avoided Medicaid participation because of confusion about their eligibility status.
21. E.R. Brown, T. Rice, and L. Lara, "Access to Job-Based Insurance: Why Are So Many California Employees Uninsured?" (Presented at the Association for Health Services Research annual meeting, Los Angeles, 25 June 2000).
22. G. Flores et al., "Access Barriers to Health Care for Latino Children," *Archives of Pediatric and Adolescent Medicine* 152, no. 11 (1998): 1119–1125.