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SUMMARY

This brief describes national policy efforts from 1986 to 2010 affecting access to health care for immigrants. An understanding of the policy actions that have affected immigrants' access to health care will provide context for future policy discussions.

Introduction

Immigration has been a controversial subject of public discourse and policy efforts in the United States for many years, as both citizens and policy makers debate whether immigrants are responsible for lost jobs, lower wages, overcrowded emergency rooms, and economic and cultural decline in the United States.¹

In 1965, the Immigration and Nationality Act (H.R. 2580; Pub.L. 89-236; 79 Stat. 911) was passed. This legislation marked a significant shift in policy for immigrants and was the last major reform effort directed at defining eligibility for entrance into the United States.² The Act abolished the national origins quota system that had been in place since the Immigration Act of 1924. Under the new policy, anyone could apply for entrance into the United States, particularly family members hoping to reunite.

The Immigration and Nationality Act had substantial implications for the demographic landscape of the United States.² After the passage and implementation of this policy, the number and share of the immigrant population rose dramatically. In 1970, only 5% of the population was foreign born, but that figure had risen to nearly 13% by 2009.^{3,4} Even more dramatic than the steady rise in the foreign-born population was the shift in country of origin. Prior to 1965, under the quota system, most

immigrants originated from European countries. After 1965, most immigrants came from countries in Latin America, Africa, and Asia.^{3,5,6}

This brief describes national policy efforts from 1986 to 2010 affecting access to health care for immigrants. An understanding of the policy actions that have affected immigrants' access to health care will provide context for future policy discussions.

Immigrant Categories

An immigrant is someone living in the United States who was foreign born (i.e., was not born in a state or territory of the United States or was not born abroad to a U.S. citizen). A foreign-born person may be (1) a naturalized citizen (someone who has lawfully become a citizen of the United States), (2) a noncitizen who is living in the United States legally (legal permanent residents, i.e., those with "green cards"; refugees; persons seeking asylum; other humanitarian immigrants; and lawfully present temporary immigrants),⁷ or (3) a noncitizen who is living in the United States illegally (an undocumented or unauthorized immigrant [sometimes also referred to as an illegal immigrant]). Undocumented persons include those who entered the United States without authorization, as well as those who were admitted

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temporarily and have stayed after their visa expired. Another category, “quasi-legal,” includes people with temporary protective status, those with extended voluntary departure, those who have applied for asylum, and those waiting for “green cards” or legal permanent resident status.⁷

These categories assist policy makers with identifying persons qualified for certain public resources such as health care and education.^{1,2} Exhibit 1 highlights major policies that have impacted access to health care for immigrants from 1986 to 2010.

Impact of Policies on Immigration and Health Service Use

The immigrant population has continued to grow since 1986, although it is unclear whether the growth would have been even greater had restrictive policies not been put in place. The primary source of reliable data on the immigrant population is the US Census Bureau. Although not ideal for addressing the impact of several specific policies within a given decade, census data has been used effectively in analyses that have estimated the flow of undocumented immigrants over time. Those analyses indicate that immigration is highly correlated with economic patterns; unauthorized immigration spikes during good economic times and recedes during bad economic times.⁸

The question of immigrant use of health services has been addressed by several recent studies, all of which have concluded that health care use and expenditures are lower among immigrants than among US natives.⁹⁻¹⁶ In fact, recent immigrants have lower health care expenditures than established immigrants.¹⁶ Quantifying the deterrent effect of policies on immigrant health service use is difficult given the limitations of trend data on this subject. The leading sources of health care use and cost data, the National Health Interview Survey and the Medical Expenditure Panel Survey, started collecting data on nativity and citizenship only in 1997, by which time it was too late to adequately assess the effects of previous policies on immigrant health service use. There-

fore, no one has published an analysis that examines the impact of health policies on migratory flows into the United States. Going forward, the policy community will have sufficient data available to assess the impact of the Affordable Care Act on immigrants.

Conclusion

Proponents of policies that restrict immigrants' access to health care believe that public policies should support tax-paying citizens rather than noncitizens who have not paid taxes or recent citizens whose tax payments do not yet justify access to publicly funded programs. Proponents also believe that restrictions are necessary to prevent people who are unprepared to support themselves from entering the country. Policies that restrict access to public resources, such as health care, are believed to deter immigration in general, and illegal immigration in particular.

Opponents of policies that restrict immigrants' access to health care believe that doing so may endanger public health because immigrants may not get treatment for infectious diseases. Opponents also do not believe that restrictive policies deter immigration. Immigrants come to the United States in search of economic opportunities, not publicly funded programs.¹⁷

The fact is that US public policy over time has increasingly restricted access to health care for immigrants. Today, undocumented immigrants and persons who immigrated less than five years ago have few options for health care access through public programs, leaving only the option to pay out of pocket or to secure private insurance. The safety net available for immigrant populations includes hospital emergency rooms and federally qualified health centers. Such limited access is not optimal for accessing quality care and finding a medical home. Furthermore, these policies have merely shifted the financial burden of paying for the care of immigrants, and have potentially put the public's health at risk, as immigrants defer treatment for illness. Those on both sides of the debate will have to address these facts as the United States develops new policies directed toward immigrants and other vulnerable populations.

Exhibit 1. US Health Care Policies Specific to Immigrants, 1986-2010

Year	Policy	Effect on Immigrants
1986	Immigration Reform and Control Act of 1986 (S. 1200; Pub.L. 99-603; 100 Stat. 3359)	<ul style="list-style-type: none"> • Made it illegal to hire unauthorized immigrants • Offered amnesty to millions of illegal immigrants • Created the I-9 form, which certifies the eligibility of persons to legally work in the United States
1986	Emergency Medical Treatment & Labor Act (EMTALA) (H.R. 3128; Pub.L. 99-272)	<ul style="list-style-type: none"> • Ensured access to emergency services regardless of ability to pay or immigration status
1996	The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (H.R. 3610; Pub.L. 104-208; 110 Stat. 3009-546)	<ul style="list-style-type: none"> • Little implication for immigrant access to health care
1996	The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (H.R. 2260; Pub.L. 104-193; 110 Stat. 2105)	<ul style="list-style-type: none"> • Barred most legal immigrants from eligibility for Medicaid and the State Children's Health Insurance Program for the first five years they lived in the United States
1996	The Health Centers Consolidation Act of 1996 (S.1044; Pub.L. 104-299)	<ul style="list-style-type: none"> • Consolidated funding for community/migrant/federally qualified health centers, health care for the homeless, and health centers for residents of public housing • Aimed to reduce patient load on hospital emergency rooms • Provided a safety net for vulnerable populations' basic health care needs
2003	Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (section 1011 of H.R.1.ENR; Pub.L. 108-173)	<ul style="list-style-type: none"> • Provided a mechanism to reimburse eligible providers for unreimbursed costs of emergency health services delivered to undocumented aliens and certain other aliens • Alleviated the financial burden of hospitals that are required to provide care in emergency rooms regardless of a patient's ability to pay
2005	Deficit Reduction Act of 2005 (S.1932; Pub.L. 109-171)	<ul style="list-style-type: none"> • Required documentation of citizenship to receive Medicaid
2010	Patient Protection and Affordable Care Act of 2010 (H.R.3590; Pub.L. 111-148) & Health Care and Education Reconciliation Act of 2010 (H.R. 4872; Pub.L. 111-152)	<ul style="list-style-type: none"> • Minimal impact for legal immigrants • Immigrants must verify citizenship status to be eligible for federal premium credits • Undocumented immigrants <ul style="list-style-type: none"> ○ Will not receive any federal coverage ○ Are not eligible for Medicare, nonemergency Medicaid, or the Children's Health Insurance Program ○ Are not allowed to purchase private health insurance at full cost in state insurance exchanges ○ Are not eligible for premium tax credits or cost-sharing reductions ○ Are exempt from the individual mandate ○ Remain eligible for emergency medical care under federal law and for Emergency Medicaid, depending on state policy

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Conflict of Interest

None.

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