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# Trends In Health Care Spending For Immigrants In The United States

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**ABSTRACT** The suspected burden that undocumented immigrants may place on the U.S. health care system has been a flashpoint in health care and immigration reform debates. An examination of health care spending during 1999–2006 for adult naturalized citizens and immigrant noncitizens (which includes some undocumented immigrants) finds that the cost of providing health care to immigrants is lower than that of providing care to U.S. natives and that immigrants are not contributing disproportionately to high health care costs in public programs such as Medicaid. However, noncitizen immigrants were found to be more likely than U.S. natives to have a health care visit classified as uncompensated care.

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In 2009 President Barack Obama was called a liar during a joint session of Congress after assuring members of the House and Senate that undocumented immigrants would not be eligible for federal subsidies to purchase health insurance under his proposed reforms. This outburst underscores how current controversy over U.S. policies toward immigrants is fueled in part by the perception that they burden taxpayer-supported systems such as publicly funded health care. However, the facts about patterns of health care use among immigrant populations are more complex, and less well understood, than is often conveyed in the public debates.<sup>1,2</sup>

## Immigration: Background

A central fact in the immigration debate in the United States is the growth of the immigrant population. Data from the Current Population Surveys from 1999–2006 indicate that the immigrant population grew by about 8.5 million people during that period. Most of that growth was fueled by people coming to the United States from Latin America. (The Current Population Survey does not track undocumented immi-

grants, and therefore it is unknown what portion of this 8.5 million number might have been undocumented.) The share of the U.S. population composed of foreign-born people surpassed 12 percent in 2003, which is the highest rate since 1930.<sup>3</sup>

As a consequence, the policy debate has questioned the impact of a growing immigrant population on public resources, particularly the impact on health care costs. Immigrants were profoundly affected by a major policy shift in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which denied Medicaid eligibility to immigrants until they had lived in the United States for at least five years. Little is known about the impact of the act on the use of medical services by immigrants, and this area needs further study.

Notwithstanding the act, however, both legal and undocumented immigrants may be eligible for emergency care under Medicaid. Emergency Medicaid services are available only to certain classes of Medicaid-eligible populations such as children, pregnant women, families with dependent children, and elderly or disabled people who meet specific income and residency requirements. One recent study ascertained the emer-

gency Medicaid spending for undocumented immigrants in North Carolina.<sup>4</sup> The results showed that spending increased across the board by 28 percent during 2001–2004. Most of the expenditures were related to childbirth or complications related to pregnancy; the remainder were concentrated in severe complications of chronic diseases.

Some recent national studies have attempted to estimate overall health care spending for immigrants. Using 1998 nationally representative data, Sarita Mohanty and colleagues concluded that health care expenditures for foreign-born people were 55 percent lower than those for U.S.-born people.<sup>5</sup> Supporting evidence for this conclusion came from a study that used data from the 2000 Los Angeles Family and Neighborhood Survey.<sup>6</sup> The study found that immigrant expenditures were lower than expenditures for the native-born relative to their share of the population, but it also concluded that immigrants were less likely than the native-born to use public sources of funding for health care.

These findings have been further updated by a recently published study using 2003 data from the Medical Expenditure Panel Survey (MEPS).<sup>7</sup> The study found that recently arrived immigrants had lower health spending than more established immigrants. Both groups had lower health care spending than U.S.-born people. This study further documented the fact that medical spending for immigrants is 14–20 percent lower than spending for the native-born.

Much of the current debate on immigration has centered on whether undocumented immigrants should be granted citizenship or some other form of permanent residency status that could make them eligible for public services—in particular, for health care. Limited information from cross-sectional studies suggests that immigrants use fewer public monies for health care than native-born people. However, there is little information comparing expenditures by citizenship status and even fewer data about trends in public expenditures by nativity and citizenship status.

Information about trends in health care spending may further inform the public debate about whether immigrants' use of public services such as health care is a growing problem. Therefore, this paper compares national trends in public spending for health care of adult naturalized citizens and immigrant noncitizens relative to U.S. natives. It does not attempt to directly measure health care expenditures for undocumented immigrants.

## Study Data And Methods

**DATA SOURCES** Secondary data analysis was performed with publicly available data from the 1999–2006 Medical Expenditure Panel Surveys (MEPS). This nationally representative sample of civilian, noninstitutionalized people living in the United States is a two-year overlapping panel design, consisting of five rounds of personal interviews held over the course of two calendar years.

Respondents' medical care providers were also surveyed to supplement and verify respondents' health care information. The sampling frame for the survey is drawn from the National Health Interview Survey (NHIS).<sup>8</sup>

Linkage files are available from the National Center for Health Statistics, which allow data from MEPS to be merged with data from the previous year's NHIS. For example, data for people surveyed in Rounds 1, 2, or 3 of the 2006 MEPS may be linked with corresponding data for these people from the 2005 NHIS using the appropriate linkage file.

However, some respondents cannot be matched between the two surveys. These include previously institutionalized people, former military personnel, people returning from out of the country, newborns, or the deceased. In 2006, respondents who could not be matched between surveys represented 12 percent of the sample. There were no statistically significant differences by nativity status.

Information on nativity and legal status was captured from the NHIS and merged with data from MEPS. Data on citizenship were not available in MEPS before 1999. Respondents' medical care providers reported medical spending data. The enumerated categories were defined as people born in the United States, naturalized citizens, and noncitizen immigrants. The data set included 196,670 U.S. natives, 13,958 naturalized citizens, and 21,761 noncitizen immigrants for 1999–2006.

Annual inflation and age-adjusted spending per capita are presented by nativity and citizenship status over an eight-year period. The Consumer Price Index—All Urban Consumers (CPI-U) was used to adjust expenditure estimates to 2008 dollars. Age-adjusted estimates are standardized to the U.S. population age distribution in the 2000 census. *Public expenditures* are defined as reimbursement from federal, state, and local government health insurance programs including Medicare; Medicaid; Department of Veterans Affairs (VA); Tricare and its predecessor program, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and other public programs.

Given the concern over the use of taxpayer

dollars for health care expenses, the cumulative distributions of public expenditures per capita are calculated for the eight-year study period. Age-adjusted trends in uncompensated or charity care are also presented as a percentage of total visits to health care settings. Uncompensated or charity care was defined by charges that had not been paid by any source. These charges could have been incurred at a hospital or ambulatory care facility. STATA software, version 10.1 SE, a statistical software program, was used to adjust for sample weights and the complex sample design.

**STUDY LIMITATIONS** The findings from this study should be viewed in light of some limitations. First, we were not able to separately enumerate legal residents and undocumented or unauthorized immigrants. It is likely that there are major differences in insurance characteristics, use of services, and spending for these groups that may affect the trend in medical costs. For example, at least some legal residents may be eligible for public assistance programs such as Medicaid.

Another limitation is that although the Personal Responsibility and Work Opportunity Reconciliation Act limits access to Medicaid for recent immigrants, some states have the option to cover immigrants who are ineligible for federal programs. Future analyses are needed that either account for state of residence or com-

pare different states with different policies and approaches toward covering immigrants' health expenditures.

However, although naturalized citizens qualify for federal and state programs, differences in public spending per capita between naturalized citizens and noncitizens were small. Analysis of public spending and citizenship for the Northeast region, in which most states provide Medicaid to immigrants, also showed that spending for noncitizens was generally lower than spending for U.S. natives.

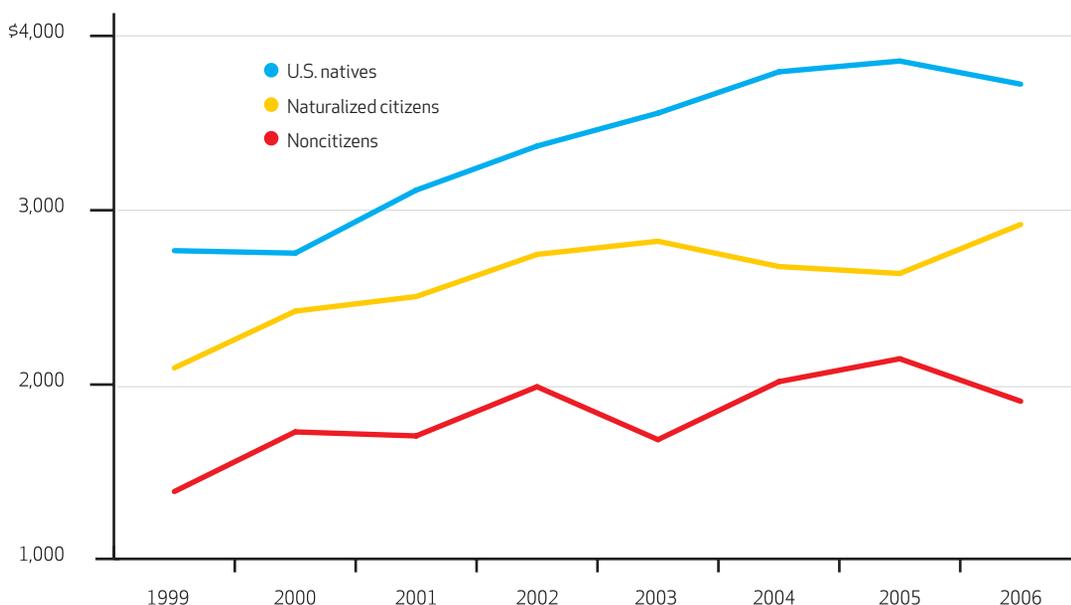
Finally, this study adjusted for age, but several factors that contribute to health spending will vary by nativity and legal status. These include health behavior, health status, access to health care, and other demographic characteristics. We performed supplemental analyses that stratified the findings by sex and ethnicity. However, the results were inconclusive because the additional stratifications reduced the sample size for each immigrant group and therefore increased the standard error.

## Study Findings

**TOTAL HEALTH SPENDING** Nearly 12 percent of people in the United States are immigrants. Of these, 47 percent are naturalized citizens and 53 percent are noncitizens. Exhibit 1 shows the trend in

### EXHIBIT 1

**Age-Adjusted Total Per Capita Health Spending (2008 Dollars) For U.S. Natives, Naturalized Citizens, And Noncitizens, 1999–2006**



**SOURCE** Authors' analyses of data from Medical Expenditure Panel Surveys, 1999–2006.

total health care spending per capita, adjusted for age and inflation, by people born in the United States, foreign-born naturalized citizens, and foreign-born noncitizens. From 1999 to 2006, expenditures increased for all groups.

However, average expenditures for naturalized citizens were significantly smaller from 2001 to 2005. Expenditures for noncitizens were about 50 percent smaller, on average, than those for U.S. natives. For example, in 2006, total per capita spending for noncitizens was \$1,904, while that for U.S. natives was about \$3,723. Spending for noncitizens increased by only \$500 after 1999; in contrast, spending for U.S. natives increased nearly \$1,000. In fact, noncitizens' health care spending was lower than that of naturalized citizens for every year. From 1999 to 2006, differences in per capita spending increased by more than 30 percent between U.S. natives and noncitizens.

**PUBLICLY FUNDED HEALTH SPENDING** Exhibit 2 shows the trend in age-adjusted real public-sector health care spending per capita by U.S. natives, naturalized citizens, and noncitizens. Differences between noncitizens and naturalized citizens were generally insignificant after 1999. However, public spending for noncitizen immigrants was significantly lower than that for U.S. natives and naturalized citizens in 2003.

Public spending for U.S. natives was slightly higher than spending for immigrants in every year of the study period.

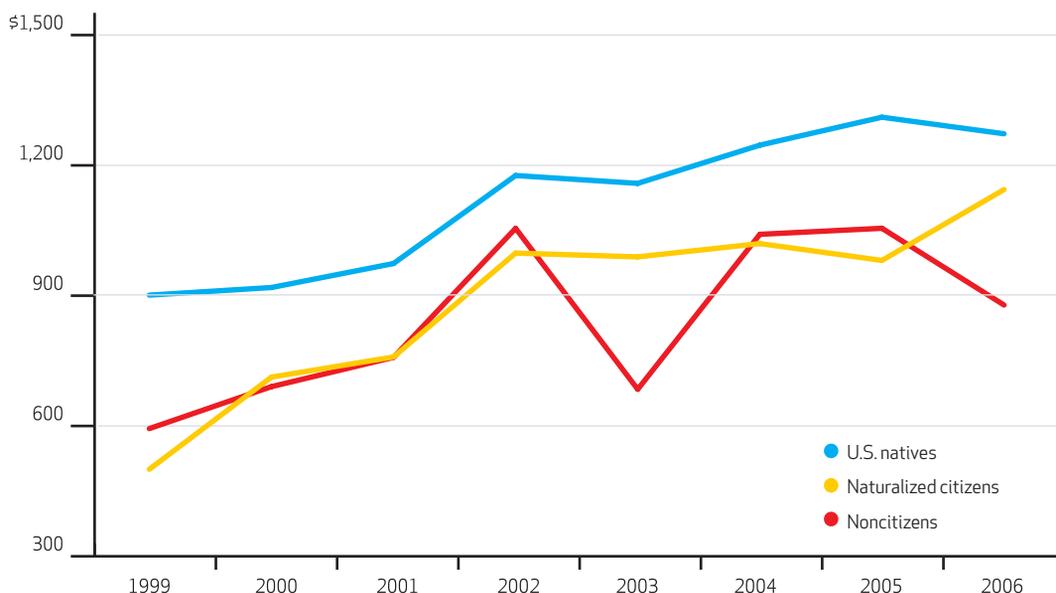
Although average public expenditures were lower for noncitizens, this may be the result of noncitizens' being less likely than citizens to be covered under public insurance programs. If covered under public insurance, immigrants may have disproportionately high public health spending. To examine this possibility, Exhibit 3 presents the distribution of public per capita expenditures by immigrant status for people who had positive public health care expenditures over the eight-year study period. Overall, noncitizen immigrants had proportionally lower public health expenditures than U.S. natives and naturalized citizens.

For example, 50 percent of noncitizens had public per capita expenditures of \$200 or less, while 50 percent of naturalized citizens had per capita public expenditures up to \$1,100. The distribution of public expenditures was consistent from 2000 to 2006. However, the distribution was different in 1999. At that time, U.S. natives accounted for a slightly larger proportion of public expenditures than the immigrant population.

Even after enactment of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, states may choose to provide state-

**EXHIBIT 2**

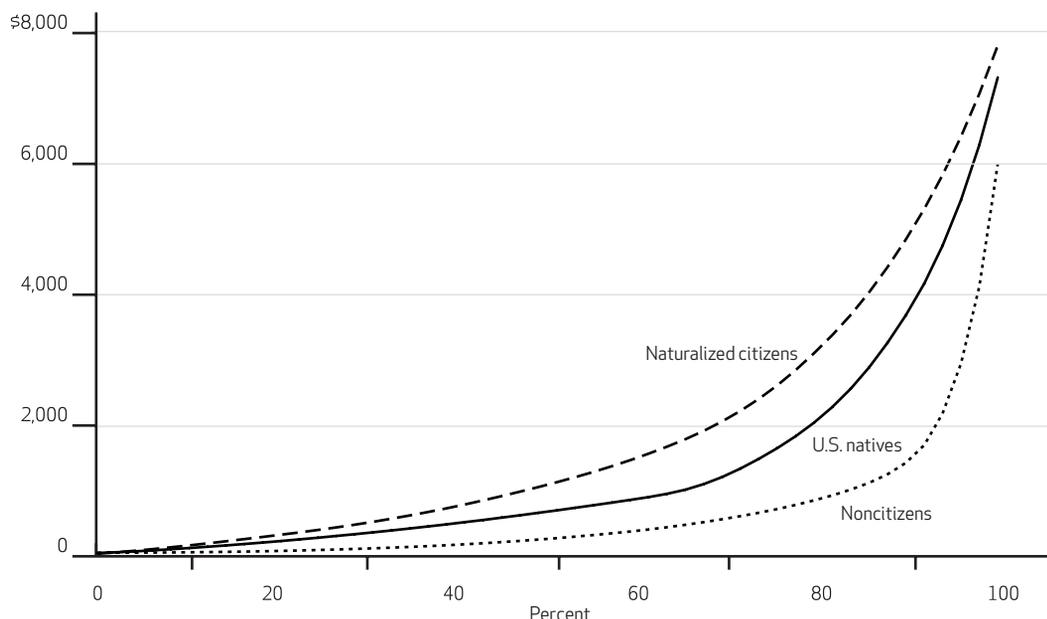
**Age-Adjusted Public-Sector Per Capita Health Spending (In 2008 Dollars) For U.S. Natives, Naturalized Citizens, And Noncitizens, 1999-2006**



SOURCE Authors' analyses of data from Medical Expenditure Panel Surveys, 1999-2006.

**EXHIBIT 3**

**Distribution Of Age-Adjusted Public-Sector Per Capita Health Spending For U.S. Natives, Naturalized Citizens, And Noncitizens, 1999–2006**



**SOURCE** Authors' analyses of data from Medical Expenditure Panel Surveys, 1999–2006.

funded coverage for immigrants otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP). To examine the effect of this coverage on public expenditures for noncitizens, we examined public expenditures per capita for the Northeast region. The region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; of these, only Vermont and New Hampshire do not offer state coverage of immigrants.

For the period 1999–2006, noncitizen immigrants in the Northeast had lower average public expenditures than naturalized citizens or U.S. natives: \$1,200 for U.S. natives and \$780 for noncitizen immigrants.<sup>9</sup>

**UNCOMPENSATED CARE** As was not the case in the previous exhibits showing trends in expenditures per capita, it is difficult to assign a dollar figure for uncompensated care. Provider charges are unreliable measures of health care expenditures. Therefore, trends in uncompensated care are presented in Exhibit 4 as a percentage of people having at least one uncompensated health care visit in a year.

Over eight years, uncompensated care declined for all groups after 1999, but the decline was steeper for noncitizens than for other groups studied. Health care providers were sig-

nificantly less likely to receive compensation for services from noncitizens than naturalized citizens and U.S. natives. For example, approximately 13 percent of noncitizens had one or more uncompensated visits in 2006, compared to 11 percent of U.S. natives. However, the difference between U.S. natives and noncitizens in uncompensated care was small, in the range of 2–4 percent.

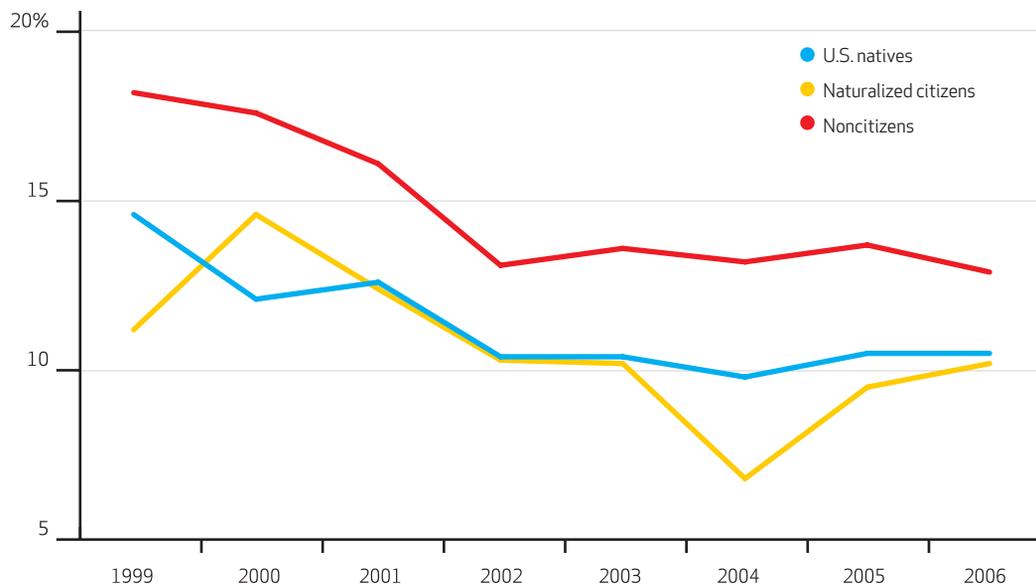
**Discussion**

Our study not only documents the trend in expenditures by nativity, but also highlights how residency status in the United States is an important contributor to the cost of health care services. The findings of this study support those of previous cross-sectional research that found health care expenditures to be lower among immigrants compared to U.S. natives.<sup>4–7</sup> We found that inflation and age-adjusted health care expenditures among noncitizen immigrants were consistently been lower than those of naturalized citizens and U.S. natives during 1999–2006. These results suggest that immigrants might not be disproportionately contributing to high health care costs in the United States.

Our findings also support other research showing that established immigrants have

## EXHIBIT 4

## Trends In The Age-Adjusted Percentage Of People With Uncompensated Care, By Immigration Status, 1999–2006



SOURCE Authors' analyses of data from Medical Expenditure Panel Surveys, 1999–2006

higher expenditures than recent immigrants.<sup>7</sup> We found that age-adjusted health care expenditures were consistently higher for naturalized citizens than for noncitizen immigrants. This finding makes sense, given that federal law prohibits immigrants from applying for Medicaid (unless covered solely by states) until they have lived here for five years. Furthermore, compared to noncitizen immigrants, naturalized citizens have easier access to employment opportunities with higher compensation or employer-sponsored insurance.

By extension, this study found that noncitizen immigrants were more likely than U.S. natives to have a health care visit classified as uncompensated care. If immigrants face financial barriers to health insurance and are more likely than others to live in poverty, then it is more likely they will receive uncompensated care, either as charity care or as care that goes unpaid-for. Therefore, although the intention of tightening residency requirements for immigrants to qualify for government health care programs is to reduce health care costs, our findings suggest that even if immigrants are not covered by insurance, they still incur costs that need to be paid. Therefore, providers experience higher rates of uncompensated care, which is passed on to insured consumers through higher charges for other services.

There is evidence that differences in spending

between noncitizen immigrants and U.S. natives grew during 1999–2006. Growth in health care spending is expected, given that national trends show that health care is fast becoming a major contributor to U.S. gross domestic product (GDP).<sup>10</sup>

However, it is notable that noncitizens' per capita spending remained relatively flat over this period. Recent studies have reported that rates of health care use are lower among immigrants compared to natives.<sup>11</sup> It is likely that lower expenditures are due to lower need for services and to increasing barriers to care such as fear, lack of insurance, or lack of a regular provider.<sup>12</sup>

Health insurance coverage and the percentage of people reporting a usual source of care are lowest in immigrant and minority populations.<sup>12–15</sup> Barriers to health care in the United States may lead to substitution of complementary and alternative care outside of the formal U.S. medical care system, or to return migration to one's country of origin to seek medical care.<sup>16</sup> Further research is needed to identify how expenditures have remained consistently low among noncitizen immigrants.

## Conclusion

By documenting trends in health care expenditures for immigrants, we hope through this study to inform the public debate on whether immi-

grants' use of health care resources is a growing problem for public programs. We conclude that health care expenditures for the average immigrant have not been a growing problem relative to expenditures among U.S. natives.

Given the findings from this and other studies, the balance of the evidence appears to suggest that providing health care to immigrants costs significantly less than providing it to the native-born. In fact, noncitizens, most of whom are recent immigrants, use fewer health care resources than even naturalized citizens. The one exception appears to be that noncitizens have a significantly greater proportion of uncompensated and charity care than naturalized citizens or U.S. natives. However, this finding likely reflects noncitizens' poor access to care and low socioeconomic status.

These findings have important implications regarding both immigration reform and health care reform. The debate about health reform

throughout 2009 ignored how the immigrant population, and particularly noncitizens, would be treated under a new system. The Personal Responsibility and Work Opportunity Reconciliation Act blocked immigrants' access to much public health insurance coverage, which we suspect is partly responsible for the high level of uncompensated and charity care being provided to noncitizens. The noncitizen and recent immigrant populations have been given few options to obtain high-quality, affordable health care.

Careful study will still be needed to estimate how changes in national immigration policy will affect public health care programs. Meanwhile, future federal and state health insurance initiatives should consider the evidence presented in this and other recent studies that show that the cost of providing care to U.S. immigrants is lower than that of covering U.S. natives. ■

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## NOTES

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