Improving access to health care for undocumented immigrants in the United States

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Wallace SP, Rodriguez M, Padilla-Frausto I, Arredondo A, Orozco E.
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Salud Publica Mex 2013;55 suppl 4:S508-S514.

Abstract

Objective. To identify policies that increase access to health care for undocumented Mexican immigrants. **Materials and methods**. Four focus groups (n=34 participants) were conducted with uninsured Mexican immigrants in Los Angeles, California. The feasibility and desirability of different policy proposals for increasing access were discussed by each group. **Results**. Respondents raised significant problems with policies including binational health insurance, expanded employer-provided health insurance, and telemedicine. The only solution with a consensus that the change would be feasible, result in improved access, and they had confidence in was expanded access to community health centers (CHC's). **Conclusions**. Given the limited access to most specialists at CHC's and the continued barriers to hospital care for those without health insurance, the most effective way of improving the complete range of health services to undocumented immigrants is through immigration reform that will bring these workers under the other health care reform provisions.

Key words: health services accessibility; undocumented immigrants; health policy; medically uninsured; insurance health United States; Mexico

Wallace SP, Rodriguez M, Padilla-Frausto I, Arredondo A, Orozco E.
Mejor acceso a la atención en salud para inmigrantes indocumentados en los Estados Unidos.
Salud Publica Mex 2013;55 supl 4:S508-S514.

Resumen

Objetivo. Identificar políticas para mejorar el acceso a la salud en migrantes indocumentados mexicanos en los Estados Unidos. **Material y métodos**. Se realizaron cuatro grupos focales (34 participantes) con migrantes mexicanos sin seguro médico residentes de Los Ángeles, California. Se discutieron la factibilidad y pertinencia de varias propuestas de políticas de mejora en el acceso. **Resultados**. Los participantes identificaron limitaciones profundas con propuestas como seguro binacional de salud, expansión de seguro por medio de trabajo y programas de telemedicina. La única con consenso de factibilidad, accesibilidad y pertinencia fue el crecimiento de la red de centros a la atención de salud comunitaria (CHC por sus siglas en ingles). **Conclusiones**. Dado la escasez de especialistas en CHC y las barreras para acudir a hospitales cuando no cuentan con seguro médico en EUA, la manera más eficaz para mejorar acceso para migrantes indocumentados es por medio de una reforma de las leyes de migración.

Palabras clave: acceso a los servicios de salud; migrantes indocumentados; política de salud; seguro de salud; pacientes no asegurados; Estados Unidos; México

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Fecha de recibido: July 6, 2011 • **Fecha de aceptado:** May 8, 2012
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Health insurance is the best predictor of having access to health care in the United States.[1,2] Access barriers can lead to more costly and serious health problems and hospitalization for avoidable conditions.[3,4] Mexican immigrants are among the least likely to have health insurance of any population. In 2007, over half of all immigrants from Mexico in the US had no health insurance, compared with 19% of non-Latino immigrants and 12% of US-born non-Latino whites.[5] Unauthorized immigrants (undocumented) were over twice as likely to have no insurance as documented immigrants (59 versus 24% without health insurance).[6]

Work-based health insurance is the primary source of health insurance for both immigrants and natives. Mexican immigrants in the US have a higher labor force participation rate than US-born non-Latino whites (hereafter referred to as US-born whites), but a majority of Mexican immigrants are concentrated in low-wage industries such a construction and service occupations that are the least likely to offer health insurance. Nationally, three-quarters of employed US-born white men obtain health insurance through their work. In contrast, under one-quarter of Mexican immigrant workers in heavily Mexican immigrant occupations obtain work-based health insurance, and under half of Mexican immigrant workers in non-immigrant dominated occupations obtain work-based insurance. The pattern for employed women is similar.[7] Even though the employment coverage rate for Mexican immigrants is low, it is still the most common source of health insurance for adults. Most of this gap in coverage is the result of employers not offering insurance to their low-waged workers.[8,9]

The Affordable Care Act (ACA) of 2010 changes the landscape for health insurance coverage. Employers will be incentivized to provide health insurance to their workers, the eligibility requirements for public insurance (Medicaid) for low-income persons will be broadened, and individuals will be required to purchase private health insurance if they do not have employer-provided or public insurance. The government will offer subsidies to purchase private health insurance for low-income persons. Legal permanent resident immigrants (LPRs) will not qualify for federally-financed public health insurance, Medicaid or State Children's Health Insurance Programs (SCHIP), during their first five years in the country, although several states have covered that group with nonfederal funds in the past. LPRs will be eligible for subsidies to purchase private insurance even during their first five years. Undocumented immigrants are explicitly barred from all insurance subsidies and the mandate that they have insurance coverage, although many will continue to obtain health insurance through their employer as they have in the past.[10,11] Undocumented immigrants will continue to have access to publically funded community health centers (CHC's which are primary care clinics) where the charges are adjusted by the patient's ability to pay, as well as emergency Medicaid that pays for hospital care for low-income uninsured persons in life-threatening situations.[12] The ACA has also added substantial new resources to the CHC network which will expand their capacity.[13]

California has a larger share of immigrants than any other state, with an estimated 10 million residents who were born abroad. Over 4 million California residents are Mexican immigrants; an estimated 2.7 million of them are undocumented.[6] California mirrors the country with high rates of uninsurance among documented Mexican immigrants (25%) and especially among the undocumented (53%).[14] The large number of uninsured and undocumented Mexican immigrants presents a special challenge when attempting to expand health insurance coverage as envisioned under the ACA.

Access to health care varies between different groups of Mexican immigrants and US-born whites in California. The proportion reporting a usual source of care is lowest among undocumented Mexican immigrant adults (66%), increasing for those with a green card (79%), US-born Mexican Americans (88%), and US-born whites (92%).[15] Health insurance has the largest impact on having a usual source of care and having a doctor visit for all Mexican immigrants; it is also one of the largest predictors of emergency department and obtaining needed medications.[14]

Barriers to health care in the United States may lead some Mexican immigrants to seek care back in Mexico. Nationally, 9% of Latino immigrants report obtaining some of their medical care, dental care, or prescription drugs outside of the US in the past year.[16] In California, 13% of Mexican immigrants report receiving one of those medical services in Mexico during the past year.[17] These studies suggest that there is a likely demand for health care coverage by immigrants that transcends national borders.[18]

In order to better understand how to improve access to care for Mexican immigrants in California, we conducted focus groups with noncitizen Mexican immigrant adults who had no health insurance. We identified the most significant current barriers to care for them, and asked about the feasibility and attractiveness of several different approaches to improving their access to care.

Materials and methods

Four focus groups were held in late 2008 with Mexican immigrants, mostly undocumented, who had no current health insurance. One group was all male day laborers, one was all female domestic workers, and two were parents (all women) of young children. A total of 34 immigrants participated in the focus groups that ran 40-60 minutes each. Recruitment for the groups was facilitated by Instituto de Educación Popular del Sur de California (IDEPSCA), a community-based organization that provides advocacy and services for Spanish-speaking immigrants. Participants were each given an information sheet describing the study in Spanish which was reviewed orally and they then provided verbal consent. Participants were asked about where they and their families currently go for medical care, about any use of medical care in Mexico, and about their opinions on different ways of expanding access to care for immigrants in California. All groups were conducted in Spanish by a bilingual doctoral student, tape recorded, and transcribed. No identifying information about the respondents was recorded and participants were given a $25 gift card at the end of the focus group. The protocol was approved by the University of California, Los Angeles (UCLA) Office for the Protection of Human Subjects. Transcripts were coded independently by three researchers who reviewed their analyses together to create the following analysis.

Different options for expanding access to healthcare were presented to the focus groups to obtain their perceptions of advantages and disadvantage for each approach. The approaches were developed based on discussions with key policy informants in California and Mexico concerning options that they saw as viable for expanding access. This article provides data on the approaches most often discussed in policy circles, binational health insurance and expanded employer provided health insurance. We also provide data on the participants' reaction to expanded community health centers, since that is a component of the ACA, and telemedicine as a way to increase the availability of specialists at community clinics.

Results

Binational health insurance

Binational health insurance provides insurance that can be used in two different countries, such as offering primary care in the US while diverting expensive treatments to providers in Mexico. The savings could lead to lower premiums, making this type of product more affordable for low waged workers. In addition, if the insurance provides family coverage, it could provide coverage for any of the worker's family that remains in Mexico. Since some remittances are already used for health care in Mexico, this approach could provide a predictable level of health care access as well as insure against catastrophic costs.

Private binational health insurance between the United States and Mexico is already offered through a few organizations, including HealthNet, Blue Shield of California, Pacificare and SIMNSA.[19] In the late 1990s California passed legislation that allowed insurance companies to have provider networks on both sides of the border. Current products are marketed as low-cost options that provide primary care in both the US and Mexico, but more expensive hospital care primarily in Mexico. These policies have been sold mostly to employers located near the border, and the total number of enrollees has remained relatively small (under 300 000 total).

A public binational health insurance, "Salud Migrante", also exists. It builds on Seguro Popular in Mexico and care through community health centers for primary care in the United States. It provides comprehensive coverage for the families of immigrants who remain in Mexico through the Seguro Popular network, primary care for immigrants in the US through referrals to community health centers, and catastrophic coverage in Mexico for the immigrants.[20,21]

Focus group participants, who were mostly undocumented immigrants, voiced a number of concerns about binational health insurance. The most significant concern was that those who were not US legal permanent residents would find it difficult and risky to try to reenter the US after receiving services in Mexico. This would deter undocumented residents from seeking most types of care across the border.

> It's like a trick. You're sick, you have the flu, and you go to your country and when you want to return you have to remain! We can leave but not return

One focus group participant suggested the only way binational care could work would be if the US issued a temporary reentry visa for those leaving the country for medical care.

A second concern was that a limited, closed network of providers in the US in a binational plan might not increase the actual level of access to care compared with what the uninsured immigrants already have through low-cost programs at community clinics and public health care centers.

Participants in the focus groups liked the idea of having expanded coverage for family members in

Mexico, but those who participated in our groups had few children who remained in Mexico. The family most commonly left behind included grandparents, parents and siblings. Money that was being sent to Mexico for health care needs was mostly used for private providers in Mexico, so a binational product that relies on the public system of Seguro Popular would not be seen as providing an added benefit. The response is likely to be different for the sizeable number of recent migrants not represented in these focus groups who still have children in Mexico.

Employer mandated health insurance

As noted earlier, employer-sponsored health insurance is the most common source of insurance for both immigrants and US-born whites. A key component of the ACA is to incentivize employers to provide health insurance to their workers.[10] For undocumented immigrants, in particular, this might be attractive since private insurance offered through employers does not make any additional demands for proof of legal residency. In California, expanding employer provided insurance could be particularly effective in covering uninsured undocumented adults since three-quarters of uninsured undocumented adults are in families with at least one full-time employee (compared to 57% of uninsured citizens[22]). Of the uninsured projected to be newly covered under the ACA in California, 16% are expected to receive new coverage through their employer.[23]

Participants in the focus groups generally thought that employer provided insurance was a good idea, but not one that would help them. Most of the uninsured Mexican immigrants in our focus groups reported that they worked for multiple employers, were part time workers, or worked for cash and would therefore not qualify as a "full-time" employee of a business. In addition, migrant workers, who may have a single employer full-time, but only for a short amount of time, would likely not be eligible. It is difficult to estimate what percent of uninsured, undocumented workers would be impacted by having multiple part time jobs, cash wages, or other characteristics that would exclude them from employer-provided insurance, but it is likely to be significant.

Expanded community clinic access

Instead of expanding "coverage" via insurance, an alternative approach to improving access is by focusing on improving "care." In California's health care reform proposals of 2008, community health centers (CHCs) and county clinics were designed to provide the health care for undocumented immigrants who would not otherwise be covered.[24] As existing safety net providers, they are already located in underserved communities and often provide culturally competent and bilingual staff. The 2010 ACA included a significant increase in the capacity of this sector,[25] which should improve access for immigrants, and to the extent that undocumented immigrants already use those services it could provide a broad-based improvement in access. The advantages of providing "care" rather than "coverage" are that additional resources could be devoted to primary care and prevention rather than expensive hospital care (unlike insurance policies that are required by law to include hospital care), existing CHCs are sites where many immigrants already obtain services without fear about their documentation status, and expanding coverage is administratively less complex than using insurance products. The Salud Migrante insurance proposal noted earlier also builds on this public clinic network.

Overall, the expansion of CHCs was the consensus choice of the participants in the focus groups. The respondents liked the fact that they were often already receiving care at these locations and that additional resources could improve the responsiveness of care (e.g. shorter wait time) and make it more affordable. Unlike insurance linked to employment, coverage through clinics would be available when the person was unemployed or did not otherwise qualify for employer-provided insurance. "There is more security there, right? Because it doesn't depend on employment."

One disadvantage of relying on primary care clinics is the limited range of services that they offer. Focus group respondents wanted to know how they would get lab tests and x-rays that were not available at some CHCs. Another drawback would be difficulty obtaining referrals to specialists, which is already an issue for some specialties even when the patient has public insurance like Medicaid. One participant liked the concept of expanded clinic services based on a good experience she had through a CHC when she had been referred and quickly seen for needed specialist care after a positive mammogram. She was not aware of how it was paid, but it was probably covered under California's Medi-Cal Breast and Cervical Cancer Treatment Program (BCCTP) that covers undocumented women.[26] She would likely have had much less access to care if she had been diagnosed with colon cancer where there is no special program to improve access for the uninsured that includes the undocumented.

The participants all wanted improved access and quality of care. They were not enthusiastic about being required to go to the same "mediocre" public hospitals and clinics that they are currently limited to; if there is no improvement in the quality of care received they would see little benefit to "enhanced access" since those services are already low or no cost.

Telemedicine for specialty care

There has been growing interest in the US in the use of telemedicine to provide care to underserved areas.[27] The focus group respondents complained about limited access to specialist and referral services, a common problem for all uninsured persons.[28] One way to increase access to culturally and linguistically appropriate services would be to provide telemedicine consultations from US clinics to specialists in Mexico. This idea was raised by a Ministry of Health delegation from Mexico City during a visit to UCLA; the Mexican officials expressed interest in a collaborative pilot test of the idea.

None of the immigrants expressed interest in this option. Few had ever heard of the concept and the option seemed strange and abstract. Respondents raised numerous reservations, including distrust of the credentials of people on the screen, the inability of the doctors in Mexico to perform examinations, and uncertainty about their quality. One respondent summed it up by saying, "How are we going to be sure that it is a real doctor that we're talking to (on the screen)?" Similar concerns were voiced by low-income African-Americans in a different study.[29]

Discussion

Health care reform in the US under the Affordable Care Act (ACA) will significantly reduce uninsurance rates, but undocumented immigrants are explicitly excluded from the health insurance expansion provisions. The uninsured and mostly undocumented immigrants in our Los Angeles focus groups offered insights into what is likely to work best in expanding health insurance and access to health care for undocumented immigrants. The respondents are not a representative sample of uninsured Mexican immigrants or the undocumented, so their insights cannot be generalized to the entire population of Mexican immigrants. They can, however, alert us to important issues that have not been addressed by the ACA.

Respondents discussed two insurance and two access proposals. They explained that binational health insurance will not expand access for the undocumented since they already receive low-cost care at community clinics in the US and would be unable to easily return after receiving care in Mexico. Most remittances sent to Mexico for medical care by our respondents were to provide access to private providers for adult and elderly family members, making a family component of binational insurance through Seguro Popular unattractive. While many immigrants have children back in Mexico, other research suggests that remittances have a greater effect on health care spending when older adults are in the household, even when controlling for their higher likelihood of needing health care.[30] Thus, binational family coverage may be attractive for some immigrants, but the mix of child and elderly health needs in Mexico should be taken into account.

Employer-provided insurance encouraged by the ACA will not reach a large proportion of undocumented immigrants since many have no permanent formal full-time employer, even though most work full-time. In addition, almost three-quarters of recent Mexican immigrants work for small employers (<50 employees) who are exempt from the ACA employer mandate. Finally, undocumented immigrants' concentration in seasonal occupations like construction and agriculture, as well as in occupations that are less likely than others to offer full-time work as in the service sector, suggest that employer provided insurance is not likely to expand coverage significantly for this group.

Improved access to community health centers (CHCs), which is also a component of the ACA, was the consensus preference for expanded access, despite limited access to specialists at those centers. Respondents were negative about using telemedicine with specialists in Mexico as a way of expanding specialist consultations. In any solution, the participants prioritized reducing the amount of time they have to wait for care, receiving services by the same doctor over time (versus ever changing residents, care in high-turnover settings, or high volume care where they have no choice of doctors), and affordability.

The respondents in the focus groups liked the idea of having security that they would be seen when they were sick. This was expressed in terms of the benefits of having health insurance.

> It is knowing that you can get in, that you don't have to apply since you already have coverage… that confidence of going and they see you at whatever time you get sick

The discussion of barriers to health care included multiple examples of long waits and a lack of treatment they experienced when seeking care at emergency rooms for injuries and illnesses that were not immediately life-threatening, and of high charges for emergency room and hospital care. Those barriers would not be addressed by expanded community clinic services.

The discussions of access to medical care were almost totally focused on medical care needs for health problems and not for prevention. Some participants joked that they were too poor to get sick and so had no experience in seeking medical care. While focus group members were mostly younger adults (ages 20-40),

there was little discussion of issues around reproductive health care (contraception, STDs).

While undocumented immigrants will continue to face the most barriers to health care, recent immigrants who are legal permanent residents (LPR, i.e. documented) will also continue to face insurance barriers in many states during their first five years in the country. After the ACA is fully implemented they can be barred from the public insurance programs Medicaid and the State Children's Health Initiative (SCHIP), but will still face a mandate that they have health insurance. They will be eligible for subsidized private health insurance, and several states use non-federal money to provide Medicaid to this population. Recent LPRs might be particularly attracted to low-cost binational health insurance since they are able to cross the border freely, are more likely to prefer the linguistic and cultural characteristics of care in Mexico, and may still have families in Mexico. Many Mexican immigrants in California already obtain some medical care in Mexico,[17] so it would be important that binational policies qualify as "creditable" insurance under the individual insurance mandate of the ACA.

Our research shows that the expanded funding for CHCs in health care reform is an important first step in improving access to care for undocumented immigrants who are excluded from public insurance under the ACA and are unable to easily cross the border for low cost care. CHCs are trusted sources of care for many, usually provide linguistically and culturally appropriate services, and are located in high-need communities. They provide critical primary care that is most needed by a generally young and healthy immigrant population, but they are limited in their ability to provide specialty and hospital care when it is needed. Community health centers accept insurance, and under health care reform will become increasing oriented to both Medicaid and private insurance as funding mechanisms.[25] As a consequence, it would best serve the undocumented if they were covered by health insurance. Given the restrictions on federal funding of health insurance for immigrants without documentation, the only way to assure their coverage is through immigration reform that provides a pathway to citizenship.

One focus group participant's closing words aptly summarizes the tenor of all four focus groups, "I have this dream, I hope that this [expanded health care access] becomes a reality, since it's the truth that it's really needed."

Declaration of conflict of interests. The authors declare that they have no conflict of interests.

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