Annals of Health Law

Volume 17
Issue 2 *Summer 2008*

Article 16

2008

Transcribed Speech of Dr. E. Richard Brown

E. Richard Brown

Transcribed Speech of Dr. E. Richard Brown

DR. BROWN: Thank you Dr. Parsi and thank you Professor Yearby for inviting me to this symposium. I'm very pleased to be here.

This is a very important topic, obviously, because we are in the midst of a debate on the issues of citizenship and immigration status and all the benefits that accrue to people on one side or the other of certain divides. That is really what this whole debate is about. It's about who we are, and who's a part of us. When we define who's a part of us and who we are, typically in every nation people define themselves in that way by defining who's not a part of their community. We see that tearing apart countries all over the world. A number of countries in Africa are having civil wars over these issues. Certainly the Iraq conflict is hugely about that issue and so, of course, are the battles in this country. The battles in this country touch health care in very critical ways so I'm very pleased to be here and be able to talk about this with my colleagues on this panel and then the other panels that preceded ours.

I'm going to actually zip through most of my slides because a lot of the information has already been presented by previous speakers. It's going to let me focus on a few points that I think are important to think about as we [set] about trying to solve the problem. [My presentation] actually touches on points that Dr. Pagán was trying to make in his presentation as well.

Compared to U.S. citizens, both U.S. born and naturalized, noncitizens are far less likely to have employment-based coverage, far less likely to have any other type of health insurance, and therefore more likely to be uninsured and more likely to face barriers accessing health care. They are less likely to have, what's called in health services research, 'a usual source of care,' meaning a place that people can identify when they feel they need information about their health, advice, or medical care. This is true even when we control demographic and labor market kinds of factors that we know shape people's need for health care and perceptions of their own need for health insurance. So when we control things like age, gender, education, and income on the sociodemographic side and when we control labor force participation and whether you're an employee versus self-employed worker, your occupation, or your industry, noncitizens still have less access to our health care system. These are data that I think make this point pretty clearly.

You can see here that noncitizens are far more likely to be uninsured. That's because they have much lower rates [of] employment-based health

insurance coverage. That's the distinguishing characteristic between noncitizen, on one hand, and both naturalized and U.S. born citizens, on the other hand. These national data are from the 2005 current population survey.

The same pattern holds even when we restrict our perspective to looking at just the low-income population . . . where noncitizens are . . . more concentrated than . . . citizens. So we see the same thing. [The low-income population has] twice the rate of uninsurance of naturalized citizens and lower rates of employer-based coverage [than naturalized citizens].

I'm going to turn to some California data, which looks at the citizenship and health insurance status of adult Californians. We're looking at their health insurance coverage over the last twelve months. These data are from my survey, the California Health Interview Survey. You can see that among citizens, only 18.7% were uninsured [for] all or part of the year in 2005, and 62% [of citizens] had job-based coverage. The figures are literally the opposite of that for noncitizens without green cards. In 2005, 62.8% [of noncitizens without green cards were] uninsured all or part of the year compared to 18.8% who had employment-based coverage all year during that time. Here you can see that the noncitizens who have green cards, those with a legal permanent resident status or other documents, fall right in between those two groups. We see a very similar pattern when we look at just working adults. These are adult workers, non-elderly adult workers, and we see the same kinds of differences between these groups.

The sins of the parents are also visited on the children, but not in ways you might necessarily expect. The first three rows [of the graph] are all U.S. citizen children. The first row [represents] those citizen children who have citizen parents. And you can see that they have the lowest uninsured rate—7.4% . . . . [Citizen children with parents who have a green card or who are noncitizens without a green card] have about a 14.5% uninsured rate. Children, who are themselves noncitizens, have a nearly 38% uninsured rate.

What we see in these slides, the previous slides, and this slide, is the incredible divide that citizenship makes. Naturalization brings nearly all the benefits in health insurance coverage that being a native-born citizen gives people. But those who do not have citizenship status are much more likely to be uninsured. You can see it in the last slide even for children.

The main barrier that uninsured workers face and the reason why they are so much more likely to be uninsured is that they are far less likely to work for an employer that offers coverage at all. Here we see that 84.6% of naturalized citizen workers work for an employer that offers benefits, 92% of them are eligible for those benefits, and 84% of those who are eligible take it up. Compare that to noncitizen workers. Sixty-one point three percent work for an employer that offers health benefits to anybody who

works in that workplace. But 88% of those who do work for an employer that offers it are eligible and nearly 77% of those who are eligible take it up. What's evident here is the huge gap between those two groups in what we call the offer rate compared to the eligibility rate and the take-up rate, which are much closer together.

Poor access to employment based insurance is actually the main barrier that both undocumented employees and citizen employees face and is the primary contributing factor to their being uninsured. Here we are comparing two populations. On the left are adult undocumented immigrant employees in California age nineteen to sixty-four, compared to citizen employees. We can see how similar those patterns look to each other. Among these uninsured employees, 78% of the undocumented have no access to employment-based coverage insurance through their own or family members' employment compared to 73% for citizen employees. Both have significant shares that have access to employment-based health insurance, but their families have very low incomes making it very likely that their employers offer an eligibility of health insurance [that] is unaffordable to them given the very high cost of coverage. In fact, in the United States today, the . . . average cost for an employment-based family health insurance plan is over $12,000 a year. The average employee is expected to pay over $9,000 of that to get coverage. So, if you think about many of these workers working in the average workplace, those would be the costs that they would face for family coverage. Hence, in California even though we see such high uninsured rates for undocumented immigrants, because their proportion of the population is so much smaller than that of citizens and people who are in the state and in the country legally, the overwhelming majority of the uninsured in our state are citizens and legally resident immigrants. California has one of the highest uninsured rates in the country—not as high as Texas, but not far below Texas. And 60% [of the uninsured] are U.S. citizens, either U.S. born, or naturalized. Another 16% are noncitizens who have legal documentation to be in our country. Only one in five is an undocumented immigrant adult and only 136,000 are undocumented immigrant children.

So when we hear about the magnitude of the uninsured problem in this country or in a state like California and we hear many people, including people who our previous panel talked about in Texas—arguing that it's really all due to all of these people rushing across the border for medical care and being uninsured, the reality is very different from that.

Uninsured, undocumented, and citizen adults are overwhelmingly in working families, we again are comparing undocumented uninsured adults with citizen uninsured adults. You can see that even among the undocumented, 75% have at least one adult in the family who works as a full time employee, compared to 57% of the citizen families.

A variety of federal laws have aggravated the problem of access to health care for immigrants. We've heard about some of them previously. [These include] the Welfare Reform and Immigration Reforms of 1996, including being classified as a public charge, which could result in denial of citizenship later upon application, and the Deficit Reduction Act of 2005, which was targeted at immigrants and especially at undocumented immigrants and ends up actually having a greater impact on U.S. citizens with enormous delays now in processing Medicaid applications throughout the country.

We have mixed evidence about whether public charge is still a very significant barrier. In 1999, the Department of Justice sent a letter to all the states clarifying that enrollment in Medicaid and SCHIP would not result in residents being classified as public charge, which could negatively affect their becoming a citizen, with the exception of receiving long-term care benefits. That was followed by very aggressive outreach by advocacy groups all over the country and by many public agencies in California. County and State agencies really went all out to try to get that word out to immigrants throughout California. We saw an impact of that in the very high rate of enrollment: 70% of [U.S. citizen children with undocumented immigrant parents] are enrolled in Medicaid or SCHIP in California. But, there is still anecdotal evidence that suggests that it remains a barrier for many people.

Limited English proficiency is a barrier, as is knowing where to seek care. Communicating with doctors and other medical staff [is also a barrier that] results in lower quality of care. This means people can get care but they also get less access to medical care. This is less of a problem in places with long established immigrant communities where in ethnic enclaves there tend to be more social support systems that have been built up over time and are very protective of the residents of those communities. You often see much lower rates of people having access barriers in those communities than you do in other communities.

I think you've heard about the barriers today. I won't even stop to summarize those. Let me just mention a couple of possible policy solutions. First, looking at Title VI of the Civil Rights Act and taking it seriously could mean that we follow through on the culturally and linguistically appropriate service standards that have been developed and issued by the federal Office of Minority Health. We can more effectively implement and enforce those standards. California has gone even further. They have not only been collaborating in the enforcement of those standards but they have added new laws. Our Medicaid program requires managed care plans to provide translation services and other support for limited English proficient members. And, we have a relatively new law in California, which is being enforced by the Department of Managed Health

Care, that requires HMOs to provide translation services and other support for their LEP members above a certain minimum share of membership in order to make it practical. We can encourage other states to follow California's example.

States can also strengthen their safety net providers. I think that one way to do it is what Dr. Pagán talked about. We can also revise the Welfare Reform Act of 1996 and end the penalties that it imposes, [especially] the extra penalties on noncitizens. Approximately half the states have continued to maintain coverage for legal immigrants but they do so at state expense with no federal participation. Most states with long standing large immigrant populations, including Illinois, provide coverage for legal immigrant children and pregnant women who would be disqualified under the five-year waiting rule that was described earlier. But the new growth states like Iowa, which we saw on the map, do not provide that kind of coverage. Congress could rescind that provision so the legal immigrant children and pregnant women could get Medicaid with federal matching funds in their first years.

California has done other things too, which I think are very useful. I do want to mention that in addition to the state funded programs that California runs through the Medicaid and SCHIP programs, twenty counties throughout the state run their own programs. [These are] counties that have large Latino, immigrant, and undocumented populations. The counties have encouraged the development of county government and private collaborations to create coverage programs for undocumented immigrant children with the goal of having insurance for every child in California. About 80,000 undocumented immigrant children in California get their coverage through these programs, but these programs are financially struggling to survive and sustain their funding.

Let me close with one of the points I was trying to make with the data comparing uninsured undocumented workers with uninsured citizen workers. Both groups face the same kinds of barriers in getting health insurance coverage through employment. The barriers hit a larger share of the undocumented because of their low incomes and the discrimination that they often face in the labor market, but the barriers really are the same. As we attempt to address the problem of the uninsured and expand health insurance coverage, I think it behooves us to try to find the common ground between citizens and noncitizens to shift the focus away from who's in our community and who's excluded from our community onto what are the common problems that we all face in trying to obtain decent health care, quality health care for ourselves and our families. Thank you.