# Medicaid under an Immigration Moratorium

*Part 4*

Medicaid is the United States's largest means-tested social program. As the economy went into recession in 2009, enrollment jumped by more than 5 million to 48 million. A record 15.7 percent of the population is enrolled. Ten years ago only 10.3 percent of the population was enrolled in the program.[1]

In FY2008, the Department of Health and Human Services' (DHHS) spent more than one-third of the DHHS budget, or $202 billion, on the program. As recently as 1990, Medicaid was a $41-billion program, accounting for only 23 percent of DHHS outlays.

Medicaid spending has often risen at twice the rate predicted in official federal projections. Many factors are responsible. The federal government's open-ended commitment to match state Medicaid spending has created a powerful incentive for states to expand Medicaid eligibility. The proliferation of diagnostic tests and other procedures has increased per-recipient costs. Some observers argue that private health insurance providers have priced themselves out of the market, forcing many Americans to seek Medicaid coverage. Finally, as the population ages and life spans increase, more Americans are relying on Medicaid to provide nursing home and other long-term care.

Immigration is another important albeit rarely mentioned driver. Most immigrants are poorly educated and lack the basic skills required for middle-class jobs — jobs that include health insurance coverage. Even full-time non-citizen workers are likely to be uninsured at far greater rates than their native counterparts, with nearly half — 49 percent — lacking employer-based health coverage compared to just 19 percent of full-time U.S.-born workers.[2]

The 1996 Welfare Reform Act made it more difficult for legal immigrants to receive Medicaid. For the first time, their eligibility was tied to their length of residency in the United States. After five years, they became eligible for Medicaid if they met the other eligibility requirements. However, the 1996 law also gave states the option of extending Medicaid coverage to new immigrants with their own funds. Several have done so, while implementing outreach initiatives designed to alert immigrants to the health programs available to them and their children. As a result, Medicaid coverage in the years after 1996 actually declined *less* for some immigrant categories than for natives.[3]

Some legal immigrants are eligible for Medicaid regardless of how recently they arrived. These include refugees and other humanitarian immigrants, as well as active-duty members of the U.S. military. Individuals entering the country on temporary work or student visas are not eligible.

The 1996 law made illegal immigrants ineligible for all Medicaid services except emergency room care — no matter how long they've lived in the U.S. However, their U.S.-born children are entitled to the full gamut of services. There are an estimated 3 million such "anchor babies" living in the United States.

Although immigrants are generally younger than natives, they and their children are more prone to certain conditions and risky behaviors. Compared to non-Hispanic white and black children, for example, Latino children generally are less likely to be immunized, have higher rates of tuberculosis, have higher rates of obesity

and sedentary activity, have more dental problems, and are more likely to experience intentional and unintentional injuries. Latino adolescents are also more likely to use drugs, alcohol, and tobacco; less likely to use contraceptives; more likely to be injured; and more likely to attempt suicide than African-American and non-Hispanic white adolescents.[4]

How much of Medicaid spending goes to immigrants? To determine this, we need two pieces of information: the number of immigrants receiving benefits and the average cost per recipient. In 2007, 14.7 percent of households headed by a native were eligible for Medicaid versus 24.4 percent of households headed by immigrants.[5] These are estimates based on the two major eligibility criteria: income and the presence of children. High immigrant eligibility reflects their below-average incomes and above-average family size. Another factor: U.S.-born children of illegal alien households can enroll in Medicaid although their parents cannot.

We can estimate the number of immigrant and native-born Medicaid recipients by stringing together known pieces of information, as follows:

*Immigrant Medicaid recipients* = immigrant household eligibility rate (24.4 percent) x number of immigrant households (12.9 million) x average size of immigrant household (3.1 persons) = *9.8 million*

*Native Medicaid recipients* = native household eligibility rate (14.7 percent) x number of native households (112.5 million) x average size of native household (2.4 persons) = *39.7 million*

Conclusion: About *one-fifth* (19.8 percent) of all Medicaid recipients are foreign-born.

Per recipient spending is not as easily determined. The Medicaid Statistical Information System does not track the nativity of Medicaid recipients. It does, however, identify their race and ethnicity. Thus, we use the following as proxies – Hispanic for immigrant recipients, and non-Hispanic for native-born recipients. This is reasonable given the fact that over half (52 percent) of the foreign-born population is from Mexico and Latin America.

Hispanics enrolled in Medicaid received an average Medicaid benefit of *$2,244* in 2007; non-Hispanics received a benefit worth *$5,282*.[6] The difference primarily reflects a younger Hispanic population.

Estimated Medicaid spending on immigrants = 9.8 million x $2,244 per recipient = *$22.0 billion*

Estimated Medicaid spending on natives = 39.7 million x $5,282 per recipient = *$209.7 billion*

Total Medicaid spending = *$231.9 billion*

Bottom line: *Immigrants receive approximately 9.5 percent ($22.0 billion/$231.9 billion) of current (2007) Medicaid spending.*

These are estimates. Not all households eligible for Medicaid actually enroll in the program. Households that enroll may differ in size and other characteristics from those that do not. Hispanic households headed by immigrants may receive a far different array of Medicaid benefits than those headed by native-born Hispanics. For these reasons, our Medicaid spending figures differ from those reported by the government. We believe our calculations are more useful in determining the *share* of Medicaid going to immigrants and natives than the dollar amounts flowing to each group.

## Medicaid under a moratorium

In 2007 immigrants accounted for 12.6 percent of the U.S. population and received an estimated 9.5 percent of Medicaid spending. In other words, their share of Medicaid expenses was about 25 percent below their population share. If Medicaid eligibility rules along with the relative income, size, and age profiles of the immigrant and native-born households remain as in 2007, that differential will pertain to future immigrant cohorts also.

Under current immigration policy, the foreign-born population will reach 81.6 million, or 18.6 percent of the population, in 2050. Assuming current (2007) Medicaid rules and conditions remain in place, about 14 percent of all Medicaid spending will go to immigrants and their U.S.-born children that year. By contrast a 40-year moratorium would cut the immigrant population share to 6.3 percent, reducing the share of Medicaid spending flowing to immigrants to 4.7 percent.

Bottom line: A 40-year moratorium will reduce the share of Medicaid outlays going to immigrants by nearly 10 percent. This could be used to increase Medicaid benefits for both native-born and older (pre-moratorium) foreign-born beneficiaries or to reduce total Medicaid outlays with no diminution in benefits.

## Enter Obamacare

Big changes are in store for Medicaid under President Obama's health reform plan — the Patient Protection and Affordable Care Act (PPACA):

"Of the estimated $828 billion net increase in Federal expenditures related to the coverage provisions of

PPACA, about one-half ($410 billion) can be attributed to expanding Medicaid coverage for all adults who live in households with incomes below 133 percent of the FPL [Federal Poverty Limit]."[7]

This legislation is expected to increase Medicaid enrollment by 32 percent above the prior law — the one in effect in 2007. How much of that enrollment increase will be foreign born?

The details of Obamacare are so fiendishly complex that the government itself is uncertain who will be affected. However, we know that PPACA's goal is to reduce the uninsured population, and that foreign-born individuals comprise a disproportionate share of the uninsured:

**People without Health Insurance, 2009**

(numbers in thousands)

| | | Uninsured | |
|---|---|---|---|
| | Population | Number | % of population |
| Total | 304,280 | 50,674 | 16.7 |
| Native born | 266,674 | 37,694 | 14.1 |
| Foreign born | 37,606 | 12,980 | 34.5 |

Data source: Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009, September 2010. http://www.census.gov/prod/2010pubs/p60-238.pdf

Foreign-born individuals are more than twice as likely as natives to be uninsured. As a result, they will account for a disproportionate share of new Medicaid enrollees under Obamacare. Total Medicaid enrollment is projected to rise 32 percent when Mr. Obama's healthcare takeover is fully implemented, so it is not unreasonable to expect the number of foreign-born recipients will increase by about 60 percent — roughly twice the average.

One thing is certain. Obamacare will increase the share of Medicaid going to immigrants — and will increase the potential Medicaid savings arising from a moratorium on immigration. ■

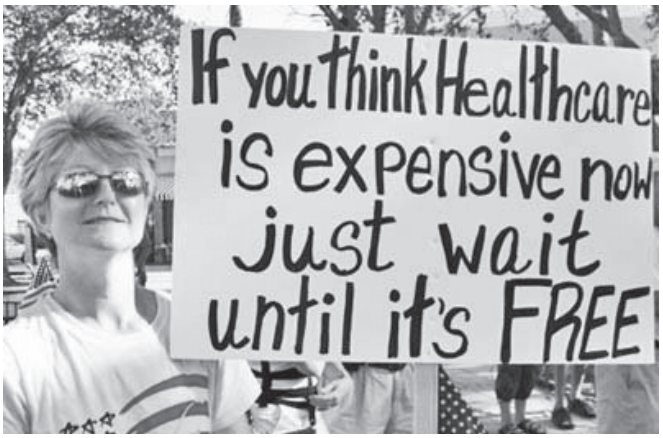
## Endnotes


1. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, September 2010. Table 2. http://www.census.gov/prod/2010pubs/p60-238.pdf

2. Federation for American Immigration Reform (FAIR), *The Sinking Lifeboat: Uncontrolled Immigration and the U.S. Healthcare System*, February 2004. http://www.fairus.org/news/NewsPrint.cfm?ID=2379&c=55

3. Edwin Rubenstein, *Department of Health and Human Services*, The Social Contract, Winter 2007-08.

4. Ruth E. Zambrano and Laura A. Logie, *Latino Child Health: Need for Inclusion in U.S. National Discourse*, American Journal of Public Health, December 2000.



5. Steven A. Camarota, *Immigrants in the United States: 2007*, CIS, November 2007. Table 12.

6. Per-recipient amounts are based on data e-mailed to the author on October 1, 2010, by Christian Wolfe, Actuary, Centers for Medicare and Medicaid Services, (410) 786-2266.

7. Richard S. Foster, *Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended,* Memorandum from Centers for Medicare and Medicaid Services, April 22, 2010, page 4. http://www.politico.com/static/PPM130_oact_memorandum_on_financial_impac....