

Department of Health and Human Services

SHADOW SECRETARY OF HEALTH AND HUMAN SERVICES EDWIN S. RUBENSTEIN

The Department of Health and Human Services (HHS) is the cabinet-level department entrusted with protecting the health of all Americans and providing essential human services. Departmental outlays are estimated at \$672.9 billion for fiscal year (FY) 2007—about one-quarter of the entire federal budget.

Individual Development Accounts (IDAs)

IDAs are matched savings accounts made available to refugees whose annual income is less than 200 percent of the poverty line and whose assets are less than \$10,000. They are funded by HHS's Office of Community Services. http://www.nlihc.org/detail/article.cfm?article_id=2785&id=23

The government matches up to \$1 for every \$1 deposited by a refugee in a savings account. The total match amount may not exceed \$2,000 for individuals or \$4,000 for households. When enrolling in an IDA program, a refugee signs a savings plan agreement which specifies the savings goal, the match rate, and the amount the refugee will save each month.

Funds accumulated in IDAs are supposedly restricted to one (or more) of the following uses: home purchase; microenterprise capitalization; postsecondary education or training; or purchase of an automobile if needed to maintain or upgrade employment. http://www.acf.hhs.gov/programs/ort/programs/ind_dev_acc_prg.htm

None of these goals appear to be related to health or essential human services. They are above

and beyond the broad goals articulated in HHS's mission statement.

Congress authorized \$10 million per year for FY1999 and FY2000 and roughly \$25 million per year for each subsequent year. By the end of 2004 (the most recent data available), the IDA program had received \$145 million from HHS. http://www.nlihc.org/detail/article.cfm?article_id=2785&id=23

There are currently more than 30,000 IDA accounts. President Bush wants to fund 900,000 such accounts, and he wants financial institutions that match refugee deposits to receive a one to one federal tax credit of up to \$500. http://www.nlihc.org/detail/article.cfm?article_id=2785&id=23

While the IDA program is not nearly as expensive as Medicaid or the State Children's Health Insurance Program (SCHIP), it does not fit into the

objectives of HHS. Special interest groups have succeeded

in creating an entitlement for refugees in the government's enormous health care bureaucracy.

Medicaid

Medicaid is the largest means-tested government program in the United States. Enacted in 1965, it provides medical care to more than 50 million low-income Americans.

Supporters praise the program for making essential care available to those who otherwise cannot afford it. Some even urge that Medicaid be expanded to cover individuals who are currently uninsured. However, a considerable body of research finds that Medicaid actually exacerbates the problems of poverty and the lack of affordable medical care.

Immigration Fiscal Impact Statement

One thing is undeniable: Medicaid is the fastest growing government program. Double-digit rates of annual outlay growth are common. In 2004 Medicaid surpassed primary and secondary education to become the largest component of state government spending—22 percent of the total.

About one-third of the HHS budget is spent on the program:

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. Meanwhile, the proliferation of expensive 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 lifespans increase, more Americans are relying on Medicaid to provide nursing home and other long-term care.

Immigration is another important, albeit rarely mentioned, driver. Between 1990 and 2000, the immigrant population increased 57 percent compared to a 9 percent rise in the U.S.-born population. In

the first five years of the 21st century (2000 to 2005) immigration accounted for 43.2 percent of U.S. population growth.

In 2006 about 38 million U.S. residents—about 12.7 percent of the population—were foreign born.

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 at a great disadvantage, with nearly half—49 percent—lacking employer-based health coverage compared to just 19 percent of full-time U.S.-born workers.¹

Not surprisingly, the share of immigrants lacking any health insurance coverage (33 percent) is significantly above that of U.S. natives (12 percent).² Immigrants accounted for more than half—59 percent—of the growth in uninsured population during the 1992–2001 period.³

Even after the 1996 welfare reforms, which curtailed welfare eligibility for new immigrants, immigrant households received Medicaid at far greater rates than households headed by natives. In 2005, 14.8 percent of households headed by a native received Medicaid versus 24.2 percent of households headed by immigrants. <http://www.cis.org/articles/2005/back1405.html>

Medicaid as a Share of HHS Spending, 1970–2008 Est.

Fiscal Year	HHS Outlays	Medicaid Outlays	Medicaid as a % of HHS
1970	\$17.3	\$2.7	15.6
1980	68.3	14.0	20.5
1990	175.5	41.1	23.4
1995	303.1	89.1	29.4
2000	382.3	129.4	33.8
2005	581.5	181.7	31.2
2006	614.3	180.6	29.4
2007 EST.	671.3	191.9	28.6
2008 EST.	599.2	202.0	33.7

Source: OMB, Historical Tables, 2008 Budget. HHS: Table 4.1; Medicaid, Table 11.3. <http://www.whitehouse.gov/omb/budget/fy2008/pdf/hist.pdf>

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 caries, 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.

<http://web.ebscohost.com/ehost/detail?vid=1&hid=123&sid=40af45d4-4602-4216-9b11-5c9d1eb772d5%40sessionmgr107>

Implication: Immigrant children account for a disproportionate share of Medicaid spending.

What percent of Medicaid outlays go to immigrants? To estimate this we use the following three factors as “weights”:

Using these three factors as weights, we calculate that 11.0 percent of all Medicaid outlays go to immigrant households. Thus the share of Medicaid benefits received by immigrants is less than their population share.

However, immigrants account for a disproportionate share of enrollment and enrollment growth. In 2003 (the latest year of readily available Medicaid data) Hispanics accounted for 19.2 percent of Medicaid enrollment and [missing figure] percent of the U.S. population. ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/

[hus06tables](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/Health_Statistics/NCHS/Publications/Health_US/hus06tables)

From 1990 to 2003 the number of Hispanic recipients rose by 163 percent while non-Hispanic recipients rose by 95 percent. Thus Hispanics accounted for 23 percent of Medicaid enrollment growth over this period. ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/hus06tables

Medicaid Cost Allocation Factors Immigrants versus Natives		
	Natives	Immigrants
Population Share (2005)	87.9 %	12.1 %
Medicaid Recipient Rate (2005)	14.8 %	24.2 %
Payments per Recipient (2003)^a	\$4,487	\$2,463

a. Medicaid cost data are broken out by race and ethnicity, but not by nativity. Therefore, we use data for Hispanics as a proxy for immigrants, and data for total recipients as a proxy for natives.

Sources: Population shares, reciprocity rates: <http://www.cis.org/articles/2005/back1405.html>; Payments per recipient: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/hus06tables

<http://www.cis.org/articles/2005/back1405.html>; ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Health_US/hus06tables

(Note: The Medicaid Statistical Information System <http://msis.cms.hhs.gov/> does not break out foreign-born beneficiaries separately. It does, however, identify beneficiaries by race and ethnicity. Thus in the preceding analysis we used Hispanic beneficiaries as a proxy for foreign-born beneficiaries. This is reasonable given the fact that over half [52 percent] of the foreign-born population is from Latin America. More important, Hispanic immigrants accounted for 56 percent of immigrant population growth over the past decade.)

Controlling Access to Medicaid

The 1996 welfare reform law made it more difficult for immigrants to receive Medicaid. For the first time, the eligibility of legal immigrants was tied to their length of residency in the United States. After five years, they become eligible for Medicaid if they meet the other eligibility requirements.

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 generally not eligible.

Despite these exceptions, the 1996 welfare reform seems to have reduced immigrant Medicaid use—at least initially:

for all Medicaid services except emergency room care—no matter how long they’ve lived in the United States. 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.

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 actually declined less for some low-income immigrant parents than for their U.S.-born counterparts (see table next page).

Harvard University economist George Borjas studied the outcome of the 1996 welfare reform on immigrants.

He found that the result of that “draconian” measure was exactly the opposite of what many would predict—health coverage among non-citizen immigrants actually grew. One reason was that immigrants most adversely affected by the new Medicaid restrictions were forced into the labor force, working longer hours to make themselves eligible for employer-sponsored health insurance. http://findarticles.com/p/articles/mi_m1272/is_2728_134/ai_n16882277/pg_1

The bottom line: Immigrant health insurance coverage was largely unaffected by welfare reform.⁴

Medicaid Reciprocity Rates for Immigrants and Natives, 1994–2001 (Percent of Households Receiving Assistance)

	Natives	All Immigrants	Illegal Immigrants
1994	13.5	21.3	NA
1995	13.2	21.9	NA
1996	13.5	20.5	20.4
1997	12.5	18.7	17.9
1998	12.1	16.9	19.2
1999	12.1	18.6	18.2
2000	12.6	19.9	20.6
2001	13.4	21.8	23.0

Sources: George Borjas, “The Impact of Welfare Reform on Immigrant Welfare Use,” Center for Immigration Studies (CIS), March 2002. Table 2 <http://www.cis.org/articles/2002/borjas.htm>; Steven Camarota, “Back Where We Started,” CIS, March 2003. Table 1. <http://www.cis.org/articles/2003/back503.pdf>

For the first two years following welfare reform (1996–1998) Medicaid usage dropped relatively more for immigrants in than for natives. Illegal immigrants were especially affected, their reciprocity rate falling by more than 20 percent.

But it is absurd to attribute this decline to welfare reform. That law changed the eligibility rules for new immigrants, that is, those arriving after the effective date of the 1996 legislation (August 22, 1996). Only a small fraction of the immigrant population living in the United States in the late 1990s arrived after that date.

The 1996 law made illegal immigrants ineligible

State Child Health Insurance Program (SCHIP)

SCHIP is a health insurance program for children (and in some states, adults) in families that earn too much to qualify for Medicaid. Typically families with incomes above the poverty level, but no more than 200 percent of poverty, are eligible. Congress is currently considering an expansion to 400 percent of the poverty line—\$83,000 for a family of four. <http://www.ncpa.org/pub/ba/ba589/>

Approximately 6.7 million children and adults are covered. In FY2006 federal SCHIP expenditures totaled \$5.5 billion. <http://www.state-healthfacts.org/comparetable.jsp?ind=234&cat=4> About \$605 million of this amount was spent on immigrants.⁵

In FY1999—its first full year of operation—total SCHIP outlays were \$922 million.

The rules governing immigrant eligibility for SCHIP are identical to those for Medicaid. That means most legal immigrants are not eligible during their first five years in the United States while illegal aliens are not eligible no matter how long they've lived in the country.

However, legislation currently being considered in Congress would greatly weaken the illegal alien prohibition. In particular, an SCHIP reauthorization bill sponsored by congressional Democrats would eliminate the requirement that anyone applying for SCHIP services provide original documents attesting to their U.S. citizenship. [\[journal.com/apps/pbcs.dll/article?AID=/20070730/BLOGS28/70730059/1046/OPINION\]\(http://journal.com/apps/pbcs.dll/article?AID=/20070730/BLOGS28/70730059/1046/OPINION\) This will open the door to document fraud even wider than it already is.](http://www.statesman-</p>
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Another proposal would reportedly raise the age for “children” to 25 years. This would effectively give immigrant gang members and other illegal aliens “free health care” at taxpayer expense.

Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA)

EMTALA requires hospitals to screen and stabilize all individuals, including illegal immigrants, who seek care in an emergency room. In recent years the federal government (HHS) has provided \$250 million to help cover the costs of this mandate. <http://www.hhs.gov/asl/testify/t060726c.html>

Medicaid Coverage of Low-Income Parents and Children		
	Percentage Covered by Medicaid, 2001	Percentage Point Change, 1995-2001
U.S.-born parents	22.6	-6.1
Naturalized citizen parents	16.1	-2.5
Non-citizen parents	12.3	-9.5
Citizen children in citizen family	46.5	1.9
Citizen children in immigrant family	49.6	2.5
Non-citizen children	24.3	-11.7

Source: Kaiser Commission on Medicaid and the Uninsured, “How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage,” August 2003. Tables 1 and 2. <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22103>

Each year, two-thirds of this \$250 million, or \$167 million, is allocated to the states based on their relative percentages of illegal aliens. The remaining \$83 million is allotted to the six states with the highest number of illegal alien apprehensions for each fiscal year. In FY 2005 and FY 2006, Arizona, Texas, California, New Mexico, Florida, and New York were the six states determined to have the highest number of illegal immigrant apprehensions.

<http://www.hhs.gov/asl/testify/t060726c.html>

An “emergency,” as defined by this statute, is any complaint brought to the emergency room (ER), from hangovers to hangnails, from gunshot wounds to AIDS.

The hottest ER diagnosis, according to medical lawyer Madeleine Cosman, is “permanent disability”—a vaguely defined condition that covers mental, social, and personality disorders. (Source: Madeleine Perner Cosman, “Illegal Aliens and American Medicine,” *Journal of American Physicians and Surgeons*, Spring 2005.)

Drug addiction and alcoholism (DA&A) are among the fastest-growing “disabilities”:

- ◆ In 1983 only 3,000 ER cases were classified as DA&A
- ◆ In 1994 DA&A cases exploded to 101,000
- ◆ In 2003 about 325,000 such cases were reported

And EMTALA gives illegals more than medical treatment. A “disability” diagnosis automatically qualifies them for Supplemental Security Income (SSI), a federally funded cash transfer payment.

The numbers are staggering:

- ◆ 127,900 immigrants on SSI in 1982 (3.2 percent of recipients)
- ◆ 601,430 immigrants in 1992 (10.9 percent of recipients)
- ◆ 2 million in 2003 (about 25 percent of SSI recipients)

Unlike the other laws affecting illegal aliens, EMTALA is vigorously enforced. Hospital ERs must have physicians available to them at all times from every department and specialty covered by the hospital. The feds impose fines of up to \$50,000 on any physician or hospital refusing to treat an ER patient—even when the attending physician examines and declares the patient’s illness or injury to be a non-emergency. Lawyers and special interest groups are granted more authority than doctors in these matters.

EMTALA was supposed to make ERs more accessible to the uninsured. It didn’t work out that way:

Not only did this unfunded mandate contribute to the closure of numerous emergency departments and trauma centers, it also created a perverse incentive for hospitals to tolerate emergency department crowding and divert ambulances while continuing to accept elective admissions. Rather than improving access to emergency care, EMTALA diminished it.

(Arthur L. Kellermann, “Crisis in the Emergency Department,” *NEJM*, September 28, 2006)

Talk about unintended consequences! ■

End Notes

1. 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>
2. Edwin S. Rubenstein, “ERs: \$10 Billion Subsidy to Immigrants—and Their Employers,” VDARE.com, April 7, 2005. http://www.vdare.com/rubenstein/050407_nd.htm
3. FAIR, op. cit. 2004.
4. Medicaid is apparently unique in this respect: “The persistently high rate of welfare use by immigrant households is almost entirely explained by their heavy reliance on Medicaid, use of which has actually risen modestly. In contrast, their use of TANF has fallen significantly, from a little under 6 percent to slightly over 2 percent in 2001. Food stamp use has also declined significantly, from about 10 percent to 6 percent.” Steven Camarota, “Back Where We Started,” CIS, March 2003. <http://www.cis.org/articles/2003/back503.pdf>
5. This assumes immigrants receive the same share of SCHIP as they do Medicaid—11 percent by our estimates.