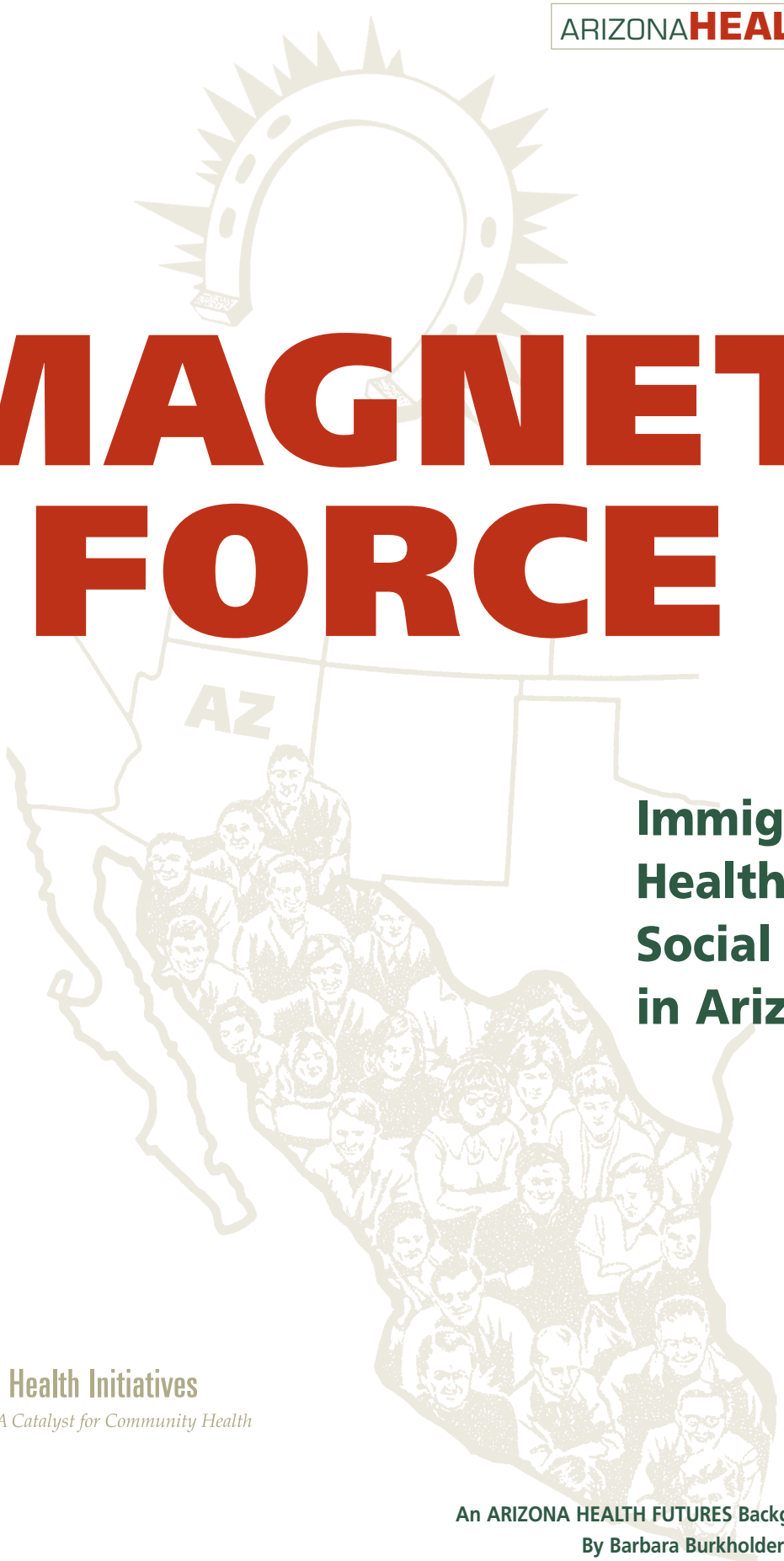
ARIZONA**HEALTH**FUTURES

MAGNET FORCE

Immigrants, Health and Social Policy in Arizona



St. Luke's Health Initiatives

A Catalyst for Community Health

An ARIZONA HEALTH FUTURES Background Report

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February, 2002

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MAGNET FORCE:

Immigrants, Health and Social Policy in Arizona

If Clint Eastwood were to make the movie "Magnet Force" in Arizona today, he'd make a daring cross at the Mexican border in search of a better life, battle indifference, low wages and restricted access to health care; and emerge triumphant in the end as a naturalized citizen and successful entrepreneur, a "magnet" himself for thousands of other immigrants to follow and participate in the American dream.

People like Rosa, a single Mexican immigrant waiting to be seen at a mobile Mission of Mercy clinic on Phoenix's south side. She's pregnant, here illegally and worried that she might be deported.

Or Sakib, a Bosnian refugee whose wife was killed by the Serbs. With two bright teenage daughters, he's starting a new life in Arizona, works two jobs and still can't get dental care for his family.

The magnet is real enough: freedom, opportunity, a thriving and vibrant land built by immigrants from all over the world. Over 30 million foreign-born people currently reside in the U.S.; between 400,000 and 500,000 *annually* are expected to come from Mexico alone over the next 30 years.

Plus and Minus

Arizona knows only too well how powerful the magnet is. As a border state, our economy and culture are inextricably intertwined with our neighbors to the south.

On the plus side, this creates jobs, expands services and fuels a dynamic, multicultural society.

On the minus side, it burdens already stressed systems of education, health and social services; adds to a steadily growing gap between the rich and poor, and exacerbates what are often contentious divisions of values, ideology and politics.

In this *Arizona Health Futures* Background Report, we probe some of these tradeoffs by focusing on the status of health and health care for immigrants in our state. Immigrant health is not a discrete factor by itself, but is interrelated with a complexity of other factors, such as country of origin, age, education, language proficiency, occupation and wages, legal status and length of time in the U.S.

Our intent is not to unravel this complexity in exhaustive detail, but to paint with a broad brush and sketch out the central policy issues impacting health care for immigrants.

We've arranged the report to briefly describe the immigrant population and their health status, outline gaps and barriers to health care, analyze policies impacting health care, and how other states are dealing with these issues; sample the views of various individuals and organizations close to this topic, and suggest policy options for the future. Readers who wish more information on these subjects can consult the source material and other resources listed.

Ideally, this AHF report will serve as background for a thoughtful discussion among health leaders, policy experts, community leaders and other stakeholders on how we might fashion constructive health policy in the future and work together to improve the health of all Arizonans, no matter where we were born.

SLHI will host an Arizona Health Futures Policy Forum on this issue in late February 2002. [Ed].

Immigrants: Who Are They?

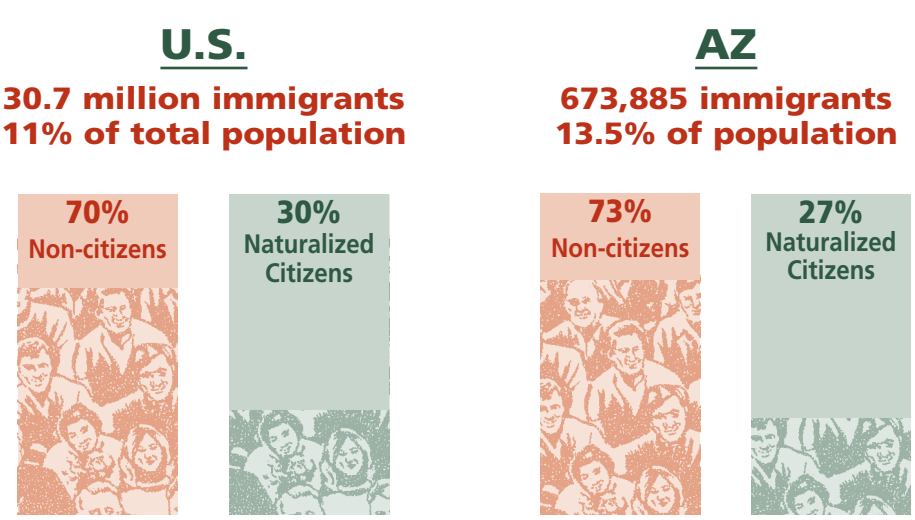
We'll know more detail about Arizona's immigrants after the release of specific subsets of the 2000 census survey in mid-2002. But no one expects any huge surprises: Arizona's immigrants are overwhelmingly Hispanic, have lower educational achievement, less English proficiency, fewer job skills and larger families than immigrants from Europe, Canada, Russia, India and Asia.

Mexico: The largest source of immigrants entering both Arizona and the U.S. in the last decade. The U.S. Border Patrol in Arizona apprehended over 500,000 illegal Mexican border-crossers in the 2001 fiscal year. Over 90 percent were male with an average age of 24 years. According to a report from the National Population Council of Mexico, out of eight million Mexicans who live in the U.S., three million crossed the border illegally, and only 12.5 percent reported being caught and deported. An unknown number reach safe haven every year and remain in this country. [19]

FIGURE 1

Arizona: Above Average

Legal Status of Immigrants, 2000*



* National figures are from the Urban Institute's preliminary estimates of 2000 census data, which also include an estimate of 28% undocumented persons among non-citizens. Arizona figures are from the Census 2000 Supplementary Survey, which includes certain restrictions and does not break out figures for undocumented immigrants. More specific Census 2000 information will be available in mid-2002. Since this survey did not ask whether an immigrant was undocumented or not, researchers caution that statistics could have large margins of error and potentially be misleading. [11]

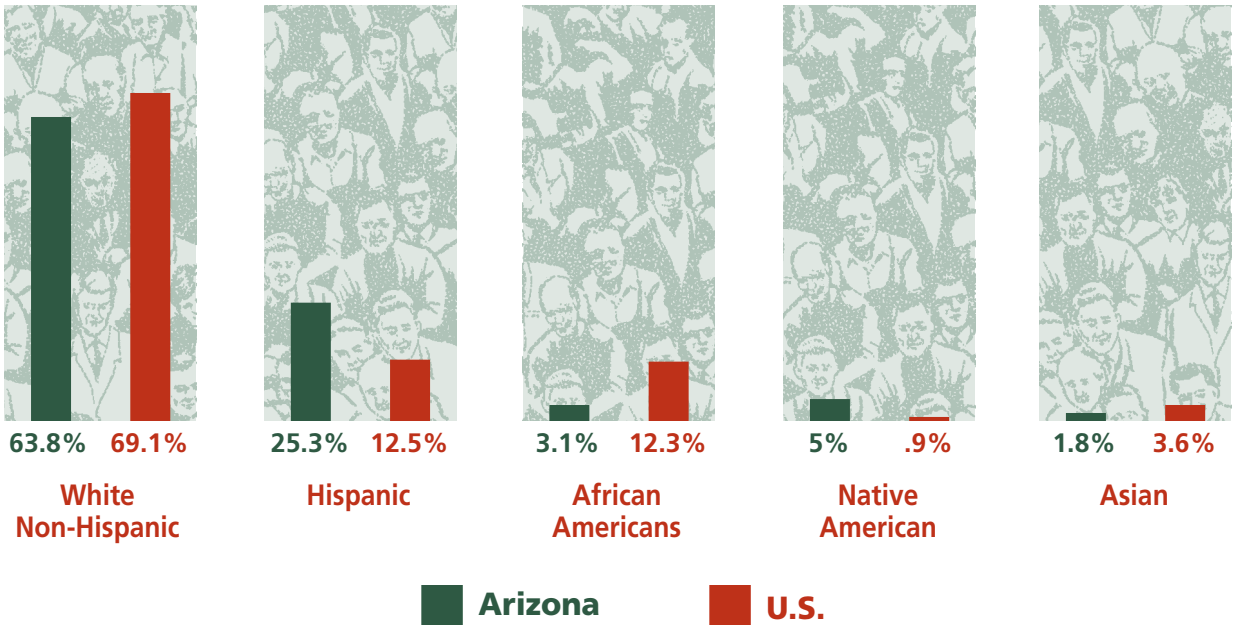
Children of Immigrants

85% of immigrant families include children who are U.S. citizens.

Arizona's percentage of Hispanic population, not all of them immigrants, is twice the national rate. Because health status information is not available by immigrant status, we use health related data on Arizona's Hispanic population as a proxy indicator. Therefore, when we talk about health issues affecting immigrants in this report, we're primarily talking about Hispanics, most of who come from Mexico.

FIGURE 2

Comparative Distribution of Ethnic Population [33]



Types of Immigrants

NATURALIZED CITIZEN: Legal aliens who become citizens through the naturalization process.

LEGAL PERMANENT RESIDENT (LPR): Aliens granted permanent resident status and issued a "green card" to work in the U.S. The U.S. admits about 700,000 legal immigrants annually.

UNDOCUMENTED ALIEN: Illegal aliens who enter the U.S. without documentation, or visitors who remain after their visas expire. Mexico is the main country of origin for this group (54 %), followed by El Salvador, Guatemala and Canada. California is home to 30% of illegal aliens in the U.S., followed by Texas, New York, Florida, Illinois, New Jersey and Arizona. These seven states reportedly accounted for 83% of estimated illegal immigrants in the U.S. in 1996.

REFUGEE/ASYLEE: An immigrant fleeing his or her country because of persecution.

PAROLEE: An alien allowed into the U.S. for urgent humanitarian reasons or significant public benefit. This status is temporary.

STUDENTS, VISITORS AND TEMPORARY WORKERS: Aliens who come to the U.S. on a visa for a temporary period of time.

Key Factors affecting Immigrant Health Access and Status

Education

Many immigrants face educational gaps upon entering school. In Arizona, 32% of all school children are Hispanic.* They score at the 25th percentile on reading scores, compared to the 49th percentile for all students; 58% of Hispanics between the ages of 18-24 have a high school education, compared to 73.5% for all students. Almost 28% of all children speak a foreign language at home, primarily Spanish.

Citizenship

Citizenship matters. Among non-citizen immigrants, only 34% have more than 12 years of education, compared to 51% of adult immigrants who have become naturalized citizens – the same rate as U.S.-born residents. Naturalized citizens are more likely to have higher rates of employment and earn higher salaries than non-citizens.

Employment

Hispanics are more likely than other immigrant groups to work in low-income industries. Nationally, 45% of full-time Mexican workers in the U.S. earned less than $15,000 annually, compared to 17% of the U.S.-born population (2000 census data). In Arizona, Hispanics* comprise 21% of the labor force but represent 45.4% of laborers and 30.4% of service workers (1999). An unknown number of immigrants work in Arizona's large agriculture industry, where the average field worker earns less than $7 per hour (2001).

Nevertheless, most immigrants and their descendants over a lifetime will pay $80,000 more in taxes than they use in government services. [20]

There is conflicting data on the cost of immigration to the U.S. economy. The Social Security Administration estimates that illegal workers paid over $20 billion in Social Security taxes between 1990-98, and they will most likely not receive the benefits. [15] A report from the National Research Council concluded that immigrants add as much as $10 million to the economy each year. On the other hand, low-income immigrant households use more services and impose a net fiscal burden of $11.4 to $20.2 billion on all levels of government each year. Nevertheless, most immigrants and their descendants over a lifetime will pay $80,000 more in taxes than they use in government services. [20]

* The report references "Mexican immigrants" when the data are specific to that population and references "Hispanic populations" to differentiate the use of the proxy indicator.

The Bottom Line: *Mexicans are the largest immigrant group in Arizona. They come to Arizona for work and a better life. Compared to immigrants from Europe and some Asian countries, they tend to be younger, have lower education, lower wages, larger families, lower rates of citizenship, and have lived less time in the U.S. Eighty-five percent of these families include children who are U.S. citizens. Hispanic children face significant challenges in school and have a higher dropout rate than the state as a whole, thereby reducing their job prospects and economic well being in the future. Over a lifetime, most immigrants make a substantial net contribution to the economy.*

Health Insurance: Below Average

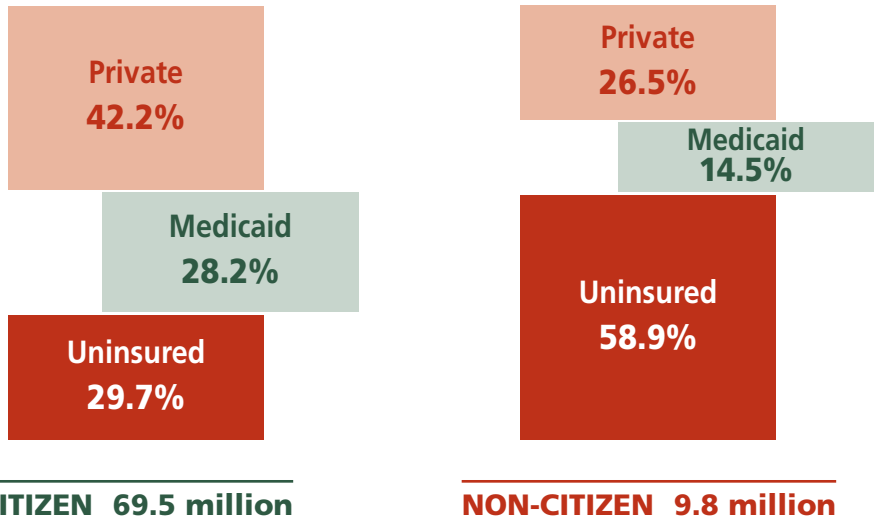
Health insurance matters. The medical literature confirms that people who lack insurance experience poorer health outcomes such as unnecessary illness, more severe disease, late diagnosis and even premature death. It is often more expensive to provide medical treatment for the uninsured than it is to provide preventive, acute and chronic care on a regular basis. [21]

Arizona's rate of insurance coverage for immigrants cannot be determined until the results of the Year 2000 U.S. census are reported in Summer 2002. However, the uninsured rate for Hispanics was 34.6% in 2000. [12]

Nationwide, 31.6% of all immigrants have no health insurance compared with 11.4% of the U.S.-born population. Low-income immigrants are twice as likely to lack insurance as low-income U.S. citizens. For 9.8 million low-income non-citizens in 1999, almost 59% had no health insurance compared to 30% of low-income citizens, and citizens had nearly double the rate of Medicaid coverage. This is illustrated in Figure 3.

FIGURE 3

Health Insurance Coverage of the Low-Income U.S. Population, by Citizenship Status [12]



Note: Low-income is less than 200% of poverty. Low-income population is the non-elderly only.

The likelihood of non-citizen immigrants obtaining health insurance depends on a number of factors:

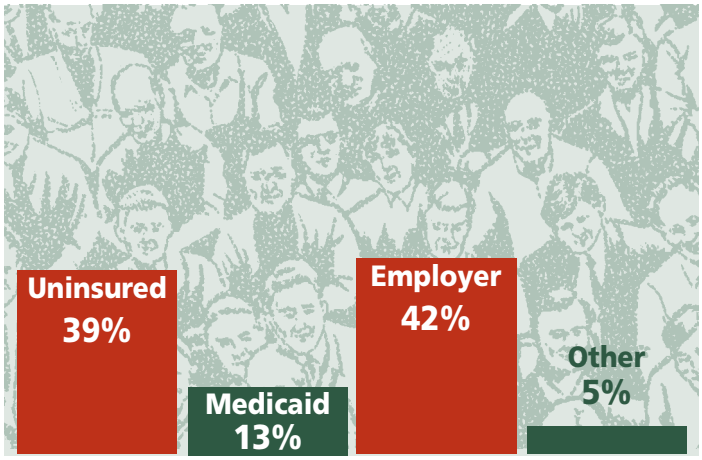
- **LACK OF EDUCATION:** Failure to finish high school nearly doubles the risk of being uninsured.
- **LOW INCOME:** Not surprisingly, salary is the most important predictor of having employer health insurance coverage. 55.3% of immigrants who earn less than $25,000/year remain uninsured vs. 24.4% among those earning over $59,999.
- **SHORTER TIME IN THE U.S.:** The uninsured rate for those in the U.S. less than five years is 48%, compared to 29% for those in U.S. more than 15 years.
- **YOUNGER AGE:** 44% of children under age 18 are uninsured vs. 14% for U.S. born. Among 18-39 year olds, 49% have no insurance vs. 17.6% for naturalized citizens and 14.4% for U.S.-born. [6]

Type of Health Insurance

Type of health insurance varies among immigrants. Figure 4 displays the health insurance coverage types for non-elderly, non-citizen families regardless of income in 1998.

FIGURE 4

Health Insurance Coverage for Non-Elderly, Non-Citizen Families, 1998



EMPLOYER-BASED INSURANCE: Coverage is most common in higher income groups. However, even among full time workers, only 50% of non-citizens had access to coverage from an employer as a policy holder or dependent, compared to 81% of U.S. workers and 75.6% of naturalized citizens. Part-time workers are even less likely to have health insurance. In each income category, differences were pronounced between non-citizens and U.S.-born. For example, among those employed and earning less than $15,000/year, only 27.3% were covered by employer health insurance compared to 58% of U.S.-born.

GOVERNMENT HEALTH INSURANCE: Medicaid provides coverage for the nation's low-income population. Naturalized citizens are eligible for the same public benefits as U.S.-born residents, and their rates of coverage by Medicare and Medicaid are similar – 26.5% in 1997.

However, as a result of welfare reform passed in 1996, new immigrants became ineligible for coverage. Medicaid and Medicare covered only 13% of non-citizens in 2000, compared to 19% in 1995. During the same period, low-income non-citizens experienced a 5% jump in uninsured rates, from 54% to 59%. Refugees and asylees from Dominican Republic, Russia, Cuba and Vietnam received the highest rate of Medicaid coverage. [12]

UNINSURED: 39% of non-citizen families lacked health insurance in 1998.

In Arizona, employers in industries such as agriculture and hospitality, which hire a substantial number of immigrants, may offer a choice of health plans. However, young adult workers often choose not to enroll. They perceive that they don't need insurance because they view themselves as healthy and don't want to pay the employee share of the monthly premium because it cuts into take-home pay. Part-time workers are usually ineligible for health insurance or other employee benefits.

Migrant agricultural workers in Arizona may have several options for health insurance if their employers offer health plans from the statewide Growers' Association:

- The less expensive plan allows workers to access care in Mexico. Some workers prefer this because of cultural issues. Workers generally cannot access care during the week and must go across the border on weekends to get medical care and medications.
- The more expensive plan, which has more co-pays and costs to the worker, provides care in Arizona.

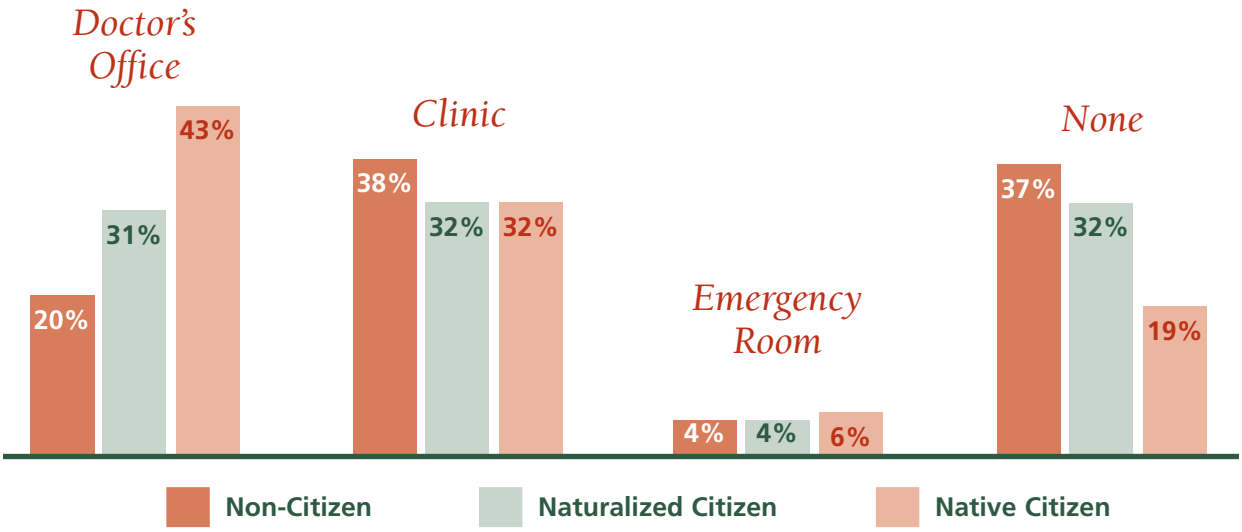
The Bottom Line: *Among Hispanics, 34.6% have no health insurance. Salary is the most important predictor of having employer health insurance coverage. Those at highest risk of being uninsured are non-citizen children and adults under age 40 who lack education, earn low wages and work part-time.*

Access to Health Care Services

Immigrants who lack health insurance often have no usual source of health care. They depend on clinics, community health centers and hospital outpatient departments – the so-called "Safety Net." Figure 5 shows that among adults with income below 200% of the Federal Poverty Level (FPL), 37% of non-citizens had no usual source of care compared to 19% for U.S.-born citizens. Non-citizens are more likely to use clinics and less likely to go to doctors' offices and emergency rooms than U.S.-born citizens.

FIGURE 5

Usual Source of Care for Low-Income Adults by Citizenship Status, U.S. 1997 [12]



Note: Low-income is less than 200% of poverty.
Data: National Survey of America's Families, Urban Institute.

Non-citizen children and adults from low-income families also had fewer medical, dental and mental health visits per year than U.S.-born:

- 60% fewer medical visits
- 72% fewer ER visits
- 89% fewer mental health visits
- 20% fewer dental visits

Many immigrants experience additional barriers. Focus group interviews with immigrants in four U.S. cities with high Hispanic populations [8] revealed information about their knowledge and attitudes that may influence access to care. Key factors include:

COST

- High cost of care leads people to postpone or forgo care. This was the most frequently reported barrier.

CULTURAL DIFFERENCES

- Language barriers hinder communication and may produce confusion about diagnosis and treatment.
- Belief that American citizens and some immigrant groups receive preferential treatment in getting private or public coverage.

KNOWLEDGE AND AWARENESS

- Fear that seeking help from a government program will jeopardize the opportunity to become a citizen.
- For immigrants who are insured, confusion about navigating the managed care system.
- Lack of awareness and understanding of public programs like Medicaid and State Children's Health Programs (SCHIP).
- Difficulty in understanding complex eligibility rules, enrollment procedures, benefits and limitations for public coverage.
- Little understanding of the concepts of insurance and cost sharing.
- Frustration that despite working and paying taxes, many are unable to get employer or Medicaid coverage.

*Safety Net Providers**

Immigrants who reside in Arizona and have no health insurance or usual source of care rely on the following organizations as their health care "providers of last resort" or "safety net."

Public Hospitals & Affiliated Clinics

Seventy-four hospitals operate in Arizona. They all provide emergency care. Federal law requires that hospitals provide care for all patients who present in an emergency situation.

Hospitals also provide emergency care for sick or injured illegal aliens apprehended by the U.S. Border Patrol. Injured immigrants who are not likely to abscond – called "parolees" – are taken to community hospitals for emergency or trauma care. In the past, hospitals were not paid for care to parolees but the Immigration and Naturalization Service (INS) are testing a pilot plan for reimbursement.

Community Health Centers

There are 13 federally qualified and funded community health centers in Arizona. Federal funds target clinics in medically underserved areas with a shortage of primary care providers. An additional 13 primary care clinics, which serve low-income populations, belong to the Arizona Association of Community Health Centers. All 26 of these member clinics and their satellites provide care for the uninsured, including immigrants, as well as for people covered by public and private insurance.

* A more complete analysis of the condition of Maricopa County's safety net, which includes more than the issue of immigrant access, is found in the ***Arizona Health Futures Winter 2002 Issue Brief,*** due to be released in late February-early March 2002. It can be accessed on the web at **www.slhi.org**.

Tobacco Tax Primary Care Clinics

For FY 2002, Arizona's tobacco tax program funds 21 primary care clinics in 11 of Arizona's 15 counties. The program supports medical (and some dental) services for medically needy and uninsured populations with income below 200% FPL, regardless of immigration status. Patients pay what they can, on a sliding fee scale.

County Public Health Services

Counties provide limited, direct health services to Arizona residents regardless of immigration status. All 15 county health departments provide childhood immunizations, TB control, HIV prevention, communicable disease investigation and control, and linkage of people to services. Most counties also offer well child assessments, adult immunizations, flu and pneumonia immunizations, family planning and STD clinics, HIV case management, home visits to high-risk children and nutrition programs. County jail nursing is offered in seven counties, while juvenile detention nursing is provided in six. Three counties offer prenatal care, dental health services for uninsured populations.

School Based & School-Linked Clinics

Arizona has 95 school-based or school-linked clinics, all located in elementary schools with concentrations of low-income families. Two-thirds of the programs are located in Maricopa County, but needs are well established throughout the state, especially in rural areas where uninsured people lack a regular source of care. School-based clinics are staffed by nurse practitioners but school-linked clinics deliver care off-site through providers who are often affiliated with hospitals.

"Government needs balance between capitalism and socialism. Effective government provides benefits to the least powerful. This engenders loyalty."

~ (A legislator)

The Bottom Line: *Non-citizens with family income below 200% of the Federal Poverty Level have fewer medical, dental and mental health visits than U.S.-born citizens. Immigrants also face added barriers related to cost, language, culture, and lack of awareness of health services and public policies. Because they lack a usual source of care, non-citizens often depend on "safety net" services such as emergency rooms and community or school clinics whose funding may be precarious from year to year.*

Data on health status among immigrants are sparse. Most states and the federal Centers for Disease Control (CDC) collect vital statistics based on ethnicity, not citizenship status. However, a large National Survey of America's Families conducted in 1997 by the Urban Institute revealed that even after immigration status was controlled for, being Hispanic is associated with reduced medical care and poorer health status than non-Hispanics. [14]

The available data provides no distinction between foreign births versus first- and second-generation residents. Until we learn more about immigration and health care status from the 2000 Census to be released in Summer 2002, it is useful to examine the health status for Arizona's Hispanics from recent vital statistics and risk factor surveys as a proxy for Hispanic immigrants.

In Arizona, Hispanics experience substantial disparities and different health risks compared to the general population. The most significant factor is premature death: Hispanics on average die at age 59.2, or 12.5 years sooner than the Arizona population as a whole, age 71.7. Teen pregnancy, sexually transmitted diseases, tuberculosis, and mortality from diabetes and homicide occur at higher rates among Hispanics than for the state as a whole. See Figure 6.

FIGURE 6

Comparative Hispanic Health Status, Arizona 1999 [18]

Health Indicator	Hispanics	Total Arizona
Average age at death	59.2 years	71.7 years
Teen pregnancy, age 17 & younger (1)	30.1	15.3
Sexually Transmitted Diseases:		
Early syphilis (2)	21.1	10.2
Gonorrhea (2)	154.2	86.8
Chlamydia (2)	408.9	241.0
Tuberculosis (2)	10.7	5.1
Diabetes mortality (2)	26.7	13.5
Homicide (2)	18.6	10.0

(1) rate per 1,000 (2) rate per 100,000

High Risk

Each year the state conducts a telephone Behavioral Risk Factor Survey (BRFS) of adults. In 1999, Hispanic respondents showed higher than average risk for the following factors seen in Figure 7. Lack of health insurance and dental care, overweight and diabetes pose significant risks among Hispanics compared to the rest of the Arizona population.

FIGURE 7

Comparative Hispanic Risk Factor and Chronic Disease Prevalence, 2000 [35]

Risk Factors	Arizona Prevalence	Hispanic Prevalence
No health care coverage	14.1%	34.6%
Diabetes	4.3%	10.6%
No high blood pressure screening	8.8%	15.1%
Never had cholesterol screening	22.6%	35.8%
Never used a blood stool kit (over age 50)	43.5%	74.6%
Overweight (Body Mass Index)	21.9%	30.9%
No dental visit in past year	33.5%	49.9%
Diet: Low fruit & vegetable consumption	69.8%	81.6%

Migrants and Illegal Immigrants

Migrant laborers in Arizona face additional health risks. They may be geographically isolated from health care providers, lack health insurance and face unsanitary working and housing conditions. Occupational hazards typically include dermatitis and respiratory problems caused by dusts, pesticides and exposures to natural substances such as fungi.

Another population at risk is illegal immigrants trying to enter Arizona from Mexico, especially in the heat of summer. Treks across desert terrain and smuggling of illegal immigrants in crowded, hot vehicles led to 77 deaths from dehydration or trauma in the first nine months of 2001.

A Paradox?

An interesting piece of Arizona health data that addresses immigration status is related to maternal and child health: ***Foreign-born Hispanic women in the state have better birth outcomes than their U.S.-born counterparts.***

In a study of Arizona 1990 and 1996 birth certificates, foreign-born Hispanic women had the highest rate of inadequate prenatal care among all ethnic and immigrant groups. Nevertheless, they experienced the lowest rates of low and very low birth weights. This paradoxical effect appears to last for about five years. As these women become more acculturated to American life, their birth outcomes worsen. Factors that relate to low birth weight during acculturation are not well known, but several studies have shown changes such as worsening dietary intake, increased smoking, illicit drug use, alcohol use, loss of family support, increased stress during pregnancy and an increase in out of wedlock births. [7]

The Bottom Line: *Hispanics in Arizona are at higher risk than the general population for a number of preventable health conditions. These health disparities are exacerbated by lack of health insurance, including inadequate access to medical and dental care, occupational conditions and the dangers encountered in entering the state illegally.*

Federal Polices

Immigrant status is the most important criterion for determining whether low-income immigrants are eligible for government health benefits such as Medicaid, Medicare and State Children's Health Insurance.

Welfare Reform

The 1996 welfare law was designed to get people off welfare and into jobs, so the government set a five-year limit on cash benefits for needy families called Temporary Assistance for Needy Families (TANF). It also imposed a five-year ban on Medicaid for new legal immigrants arriving in the U.S. after August 1996. In general, naturalized immigrants are eligible for the same benefits as U.S.-born, but recent legal and illegal immigrants are not. The impact of this policy has essentially been to shift the fiscal burden from the Federal government to states and communities.

The Public Charge Issue

Temporary legal immigrants may be barred from changing to permanent resident status if the government rules that they are likely to become dependent on tax-funded benefits. Before 1996, receipt of cash welfare was considered a "public charge" benefit, but Medicaid was not. In 1999, INS clarified that Medicaid and non-cash benefits like food stamps and nutrition programs for women, infants and children (WIC) would not be considered "public charge" when applying for permanent residence. Immigration status may be jeopardized, however, if immigrants use cash benefits like Supplemental Security Income (SSI), TANF, general assistance programs or Medicaid long-term care nursing home or mental health services. The income of sponsors must also be counted to determine immigrants' eligibility for various benefits.

Medicaid Health Insurance

Medicaid is a means-tested entitlement program for low-income people. Arizona's program, AHCCCS, covers people earning up to 100% of the Federal Poverty Level (FPL). Welfare reform substantially cut non-citizens' Medicaid coverage and created confusion about access to other safety net services. Legal immigrants admitted to the U.S. after 8/22/96 are banned from Medicaid for five years. Illegal immigrants are never eligible. However, the following "Qualified Immigrants" residing in the U.S. prior to 8/22/96 are eligible: legal permanent residents with 40 quarters of work; certain SSI cash recipients; refugees, asylees; Cuban, Haitian and Amerasian immigrants; parolees; and other special categories. Federal funding of 65% is matched by the state at 35%.

Before August 1996, legal immigrants had the same access to Medicaid and public benefits as U.S. citizens. Several lawsuits now in the courts claim that all legal immigrants who meet the income eligibility guidelines, regardless of arrival date in the U.S., deserve equal protection under the constitution and should be covered by Medicaid.

Refugees and Asylees

Immigrants who are granted "refugee" and "asylee" status are eligible for public benefits (e.g. Cubans who escape for political reasons). However, undocumented immigrants from Guatemala and El Salvador may leave their country for political reasons but not be granted refugee status.

Emergency Care

Under the Emergency Medical Treatment and Labor Act of 1987 (EMTALA), hospitals must provide emergency care to all patients regardless of their immigration status or ability to pay. The impact of this policy is to shift the fiscal burden from the Federal government to states and hospitals.

Linguistic Policy

Health care providers must ensure language interpreters for patients, but language problems are common. While Spanish is the most common language of Arizona immigrants, translation services are more difficult to provide for smaller number of immigrants from Korea, China, Vietnam, Russia and other countries of origin. There is little data to determine if this policy is being followed. [12]

State Children's Health Insurance Program (CHIP)

This means-tested program, Arizona's "KidsCare," provides coverage for several types of children if their family income is 200% of FPL or less:

- Children born in the U.S. are citizens and automatically eligible. Parents who are illegal immigrants may be reluctant to enroll eligible children for fear that their status may be revealed to immigration authorities.
- Legal immigrants who arrived in the U.S. before August 1996.
- Legal immigrants who arrive after August 1996 become eligible after five years.

Required documentation includes a declaration of citizenship or immigration status of the child-applicant, not the family. No social security number is required. Children who are illegal immigrants are not eligible. Federal funding is matched by the state at a ratio of 75:25.

Social Security

Supplemental Security Income (SSI) pays cash assistance to disabled people with few resources and low income. All cash SSI recipients are mandatory Medicaid recipients. Welfare reform restricted access to this program for immigrants. Benefits are limited to qualified aliens and immigrants who meet one of the eight eligibility categories including:

- People receiving SSI on 8/22/96 and are lawfully in the U.S.
- Legal immigrants admitted for permanent residence who have 40 qualifying quarters of work.
- Those on active duty in the Armed Forces.
- Legal immigrants in the U.S. on 8/22/96 and blind or disabled.
- Refugees, asylees, Amerasians and others granted special status.

Medicare

Citizens or permanent residents of the U.S. are eligible for this health insurance program at age 65 if they worked for at least ten years in Medicare-covered employment. Younger people may qualify if they have a disability or End-Stage Renal Disease. Coverage is not available to recent immigrants, illegal aliens or to elders who move to the U.S. from other countries to join their families.

Federal Emergency Services Program (FES)

Illegal and qualified aliens who are not eligible for Medicaid or Medicare are always eligible for emergency services under this program. If they earn less than 100% of FPL and belong to categories such as children, families with children, pregnant women, aged, blind or disabled, then immigrants are eligible for medical services for sudden onset and acute symptoms so severe that medical attention is required. For pregnant immigrant women, labor and delivery services are provided, but not prenatal care. FES reimbursement goes to Arizona providers with no charge to patients. In FY 2000-01, the federal government paid $7.99 million for emergency services provided to 7,705 immigrants served by this program. [16]

State Omnibus Budget Reconciliation Act (SOBRA)

This federal-state matching program provides Medicaid coverage for prenatal care, labor and delivery, and family planning services for two years post-delivery. Uninsured low-income U.S. citizens and legal or qualified aliens who came to the U.S. before 8/22/96 are eligible.

Disproportionate Share

Hospitals that provide uncompensated care to indigents receive "disproportionate share" payments based on a federal formula. In FY 2000, $80,999,991 in Federal funds was paid to 28 private hospitals, three public hospitals and two children's facilities in Arizona. With the state match, total payments were $122,876,200. [16]

Immigration and Naturalization Service (INS)

This agency determines who may be admitted into the U.S. and enforces immigration laws. The Border Patrol secures ports of entry and 8,000 miles of land and water along the national borders. Arizona is part of the Southwest Border sector, which also includes California, New Mexico and Texas. Over 1.6 million illegal immigrants were apprehended as they tried to enter these four states in FY 2000. Most waived their rights to hearings and voluntarily returned to Mexico. Tougher enforcement strategies in El Paso and San Diego have pushed illegal immigrants toward Arizona, which has more apprehensions than any other state. An unknown number of illegal immigrants escape detection and become U.S. residents. [34]

Title X

The federal Public Health Service Act of 1970 created Title X grants for family planning services to low-income women. Arizona's program is administered through the Arizona Family Planning Council, a private, nonprofit agency. Immigration status is not an issue.

Title V Maternal Child Health Block Grant

Arizona receives nearly $7 million annually to promote maternal and child health. The Arizona Department of Health Services (ADHS) uses this funding along with state matching funds for population-based and direct/personal health programs and services. The following is a list of personal/direct program services:

- **CHILDREN'S REHABILITATIVE SERVICES.** This program provides medical and rehabilitative services to children with complex medical problems. Undocumented immigrant children were included until July 1, 2000, when the state changed eligibility criteria. An estimated 120 severely disabled illegal immigrant children would have enrolled in the program in 2001 and each year thereafter if the old policy had remained in effect. This population remains one of the most vulnerable and underserved among all of Arizona's immigrants.
- **NEWBORN INTENSIVE CARE.** This program provides transportation for high-risk mothers and infants, neonatal intensive care, maternal hospital care and follow-up case management by county health nurses. All newborns born in Arizona that meet the medical criteria are eligible.
- **DENTAL SEALANTS.** Children with no access to dental care can receive sealants to prevent tooth decay through this school-based program. There is no citizenship requirement.
- **FAMILY PLANNING.** Comprehensive contraceptive services are provided at county clinics for uninsured, low-income women. There is no citizenship requirement.
- **SCREENING AND EARLY INTERVENTION.** Children age 0-3 are screened for health and social risks and referred for early intervention services. There is no citizenship requirement.

Women, Infants and Children's Nutrition Program (WIC)

The U.S. Department of Agriculture provides funding for food assistance through vouchers for needy women and children, regardless of immigration status.

Breast and Cervical Cancer Screening

Funding from the Federal Centers for Disease Control provides cancer screening for low-income women. If tumors are detected, women are referred to Medicaid for treatment. However, non-qualified and illegal immigrants are ineligible and must find care elsewhere in the "safety net."

State Policies

State Emergency Services (SES)

State funds pay 100% of the cost of acute emergency medical services for illegal and qualified aliens who are single adults and couples without children. This program is more restrictive and less generous than FES: the patient's income must be less than 40% of the FPL. In FY 2000-01, 227 immigrants were served by this program at a cost to the state of $18.5 million. [16]

Tobacco Tax Primary Care Services

(See Arizona safety net services.)

Proposition 204

This successful ballot initiative raised eligibility for Medicaid/AHCCCS to 100% of FPL by October 1, 2001, up from the former level of 40% for adults. All of the state's tobacco litigation settlement – about $100 million annually – will be used to cover enrollment for several hundred thousand more uninsured people within five years. A conflict is brewing because the initiative states that "any person who has an income...between zero and 100% of the FPL is eligible for AHCCCS." However, the agency's rule package does not grant eligibility to recent legal immigrants and illegal immigrants. Litigation can be expected on this issue.

Premium Sharing

Tobacco tax subsidizes health insurance for low-income families who are ineligible for AHCCCS. Eligibility includes families with income up to 200% FPL and chronically ill individuals with income up to 400% FPL. Members pay a monthly premium. This three-year pilot program enrolled an average of 8,000 participants in 2001, when the Legislature extended the program statewide. Most low-income immigrants may consider the premium too expensive, and there is no data on their participation.

Health Care Group

Arizona's tobacco tax subsidizes this program, which offers a choice of three commercial health insurance plans for employees in small businesses or the self-employed. In 2001, the average enrollment was 12,000 members. Seventy-three percent of enrollees earn more than $20,000. So, while there are no restrictions regarding immigration status, this program is unlikely to cover many low-wage immigrants.

State-Funded Add-Ons to Medicaid (AHCCCS)

SB1357, passed on 4/21/97, provides full Medicaid services through "state option." Federal and state matching funds cover qualified immigrants who belong to specific categories. There are a number of complex eligibility requirements, and certain categories gain coverage under the state option. A chart that provides the detail of these options is available at AHCCCS's *Medical Eligibility for Immigrants, 1999.*

The State Experience

All states have to operate under Federal Medicaid policy that prohibits funding for illegal and recent legal immigrants. How do other states approach this issue, and what can Arizona learn from their experience?

Thirteen states use state-only funds to cover new immigrant children for Medicaid, while nine states cover them in CHIP programs. California has the most generous benefits for immigrant children and adults. Figure 8 shows some of the adaptations provided by states with the largest immigrant populations. Arizona does not provide Medicaid or CHIP coverage for unqualified or illegal immigrants but could exercise this option with state-only funds.

FIGURE 8

Health Policies in States With the Largest Immigrant Populations [11, 16]

	California	Florida	Illinois	New Jersey	New York	Texas	Arizona
Medicaid to Immigrants in U.S. before 8/96	▮	▮	▮	▮	▮	▮	▮
State-Only Funded Medicaid to Immigrants in U.S. after 8/96	▮		▮				
Medicaid to Immigrants following 5-Year Ban	▮	▮	▮	▮	▮		▮
Medicaid to Unqualified Immigrants	▮			▮	▮		(1)
State Health Program includes Immigrants (2)	▮	▮		▮	▮		(3)
CHIP Program includes Immigrants	▮		▮		▮	▮	(4)

Notes:
States are barred from using federal funds for five years for immigrants arriving after 8/96 but can use state funds.
The first six states account for almost 70% of US immigrants.
(1) AZ provides Federal Emergency Services (FES) only.
(2) Defined as services to elderly and disabled, families and children, childless adults.
(3) AZ provides State Emergency Services (SES) only.
(4) Same eligibility rules as Medicaid; illegal and unqualified immigrants not eligible.

States have developed programs to increase insurance coverage for low-income residents. Some of these principles could be applied to increase access for immigrants: [17]

- New Mexico established a purchasing pool to provide affordable health insurance for small businesses and individuals. It has become a high-risk pool with rising expenses and premiums.
- Kansas has a tax credit for small employers to provide health insurance for employees. The maximum state contribution is $35/month, which phases out by the sixth year.
- Hawaii mandates that employers offer and help to pay for health insurance for full-time workers. Massachusetts and Washington passed similar mandates that were eventually repealed because small businesses protested that rising costs would harm their bottom line.
- Massachusetts subsidizes small employers with up to 50 employees under an "Insurance Partnership" component of the MassHealth Family Assistance program. This program helps pay for health premiums for low-wage workers and low-income, self-employed individuals.

Communities with large immigrant populations also have experimented with innovative approaches to preserve safety net services for immigrants:

- Los Angeles developed a Public Private Partnership Program, funded under a Medicaid Section 1115 waiver, to help non-profit clinics pay for services to low income, uninsured clients.
- New York added requirements to Medicaid Managed care contracts for language accessibility and interpretation services.
- Community groups in Los Angeles and the San Fernando Valley in California developed a small insurance network for low-income immigrants.
- Advocates shaped policy in New York and California by litigation, which blocked, delayed or modified executive and legislative actions.
- Los Angeles aggressively tried to increase Medicaid and CHIP enrollment while defusing concerns about the public charge issue. [13]

"The United States has no immigration policy."

~ (former immigration official)

Country Policies

Other industrialized countries provide an array of health services for immigrants and visitors, as seen in Figure 9. Countries which cover non-citizens usually provide the same benefits for all legal immigrants. Two countries single out specific populations. Spain covers immigrant children under age 18. Italy covers legal immigrants, but the only services for illegal immigrants are infectious disease and health care treatment for pregnant women and babies.

FIGURE 9

Summary of Health Coverage for Immigrants in Other Countries [25]

Country	Financing of Health System	Non-Citizen Coverage
United Kingdom	Payroll taxes, general revenue & user fees	Same for all residents regardless of citizenship. Reciprocal agreements with other European countries for visitors
Sweden	Income tax & user fees	Same for all residents regardless of nationality. Reciprocal exchange with all EU countries & 7 others
Spain	General revenue & some private insurance	Children under age 18
Italy	Regional value add & income taxes, user fees	Legal immigrants covered. Limited services for illegal immigrants = infectious disease treatment & health care for babies/ pregnant women
New Zealand	General revenue & user fees	Permanent residents & persons with immigrant visas covered
Germany	Payroll taxes by employers & employees, user fees	Local social support systems funded by the cities
Switzerland	Income taxes & user fees	Emergency care only
France	General revenue & cost sharing paid by mutual aid funds	Limited; illegal immigrants can use charitable associations
Mexico	Employer, employee, state & user fees	Emergency care only
Canada	Provincial & federal taxes; decentralized system with differences among provinces	Legal immigrants covered; emergency care only for illegal immigrants

The Bottom Line: *Federal policies on immigration and eligibility for Medicaid are unlikely to change soon. Arizona has twice the percentage of Hispanics compared to the U.S., and almost one third of Arizona's Hispanics are uninsured. Other states and industrialized countries provide more generous health insurance options for immigrants. Arizona could explore these models to determine the feasibility of expanding AHCCCS and KidsCare benefits to immigrant children, pregnant women, recent legal immigrants and illegal aliens by using 100% state funding. The state could also evaluate options involving employers, mandates and community-based efforts.*

Myth: **The harsh enforcement of immigration laws and borders will stop the influx of illegal immigrants from Mexico.**

Reality: **The population of Mexican immigrants is growing and will continue to expand in Arizona. Concerns observed today are likely to become exacerbated if they are not addressed.**

Arizona stakeholders hold a number of attitudes and beliefs in common. They understand that there is a complex relationship between access to care for immigrants and their health status, education, occupation, income, productivity and ultimately the viability of Arizona's economy. These common themes can serve as the starting point for an open and civil discussion about ideological differences.

Perhaps the biggest ideological divide is between those who think that illegal immigrants should not be eligible for any benefits or safety net services, versus others who acknowledge the economic contribution of immigrants and want to reduce their health care barriers through state funding and programs.

Arizona has the opportunity to explore some new strategies to address the needs of the state. These options might be considered along a continuum of public and private alternatives.

The Options Considered

1. Do Nothing

PRO: In the short term, this strategy may appear to be least expensive. Revenue shortfalls put pressure on lawmakers to reduce expenditures and keep taxes low. Ideological differences lead some lawmakers to oppose incentives for illegal immigrants or entitlement to public benefits for any new group.

CON: Over time the state may pay more for expensive emergency care than it would for basic preventive and primary care for today's uninsured low-income immigrants. The state should promote strategies that shift immigrant health care delivery away from emergency care settings and into more efficient, less costly ambulatory settings. Continued low investment in education for immigrant children will perpetuate low educational achievement and the prospect of low-wage jobs. The future prosperity of Arizona is at stake.

2. Expand AHCCCS and KidsCare

Arizona could elect to use state-only funds to extend AHCCCS and KidsCare to one or more groups of currently ineligible immigrants.

- children
- prenatal care for pregnant women
- recent legal immigrants
- unqualified and illegal immigrants

PRO: All children in the state are eligible for public school education, so many stakeholders believe that all low-income children, including recent and illegal immigrants, should also be eligible for KidsCare and AHCCCS. This is the least costly age group to insure. Access to care would provide lifelong health benefits. Prenatal care for pregnant women is also cost effective. As a matter of equity and constitutional protection, all legal immigrants should be covered, according to advocates for equal justice. Initial state costs for extending coverage to immigrant groups could be offset by later savings in emergency care and hospital bailouts. There is

PUBLIC
AHCCCS/ KidsCare
Better Data
Strengthen the Safety Net
English Language
Employer Incentives
Alternatives
Mandates
PRIVATE

political support to fund increased access to care by raising tobacco and alcohol taxes.

CON: Opponents resist any new entitlements on ideological grounds. Immigrants who come to Arizona should work and take care of their own families, and not depend on state benefits. Illegal immigrants should not be eligible for public benefits. Any new benefits for immigrants will increase the incentives for them to come to Arizona. Taxes should be cut, not raised, in a time of economic downturn; taxes are already too high.

3. Collect Better Data

Arizona lacks information about the number and types of immigrants who live in the state; consequently, it is difficult to assess their needs, barriers and economic impact. The state could make a modest investment in data systems that provide more accurate information to decision makers, providers, schools, employers and advocacy groups. For example, it would be useful to know employment and insurance coverage patterns among immigrants, the amount of hospital uncompensated care attributable to immigrants, health care utilization, number/location and characteristics of migrant agricultural workers, and patterns of illegal immigration.

PRO: State policies and resources for immigrants could be based on more accurate estimates of needs, costs and benefits of various strategies. Safety net programs could be placed in areas that are currently underserved. Coalitions of stakeholders could participate in identifying needs and helping to develop strategies regarding immigrants.

CON: There is no mandate for the state to develop an immigrant information system. Advocates for immigrants fear that more detailed information could be used to apprehend people and to withdraw safety net services.

4. Formalize & Strengthen the Safety Net

The current safety net for uninsured immigrants includes hospitals, community clinics, school-related health services, county programs and a variety of federally funded services. These providers are not well coordinated to address gaps and barriers, and funding varies from year to year. As an alternative to expanding AHCCCS and KidsCare, the state could formally acknowledge and promote these concepts:

- Support for safety net services is essential to the state's welfare, and a proper use of state funds.
- The state and communities will assess primary care needs in medically underserved areas and develop a strategic plan to address gaps or barriers in areas with inadequate services.
- Immigrants should be encouraged and assisted to enroll in community clinics for regular care rather than use emergency rooms for episodic care.
- School-based and school-linked clinics should be expanded and supported with new sources of funding.

Under this scenario, the state could provide organizational leadership for more coordination, allocate more state money to these services, and seek new opportunities for Federal funding.

PRO: Immigrants gain better access to care without granting new entitlements by the state. Safety net providers could rely on stable funding. School clinics could serve communities where other providers are not available.

CON: Safety net services would be targets for budget cuts during economic downturns, or when fiscal conservatives prevail in the legislature. Taxes should be cut, not raised; taxes are already too high. Health care is a privilege, not a right, especially for those who are here illegally.

5. Strengthen English-Learner Programs in Schools

A Federal Court order requires Arizona to ensure that students overcome language barriers by increasing school funds and programs for immigrant children.

PRO: Compliance will provide smaller classes, more qualified teachers and aides to help children learn English. Potential outcomes include improved academic achievement, higher completion rate for 12th grade, and more children, especially Hispanics, who qualify for higher education and better jobs.

CON: Opponents dislike being pressured into spending money by the Federal Court. Opposition is based on philosophy, racial discrimination and financial concerns, according to some legislators. The court can impose sanctions if the state fails to comply.

6. Incentives for Employers to Provide Health Insurance Coverage

The goal is to stimulate the development of basic affordable health coverage for uninsured workers. Several models might be explored:

- **Trade Association Plans:** Several statewide associations have developed voluntary health plans for their members. Participation in the plans varies, and some businesses offer no benefits at all. Even when insurance is offered, some low-wage employees opt out because premiums and co-pays reduce take-home pay.

  PRO: New, basic health plans could be designed to be affordable for both employers and employees. More workers could have access to health insurance for themselves and dependents. The larger the pool of employees to be insured, the lower the chance of adverse risk selection, which causes some pools to fail. The cost would be borne by businesses, not the state.

  CON: Employers and health insurance plans may have low incentive to participate. Employers could opt out of voluntary plans, as many do now, claiming that the cost is too high.

- **State insurance pool:** Pools, which include a large number of businesses with employees of diverse ages, could negotiate lower cost plans for small employers and individuals. The state could provide start-up funding and administration, then require any employer who does not voluntarily provide health insurance to workers to contribute to the pool.

  PRO: This plan provides an incentive for employers to offer health insurance to all workers. All employers have the option to either provide coverage or pay into the pool. This plan is equitable for all businesses.

  CON: Pools with a disproportionate share of high-risk participants incur excessive medical expenses (adverse selection), driving up the cost of premiums. Private health plans and agents oppose state-run plans. State subsidies would be needed to support this concept. Administration of a pool would be costly.

- **Employer buy-in:** The state could subsidize employer-based coverage where the employer contributes only 50% of the premium. This is being tried in Massachusetts to expand CHIP.

  PRO: Provides a source of funding to extend eligibility to more children.

  CON: This plan may reduce incentives for employers to offer health coverage independently, shifting some of the burden to the state budget. Administrative cost might be expensive.

"The United States is not likely to adopt a universal health care system, but is more likely to retain a market-based patchwork of services – two or three tiers of service including private and employer-based health insurance, government-based, and safety net services for the ineligibles. It may be more practical for Arizona to support safety net services for immigrants rather than providing state money for their health coverage in AHCCCS and KidsCare."

~ (professor & health expert)

7. Mandates

Several types of mandates might be considered.

- **Require employers to provide health insurance for all full-time workers:**
  PRO: This model would be uniform and the most effective method to reduce the rate of the uninsured. It succeeds in Hawaii.
  CON: A mandate would raise the costs of doing business for employers and make their products or services more expensive for consumers. This would put Arizona businesses at a competitive disadvantage. Hawaii is geographically isolated and not comparable to Arizona.
- **Regulate insurance plans:** State insurance rules could limit premiums or require employers to offer standard benefit packages.
  PRO: More low-income workers and dependents could gain insurance coverage.
  CON: Employers and health plans oppose mandates.
- **Require all employers to contribute to the state health insurance pool:** This pool could provide coverage for uninsured immigrants and their families.
  PRO: More low-income workers and dependents could gain insurance coverage.
  CON: Employers and health plans oppose mandates. A pool might be costly to administer.

8. Other Alternatives

- **Discounts:** Expand opportunities for group discounts for ambulatory and hospital care and medical and prescription drugs. Tucson community health clinics and the Arizona Latin-American Medical Association (ALMA) are testing discount plans for their clientele.
  PRO: Discounts can provide more affordable services and prescriptions for uninsured immigrants who must pay fees for services.
  CON: Limited history of community-based initiatives in Arizona. Leaders need to be recruited to organize stakeholders and negotiate discounts.
- **Partnerships & Local Initiatives:** Encourage private-public partnerships at the county or regional level to develop demonstration projects that improve access to care for immigrants.
  PRO: Demonstration projects can provide Arizona-specific information about populations, health utilization, costs and benefits, and develop potential systems that could benefit the entire state.
  CON: Start-up, matching and grant funds must be generated to support local projects.
- **Culturally-Appropriate Outreach:** Churches, community organizations, providers, schools and employers could collaborate to offer information for immigrants at worksites, community agencies and schools on how to access benefits, navigate managed care plans and utilize safety net services.
  PRO: Outreach and information will promote acculturation.
  CON: Leaders, volunteers and funds would be needed to initiate and support these programs.

What Do the Stakeholders Say?

Some common themes emerged among stakeholders who were interviewed for this report:

- Mexicans are likely to continue to migrate into Arizona, whether legally or illegally.
- Employment is the magnet. Employers need immigrants to fill essential jobs, and immigrant workers make a substantial contribution to the state's economy.
- Illegal immigrants are the biggest problem. There is general agreement that legal immigrants should all be eligible for benefits and treated equitably.
- It's easy for illegal immigrants to get fraudulent documents and use them for access to jobs.
- We should address the underground immigrant economy. A guest worker program would be helpful if immigrants were given legal standing documentation; accountability would be achieved.
- The federal government is not likely to change immigration policy soon. We should explore changes at the state level.
- There is no political will to deal with the needs of non-citizens or to expand services. We can't avoid the issue by ignoring it.
- Hospitals should be reimbursed for emergency services to immigrants. This is a problem created by federal policy, so the federal government should pay for it.
- There is little accurate data about immigrants in Arizona. We need data on who is here and how people use services in order to address costs, needs and strategies.
- Advocates fear that if safety net providers track the number of immigrants whom they serve, especially illegal immigrants, attention will be drawn to the issue, and conservatives in the legislature will try to cut off funds.
- Emergency rooms are not the best places to get basic health care. It is cheaper to provide regular ambulatory care than hospital emergency care.
- Lawsuits may be a useful strategy to address inequities among legal immigrants.
- Learning English is an important way for immigrants to get into the culture. Otherwise they remain second-class citizens who cannot participate in the society.
- There are two differing political philosophies among stakeholders in Arizona:
    - One group believes that immigrants are here, working and productive. We should address their health care gaps and barriers.
    - Another group wants strict enforcement of immigration laws to discourage illegal immigrants from coming here. Those who do come should provide for themselves. Benefits should be limited to citizens only.

Conclusion

No one policy direction will resolve the significant problems of immigrants who lack access to health care in Arizona. It will require a coalition of stakeholders to address the complex interrelationships among factors such as education, employment and health status. Immigrants are here to stay, and they will keep coming. How the state responds will determine the long-term prosperity of Arizona and all of its people.

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Barbara Burkholder is a public health consultant with experience in the public, private and nonprofit sectors. Her expertise includes community organizing, strategic planning, needs assessment, program development and management as well as writing and advocacy on public policy issues. In her role as Executive Director of the Arizona Public Health Association, she provided leadership to statewide coalitions, communicated information to the public and policy makers and served as an advocate for public health policy on a local, state and national level. Before moving to Arizona in 1989, she directed health promotion programs at one of the largest hospitals in Michigan and the State University of New York at Albany.

Arizona Health Futures *is the health policy and education arm of SLHI. Its purpose is to conduct relevant and timely research; provide balanced, non-partisan information and perspectives on health issues in Arizona; serve as a convener and forum for the critical discussion of those issues in an independent and policy-neutral setting; and translate good ideas into action through the support of community-based initiatives.*

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