

# UNDOCUMENTED and UNINSURED

## Barriers to Affordable Care for Immigrant Populations

Steven P. Wallace, Jacqueline M. Torres,  
Tabashir Z. Nobari, and Nadereh Pourat  
UCLA CENTER FOR HEALTH POLICY RESEARCH

AUGUST 2013



**The Commonwealth Fund**, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

---

The **UCLA Center for Health Policy Research** is one of the nation's leading health policy research centers and the premier source of health policy information for California. The Center improves the public's health by advancing health policy through research, public service, community partnership, and education.

---

# UNDOCUMENTED and UNINSURED

## Barriers to Affordable Care for Immigrant Populations

Steven P. Wallace, Jacqueline M. Torres,  
Tabashir Z. Nobari, and Nadereh Pourat

UCLA CENTER FOR HEALTH POLICY RESEARCH

AUGUST 2013

**Abstract:** The Affordable Care Act will significantly reduce the number of U.S. residents without health insurance and ensure appropriate access to health services, but the law specifically excludes one group from all its provisions: the approximately 11 million undocumented immigrants residing in this country. Research nationally—and new data from California—show that undocumented residents are most often young, working adults who are in good health but infrequently use health services. Projections show the health reform law will have little impact on health insurance coverage for such individuals, and excluding them from coverage under the law will create new financial pressures on safety-net hospitals. Strategies for improving coverage and access for undocumented immigrants include: providing comprehensive insurance coverage to some or all undocumented immigrants; providing coverage for specified services; and decreasing the out-of-pocket health care costs of undocumented immigrants by increasing direct funding to providers who offer free or low-cost services.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and [register to receive email alerts](#). Commonwealth Fund pub. 1699.



## CONTENTS

ABOUT THE AUTHORS .....	6
ACKNOWLEDGMENTS .....	6
EXECUTIVE SUMMARY .....	7
INTRODUCTION .....	9
TRENDS AND DATA NATIONALLY AND IN CALIFORNIA .....	9
HEALTH INSURANCE RATES AMONG UNDOCUMENTED IMMIGRANTS WILL REMAIN LARGELY UNCHANGED AFTER AFFORDABLE CARE ACT IMPLEMENTATION.....	12
POLICY LESSONS FROM HOME AND ABROAD .....	12
ABOUT THIS STUDY.....	15
NOTES.....	16

## LIST OF EXHIBITS

EXHIBIT 1	LABOR FORCE PARTICIPATION RATES, POVERTY RATES, AND UNINSURANCE RATES, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS (UNADJUSTED), 2009
EXHIBIT 2	HEALTH CONDITIONS AND HEALTH BEHAVIORS, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS, ADJUSTED FOR AGE AND GENDER, 2009
EXHIBIT 3	HEALTH CARE ACCESS AND UTILIZATION, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS, ADJUSTED FOR AGE AND GENDER, 2009
EXHIBIT 4	PERCENT OF UNDOCUMENTED IMMIGRANTS UNDER AGE 65 WITHOUT HEALTH INSURANCE, SELECTED STATES AND U.S., 2012 AND 2016 PROJECTIONS

## ABOUT THE AUTHORS

Steven P. Wallace, Ph.D., is associate director of the UCLA Center for Health Policy Research and professor and chair of the department of community health sciences at UCLA Fielding School of Public Health. He has conducted research on immigrant incorporation and access to health care for almost 30 years, beginning with his study on the Immigration Reform and Control Act of 1986. He also leads several studies of the impact of state health policies on vulnerable populations. Wallace has a Ph.D. in sociology from the University of California, San Francisco. He can be emailed at [swallace@ucla.edu](mailto:swallace@ucla.edu).

Jacqueline M. Torres, M.A., M.P.H., is a graduate student researcher at the UCLA Center for Health Policy Research. She is conducting research on the effect of migration on the health of older Mexicans, and has published on the effect of immigration stress on the health of Latino immigrants in the United States. Torres has an M.A. in Latin American Studies and an M.P.H. in Community Health Sciences from UCLA.

Tabashir Z. Nobari, M.P.H., was a graduate student researcher at the UCLA Center for Health Policy Research. Her research interest is the nutritional outcomes of immigrants and low-income populations, and she has published on the effect of immigrant enclaves on obesity among very young children in Los Angeles County. Nobari has an M.P.H. in international epidemiology from the University of Michigan.

Nadereh Pourat, Ph.D., is professor of health policy and management at the UCLA Fielding School of Public Health and director of research at the UCLA Center for Health Policy Research. Her research interests include disparities in access to health care for underserved populations such as undocumented, elderly, and the uninsured; implementation and outcomes of patient-centered medical home; safety-net system integration and care delivery challenges; long-term care services; and oral health care. She has a Ph.D. in health services from UCLA.

## ACKNOWLEDGMENTS

The authors gratefully acknowledge reviewer comments from Sonal Ambegaokar, Frank Bean, Max Hadler, Manuel Pastor, Beatriz Solis, and Arturo Vargas Bustamante. This Fund issue brief was drawn from a longer report, which contains both adjusted and unadjusted California data and extensive citations to the literature, available at <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1194>.

---

*Editorial support was provided by Deborah Lorber.*

## EXECUTIVE SUMMARY

The Affordable Care Act will significantly reduce the number of U.S. residents without health insurance to ensure appropriate access to health services, but the law specifically excludes one group from all its provisions: the approximately 11 million undocumented immigrants residing in this country.

In California, where almost one-quarter of the nation's undocumented immigrants reside, data show that, as compared with lawful permanent residents (LPRs), naturalized citizen immigrants, and U.S.-born nonelderly adults, undocumented immigrants:

- have the highest male labor force participation (95%);
- are younger (90% are between ages 18 and 44);
- are more likely to live in families with children (61%);
- have the highest rates of poverty (57%); and
- have the highest rate of being uninsured (51%).

When statistically controlling for age and gender, undocumented residents of California have a health profile that is generally similar to U.S.-born residents. Undocumented immigrants report the lowest rates of asthma but the highest rates of obesity and being overweight. This is significant since obesity and being overweight increase the risk of diabetes, hypertension, and other conditions where timely access to medical care is essential.

Access to health care in California is significantly worse for undocumented immigrants, even after controlling for age and gender. Compared with LPRs, naturalized citizen immigrants, and U.S.-born nonelderly adults, undocumented immigrants:

- have the highest rate of having no usual source of care (35%);
- are the least likely to have seen a doctor in the past year (28%); and
- are the least likely to have used an emergency department in the past year (12%).

Estimates presented in this report show that the health reform law will have little impact on the coverage of undocumented residents. Nationally, an estimated three-fifths (61.5%) of nonelderly adults who are undocumented immigrants are expected to remain uninsured. As a result, undocumented residents will make up a larger share of the remaining uninsured population in the country. In states with the highest concentration of undocumented immigrants, such as California, they will account for up to two-fifths of all remaining uninsured residents.

Undocumented residents are concentrated in a small number of states. As a result, safety-net hospitals in those states will be particularly affected by the reduction in disproportionate share hospital (DSH) payments scheduled under the Affordable Care Act that have previously cushioned the impact of providing uncompensated care. Many hospitals are expected to have a lower uncompensated care burden as a result of fewer uninsured patients, but those with a large proportion of undocumented immigrants may not experience the increase in insured patients that would otherwise be expected.

Despite being in working families, most undocumented immigrants are not covered by health insurance and face significant access-to-care barriers. Policy innovations for undocumented residents from around the United States and internationally provide examples of how access to health care can be improved. These include:

- expanding insurance options to undocumented residents, either directly as in Vermont's proposed single-payer system, or indirectly through increased employer coverage;
- increasing access to specific high-value services through low-cost or free care to those without health insurance; and
- maintaining or increasing subsidies to safety-net providers in communities with a high number of immigrants to allow them to provide uncompensated or low-cost services to all persons without health insurance.

The Affordable Care Act's goal of affordable, quality health care for all will not be achieved unless policies also assist the country's approximately 11 million undocumented residents. Helping improve access to care or health insurance coverage is an investment in maintaining the good health of this population and will also stabilize the financial viability of safety-net providers who are essential to the residents of their communities.

# UNDOCUMENTED AND UNINSURED: BARRIERS TO AFFORDABLE CARE FOR IMMIGRANT POPULATIONS

## INTRODUCTION

The Affordable Care Act aims to provide affordable, quality health care for all Americans and reduce the growth in health care spending. The law improves access to coverage by expanding eligibility for the Medicaid program, providing subsidies for middle-income individuals to help buy individual insurance policies, and creating financial incentives for employers to offer health insurance. However, despite efforts to cover the entire population, the law explicitly bars undocumented residents from all of its provisions. Furthermore, immigrants in two categories—those with “deferred action” status or those with registered provisional immigrant status (both discussed later in this report)—are also excluded from receiving health insurance coverage under the law’s health exchanges or public benefits expansions.<sup>1</sup> As a result, the Affordable Care Act will not benefit the approximately 11 million undocumented residents in the United States and their families, as well as the health care providers they rely upon. In addition to providing nationwide data, this report focuses on the state with the largest number of undocumented residents, California. It reports on the health status and health usage of undocumented immigrants and suggests policy alternatives that could improve their access to health care.

## TRENDS AND DATA NATIONALLY AND IN CALIFORNIA

Few national studies provide information beyond the number and general characteristics of undocumented immigrants. With almost one-quarter of all undocumented immigrants living in California,<sup>2</sup> the California Health Interview Survey provides a unique data source on the health status and health care use of undocumented immigrants. Undocumented residents in California are more likely to be from Mexico than undocumented immigrants nationally (70% v. 58%) and

are somewhat less likely to be from Central or South America and Africa.

## Undocumented Immigrants Are Primarily Young Adults in Working Families with Low Incomes and Low Rates of Health Insurance

Nationally, undocumented immigrants are younger than other immigrant groups and the U.S.-born adult population. In 2009, the median age of undocumented immigrant adults was 35.5 years, compared with 45.9 for legally residing immigrant adults and 46.3 for U.S.-born adults.<sup>3</sup> In California, nearly 90 percent of non-elderly adult undocumented immigrants in 2009 were between 18 and 44 years old, compared with only 40 percent of nonelderly adult U.S.-born citizens.

Undocumented immigrants are often members of “mixed-status” families that include U.S.-born children. An estimated 5.5 million children of undocumented immigrants lived in the United States in 2009, the majority of whom (73%) were U.S.-born.<sup>4</sup> In California, 61 percent of undocumented adult residents lived in families with children, compared with 32 percent of U.S.-born residents.<sup>5</sup> U.S.-citizen children of undocumented immigrants are eligible for all public programs, but often face barriers to health care because of concerns that undocumented family members might be identified and reported to immigration authorities as the result of their children’s participation.<sup>6</sup>

Undocumented immigrants are heavily engaged in the labor force. Nationally, undocumented immigrants accounted for 5.7 percent of the labor force in 2010 although they composed only 3.7 percent of the U.S. population.<sup>7</sup> In California, undocumented immigrant men ages 18 to 64 had the highest labor market participation rate of any group (Exhibit 1). Undocumented immigrants pay a variety of taxes, making contributions at local, state, and federal levels. Those who receive registered provisional immigrant (RPI) status under proposed immigration reform bills will be required to pay any back taxes owed.<sup>8</sup>

Despite high levels of participation in the labor force, undocumented immigrants have disproportionately low incomes. In California, over half (57%) of undocumented immigrant adults were living in households with incomes below the federal poverty level in 2009,<sup>9</sup> a rate five times higher than the approximately 11 percent of U.S.-born and naturalized citizens (Exhibit 1).

Undocumented immigrant adults are generally not eligible for Medi-Cal, California’s Medicaid program, and disproportionately work in industries that have low rates of employer-provided health insurance (e.g., construction). As a result they have the highest rates of uninsurance; 51 percent were uninsured compared with 34 percent for immigrants with lawful permanent residency (LPR) status (Exhibit 1).

### Health of Undocumented Immigrants Is Similar to Other Immigrant and U.S.-Born Groups

Studies from around the country consistently show that undocumented immigrants have similar or better levels of health compared with U.S.-born citizens, naturalized citizens, and immigrants with LPR status.

The trend is similar in California. The health status of the nonelderly adult undocumented resident population is quite good. The diabetes and high blood pressure rates of undocumented nonelderly adults (9.2% and 24.8%, respectively) appear similar to other groups,

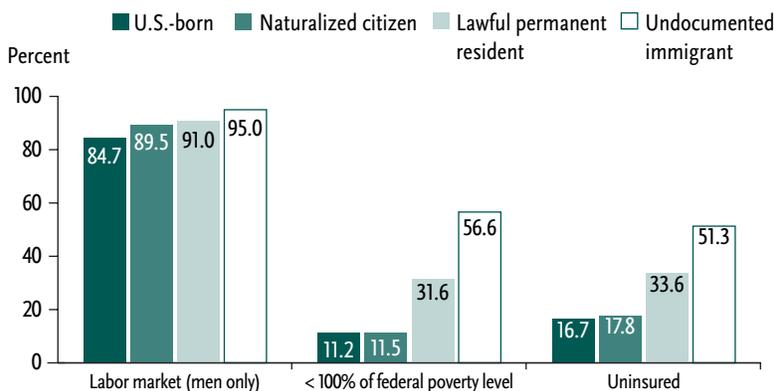
when data are adjusted for age and gender (Exhibit 2). The observed (i.e., unadjusted) rates of diabetes and high blood pressure are much lower for undocumented nonelderly adults (4.4% and 14.1%, respectively), given their younger age distribution (data not shown). Asthma rates are lower for undocumented nonelderly adults compared with U.S.-born and naturalized citizens, as well as immigrants with LPR status (Exhibit 2).

Undocumented immigrants report similar or better health behaviors as U.S.-born or other immigrant groups in studies nationally. In California, adjusted smoking rates of undocumented immigrants (10.9%) are lower than that of U.S.-born citizens and lawful permanent residents (14.5% and 11.3%, respectively). Overweight/obesity is common across all groups, although undocumented immigrants have the highest rates of all immigrant groups in California (Exhibit 2). While the overall health status of undocumented immigrants is favorable, overweight and obesity leads to increased risk of diabetes, hypertension, and other conditions where timely access to medical care is essential.

### Undocumented Immigrants Experience Significant Barriers to Access to Care

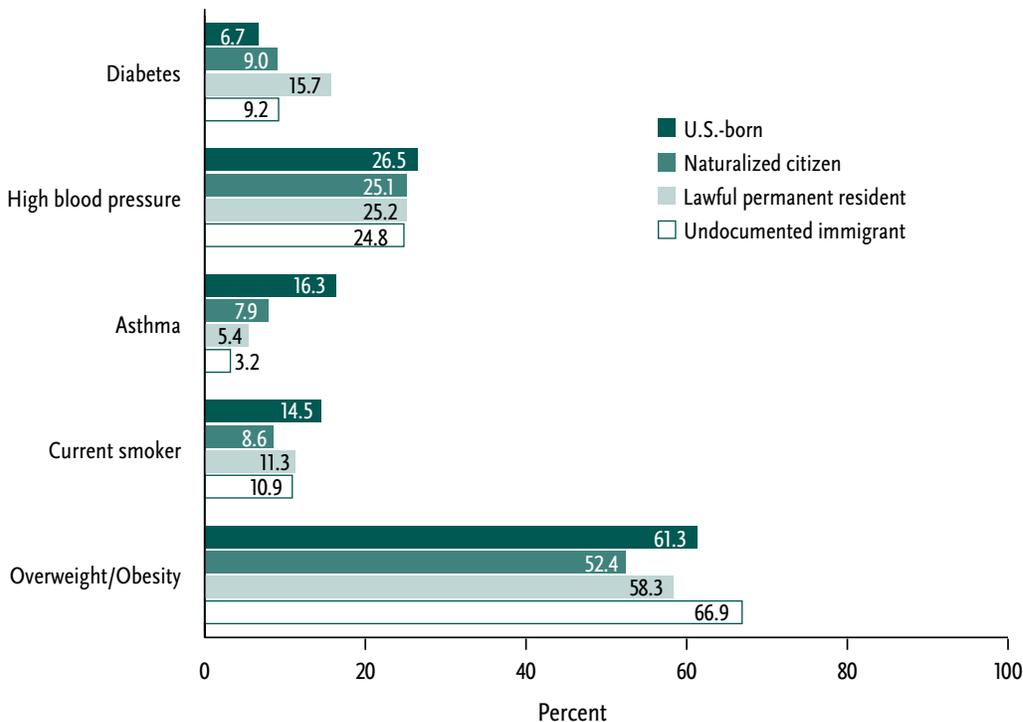
Maintaining the relatively good health status of undocumented immigrants requires adequate access to health care. Nationally, studies have found that undocumented immigrants have substantially lower access to health

**EXHIBIT 1. LABOR FORCE PARTICIPATION RATES, POVERTY RATES, AND UNINSURANCE RATES, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS (UNADJUSTED), 2009**



Source: California Health Interview Survey, 2009.

**EXHIBIT 2. HEALTH CONDITIONS AND HEALTH BEHAVIORS, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS, ADJUSTED FOR AGE AND GENDER, 2009**



Note: Overweight/Obesity defined as having a body mass index of 25 or higher.  
Source: California Health Interview Survey, 2009.

care and use fewer health care services than their U.S.-born and other immigrant counterparts.

In California, nonelderly undocumented adults were more than twice as likely to report having no usual source of care as U.S.-born and naturalized citizens of similar ages and genders. Similarly, undocumented immigrants were almost twice as likely to report making no past-year doctor visits as U.S.-born residents. Despite having no usual source of care and reporting significantly fewer doctor visits than their U.S.-born and naturalized citizen counterparts, undocumented immigrants were the least likely to have used an emergency department in the past year (Exhibit 3).

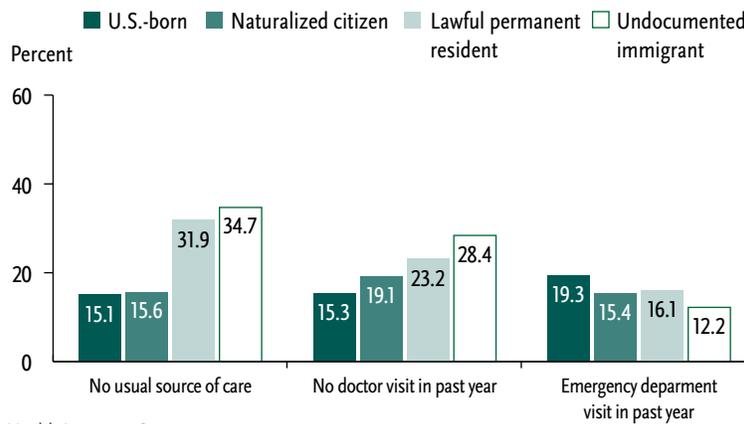
When undocumented immigrants do visit the doctor, they often face high out-of-pocket costs since over half do not have health insurance coverage. Among Californians who reported having medical bills, 42 percent of undocumented immigrants said they were unable to pay for basic necessities because of these bills, a significantly higher proportion than the 27 percent of U.S.-born citizens who reported similar problems (data not shown).

**Limited Safety-Net System Provides a Porous Patchwork of Services But Leaves Major Gaps in Care**

Under current laws, Medicaid covers low-income, undocumented individuals for life-saving emergency care, labor and delivery, and, in some states, dialysis for end-stage renal disease.<sup>10</sup> Many states do not cover prenatal care,<sup>11</sup> outpatient dialysis services, or life-saving chemotherapy.<sup>12</sup> Limited disease-specific screening and treatment is also available, regardless of immigration status.<sup>13</sup> Most safety-net clinics provide free or low-cost primary care services to all uninsured persons based on their ability to pay, regardless of immigration status.

Prenatal care regardless of immigration status is available in some states through the Children’s Health Insurance Program (CHIP), which was reauthorized under the Affordable Care Act through 2015. Local-level initiatives, such as the Los Angeles Healthy Kids program, offer health insurance coverage to all low-income children who are not eligible for other coverage, including undocumented children, but do not cover all

**EXHIBIT 3. HEALTH CARE ACCESS AND UTILIZATION, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS, ADJUSTED FOR AGE AND GENDER, 2009**



Source: California Health Interview Survey, 2009.

eligible children because of high demand and limited funding.<sup>14</sup>

Whether insured or not, immigrants and their families face a number of other barriers to adequate health care, including language, transportation, and concerns about immigration authorities.<sup>15</sup>

### HEALTH INSURANCE RATES AMONG UNDOCUMENTED IMMIGRANTS WILL REMAIN LARGELY UNCHANGED AFTER AFFORDABLE CARE ACT IMPLEMENTATION

Undocumented immigrants are likely to experience little change in coverage under the health reform law. They will be excluded from Medicaid expansions and cannot purchase insurance through the exchanges, even with their own money at full price. While some employers may be motivated to add insurance benefits, others are expected to drop current coverage. The net effect is estimated to be a negligible increase in health insurance coverage of undocumented immigrants. According to estimates based on a simulation model, three-fifths (61.5%) of the undocumented immigrant population nationwide will remain uninsured in 2016. This model predicts a small increase in employer-sponsored coverage for undocumented immigrants under the law, from 25 percent in 2012 to 25.5 percent in 2016. The proportion of uninsured undocumented residents in states with the largest numbers of undocumented

immigrants is not projected to change significantly. The highest rates of uninsurance will be in North Carolina and Texas and the lowest rates in New York and California (Exhibit 4).

Because the number and proportion of undocumented immigrants without health insurance are not projected to change much, these individuals will make up a larger share of the shrinking group of U.S. residents who remain uninsured after the law is fully implemented. Assuming full implementation of Medicaid expansion by all states, undocumented immigrants are estimated to account for 24.5 percent of the remaining uninsured population in the United States by 2016, up from 9.5 percent in 2012. This figure is higher in states with large undocumented immigrant populations. Undocumented immigrants will account for up to two-fifths (41%) of the remaining uninsured in California and at least a third of the uninsured population in Arizona, Florida, North Carolina, and Texas.

### POLICY LESSONS FROM HOME AND ABROAD

Undocumented immigrant adults tend to be relatively young, healthy, and in the labor force; however, they are also more likely to live in poverty and be uninsured compared with either legal immigrants or U.S.-born populations. Because of a lack of affordable coverage options for undocumented immigrants, hospitals and

**EXHIBIT 4. PERCENT OF UNDOCUMENTED IMMIGRANTS UNDER AGE 65 WITHOUT HEALTH INSURANCE, SELECTED STATES AND U.S., 2012 AND 2016 PROJECTIONS**



Source: Gruber MicroSimulation Model (GMSIM), 2012.

individual providers are often left with uncompensated care costs when they provide necessary treatment.<sup>16</sup>

After the Affordable Care Act is fully implemented, safety-net hospitals may face additional challenges to providing life-saving care because of scheduled cuts in disproportionate share hospital (DSH) payments that were designed to help safety-net hospitals cover the costs of uncompensated care for all uninsured patients. While the total number of uninsured persons will decline under the law, the majority of undocumented immigrants will have little choice but to depend on safety-net hospitals for care.<sup>17</sup>

Undocumented immigrants will constitute a significant proportion of the remaining uninsured population and their concentration in a small number of states and localities places an uneven burden on the safety-net facilities in those areas. The United States is not the only country facing these issues. A recent survey of European countries<sup>18</sup> illustrates policy approaches that would improve access to care for undocumented immigrants and assist providers who face uncompensated care burdens. These include: providing comprehensive insurance coverage to some or all undocumented immigrants; providing coverage for specified services; and decreasing the out-of-pocket health care costs of undocumented immigrants by increasing direct funding to providers who offer free or low-cost services. In addition, immigration reform offers the opportunity to allow binational insurance coverage that preferentially pays for high-cost services to be performed in

Mexico while providing coverage of primary care in the United States. The policies are designed to cost less than those providing comparable coverage only in the U.S. Binational policies could decrease the financial barriers to purchasing insurance for some currently undocumented immigrants during the registered provisional immigrant (RPI) phase that occurs before they gain lawful permanent resident (LPR) status.

**POSSIBLE OPTIONS FOR IMPROVING HEALTH CARE ACCESS FOR THE UNDOCUMENTED**

- Provide comprehensive insurance coverage to some or all undocumented immigrants.
- Provide coverage for specified services.
- Decrease out-of-pocket health care costs by increasing direct funding to providers that offer free or low-cost services.
- Allow binational insurance coverage that preferentially pays for high-cost services to be performed in Mexico, while providing coverage of primary care in the United States.

Reducing the number of undocumented immigrants through federal immigration reform would eventually ameliorate many of the issues discussed in this report. Certain reform proposals would grant undocumented immigrants RPI status, which would provide applicants with a status that allows them to work legally and the potential to move out of poverty. This, in turn, is likely to improve health outcomes in the long term.

However, such proposals would also bar immigrants who are on the path to citizenship from public benefits such as Medicaid or CHIP for as long as 10 years, possibly causing health care problems to persist or worsen. In addition, individuals who have obtained “deferred action” status under the Deferred Action for Children of Arrivals (DACA) Initiative have been excluded from public benefits. Individuals who are eligible for DACA are those who are undocumented but arrived in the United States as children; under DACA they are allowed to remain lawfully present and work in the U.S. However, neither DACA nor RPI residents are eligible to purchase health insurance coverage through the exchanges created under the health care reform law.<sup>19</sup>

If those with RPI status are allowed to leave the U.S. for medical care without it affecting their application, binational health insurance offered in Mexico would be an option for this largest group of undocumented immigrants.<sup>20</sup> Receiving care in Mexico is not practical for most primary care, particularly for those not residing in Southwestern communities, but the low cost of coverage could significantly reduce out-of-pocket costs for many diagnostic and nonemergency services.

Since immigration reform is unlikely to reduce the number of currently undocumented and uninsured individuals, policymakers must consider other possible solutions.<sup>21</sup> One approach is to provide insurance to all residents, regardless of immigration status. Vermont, for example, is proposing to institute a single-payer health care system under the Affordable Care Act that will cover all state residents without regard to their immigration status. The proposal includes using state funds to provide free or subsidized coverage as needed for undocumented residents.<sup>22</sup> Alternatively, the federal government could require employers to offer insurance, as is currently the case in Hawaii. Since employment rates are very high among undocumented adults, this would result in higher coverage rates for undocumented employees and their families. Or, low- or no-cost insurance coverage could be provided to some categories of low-income individuals, like children. Undocumented children have benefitted from programs in some parts

of the United States that offer coverage without regard to immigration status.<sup>23</sup>

Another alternative is to allow undocumented state residents to purchase insurance in their state health benefit exchange without subsidies. Current law excludes undocumented immigrants from purchasing policies through exchanges even with their own funds. Some states, including California, require insurers in the exchange to offer the same policies with similar premiums outside the exchange, which will expand options for health insurance coverage for undocumented immigrants.

An additional approach is to create low- or no-cost insurance for a limited set of services for those not otherwise covered by insurance. The services could cover high-value care,<sup>24</sup> such as coverage for chronic disease management or clinical preventive services that are required benefits under the Affordable Care Act. It is likely that this coverage would save money in the long run by helping young, healthy immigrants avoid health problems and maintain general good health. Along these lines, the National Breast and Cervical Cancer Early Detection Program provides resources to detect and treat cancer early in uninsured women, which helps to save lives and money.

The last approach is to directly provide low-cost care, rather than insurance, to reduce the access barrier created by high out-of-pocket costs. Increased funding under the health reform law for community health centers (CHCs) helps accomplish this for primary care because CHCs charge fees that vary with patients’ incomes and are already a common source of care for all uninsured persons. Even with the increases, though, funding for CHCs may not be sufficient to cover expanded need for care. People may remain with their CHC, if it is one of few providers in a low-income area, and these newly insured individuals may be more likely to use health care services. This surge in demand could overwhelm CHCs’ ability to provide care and crowd out those without insurance. In addition, low-cost access to specialist and hospital care, and sometimes even basic laboratory and diagnostic services, would continue to be limited. The burden on safety-net

hospitals for providing emergency services to undocumented immigrants could be ameliorated by targeted special funding for facilities serving large numbers of immigrants, such as that provided in the Balanced Budget Act of 1997 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.<sup>25</sup>

The Affordable Care Act's goal of affordable, quality health care for all will not be achieved unless policies also assist the country's approximately 11 million undocumented residents. Helping improve access to care or health insurance coverage is an investment in maintaining the good health of this population and will also stabilize the financial viability of safety-net providers who are essential to the residents of their communities.

## ABOUT THIS STUDY

Original data are from a special run of the Gruber MicroSimulation Model (GMSIM) and from the 2009 California Health Interview Survey (CHIS 2009). CHIS 2009 interviewed 44,567 adults from households in every county in California, including 1,515 who were likely undocumented immigrants. Interviews were conducted in English, Spanish, Chinese (Mandarin and Cantonese), Vietnamese, and Korean. More information on the GMSIM and the calculation of undocumented immigrant respondents to the CHIS is available in a methodological appendix at <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1194>.

CHIS is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health, the Department of Health Care Services, and the Public Health Institute. For more information on CHIS, visit <http://healthpolicy.ucla.edu/chis>.

## NOTES

- <sup>1</sup> National Immigration Law Center, "Frequently Asked Questions: Exclusion of People Granted 'Deferred Action for Childhood Arrivals' from Affordable Health Care" (Los Angeles, Calif.: National Immigration Law Center, 2012; revised Nov. 26, 2012), available at <http://www.nilc.org/acadacafaq.html>.
- <sup>2</sup> J. S. Passel and D. Cohn, *Unauthorized Immigrant Population: National and State Trends, 2010* (Washington, D.C.: Pew Hispanic Center, Feb. 2011).
- <sup>3</sup> J. S. Passel and P. Taylor, *Unauthorized Immigrants and Their U.S.-Born Children* (Washington, D.C.: Pew Hispanic Center, Aug. 2010).
- <sup>4</sup> Passel and Cohn, *Unauthorized Immigrant Population, 2011*.
- <sup>5</sup> Data from the 2009 California Health Interview Survey, not shown on tables; see <http://healthpolicy.ucla.edu/chis>.
- <sup>6</sup> K. M. Perreira, R. Crosnoe, K. Fortuny et al., *Barriers to Immigrants' Access to Health and Human Services Programs* (Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy, U.S. Department of Health and Human Services, May 2012).
- <sup>7</sup> Passel and Cohn, *Unauthorized Immigrant Population, 2011*.
- <sup>8</sup> J. Preston, "Readers Have Questions, Too, on a Complex Measure," *New York Times*, April 22, 2013, p. A10.
- <sup>9</sup> The federal poverty guideline for the annual income for a family of four in 2009 was \$22,050; see <http://aspe.hhs.gov/poverty/09poverty.shtml>.
- <sup>10</sup> A. M. Siskin, *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses* (Washington, D.C.: Congressional Research Service, Oct. 2004).
- <sup>11</sup> Perreira, Crosnoe, Fortuny et al., *Barriers to Immigrants' Access, 2012*.
- <sup>12</sup> G. A. Campbell, S. Sanoff, and M. H. Rosner, "Care of the Undocumented Immigrant in the United States with ESRD," *American Journal of Kidney Diseases*, Jan. 2010 55(1):181–91.
- <sup>13</sup> Centers for Disease Control and Prevention, "Breast and Cervical Cancer Prevention and Treatment Act of 2000," National Breast and Cervical Cancer Early Detection Program (Atlanta, Ga.: CDC, 2011), available at <http://www.cdc.gov/cancer/nbccedp/legislation/law106-354.htm>.
- <sup>14</sup> E. M. Howell, L. Dubay, and L. Palmer, *The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status* (Washington, D.C.: The Urban Institute, Jan. 2008).
- <sup>15</sup> B. H. Gray and E. van Ginneken, *Health Care for Undocumented Migrants: European Approaches* (New York: The Commonwealth Fund, Dec. 2012).
- <sup>16</sup> K. Sack, "Hospital Falters as Refuge for Illegal Immigrants," *New York Times*, Nov. 20, 2009, p. A1.
- <sup>17</sup> Kaiser Family Foundation, "Summary of the Affordable Care Act" (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2011; updated April 23, 2013).
- <sup>18</sup> Gray and van Ginneken, *Health Care for Undocumented Migrants, 2012*.
- <sup>19</sup> National Immigration Law Center, "Frequently Asked Questions," 2012.
- <sup>20</sup> M. A. González Block, A. Vargas Bustamante, L. A. de la Sierra et al., "Redressing the Limitations of the Affordable Care Act for Mexican Immigrants Through Bi-National Health Insurance: A Willingness to Pay Study in Los Angeles," *Journal of Immigrant and Minority Health*, e-published ahead of print Sept. 2, 2012.
- <sup>21</sup> Gray and van Ginneken, *Health Care for Undocumented Migrants, 2012*.
- <sup>22</sup> State of Vermont, *Report Regarding the Costs of Health Services Provided to Undocumented Immigrants* (Montpelier, Vt.: Green Mountain Care Board, Jan. 2013).
- <sup>23</sup> Howell, Dubay, and Palmer, *Impact of the Los Angeles Healthy Kids Program, 2008*.
- <sup>24</sup> R. Z. Goetzel, R. J. Ozminkowski, V. G. Villagra et al., "Return on Investment in Disease Management: A Review," *Health Care Financing Review*, Summer 2005 26(4):1–19.
- <sup>25</sup> Siskin, *Federal Funding, 2004*.



One East 75th Street  
New York, NY 10021  
Tel 212.606.3800

1150 17th Street NW  
Suite 600  
Washington, DC 20036  
Tel 202.292.6700

[www.commonwealthfund.org](http://www.commonwealthfund.org)