Noncitizen Health Insurance Coverage and Use of Select Safety-Net Providers

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Summary

The 111th Congress has made health reform a priority. As health reform is debated, one possible issue that may surface is the rights and requirements of noncitizens (aliens) under health reform. Because some of the proposals to address health reform in the United States would create a mechanism to provide health insurance to the overwhelming majority of individuals in the nation, this report explores the health insurance coverage of noncitizens, as well as noncitizen use of selected safety-net providers and the impact of unauthorized aliens on the health care system.

Noncitizens are not barred from having health insurance or from paying for health care on their own. Indeed, due to the quality of health care in the United States, some noncitizens come to the United States to receive health care from world-renowned doctors and hospitals. Furthermore, U.S. law mandates that Medicare-participating hospitals provide emergency medical services for all patients who seek care, regardless of their ability to pay, including services to noncitizens, regardless of their immigration status.

Nonetheless, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) established comprehensive new restrictions on the eligibility of noncitizens for federal, state, and local public benefits, setting specific eligibility requirements and exceptions for many health care services. In general, noncitizens have specific eligibility requirements under law for public benefits, including means-tested public benefits such as Medicaid and the State Children's Health Insurance Program, but are eligible for emergency medical services. In addition, due to the exemptions and the fact that federally funded health centers are not defined as federal public benefits under regulation, there do not appear to be specified eligibility requirements related to noncitizens' use of Federally Qualified Health Centers (FQHCs).

In terms of insurance coverage, noncitizens are more than three times as likely as native-born U.S. citizens and more than two times as likely as naturalized U.S. citizens to be uninsured. Similarly, noncitizens have a lower rate of private insurance coverage, while native-born and naturalized U.S. citizens have similar rates of private health insurance. The noncitizen population also has the lowest rate of Medicare coverage, while naturalized citizens, who tend to be older than native-born citizens and noncitizens, have the highest rate of Medicare coverage. Lastly, the noncitizen population has much lower rates of military/veterans coverage than the naturalized and native-born citizen populations. The rates and types of health insurance coverage are affected by variables such as occupation, industry, education, and region of birth; however, other socio-economic variables, such as age, do not seem to have an effect.

Between 2000 and 2006, the percentage of noncitizens in the uninsured population increased from 19.6% to 21.5% and then decreased slightly (to 21.1%) in 2007. Conversely, in 2000, native-born citizens made up the largest percentage of the uninsured population (75.5%), and the percentage decreased, though not uniformly, to a low of 73.1% in 2007. As with the noncitizen population, the naturalized citizens percentage of the uninsured population increased from a low of 4.6% in 2000 to a high of 5.8% in 2007. In FY2006, 1.5% of the total Medicaid recipients received emergency Medicaid, and $2.6 billion was spent on emergency Medicaid, constituting 1.1% of the total Medicaid spending. The impact of noncitizen usage on emergency departments and FQHCs is unclear. Finally, several studies have attempted to quantify the health care costs of unauthorized aliens to certain states or geographic areas. The studies do not tend to be comparable because of differences in timeframes, methodology, and the types of costs studied. This report will not be updated.

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Introduction

The 111th Congress has made health reform a priority. As health reform is debated, one possible issue that may surface is the rights and requirements of noncitizens (aliens)[1] under health reform. Because some of the proposals to address health reform in the United States would create a mechanism to provide health insurance to the overwhelming majority of individuals in the nation,[2] this report explores the health insurance coverage of noncitizens in the United States, as well as noncitizen usage of selected safety-net providers and the impact of unauthorized aliens on the health care system.

The report begins with an overview of noncitizen eligibility for health insurance in the United States. Next, it provides an analysis of health insurance coverage for noncitizens in the United States and an examination of the impact of noncitizens on the number of uninsured persons in the United States over time. The report continues with discussions of noncitizen usage of emergency Medicaid and emergency departments, and of noncitizens' eligibility to receive care through federal health centers.[3] The report concludes with an overview of the literature on the cost to the health care system of unauthorized aliens.

Terminology for Noncitizens

One of the issues with analyses of the noncitizen population is that researchers are often not studying the same population or using the same terminology. For example, some research examines immigrants,[4] some the Hispanic population, others immigrant- headed households, and some the unauthorized (illegal) alien population. Also, some studies use the same term to refer to different groups. For example, the term *immigrant* is often used to refer to all noncitizens (especially when using Current Population Survey [CPS] or other Census data), but it can also be used to refer to foreign born persons permanently in the United States (e.g., legal permanent residents, naturalized U.S. citizens). **Table 1** presents the definitions of some of the groups for whom health policy studies have been done. For this report, however, the studies discussed are limited to those that examine some portion of the noncitizen population.

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[1] A noncitizen is anyone who is not a citizen or national of the United States. Noncitizen is synonymous with the term alien.

[2] For examples, see H.R. 3200, the Senate Health, Education, Labor and Pensions (HELP) committee approved health reform legislation; and Senator Max Baucus, Chairman Senate Finance Committee, *Call to Action: Health Care Reform 2009*, Senate Finance Committee, Washington, DC, November 12, 2008, http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

[3] For the Department of Health and Human Services, the term "health centers" refers to all the diverse public and nonprofit organizations and programs that receive federal funding under the Consolidated Health Centers program. For more information on this program, see CRS Report RL32046, *Federal Health Centers Program*, by Barbara English.

[4] Under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*) immigrants are noncitizens who are permanently residing in the United States.

Table 1. Terminology Related to Noncitizens

Term	Definition	Common Data Sources
Noncitizens	Anyone who is not a citizen or national of the United States, this is synonymous with alien. The noncitizen may be in the United States temporarily or permanently.	Census bureau data
Alien	Anyone who is not a citizen or national of the United States, this is synonymous with noncitizen	Census bureau data
Immigrant	A noncitizen who is legally admitted to the United States, as defined in the Immigration and Nationality Act (INA), and comes to live permanently in the United States. CRS usage of this term excludes unauthorized aliens and naturalized U.S. citizens; however, when the term is used in other studies it may or may not include naturalized citizens and unauthorized aliens.	Department of Homeland Security (DHS) administrative data
Legal Permanent Resident (LPR)	A noncitizen who is legally admitted to the United States, as defined in the INA, and comes to live permanently in the United States. In the INA it is synonymous with the term immigrant.	Department of Homeland Security (DHS) administrative data
Nonimmigrant	A noncitizen who is present in the United States for a temporary period of time and a specific purpose. This term is defined in INA §101(a)(15).	DHS administrative data
Unauthorized (illegal) alien	A noncitizen who is lacks legal authorization to be present in the United States	Residual estimates using the Census data. All counts of unauthorized aliens are estimates.
Immigrant Headed Household	A household in which the head is an immigrant. Often this term is misused and refers to household where the head is a noncitizen. These households are often mixed status and contain noncitizens and U.S. citizens.	Census data
Unauthorized (illegal) alien headed household	A household in which the head is an unauthorized alien. These households are often mixed status and may contain noncitizens and U.S. citizens.	Often estimated using census data by using a model to assign a probability that a specific individual is unauthorized based on socio-demographic characteristics.[a]
Hispanic Population	Anyone who notes their race/ethnicity as Hispanic. Includes U.S. citizens as well as noncitizens.	Census data
Foreign-Born Population	Anyone who is not a native-born U.S. citizen. Includes naturalized U.S. citizens and noncitizens.	Census data
Naturalized Citizen	Any person who acquired U.S. citizenship through the naturalization process, not automatically by birth. [INA §§310-319]	Census data/DHS data

a. For an example of this type of analysis see Steven A. Camarota, *The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget* (Washington, D.C.: Center for Immigration Studies, Aug. 2004).

Overview of Noncitizen Eligibility for Health Insurance

Noncitizens are not barred from having health insurance or from paying for health care on their own.[5] Indeed, due to the quality of health care in the United States, some noncitizens come to the United States to receive health care from world-renowned doctors and hospitals. In the group (employer) health insurance market, there is no legal burden for the insurer to confirm that a worker is legally entitled to work in the United States.[6] Furthermore, U.S. law mandates that Medicare-participating hospitals provide emergency medical services for all patients who seek care, regardless of their ability to pay; this includes services to all noncitizens, regardless of their immigration status.

Nonetheless, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)[7] established comprehensive new restrictions on the eligibility of noncitizens for federal, state, and local public benefits—with significant exceptions for those with a substantial U.S. work history or military connection—setting specific eligibility requirements and exceptions for many health care services. In general, PRWORA states that an alien who is not a qualified alien[8] is not eligible for any *federal* public benefit with specified exceptions for certain short-term, emergency related benefits (see below). In addition, with specified exceptions, any alien who is not a qualified alien, a nonimmigrant, or an alien paroled into the United States under INA section 212(d)(5) for less than one year[9] is not eligible for a *state or local* public benefit.[10] In

[5] In addition to providing longer-term coverage, there are certain health insurance companies that provide short-term insurance (for five days to two years) for aliens coming to the United States as tourists or workers. For example, see http://www.nriol.net/non-us-citizen-insurance/.

[6] For example, Mexican noncitizens can purchase health insurance from Blue Cross of California (and other providers in California) using the Metricular Consular cards (i.e., identity cards issued to Mexican citizens in the United States). Dana P. Goldman, James P. Smith, and Neeraj Sood, "Legal Status and Health Insurance Among Immigrants," *Health Affairs*, vol. 24, no. 6 (November/December 2005), p. 1645.

[7] P.L. 104-193, also called the Welfare Reform Act.

[8] PRWORA created the term "qualified alien," a term which did not exist in immigration law, to encompass the different categories of noncitizens who were not prohibited by PRWORA from receiving federal public benefits. Qualified aliens (P.L. 104-193 §431; 8 U.S.C. §1641) are defined as:

(1) Legal Permanent Residents (an alien admitted for lawful permanent residence (LPRs));

(2) refugees (an alien who is admitted to the United States under §207 of the Immigration and Nationality Act (INA));

(3) asylees (an alien who is granted asylum under INA §208);

(4) an alien who is paroled into the United States (under INA §212(d)(5)) for a period of at least one year;

(5) an alien whose deportation is being withheld on the basis of prospective persecution (under INA §243(h) or §241(b)(3));

(6) an alien granted conditional entry pursuant to INA §203(a)(7) as in effect prior to April 1, 1980; and

(7) Cuban/Haitian entrants (as defined by P.L. 96-422).

Additionally, victims of trafficking (T-visa holders) are treated as refugees for the purpose of receiving benefits. For a discussion of the different categories of noncitizens, see CRS Report RS20916, *Immigration and Naturalization Fundamentals*, by Ruth Ellen Wasem.

[9] "Parole" is a term in immigration law which means that the alien has been granted temporary permission to enter and be present in the United States. Parole does not constitute formal admission to the United States and parolees are required to leave when the parole expires, or if eligible, to be admitted in a lawful status.

[10] The law allows states to provide state or local public benefits to unauthorized aliens through the enactment of a state (continued...)

other words, almost all legally present noncitizens are eligible for state and local public benefits, but in general, only those aliens who are or are expected to become immigrants (legal permanent residents) are eligible for federal public benefits. In addition, PWORA placed additional restrictions on receiving federal means-tested public benefits. The health related means-tested public benefits are Medicaid and the State Children's Health Insurance Program (CHIP), and are discussed below.

The law defines "public benefit" as:

> …any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States. [8 U.S.C. 1611(c) and 8 U.S.C. 1621(c)]

The exemptions to these restrictions consist of the following:

> (A) Medical assistance under title XIX of the Social Security Act [Medicaid]…for care and services that are necessary for the treatment of an emergency medical condition…of the alien involved and are not related to an organ transplant procedure, if the alien involved otherwise meets the eligibility requirements for medical assistance under the State plan approved under such title.
>
> (B) Short-term, non-cash, in-kind emergency disaster relief.
>
> (C) Public health…for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease.
>
> (D) Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the Attorney General, in the Attorney General's sole and unreviewable discretion after consultation with appropriate Federal agencies and departments, which
>
> (i) deliver in-kind services at the community level, including through public or private nonprofit agencies;
>
> (ii) do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
>
> (iii) are necessary for the protection of life or safety. [8 U.S.C. 1611(b)]

A notice published by the Attorney General includes in the exemptions from the alienage restrictions for public benefits ambulance services; medical and public health services (including treatment and prevention of diseases and injuries) and mental health, disability, or substance abuse assistance necessary to protect life or safety; activities designed to protect the life and

(...continued)

law which affirmatively provides for such eligibility (8 U.S.C. 1621(d)).

safety of workers, children and youths, or community residents; and any other programs, services, or assistance necessary for the protection of life or safety.[11]

In summary, noncitizens have specific eligibility requirements under law for public benefits, including means-tested public benefits such as Medicaid and CHIP, which can, however, pay for emergency medical services of certain noncitizens who are otherwise eligible. In addition, due to the exemptions and the fact that under regulation federally funded health centers are not defined as federal public benefits,[12] there does not appear to be specified eligibility requirements or prohibitions related to noncitizens' use of Federally Qualified Health Centers, including community health centers and migrant health centers.[13]

Medicaid and State Children's Health Insurance Program (CHIP)

The Medicaid program is authorized by Title XIX of the Social Security Act, as amended. It is a federal/state matching program of medical assistance for low-income persons who are aged, blind, disabled or members of families with dependent children. In general, CHIP allows states to cover targeted low-income children with no health insurance in families with income above Medicaid eligibility levels. States may also extend CHIP coverage to pregnant women when certain conditions are met.[14]

As discussed above, PRWORA defined Medicaid as a means-tested public benefit, triggering additional eligibility requirements for "qualified aliens." Currently, noncitizens' eligibility for federal Medicaid and CHIP benefits depends largely on their immigration status and whether they arrived (or were on a program's rolls) before August 22, 1996, the enactment date of PRWORA.[15] Notably, the aliens must also meet the financial and categorical eligibility requirements for Medicaid[16] or be targeted low-income uninsured children or eligible pregnant women for CHIP.[17] Most legal permanent residents[18] (LPRs) entering after August 22, 1996, are barred from Medicaid and CHIP for five years, after which they are eligible for CHIP and eligible for Medicaid at the state's option. States may also choose to use state and federal Medicaid and CHIP funds to cover pregnant women and children who are LPRs within the first five years of arrival.[19]

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[11] Department of Justice, "Specification of Community Programs Necessary for Protection of Life or Safety Under Welfare Reform Legislation," 61 *Federal Register* 45985, August 30, 1996.

[12] Department of Health and Human Services, "Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit"," 63 *Federal Register* 41658-41661, August 4, 1998.

[13] Note that some of these "health centers" may also receive funding through the Medicaid program to provide assistance to those who receive Medicaid.

[14] CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

[15] P.L. 104-193; also called the Welfare Reform Act.

[16] Medicaid is a means-tested entitlement program operated by states within broad federal guidelines. To qualify, an individual must meet both categorical and financial eligibility requirements. Categorical eligibility requirements relate to the age or other characteristics of an individual. People aged 65 and over, certain persons with disabilities, children and their parents, and pregnant women are among the categories of individuals who may qualify.

[17] In general, Title XXI of the Social Security Act defines a targeted low-income child for CHIP eligibility as one who is under the age of 19 with no health insurance and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income threshold for targeted low-income children up to 200% of the federal poverty level (FPL) or 50 percentage points above the applicable pre-CHIP Medicaid threshold.

[18] Legal permanent residents are also called immigrants in the INA.

In addition, states have the option to use state funds to provide medical coverage for other LPRs within five years of their arrival in the United States.

Refugees and asylees[20] are eligible for Medicaid and CHIP for seven years after arrival. After the seven years, they may be eligible for Medicaid and CHIP at the state's option. LPRs with a substantial (10-year) U.S. work history or a military connection are eligible for Medicaid and CHIP without regard to the five-year bar. LPRs receiving Supplemental Security Income (SSI) on or after August 22, 1996, are eligible for Medicaid because Medicaid coverage is required for all SSI recipients. Finally, in the case of LPRs sponsored for admission after 1997, the income and resources of their sponsor are "deemed" available to them when judging their eligibility.[21] Nonetheless, all aliens regardless of immigration status who otherwise meet the eligibility requirements for Medicaid are eligible for emergency Medicaid. Thus, unauthorized aliens are ineligible for Medicaid but may qualify for emergency Medicaid. In addition, states may use their own money to cover noncitizens who are ineligible for Medicaid or CHIP.

Emergency Medicaid

Generally, as noted above, noncitizens face additional eligibility restrictions for Medicaid. In general, unauthorized aliens are ineligible for Medicaid, with the exception of emergency Medicaid. Emergency Medicaid may pay for the care of unauthorized aliens, nonimmigrants, and LPRs within the first five years of arrival (or longer if the state does not exercise the option to provide coverage for LPRs after the five years) for emergency conditions if they meet the other eligibility requirements of the Medicaid program.[22]

Specifically, aliens who are otherwise eligible for Medicaid except for their immigration status (e.g., unauthorized aliens, nonimmigrants) may receive "medical assistance under Title XIX of the Social Security Act ... for care and emergency services that are necessary for the treatment of an emergency medical condition (as defined in Section 1903(v)(3) of such Act) of the alien involved and are not related to an organ transplant procedure."[23] This language from PRWORA

(...continued)

[19] Prior to the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3, signed into law on February 4, 2009), states had to use their own money to cover any LPRs within the first five years after entry.

[20] Refugee and asylee status require a finding of persecution or a well-founded fear of persecution in situations of "special humanitarian concern" to the United States. Refugees are admitted from abroad. Asylum is granted on a case-by-case basis to aliens physically present in the United States who meet the statutory definition of "refugee."

[21] Although it does not directly amend the subsection of the INA that makes the sponsor financially responsible for the LPR, §214 of P.L. 111-3 states: "no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost." According to the legislative language, this provision applies only to LPRs provided CHIP and Medicaid under §214 of this Act (i.e., pregnant women and children who are LPRs within the first five years after arrival). CRS Report R40144, *State Medicaid and CHIP Coverage of Noncitizens*, by Ruth Ellen Wasem.

[22] In other words, aliens who except for their immigration status would be eligible for Medicaid by being in a Medicaid-eligible category such as children and pregnant women and who meet the state residency and income requirements. Emergency Medicaid is solely for noncitizens and came into being as a result of the alien eligibility restrictions enacted in The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

[23] The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996; P.L. 104-193, §401(a)(1)(A).

restates and carries forward a provision which had been enacted 10 years previously as an amendment to the Medicaid provisions of the Social Security Act.[24]

Section 1903(v)(3) defines "emergency medical condition" as:

> a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.

Like other Medicaid recipients, such aliens must demonstrate that they are state residents, and many are not (or are unable or unwilling to prove that they are). This is particularly true of unauthorized aliens requiring emergency hospital care during attempted illegal entries. To be eligible for emergency Medicaid, these aliens must also be a member of a Medicaid eligible category (e.g., disabled) and meet that category's income requirements. Working-age single males, for example, are generally not eligible for any form of Medicaid regardless of their financial status or residence.

Statute requires that all Medicare-participating hospitals with emergency departments treat all medically unstable patients and women in active labor regardless of their immigration or insurance status.[25] Thus, for many low-income, uninsured noncitizens who require and obtain emergency medical care, emergency Medicaid may be a source of funding to help hospitals pay for those costs.

Medicare

Medicare is the nation's federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Medicare, which consists of four parts (A-D), covers hospitalizations, physician services, prescription drugs, limited skilled nursing facility care, home health visits, and hospice care, among other services.

Generally, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, and are 65 years old. In general, noncitizens who are legally present in the United States and who meet the requirements are eligible for Medicare. In addition, LPRs who did not work in Medicare-covered employment but have been in the United States for five continuous years are also eligible to enroll in Medicare.[26]

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[24] The provision was added by Section 9406 of the Omnibus Budget Reconciliation Act of 1986, P.L. 99-509.

[25] 42 U.S.C. 1395dd. This provision was added by the Emergency Medical Treatment and Active Labor Act (EMTALA) and is discussed below.

[26] For more information on Medicare, see CRS Report R40425, *Medicare Primer*, coordinated by Hinda Chaikind.

Health Insurance Coverage

Some health reform proposals try to devise a system to ensure that the overwhelming majority of people in the United States have health insurance. The following section examines current health insurance coverage for noncitizens and the characteristics that affect having health insurance. The section begins with an overview of the data and methodology employed in this study and then continues with a presentation of the findings. The section concludes with a summation of the results and presents findings from select articles that examined characteristics or populations that could not be analyzed by using the Current Population Survey (CPS).

Overview of Data and Methodology

The data used in this study are from the March 2008 supplement of the Current Population Survey (CPS), the main source of labor force data for the nation. The CPS is a household survey conducted by the Census Bureau for the Bureau of Labor Statistics (BLS). The data are weighted to reflect the population.[27] All differences discussed in the text of the report are statistically significant at the .05 level, unless otherwise specified. (For a full discussion of the CPS and the methodology, see **Appendix A**.)

The comparisons in this report are based on three groups residing in the United States: (1) native-born U.S. citizens, (2) naturalized U.S. citizens, and (3) noncitizens. Although one of the issues surrounding health insurance coverage for noncitizens is the number of unauthorized aliens living in the United States, it is not possible using CPS data to differentiate between aliens who are in the United States legally and illegally; nor is it possible to differentiate between different categories of noncitizens (e.g., legal permanent residents, temporary workers, students, refugees, asylees).

The CPS asks whether the respondent has had various types of coverage during the previous year. Thus, respondents may have more than one type of health insurance during the year. Theoretically, an uninsured respondent is someone who lacked any type of health insurance during the past year and the term does not capture people who were uninsured for part of the year. However, research has shown that the CPS estimates appear to reflect the number of people uninsured at a point in time (that is when the survey was taken) rather than uninsured for the entire previous year.[28] The types of health insurance used in this report are private insurance (both employer sponsored and individually purchased),[29] Medicare, Medicaid,[30] and military or

[27] For more detailed information on federal data sources for analysis of the uninsured, see CRS Report RL31275, *Health Insurance: Federal Data Sources for Analyses of the Uninsured*, by Chris L. Peterson and Christine M. Devere.

[28] For example, see National Institute for Health Care Management, *A Primer on the CPS Estimate of America's Uninsured*, NIHCM Brief, Washington, DC, August 29, 2006; and Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?*, Washington, DC, May 2003.

[29] Private insurance may be purchased through the individual's employer, through the employer of a spouse or parent, or on one's own. For general information on health insurance coverage, see CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady; and CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

[30] Includes State Children's Health Insurance Program (CHIP) and other state programs for low-income individuals.

veterans coverage.[31] If the respondent reported not having any of these types of coverage, they are considered uninsured.

Analysis: Overview

Overview of Health Insurance Coverage

As shown in **Figure 1**, noncitizens are more than three times as likely as native-born U.S. citizens, and more than two times as likely as naturalized U.S. citizens, to be uninsured: 43.8% of noncitizens lacked any type of health insurance, compared with 12.7% of native-born and 17.6% of naturalized populations. Similarly, noncitizens have the lowest rate of private insurance coverage (42.5%), while native-born citizens have a slightly higher rate of private health insurance than naturalized citizens (69.9% and 63.9%, respectively).

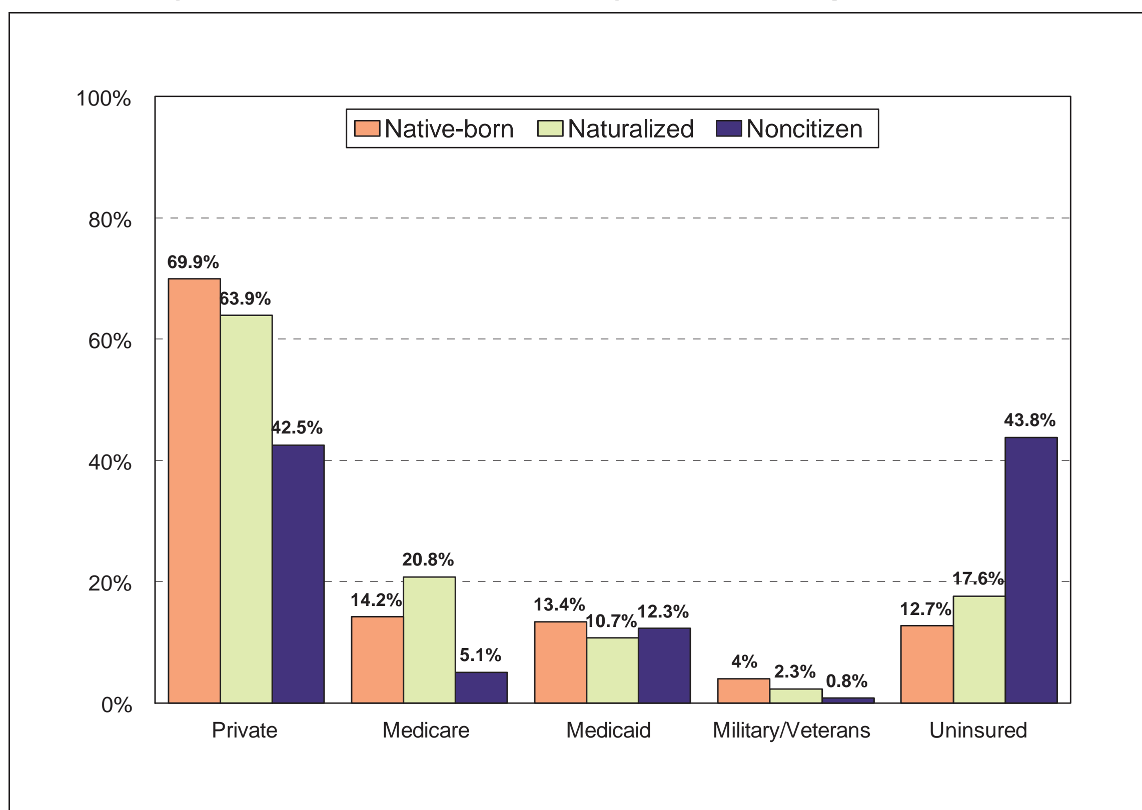
The noncitizen population also has the lowest rate of Medicare coverage, most likely due to the relatively young age of the population and the decreased likelihood that they would meet the eligibility requirements for Medicare. Naturalized citizens have the highest rate of Medicare coverage, which may be attributable to the fact that the naturalized population is, on average, older than both the native-born and noncitizen populations.[32] Noncitizens are slightly less likely to have Medicaid coverage (12.3%) than native-born citizens (13.4%), while naturalized citizens are the least likely to have Medicaid coverage (10.7%). Lastly, due to the fact that, in general, noncitizens must be legal permanent residents (LPRs) to join the armed forces, the noncitizen population has much lower rates of military/veterans coverage (0.8%) than the naturalized (2.3%) and native-born citizen (4%) populations.[33]

[31] Military or veterans insurance includes TRICARE (formerly known as CHAMPUS), which is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. This system of military and private health insurance offers benefits to active duty personnel and other beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. It also includes CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, which is primarily a fee-for-service program that provides reimbursement for most medical care for certain eligible dependents and survivors of veterans rated permanently and totally disabled from a service-connected condition. For more information, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen. For more information on CHAMPVA see, CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

[32] Approximately 21% of naturalized U.S. citizens are age 65 or over, compared to 12% of native-born U.S. citizens and 6% of noncitizens. (See **Table A-1**.)

[33] The CPS interviews the civilian population, not active duty military.

Figure 1. Health Insurance Coverage, by Citizenship Status, 2007



Source: CRS analysis of March 2008 CPS. The CPS is a survey of the non-institutionalized, civilian population.

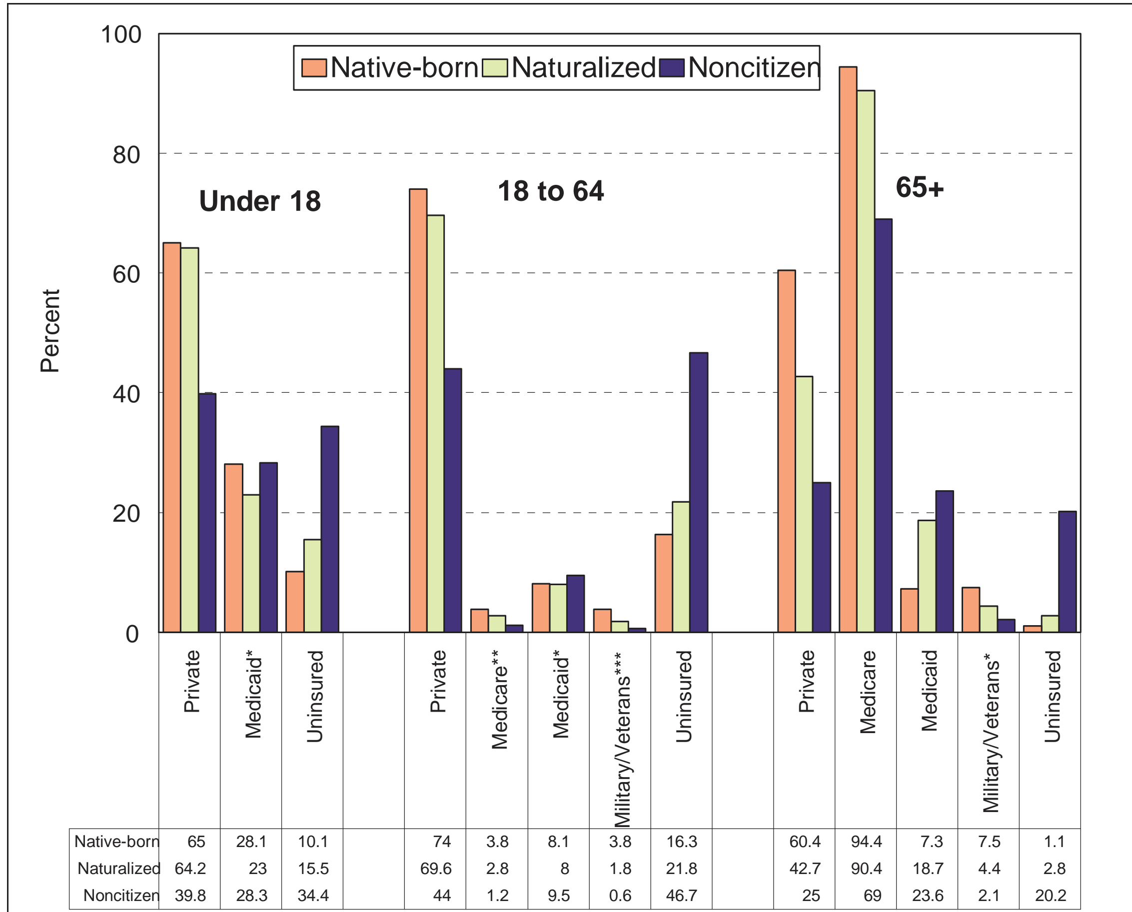
Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. The differences between the three groups in each category are significant at the .05 level.

Analysis: Demographic Characteristics

Age

Health insurance coverage follows the same pattern over the life cycles of the noncitizen, native-born, and naturalized populations (see **Figure 2**). For example, for all three groups, the rates of private insurance and uninsurance are higher for those aged 18 to 64 than for those under 18. Private insurance and uninsurance rates are lowest for those 65 years and older in all three groups. Nonetheless, although the populations have similar coverage patterns throughout the age groups, their rates of private insurance and uninsurance differ, with the biggest differences being in the 65-and-older populations, possibly due to Medicare coverage. For example, noncitizens over the age of 64 are more than 20 times as likely to be uninsured than similarly aged native-born citizens.

Figure 2. Type of Health Insurance, by Age and Citizenship Status, 2007



	Under 18: Private	Under 18: Medicaid*	Under 18: Uninsured	18 to 64: Private	18 to 64: Medicare**	18 to 64: Medicaid*	18 to 64: Military/Veterans***	18 to 64: Uninsured	65+: Private	65+: Medicare	65+: Medicaid	65+: Military/Veterans*	65+: Uninsured
Native-born	65	28.1	10.1	74	3.8	8.1	3.8	16.3	60.4	94.4	7.3	7.5	1.1
Naturalized	64.2	23	15.5	69.6	2.8	8	1.8	21.8	42.7	90.4	18.7	4.4	2.8
Noncitizen	39.8	28.3	34.4	44	1.2	9.5	0.6	46.7	25	69	23.6	2.1	20.2

Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. Medicare and Military/Veterans coverage is excluded from the under 18 group because of the small sample sizes. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

* Differences between noncitizens and native-born and naturalized citizens are not significant.

** Difference between noncitizens and naturalized citizens are not significant, and the difference between noncitizens and native-born are significant at the .05 level.

***Differences between noncitizens and naturalized citizens are not significant, and the difference between noncitizens and native-born are significant at the .1 level.

Under 18

Noncitizens under the age of 18 are less likely to have private insurance coverage (39.8%) than native-born and naturalized citizens, who have very similar rates of private insurance coverage (65% and 64.2%, respectively). As a possible result of the difference in private insurance coverage, noncitizens under the age of 18 are much more likely than their U.S. citizen counterparts to be uninsured. While 34.4% of noncitizen children lack health insurance, only 10.1% of native-born children and 15.5% of naturalized children are uninsured.

18 to 64 Years of Age

Similar to the under-18 populations, noncitizens between the ages of 18 and 64 are less likely to have private insurance coverage than their naturalized and native-born citizen counterparts. While only 44% of the noncitizen population between 18 and 64 has private insurance, 74% of the native-born and 69.6% of the naturalized populations between 18 and 64 have private health insurance. Noncitizens between ages 18 and 64 are also less likely than naturalized and native-born citizens of the same age to be covered by Medicare. Noncitizens in this age group are also more than twice as likely as comparable native-born and naturalized citizens to be uninsured: 46.7% of noncitizens between the ages of 18 and 64 lack health insurance, compared with 16.3% of native-born and 21.8% of naturalized citizens aged 18 to 64.

65 and Over

As with the other age groups, noncitizens age 65 and over have lower rates of private insurance coverage than both the comparable naturalized and native-born populations; however, the difference between the populations is most striking for this age group. Noncitizens (25%) over the age of 64 are less than half as likely as native-born citizens (60.4%) of the same age to have private insurance. The naturalized over-64 population (42.7%) is also significantly more likely than the noncitizen population to have private insurance. As expected, both U.S. citizen populations aged 65 and older have very high rates of Medicare coverage (94.4% for native-born and 90.4% for naturalized); although the rate of Medicare coverage for the noncitizen population aged 65 and older is high (69%), it is significantly less than that of the other groups.

Conversely, the noncitizen population over age 64 is more than three times as likely as the comparable native-born population to be covered by Medicaid (23.6% compared to 7.3%). Likewise, the over-64 noncitizen population is almost 20 times as likely as the same-aged native-born population and seven times as likely as the same-aged naturalized population to lack health insurance. Of noncitizens over age 64, 20.2% lack health insurance, compared with 1.1% of native-born and 2.8% of naturalized citizens over age 64.

Education Levels[34]

For all three groups, as educational attainment increases, rates of private insurance increase, while uninsurance rates decrease. Nonetheless, for all educational categories, the private insurance rate for noncitizens lags behind the private insurance rates of native-born and naturalized citizens. However, the differences in rates of private insurance coverage between noncitizens and native-born and naturalized citizens decrease as education increases. As a corollary, at all levels of educational achievement, even at the highest level (having an advanced degree), noncitizens were more likely to be uninsured than native-born and naturalized citizens. As with private insurance coverage, the differences between the uninsurance rates of noncitizens and native-born and naturalized citizens decrease as education increases.[35]

[34] The population in this analysis includes only those aged 18 and over.

[35] Analysis by educational attainment does not include a discussion of rates of military/veterans coverage, as the sample size makes the results unreliable.

No High School Diploma or Equivalent

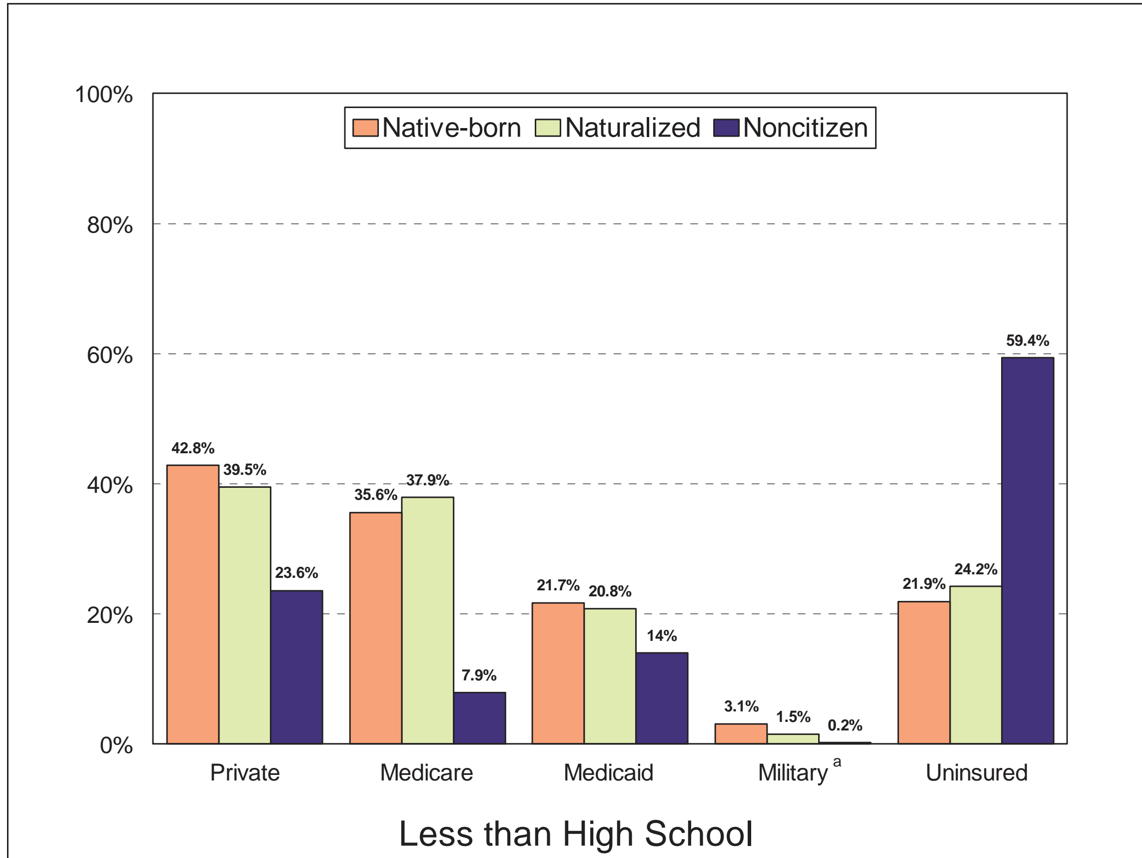
For the lowest level of educational achievement, lacking a high school diploma, noncitizens have lower rates of private insurance than naturalized and native-born citizens, who have similar rates. Only 23.6% of noncitizens without a high school diploma have private insurance coverage. Of native-born citizens who lack a high school diploma, 42.8% have private insurance, while 39.5% of naturalized citizens who lack a high school diploma have private insurance. Similarly, noncitizens without high school diplomas are significantly less likely to be covered by Medicaid (14%), while similarly educated native-born and naturalized citizens have similar rates of Medicaid coverage (21.7% and 20.8%). The noncitizen population (7.9%) without a high school diploma is less likely than the comparable naturalized and native-born populations to be coved by Medicare (37.9% versus 35.6%).[36]As expected by the differences in the rates of private insurance, Medicare, and Medicaid coverage, noncitizens who lack a high school diploma are more than twice as likely to be uninsured than native-born and naturalized citizens with similar levels of educational attainment.

[36] The difference in Medicare coverage between the citizen groups may be attributable to the relative older age distribution of the naturalized population. See **Table A-1**.

Figure 3. Health Insurance Type, by Citizenship: Less than a High School Degree, 2007

Ages 18 and over

(Percentages)



Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. Differences between noncitizens and the naturalized and native-born populations are not statistically significant.

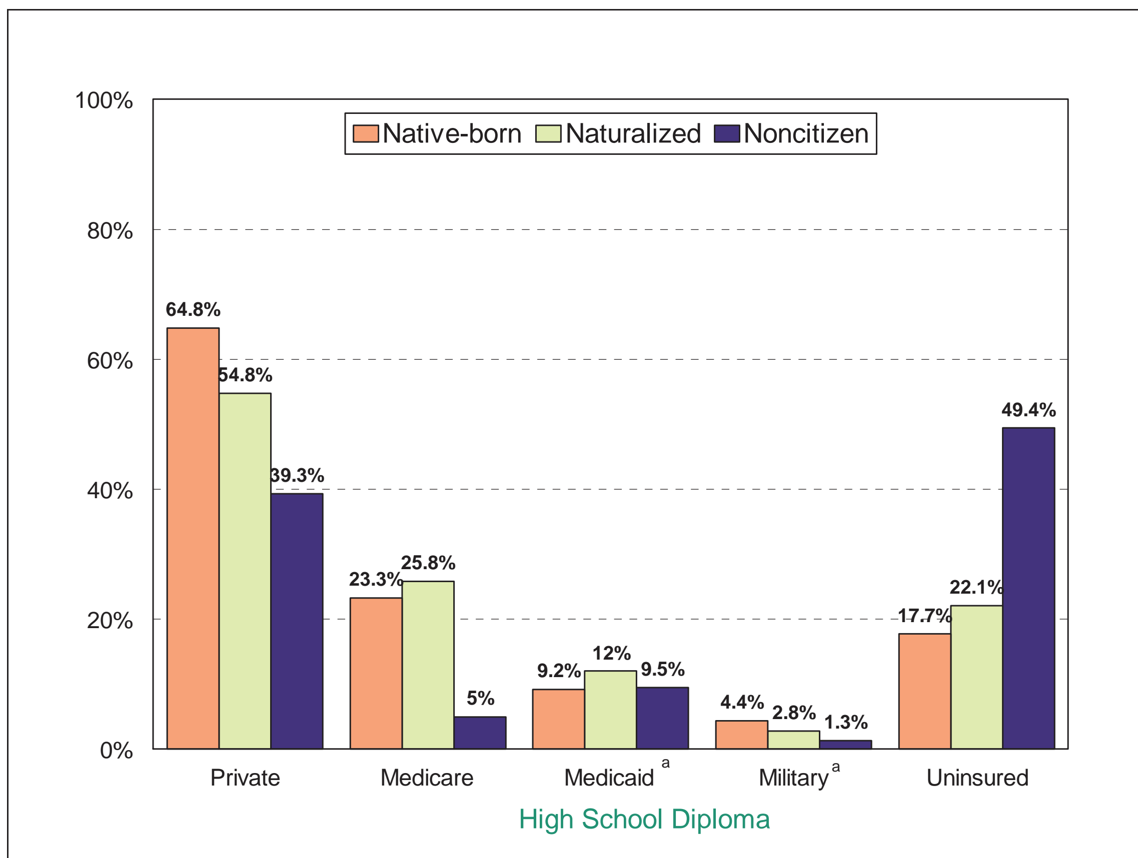
High School Diploma or Equivalent

Noncitizens with high school diplomas have lower rates of private health insurance coverage (39.3%) than similarly educated naturalized citizens (54.8%) and native-born citizens (64.8%). Noncitizens with a high school diploma have a lower rate of Medicare coverage than native-born and naturalized citizens with high school diplomas. Only 5% of high school graduate noncitizens have Medicare coverage, while 25.8% of naturalized citizens with high school diplomas have Medicare coverage, and 23.3% of their native-born counterparts are covered by Medicare. Nonetheless, as in all educational categories, noncitizens with high school diplomas are much more likely than their U.S. citizen counterparts to lack health insurance. The uninsurance rate for noncitizens with high school diplomas is more than double that of similarly educated native-born and naturalized citizens (49.4% compared to 17.7% and 22.1%).

Figure 4. Health Insurance Coverage, by Citizenship: High School Diploma, 2007

Age 18 and Over

(Percentages)



Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. Differences between noncitizens and the naturalized and native-born populations are not statistically significant.

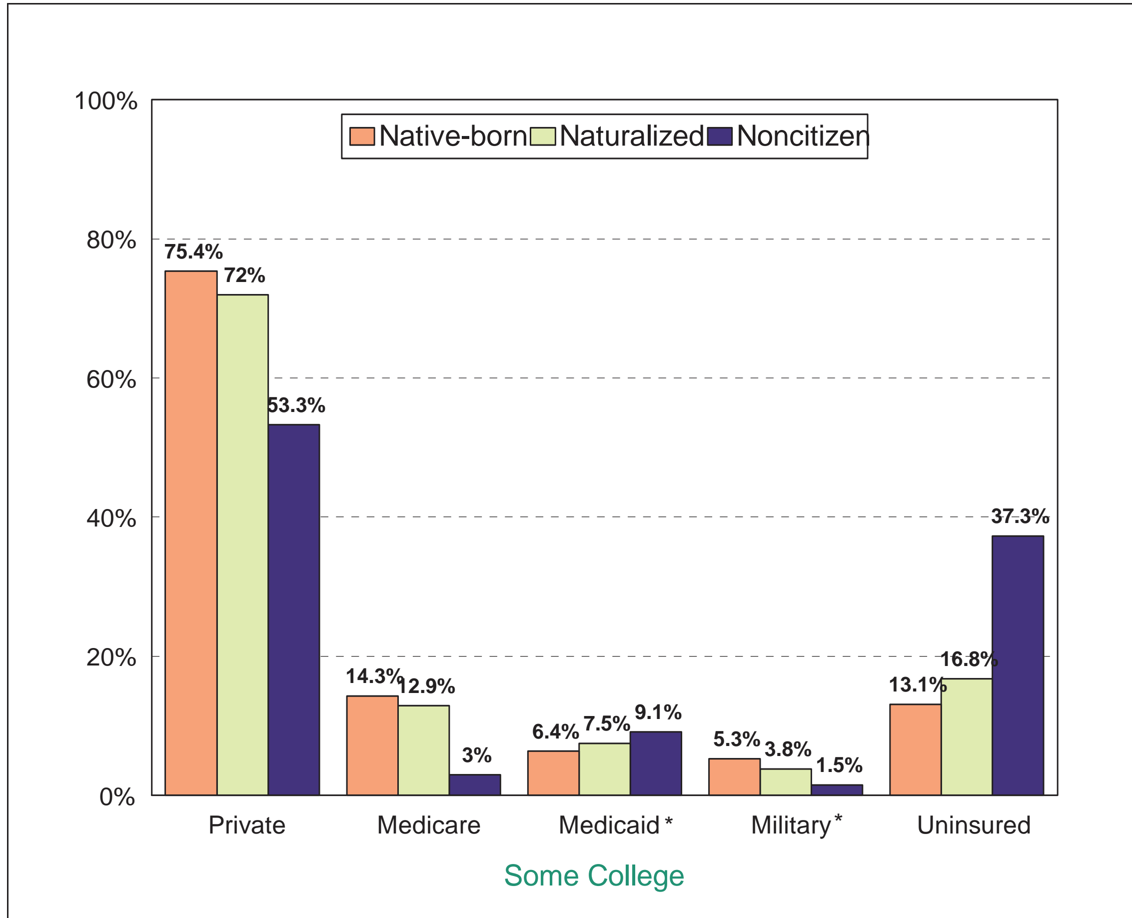
Some College

As with all educational levels, for those with some college education, noncitizens have lower rates of private insurance coverage (53.3%) than naturalized citizens (72%) and native-born citizens (75.4%). Noncitizens also have a lower rate of Medicare coverage (3%) than similarly educated naturalized citizens (12.9%) and native-born citizens (14.3%). In addition, the percentage of noncitizens with some college who lack health insurance was more than double that of similarly educated native-born and naturalized citizens (37.3% compared to 13.1% and 16.8%).

Figure 5. Health Insurance, by Education and Citizenship Status: Some College, 2007

Age 18 and Over

(Percentages)



Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

* Differences between noncitizens and the naturalized and native-born populations are not statistically significant.

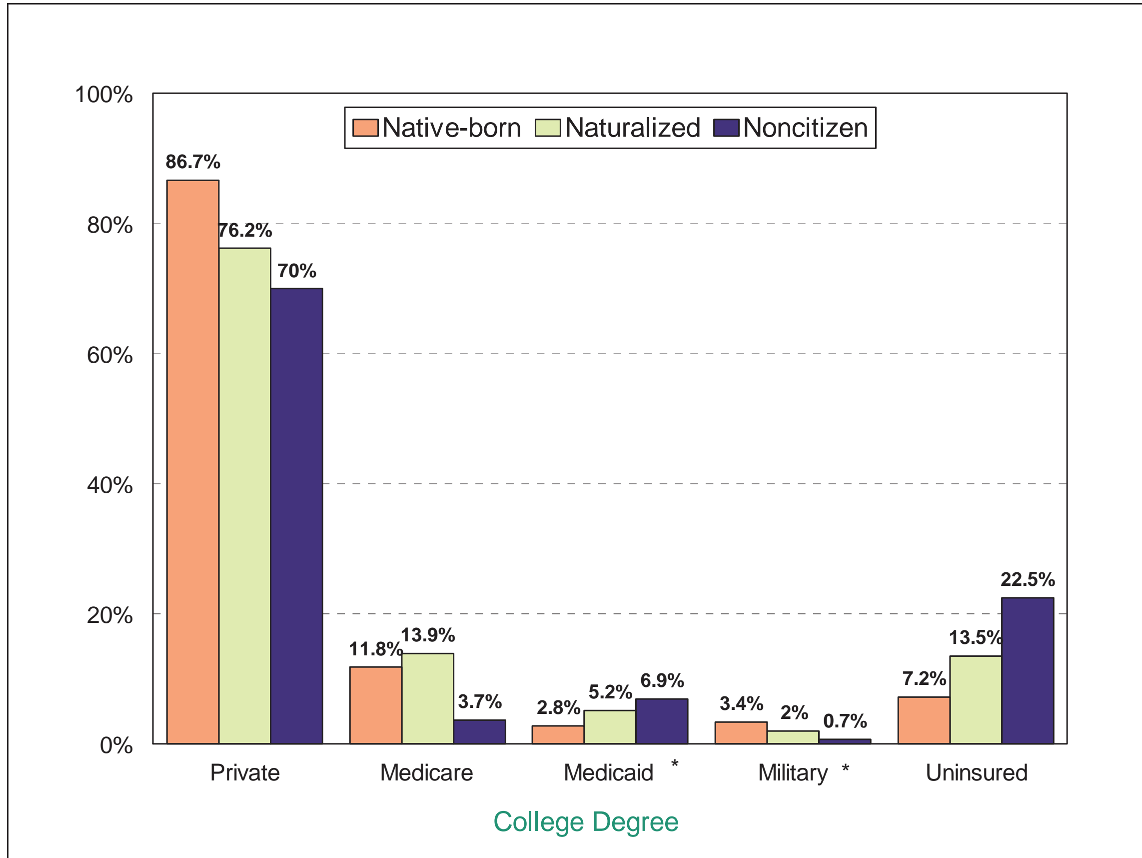
College Diploma

Having a college diploma increases the likelihood that those in all three groups have private insurance. Seventy percent of college-educated noncitizens have private insurance, while 86.7% of similarly educated native-born and 76.2% of naturalized citizens have private insurance. Noncitizens with college diplomas also have lower rates of Medicare coverage than the native-born and naturalized populations (3.7% versus 11.8% and 13.9%). College-educated noncitizens are three times more likely than college-educated native-born citizens to lack health insurance (22.5% compared to 7.2%). The percentage of uninsured naturalized citizens with college diplomas (13.5%) was between that of noncitizens and native-born citizens.

Figure 6. Health Insurance, by Education and Citizenship Status: College Diploma, 2007

Age 18 and Over

(Percentages)



Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

* Differences between noncitizens and the naturalized and native-born populations are not statistically significant.

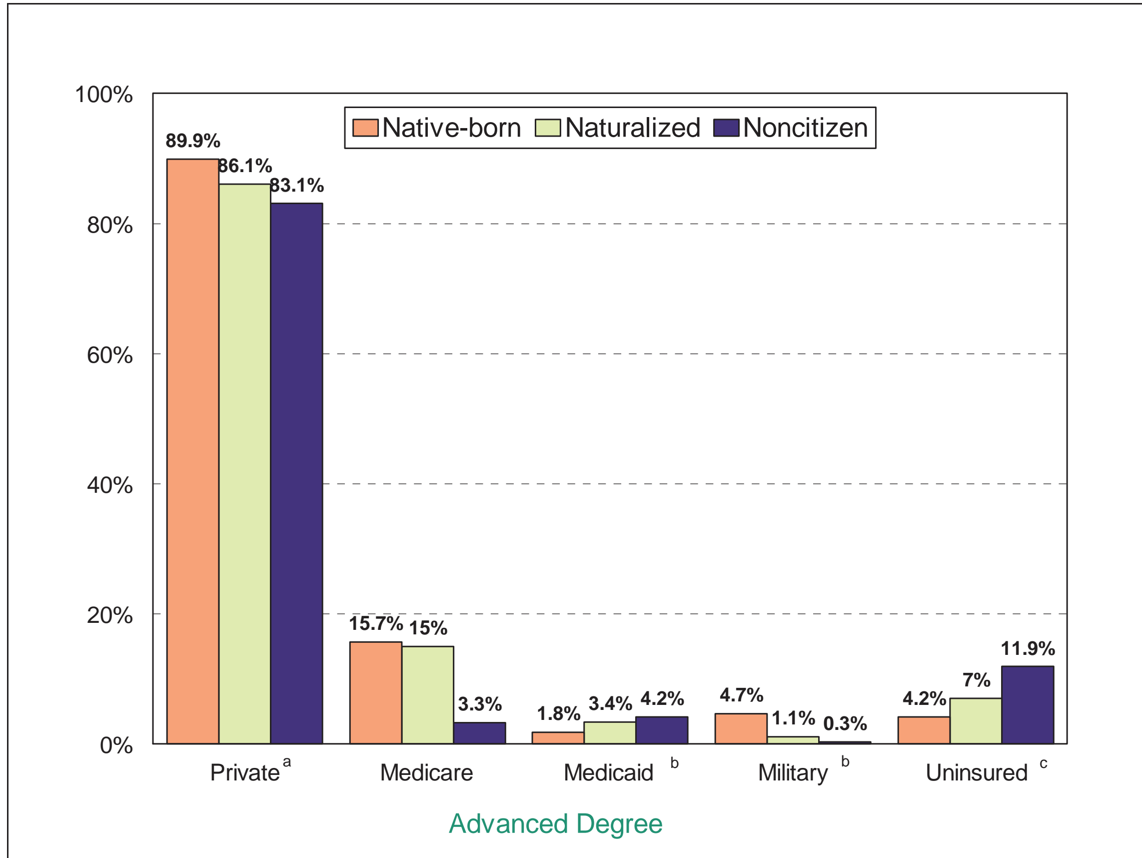
Advanced Degree

The difference between the rates of private insurance coverage for the noncitizen, naturalized, and native-born populations is smallest for those with advanced degrees, and the overwhelming majority of all three groups have private insurance. Of noncitizens with advanced degrees, 83.1% have private insurance, as do 89.9% of native-born citizens. Nonetheless, while the percentage of uninsured persons is small for those with advanced degrees, noncitizens are still more than twice as likely as native-born citizens to be uninsured (11.9% compared to 4.2%).

Figure 7. Health Insurance, by Education and Citizenship Status: Advanced Degree, 2007

Age 18 and Over

(Percentages)



Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. The difference between noncitizens and naturalized citizens is not significant.

b. Differences between noncitizens and the naturalized and native-born populations are not statistically significant.

c. The difference between noncitizens and naturalized citizens is significant at the .1 level.

Region of Residence and Top Five Noncitizen States

More than a quarter of all noncitizens and naturalized citizens live in California compared to only 10.1% of native-born citizens. (See **Table A-1**.) Almost half of all native-born citizens reside in the Midwest or South,[37] compared to less than a quarter of noncitizens and naturalized citizens. As with most other variables, for every region and the five states with the highest noncitizen

[37] The South excludes Texas and Florida, two of the top five states with the largest noncitizen population.

populations, noncitizens are less likely than citizens to have private insurance or Medicare, and more likely to be uninsured.

Table 2. Health Insurance by Residence and Citizenship: Regions and 5 States with Highest Noncitizen Populations

(Percentages)

	Native-born	Naturalized	Noncitizen
Private			
Northeast	76.2	73.8	59.1
New Jersey	74.6	72.3	49.7
New York	69.8	55	40.5
Midwest	74.5	72.8	55.7
South	66.6	69.1	44.1
Florida	66.7	60.6	40.3
Texas	60.3	51	32.1
West	70.9	68.4	41.4
California	68.1	61.9	37.9
Medicare			
Northeast	15.9[a]	25.5	5.2
New Jersey	14.1	23.1	5.6
New York	13.4[b]	26	8.7
Midwest	14.1	19.5	3.9
South	15.2	14.9	2.2
Florida	18.3	28.7	6.2
Texas	12.7	16.7	3.2
West	12.8	16.7	3.9
California	11.2[a]	18.8	6.5
Medicaid			
Northeast	13.8[b]	12.1[b]	18.1
New Jersey	8.6[b]	7.5[b]	7.3
New York	18.4	20.7[b]	27.8
Midwest	12.2[b]	6.8[b]	8.1
South	14.1	3.4[b]	5.4
Florida	10.5[b]	6.6[b]	5.7
Texas	13.9	6.5[b]	5.9
West	11.8[b]	8.8[b]	10.5
California	16.1[b]	13.3[b]	17.7

	Native-born	Naturalized	Noncitizen
Uninsured			
Northeast	8	8.4	22.4
New Jersey	12	13.1	41.5
New York	10.3	15.5	31.5
Midwest	10.4	14.2	34.9
South	13.9	22.1	49.5
Florida	16.3	18.1	52
Texas	20.4	33	60
West	13	16.5	46.6
California	12.9	17.9	42.7

Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified. For the states in the specific regions, see **Appendix C**.

a. The difference between noncitizens and the group is significant at the .1 level.

b. The difference between noncitizens and the group is not statistically significant.

Interestingly, for all three groups, those residing in Texas have the lowest rates of private insurance, but the rate of private insurance for noncitizens is less than that of both citizen populations. Thirty-two percent of noncitizens in Texas have private health insurance compared to 60.3% of native-born and 51% of naturalized citizens. With the exception of New Jersey, the lowest rates of private insurance for noncitizens are in the states with the largest noncitizen populations. In addition, although noncitizens in California have the second lowest rate of private insurance (37.9%), the rates of private insurance for native-born and naturalized citizens are closer to the median. Of native-born citizens in California, 68.1% have private insurance, which is higher than native-born citizens in the South, including both Florida and Texas. For naturalized citizens living in California, the rate of private insurance (61.9%) is less than that of those living in Texas, but not the other Southern states. As shown in **Table 2**, the highest rates of private insurance for all groups occur in the Northeast and Midwest, which is also where there is the smallest difference between the private insurance rates of citizens and noncitizens. Notably, while 15.9% of noncitizens and 17.9% of naturalized citizens live in the Northeast and Midwest, 32.7% of native-born citizens live in the same area. (See **Table A-1**.)

Noncitizens and citizens in Texas, Florida, and the other Southern states are more likely than noncitizens in other states to be uninsured, but as expected, the percentage of noncitizens lacking health insurance is higher than for native-born and naturalized citizens. For example, 60% of noncitizens in Texas are uninsured compared to 20.4% of native-born and 33% of naturalized citizens. In addition, noncitizens in New York have lower uninsurance rates than the other states with the largest noncitizen populations. Nonetheless, noncitizens in New York (31.5%) are more than three times as likely as native-born citizens (10.3%) and more than two times as likely as naturalized citizens (15.5%) to be uninsured.

Arrival Year

As shown in **Table 3**, year of arrival in the United States affects the percentage of naturalized citizens and noncitizens who lack health insurance, but does not strongly influence private insurance or Medicaid coverage. Obviously, year of arrival does affect Medicare coverage with higher coverage rates for those who have been in the United States longer, due to the fact that the program is tailored for those 65 and over who have contributed through the payroll tax for a specified period of time.

Table 3. Type of Health Insurance, by Arrival Year: Naturalized Citizens and Noncitizens, 2007

Arrival Year	Private		Medicare[a]		Medicaid[a]		Uninsured	
	Nat.	Noncit	Nat.	Noncit.	Nat.	Noncit.	Nat.	Noncit.
Before 1970	60.7	46.7	57.4	46.1	8.9	12.7	7.7	17.8
70-79	66.1	51.9	19.1	17	11.3	11.4	16	29.6
80's	66.9	43.9	9.7	7	10.1	13	19.6	40.6
90-95	62.5	42.4	7.9	4.8	11.3	11.8	23.7	43.8
96-01	59.5	42.2	8.4	2.2	13.1	12.6	23.5	45.4
2002-08	64.1	40.4	5.7	1.6	12.7	12.2	22.9	48.3

Source: CRS analysis of 2008 March CPS.

Note: Military/Veterans insurance is excluded due to the small sample size. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. Differences between naturalized citizens and noncitizens for each arrival year are not statistically significant.

For noncitizens, private insurance coverage peaks for those who arrived in the 1970s (51.9%) and is smallest for those who arrived between 2002 and 2008 (40.4%) (see **Table 3**). There is very little difference in rates of private insurance for noncitizens who arrived between 1980 and 2001. In keeping with previous findings, naturalized citizens have higher rates of private insurance than noncitizens for all arrival years, but there are not strong differences in private insurance coverage of naturalized citizens between the different arrival years. For example, the highest rate of private insurance coverage occurs for naturalized citizens who arrived in the 1980s (66.9%), and the lowest rate is for those who arrived between 1996 and 2001 (59.5%). For both groups, Medicare coverage is higher for those who arrived before 1970 and decreases significantly for more recent arrivals.

As expected, the longer a noncitizen has been in the United States, the less likely he or she is to be uninsured. For those who arrived after 2001, 48.3% of noncitizens lack health insurance, compared with 40.6% of those who arrived in the 1980s and 17.8% of those who arrived prior to 1970. For naturalized citizens, the uninsurance rate is similar for those who arrived between 1990 and 2008 (ranging between 23.7% and 22.9%) and lowest for those who arrived before 1970 (7.7%). Importantly, there is a difference between the percentage of naturalized citizens and noncitizens who lack health insurance across all arrival periods, except prior to 1970. For example, for arrivals between 2002 and 2008, 22.9% of naturalized citizens lacked health insurance, compared with 48.3% of noncitizens. (See **Table 3**.)

Region of Birth

There is more variance between types of coverage for noncitizens from different regions than between naturalized citizens and noncitizens from the same region. (See **Table 4**.) Noncitizens from North America[38] have the highest rate of private health insurance coverage (85.5%), while noncitizens from Mexico have the lowest rate (26.5%). Noncitizens from Central America also have a low rate of private insurance coverage (27.4%), and the Caribbean (39.2%) is the region with the next lowest percentage. Similarly, naturalized citizens from North America have the highest rate of private health insurance coverage among the naturalized population (77.3%), while naturalized citizens from Mexico have the lowest rate (50.2%).

Table 4. Health Insurance, by Region of Birth for Naturalized Citizens and Noncitizens, 2007

(Percentages)

Region	Private		Medicare		Medicaid[a]		Uninsured	
	Nat.	Noncitizen	Nat.	Noncitizen	Nat.	Noncitizen	Nat.	Noncitizen
Africa	69.7	53.6	10[a]	5.3	11.8	16.2	18.6	28.5
Asia	69.2	64.8	15.7	5	9.7	11.4	14.2	22.3
Caribbean	59.2	39.2	23.6	7.8	16.6	21.2	15.3[b]	39
Central America	56.7	27.4	13.6[a]	2.5	11	10.2	29.2	62.1
Europe	70.3[a]	70.5	43	13.4	7.1	6.9	8.3[a]	16.6
Former Soviet	68.2[b]	55.5	23.1[a]	11.6	13.4	23.8	9.5[a]	17
Mexico	50.2	26.5	12.3	3.4	10.9	12.1	23.8	60.3
Middle East	59.8[a]	49.2	21.4[a]	6.6	15.8	19.9	17	32
North America	77.3[a]	85.5	26.6	13.3	3.9	6.1	6.8[a]	7.8
South America	61.4	46.4	16.7	2.7	9.7	8	22.5	45.1
Oceania, Pacific, Other	78.4	56.4	15.6[a]	6.7	7.6	13.3	8.8[b]	32.1

Source: CRS analysis of data from the 2008 CPS.

Note: All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified. For the definitions of the regions of birth, see **Appendix C**.

a. The difference between noncitizens and naturalized citizens is not significant.

b. Differences between noncitizens and the naturalized citizens are significant at the .1 level.

[38] Because Mexico is considered a separate category for this analysis, North America consists only of Canada and Bermuda. Due to the relative sizes of the countries, findings for North America are driven primarily by the Canadians.

As shown in **Table 4**, noncitizens and naturalized citizens from the former Soviet Union and the Caribbean have the highest rates of Medicaid coverage, possibly a result of having certain countries in those regions with large refugee and asylee populations.[39] The noncitizen and the naturalized populations from Europe and North America have the lowest rates of Medicaid coverage. For the naturalized population, only 3.9% of those from North America have Medicaid, while 16.6% of those from the Caribbean are covered by Medicaid. In addition, 23.8% of noncitizens from the former Soviet Union have Medicaid, compared with 10.2% of Central Americans and 6.1% of North Americans.

Noncitizens and naturalized citizens from Europe and North America also have higher rates of Medicare coverage than those from other regions. For example, 13.4% of European noncitizens and 2.5% of Central American noncitizens have Medicare.

Analysis: Economic Characteristics

Type of Employer[40]

As shown in **Table A-1**, noncitizens are more likely to be employed by private employers and slightly more likely to be self-employed than native-born citizens, while native-born citizens are more than twice as likely to be employed by governments. Naturalized citizens are more likely than native-born citizens and noncitizens to be self-employed, and more likely than the native-born citizens and less likely than noncitizens to be privately employed.

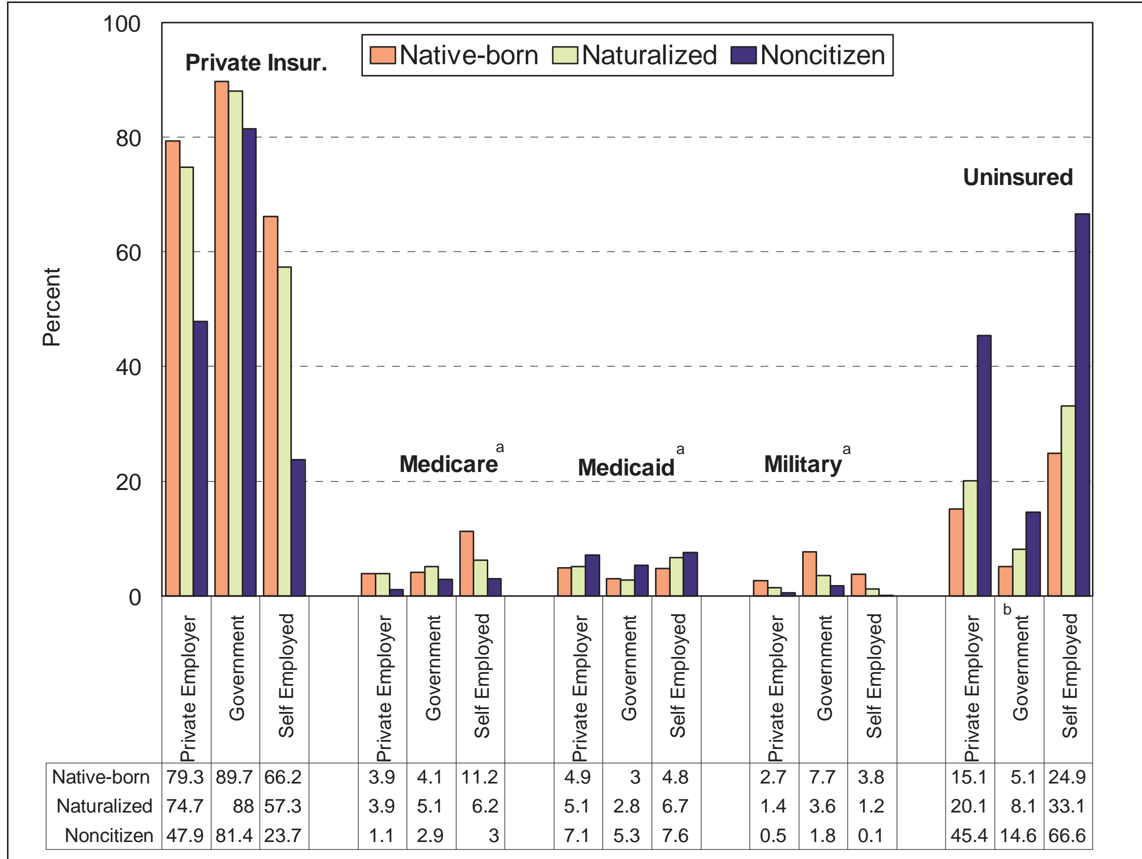
Noncitizens with private employers are much less likely than native-born and naturalized citizens to have private health insurance, while members of each group employed by the federal, state, or local governments have similar and high rates of private insurance that are statistically different. Similarly, in private and self employment, noncitizens are more likely than citizens to be uninsured. (See **Figure 8**.)

[39] For example, Cuba is included in the Caribbean region.

[40] Analysis in this section is limited to those who are employed and between the ages of 18 and 65.

Figure 8. Type of Health Insurance, by Employer Type and Citizenship Status, 2007

(Employed Persons Ages 18 to 65)



	Private Insur.: Private Employer	Private Insur.: Government	Private Insur.: Self Employed	Medicare: Private Employer	Medicare: Government	Medicare: Self Employed	Medicaid: Private Employer	Medicaid: Government	Medicaid: Self Employed	Military: Private Employer	Military: Government	Military: Self Employed	Uninsured: Private Employer	Uninsured: Government[b]	Uninsured: Self Employed
Native-born	79.3	89.7	66.2	3.9	4.1	11.2	4.9	3	4.8	2.7	7.7	3.8	15.1	5.1	24.9
Naturalized	74.7	88	57.3	3.9	5.1	6.2	5.1	2.8	6.7	1.4	3.6	1.2	20.1	8.1	33.1
Noncitizen	47.9	81.4	23.7	1.1	2.9	3	7.1	5.3	7.6	0.5	1.8	0.1	45.4	14.6	66.6

Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. The differences between noncitizens and naturalized and native-born citizens are not significant.

b. The difference between noncitizens and naturalized and citizens is not significant.

Firm Size[41]

For all groups, as firm size increases, rates of private insurance increase, and uninsurance rates decrease. Notably, noncitizens tend to work in smaller firms than citizens. (See **Table A-1**.) The largest percentage of noncitizens work for firms with less than 10 people (28.1%). In addition, while 30.5% of noncitizens work for firms with at least 500 employees, 45.7% of native-born and 43.1% of naturalized citizens work for comparably sized firms.

[41] Analysis in this section is limited to those who are employed and between the ages of 18 and 64.

Table 5. Private Insurance Coverage and Lacking Health Insurance by Firm Size and Citizenship

Employed Persons aged18 to 65

(Percentages)

	Native-Born	Naturalized	Noncitizen
		Private	
Under 10	68.3	56.7	28.3
10 to 24	72.6	66.9	34.8
25-99	79.3	76.4	45.5
100-499	84.4	78.1	58
500-999	86	83.5	64.9
1000+	85.7	86.1	69.5
		Uninsured	
Under 10	23.5	34.1	62.1
10 to 24	21.3	25.7	59.5
25-99	15.2	18.3	48.1
100-499	11.2	17.1	36.6
500-999	9.9	13.4[a]	28.3
1000+	9.2	10.9	25.3

Source: CRS analysis of March 2008 CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. Medicare, Medicaid, and Military/Veterans coverage are not presented, as the differences between the groups were not significant and did not reveal any consistent patterns. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. The difference between noncitizens and citizens is significant at the .1 level.

Furthermore, similar to other variables examined in this study, for the same firm size noncitizens are significantly less likely than native-born and naturalized citizens to have private insurance and more likely to be uninsured. (See **Table 5**.) For firms with less than 10 employees, noncitizens are less than half as likely as native-born and naturalized citizens to have private insurance (28.3% compared to 68.3% and 56.7%, respectively). For the largest sized firms with more than 1,000 employees, 69.5% of the noncitizen population has private insurance compared to 85.7% of the native-born and 86.1% of the naturalized populations. In addition, noncitizens who work for firms with less than 10 employees are more than twice as likely as native-born citizens to lack health insurance (62.1% versus 23.5%). Naturalized citizens (34.1%) in same sized firms are also less likely than noncitizens to be uninsured. Furthermore, noncitizens in firms with over 1,000 employees are more than twice as likely as native-born and naturalized citizens to be uninsured. Approximately a quarter of noncitizens in the largest firms lack health insurance compared to 9.2% of native-born and 10.9% of naturalized citizens.

Occupation[42]

For almost all occupations, noncitizens and naturalized citizens have lower rates of private insurance than native-born citizens; however, the differences between native-born and naturalized citizens tend to be much smaller than the differences between native-born citizens and noncitizens (see **Table 6**).[43] The same pattern holds for the percentage of those lacking insurance, while for all occupations, noncitizens and naturalized citizens have higher uninsurance rates than native-born citizens; however, the differences between native-born and naturalized citizens tend to be smaller than the differences between native-born citizens and noncitizens.

A quarter of all noncitizens are in service occupations (25.4%), a higher percentage than native-born (15.3%) and naturalized (17.9%) citizens. (See **Table A-1**.) As shown in **Table 6**, an examination of health insurance coverage for those in service occupations shows that noncitizens are almost half as likely as citizens (both naturalized and native-born) to have private insurance coverage, and twice as likely as the other groups to be uninsured.

For construction and extraction occupations, where noncitizens are overrepresented compared with native-born and naturalized citizens (16.1% compared to 5.7% for both citizen groups),[44] noncitizens are less than half as likely than native-born and naturalized citizens to have private insurance (24.9% compared to 64.7% of native-born and 57.2% of naturalized citizens). In addition, noncitizens in construction and extraction occupations are more than twice as likely than native-born citizens in similar occupations to be uninsured (71.5% versus 30.6%). (See **Table 6**.)

In the occupations where noncitizens are underrepresented compared to the native-born and naturalized populations, the differences in private insurance and uninsurance rates still exist, but they are not as stark as those in occupations where noncitizens are overrepresented. As shown in **Table 6**, noncitizens in management, business, and financial occupations and in professional and related occupations have high rates of private insurance (72.7% and 85.1%), but their rates are not as high as native-born (90.2% and 91%) and naturalized (86.9% and 90.4%) citizens. In addition, for all groups, the uninsurance rates for those in these two occupational categories are lower than in all other occupational categories, but the percentage of noncitizens who lack insurance is still higher than that of native-born and naturalized citizens. Of those in management, business, and financial occupations, 23.9% of noncitizens lack health insurance, compared with 7.7% of native-born and 11% of naturalized citizens. In professional and related occupations, only 11.8% of the noncitizen population lacks health insurance, compared with 6.9% of the native-born. (See **Table 6**.)

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[42] Medicare is excluded from the analysis of occupation because the percentage covered by Medicare was less than 1% for all groups in almost all occupational categories. Analysis in this section is limited to those who are employed and between the ages of 18 and 65.

[43] The U.S. Census Bureau defines occupation as the kind of work a person does to earn a living. U.S. Census Bureau: Housing and Household Economic Statistics Division , *Frequently Asked Questions: Industry and Occupation*, Washington, DC, April 11, 2008, http://www.census.gov/hhes/www/ioindex/faqs.html.

[44] See **Table A-1**.

Industry[45]

The largest concentration of noncitizens is in the construction industry (16.5%), where noncitizens are also overrepresented compared to native-born (7.3%) and naturalized (6.5%) citizens (see **Table A-1**).[46] As shown in **Table 7**, noncitizens in the construction industry are less likely than their counterparts in all other industries except agriculture to have private insurance and more likely to be uninsured. Interestingly, native-born citizens in the construction industry are less likely than their counterparts in all other industries except the hospitality industry to have private insurance and are more likely to be uninsured. Nonetheless, noncitizens in construction are less than half as likely as native-born and naturalized citizens to have private health insurance (25.9% compared to 69.1% and 60.6%). Similarly, noncitizens in construction are more than twice as likely as native-born and naturalized citizens to be uninsured (70.5%, 26.9%, and 36.5%, respectively).

The largest differences between noncitizens and native-born citizens in uninsured and private insurance rates occur in the agricultural, forestry, fishing, and hunting industry.[47] While only 17.9% of noncitizens have private insurance, 71.2% of native-born citizens in the same industry have private insurance. In addition, noncitizens in the agriculture industry have a high rate of being uninsured (71.2%). Comparatively, only 23.9% of native-born noncitizens in the agriculture industry lack health insurance. (See **Table 7**.)

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[45] Medicare is excluded from the analysis of industry because the percentage covered by Medicare was less than 1% for all groups in almost all industries. Analysis in this section is limited to those who are employed and between the ages of 18 and 65.

[46] The U.S. Census Bureau defines industry as the type of activity at a person's place of work. U.S. Census Bureau: Housing and Household Economic Statistics Division, *Frequently Asked Questions: Industry and Occupation*, Washington, DC, April 11, 2008, http://www.census.gov/hhes/www/ioindex/faqs.html.

[47] Another study found that farm worker's children (both citizen and noncitizen) were uninsured at roughly three times the rate of all other children and almost twice the rate of those at or near the poverty level. RL Rodriguez, MN Elliot, and KD Vestal, "Determinants of Heath Insurance Status for Children of Latino Immigrant and Other US Farm Workers: Findings from the National Agricultural Workers Survey," *Archives of Pediatrics and Adolescent Medicine*, vol. 162, no. 12 (December 2008), pp. 1175-80.

Table 6. Health Insurance Coverage, by Occupational Category and Citizenship Status, 2007

Employed Persons Ages 18 to 65

(Percentages)

Occupation	Private			Medicaid[b]			Military/Veterans[b]			Uninsured		
	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen
Management, Business, Financial	90.2	86.9	72.7	1.6	2.1	3.1	2.7	2	0.6	7.7	11[c]	23.9
Professional and Related	91	90.4	85.1	2.2	2	3.8	2.5	1.4	0.1	6.9	7.6[d]	11.8
Service	65.4	64.2	34.2	8.8	8.2	9.5	2.7	1.6	0.5	25.6	27.3	56.3
Sales	76.6	67.8	46.8	5.4	5.2	6.9	2.8	1.1	0.9	17.7	27.5	46.9
Office, Admin. Support	83.3	76.9	62.3	4	4.1	7.2	3.1	1.3	1.2	12.6	19.1[c]	31.1
Farming, Fishing, Forestry	59.3	[a]	17.8	6.2	[a]	10.6	2.4	[a]	0.4	34.5	[a]	72.4
Construction and Extraction	64.7	57.2	24.9	4.4	5.3	4.4	2.3	0.3	0.3	30.6	39.2	71.5
Installation, Maintenance, Repair	81.2	72.6	50.2	2.9	.3	6.4	2.8	2.3	0	15.8	25.8[d]	44
Production	78.5	74.4	50.3	5.2	7	7.8	1.9	0.9	0.3	16.9	19.3	42.6
Transportation, Material Moving	70.8	59.2	42.5	5.8	9.4	7	2.8	0.3	0.1	23.1	36.5	51.3

Source: CRS analysis of the 2008 March CPS.

Notes: Medicare is excluded from the analysis because the percentage covered by Medicare was less than 1% for all groups in almost all occupations. The armed forces category was excluded due to the small sample size. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. Sample size too small for analysis.

b. Differences between noncitizens and native-born citizens, and noncitizens and naturalized citizens not statistically significant.

c. The difference between noncitizens and naturalized citizens is significant at the .1 level.

d. The difference between noncitizens and naturalized citizens is not significant.

Table 7. Health Insurance Coverage, by Industry Category and Citizenship Status, 2007

Employed Persons Ages 18-65

(Percentages)

Industry	Private			Medicaid[a]			Military/Veterans[a]			Uninsured		
	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen	Native	Naturalized	Noncitizen
Agriculture, Farming, Fishing, Forestry	71.2	42[a]	17.9	4.9	5.8	11.6	2	0.5	0.4	23.9	51.2[a]	71.2
Construction	69.1	60.6	25.9	3.7	4.6	4.2	2.1	0.3	0.2	26.9	36.5	70.5
Manufacturing	85.8	81.3	61.5	3	4.4	6.6	1.9	0.7	0.2	11.5	14.8	32.5
Wholesale and Retail	76.4	69.3	48	5.6	6.2	7	2.9	0.9	0.6	17.8	25.2	46
Transport , Utilities	82.3	70.5	45.1	3.2	5.9	8.2	3.6	0.4	0.2	14.2	24.8	47.1
Information	85.3	87.4[b]	75	2.6	1.7	2.4	1.7	1.7	3.4	11.9[a]	10.3[a]	23.4
Financial Activities	88.9	84[b]	75.3	2.5	2.5	1.7	1.8	1.4	0.9	8.7[b]	14.4[a]	23.7
Professional and Business Services	78.5	75	49.3	4.1	2.9	5.9	3.1	1.9	0.6	16.8	21.5	44.7
Education and Health Services	85.9	83.9	71.3	4.2	4.3	7.9	2.8	1.4	0.2	9.9	11.4	22.2
Leisure and Hospitality	62.9	66	35.7	8.8	7.2	7.2	2.1	1.6	0.3	28.4	27.5	57.1
Other Service	70.9	54.8	33.3	5.7	8.9	12.1	2.6	2.5	0.5	23	35.7	53.9

Source: CRS analysis of the 2008 March CPS.

Note: Medicare is excluded from the analysis because the percentage covered by Medicare was less than 1% for all groups in almost all industries. The industrial categories of mining, armed forces, and public administration are not included due to the small sample sizes. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified.

a. Difference with noncitizens and the other population is not statistically significant.

b. The difference between the population and noncitizens is significant at the .1 level.

Examining the three industry categories that each have concentrations of approximately 13% of noncitizens (manufacturing, professional and business services, and leisure and hospitality), noncitizens are less likely than native-born and naturalized citizens to have private insurance, but the differences are not as great as in the industries where noncitizens are more strongly overrepresented. (See **Table A-1** and **Table 7**.) For example, 35.7% of noncitizens in the leisure and hospitality industry have private insurance, compared with 62.9% of native-born and 66% of naturalized citizens in the same industry. In addition, noncitizens in these industries are more than twice as likely as native-born and naturalized citizens to lack health insurance.

In the two industries where noncitizens are strongly underrepresented—financial activities, and education and health services[48]—noncitizens have high rates of private insurance (over 70%), but the rates are less than those for native-born and naturalized citizens.[49] Noncitizens in these industries also have low rates of being uninsured compared to noncitizens in other industries, but the rates are higher than native-born and naturalized citizens. For example, in the education and health services industry, 22.2% of noncitizens lack insurance, compared with 9.9% of native-born and 11.4% of naturalized citizens. (See **Table 7**.)

Poverty Levels

Total Population

Overall, noncitizens tend to be poorer than native-born and naturalized citizens. Forty-nine percent of noncitizens have family incomes that are less than 200% of the poverty line,[50] compared with 29.1% of native-born and 28.4% of naturalized citizens (see **Table A-1**). As shown in **Table 8**, expectedly, as family income increases, people are more likely to have private health insurance. Nonetheless, for all levels, noncitizens are less likely than citizens to have private insurance, but this difference is smallest for those whose family income is more than 500% of poverty. Only 14.4% of noncitizens with family incomes less than 100% of poverty have private insurance, while 22.3% of native-born and 21.9% of naturalized citizens with similar family incomes have private insurance. For those with family incomes that are at least 500% of poverty, 82.5% of noncitizens, 90.9% of native-born citizens, and 85.4% of naturalized citizens have private insurance.[51]

[48] See **Table A-1**.

[49] The difference in private insurance for noncitizens and naturalized citizens in the financial activities industry is significant at the .1 level.

[50] In 2007, the poverty threshold (which is used mainly for statistical purposes and differs slightly from the poverty guideline used for program eligibility and other administrative purposes) for a family with two adults and two children was $21,027. Children are excluded from CPS-based poverty analyses if they are living with a family to which they are not related.

[51] The difference between noncitizens and naturalized citizens is significant at the .1 level.

Table 8. Type of Health Insurance, by Federal Poverty Level (FPL) and Citizenship, 2007

(Percentages)

Type of Health Insurance	Federal Poverty Level	Native-Born	Naturalized	Noncitizen
Private	Less than 100%	22.3	21.9	14.4
	100%-199%	47.2	39.8[a]	26.6
	200%-499%	78.4	68.9	54.9
	500% +	90.9	85.4[a]	82.5
Medicare	Less than 100%	14.2	27.8	5.3
	100%-199%	23	33.7	5.2
	200%-499%	13.8	19	4.9
	500% +	9.5	13[b]	4.8
Medicaid	Less than 100%	47.2	31.7[a]	24.2
	100%-199%	24.6	19.1[b]	15
	200%-499%	6.9[b]	7.4[b]	6.9
	500% +	2.3[b]	3.3[b]	3.6
Uninsured	Less than 100%	26.2	35.7	59.9
	100%-199%	20.2	26.7	56.5
	200%-499%	11.1	16.7	37.2
	500% +	5	7.4	13

Source: CRS Analysis of the 2008 March CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. In 2007, 100% of poverty, defined as the "poverty threshold" by the U.S. Census Bureau for a family with two adults and two children, was $21,027.

a. The difference with noncitizens is significant at the .1 level.

b. Difference with noncitizens not statistically significant.

As discussed above, although overall noncitizens are only slightly less likely to have Medicaid coverage (12.3%) than native-born citizens (13.4%), and naturalized citizens are the least likely to have Medicaid coverage (10.7%), when examining those below 200% of poverty, noncitizens are much less likely than the native-born to be covered by Medicaid. For those with family incomes less than 100% of poverty, 24.2% of noncitizens are covered by Medicaid, compared with 31.7% of naturalized and 47.2% of native-born citizens.[52] Similarly, for those with family incomes between 100% and 199% of poverty, 15% of noncitizens and 24.6% of native-born citizens have Medicaid coverage.

For all poverty levels, noncitizens are more likely to be uninsured than native-born and naturalized citizens. Nonetheless, going from a family income less than 100% of poverty to one that is 100% to 199% of poverty has a much stronger effect on reducing the percentage of people who are uninsured for U.S. citizens than it does for noncitizens.

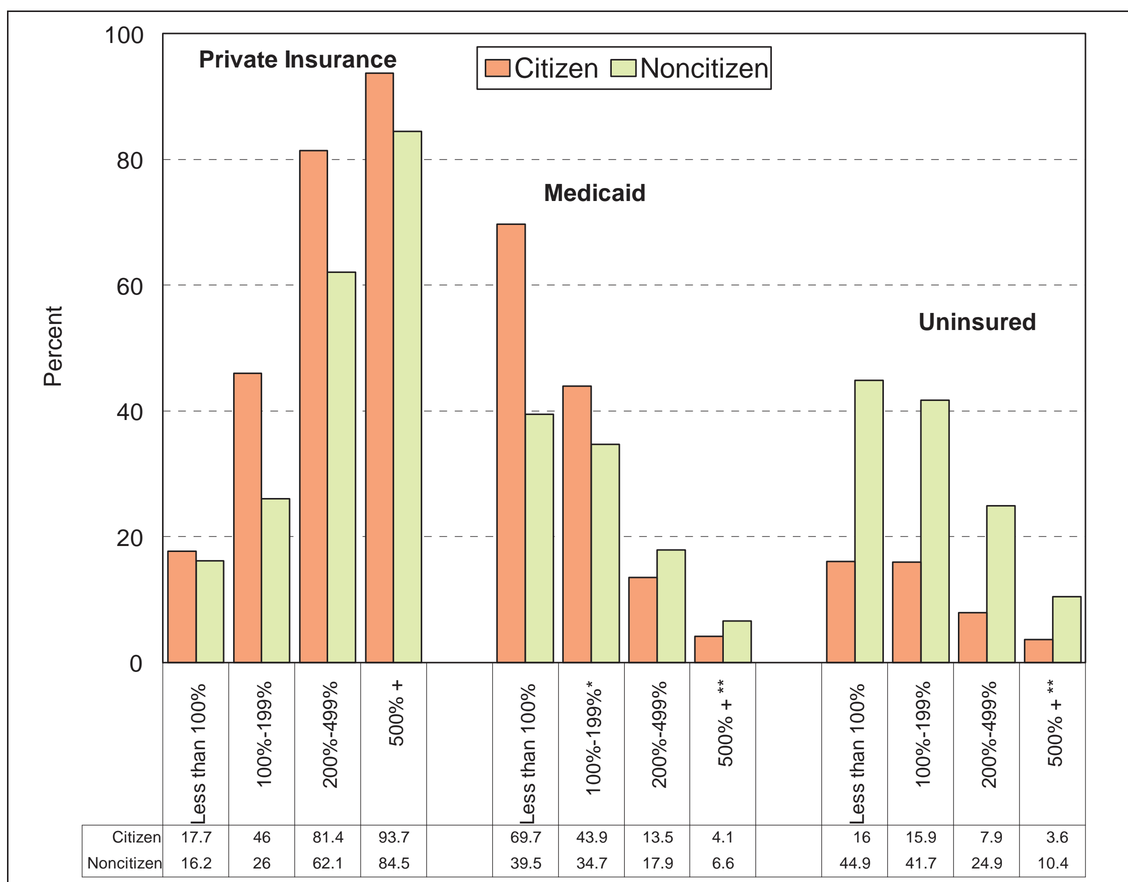
[52] The difference between the noncitizens and naturalized citizens is significant at the .1 level.

Children and Poverty Levels

As with the total population, noncitizen children in families with incomes less than 100% of poverty are less likely to have private insurance than citizen children with similar family incomes. (See **Figure 9**). As with the total population, noncitizen children at all income levels are more likely to be uninsured than citizen children; however, the percentage of children with family incomes below 100% of poverty who lack insurance is less than the uninsurance rate for the total population at the same poverty level.[53] For those with family incomes under 200% of poverty, citizen children have higher rates of Medicaid coverage than noncitizen children. Conversely, for those with family incomes of at least 200% of poverty, noncitizen children have higher rates of Medicaid coverage than citizen children.

Figure 9. Health Insurance Coverage, by Poverty Level and Citizenship: Children Under Age 18, 2007

(Percentages)



	Private Insurance: Less than 100%	100%-199%	200%-499%	500% +	Medicaid: Less than 100%	100%-199%*	200%-499%	500% + **	Uninsured: Less than 100%	100%-199%	200%-499%	500% + **
Citizen	17.7	46	81.4	93.7	69.7	43.9	13.5	4.1	16	15.9	7.9	3.6
Noncitizen	16.2	26	62.1	84.5	39.5	34.7	17.9	6.6	44.9	41.7	24.9	10.4

Source: CRS Analysis of the 2008 March CPS.

Notes: Percentages may sum to more than 100 because persons can have more than one type of insurance. Medicare and Military/Veterans Coverage excluded due to sample size. Due to the small size of the under 18 naturalized population, naturalized and native-born citizens were combined for this analysis. Differences between citizens and noncitizens are significant at the .05 level unless otherwise noted.

[53] Children are more likely than adults to be able to meet the Medicaid and CHIP eligibility requirements.

* Difference between citizens and noncitizens is significant at the .1 level.

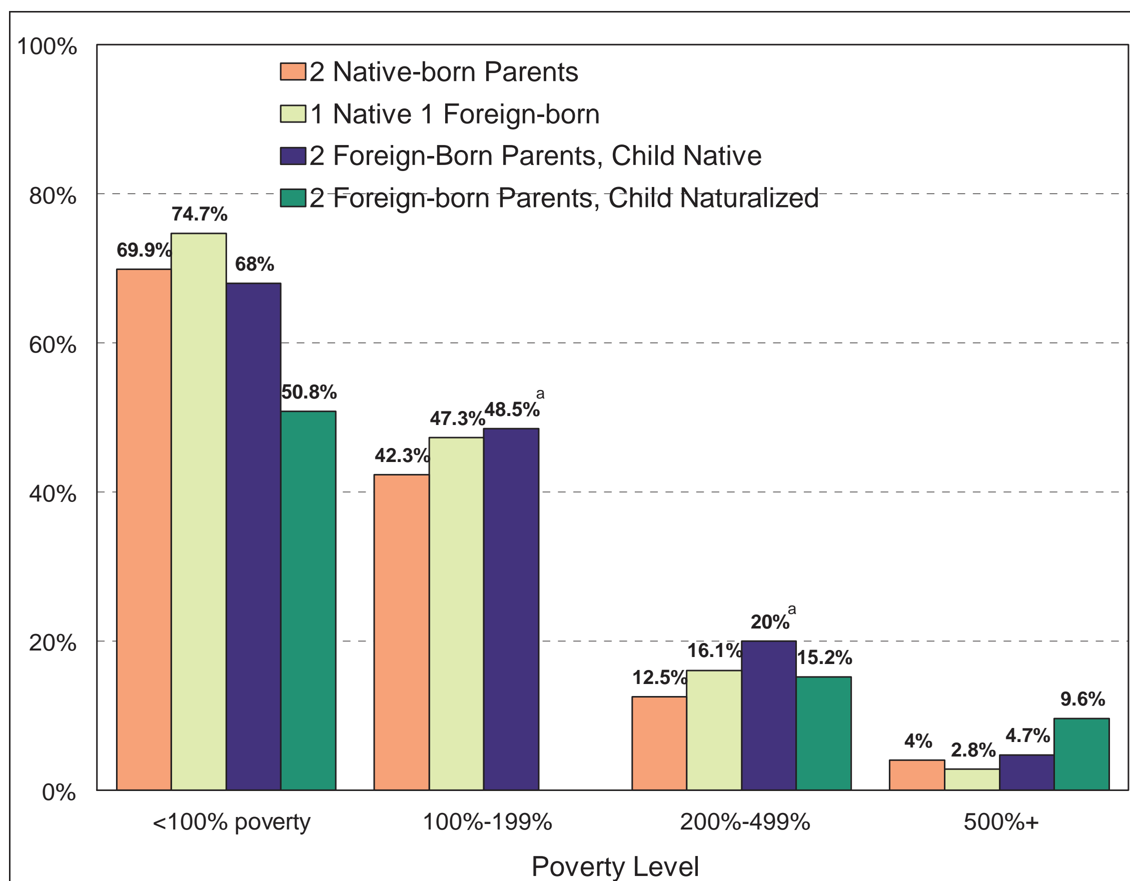
** Difference between citizens and noncitizens is not statistically significant.

Some argue that there is a "chilling effect" and many noncitizen parents do not obtain Medicaid coverage for their eligible U.S. citizen children. In other words, these parents are either afraid to make themselves known to any governmental authority or, because of language or other barriers, they are unable to navigate the Medicaid system. Examining U.S. citizen children with foreign-born parents, CRS found that for children whose family income is under 100% of the poverty line, there is not a statistically significant difference in the Medicaid coverage of this population. (see **Figure 10**). Almost 70% of native-born citizen children with native-born parents and family incomes under 100% of the poverty line have Medicaid coverage, compared with 74.7% of native-born children with one foreign-born parent[54] and 68% of native-born children with two foreign-born parents. Conversely, for children between 100% and 199%, and 200% and 499% of poverty, native-born citizen children with two foreign-born parents are significantly more likely than citizen children with two native-born parents to be covered by Medicaid.[55]

[54] One foreign born parent means that either the other parent is a native-born U.S. citizen or that the citizenship of the other parent is unknown.

[55] One study, using a different data source, arrived at a different conclusion on the "chilling effect" for citizen children of noncitizen parents receiving Medicaid. The study found that between 1996 and 2001, coverage of the children of "non-permanent residents" from low social economic status fell by approximately 10 percentage points. In addition, citizen children of "non-permanent residents" had an approximately 17 percentage-point decline in coverage relative to citizen children of permanent residents. Ithai Zvi Lurie, "Welfare Reform and the Decline in the Health Insurance Coverage of Children of Non-Permanent Residents," *Journal of Health Economics*, vol. 27 (2008), pp. 786-793.

Figure 10. Medicaid Coverage of Citizen Children, by Poverty: Native-Born and Foreign-Born Parents, 2007



Source: CRS Analysis of the 2008 March CPS.

Note: Foreign-born is not the same as non-citizen, as some of the foreign-born population in the United States has naturalized. None of the comparisons with citizen children of two native-born parents are statistically significant except where noted.

a. Difference between the children of two native-born parents and native-born children with two foreign-born parents is significant at the .05 level.

Summary of Findings

CRS Results

In terms of insurance coverage, noncitizens are more than three times as likely as native-born U.S. citizens and more than two times as likely as naturalized U.S. citizens to be uninsured. Similarly, noncitizens have a lower rate of private insurance coverage, while native-born and naturalized U.S. citizens have similar rates of private health insurance. The noncitizen population also has the lowest rate of Medicare coverage, while naturalized citizens, who tend to be older than native-born citizens and noncitizens, have the highest rate of Medicare coverage. Lastly, the noncitizen population has much lower rates of military/veterans coverage than the naturalized and native-born populations. The rates and types of health insurance coverage are affected by variables such as occupation, industry, education, and region of birth; however, other socio-economic variables, such as age, do not seem to have an effect.

Findings in Other Research

Some studies have investigated health insurance coverage of noncitizens using different data sources that allowed for certain analyses that were not possible with CPS data. For example, the Survey of Income and Program Participation (SIPP) has annual data on whether individuals chose to accept employer-sponsored health insurance. In addition, other studies that used their own samples were able to distinguish between aliens with different immigration statuses, including those that were unauthorized aliens.[56] The results from some of these studies can add to an understanding of health insurance coverage for noncitizens.

The Unauthorized Population

Although this report was unable to isolate the unauthorized population from legally present noncitizens, some studies that focused on small samples and specific geographic areas have found that unauthorized aliens are more likely than other noncitizens to be uninsured. One study found that in 2005, only 20% of the unauthorized population in Los Angeles County had job-based coverage, and almost none of these individuals purchased coverage on their own. The same study noted that 68% of the unauthorized population in Los Angeles County lacked health insurance, compared with 38% of LPRs and 49% of nonimmigrants.[57] The authors also reported that uninsurance is a "chronic state" for unauthorized workers; of the currently insured unauthorized aliens in the survey, only 62% were continuously insured during the previous two years.[58] The study concluded that although insurance disparities between the foreign-born and native-born can be explained by traditional socioeconomic factors, unauthorized aliens had lower rates of coverage, even after controlling for a wide array of factors.[59]

Another study found that Mexican and other Latino unauthorized aliens are more likely than Mexican and other Latino immigrants and native-born and naturalized citizens to lack health insurance.[60] A different study of unauthorized Mexicans in New York found that having health insurance coverage during the past six months was associated with being a woman, living in a residence with fewer other adults, having an earlier year of entry to the United States, having higher levels of linguistic acculturation, having higher levels of incomes, not working as a day laborer, not sending money to family in Mexico, and having higher levels of social support. The same study concluded that personal resources, including financial and social resources, are

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[56] Notably, the sample in studies that conducted their own sampling tend to be small and regionally limited, and thus the results are not representative of the whole country.

[57] The same study found that 23% of naturalized U.S. citizens and 17% of native-born U.S. citizens lacked health insurance in 2000. Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), p. 1703.

[58] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Legal Status and Health Insurance Among Immigrants," *Health Affairs*, vol. 24, no. 6 (November/December 2005), pp. 1640-1649.

[59] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Legal Status and Health Insurance Among Immigrants," *Health Affairs*, vol. 24, no. 6 (November/December 2005), pp. 1645-7.

[60] Alexander N. Ortega, Hai Fang, and Victor H. Perez, et al., "Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos," *Archives of Internal Medicine*, vol. 167, no. 21 (November 26, 2007), p. 2356. Note in this study, the unauthorized population includes nonimmigrants (i.e., those in the United States temporarily and for a specific purpose). According to the authors, their "unauthorized population" is 93% unauthorized aliens and 7% nonimmigrants.

important determinants of health insurance coverage, even after accounting for differences in health need.[61]

Likewise, a small study of Latino women in northern Texas found that unauthorized Latino women were more than three times as likely as legally present Latino noncitizens to be uninsured. In this study, 91% of unauthorized Latino women reported having no health insurance.[62]

Employer-Sponsored Insurance

Several studies described in this section have found that the gap in health insurance coverage between citizens and noncitizens is influenced by differences in the likelihood of working for a firm that offers insurance. Studies have noted that although noncitizens are as likely as citizens to work, a disproportionate number work in low-wage jobs that do not offer health coverage,[63] and that the substantially higher uninsurance rate among noncitizens is affected by the lower rate of health insurance offers being made by the employers of immigrants.[64] Some studies have found that noncitizens are disproportionately employed in low-wage jobs, in small firms, and in service or trade occupations—jobs that are less likely to offer health benefits.[65] Although some point to PRWORA as having an increasing effect on the uninsurance rates for noncitizens, some argue that whether noncitizens have employment-based coverage is a larger factor than whether they have coverage from public programs.[66] In general, studies have found that when offered insurance, noncitizens are only slightly less likely than citizens to take up coverage.[67]

A study that tried to explain the gap between citizens and noncitizens health insurance found that a total of 80% of the difference in employer sponsored health coverage was associated with noncitizens being less likely than citizens to work for a firm that offers health benefits. Explanations of the differences in the types of firms found that differences in education accounted for about 60% of the gap in employer-sponsored health insurance between citizens and noncitizens. Age differences also accounted for a small but significant part of the gap. Firm size and unionization were also found to affect the offering of employer-sponsored insurance, with those in bigger firms and unionized workplaces being more likely to have employer-sponsored

[61] Arijit Nandi, Sandro Galea, and Gerald Lopez, et al., "Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area," *American Journal of Public Health*, vol. 98, no. 11 (November 2008), pp. 2014-2017.

[62] Khiya J. Marshall, Ximena Urrutri-Rojas, and Francisco Sota Mas, et al., "Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women," *Health Care for Women International*, vol. 26, no. 10 (December 2005), pp. 916-936.

[63] Andrea B. Staiti, Robert E. Hurley, and Aaron Katz, *Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs*, Center for Studying Health System Change, Issue Brief 104, Washington, DC, February 2006, p. 1.

[64] Thomas C. Buchmueller, Anthony T. Lo Sasso, and Ithai Lurie, et al., "Immigrants and Employer-Sponsored Health Insurance," *Health Services Research*, vol. 42, no. 1 (February 2007), p. 286. Under law, employers must offer the same benefits to U.S. citizens and noncitizens in the same jobs.

[65] It is unknown whether the employers of noncitizens are less likely to offer health insurance, or whether health insurance is less important to noncitizens than citizens when deciding whether to accept employment. Gary Claxton, Jon Gabel, and Bianca DiJulio, et al., "Health Benefits In 2007: Premium Increases Fall to An Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs*, vol. 26, no. 5 (September/October 2007), pp. 1407-1416.

[66] Paul Fronstein, *The Impact of Immigration on Health Insurance Coverage in the United States: 1994-2006*, Employee Benefits Research Institute Notes, vol. 29, no. 8 (August 2008), p. 3.

[67] Thomas C. Buchmueller, Anthony T. Lo Sasso, and Ithai Lurie, et al., "Immigrants and Employer-Sponsored Health Insurance," *Health Services Research*, vol. 42, no. 1 (February 2007), p. 286.

insurance. The study noted that noncitizens are less likely than native-born citizens to be in larger firms (with more than 100 employees) and in unionized workplaces.[68]

Effect of Noncitizens on the Uninsured Rate Over Time

Although there appears to be general agreement on the fact that noncitizens are more likely than U.S. citizens to lack health insurance, there is not a consensus on the impact of noncitizens on the U.S. uninsured population over time. One study concluded that immigrants who arrived between 1994 and 1998 accounted for the majority of the growth in the uninsured population during that time period.[69] Conversely, another study during the same time period concluded that although uninsured rates among recent immigrants are high, this population was not a significant factor in the growth of the uninsured population.[70] Several studies, as well as CRS analyses, have found that the time period examined has a significant impact on the estimated effect of noncitizens on the uninsured population.[71]

CRS Analysis of Effects of Noncitizens on Uninsurance Rates Between 2000 and 2007

CRS analysis of the nonelderly (under 65) population between 2000 and 2007 found that the overall number of the uninsured increased steadily between 2000 and 2006, from 38.5 million to 46.5 million, and then decreased to 45 million in 2007. As a percentage of the total population, the percentage of the population lacking health insurance increased from 14% in 2000 to 17.9% in 2005 and then decreased very slightly to 17.1% in 2007.[72]

During that time period, the percentage of noncitizens in the uninsured population increased from 19.6% in 2000 to a high of 21.5% in 2006, and then decreased slightly to 21.1% in 2007 (see **Table 9**). Notably, the increase was not consistent across the time period. Conversely, in 2000, native-born citizens comprised their largest percentage of the uninsured population (75.5%) and the percentage decreased, though not uniformly, to a low of 73.1% in 2007. As with the noncitizen population, the percentage of naturalized citizens in the uninsured population increased from a low of 4.6% in 2000 to a high of 5.8% in 2007, but the increase was not steady during the period.

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[68] Thomas C. Buchmueller, Anthony T. Lo Sasso, and Ithai Lurie, et al., "Immigrants and Employer-Sponsored Health Insurance," *Health Services Research*, vol. 42, no. 1 (February 2007), pp. 294-304.

[69] Steve Camarota and James R. Edwards, *Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance*, Center for Immigration Studies, July 2000.

[70] John Holahan, Leighton Ku, and Mary Pohl, *Is Immigration Responsible for the Growth in the Number of Uninsured?* The Kaiser Commission on Medicaid and the Uninsured, Publication no. 2221, Washington, DC, February 2001.

[71] Paul Fronstin, *The Impact of Immigration on Health Insurance Coverage in the United States*, Employee Benefits Research Institute Notes, vol. 26, no. 6 (June 2005); and John Holahan and Allison Cook, *Are Immigrants Responsible for Most of the Growth of the Uninsured?* Kaiser Commission on Medicaid and the Uninsured, November 2005.

[72] This section is based on data presented in CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady, and from earlier versions of this report, available from the author, which have the same CRS report number.

Table 9. Percentage of the Population that Is Uninsured, Number of Uninsured, and Percentage of Total Uninsured Population for Native-Born, Naturalized Citizens, and Noncitizens: 2000-2007

	Native-born Citizen			Naturalized Citizens			Noncitizens		
Year	% Uninsured	Number of Uninsured (millions)	% of Uninsured Population	% Uninsured	Number of Uninsured (millions)	% of Uninsured Population	% Uninsured	Number of Uninsured (millions)	% of Uninsured Population
2000	13.4%	29.1	75.5%	19.7%	1.8	4.6%	42.8%	7.5	19.6%
2001	13.8	30.2	73.8	21	2.0	4.9	44.3	8.6	21.1
2002	14.5	32.3	74.6	21.6	2.2	5.1	45.3	8.8	20.3
2003	14.8	33	73.8	21.1	2.2	4.9	47.1	9.4	21.0
2004	15.1	33.8	74.3	21	2.3	5.1	45.7	9.4	20.7
2005	15.2	34.4	74.6	21.7	2.4	5.2	45.3	9.4	20.4
2006	15	34.1	73.3	19.8	2.3	4.9	46.6	10	21.5
2007	14.4	32.9	73.1	21.5	2.6	5.8	45.3	9.5	21.1

Source: CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady. This table utilizes data collected from earlier versions of this report, for 2000 through 2006, available from the author, which have the same CRS Report Number,

Notes: Amounts may not total due to rounding.

As shown in **Table 9**, due to the relative size of the populations, native-born citizens make up the highest percentage of the uninsured population, and have also made up the majority of the increase in the uninsured population between 2000 and 2005. Nonetheless, the percentage of the increase during this time period attributable to both the noncitizen and naturalized citizen populations (24.6% and 8.2%, respectively) is slightly larger than the groups' percentage of the uninsured population (approximately 20% and 5%, respectively), but this difference is not statistically significant.

Nonetheless, if the time period is examined in two groups—2000 to 2003 and 2003 to 2005—the results are not the same.[73] Between 2000 and 2003, the number of the uninsured grew by 6.2 million people (1.9 million noncitizens, 3.9 million native-born citizens, and .4 million naturalized citizens). Sixty-three percent of the increase in the number of the uninsured was attributable to native-born citizens, compared with 30% for noncitizens. However, the percentage of the increase caused by the increase in the number of uninsured noncitizens (30%) was larger than their percentage of the uninsured population (approximately 21%), while the percentage of the increase caused by the increase in the number of uninsured native-born citizens (63%) was smaller than their percentage of the uninsured population (approximately 74%). Comparatively,

[73] These two time periods were chosen for two reasons: (1) there is a natural break in the data as the number of uninsured noncitizens increased between 2000 and 2003, and then remained constant between 2003 and 2005; and (2) to illustrate that the effects of noncitizens on the number and percentage of the uninsured population is dependent on the time period studied.

the increase in the uninsured population between 2003 and 2005 was driven almost entirely by the native-born citizen population. During that time period, the number of uninsured noncitizens remained almost constant.

Between 2005 and 2006, the entire increase (approximately 400,000 people) in the uninsured population was due to noncitizens. Both the number of uninsured naturalized and native-born citizens decreased. Nonetheless, while the number of uninsured noncitizens and native-born citizens decreased between 2006 and 2007, the number of uninsured naturalized citizens increased slightly, but not significantly. If the decrease in the number of uninsured between 2005 and 2007 is examined, the total decrease is due to the native-born citizen population, as both the noncitizen population and the naturalized citizen population saw a small increase in the number of uninsured (approximately 100,000 noncitizens and 200,000 naturalized citizens).

Published Studies on of Effects of Noncitizens on Uninsurance Rates

Although the CRS analysis above is limited to the year 2000 and beyond because of changes made in the CPS, other studies have examined the longer-term effect of noncitizens on the uninsured population. A report by the Employee Benefits Research Institute (EBRI) found that noncitizens accounted for 55% of the increase in the uninsured population from 1994 to 2006.[74] Similarly, another study found that by applying the uninsurance rates of unauthorized aliens in Los Angeles County to the entire country, unauthorized aliens accounted for one-third of the increase in the number of uninsured adults in the United States between 1980 and 2000.[75]

A Kaiser Commission study using CPS data found that the impact of noncitizens on the uninsured population depended on which years were analyzed and grouped together. The Kaiser Commission study analyzed the uninsured population during three periods: 1994 to 1998, 1998 to 2000, and 2000 to 2003. As **Table 10** shows, the Kaiser Commission study found that when combining the data from 1998 through 2003, almost two-thirds of the increase in the uninsured population was due to noncitizens, but the result was largely driven by the reduction in the number of uninsured U.S. citizens between 1998 and 2000.[76] In contrast, the report noted that in the 1994 to 1998 and 2000 to 2003 periods, most of the growth in the uninsured population was due to native-born citizens. Seventy-four percent of the growth in the uninsured population between 1994 and 1998 was due to native-born U.S. citizens, while 10% was due to noncitizens. Likewise, between 2000 and 2003, 24% of the growth in the uninsured population was due to noncitizens, while 71% of the growth could be attributed to native-born U.S. citizens. The Kaiser Commission study concluded that immigration trends are not responsible, in large part, for the increase in the number of uninsured. In addition, the researchers noted that, mostly due to the fact that noncitizens make up a much smaller proportion of the population than U.S. citizens,

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[74] The study also found that noncitizens accounted for 43% of the increase in the uninsured population between 1994 and 1998, but 92% of the increase between 1998 and 2003. Paul Fronstin, *The Impact of Immigration on Health Insurance Coverage in the United States: 1994-2006*, Employee Benefits Research Institute Notes, vol. 29, no. 8 (August 2008).

[75] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Legal Status and Health Insurance Among Immigrants," *Health Affairs*, vol. 24, no. 6 (Nov/Dec. 2005), p. 1640.

[76] Holahan, *Are Immigrants Responsible for Most of the Growth of the Uninsured?*, p. 2.

noncitizens would have to fare dramatically worse than citizens to be responsible for the majority of the change in the uninsured population.[77]

Table 10. Kaiser Commission Study: Change in the Number of Uninsured by Citizenship Status, 1994-2003

(in millions)

	1994-1998	1998-2000	2000-2003
U.S. Citizens	3.1	-2.9	3.6
Naturalized U.S. Citizens	0.7	0.1	0.3
Noncitizens	0.4	0.8	1.2

Source: CRS Presentation of **Figure 1** in John Holahan and Allison Cook, *Are Immigrants Responsible for Most of the Growth of the Uninsured?* Kaiser Commission on Medicaid and the Uninsured, Oct. 2005: p. 1.

Note: Reweighting in the 2000 Census also contributed to the growth in the uninsured population by 0.1 million for citizens, 0.1 million for naturalized citizens, and 0.6 million for noncitizens.

Use of Safety-Net Providers

As discussed above, noncitizens are less likely than citizens to have health insurance coverage. This next section discusses two of the most likely sources of care for those who lack health insurance: emergency departments (EDs) and health centers.[78] The discussion of EDs includes use of emergency Medicaid and studies examining noncitizen visits to EDs. Due to a lack of published research, the discussion of health centers is general and does not contain information on noncitizen usage.

Emergency Medicaid Usage

The following section provides analysis of the 2006 data on emergency Medicaid expenditures and presents findings from two studies on emergency Medicaid. Notably, few studies have examined emergency Medicaid expenditures, and except for one study discussed below, information about patient characteristics and services for which emergency Medicaid funding has been used is absent in the published literature.[79]

[77] Holahan, *Are Immigrants Responsible for Most of the Growth of the Uninsured?*, p. 2.

[78] For example, one study of 12 different communities noted that because most unauthorized aliens lack health insurance, they primarily rely on safety-net providers (e.g., hospitals, community health centers, free clinics, emergency departments) for care. Andrea B. Staiti, Robert E. Hurley, and Aaron Katz, *Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs*, Center for Studying Health System Change, Issue Brief 104, Washington, DC, February 2006, p. 1.

[79] C. Annette DuBard and Mark W. Massing, "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association*, vol. 297, no. 10 (March 14, 2007), p. 1086.

CRS Analysis

Data[80]

The Medicaid Statistical Information System (MSIS) is an administrative data source compiled by the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) from eligibility and claims files submitted by the 50 states and the District of Columbia since 1999.[81] Currently, states must submit five MSIS files every quarter: one containing eligibility-related information on all individuals enrolled in the state Medicaid program and four containing information on adjudicated claims. Each quarterly file submitted by a state undergoes editing and validation testing.[82] Once accepted, CMS processes the MSIS files in a number of ways, including the summary person-level data files for each fiscal year.[83]

The summary person-level files for each fiscal year contain a limited number of variables from the detailed eligibility and claims data submitted by states. Available variables include monthly indicators for Medicaid enrollment, basis of eligibility, restricted benefit status, and Medicare enrollment; demographic variables (state of residence, age, sex, race); and the total dollar amount paid by Medicaid during the fiscal year (based on adjudicated claims), categorized by 30 types of service.[84] It should be noted that estimates derived from the summary person-level files may differ from those derived from other MSIS data sources (e.g., the online datamart that provides state-level information) because of revisions made after the person-level files are produced.

Of the states in FY2006, only Maine did not provide data on Medicaid usage. In addition, 10 other states did not provide data on emergency Medicaid usage.[85] The reported expenditures include both federal and state funding.[86] Notably, state differences in expenditures need to be interpreted cautiously because of the differing reporting standards among the states.

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[80] The data in this section were prepared by April Grady.

[81] See http://www.cms.hhs.gov/MSIS/.

[82] If a file fails acceptance testing, the state must make corrections until it passes. Known issues that remain unresolved are detailed by CMS in a state-specific "data anomalies" document; however, because the data are state-reported, they may contain some errors not identified in the review process.

[83] CRS receives these "person summary files" each year from CMS via the Congressional Budget Office under the conditions of a data use agreement. CMS also produces summary state-level statistics for months, quarters, and fiscal years, and detailed person-level Medicaid Analytic eXtract (MAX) data files for each calendar year. Summary state level statistics are available online, referred to as the "datamart" or "cube"; see http://msis.cms.hhs.gov/. See also http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp.

[84] CMS has added additional variables over the years, including a county code, certain condition flags (e.g., indicating whether a person has at least one claim that contains a diabetes diagnosis code), waiver type and ID (beginning with FY2005), and managed care plan type and ID (beginning with FY2006).

[85] These states were Arkansas, Connecticut, Missouri, Montana, New Hampshire, Ohio, South Dakota, Vermont, Washington, and West Virginia

[86] The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). Determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For FY2009, FMAPs range from 50.00% to 75.84%. For each state's FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady.

Table 11. Medicaid and Emergency Medicaid Recipients and Service Expenditures, FY2006

	Recipients			Service Expenditures		
State	**Total Medicaid**	**Emergency Care Based on Alien Status (Emergency Medicaid)**	**Emergency Medicaid % of total**	**Total Medicaid**	**Emergency Care Based on Alien Status (Emergency Medicaid)**	**Emergency Medicaid % of total**
AK	120,508	10	0.0%	$953,780,081	$127,232	$0
AL	844,988	2,764	0.3%	$3,896,758,811	$9,376,497	0.2%
AR	754,732	NR	NR	$2,777,650,553	NR	NR
AZ	1,018,666	33,789	3.3%	$3,152,835,042	$252,568,663	8.0%
CA	10,427,093	467,441	4.5%	$29,009,839,498	$1,211,985,234	4.2%
CO	624,910	9,644	1.5%	$2,679,373,384	$49,237,039	1.8%
CT	517,529	NR	NR	$3,986,150,305	NR	NR
DC	159,335	1,044	0.7%	$1,385,459,157	$11,503,406	0.8%
DE	170,659	1,879	1.1%	$946,873,408	$8,746,562	0.9%
FL	3,123,301	25,780	0.8%	$12,568,860,350	$127,768,961	1.0%
GA	1,817,822	13,975	0.8%	$6,041,739,927	$63,308,471	1.0%
HI	227,043	69	0.0%	$988,581,171	$201,385	0.0%
IA	431,184	1,373	0.3%	$2,524,284,822	$4,675,679	0.2%
ID	216,958	NR	NR	$1,056,588,201	NR	NR
IL	2,194,735	30	0.0%	$9,962,885,054	$511,966	0.0%
IN	999,079	9,279	0.9%	$5,011,053,353	$20,568,534	0.4%
KS	343,498	1,718	0.5%	$1,995,637,927	$7,470,960	0.4%
KY	899,617	1,643	0.2%	$4,135,095,931	$5,821,982	0.1%
LA	1,148,972	737	0.1%	$3,977,640,001	$2,218,163	0.1%

State	Recipients			Service Expenditures		
	Total Medicaid	Emergency Care Based on Alien Status (Emergency Medicaid)	Emergency Medicaid % of total	Total Medicaid	Emergency Care Based on Alien Status (Emergency Medicaid)	Emergency Medicaid % of total
MA	1,166,759	17,538	1.5%	$8,660,949,681	$50,558,328	0.6%
MD	759,002	5,855	0.8%	$5,218,617,669	$45,484,214	0.9%
ME	NA	NA	NA	NA	NA	NA
MI	1,872,398	15,349	0.8%	$7,139,180,889	$17,357,567	0.2%
MN	717,738	1,316	0.2%	$5,505,113,469	$2,465,182	0.0%
MO	1,136,495	NR	NR	$4,771,200,728	NR	NR
MS	745,291	342	0.0%	$3,144,213,092	$863,749	0.00
MT	115,278	NR	NR	$639,189,507	NR	NR
NC	1,631,253	15,724	1.0%	$8,120,839,869	$49,901,837	0.6%
ND	74,076	8	0.0%	$509,987,201	$25,172	0.0%
NE	247,503	2	0.0%	$1,451,129,989	$23,955	0.0%
NH	126,458	NR	NR	$854,602,809	NR	NR
NJ	1,004,376	9,449	0.9%	$7,511,903,672	$39,269,486	0.5%
NM	515,658	1,406	0.3%	$2,332,524,023	$4,793,429	0.2%
NV	258,962	3,105	1.2%	$1,149,676,456	$12,139,530	1.1%
NY	5,194,411	8,282	0.2%	$40,234,563,139	$188,606,263	0.5%
OH	2,020,532	NR	NR	$11,833,989,678	NR	NR
OK	725,736	3,097	0.4%	$2,933,651,705	$9,263,435	0.3%
OR	516,067	7,857	1.5%	$2,273,683,995	$25,031,232	1.1%
PA	2,064,061	4,837	0.2%	$10,052,037,109	$26,868,099	0.3%
RI	212,498	176	0.1%	$1,646,888,916	$2,055,295	0.1%

State	Recipients			Service Expenditures		
	Total Medicaid	Emergency Care Based on Alien Status (Emergency Medicaid)	Emergency Medicaid % of total	Total Medicaid	Emergency Care Based on Alien Status (Emergency Medicaid)	Emergency Medicaid % of total
SC	861,838	2,899	0.3%	$4,012,808,875	$12,827,335	0.3%
SD	130,509	NR	NR	$605,696,748	NR	NR
TN	1,590,807	5,779	0.4%	$5,954,681,880	$16,363,131	0.3%
TX	3,910,487	72,136	1.8%	$13,763,887,106	$272,768,217	2.0%
UT	288,149	4,145	1.4%	$1,521,109,847	$20,537,190	1.4%
VA	820,625	6,021	0.7%	$4,172,888,580	$26,824,221	0.6%
VT	149,808	NR	NR	$813,394,559	NR	NR
WA	1,127,976	NR	NR	$5,230,422,930	NR	NR
WI	973,369	2,038	0.2%	$4,451,125,727	$9,037,844	0.2%
WV	373,297	NR	NR	$2,225,591,484	NR	NR
WY	69,662	472	0.7%	$411,917,192	$1,376,205	0.3%
Subtotal: States with E.M. Responses	50,772,136	759,008	1.5%	$231,404,077,998	$2,610,531,650	1.1%
Total	57,441,708	759,008		$266,198,555,500	$2,610,531,650	

Source: CRS analysis of person-level Medicaid Statistical Information System (MSIS) data compiled by CMS from eligibility and claims information submitted by states. Original analysis performed by April Grady.

Notes: NA= not available; NR= not reported. Recipients are individuals on behalf of whom Medicaid payment was made during the year. Includes federal and state expenditures. Nevada data are for 2005. Estimates shown here may differ from those derived from other MSIS data sources because of revisions made after the person-level files are produced. The most recent year for which CRS has data is 2006.

Findings

As discussed above, aliens who do not qualify for Medicaid because of their alien status but who meet the other eligibility requirements for Medicaid may receive emergency Medicaid for emergency medical care. In FY2006, of the 50.8 million total Medicaid recipients reported by states reporting the number of emergency Medicaid recipients, 759,008 recipients (1.5%) received emergency care based on alien status (i.e., emergency Medicaid). (See **Table 11**.) In FY2006, $2.6 billion was spent on emergency Medicaid, which constituted 1.1% of the total Medicaid spending.[87]

According to the state responses, California had the largest number of recipients and amount spent on emergency Medicaid. In FY2006, California reported spending $1.2 billion on emergency Medicaid, which was 4.2% of its Medicaid budget. Of California's 10.4 million Medicaid recipients, 4.5% (467,441) received emergency Medicaid.[88] Nonetheless, Arizona reported spending 8% of its Medicaid budget on emergency Medicaid ($252.6 million), a higher percentage than any other state.[89] In addition, only Texas reported spending more on emergency Medicaid than Arizona ($272.8 million). Only two other states reported spending more than $63 million on emergency Medicaid: Florida ($127.8 million) and New York ($188.6 million).

Published Studies on Emergency Medicaid

North Carolina

Two doctors in North Carolina published a descriptive analysis of emergency Medicaid expenditures in North Carolina for 2001 through 2004.[90] The authors found that 48,391 people received services reimbursed by emergency Medicaid during the four-year study period, and 99% of the people were unauthorized aliens. More than 89% of the patients were between the ages of 18 and 40, and 95% were female, with 90% being eligible due to pregnancy.[91] Childbirth and pregnancy complications accounted for the majority of the spending, but spending on elderly and disabled patients was the fastest increasing reason for care. Among nonpregnant noncitizens, injuries, other acute emergencies, and severe complications of chronic diseases were major contributors to emergency Medicaid use.[92]

North Carolina emergency Medicaid spending grew from $41.3 million to $52.9 million during the four years of the study. The 28% increase in emergency Medicaid spending was less than the 35% increase in the North Carolina Medicaid program during the same time period. Emergency

[87] The percentage calculations exclude states that did not report on emergency Medicaid expenditures and recipients.

[88] According to CRS analysis of the 2008 March CPS, 26.1% of all noncitizens reside in California, and noncitizens comprise 16% of the total state population.

[89] According to CRS analysis of the 2008 March CPS, 3.1% of all noncitizens reside in Arizona, and noncitizens comprise 10.7% of the total state population.

[90] C. Annette DuBard and Mark W. Massing, "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association*, vol. 297, no. 10 (March 14, 2007), pp. 1085-1092.

[91] In 2004, 82% of the spending was for childbirth and pregnancy complications.

[92] C. Annette DuBard and Mark W. Massing, "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association*, vol. 297, no. 10 (March 14, 2007), p. 1087.

Medicaid spending represented less than 1% of the total amount of the state's Medicaid spending. Most of the increase in spending was attributable to growth in the number of nonpregnant patients served, and substantial increases in per patient expenditures were seen among elderly and disabled patients. The study noted that despite a steady increase in emergency Medicaid use, the 16,106 patients served in 2004 represented only 5% of the estimated unauthorized alien population in the state.[93]

Tennessee

A study by the Comptroller of Tennessee found that in July 2006, Tennessee's Medicaid program covered emergency care to 62 unauthorized aliens at a total cost of $1.7 million.[94] The study noted that approximately 90% of emergency services reimbursed by the Medicaid program were for labor and delivery.[95]

GAO

In May 2004, the Government Accountability Office (GAO) released a study entitled *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*.[96] The GAO study reviewed the reported Medicaid spending for the 10 states with the highest estimated unauthorized populations: Arizona, California, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, North Carolina, and Texas. Although states are not required to report to CMS the amount of Medicaid expenditures for unauthorized aliens, several states provided data or suggested to GAO that most of their emergency Medicaid expenditures were for services provided to unauthorized aliens.[97] In addition, five of the states reported that more than half of emergency Medicaid expenditures were for labor and delivery services.

GAO found that emergency Medicaid expenditures for the 10 states had increased over the past several years but remained a small proportion, less than 3%, of each state's total Medicaid expenditures. Nonetheless, the study found that between FY2000 and FY2002 in nine of the 10 states reviewed, the state's emergency Medicaid expenditures grew faster than the total Medicaid expenditures.

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[93] C. Annette DuBard and Mark W. Massing, "Trends in emergency Medicaid Expenditures for Recent and Undocumented Immigrants," *Journal of the American Medical Association*, vol. 297, no. 10 (March 14, 2007), p. 1089.

[94] The total Medicaid population in Tennessee in 2006 was approximately 1.2 million people.

[95] John G. Morgan, *Immigration Issues in Tennessee*, Office of Research and Education Accountability, Nashville, TN, August 2007, pp. 10-11. In addition, the study noted that at a field hearing in Brentwood, TN, a spokesperson for Vanderbilt University Medical Center estimated that the annual cost of unreimbursed care to unauthorized aliens was approximately $3.8 million, about 5% of the hospital's total uncompensated care costs of $74 million. U.S. Congress, House Committee on Energy and Commerce, Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System, 109th Cong., 2nd sess., August 10, 2006.

[96] Government Accountability Office, *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*, GAO-04-472 (May 2004).

[97] As discussed above, emergency Medicaid covers any alien who except for their immigration status would qualify for Medicaid. The most likely group, other than unauthorized aliens, to receive emergency Medicaid are legal permanent residents within the five-year bar.

Emergency Department Usage

Some contend that a common route for the poor, including unauthorized aliens, to receive medical care is through hospital emergency departments (EDs).[98] As discussed above, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires Medicare-participating hospitals to provide emergency medical services for all patients who seek care, regardless of their ability to pay.[99] More specifically, the Act has three primary requirements:

- hospitals must provide an appropriate medical screening examination for individuals who seek emergency care in a hospital ED;
- if an individual is found to have an emergency medical condition, the hospital must treat and stabilize the medical condition (or transfer the patient under certain circumstances); and
- if an individual's medical condition is not stable, the hospital may not transfer him or her unless (1) the individual (or someone acting on the individual's behalf) requests the transfer and/or (2) the transfer is appropriate as defined under the Act.

Because hospitals are required to evaluate and treat all patients who seek care in hospital EDs, EMTALA in effect requires hospitals to provide free (uncompensated) care for some patients.

Overall, in the United States, 17% of the approximately 115 million annual ED visits are made by patients without health insurance.[100] A study that examined data on ED usage concluded that the literature does not support the notion that uninsured patients are a primary cause of ED overcrowding, present with less acute conditions than insured patients, or seek ED care primarily for convenience.[101] Nonetheless, others have reported that the increase in ED usage is caused by uninsured patients,[102] and that EMTALA has led to more patients seeking care for non-urgent

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[98] J. Blum, P. Carstens, and N. Talib, "The Impact of Immigration on Health Systems: A Legal Analysis from A Three-Country Perspective," *Medicine and Law*, vol. 24 (2005), p. 334. The authors of this report contend that from the standpoint of medical economics, an ED is the most costly setting in which to provide care; and from a medical point of view, routine primary care would be more beneficial to the individual than relying on treatment rendered for an emergency condition that may have been prevented.

[99] For more information on the requirements, see Section 1867 of the Social Security Act [42 U.S.C 1395dd], available at http://www.ssa.gov/OP_Home/ssact/title18/1867.htm#t. Section 1866 of the Act (on Medicare conditions of participation for providers) also addresses compliance with EMTALA requirements in subparagraphs (I)(i), (ii), and (iii), and (N)(iii), available at http://www.ssa.gov/OP_Home/ssact/title18/1866.htm#t.

[100] Eric W. Nawar, Richard W. Niska, and Jianmin Xu, *National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary*, US Department of Health and Human Services, Centers for Disease Control and Prevention, National Health Statistics, Advanced Data from Vital and Health Statistics, no. 386, Washington, DC, June 29, 2007, pp. 1-32, http://www.cdc.gov/nchs/data/ad/ad386.pdf.

[101] Manya F. Newton, Carla C. Keirns, and Rebecca Cunningham, et al., "Uninsured Adults Present to US Emergency Departments: Assumptions vs Data," *Journal of the American Medical Association*, vol. 300, no. 16 (October 22/29 2008), p. 1914.

[102] U.S. Congress, House Committee on Oversight and Government Reform, *Response of the Department of Health and Human Services to the Nation's Emergency Care Crisis*, 110th Cong., 1st sess., June 22, 2007, Serial No. 110–25 (Washington: GPO, 2007). E. J. Webber, J. A. Showstack, and K. A. Hunt, et al., "Does Lack of a Usual Source of Care or Health Insurance Increase the Likelihood of an Emergency Department Visit?," *Annals of Emergency Medicine*, vol. 45, no. 1 (January 2005), pp. 13-14.

conditions in EDs.[103] As discussed above, noncitizens are more likely than U.S. citizens to be uninsured. In addition, research from the 1980s and the early 1990s indicated that unauthorized aliens obtained health care in the United States primarily though hospital emergency departments; however, it is unknown if this is still true. [104]

Emergency Department Usage and Noncitizens: Select Studies

Although some have pointed to aliens (especially unauthorized aliens) as a key contributor to ED problems,[105] the reality is more complicated. Several studies have examined noncitizen ED usage. These studies either surveyed select populations in limited geographic areas or analyzed the overall noncitizen population in certain cities and attempted to find a correlation between the size of the noncitizen population and ED usage.[106]

Surveys

One study of Latinos, Mexicans, and those of Mexican or Latino descent in Los Angeles found that less than 14% of Mexican unauthorized aliens and immigrants had more than one visit to the ED in the previous year, compared with 16% of naturalized and 21% of native-born citizens of Mexican decent. In addition, examining other Latinos, 16% of unauthorized aliens and 17% of immigrants had more than one ED visit in the previous year, compared with 22% of native-born and 20% of naturalized citizens of Latino decent. Thus, unauthorized aliens in this study did not have higher ED usage than their citizen counterparts, despite having lower rates of usual source of care and insurance coverage.[107] A small study of female Latino noncitizens in northern Texas reported that the noncitizen Latino women in the study did not report receiving health care at an

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[103] U.S. General Accounting Office, *Emergency Care: EMTALA Implementation and Enforcement Issues*, GAO-01-747, June 2001, http://www.gao.gov/new.items/d01747.pdf.

[104] Theodore C. Chan, Scott J. Krishel, and Kenneth J. Bramwell, et al., "Survey of Illegal Immigrants Seen in an Emergency Department," *Western Journal of Medicine*, vol. 164, no. 3 (March 1996), p. 212.

[105] John J. Miller, "Caring for Illegals, Losing Their Shirts," *National Review*, March 24, 2003, pp. 24-26.

[106] The Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of certain hospitals treating large numbers of low-income and Medicaid patients, including aliens who lack insurance, are underinsured or are unable to pay for their care. These payments implicitly recognize the disadvantaged situation of hospitals treating large numbers of Medicaid patients and other patients with no insurance. States must define hospitals in their state Medicaid plans qualifying as DSH hospitals and the DSH payment formulas. However, the identification of aliens as a component of either the DSH designation or payment formula is not required, and thus, there are no data on the amount of DSH payments used for aliens. The total FY2007 preliminary allotment for DSH payments was approximately $10.3 billion; the highest state allotment was $1.5 billion for New York, followed by $1 billion for California and $900 million for Texas. For more information, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

[107] Alexander N. Ortega, Hai Fang, and Victor H. Perez, et al., "Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos," *Archives of Internal Medicine*, vol. 167, no. 21 (November 26, 2007), pp. 2357-2359.

ED.[108] Another study found that children in foreign-born[109] families use emergency room services less than those in native-born citizen families.[110]

A study of unauthorized Mexicans in New York found that ED usage during the previous six months was more common among women and among those who reported a higher level of educational attainment, earlier year of entry to the United States, health insurance coverage in the past six months, higher levels of social support, and poor health that limited their usual activities for more than five of the past 30 days. The authors found that those who completed some college were more likely than those with less than a high school education to receive care in an ED, and noted that this may reflect greater knowledge about the U.S. healthcare system and types of health services available among better-educated unauthorized aliens.[111] Unauthorized aliens in New York with more health care needs were more likely to report ED usage, but not access to a regular provider.[112]

Notably, a study from 1996 that interviewed 104 unauthorized aliens who received care in an emergency department in Southern California found that the large majority of those interviewed cited seeking care at an ED because they were in the United States at the time and lacked resources. A majority reported knowing of no other source of care in the United States.[113]

Emergency Department Usage and the Noncitizen Population

Use of emergency care varies significantly across communities. The one study located by CRS on ED usage and the noncitizen population found that communities with more noncitizen (alien) residents generally have lower rates of ED usage than communities with fewer noncitizen residents.[114] Based on data from the Community Tracking Study (CTS) household survey for 2003, ED use averaged about 32 visits per 100 people in 2003 (see **Table 12**). In 12 intensively studied communities, ED use varied from a high of almost 40 visits per 100 people in Cleveland to a low of about 21 visits in Orange County, California.[115]

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[108] Khiya J. Marshall, Ximena Urrutri-Rojas, and Francisco Sota Mas, et al., "Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women," *Health Care for Women International*, vol. 26, no. 10 (December 2005), p. 930.

[109] As discussed above, foreign born includes naturalized citizens and noncitizens. Foreign-born families may include citizens and noncitizen children.

[110] Leighton Ku and Sheetal Matani, "Left Out: Immigrants' Access to Health Care and Insurance," *Health Affairs*, vol. 20, no. 1 (January/February 2001), pp. 247-256.

[111] Arijit Nandi, Sandro Galea, and Gerald Lopez, et al., "Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area," *American Journal of Public Health*, vol. 98, no. 11 (November 2008), p. 2015-17.

[112] This finding is consistent with previous research on Hispanics showing that greater health care need is associated with ED use. TH Wagner and S. Guendelman, "Health Care Utilization Among Hispanics: Findings From the 1994 Minority Health Survey," *American Journal of Managed Care*, vol. 6 (2000), pp. 367-397. Arijit Nandi, Sandro Galea, and Gerald Lopez, et al., "Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area," *American Journal of Public Health*, vol. 98, no. 11 (November 2008), p. 2018.

[113] Theodore C. Chan, Scott J. Krishel, and Kenneth J. Bramwell, et al., "Survey of Illegal Immigrants Seen in an Emergency Department," *Western Journal of Medicine*, vol. 164, no. 3 (March 1996), p. 212.

[114] Peter J. Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities," Health Affairs-Web Exclusive, Jul. 18, 2006, pp. W324-W336. This study does not distinguish between noncitizens who are legally and illegally present.

[115] Survey respondents were asked to report on the number of visits to hospital EDs in the previous 12 months. ED (continued...)

Table 12. Variation in Hospital Emergency Department Use, 2003

Case-study site/metro area	Number of ED visits per 100 people	Percent of population noncitizen
Cleveland, OH	39.9	2.6
Boston, MA	36.4	6.9
Greenville, SC	36.0	2.4
Little Rock, AR	32.1	1.1
Syracuse, NY	31.9	0.7
U.S. Average	**31.8**	**6.3**
Indianapolis, IN	31.3	1.7
Seattle, WA	30.2	6.6
Lansing, MI	30.1	1.8
Northern NJ	26.2	9.2
Miami, FL	25.0	26.5
Phoenix, AZ	24.1	11.9
Orange County, CA	21.0	15.6

Source: Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities," Exhibit 1.

Both for the 12 intensively studied CTS sites (**Table 12**) and for a broader sample with data from 60 CTS communities (**Table 13**), communities with higher ED usage tended to have fewer noncitizen residents, compared with communities with lower ED usage. As **Table 12** shows, of the communities studied, the four communities with the lowest rates of ED usage do indeed have the highest percentages of noncitizen residents. In addition, the difference in the share of noncitizens between the highest- and lowest-use communities (4.1% versus 10.3%) is statistically significant. Notably, except for citizenship status, ED usage does not vary much across communities according to population characteristics.

Table 13. Variation in Emergency Department Use, by Community Use (Quartiles), and Population and Health System Characteristics, 2003

Characteristic	Quartile: 1-high ED use	2	3	4-low ED use
Population characteristics				
Noncitizen	**4.1%**	**3.8%**	**7.4%**	**10.3%**[a]

(...continued)

visits that led to an inpatient stay were excluded from the data because such visits were "likely to be the least discretionary type of visits and less affected by patients preferences and health system factors." All of the data that follows is from Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities."

	Quartile			
Characteristic	**1-high ED use**	**2**	**3**	**4-low ED use**
Less than 100% of poverty	12.9	14.7	13.8	11.3
Uninsured	12.0	12.7	13.8	14.8
Privately insured	59.6	61.4	58.7	60.1
In fair/poor health	15.1	13.7	13.3	12.9
Health system characteristics				
Average number of primary care providers per 10,000 people	5.2	4.9	5.4	5.0
Average number of hospital EDs per 100,000 people	1.6	1.3	1.1	0.9[a]
Average distance to ED (miles)	5.9	5.9	5.5	4.5
Average Community Health Center revenue (dollars) per poor person within 5 miles	109	101	71[a]	60[a]
Average appointment waiting time for sick visits (days)	23.4	22.9	20.0	18.4[a]

Source: Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities," Exhibit 2.

Note: The table presents selected characteristics from the study. The full report contains data on additional population and health system characteristics.

a. Indicates statistical significance at the $p < 0.05$ level.

Health Centers

This section discusses Federally Qualified Health Centers (FQHCs), often referred to as *clinics*. However, although it seems likely that some proportion of the noncitizen population receives care at these centers, CRS was not able to locate published information on noncitizen usage of health

centers.[116] As discussed above, because of the types of services provided and the fact that the Department of Health and Human Services (HHS) did not classify FQHCs as public benefits, it would appear that most of the health centers (unless serving a specific population discussed below) provide services to noncitizens regardless of immigration status. Due to the fact that immigration status is not a condition for receiving services, it is unlikely that health centers ask the clients' immigration status. Indeed, one study on safety-net providers (e.g., hospitals, community health centers, free clinics) found that obtaining specific information about aliens was difficult because health care providers, including those at health centers, reported that they did not attempt to distinguish patients by documentation status.[117]

The term "health center," as defined by HHS, refers to *all* of the diverse public and nonprofit organizations and programs that receive federal funding under the Consolidated Health Centers Program.[118] The Consolidated Health Center Program includes community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing.[119]

Under this authority, health centers' grants largely provide primary health care services to medically underserved populations.[120] In CY2007, there were nearly 7,000 delivery sites serving more than 16.1 million clients with a total of 1,072 grantees. The client (patient) population is primarily low-income, uninsured, or underinsured individuals. A majority of this population—which includes people with chronic diseases, pregnant teens, substance abusers, and a number of individuals living with HIV/AIDS infection—is not working. Many are unable to afford even the most basic medical or dental care.[121] An estimated 92% of health center patients are at or below 200% of the federal poverty level. Of this population, 40% have no health insurance, 64% are racial or ethnic minorities,[122] and 35% depend on Medicaid.[123]

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[116] This section was co-authored by Barbara English and is adapted from CRS Report RL32046, *Federal Health Centers Program*, by Barbara English, which has additional information on health centers.

[117] Andrea B. Staiti, Robert E. Hurley, and Aaron Katz, *Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs*, Center for Studying Health System Change, Issue Brief 104, Washington, DC, February 2006, p. 1. In addition, a study by the Comptroller of Texas (discussed in detail below) noted that since there is no data on the number of clinic visits by unauthorized aliens, the Comptroller was unable to estimate the cost of clinic services provided to unauthorized aliens.

[118] Many of these health centers also receive funding from Medicaid to serve Medicaid eligible individuals. Thus, if an alien is eligible for Medicaid and the health center treats Medicaid eligible individuals, funding for the alien's care would come from Medicaid funds. If the alien is not eligible for Medicaid, funding for the alien's care would come from federal funding under the Consolidated Health Centers Program.

[119] The Health Centers Consolidation Act of 1996 (P.L. 104-299) consolidated funding for community health centers with similar programs in Section 330 of the Public Health Service Act (P.L. 87-838). Similar programs such as the Native Hawaiian Health Care, FQHC-Look-Alikes, and Tribal FQHCs also fall under the umbrella of the Consolidated Health Centers Program.

[120] Specifically, under this authority, health centers receive grant support largely to provide primary health care services to medically underserved populations residing in "an urban or rural area designated by the Secretary of HHS as an area with a shortage of personal health services or a population group designated as having a shortage of such services." 42 U.S.C. §254b(b)(3).

[121] Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees,* FY2007, p. 80.

[122] It is unknown what percentage of the population consists of noncitizens.

[123] *America's Health Centers Fact Sheet*, #0108, National Association of Community Health Centers, United States, January 2008.

Every center provides a similar range of primary health services on an ambulatory basis. Community health centers are required to provide primary health services, as defined in the regulations,[124] which include services of physicians, physicians' assistants, and nurse clinicians; diagnostic laboratory and radiologic services; preventive health services; emergency medical services; preventive dental services; pharmaceutical services; transportation; and other enabling services. The average cost per medical patient visit[125] was $123 in 2007.[126] Centers are generally required to serve all residents of the area in which the center is located, regardless of the residents' ability to pay.[127]

The Consolidated Health Centers program includes three special categories (or types of health centers) other than the basic "community" health center category: Migrant Health Centers, Health Centers for the Homeless,[128] and Health Centers for Residents of Public Housing.[129] Native Hawaiian Health Care, [130] FQHC Look-Alikes[131], and Tribal FQHCs[132] also fall under the umbrella of FQHCs because they also receive federal grants.[133] Notably, in general, a noncitizen must be a qualified alien to receive public housing and as a result would not be able to use health centers specifically for residents of public housing.[134] In addition, it is unlikely that a noncitizen would qualify as a Native Hawaiian and be able to receive services at those clinics. Nonetheless, it seems likely that some noncitizens frequent Migrant Health Centers. The migrant health centers served 827,000 migrant and seasonal farm workers and their families in CY2007.[135]

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[124] 42 CFR 51c.102(h).

[125] The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which a Rural Health Clinic/Federally Qualified Health Center service is rendered. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist: (1) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment, or (2) the patient has a medical visit and a clinical psychologist or clinical social worker visit. Source: *Medicare Claims Processing Manual,* Chapter 9 -Rural Health Clinics/Federally Qualified Health Centers, paragraph 20.1 -"Payment Rate for Independent and Provider Based RHCs and FQHCs."

[126] *U.S. Health Center Fact Sheet*, National Association of Community Health Centers, 2007 at http://www.nachc.com/client/documents/US_Fact_Sheet_2007.pdf.

[127] Migrant, homeless, and public housing health centers are exempt from the requirement to serve all residents in a catchment area.

[128] Section 330 grants for these centers provide for a particular medically underserved population composed of homeless individuals, defined by the act as (1) one who lacks permanent housing, whether or not the individual is a member of a family, and (2) one who lives in temporary facilities or transitional housing. P.L. 104-299, Section. 330(h)(4)(A).

[129] Section 330 grants fund these centers for the delivery of health services to the medically underserved population composed of residents of public housing.

[130] This program makes primary care, health promotion, and disease prevention services available to Native Hawaiians who face cultural, financial, and geographic barriers to health care services.

[131] These are health centers that do not yet receive funding from the Department of Health and Human Service's Health Resources and Services Administration (HRSA), but based on special recommendation by HRSA are accorded all other benefits of qualified health centers and may eventually become fully qualified.

[132] These entities are operated by an Indian tribe or tribal organization and may serve some unauthorized aliens.

[133] The federal funding comes from grants under §330 of the Public Health Service Act (P.L. 87-838).

[134] CRS Report RL31753, *Immigration: Noncitizen Eligibility for Needs-Based Housing Programs*, by Alison Siskin and Maggie McCarty.

[135] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS)*, Calendar Year 2007 Data, National Rollup Report, July 1, 2008.

The Unauthorized Population and Health Care: What Do We Know?

Ascertaining the cost of unauthorized aliens to the health care system presents complex fiscal questions.[136] It is very difficult to enumerate a population that is trying to avoid detection by the government.[137] The main sources of socioeconomic information in the United States—the Current Population Survey (CPS), the Decennial Census of the Population (Census), and the American Community Survey, collected by the Census Bureau—ask about citizenship status but not immigration status.[138] Thus, it is not possible to use these data sources in calculating the health care cost of unauthorized aliens.

In addition, because it is extremely difficult to get accurate data on unauthorized aliens, many studies make assumptions about the number of unauthorized aliens, their service usage, and their revenue contributions.[139] It is not clear whether the assumptions are correct, or if they overestimate or underestimate the amounts spent. As a result, many studies that attempt to estimate the cost of health care for unauthorized aliens in the United States focus on limited geographic regions (e.g., border communities, states, or cities). In addition, some of these studies survey immigrant communities and ask immigration status, while others ask local agencies to estimate the cost of services provided to unauthorized aliens. Some studies use proxies, such as those who provided a false Social Security number or foreign-born workers who are low-wage earners, to determine who is an unauthorized alien. Each of these methods has strengths and weaknesses, and none provides a reliable estimate upon which researchers agree. For example, the few studies that have specifically examined the unauthorized Latino population have used small samples and limited health care measures.[140] Notably, a study on safety-net providers found that obtaining specific information about unauthorized aliens was difficult because health care providers reported that they did not attempt to distinguish patients by documentation status.[141]

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[136] Steven A. Camarota, *The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget* (Washington, D.C.: Center for Immigration Studies, Aug. 2004).

[137] For example see U.S. General Accounting Office, *Illegal Aliens: National Net Cost Estimates Vary Widely*, GAO/HEHS-95-133, July 1995; Georges Vernez, and Kevin F. McCarthy, *The Cost of Immigration to Taxpayers: Analytical and Policy Issues* (Santa Monica, CA: RAND, 1996); and Rebecca L. Clark, Jeffrey S. Passel, Wendy N. Zimmermann, and Michael E. Fix, *Fiscal Impacts of Undocumented Aliens: Selected Estimates for Seven States* (Washington D.C.: Urban Institute, Sept. 1994).

[138] In other words, analysis from these surveys can be done on noncitizens; however, it is unknown whether the noncitizens are legally or illegally present.

[139] Georges Vernez, and Kevin F. McCarthy, *The Cost of Immigration to Taxpayers: Analytical and Policy Issues,* (Santa Monica, CA: RAND, 1996), p. xii. (Hereafter cited as Vernez and McCarthy *The Cost of Immigration to Taxpayers*.)

[140] For example, see Alexander N. Ortega, Hai Fang, and Victor H. Perez, et al., "Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos," *Archives of Internal Medicine*, vol. 167, no. 21 (November 26, 2007), p. 2354.

[141] Andrea B. Staiti, Robert E. Hurley, and Aaron Katz, *Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs*, Center for Studying Health System Change, Issue Brief 104, Washington, DC, February 2006, p. 1.

Studies of the Cost of Medicaid and Health Care for Unauthorized Aliens

The following section analyzes selected studies that estimate the cost of health care provided to unauthorized aliens, focusing on studies completed during the previous 10 years. It is not an exhaustive review of the literature on the cost of health care for unauthorized aliens in the United States. Cost estimates mentioned in news reports that failed to specify the methodology used to calculate the estimates are not included in this analysis. Notably, all studies except one are limited to specific geographic areas (e.g., a specific state, border communities). In addition, one study on Los Angeles County extrapolated the results to estimate the nationwide costs of uncompensated care for unauthorized aliens.[142] Furthermore, the studies are for different years, use different methodologies to arrive at their estimates, and often do not examine similar costs; as a result, the studies and their findings are not comparable. **Table 14** summarizes the presented studies and the findings. In addition, **Appendix B** discusses the methodology of the studies presented below.

As discussed above, in May 2004, the Government Accountability Office (GAO) released a study entitled *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*.[143] The study concluded that because hospitals do not generally collect information on patients' immigration status, an accurate assessment of the impact of unauthorized aliens on hospitals' uncompensated care costs[144] "remains elusive."[145]

Emergency Medicaid

As discussed earlier in this report, although it is unclear what percentage of emergency Medicaid is spent on unauthorized aliens, a 2004 report by GAO reported that several states provided data or suggested to GAO that most of their emergency Medicaid expenditures were for services provided to unauthorized aliens. In addition, the study on North Carolina's emergency Medicaid expenditures found that 99% of those costs were for care for unauthorized aliens. Thus, as discussed above (**Table 11**), in FY2006, of the 50.8 million total Medicaid recipients reported by states that reported the number of emergency Medicaid recipients, 759,008 recipients (1.5%) received emergency care based on alien status (i.e., emergency Medicaid). During that period, approximately $2.6 billion was spent on emergency Medicaid, which constituted 1.1% of the total Medicaid spending.[146]

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[142] This type of extrapolation is often considered unreliable as the demographics of Los Angeles County, especially as related to noncitizens, are significantly different than the country as a whole. Nonetheless, this study is included in the nationwide section because the authors attempted to compensate for these demographic differences during the extrapolation process.

[143] Government Accountability Office, *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs*, GAO-04-472 (May 2004).

[144] Uncompensated care is care for which the hospital does not receive payment from either the patient or an insurer, including Medicaid.

[145] GAO surveyed 503 hospitals, but as a result of the low response rate to the survey was unable to determine the cost of uncompensated care provided to unauthorized aliens. In addition, over 95% of the hospitals that responded to the survey used the lack of a Social Security number as the only method to identify unauthorized aliens. It is unclear whether this method overestimates or underestimates the amount of care provided to unauthorized aliens.

[146] The percentage calculations exclude Medicaid spending from states that did not report on emergency Medicaid expenditures and recipients. In addition, both federal and state governments pay a proportion of Medicaid and emergency Medicaid expenditures.

Details of Studies

Nationwide

CRS located one study that tried to estimate certain nationwide health care costs of noncitizens. A study by Steve Camarata at the Center for Immigration Studies estimated that on average, each household headed by unauthorized aliens cost the federal treasury $658 for Medicaid (including CHIP) and $591 for medical care for the uninsured in FY2002.[147] In comparison, the study estimated that in FY2002, non-unauthorized alien headed-households, on average, cost the federal treasury $1,232 for Medicaid (including CHIP) and $123 for medical care for the uninsured.[148]

Another study of Los Angeles County extrapolated the results to the entire United States and estimated that about 1.3% of public funds spent on medical costs nationwide in 2000 ($1.1 billion) was for nonelderly, unauthorized aliens. The total medical costs for nonelderly, unauthorized aliens, including public, private, and personal costs, was estimated at $6.5 billion, or 1.5% of the total national medical costs, which was a smaller percentage than their population share of 3.2%.[149] Of this amount, approximately 36% was paid out of pocket by the alien, so the public and private spending on care for unauthorized, nonelderly aliens was $4.1 billion, and of this amount, $1.1 billion was from public sources. The study also estimated that nationwide public spending on health care was $1.8 billion for immigrants, $376 million for nonimmigrants, $2.6 billion for naturalized citizens, and $82 billion for native-born citizens.[150] The study concluded by noting that because of their lower rate of use of health care and smaller reliance on public sources, the per household cost of care to the foreign-born (which includes naturalized citizens) was $56, and was $11 for the unauthorized population.[151]

Limited Geographic Areas

Colorado (2004)

This study used demographic estimates by the Pew Hispanic Center to estimate the cost to the Colorado state government of providing federally mandated services, including emergency

[147] As discussed above, unauthorized alien headed-households may contain legally present noncitizens as well as U.S. citizens.

[148] Steven A. Camarota, *The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget* (Washington, D.C.: Center for Immigration Studies, August 2004). The study estimated that there are 3.8 million households headed by unauthorized aliens and 120.1 million other households in the United States. Other funding for uninsured persons could include Medicaid disproportionate share payments. The Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of certain hospitals treating large numbers of low-income and Medicaid patients, including unauthorized aliens.

[149] The study used the estimated finding that the total medical costs for the nonelderly unauthorized alien population in Los Angeles County was $887 million and extrapolated it to the whole country. The authors then used additional assumptions taking into account the unique socio-demographic characteristics of Los Angeles County to translate the costs to the national level. Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), pp. 1700-1708.

[150] CRS analysis of the data presented in Exhibit 4 of Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), p. 1708.

[151] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), p. 1710.

medical care, to unauthorized aliens.[152] The authors estimated that Colorado spends approximately $31.3 million annually on emergency Medicaid (most of which is assumed to be for unauthorized aliens), which represents approximately 50% of the total emergency Medicaid costs.[153]

Florida (2002)

Using case studies of 700 unauthorized aliens from 39 hospitals/health systems representing 56 hospitals, or 26% of the acute care hospitals in Florida, the Florida Hospital Association reported that these 39 hospitals/health systems spent $40.2 million on care for unauthorized aliens. Three-quarters of the unauthorized alien patients incurred charges below $50,000. However, 32 unauthorized alien patients (4.6%) incurred charges in excess of $250,000 each, totaling more than $21.4 million.[154] In other words, of the amount of uncompensated care provided to unauthorized aliens, a very small percentage of the unauthorized alien population that received care (4.6%) accounted for more than 50% of the expenditures.

Iowa (2007)

This study used demographic estimates by the Pew Hispanic Center and estimates of the annual per capita public share of medical spending on unauthorized aliens from a study on Los Angeles County.[155] The authors estimated that public spending on unauthorized alien adults in Iowa ranged between $14.2 million and $21.9 million, depending on the size of the population.[156] Of these costs, between $4 million and $6.2 million was for adult male unauthorized aliens and between $10.2 million and $15.8 million was for adult female unauthorized aliens.[157] The study did not estimate the costs of public spending on unauthorized alien children.

Minnesota (2005)

The Office of Strategic Planning and Results Management for the state of Minnesota reported that in FY2005, unauthorized aliens cost Minnesota health assistance programs approximately $35.5

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[152] Rich Jones and Robin Baker, Costs of *Federally Mandated Services to Undocumented Immigrants in Colorado*, (Denver, CO: Bell Policy Center, June 30, 2006).

[153] This estimate is for calendar year 2004 and represents 50% of the total cost, because the federal government reimbursed Colorado for half the costs. As in the Texas study, these payments may include aliens who are not unauthorized (e.g., legal permanent residents within the five-year bar).

[154] In general, hospitals tend to incur the largest medical costs not for treatment in the emergency room but for patients who need long-term hospitalization. Of the nine case studies where the patient incurred more than $600,000 in costs all required long-term hospitalizations of more than a year. Four of the patients were in a coma, and two others required respirators and feeding tubes.

[155] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), pp. 1700-1711. This study is discussed in several sections of this report.

[156] Beth Pearson and Michael F. Sheehan, *Undocumented Immigrants in Iowa: Estimated Tax Contributions and Fiscal Impact*, Iowa Policy Project, Mount Vernon, IA, October 2007, pp. 29-30.

[157] The study used the estimate that in Iowa there were 46,200 to 71,400 adult unauthorized aliens. Of those, between 26,950 and 41,650 were males, and 19,250 to 29,750 were females. Using the Los Angeles County study, the per capita public spending for health care was $148 for adult male unauthorized aliens and $530 for adult females.

million, of which approximately $17.3 million was paid by the state.[158] The cost included the following:

- $16.3 million for Minnesota Emergency Medical Assistance,[159] which covers all emergency services, including labor and delivery, of which the state and the federal governments each paid 50% ($8.15 million).
- $15.5 million for the Minnesota State Children's Health Insurance Program (CHIP), which covers medical costs for pregnant women without other health insurance through the month of birth.[160] The state paid 35% of the costs ($5.4 million), while the federal government paid 65% of the costs ($10.1 million).
- $3.7 million for the Minnesota Medical Assistance program's state noncitizen pregnant women fund, all of which was paid by the state.

Mississippi (2004)

The Mississippi Office of the State Auditor estimated that $35 million of $504.6 million spent for uninsured health care services in 2004 may be due to unauthorized aliens.[161] Importantly, the report noted that "because no data regarding immigration status is collected, it is difficult to determine the accuracy of this estimate..."

Southwest Border (2002)

In 2002, the United States/Mexico Border Counties Coalition released a study entitled *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties*.[162] The study concluded that in 2000, $189.6 million was spent by hospitals in the Southwest border communities to provide uncompensated care to unauthorized aliens.[163]

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[158] Minnesota Department of Administration, Office of Strategic Planning and Results Management, *The Impact of Illegal Immigration on Minnesota: Costs and Population Trends*, (St. Paul, MN: Minnesota Department of Administration, Dec. 8, 2005). Available at http://www.state.mn.us/mn/externalDocs/Administration/Report_The_Impact_of_Illegal_Immigration_on_Minnesota_120805035315_Illegal%20Immigration%20Brief%2026.pdf.

[159] This program provided reimbursement for care to 1,295 unauthorized aliens in FY2005.

[160] Minnesota's CHIP program had 4,354 unauthorized alien recipients in FY2005. In 2002, the U.S. Department of Health and Human Services (HHS) promulgated regulations permitting states to provide CHIP coverage to fetuses. States reportedly are using this option of CHIP coverage for fetuses to provide prenatal care services to pregnant women who are unauthorized aliens. *Federal Register*, vol. 67, pp. 61955-74, October 2, 2002.

[161] Mississippi Office of the State Auditor*, The Impact of Illegal Immigration on Mississippi: Costs and Population Trends*, (Jackson, MS: Office of the State Auditor, February 21, 2006).

[162] United States/Mexico Border Counties Coalition, *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties* (Washington, D.C.: United States/Mexico Border Counties Coalition, September 2002).

[163] This constituted approximately 23% of the total amount ($832 million) of uncompensated care spent by these counties. Alberto Coustasse, Andrea L. Lorden, and Vishal Nemarugommula, et al., "Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County," *Hospital Topics: Research and Perspectives on Health Care*, vol. 87, no. 2 (Spring 2009), p. 7.

Texas (2008, 2005, 1999-2001)

In a pilot study of hospitals in Texas County, Texas in 2008, researchers identified $190 million of uncompensated care costs from Southwestern border hospitals for emergency room treatment of unauthorized aliens and $934 million of uncompensated care *charges* for 23 hospitals in Texas County, which translated to $353 million in uncompensated care *costs*.[164]

A different study by the Comptroller of the State of Texas[165] calculated an approximation of the financial impact of unauthorized aliens on Texas.[166] The study also estimated that overall in FY2005, the Texas government spent $58 million in health care services for unauthorized aliens. This amount included the following:

- $38.7 million in emergency Medicaid costs;[167]
- $7.2 million for nonimmigrant alien children with special health needs;[168]
- $287,700 for substance abuse;[169]
- $3.8 million for mental health services;[170]
- $33,000 for immunizations;[171]
- $647,000 for women's and children's health services and school based programs;[172]
- $3.9 million for public health agencies; and

[164] Alberto Coustasse, Andrea L. Lorden, and Vishal Nemarugommula, et al., "Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County," *Hospital Topics: Research and Perspectives on Health Care*, vol. 87, no. 2 (Spring 2009), pp. 3-11.

[165] Carole Keeton Strayhorn, *Undocumented Immigrants in Texas: A Financial Analysis of the Impact to the State Budget and Economy, Office of the Comptroller of Texas*, December 2006.

[166] Overall, the study concluded that while state revenues from unauthorized aliens exceeded state expenditures for unauthorized aliens, local governments and hospitals had the reverse experience, with spending on unauthorized aliens exceeding revenues paid by unauthorized aliens.

[167] According to the report, Texas pays approximately 40% of Medicaid costs, and thus, this amount represents 40% of the total costs of emergency Medicaid expenditures for Texas. The Comptroller noted that emergency Medicaid payments represent the majority of state costs for medical care provided to unauthorized aliens. Notably, not all unauthorized aliens seeking medical care qualify for emergency Medicaid because the aliens have to meet the eligibility requirements of the program. In addition, not all aliens who receive emergency Medicaid are unlawfully present. Legal permanent residents who are barred from full Medicaid coverage—by either having arrived during the previous five years or being in a state which elected not to provide coverage to them under Medicaid—and nonimmigrants (i.e., aliens in the United States for a specific period of time and a specific purpose) may also qualify for emergency Medicaid.

[168] This number includes all noncitizens who are not legal residents.

[169] 5.5% of all persons who received substance abuse services were noncitizens. The Pew Hispanic Center estimated that 30% of all noncitizens in Texas are unauthorized aliens. Thus, the Comptroller estimated that 1.66% of all spending on substance abuse in Texas could be attributed to unauthorized aliens.

[170] As with the substance abuse estimate, the Comptroller estimated that 1.66% of spending on mental health services could be attributed to unauthorized aliens.

[171] This number was calculated by assuming that 4% of the unauthorized alien children in public schools (or 0.12% of all school children) receive state funded immunizations.

[172] This estimate was based on the assumption that in FY2005, slightly more than 3% of students enrolled in public education in Texas were unauthorized aliens.

- $3.4 million for emergency medical services.[173]

Furthermore, the study noted that local governments and private businesses are the entities that incur the largest share of health related costs for unauthorized aliens in Texas. The study also found that in FY2005, an estimated $1.3 billion in uncompensated care provided by Texas hospitals could be attributed to unauthorized aliens.[174]

Table 14. Studies on Unauthorized Aliens Presented in the Report

(in Chronological Order)

Study name and year	Study author	Universe	Findings
Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties (2002)	United States/Mexico Border Counties Coalition	Border communities in Texas, New Mexico, Arizona, California	In 2000, hospitals in the Southwest border communities spent $189.6 million on uncompensated care for unauthorized aliens.
Care for the Uninsured Non-citizens: A Growing Burden on Florida's Hospitals (2003)	Florida Hospital Association	Case studies of 700 unauthorized aliens from 39 hospitals/health systems representing 56 hospitals or 26% of the acute care hospitals in Florida	In 2002, 39 hospitals/health systems in Florida spent $40.2 million in care for unauthorized aliens.
The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget (2004)	Steven A. Camarota	Households headed by unauthorized aliens	In FY2002, unauthorized alien households cost the federal treasury $658 for Medicaid (including CHIP) and $591 for medical care for the uninsured.
Impact of Illegal Immigration on Minnesota (2005)	Minnesota Department of Administration, Office of Strategic Planning and Results Management	Unauthorized aliens in Minnesota	In FY2005, unauthorized aliens cost Minnesota health assistance programs approximately $35.5 million, of which $17.3 million was paid by the state.
Impact of Illegal Immigration on Mississippi (2006)	Mississippi Office of the State Auditor	Unauthorized aliens in Mississippi	In 2004, $35 million of the total amount spent on uninsured health care services may be due to unauthorized aliens.

[173] The estimates for public heath and emergency medical services assume that 6% of the state's residents are unauthorized aliens. Thus, these estimates represent 6% of the total expenditures for those services.

[174] The cost of uncompensated care paid by Texas hospitals is based on the assumption that 14% of uncompensated care can be attributed to unauthorized aliens. Three central Texas counties have begun tracking the percent of uninsured unauthorized aliens that they serve using a web-based system called the Community Health and Social Services Information System (CHASSIS). In FY2005, 14% of all patients screened using CHASSIS were unauthorized aliens.

Study name and year	Study author	Universe	Findings
Costs of Federally Mandated Services to Undocumented Immigrants in Colorado (2006)	Rich Jones and Robin Baker	Unauthorized aliens in Colorado	Colorado spends approximately $31.3 million on emergency Medicaid
Undocumented Immigrants in Texas (2006)	Carole Keeton Strayhorn, Texas Comptroller of Public Accounts	Unauthorized aliens in Texas	In FY2005, the Texas government spent $58 million in health care services for unauthorized aliens. The study also found that in FY2005, an estimated $1.3 billion in uncompensated care provided by Texas hospitals could be attributed to unauthorized aliens.
Undocumented Immigrants in Iowa	Beth Pearson and Michael F. Sheehan	Unauthorized aliens in Iowa	In 2006, public spending on unauthorized alien adults in Iowa ranged between $14.2 million and $21.9 million: between $4 million and $6.2 million for adult male unauthorized aliens, and between $10.2 million and $15.8 million for adult female unauthorized aliens.
Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County (2009)	Alberto Coustasse *et. al.*	Unauthorized aliens presenting at hospitals in Texas County, TX, and along the Texas-Mexico border	In 2008, $190 million of uncompensated care costs from Southwestern border hospitals for emergency room treatment of unauthorized aliens and $934 million of uncompensated care charges for 23 hospitals in Texas County, which translated to $353 million in uncompensated care costs.

Source: CRS compilation of the studies presented in this report on health care costs attributable to unauthorized aliens' medical expenses.

Conclusion

This report has presented an overview of the health insurance status of noncitizens and what is known about their usage of selected safety-net providers such as health care centers and emergency departments. Overall, even controlling for most socio-economic variables, noncitizens are more likely than native-born and naturalized U.S. citizens to be uninsured. As a corollary, noncitizens also have a lower rate of private insurance coverage than the native-born and naturalized populations. In addition, between 2000 and 2007, the noncitizens' percentage of the uninsured population increased, although the increase was not consistent across the time period. Conversely, during the same time period, the percentage of the uninsured population made up of native-born citizens decreased. As with the noncitizen population, the naturalized citizen percentage of the uninsured population increased from 2000 to 2007.

Examining emergency Medicaid expenditures, in FY2006, approximately 1.5% of the total Medicaid recipients reported by states received emergency care based on alien status (i.e., emergency Medicaid). During this period, approximately $2.6 billion was spent on emergency Medicaid, which constituted 1.1% of the total Medicaid spending. Nonetheless, although there is limited research, there does not seem to be evidence that noncitizens use emergency departments more than citizens.

Notably, some argue that one of the reasons noncitizens lack health insurance and tend to use few health services (except for those related to childbirth) is that overall they are a healthier population.[175] The literature is mixed on whether this is a valid assumption. For example, a study of Latinos found that unauthorized aliens are the least likely to report their health as poor among Mexicans and other Latinos, including immigrants and citizens.[176] Another study reported that the foreign-born reported fewer health problems than the native-born, and the health advantage was especially larger among the unauthorized population.[177] Nonetheless, other studies have found the opposite, with noncitizens being as likely as citizens to report poor or fair health and less likely to report having excellent health.[178]

In addition, the link between health insurance coverage and health care utilization is well documented,[179] and several studies have shown that their lower rate of insurance coverage is one factor contributing to noncitizens' lower utilization of health care, including preventive care (e.g. cancer screening).[180] Nonetheless, several studies have reported that the noncitizen population, including unauthorized aliens, was more likely to have hospitalization for childbirth than the citizen population.[181]

Furthermore, regardless of legal status, and in addition to the barriers caused by a lack of health insurance, immigrants often face language and cultural barriers in accessing health care.[182] These

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[175] For example, see GK Singh and M. Siahpush, "Ethnic-Immigrant Differentials in Health Behaviors, Morbidity, and Cause-Specific Mortality in the United States: An Analysis of Two National Data Bases," *Human Biology*, vol. 74 (February 2002), pp. 83-109.

[176] Alexander N. Ortega, Hai Fang, and Victor H. Perez, et al., "Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos," *Archives of Internal Medicine*, vol. 167, no. 21 (November 26, 2007), p. 2356.

[177] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), p. 1705.

[178] Thomas C. Buchmueller, Anthony T. Lo Sasso, and Ithai Lurie, et al., "Immigrants and Employer-Sponsored Health Insurance," *Health Services Research*, vol. 42, no. 1 (February 2007), p. 286.

[179] Thomas C. Buchmueller, K. Grumback, and R. Kronic, et al., "The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: A Review of the Literature," *Medical Care Research and Review*, vol. 62, no. 1 (February 2005), pp. 3-30.

[180] For example, see O. Carrasquillo and S. Pati, "The Role of Health Insurance on Pp Smear and Mammography Utilization by Immigrants Living in the United States," *Preventative Medicine*, vol. 39, no.5 (November 2004), pp. 943-950, and I. De Alba, A. Hubbell, and J. McMullin, et al., "Impact of U.S. Citizenship on Cancer Screening Among Immigrant Women," *Journal of General and Internal Medicine*, vol. 20, no. 3 (March 2005), pp. 290-296.

[181] A study of the noncitizen population in Los Angeles County reported that one in six unauthorized females reported a pregnancy related hospitalization, which is double the rate for native-born women. Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), p. 1706.

[182] Andrea B. Staiti, Robert E. Hurley, and Aaron Katz, *Stretching the Safety Net to Serve Undocumented Immigrants: Community Responses to Health Needs*, Center for Studying Health System Change, Issue Brief 104, Washington, DC, February 2006, p. 2. Khiya J. Marshall, Ximena Urrutri-Rojas, and Francisco Sota Mas, et al., "Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women," *Health Care for Women*
(continued...)

barriers include lack of knowledge about the U.S. healthcare system and lack of sufficient financial resources. Many of these barriers are the same for citizens (e.g., low incomes, poor education, being in a health care shortage area such as an inner city), but in general, noncitizens are more likely to have more of these characteristics. In addition, the Kaiser Commission reports that immigrants may underutilize health care, regardless of insurance coverage, out of fear of jeopardizing their eligibility citizenship by incurring costs as a public charge.[183] Similarly, fear of discovery by government officials may also be a barrier to accessing health services among the unauthorized population,[184] as was shown in a 1994 study on unauthorized aliens and tuberculosis.[185]

(...continued)

International, vol. 26, no. 10 (December 2005), pp. 919.

[183] Kaiser Commission on Medicaid and the Uninsured, *Key Facts: Immigrants' Health Care Coverage and Access*, March 2001, pp. 1-2, http://www.kff.org/medicaid/upload/Fact-Sheet-Immigrants-Health-Care-Coverage-and-Access.pdf.

[184] Arijit Nandi, Sandro Galea, and Gerald Lopez, et al., "Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area," *American Journal of Public Health*, vol. 98, no. 11 (November 2008), p. 2017. Marc L.Berk, Claudia L. Schur, and Leo R. Chavez, et al., "Health Care Use Among Undocumented Latino Immigrants," *Health Affairs*, vol. 19, no. 4 (July/August 2002), p. 60. L.A. Aday, *At Risk in America: The Health and Healthcare Needs of Vulnerable Populations in the United States*, 2nd ed. (San Franscisco: Jossey-Bass Publishers, 2001). Jeffrey T. Kullgren, "Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform," *American Journal of Public Health*, vol. 93, no. 10 (October 2003), p. 1630.

[185] S. Asch, B. Leake, and L. Gelberg, "Does Fear of Immigration Authorities Deter Tuberculosis Patients from Seeking Care?" *Western Journal of Medicine*, vol. 161 (1994).

Appendix A. Data and Detailed Methodology

The CRS analysis of data in this report is based primarily on the 2008 Current Population Survey (CPS) Annual Demographic Survey, March Supplement. The Current Population Survey (CPS) is a household survey conducted by the U.S. Bureau of the Census for the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor. The monthly CPS is the main source of labor force data for the nation, including estimates of the monthly unemployment rate. The CPS collects a wide range of demographic, social, and labor market information. Currently, approximately 57,000 households are interviewed each month. For the March Supplement approximately 99,000 households are interviewed. The monthly CPS sample is representative of the civilian non-institutional population; it does not include persons on active military duty. Each March, the CPS asks additional questions about earnings and health insurance for the previous year.

Employment Variables

The BLS defines the labor force as the sum of employed and unemployed persons. Unemployed persons are individuals who are not working but who are available and looking for work. Employed persons are individuals who are working for a private or public employer, are self-employed, or who work 15 hours or more a week as unpaid workers on a family farm or business. Also counted as employed are persons who are temporarily absent from work because of illness, bad weather, vacation, job training, labor-management disputes, childcare problems, maternity or paternity leave, or other family or personal reasons.

Citizenship Variable

The CPS uses five categories to define citizenship: (1) born in the United States, (2) born in Puerto Rico or another outlying area of the United States, (3) born abroad of U.S. citizen parents, (4) naturalized citizens, and (5) noncitizens. For the analysis in this report, the first three categories were combined and defined as "native-born citizens." Information on place of birth is collected for every household member in the CPS sample, and for the parents of every household member. Individuals born in the United States or its outlying areas, or whose parents were born in the United States or its outlying areas, are not asked questions about citizenship. Individuals born outside the United States or its outlying areas, and whose parents were born outside the United States or its outlying areas, are asked, "Are you a citizen of the United States?" Respondents who answer "Yes" are coded as naturalized citizens, while respondents who answer "No" are categorized as noncitizens. In the CPS, individuals for whom no birthplace is provided are assigned a citizenship status during the editing process. For example, the citizenship status of a child may be assigned based on the citizenship status of the child's mother. The CPS does not attempt to verify the accuracy of responses to the questions about citizenship. It is not possible using CPS data to differentiate between different categories of noncitizens (e.g., legal permanent residents, temporary workers, students, refugees, and asylees). Nor is it possible to differentiate between aliens who are in the United States legally and those who are unauthorized.

Basic Demographic and Socio-economic Characteristics

Table A-1. Demographic and Socio-economic Characteristics of the Native-Born, Naturalized, and Noncitizen Populations

	Native-Born	Naturalized	Noncitizen
Population	261.8 million	15.1 million	22.2 million
Percent of Population	87.5%	5%	7.4%
Sex			
Male	49%	45.9%	53%
Female	51%	54.2%	47%
Age			
Under 18	27.3%	2.6%	10.8%
18-64	60.3%	75.7%	83.4%
65+	12.4%	20.7%	5.8%
Median Family Income	$55,000	$60,000	$39,000
Education (Age 18+)			
Less than High School	11.3%	19.2%	29.3%
High School Diploma or Equivalent	31.8%	26.6%[a]	25.3%
Some College	29.9%	20.7%	13.8%
College Graduate	18.1%	21%	13.3%
Advanced Diploma	8.9% [a]	12.5%	8.3%
Region of Residence and 5 States with Largest Nonimmigrant Population			
Northeast	9.3%	6.9%[a]	4.9%
New Jersey	2.6%[a]	5.3%	4.7%
New York	5.7%	14.4%	9.4%
Midwest	23.4%	11%[a]	11%
South	24.2%	10%	13.4%
Florida	5.6%	9.6%	8.6%
Texas	7.7%	7.2%	11.4%
West	11.4%	8.9%	10.5%
California	10.1%	26.8%[a]	26.1%
Arrival Period			
Before 1970	N.A.	20.6%	2.9%
1970s	N.A.	20.2%	4.7%
1980s	N.A.	28.2%	14.7%
1990-1995	N.A.	16.5%[a]	16.1%
1996-2001	N.A.	10.9%	29.3%
2002-2008	N.A.	3.6%	23.4%

	Native-Born	Naturalized	Noncitizen
Region of Birth			
Europe	N.A.	14.8%	6.5%
Former Soviet Union	N.A.	4%[a]	1.8%
Asia	N.A.	30.2%	19.3%
North America	N.A.	2.2%[a]	1.7%
Mexico	N.A.	16.3%	41.2%
Middle East	N.A.	4.5%[a]	2%
Caribbean	N.A.	11.4%	7.6%
South America	N.A.	6.2%[a]	6.4%
Africa	N.A.	3.5%[a]	4%
Central America	N.A.	5.2%	8.2%
Oceanic/Pacific/Other	N.A.	1.6%[a]	1.4%
Type of Employer (Employed 18 to 65 only)			
Private	77.7%	79.5%	88.9%
Government	16.3%	13.0%	4.7%
Self-Employed	6.0%	7.4%	6.4.%
Firm Size (Employed 18 to 65 only)			
Under 10	19.6%	23.7%	28.1%
10 to 24	9.2%[b]	9%[b]	13.5%
25-99	12.4%[b]	12.2%[b]	15.8%
100-499	13.1%[a]	12.1%[a]	12.2%
500-999	5.8%	5.6%	4.4%
1000+	39.9%	37.5%	26.1%
Occupation (Employed 18 to 65 only)			
Management, Business, Financial	15.3%	14.3%	7.3%
Professional and Related Occupations	21.5%	23.2%	13.1%
Service	15.3%	17.9%	25.4%
Sales	11.4%	10.2%[a]	7.9%
Office and Administrative support	14.5%	11.5%	6.5%
Farming, Fishing, and Forestry	.5%[a]	.7%[a]	2.9%
Construction and Extraction	5.7%	5.7%	16.1%
Installation, Maintenance and Repair	3.6%[a]	3.2%[a]	2.7%
Production	6.1%	7.6%[a]	10.5%
Transportation and Material Moving	6.2%[a]	6%[a]	7.7%
Industry (Employed 18 to 64 only)			
Agriculture, Forestry, Fishing	1.2%[a]	.9%[a]	3.1%

	Native-Born	Naturalized	Noncitizen
Construction, Extraction	7.3%	6.5%	16.5%
Manufacturing	10.9%[a]	12.3%[a]	13.3%
Wholesale and Retail Trades	14.3%	12.4%[a]	12.1%
Transport and Utilities	5.6%[a]	6.5%[a]	3.9%
Information	2.6%[a]	2.4%[a]	1.4%
Financial Activities	7.2%	8.1%	3.3%
Professional and Business Services	10.8%	10.1%[a]	13.3%
Education and Health Services	22.2%	22.8%	12.4%
Leisure and Hospitality	8%	8.5%	13%
Other Service	4.3%[a]	5.8%[a]	6.6%
Public Administration	5.1%	3.8%[a]	.9%
Poverty Level (total population)			
Less than 100%	12%	9.5%	21.4%
100%-199%	17.1%	18.9%	27.6%
200%-499%	42.1%	41.9%	36.5%
500% +	28.7%	29.7%	14.6%
Poverty Level (under 18)	**Citizens (Native-Born and Naturalized)**		
Less than 100%	18%	N.A.	32.7%
100%-199%	20.9%	N.A.	26.8%
200%-499%	41.4%	N.A.	30.2%
500% +	19.7%	N.A.	10.4%

Source: CRS analysis of the March 2008 CPS.

Notes: Percentage totals may not equal 100% due to rounding. Mining and Armed Forces are not reported in the industry category due to small sample sizes. Armed Forces are not reported in the occupational category due to small sample sizes. The CPS is a survey of the civilian population. All comparisons between noncitizens and naturalized citizens and noncitizens and native-born citizens are significant at the .05 level unless otherwise specified. For definitions of the regions of residence and birth, see **Appendix C**.

a. Difference with noncitizens and the other population is not statistically significant.

b. The difference between the population and noncitizens is significant at the .1 level.

Appendix B. Methodology of Studies Presented in Section on Estimated Health Care Costs for Unauthorized Aliens

Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County (2009)

The study's authors used three sources to identify uncompensated care costs: (1) the United States/Mexico Border Counties Coalition study *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties*;[186] (2) the Centers for Medicaid and Medicare Services (CMS) report *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens:2006*;[187] and the 2004 Texas Hospital Association survey compiled by the Center for Health Statistics within the Texas Department of State Health Services. The total uncompensated care costs were developed using a model which reflects hospital characteristics (e.g., hospital size, urban or rural location, whether the hospital was a teaching or nonteaching hospital).[188]

Undocumented Immigrants in Iowa: Estimated Tax Contributions and Fiscal Impact (2007)

This study used demographic estimates by the Pew Hispanic Center,[189] and estimates of the annual per capita public share of medical spending on unauthorized aliens from the study *Immigrants and the Cost of Medical Care,* a study on Los Angeles County.[190] The authors stated that since the per capita public spending on unauthorized aliens was based on the potentially more generous care available in Los Angeles County, the methodology would provide a conservative estimate of public spending for medical care of adult unauthorized aliens in Iowa. The study did not estimate the costs of public spending on unauthorized alien children.

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[186] United States/Mexico Border Counties Coalition, *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties* (Washington, D.C.: United States/Mexico Border Counties Coalition, September 2002).

[187] Centers for Medicare and Medicaid Services, Final FY 2006 State Allocations for Section 1011 of the Medicare Modernization Act: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, Washington, DC, April 6, 2006, pp. 1-2, http://www.cms.hhs.gov/UndocAliens/Downloads/fy06_state_alloc.pdf.

[188] Alberto Coustasse, Andrea L. Lorden, and Vishal Nemarugommula, et al., "Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County," *Hospital Topics: Research and Perspectives on Health Care*, vol. 87, no. 2 (Spring 2009), pp. 3-11.

[189] Pew Hispanic Center, *Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS.*, (Washington, D.C.: Pew Hispanic Center, Apr. 26, 2006); Jeffrey Passel, *Unauthorized Migrants: Numbers and Characteristics*, Background Briefing Prepared for Task Force on Immigration and America's Future (Washington, D.C.: Pew Hispanic Center, June 14, 2005).

[190] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs*, vol. 25, no. 6 (November/December 2006), pp. 1700-1711.

Undocumented Immigrants in Texas: A Financial Analysis of the Impact to the State Budget and Economy (2006)

The Comptroller of the State of Texas calculated an approximation of the financial impact of unauthorized aliens on the state based on estimates of the unauthorized alien population by the Pew Hispanic Center;[191] reports by the Government Accountability Office (GAO) and the Border Counties Coalition; and the state's own information on the costs of providing health care.[192]

Cost of Federally Mandated Services to Undocumented Immigrants in Colorado (2006).

This study used demographic estimates by the Pew Hispanic Center to estimate the cost to the Colorado state government of providing federally mandated services, including emergency medical care, to unauthorized aliens.[193]

Impact of Illegal Immigration on Mississippi (2006)

The Mississippi Office of the State Auditor's estimate was accomplished by using a finding from the RAND Corporation that 68% of unauthorized alien adults lacked health insurance.[194] Importantly, the report noted that "because no data regarding immigration status is collected, it is difficult to determine the accuracy of this estimate..."[195]

Impact of Illegal Immigration on Minnesota (2005)

The Office of Strategic Planning and Results Management for the State of Minnesota used state program (Medicaid, CHIP) data on unauthorized alien recipients reported to estimate the costs to these programs of unauthorized aliens.[196]

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[191] Pew Hispanic Center, *Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS.*, (Washington, D.C.: Pew Hispanic Center, Apr. 26, 2006).

[192] The study concluded that while state revenues exceeded state expenditures for unauthorized aliens, local governments and hospitals had the reverse experience, with spending on unauthorized aliens exceeding revenues paid by unauthorized aliens.

[193] Rich Jones and Robin Baker, *Costs of Federally Mandated Services to Undocumented Immigrants in Colorado*, (Denver, CO: Bell Policy Center, June 30, 2006).

[194] Dana P. Goldman, James P. Smith and Neeraj Sood, "Legal Status and Health Insurance Among Immigrants." Health Affairs, vol 24, no. 6 (Nov./Dec. 2005), pp. 1640-1653.

[195] Mississippi Office of the State Auditor*, The Impact of Illegal Immigration on Mississippi: Costs and Population Trends*, (Jackson, MS: Office of the State Auditor, February 21, 2006).

[196] Minnesota Department of Administration, Office of Strategic Planning and Results Management, The Impact of Illegal Immigration on Minnesota: Costs and Population Trends, (St. Paul, MN: Minnesota Department of Administration, Dec. 8, 2005). Available at http://www.state.mn.us/mn/externalDocs/Administration/Report_The_Impact_of_Illegal_Immigration_on_Minnesota_120805035315_Illegal%20Immigration%20Brief%2026.pdf.

The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget (2004)

This study released by the Center for Immigration Studies[197] used the March Current Population Survey (CPS) and the decennial census, and relied on the methodology used in two other respected studies of the fiscal effects of immigration: (1) *The New Americans* (1997), by the National Research Council (NRC),[198] and (2) *Immigrants in New York: Their Legal Status, Incomes and Taxes* (1998), by researchers at the Urban Institute.[199] Unauthorized aliens were estimated by using socioeconomic characteristics to assign a probability to each respondent that the respondent was an unauthorized alien. The study used households as the unit of analysis arguing, as in the NRC study, that the household is the primary unit through which taxes are paid and services used. It is important to note that although the head of the household is an unauthorized alien, it is possible that others in the household are legally present, or United States citizens. The study noted that ascertaining the cost of unauthorized alien households presents complex fiscal questions.[200]

Care for the Uninsured Non-citizens: A Growing Burden on Florida's Hospitals (2003)

The Florida Hospital Association used case studies of 700 unauthorized aliens from 39 hospitals/health systems representing 56 hospitals, or 26% of the acute care hospitals in Florida, to comprise its estimate of the amount spent on care for unauthorized aliens.[201]

Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties (2002)

In 2002, the United States/Mexico Border Counties Coalition released a study entitled *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties*.[202] The survey conducted statistical modeling by identifying sets of non-border communities that "capture essential characteristics of each border community with respect to the demand for emergency medical services." The researchers note the complexity of matching border communities with other communities, as the counties on the U.S./Mexico border are unique on many important dimensions, and this complexity may have impacted the results. The researchers then performed a

[197] Steven A. Camarota, *The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget* (Washington, D.C.: Center for Immigration Studies, August 2004).

[198] National Research Council, *The New Americans: Economic, Demographic, and Fiscal Effects of Immigration* (Washington, D.C.: National Academy Press, 1997). This study is not included in this memorandum because it does not distinguish between aliens who are legally present and aliens who are unauthorized.

[199] Jeffrey S. Passel, and Rebecca L. Clark, *Immigrants in New York: Their Legal Status, Incomes and Taxes*, (Washington D.C.: Urban Institute, April 1998).

[200] The study estimated that there are 3.8 million households headed by unauthorized aliens, and 120.1 million other households in the United States.

[201] In general, hospitals tend to incur the largest medical costs not for treatment in the emergency room but for patients who need long term hospitalization. Of the nine case studies where the patient incurred more than $600,000 in costs, all required long-term hospitalizations of more than a year. Four of the patients were in a coma, and two others required respirators and feeding tubes.

[202] United States/Mexico Border Counties Coalition, *Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties* (Washington, D.C.: United States/Mexico Border Counties Coalition, September 2002).

linear regression, and assumed the differences between the border communities and the similar non-border communities could be attributed to unauthorized aliens.[203]

[203] This constituted approximately 23% of the total amount ($832 million) of uncompensated care spent by these counties. Alberto Coustasse, Andrea L. Lorden, and Vishal Nemarugommula, et al., "Uncompensated Care Costs: A Pilot Study Using Hospitals in Texas County," *Hospital Topics: Research and Perspectives on Health Care*, vol. 87, no. 2 (Spring 2009), p. 7.

Appendix C. State and Region Definitions

States/Regions of Residence

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, Pennsylvania, Rhode Island, and Vermont.

Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

South: Alabama, Arkansas, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia.

West: Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, New Mexico, Nevada, Oregon, Utah, Washington, and Wyoming.

New Jersey, New York, Florida, Texas, and California were analyzed separately in the analysis.

Regions of Birth

Africa: Algeria, Cameroon, Cape Verde, Egypt, Ethiopia, Eritrea, Ghana, Kenya, Liberia, Morocco, Nigeria, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Tanzania, Uganda, Zimbabwe, and Africa, not specified

Asia: Afghanistan, Bangladesh, Cambodia, China, Cyprus, Hong Kong, India, Indonesia, Japan, Korea, Laos, Malaysia, Myanmar (Burma), Nepal, Pakistan, Philippines, South Korea, Singapore, Sri Lanka, Taiwan, Thailand, Vietnam, and Asia, not specified.

Caribbean: Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, St. Kitts-Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago, and West Indies, not specified.

Central America: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

Europe: Albania, Austria, Azores, Belgium, Bosnia & Herzegovina, Bulgaria, Croatia, Czech Republic, Czechoslovakia, Denmark, England, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Kosovo, Macedonia, Netherlands, Northern Ireland, Norway, Poland, Portugal, Romania, Scotland, Serbia, Slovakia, Spain, Sweden, Switzerland, United Kingdom, Wales, Yugoslavia, and Europe, not specified.

Former Soviet Union: Armenia, Azerbaijan, Belarus, Georgia, Latvia, Lithuania, Moldova, Russia, Ukraine, USSR, and Uzbekistan.

Mexico: Mexico

Middle East: Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Saudi Arabia, Syria, Turkey, and Yemen.

North America: Bermuda and Canada.

South America: Argentina, Bolivia, Brazil, Chile, Columbia, Ecuador, Guyana, Paraguay, Peru, Uruguay, Venezuela, and South America, not specified.

Oceana and Other: Australia, Fiji, New Zealand, Samoa, Tonga, Oceania not specified, Americas not specified, and Elsewhere.

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