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Abstract

Health care reform in the United States has emphasized expanding health insurance to improve access to health care, but undocumented residents and recent immigrants will continue to face many restrictions. This article reports on the results of four focus groups conducted in the Los Angeles area with uninsured Mexican immigrants about ways of improving their access to health care. Alternatives included binational health insurance, expanded employer-provided health insurance, improved access to community health centers, and telemedicine as a way to improve access to specialists. The only solution where there was a consensus that the change would be feasible, result in improved access, and they had confidence in was expanded access to community health centers (CHC's). Given the limited access to most specialists at CHC's and the continued barriers to hospital care for those without health insurance, the most effective way of improving the complete range of health services to undocumented immigrants is through immigration reform that will bring these workers under the other health care reform provisions.

Background

Health insurance is the largest predictor of having access to health care in the United States (Burstin, Swartz et al. 1998; Kasper, Giovannini et al. 2000). Access barriers can lead to more costly and serious health problems and hospitalization for avoidable conditions (Okie 2007; Kaiser Commission on Medicaid and the 2008). Among those who do not have health insurance, immigrants have the highest uninsured rates, especially Mexican immigrants. In 2007, over half of immigrants from Mexico had no health insurance, compared with 19% of non-Latino immigrants and 12% of U.S.-born non-Latino whites (Castañeda, Wallace et al. 2008).

Work-based health insurance is the primary source of health insurance for both immigrants and natives. Mexican immigrants in the U.S. have a higher labor force participation rate than U.S.-born non-Latino whites (hereafter referred to as U.S.-born whites), but a majority of Mexican immigrants are concentrated in low-wage industries such as construction and service occupations that are the least likely to offer health insurance. The result is that Mexican immigrants have low rates of employment-based health insurance (Brown, Nadereh et al. 2007). Nationally in 2006, three-quarters of employed U.S.-born white men obtained health insurance through their work. In contrast, under one-quarter of Mexican immigrant workers in heavily Mexican immigrant occupations obtained work-based health insurance, and under half of Mexican immigrant workers in non-immigrant dominated occupations obtained work-based insurance. The pattern for employed women is similar (Brown, Nadereh et al. 2007). Even though the employment coverage rate for Mexican immigrants is low, it is still the most common source of health insurance for adults. Most of this gap in coverage is the result of employers not offering insurance to their low-waged workers (Clemans-Cope, Kenney et al. 2007; McCollister, Arheart et al. 2009).

Despite the expanded employment and subsidized individual-based health care coverage planned under the 2010 health care reform law, the expansion will continue to exclude all undocumented immigrants and retains a five year waiting period after migration for most documented immigrants to be eligible for federally-funded Medicaid or State Children's Health Insurance Programs (SCHIP) (Davis 2010; NILC 2010). Similar restrictions have resulted in less than 10% of Mexican immigrant adults under age 65 having any type of public health insurance (Castañeda, Wallace et al. 2008).

Access to health care varies between different groups of Mexican immigrants and U.S.-born whites in California. Under half of undocumented Mexican immigrant adults have any health insurance, compared to two-thirds of those with a green card and 85% of U.S.-born Mexican Americans. The proportion reporting a usual source of care similarly increases from the lowest among undocumented Mexican immigrant adults (66%), to those with a green card (79%), U.S.-born Mexican Americans (88%), and U.S.-born whites (92%) (Ortega, Fang et al. 2007). Health insurance has the largest impact on having a usual source of care and having a doctor visit for Mexican immigrants; it is also one of the largest predictors of emergency department and obtaining needed medications (Vargas Bustamante, Fang et al. 2009).

Barriers to health care in the United States may lead some Mexican immigrants to seek care back in Mexico. Nationally, 9% of Latino immigrants report obtaining some of their medical care, dental care, or prescription drugs outside of the U.S. in the past year (Livingston, Minushkin et al. 2008). In California, 13% of Mexican immigrants reported receiving one of those medical services in Mexico during the past year (Wallace, Mendez-Luck et al. 2009). These studies suggest that there is a likely demand for health care coverage by immigrants that transcends national borders (Bustamante, Ojeda et al. 2008).

California has a larger share of immigrants than any other state, with an estimated 10 million residents who were born abroad. Over 4 million California residents are Mexican immigrants and an estimated 2.7 million Mexican immigrants in California are undocumented (Passel and Cohn 2009). California mirrors the country with a high rate of uninsurance among Mexican immigrant adults, 39.8% or 1.5 million (CHIS 2007). This large number of Mexican immigrants who are uninsured presents a special challenge when designing health care reform proposals that attempt to move toward universal health insurance coverage since their employers disproportionately do not offer health insurance, and a large number are undocumented.

In order to better understand how to improve access to care for Mexican immigrants in California, we conducted focus groups with noncitizen Mexican immigrant adults who had no health insurance. We identified the most significant current barriers to care for them, and asked about the feasibility and attractiveness of several different approaches to improving their access to care.

Methods

Four focus groups were held with Mexican immigrants who had no current health insurance, one each month between September and December October 2008. One group was all male day laborers, one was all women domestic workers, and two were parents (all women) of young children. A total of 34 immigrants participated in the focus groups that took from 40-60 minutes each. Recruitment for the groups was facilitated by IDEPSCA (Instituto de Educacion Popular del Sur de California), a community-based organization that provides advocacy and services for Spanish-speaking immigrants. Participants were asked about where they and their families currently go for medical care, about any use of medical care in Mexico, and about their perceptions concerning different ways of expanding access to care for immigrants in California.

All groups were conducted in Spanish by a bilingual doctoral student, tape recorded, and transcribed. No identifying information about the respondents was recorded and participants were given a \$25 gift card at the end of the focus group. The protocol was approved by the UCLA Office for the Protection of Human Subjects. The information from the groups were coded independently by three researchers who reviewed their analyses together to create the following analysis.

Different options for expanding access to healthcare were presented to the focus groups to obtain their perceptions of advantages and disadvantage for each approach. The approaches were developed based on discussions with key policy informants in California and Mexico concerning options that they saw as viable for expanding access. This article provides data on the approaches most often discussed in policy circles, BiNational Health Insurance and expanded employer provided health insurance. We also provide data on the participants reaction to expanded community health centers, since that is a component of health care reform, and telemedicine as a way to increase the availability of specialists at community clinics.

BiNational Health Insurance: Binational health insurance provides insurance that can be used in two different countries. In concept it should be possible to provide primary care in the U.S. while diverting expensive treatments to providers in Mexico. The savings could be passed on to the beneficiary and employer in the form of lower premiums, making this type of product more affordable for low waged workers. In addition, if the insurance provided family coverage, it could provide coverage for any of the worker's family that remains in Mexico. Since some remittances are already used for health care in Mexico, this approach could provide a predictable level of health care as well as insure against catastrophic costs.

Private binational health insurance between the United States and Mexico is already offered through a few organizations, HealthNet, Blue Shield of California, Pacificare and SIMNSA (Darce 2007). In the late 1990s California passed enabling legislation that allowed insurance companies to have provider networks on both sides of the border. Current products are marketed based on the lower cost of insurance that is possible when primary care is provided in both the U.S. and Mexico, but more expensive hospital care is provided primarily in Mexico. These policies have been sold mostly to employers located near the border, and the total number of enrollees has remained relatively small (under 300,000 total).

Focus group participants voiced a number of concerns about binational health insurance. The most significant concern was that those who were not U.S. legal permanent residents would find it difficult and risky to try to reenter the U.S. after receiving services in Mexico. This would deter undocumented residents from seeking most types of care across the border.

It's like a trick. You're sick, you have the flu, and you go to your country and when you want to return you have to remain! We can leave but not return.

One focus group participant suggested the only way this would work would be if the U.S. issued a temporary reentry visa for those leaving the country for medical care. Since about half of all undocumented Mexicans in California are estimated to have no health insurance (Ortega, Fang et al. 2007), the lack of documents to return the United States easily would be a significant barrier to a large number of those who need coverage under this plan.

A second concern that was voiced was that a limited, closed network of providers in the U.S. that might be part of a binational plan might not increase the actual level of access to care compared with what the uninsured immigrants already have through sliding-scale programs at community clinics and public health care centers.

Participants in the focus groups liked the idea of having expanded coverage for family members in Mexico, but those who participated in our groups had few children who remained in Mexico. The family who was most commonly left behind were grandparents, parents and siblings. Money that was being sent to Mexico for health care needs appears to be mostly used for private providers in Mexico, so a binational product that relied on the public systems of Seguro Popular or IMSS (which would be more affordable) might not be seen as providing an added benefit.

Employer Mandated Health Insurance

As noted earlier, employer-sponsored health insurance is the most common source of insurance for both immigrants and U.S.-born whites. A key component of the 2010 health care reform in the U.S. was to incentivize more employers to provide health insurance to their workers (Davis 2010). For undocumented immigrants, in particular, this might be attractive since private insurance offered through employers does not make any additional demands for proof of legal residency. The lack of governmental involvement would make it relatively “safe” for all workers and their families to obtain needed care. In California this could be particularly effective in covering uninsured undocumented adults since three-quarters of uninsured undocumented adults are in families with at least one full-time employee (compared to 57% of uninsured citizens (Brown, Nadereh et al. 2007)).

Participants in the focus groups generally thought that employer provided insurance was a good idea in principal, but not one that would help them. Most of the uninsured Mexican immigrants in our focus groups reported that they worked for multiple employers, were part time workers, or worked for cash and would therefore not qualify as a “full-time” employee of a business under an employer mandate. This is not inconsistent with the data reported above since

a worker with two 15-20 hour per week jobs would be considered as working full time, but would likely not qualify for coverage from either employer. Nationally, however, only 3% of Hispanics report holding multiple jobs. It is difficult to estimate what percent of uninsured, undocumented workers would be impacted by having multiple part time jobs, cash wages, or other characteristics that would exclude them from employer-provided insurance. In addition, migrant workers, who may have a single employer full-time, but only for a short amount of time, would likely not be eligible.

Expanded Community Clinic Access

Instead of expanding “coverage,” an alternative approach to improving access is by focusing on improving “care.” In California’s health care reform proposals of 2008, community health centers (CHCs) and county clinics were designed to provide the health care for undocumented immigrants who would not be covered by the proposed state health care expansion (Gruber 2007). As existing safety net providers, they are already located in underserved communities and often provide culturally competent and bilingual staff. The 2010 national health care reform included a significant increase in the capacity of this sector (Rosenbaum, Jones et al. 2010), which should improve access for immigrants, and to the extent that undocumented immigrants already use those services it could provide a broad-based improvement in access. The advantages of providing “care” rather than “coverage” are that additional resources could be devoted to primary care and prevention rather than expensive hospital care (laws require insurance policies to be comprehensive), existing community clinics are sites where many immigrants already obtain services without fear about their documentation status, and it is administratively less complex than insurance products.

Overall, the expansion of community clinics was the consensus choice of the participants in the focus groups. The respondents liked the fact that they were already often receiving care at these locations and that additional resources could improve the responsiveness of care (e.g. shorter wait time) and make it more affordable. Unlike insurance linked to employment, coverage through clinics would be available when the person was unemployed or between jobs. “There is more security there, right? Because it doesn’t depend on employment.”

One limitation of relying on primary care clinics is the limited range of services that they offer. Focus group respondents wanted to know how they would get lab tests and x-rays that were not available at some clinics. Another limitation would be referrals to specialists, which are already difficult in some specialties even when the patient has Medi-Cal. One participant liked the concept of expanded clinic services based on a good experience she had through community clinics because she had been referred and quickly seen for needed follow-up specialist care for a positive mammogram. She was not aware of how it was paid, but it was probably covered under California’s Medi-Cal Breast and Cervical Cancer Treatment Program (BCCTP) that covers undocumented women (Malin, Diamant et al. 2010).

The participants all wanted improved access and quality of care. They were not enthusiastic about being required to go to the same “mediocre” public hospitals and clinics that they are currently limited to; if there is no improvement in the quality of care received they would see little benefit since those services are already low or no cost.

Telemedicine for Specialty Care

There is a growing interest nationally in the U.S. in the use of telemedicine to provide care to underserved areas. Since the focus group respondents complained the most about limited access to specialist and referral services, one possible way to increase access to culturally and

linguistically appropriate services would be to provide telemedicine consultations from U.S. clinics to specialists in Mexico. Providers in Mexico would be less expensive or free if the specialist was employed by the Mexican government.

The idea occurred after a visit from the Ministry of Health of Mexico City to UCLA, where the Mexican officials expressed an interest in a collaborative project. Given the limited resources in Mexico to directly pay for care of Mexican citizens in the U.S., we thought that some of the specialty resources available in Mexico might be made available to Mexican citizens at a low additional cost via telemedicine.

None of the immigrants seemed interested in this option. Few participants had ever heard of the concept and so the option seemed strange and abstract. The immigrants raised a host of reservations about the concept, including distrust of the credentials of people on the screen, their inability to perform personal examinations, and uncertainty about their quality. One respondent summed it up by saying, “How are we going to be sure that it is a real doctor that we’re talking to (on the screen)? “

Conclusion

The 2010 U.S. health care reform promises a significant reduction in the proportion of U.S. residents who have no health insurance, but undocumented immigrants are explicitly excluded from the expansion of insurance and all recent immigrants will face continued barriers to accessing insurance and health care. The uninsured immigrants in our Los Angeles focus groups offered insights into what is likely to work best in expanding health insurance and access to health care for them. Since these groups included many undocumented immigrants, binational health insurance did not seem to be a feasible way of expanding access since they are unable to cross the international border and since most remittances sent to Mexico for medical care was to

provide access to private providers. The expanded employer-provided insurance promised by health care reform would not reach many of these immigrants since many have no permanent formal full-time employer, even though most work full-time. Improved access to community health centers, which is also a component of health care reform, was the consensus preference for expanded access, despite the limited access to most specialists at those centers. Respondents negative about the idea of telemedicine to specialists in Mexico as a way of expanding specialist consultations. In any solution, the participants prioritized reducing the amount of time they have to wait for care, services by the same doctor over time (versus ever changing residents, care in high-turnover settings, or high volume care where they have no choice of doctors), and affordability.

The respondents in the focus groups liked the idea of having security that they would be seen when they were sick. This was expressed in terms of the benefits of having health insurance.

It is knowing that you can get in, that you don't have to apply since you already have coverage... that confidence of going and they see you at whatever time you get sick.

The discussion of barriers to health care included multiple examples of long waits and a lack of treatment experienced when seeking care for injuries and illnesses that were not immediately life-threatening at emergency rooms, and of high charges for emergency room and hospital care. Those barriers would not be addressed by expanded community clinic services.

The discussions of access to medical care were almost totally focused on medical care needs for health problems and not for prevention. Some participants joked that they were too poor to get sick and so had no experience in seeking medical care. While the groups were generally younger adults (ages 20-40), there was little discussion of issues around reproductive health care (contraception, STDs) even though the four groups were all single-sex (and in two groups the facilitators and observers were the same sex as the group participants).

Our research shows that the expanded funding for community health centers in health care reform is an important first step in improving access to care for immigrants. They are the current trusted sources of care for many, usually provide linguistically and culturally appropriate services, and are located in high-need communities. They provide the critical primary care that is most needed by a generally young and healthy immigrant population, but they are limited in their ability to provide specialty and hospital care when it *is* needed. Community health centers accept insurance, and under health care reform will become increasingly oriented to both Medicaid and private insurance as funding mechanisms {Rosenbaum, 2010 #70}. As a consequence, it would best serve all immigrants, including the undocumented, if they were covered by health insurance. Given the restrictions on federal funding of health insurance for immigrants without documentation, the only way to assure their coverage is through immigration reform that provides a pathway to citizenship.

One focus group participant's closing words aptly summarize the tenor of all four focus groups, "I have this dream, I hope that this [expanded health care access] becomes a reality, since it's the truth that it's really needed."

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