Inclusion of Immigrant Families in U.S. Health Coverage Expansions

Sherry Hirota
Jane García, MPH
Ralph Silber, MPH
Ingrid Lamirault, MPH
Luella J. Penserga, MPH
Margo B. Hall, PhD

Abstract: This paper examines federal and state restrictions on immigrants and the negative impact of these restrictions on local efforts to serve the uninsured. It examines a health coverage program offered to low-income residents in Alameda County, California from 2000 to 2005, illustrating local efforts to expand health coverage to both adults and children, regardless of immigration status. After five years of operating the pilot program, leaders of Alameda County's health care safety net conclude that local health coverage programs are unsustainable over a long period of time without significant federal and state support. The financial resources that federal, state, and local governments are patching together for health coverage could be used more efficiently if consolidated. Stabilizing the federal tax base and recognizing the phenomenal amount of federal, state, and local funding that is already spent on medical care for the uninsured are the first steps towards achieving meaningful health care reform.

Key words: Health insurance, health coverage, immigrants, undocumented, low-income, underserved, welfare reform.

Health coverage is simply unaffordable for many working families in the U.S. The U.S. Census Bureau estimates that almost 45 million people in the U.S. are uninsured.[1] The reasons that people are uninsured are mostly straightforward: (1) employers are not offering health insurance, and (2) health coverage is too expensive for families to afford on their own.[2] Notably, the majority (80%) of the uninsured in the U.S. are working people.[2]

In current national and state debates concerning the problem of the uninsured, little interest is shown in extending coverage to immigrant populations or other socially stigmatized groups. U.S. history illustrates that immigrants are often targets

***SHERRY HIROTA** is the Chief Executive Officer of Asian Health Services in Oakland, CA and can be reached at shirota@aol.com. **JANE GARCIA** is the Chief Executive Officer of La Clinica de La Raza and Ralph Silber is the Executive Director of the Alameda Health Consortium. **INGRID LAMIRAULT** is the Chief Executive Officer of Alameda Alliance for Health, **LUELLA J. PENSERGA** is the Project Director of Community Voices Project-Oakland, and **MARGO B. HALL** is a Senior Research Consultant with ERA Associates in Silver Spring, Maryland.*

Journal of Health Care for the Poor and Underserved 17 (2006): 81–94.

17.1hirota.indd 81 1/3/06 10:31:17 AM

of negative public sentiment during times of economic strain or military conflict.[3] Debate about the presence of immigrants in the U.S. sharply increased after the tragedy of 9–11[4,5], after which the federal government increased surveillance and arrests of immigrants, and directed additional federal support towards border patrol efforts on the U.S.-Mexico border.[6,7]

Debates about both health coverage and U.S. immigration are complicated by the fact that a large undocumented, uninsured, low-wage workforce presently exists in the U.S. Interestingly enough, this undocumented workforce is both actively sought after and employed by many American businesses. Indeed, researchers agree that immigration has benefited the U.S. economy as a whole.[8] Immigrant workers, legal and undocumented, have been credited with half of the net increase of the labor force in the late 1990s.[9]

Legal and undocumented immigrants face certain social stigmas and as a group constitute a minority of the uninsured (20% of the total). On occasion policymakershave suggested ways to finance their health coverage, such as imposing an additional payroll tax on businesses that employ undocumented immigrant workers.[10] In terms of taxes already contributed by undocumented immigrant workers, researchers have found that the undocumented pay more in taxes than they receive in benefits; they pay as much as $7 billion annually in payroll taxes for Medicare and Social Security, federal programs for which many are ineligible primarily because of immigration status, and others because they are still of working age.[11]

This paper contributes to the literature on health insurance coverage expansions in that it examines efforts by local communities to serve the uninsured regardless of immigration status, and provides an argument for increased federal and state support to cover the uninsured. Discussion about the quality of health care services for immigrant populations, and the cultural and linguistic dimensions of health care are discussed extensively elsewhere in the literature and are not covered in the limited scope of this paper.[12,13,14]

The paper is organized as follows: a general discussion about the role of health insurance, followed by a description of low-income, immigrant families, and the public policies that determine their access to publicly-financed health coverage, particularly Medicaid and the State Children's Health Insurance Program (SCHIP). As a case study, we examine a locally-initiated, subsidized health coverage program in Alameda County, California, that provided coverage to children and adults regardless of immigration status. The program was conducted as a pilot program for five years, from 2000 to 2005. We conclude with a discussion about financing health coverage programs for the poor and underserved in the U.S.

The Role of Health Insurance Coverage

Protection from financial ruin. Generally, the role of health insurance is to give individuals and families the ability to access health care in a timely manner, while providing them with a measure of financial predictability and protection from financial ruin. Health insurance coverage also provides health care providers (hospitals, health care clinics, private physicians) with compensation for the services that they provide.

All low- and middle-income individuals and families (immigrants or not) who are uninsured live with grave financial risks. In fact, approximately half of all personal bankruptcies in the U.S. are attributed in part to medical debt.[15, 16] Therefore, it is not surprising that financial risk influences the willingness of the uninsured to seek medical services when they need them the most. Although presumably not a healthier population, the uninsured tend to seek emergency services less than the insured and, when they do seek care, they are in more advanced stages of illness than those with insurance. In short, the uninsured have worse health and die sooner than their insured counterparts.[17]

Pooling financial risk. A basic tenet of insurance is that the pool of the insured must be big enough and diverse enough to distribute the financial risks among high users (the sick) and low users (the healthy) of services. In other words, insurance companies desire a balanced risk pool in order to guard against adverse selection, a situation in which there is a high proportion of high (i.e., expensive) users in the risk pool. In the private market, insurance companies mitigate against adverse selection by charging high users more expensive premiums.

Within the context of publicly financed programs such as Medicaid and SCHIP, however, the problem of adverse selection must be approached differently. Because both programs enroll large numbers of people based on categorical criteria (e.g., children, mothers with dependent children, elderly, people who are blind or disabled) beneficiaries are generally not charged differently based on their predicted use of services, or are not charged at all.

How can policymakers draw the right mix of beneficiaries into a new health coverage programs so that beneficiaries' needs are met, and so that the insurance works properly? The simplest way to achieve a diverse risk pool would be to mandate that all people participate in the program. Although most policymakers agree that a mandatory benefit program is not politically feasible, segmenting the U.S. population by politically acceptable categories diminishes the positive aspects of risk pooling and, in effect, concentrates the highest, most expensive users of services into one group.

In a voluntary insurance program, such as the private plans offered by Kaiser Permanente, the health coverage benefit packages are designed to achieve access, as well as a balanced risk pool. To entice people to enroll in the program, enrollees must feel that they derive some benefit that is worth or worth more than the price of the insurance premium. Naturally, the willingness to pay for insurance will be higher among those who are sicker and who know that they need the services than among those who have less need for services.

Yet, because a willingness to pay cannot necessarily be interpreted as an ability to pay, problems with access may still remain. In other words, people who are sick and need the benefit may not be able to afford the premiums or meet the cost-sharing requirements. Healthy people may also decline to purchase the insurance because they see no need for it. Yet, providers of the insurance cannot ethically engage in marketing techniques that target only healthy people or design benefit packages with the intent of attracting only healthy enrollees. For the latter reason, most proposals for public health coverage expansions specify a standard benefit package that is defined in law.

One method to address access problems and attract a diverse risk pool is to reduce the price of the insurance to beneficiaries by offering subsidies. In one such possible system, beneficiaries would pay premiums for the plans that they choose, but the government or other entities would also provide either direct or indirect subsidies to them.

Containing government costs. Unfortunately, concerns about access must be balanced by concerns about the overall costs of the program. While subsidies can accomplish increased access and a better risk pool, they can also greatly increase government expenditures. The question for policymakers remains: are increased government expenditures merited by the financial security and improved health status that could be gained by covering all working families in the U.S.?

Public Financing of Health Coverage for Immigrant Families after Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also known as welfare reform, drew a new dividing line that determined which legal immigrants in the U.S. were eligible for public assistance, including public health coverage programs such as Medicaid and, later, SCHIP.[18] Before 1996, low-income legal immigrants and citizens were viewed equally in terms of eligibility for public programs. After the passage of welfare reform, however, legal immigrants were barred from Medicaid and SCHIP for the first five years of residency in the U.S. Federal and state policies barring undocumented immigrants remained unchanged.

Many states accepted the new federal restrictions. Some states, however, such as California, opted to use state funds to replace the loss of federal Medicaid and SCHIP funds. (see Table 1.) California established state-only Medicaid and SCHIP look-alike programs that continued to provide health coverage benefits to low-income legal immigrants, regardless of their date of entry into the U.S. Local counties and health care providers continued to operate as the health care safety net for the remaining groups of low-income residents who are excluded from publicly-financed programs due to categorical ineligibility, income eligibility, or immigration status.

The passage of welfare reform also complicated the enrollment of families with mixed immigration status. (see Figure 1.) Studies have documented that the use of immigration status to determine eligibility for public programs deters immigrant families from applying for these programs, even if certain members of the family, such as U.S.-born children, are eligible.[19, 20] Reasons may include perceptions that children or other members of the family could be deported, fears that the government may demand payment for services used, and concerns that the program will not cover all of their children. Many immigrant parents may also face even more basic barriers such as limited proficiency with the English language and confusion about the complex regulations governing public programs.[21]

If families fail to apply for health coverage programs even when they are eligible, innovative approaches to streamlining the enrollment process (such as California's proposed *Express Lane Eligibility* and *One-e-App*) will fall short of state goals to maximize enrollment into Medi-Cal (Medicaid) and Healthy Families (SCHIP), programs that receive a federal funding match.[22] Immigration-related restrictions

Table 1.

HEALTH COVERAGE PROGRAMS FOR LOW-INCOME FAMILIES IN CALIFORNIA AFTER WELFARE REFORM, BY IMMIGRATION STATUS

Immigration Status	Eligibility	Financing
• citizens • legal immigrants, residing in the U.S. for 5 years or more	Medi-Cal and Healthy Families	state and federal
• legal immigrants, residing in the U.S for less than 5 years	Medi-Cal and Healthy Families “look-a-like” programs	state
• undocumented immigrants	local health coverage programs (available in some counties)	counties and private funding

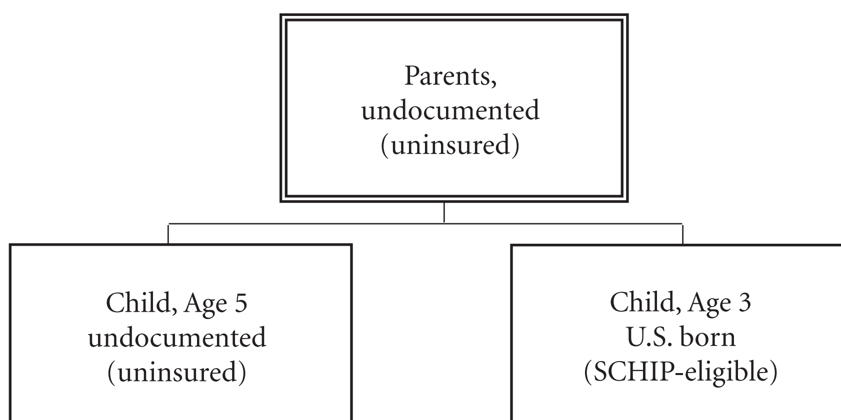

Figure 1. Example of a Mixed Immigration Status Family

add additional administrative complexity and expense to the enrollment process. Again, local counties and health care providers continue to serve as the health care safety net for those who remain uninsured and need medical care.

Local communities have been responding by initiating local health insurance programs for populations who are excluded from the Medicaid and SCHIP programs. In 2000, 5 communities in California, for example, began by developing local programs that subsidized health coverage for undocumented immigrant children and adults who had been left out of other health coverage programs.[23] Currently, 27 counties in California are either implementing or planning new health coverage programs for children, regardless of immigration status.[24]

A Local Health Coverage Program in Alameda County, California: Alliance Family Care

The case of Alliance Family Care, a health coverage program for low-income residents in Alameda County, California, illustrates local efforts to expand health coverage to both adults and children, regardless of immigration status. From 2000 to 2005, the pilot program was administered by the Alameda Alliance for Health, a public, non-profit Medi-Cal (Medicaid) managed health care plan. The Alameda Alliance for Health was the first local initiative health plan in California launched during the time that the State of California began mandating Medi-Cal beneficiaries to enroll in managed care plans in the mid-1990s.

Community support. Support for the outreach and evaluation of Alliance Family Care was provided by members of the Alameda County Access to Care Collaborative, a group of stakeholders representing Alameda County's health care safety net institutions. The Alameda County Access to Care Collaborative formalized its membership in 2001 with the goal of advancing universal health coverage and improving access to health care in Alameda County. Members worked closely with the Alameda County Board of Supervisors, the local body of elected officials that governs county funds and resources. The Alameda County Access to Care Collaborative comprises the following:

- Alameda County Health Care Services Agency,
- Alameda County Social Services Agency,
- Alameda County Medical Center (a county public hospital system),
- Alameda Alliance for Health,
- Alameda Health Consortium, a non-profit association of eight federally-qualified community health centers, and
- Community Voices-Oakland, a collaborative project focused on immigrant access to health care and funded by the W.K. Kellogg Foundation. The collaborative partnership for the project comprises two non-profit, federally-qualified community health centers, Asian Health Services and La Clínica de La Raza, and the Alameda Health Consortium.

Staff of Community Voices-Oakland served as the conveners for the Alameda County Access to Care Collaborative. Staffing was also provided through the Communities in Charge project, a project of the Alameda Health Consortium and funded by the Robert Wood Johnson Foundation.

Demographics. Alameda County, California has a population of more than 1.4 million residents, with 11% living below the federal poverty level. In Alameda County, 27% of the residents, or more than 375,000 people, were born in a country other than the U.S., and 37% of all Alameda County residents speak a language other than English at home.[22] The county has two Medi-Cal managed health care plans: the Alameda Alliance for Health, and Blue Cross, a private, commercial health plan.

Number of uninsured. During the time that Alliance Family Care was launched, it was estimated that approximately 167,000 people in Alameda County were uninsured. In 2000, a county-wide telephone survey of uninsured adults called the County of Alameda Uninsured Survey estimated that at least 147,000 adult residents of Alameda

County were uninsured.[26] The UCLA Center for Health Policy Research's 2001 California Health Interview Survey estimated the number of uninsured children in Alameda County to be 19,000.[27]

Among the uninsured adults, 13,000 were considered eligible for Alliance Family Care. More than half (53%) of the total number of uninsured adults in Alameda County were immigrants.[23] The survey, conducted in 6 languages, was led by Dr. Ninez Ponce of UCLA and financed by Community Voices-Oakland, the Alameda County Health Care Services Agency, and the Alameda Alliance for Health.

Design of Alliance Family Care. In the late 1990s, the Alameda Alliance for Health, the Alameda County Health Care Services Agency, and leaders of Alameda County's health care safety net designed Alliance Family Care. Because the planners recognized that many uninsured residents of Alameda County were immigrants, some undocumented, Alliance Family Care excluded immigration status as an eligibility criterion, effectively removing any immigration-related enrollment barriers for this new health coverage program.

In addition, Alliance Family Care was open to adults. The decision to include adults in the design of Alliance Family Care was based on the understanding that adults make up the bulk of the uninsured in the U.S. The decision was also based on the notion that if a health coverage program can cover entire families, both children and parents, the likelihood that all members of the family will access health services in a timely manner will increase. In fact, research indicates that children are less likely to see a health care provider or get a well-child visit if one or both of their parents remain uninsured.[28]

This new gap coverage product, launched in July 2000, was open to any uninsured resident of Alameda County who met the following criteria:

- currently uninsured,
- resident of Alameda County,
- ineligible for public programs such as Medi-Cal or the Healthy Families Program,
- household income up to 300% of the federal poverty level,
- at least one child enrolled in another program of Alameda Alliance for Health, such as Alliance Family Care, Medi-Cal or the Healthy Families Program.

Benefits included medical, dental, vision, pharmacy, acupuncture and chiropractic services. Enrollees were expected to pay premiums, which ranged from $20 to $120 per member, per month (N. Maruyama, personal communication).

Alliance Family Care was designed to offer affordable health care coverage for eligible families. At the time that Alliance Family Care was launched, a family of three living at 300% of the federal poverty level had a yearly income of approximately $42,000.[29] In order to keep premiums and co-pays affordable for families who were living at and below this income level, the program was heavily subsidized.

The Alameda Alliance for Health committed the largest amount of subsidies, amounting to approximately $20 million in health plan reserves over a four-year period. An additional $1.85 million from Alameda County tobacco master settlement funds and more than $4 million from private foundation grants subsidized the

program. Revenue was also derived from member premiums (A. Flores-Witte, personal communication).

Enrollment. There was no formal marketing plan for Alliance Family Care. Instead, enrollment was conducted by the Alameda Alliance for Health through its established provider network, including the community health centers. For example, staff of Asian Health Services and La Clínica de La Raza, with support from the Community Voices initiative, conducted intensive community outreach during the initial phase of Alliance Family Care. After less than 3 years, the Alameda Alliance for Health, community health centers, and school-based health centers enrolled more than 7,500 adults and children into the program. An additional 3,000 people were placed on a waiting list for the program, attesting to the high demand for coverage. (A. Flores-Witte, personal communication).

Demographic profile of Alliance Family Care members. Enrollees of Alliance Family Care reflected the demographic makeup of the uninsured population of Alameda County. The majority of Alliance Family Care members were adults (70%). Many of the adult members were immigrants, including undocumented immigrants (see Table 2.) The largest racial/ethnic groups of Alliance Family Care enrollees were Latino (55%) and Chinese (25%). According to an evaluation study by the University of Michigan and funded by the Robert Wood Johnson Foundation and the California HealthCare Foundation, the typical Alliance Family Care enrollee was an immigrant woman in her mid-thirties, living in five-person household, with an annual household income of $23,000.[30]

One-third of the enrollees never had insurance in their lives before enrolling into Alliance Family Care. Despite having no previous history of having health coverage, enrollees demonstrated a willingness and ability to pay monthly premiums. Retention in the program was high, with a 2% dis-enrollment each month.[30]

Although there was limited medical underwriting for Alliance Family Care, with less than 1% of all applicants denied coverage, members of Alliance Family Care typically were healthy. Even with its limited form of medical underwriting, the program did not suffer from adverse selection.[30]

Utilization patterns. Most notably, health insurance increased the use of preventative services. The University of Michigan study documented that during the 12-month period after enrollment into Alliance Family Care, members increased their use of preventative services within the first year of enrollment in the program.[30]

Qualitative evaluation. In 2001, Community Voices-Oakland supported a qualitative evaluation of Alliance Family Care to review member satisfaction during the first year of implementation, and to provide information for future program improvements (Evans/McDonough Company, Inc. Results of qualitative research: Focus groups among Alliance Family Care members, 2002.) Focus group results included the following highlights:

- members felt positive about their overall health care experiences in Alliance Family Care;
- many received assistance with enrollment and suggested that forms to be in languages other than English, although overall, the enrollment process was considered simple and quick;

Table 2.

ALLIANCE FAMILY CARE ENROLLEES, AUGUST 2002

	Number of Enrollees	Percentage of Enrollees
Adults and children not eligible for Medicaid or SCHIP due to income or categorical restrictions	3657	49
Children, ages 0–18 years, not eligible for Medicaid or SCHIP due to immigration status (undocumented)	1722	23
Adults, ages 19 and older, not eligible for Medicaid or SCHIP due to immigration status (undocumented)	2130	28
Total Enrolled	7509	100

Source: Alameda Alliance for Health, 2005.

- all were aware that citizenship was not an eligibility requirement;
- all agreed that they get value for the cost of Alliance Family Care and that the co-payments were affordable;
- members noted access problems such as long wait times for appointments and on phone lines;
- addition of coverage for alternative medicines was a popular suggested change.

Local lessons. Despite the initial success of the program, Alliance Family Care was not financially viable beyond its pilot phase of five years. In 2005, the Alliance Family Care program enrollment was gradually reduced based on seniority and then eventually closed altogether. Effectively, those who were dis-enrolled became uninsured. Families with incomes below 200% of the federal poverty level qualified for a limited range of medical services at community health centers that are financed by a county-funded indigent care program (A. Flores-Witte, personal communication).

After five years of operating Alliance Family Care, members of the Alameda County Access to Care Collaborative concluded that significant federal and state support is critical to sustaining local efforts to cover the uninsured. While private foundation funds are critical in supporting the initial stages of health coverage program design, implementation, and evaluation, these funds cannot be expected to provide an adequate level of health coverage premium subsidies that are needed to make health coverage affordable for low-income populations. Similarly, health plan reserves are insufficient to support a comprehensive model of health coverage for a large number of uninsured residents for a long period of time.

As with other health coverage programs in the state, the challenges of sustaining local health coverage program for low-income families are financially formidable.

17.1hirota.indd 89 1/3/06 10:31:19 AM

The failure of state and federal policymakers to commit resources to expand health coverage for working families is perhaps the greatest factor undermining local interest in covering the uninsured.

Certainly for Alliance Family Care, which covered adults and a large number of immigrants, the decision by the state not to provide a state share of funds for a federally-approved parental expansion of Healthy Families was problematic, as was the unavailability of additional federal Medicaid and SCHIP funds to serve immigrant families. Economic factors leading to reductions in private foundation funds, and state and local budget cuts also contributed to the challenges of maintaining a local health coverage program over the long run.

Health Coverage Financing

The case of Alliance Family Care in Alameda County, California and other local initiatives throughout the country demonstrate the political and financial commitment of local governments, health plans, and private foundations to expand health coverage for low-income families. The experience of Alliance Family Care also demonstrated that low-income families will contribute a share of the cost by paying regular premiums, if they are made affordable. Despite these local efforts, it was found that local health coverage programs cannot be sustained over the long run in the absence of federal and state government support.

The Bush administration has made some investments in local communities by expanding community health centers in low-income and medically underserved areas. The cost-effectiveness of community health centers and their ability to provide optimal health care to low-income and racially diverse populations is well-documented.[31,32,33] However, broader reform may be in order, as community health centers are still unable to meet the demands of the growing number of uninsured. Furthermore, community health centers do not have the capacity to provide the full range of necessary medical services, such as specialty care (e.g., radiology, dermatology, ophthalmology) and hospital services. Most of the uninsured therefore, are still likely to seek care at emergency departments at the late stages of illness or not seek care at all.

The administration has also expressed a desire to scale down Medicaid, and stimulate the private purchase of health plans and medical services through the use of individual health savings accounts and new tax credits.[34,35] Tax credits may encourage some to purchase coverage, but tax credits will do little to mitigate the financial impact of health coverage premiums and other out-of-pocket medical costs for very low-income families.[36] Furthermore, individuals with illness face the risk of insurance companies denying them coverage altogether. Therefore, those who lose Medicaid coverage under the proposed reforms are likely to remain uninsured.

Creating a stable federal tax base to finance health coverage may be the first step in securing health coverage for all residents. The rapidly growing federal deficit, $427 billion in fiscal year 2005, is currently the greatest obstacle to achieving universal health coverage, but is not insurmountable, particularly in view of the fact that in the period of one year, federal, state, and local governments already spend $34.6 billion in medical care for the uninsured in the U.S.[37,38]

Recent voter activity in California indicates that many voters are willing to accept new taxes to subsidize health care. Voters in both Alameda County and Los Angeles County passed laws to increase sales taxes and county property taxes, respectively.[39, 40] Both laws established new sources of county revenue for hospital services and other critical health care services. In 2004, California voters passed three state propositions to finance health-related programs.[41] The propositions authorized the borrowing of funds, the imposition of an additional income tax on millionaires, and increases in property taxes.

California policymakers and voters continue to debate the expansion of health coverage to more Californians, despite the constrained budgetary environment. Last year, California voters repealed, by less than a 2% margin, a state *pay-or-play* law mandating that employers provide health coverage to employees and their dependents or pay into a state fund to finance a state health coverage program for workers.[42, 43] The law would have extended coverage to approximately one million workers and their dependents. The narrow margin by which the law was repealed indicates that California voters are evenly split on their views of employers who are not already offering coverage.

State legislators also recently debated a proposal (which has since stalled in a state legislative committee) to mandate that individuals purchase health insurance in the same manner that drivers are required to purchase car insurance.[43] To keep the premiums low and the mandate affordable, the proposal included an option to purchase insurance products with relatively low premiums, but with high deductibles (up to $5,000). While the proposal may have stimulated some residents to purchase health coverage, it is unlikely that many low-income families could afford to pay the high deductible that is required prior to accessing critical services.

California legislators have also proposed legislation aimed at covering all children in California. State Assemblywoman Chan (D-Oakland) proposed the consolidation of the existing local children's health coverage programs under one state program.[44] The proposed program, recently vetoed by Governor Schwarzenegger, would have covered children under age 21, regardless of citizenship status.

State Senator Kuehl (D-Santa Monica) has put forth perhaps the boldest, if also politically challenging, proposal, which would require the elimination of all public and private health plans and establish the state government as the insurer for all Californians.[45] Under this proposal, Californians would get coverage for dental, vision, substance abuse and mental health, home health and adult day care services, as well as primary medical care. The Kuehl proposal has received attention, particularly in light of a recent analysis by the Lewin Group that concluded that the proposal could achieve $343.6 billion in overall savings over the next ten years, with $43.8 billion in savings for state and local governments; the savings would result from cuts in administrative costs, and bulk purchasing of prescription drugs and medical equipment.[47]

Proposals such as these that seek to provide comprehensive coverage to all residents, while promoting the efficient use of existing public health financing dollars, are the likely to provide the most relief to local communities like Alameda County, which, despite the presence of a local gap coverage program, continues to have high numbers of uninsured.

Conclusion

Low-income immigrants represent one of the many groups in the U.S. that are left out of efforts to cover the uninsured. Women who do not have children and low-income men are other examples of categories of populations that are generally excluded from Medicaid, SCHIP, and other public policy initiatives aimed at improving access to health care for the poor.[48]

The financial resources that federal, state, and local governments are patching together to provide medical care for these uninsured groups could be used more efficiently if consolidated at a state or federal level. Coupled with a stable tax base, federal and state leadership achieve more comprehensive and sustainable health coverage efforts, providing families with more security for the long term.

Securing health coverage for all is an expensive proposition in the short run, but it is not impossible if there is the vision and the political commitment to get the job done. Stabilizing the federal tax base and recognizing the phenomenal amount of federal, state, and local government funding that is already spent on medical care for uninsured populations not covered by existing health coverage programs are the first steps towards achieving this lofty goal.

Notes

1. DeNavas-Walt C, Proctor BD, Mills RJ. Income, poverty, and health insurance coverage in the United States: 2003. U.S. Census Bureau, Current Population Reports, P60-226. Washington, DC: U.S. Government Printing Office, 2004.
2. Hoffman C, Carbaugh A, Cook A. Health insurance coverage in America: 2003 data update. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured (KCMU), Urban Institute, 2004 Nov.
3. Feagin JR. Old poison in new bottles: the deep roots of modern nativism. In: Perea JF, ed. Immigrants out!: The new nativism and the anti-immigrant impulse in the United States (Critical America) New York: New York University Press, 1997.
4. Schildkraut DJ. The more things change . . . American identity and mass and elite responses to 9/11. Political Psychology. 2002 Sep;23(3):511.
5. Kaincar L. Post 9/11 domestic policies affecting U.S. Arabs and Muslims: A brief review. Comparative Studies of Asia, Africa and the Middle East. 2004;24(1).
6. O'Harrow Jr. R, Higham S. U.S. border security at a crossroads. Washington Post. 2005 May 23.
7. Eggen D, Tate J. U.S. campaign produces few convictions on terrorism charges. Washington Post. 2005 June 12.
8. Clune MS. The fiscal impacts of immigrants: a California case study. In: Smith JP, Edmonston B, eds. The immigration debate: studies on the economic, demographic, and fiscal effects of immigration. Washington, DC: National Academy Press, 1998.
9. Mosisa AT. The role of foreign-born workers in the U.S. economy. Monthly Labor Review. 2002 May;125(5):3–14.
10. Cairncross F. The longest journey: a survey of migration. The Economist. 2002 Nov 2;365(8297):1–16.
11. Porter E. Illegal immigrants are bolstering Social Security with billions. New York Times. 2005 Apr 5.
12. Brach C, Fraser I. Reducing disparities through culturally competent health care: an analysis of the business case. Qual Manag Health Care. 2002 Summer;10(4):15–28.

17.1hirota.indd 92 1/3/06 10:31:20 AM

13. Betancourt J, Green A, Carillo JE, et al. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003 Jul–Aug;118(4):293–302.
14. Weissman JS, Betancourt J, Campbell EG, et al. Resident physicians' preparedness to provide cross-cultural care. JAMA. 2005 Sep 7;294(9):1058–67.
15. Himmelstein DU, Warren E, Thorne D, et al. MarketWatch: Illness And Injury As Contributors To Bankruptcy. Health Aff (Millwood). 2005 Feb 2;[Epub ahead of print].
16. Gurewich D, Prottas J, Seifert R, et al. Medical debt and consumer credit counseling services. J Health Care Poor Underserved. 2004 Aug;15(3):336–46.
17. Institute of Medicine (IOM), Committee on the Consequences of Uninsurance. Lessons from previous reports. In: IOM, Committee on the Consequences of Uninsurance. Insuring America's health: principles and recommendations. Washington, D.C.: National Academies Press, 2004.
18. Ojeda V, Brown ER. Mind the gap: parents' citizenship as predictor of Latino children's health insurance. J Health Care Poor Underserved. 2005 Aug;16(3):555–75.
19. Ku L, Matani S. Left out: immigrants' access to health care and insurance. Health Aff (Millwood). 2001 Jan–Feb;20(1):247–56.
20. Granados G, Puvvula J, Berman N, et al. Health care for Latino children: impact of child and parental birthplace on insurance status and access to health services. Am J Public Health. 2001 Nov;91(11):1806–7.
21. Ku L, Freilich A, The Urban Institute. Caring for immigrants: health care safety nets in Los Angeles, New York, Miami, and Houston. Washington, DC: KCMU, 2001 Feb.
22. Chamberlain LJ, Hughes DC, Bishop JS, et al. Universal health care coverage for children: impact on pediatric health care providers. J Health Care Poor Underserved. 2005 Nov;16(4):622–33.
23. Frates J, Diringer J, Hogan L. Models and momentum for insuring low-income, undocumented immigrant children in California. Health Aff (Millwood). 2003 Jan–Feb;22(1):259–63.
24. The California Endowment. Health insurance coverage for all children: a goal within reach. (Health . . . in Brief. 2004 Jun;3(2):1–4). Woodland Hills, CA: The California Endowment, 2004 Jun.
25. U.S. Census Bureau. DP-3. Profile of selected economic characteristics: 2000 data set: Census 2000 summary file 3 (SF 3) – sample data, geographic area: Alameda County, California. Washington, D.C.: U.S. Census Bureau, 2005. Available at http://factfinder.census.gov/servlet/QTTable?_bm=n&_lang=en&qr_name=DEC_2000_SF3_U_DP3&ds_name=DEC_2000_SF3_U&geo_id=05000US06001.
26. Ponce N, Conner T, Barrera BP, et al. Advancing universal health insurance coverage in Alameda County: results of the County of Alameda Uninsured Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2001 Sep.
27. University of California, Los Angeles Center for Health Policy Research, California Department of Health Services, Public Health Institute. 2001 California Health Interview Survey. Los Angeles, CA: The Regents of the University of California, 2005. Available at http://www.chis.ucla.edu/main/DQ2/easy/output.asp.
28. Davidoff A, Dubay L, Kenney G, et al. The effect of parents' insurance coverage on access to care for low-income children. Inquiry. 2003 Fall;40(3):254–68.
29. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The 2000 HHS poverty guidelines. Federal Register. 2000 Feb 15;65(31):7555–7. Available at http://aspe.hhs.gov/poverty/00poverty.htm.

30. Taylor EF, Kullgren JT, McLaughlin CG. Who enrolls in a program for parents of publicly insured children? Health Aff (Millwood). 2003 Jul–Dec;Suppl Web Exclusives: W3-460-71.
31. Hadley J, Cunningham P. Availability of safety net providers and access to care of uninsured persons. Health Serv Res. 2004 Oct;39(5):1527–46.
32. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. Pediatrics. 2004 May;113(5 Suppl):1493–8.
33. Hawkins D Jr, Schwartz R. Health centers and the states. Partnership potential to address the fiscal crisis. J Ambul Care Manage. 2003 Oct–Dec;26(4):285–95.
34. Kaiser Commission on Medicaid and the Uninsured. Bush Administration Medicaid/ SCHIP Proposal. Washington, DC: The Henry J. Kaiser Family Foundation, May 2003.
35. President George Bush, The White House. Making health care more affordable. Washington, D.C.: The White House, 2004. Available at http://www.whitehouse.gov/ news/releases/2004/09/20040902.html.
36. Reschovsky JD, Hadley J. The effect of tax credits for nongroup insurance on health spending by the uninsured. Health Aff (Millwood). 2004 Jan–Jun;Suppl Web Exclusives: W4-113-27.
37. Weisman J. Record '05 deficit forecast: war costs to raise total to $427 billion. The Washington Post. 2005 Jan 26; p. A01.
38. Hadley J, Holahan, J. The cost of care for the uninsured: what do we spend, who pays, and what would full coverage add to medical spending? Washington, D.C.: KCMU, 2004.
39. Vesely R. Sales tax hike got 71% of county's vote. Oakland Tribune. 2004 Mar 4.
40. Ornstein C, Rabin J, Richardson L. L.A. trauma care network is revived, but at a cost. Los Angeles Times 2002 Nov 7;Sect A:1.
41. California Legislative Analyst Office. Ballot Propositions. November 2, 2004 Ballot. Sacramento, CA: Legislative Analyst Office, 2004. Available at http://www.lao.ca.gov/ ballot_source/Propositions.aspx?d=11%2f2%2f2004
42. Sinaiko A. Employers' responses to a pay-or-play mandate: an analysis of California's health insurance act of 2003. Health Aff (Millwood). 2004 Jul–Dec;Suppl Web Exclusives:W4-469-79.
43. Lauer G. Outcome of health-related ballot measures has implications for future reform efforts. California: California Healthcare Foundation, 2004. Available at http://www. californiahealthline.org/index.cfm?Action=dspItem&itemID=111100&classcd=CL1 26#.
44. Legislative Counsel, State of California. Current bill status, measure A.B. No. 1671. Sacramento, CA: State of California, 2005. Available at http://www.leginfo.ca.gov/pub/ bill/asm/ab_1651-1700/ab_1671_bill_20051117_status.html.
45. Legislative Counsel, State of California. Current bill status, measure A.B. No. 772. Sacramento, CA: State of California, 2005. Available at http://www.leginfo.ca.gov/pub/ bill/asm/ab_0751-0800/ab_772_bill_20051025_status.html.
46. Legislative Counsel, State of California. Current bill status, measure S.B. No. 840. Sacramento, CA: State of California, 2005. Available at http://www.leginfo.ca.gov/pub/ bill/sen/sb_0801-0850/sb_840_bill_20050722_status.html.
47. Sheils JF, Haught RA. The Health Care for All Californians Act: Cost and economic impacts analysis. Lewin Group, 2005 Jan 19.
48. Centers for Medicaid & Medicare Services. Who is eligible for Medicaid. Baltimore, MD: Centers for Medicaid & Medicare Services, 2004. Available at: http://www.cms. hhs.gov/medicaid/whoiseligible.asp.