New American Economy

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Immigrants Contribute More in Private Insurance Premiums than they Receive in Benefits

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Background

Politicians often raise concerns that immigrants drain U.S. health care resources.[1] However, research suggests that immigrants may contribute more in premiums and taxes to the health care economy than they receive in health care services.

Immigrants—and particularly undocumented immigrants—use relatively little health care.[2–9] For example, in several studies, we've found that immigrants pay many billions of dollars in payroll taxes that fund Medicare, but relatively few immigrants use care funded by Medicare.[5,9,10] On balance, between 1996 and 2011, immigrants contributed $182.4 billion more to the Trust Fund than the Trust Fund spent for their care. In essence, immigrants helped keep the Trust Fund solvent.[10]

Health coverage options for immigrants are limited. Most immigrants who are undocumented or have been legally present in the United States for less than five years are not eligible for coverage under public programs such as Medicaid. Undocumented immigrants are also ineligible for subsidized insurance through the Affordable Care Act's (ACA) insurance exchanges (also known as "marketplaces"). Hence, for many immigrants, non-marketplace private insurance is the only available option for health coverage. Non-marketplace private insurance includes any insurance that is provided directly by one's employer or has been purchased individually (e.g., by self-employed workers or small business owners). In short, before 2014 and the ACA, these types of private health insurance were the main type of private health insurance available to people in many states.

Prior work on this subject has also found that immigrants subsidize U.S.-born Americans in the private health insurance market. By calculating the private health insurance premiums paid by, or on behalf of immigrants, and the amounts that private insurers spent for their care, it was estimated that between 2008 and 2014 immigrants contributed $174.4 billion more in premiums than insurers paid out for their care, while, in aggregate, insurers incurred a net loss on the coverage of U.S.-born persons.[11] While this might seem to imply that insurers would avoid covering U.S.-born persons, the situation is more complex.

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The vast majority of people with private insurance are covered as part of a group through their employer. Most such groups include a majority of individuals who are profitable for insurers, and a relative few who incur extremely high medical costs and are big money losers for the insurer. When an insurer markets its plan to an

employer it assesses the expected medical costs of the overall group and sets the premiums accordingly (premiums in employer groups must, by law, be the same for all members of the group). The main predictors of expected medical costs are the employees' ages and their utilization of care in the past year. The relatively young average age of immigrant workers probably explains most of the reason they are, on average, more profitable for insurers than U.S.-born individuals. Once age and their past-year utilization of care are taken into account, immigrant status itself is unlikely to be an important predictor of future medical costs. In essence, all else being equal, insurers are likely to offer lower premiums to employer groups with a mix of immigrants and U.S.- born persons, with immigrants effectively providing a cross subsidy to U.S.-born enrollees. Conversely, employer groups without immigrants are likely to pay slightly higher premiums for coverage on average. Although not explored in this brief, a similar dynamic applies to the relatively small share of private insurance plans purchased through the ACA exchanges. In that market, insurance firms must charge uniform premiums to all enrollees in a particular locale (with some adjustment for age and smoking status). Given that insurers set their premiums based on past experience with all enrollees in the locale, areas with more immigrant enrollees would tend to have lower premiums, with a small cross subsidy within each group from immigrants to U.S.- born enrollees.

In this brief, we examine immigrants' contributions to private non-exchange insurance between 2012 and 2018 nationally and in states with large numbers of immigrants.

Results

Between 2012 and 2018 each immigrant with private insurance contributed, on average, $1,182 more in premiums than their insurer spent for their care. In contrast, the U.S.-born had an average deficit of $155 per capita.

TABLE 1: IMMIGRANT AND U.S.-BORN PERSONS' PER CAPITA CONTRIBUTIONS, EXPENDITURES, AND NET CONTRIBUTIONS, 2012-2018

	Immigrants			U.S.-Born		
Year	Contribution	Withdrawals (Spent on their behalf)	Net Surplus (Loss)	Contribution	Withdrawals (Spent on their behalf)	Net Surplus (Loss)
2012	$3,948	$2,620	**$1,328**	$3,081	$3,229	**($148)**
2013	$3,813	$2,880	**$932**	$3,045	$3,156	**($111)**
2014	$3,289	$2,300	**$989**	$2,955	$3,083	**($128)**
2015	$3,243	$2,502	**$741**	$2,991	$3,091	**($101)**
2016	$3,431	$2,225	**$1,206**	$3,021	$3,188	**($167)**
2017	$3,406	$2,082	**$1,324**	$3,015	$3,207	**($192)**
2018	$3,673	$1,916	**$1,757**	$3,078	$3,316	**($238)**

Over the 7-year period between 2012 and 2018, immigrants contributed $201 billion more in private insurance premiums than insurers spent on their care. Non-citizen immigrants accounted for nearly $117 billion of that surplus.

FIGURE 1: PRIVATE HEALTH INSURANCE NET SURPLUS OR DEFICIT ATTRIBUTABLE TO IMMIGRANTS, NON-CITIZEN IMMIGRANTS, AND THE U.S.-BORN, 2012-2018

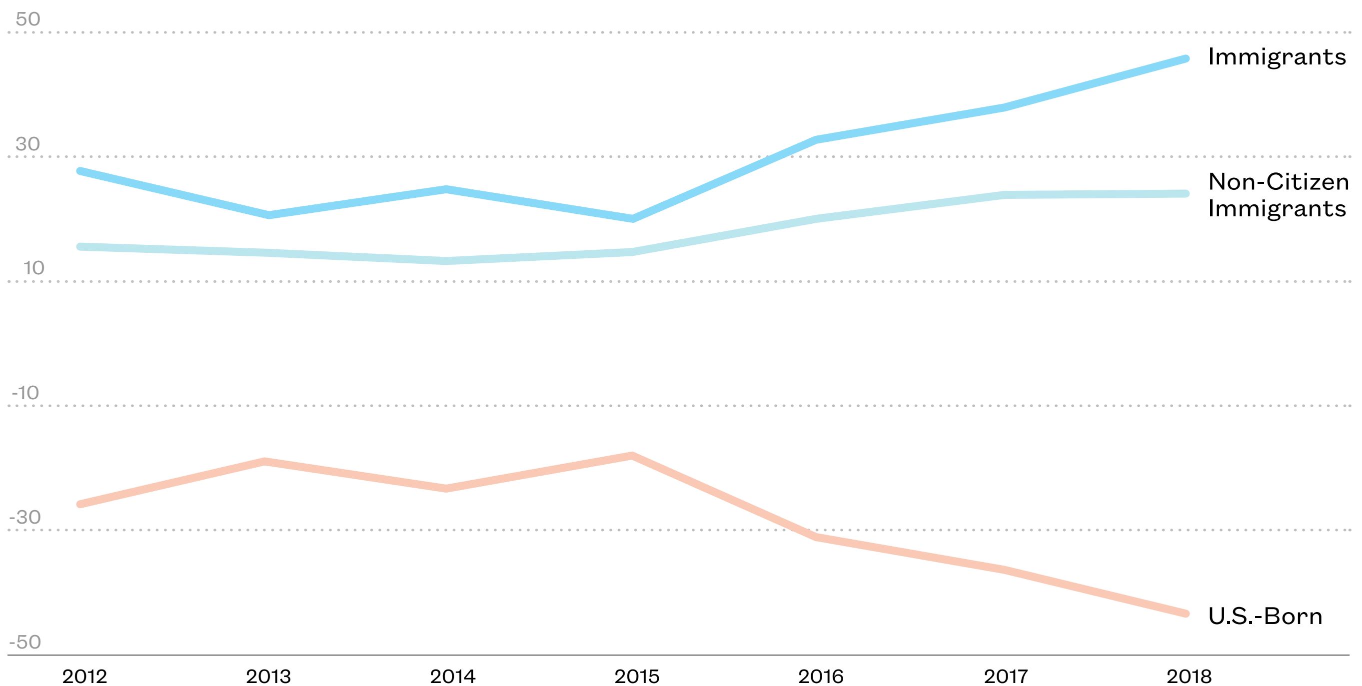

TABLE 2: IMMIGRANT AND U.S.-BORN PER CAPITA CONTRIBUTIONS TO AND WITHDRAWALS FROM PRIVATE INSURANCE BETWEEN 2012 AND 2018 IN THE STATES WITH LARGE IMMIGRANT POPULATIONS, 2012-2018

	Immigrants			**U.S.-Born**		
State	Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)	Contributions	Withdrawals (Spent on their behalf)	Net Surplus (Loss)
CA	$3,545	$2,428	**$1,117**	$2,808	$3,132	**($324)**
TX	$3,420	$1,876	**$1,544**	$2,888	$3,134	**($245)**
NY	$3,478	$2,357	**$1,121**	$3,021	$3,270	**($249)**
FL	$3,212	$2,234	**$979**	$2,778	$3,004	**($226)**
AZ	$3,281	$1,774	**$1,508**	$2,846	$3,059	**($214)**
MA	$3,588	$2,120	**$1,468**	$3,340	$3,595	**($255)**
NJ	$3,545	$2,259	**$1,286**	$3,196	$3,510	**($315)**
IL	$3,767	$2,689	**$1,078**	$3,023	$3,174	**($151)**
GA	$3,911	$3,059	**$851**	$3,028	$3,117	**($88)**
VA	$3,745	$2,441	**$1,304**	$3,292	$3,480	**($188)**
WA	$3,785	$2,688	**$1,097**	$3,196	$3,355	**($159)**

Conclusions

The data show that immigrants play a vital role in subsidizing private health insurance and offsetting the deficit incurred by U.S.-born individuals. This is mostly due to immigrants incurring fewer expenditures.

These findings contradict claims that persons born in the United States subsidize the medical care of immigrants. These claims have focused on immigrants' use of uncompensated care and Medicaid. However, they ignore the fact that immigrants contribute large subsidies to Medicare's Trust funds,[5,9,10] and, we find, that immigrants also provide tens of billions in cross subsidies annually to U.S.-born enrollees in private group insurance plans that cover many immigrants, along with U.S.-born persons.[11]

Our findings are consistent with past work suggesting immigrants tend to have lower healthcare spending and that they subsidize private group insurance.[3,4,9,11] Per capita private insurance contributions and expenditures have increased among both U.S.-born persons and immigrants since prior analyses which used earlier time periods—reflecting both inflation and rising healthcare costs. Similar to our prior work,[11] this new analysis has several methodologic strengths. We have looked at both contributions and expenditures rather than expenditures in isolation[2,3] and have taken steps to improve estimation of contributions and expenditures (see methodology for details).

Lower health expenditures among immigrants probably reflect, in part, language and other barriers they face when seeking care. Lower expenditures may also reflect immigrant's better health on average. Immigrants as a group are younger than the U.S.-born population, and healthier due to the so-called "healthy immigrant" effect – the tendency of healthier-than-average persons to migrate in search of economic opportunity, and for less healthy persons to remain in their country of origin. Insurance firms view younger, healthier persons as "actuarially desirable," and enrolling them allows insurers to reduce the premiums of older, sicker enrollees. Public policies aimed at slowing the flow of immigration to the United States are likely to reduce the number of "actuarially desirable" persons and raise private insurance premium costs for U.S.-born Americans.

METHODOLOGY

Data Sources

Medical Expenditure Panel Survey

Out-of-pocket private insurance premiums and private health insurance expenditures were determined from the 2012-2018 Medical Expenditure Panel Surveys (MEPS). MEPS is a nationally representative survey of the U.S. civilian non-institutionalized population conducted by the Agency for Healthcare Research and Quality (AHRQ). Because MEPS provides detailed information on each respondent's health insurance, health care premium amounts (paid by or on behalf of the respondent), and health expenditures paid by insurers, it allows researchers to identify each respondent's private insurance premiums and expenditures. Our final 2018 MEPS sample included 29,338 respondents for whom place of birth could be identified.

Current Population Survey

To determine employer contributions to private insurance, we analyzed data for all ages from the March supplements to the 2013-2019 Current Population Survey (CPS), mostly reflecting premiums paid in 2012-2018. The CPS is a continuous monthly survey conducted jointly by the Census Bureau and the Bureau of Labor Statistics that provides detailed information on income and employment for the civilian non-institutionalized U.S. population.[12] The CPS included 180,101 respondents in the most recent year (2019, reflecting 2018 events). Each year's survey includes self-reported personal income (from all sources) for the previous calendar year.

METHODOLOGY CONTINUED

Immigrant and Citizenship Status

The CPS also provides information on respondents' birthplace and citizenship status. Although the MEPS does not include such data, each respondent's record in the MEPS can be linked to their record in the National Health Interview Survey (from which the MEPS sample is drawn), allowing determination of their nativity and citizenship status. We considered all participants born outside of the United States to be immigrants.

Calculating Contributions, Expenditures, Surpluses, and Deficits

Analyses were restricted to persons covered by non-Marketplace private insurance at any time during the year. Out-of-pocket premiums (i.e. those paid by households) for private insurance were estimated from the MEPS. We calculated the total annual out-of-pocket premiums for each individual, summing premiums across private plans for individuals with more than one private insurance plan. We used the policy identification number (included in MEPS) to determine which individuals were covered by each insurance plan.

Employer contributions to private insurance premiums were estimated using data from CPS. To calculate the person-level employer contribution for private insurance premiums we first calculated the total employer contributions for each health insurance unit family (individuals covered under the same insurance plan), and then divided this total employer contribution value for the unit by the number of members in the health insurance unit with private insurance. This yielded a per person estimate of employer contributions. As employer contributions were not collected and reported in the 2019 CPS (2018 analytic year), we used the totals from the year prior as an approximation of employer contributions for 2018. This assumption was almost certainly valid given the relative consistency in employer contribution amounts (and proportions made on behalf of immigrants) over time. The CPS caps (i.e. top codes) employer contributions, resulting in some under-estimation of such contributions. To address top-coding of premium contributions in the CPS, we first used figures from the National Health Expenditure Accounts (NHEA) to quantify the total underestimation likely due to top-coding for each year. We then adjusted net contributions by the inverse of the of our initial underestimate of expenditures to contributions. We subtracted this adjusted net contribution from the NHEA contribution and distributed this amount equally among top-coded individuals.

All expenditure data were derived from the MEPS, which collects data on expenditures of private insurance on behalf of each respondent. These amounts are then verified with providers. Extreme outliers in MEPS' individual out-of-pocket premium and expenditures for each year of data were identified by log-transforming the data and then applying Tukey's interquartile fence rule to identify outliers. We removed <0.1% of high outlier values each year; there were no extremely low values.

Private insurance expenditures measured via MEPS are not expected to sum to insurers' premium receipts (employer contributions plus individual contributions) as: 1) premiums include insurance overhead[13] and 2) individuals with high-costs and high service use are known to be underrepresented in MEPS.[14,15] To reflect and account for this underestimate, we adjusted our populationwide expenditure estimates to match the populationwide estimates of premiums in the NHEA.

We calculated annual total expenditures, total premiums, and net contributions among U.S-born persons, among all immigrants, and among a subset of noncitizen immigrants (including both legal noncitizen immigrants and undocumented immigrants). Net contributions were defined as the difference between premium payments (the sum of employer and individual premium contributions) and private insurers' expenditures for care. In addition to the

METHODOLOGY CONTINUED

totals, we also calculated per capita contributions for our groups of interest. All values were adjusted for inflation to 2018 dollars using the Consumer Price Index,[16] and all analyses of the MEPS and the CPS used sampling weights and appropriate statistical procedures to account for each survey's the complex sampling design.

State Specific Analyses

We used publicly available information in the CPS to determine state of residence. The MEPS provides state of residence in the restricted use files which we accessed through a special request. To ensure robust estimates, we pooled data across eight years (2012-2018) for states with the largest number of immigrants in the sample.

Data Appendix

Appendix Table 1: Immigrant and U.S.-born persons' total contributions, expenditures, and net contributions to private health insurance, 2012-2018

	Immigrants			U.S.-Born		
Year	Contributions, $	Expenditures, $	Net Surplus (Loss), $	Contributions, $	Expenditures, $	Net Surplus (Loss), $
2012	78,696,366,229	52,224,375,040	**26,471,991,189**	551,179,070,031	577,651,061,220	**(26,471,991,189)**
2013	81,435,004,461	61,522,027,719	**19,912,976,742**	547,261,860,423	567,174,837,165	**(19,912,976,742)**
2014	78,623,654,444	54,980,670,196	**23,642,984,248**	545,771,837,337	569,414,821,585	**(23,642,984,248)**
2015	83,011,619,847	64,041,509,935	**18,970,109,912**	564,174,456,105	583,144,566,017	**(18,970,109,912)**
2016	90,078,121,676	58,418,586,241	**31,659,535,435**	573,849,080,129	605,508,615,564	**(31,659,535,435)**
2017	93,676,408,399	57,269,859,530	**36,406,548,869**	571,384,521,074	607,791,069,943	**(36,406,548,869)**
2018	92,362,715,542	48,180,034,087	**44,182,681,455**	570,160,829,089	614,343,510,544	**(44,182,681,455)**

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DATA APPENDIX CONTINUED

Appendix Table 2: Immigrant and U.S.-born persons' total contributions, expenditures, and net contributions to private health insurance by state, 2012-2018

	Immigrants			U.S.-Born		
State	Contributions, $	Expenditures, $	Net Surplus (Loss), $	Contributions, $	Expenditures, $	Net Surplus (Loss), $
CA	135,162,933,014	92,563,689,193	**42,599,243,821**	368,995,336,560	411,594,580,381	**(42,599,243,821)**
TX	53,731,647,728	29,477,503,642	**24,254,144,086**	285,456,317,527	309,710,461,613	**(24,254,144,086)**
NY	57,503,900,170	38,962,355,035	**18,541,545,135**	225,119,931,145	243,661,476,280	**(18,541,545,135)**
FL	49,584,587,590	34,479,756,591	**15,104,830,999**	185,755,380,482	200,860,211,481	**(15,104,830,999)**
AZ	11,366,698,294	6,144,514,838	**5,222,183,456**	69,593,284,179	74,815,467,635	**(5,222,183,456)**
MA	18,408,895,744	10,876,334,214	**7,532,561,530**	98,721,705,368	106,254,266,898	**(7,532,561,530)**
NJ	31,088,871,584	19,810,629,947	**11,278,241,637**	114,496,151,055	125,774,392,692	**(11,278,241,637)**
IL	29,213,074,983	20,853,582,081	**8,359,492,902**	167,832,919,860	176,192,412,762	**(8,359,492,902)**
GA	15,508,439,964	12,132,184,983	**3,376,254,981**	115,854,587,811	119,230,842,792	**(3,376,254,981)**
VA	18,840,989,515	12,281,514,255	**6,559,475,260**	114,592,433,959	121,151,909,219	**(6,559,475,260)**
WA	16,392,516,598	11,643,335,987	**4,749,180,611**	95,419,287,680	100,168,468,291	**(4,749,180,611)**

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