The cross-sectional study by Ommerborn et al analyzes medical expenditures from public and private insurers as well as payments by immigrants, particularly undocumented immigrants, for health care services in the US. The broad strokes of this analysis are (1) immigrants generally use fewer health care services than similar US-born citizens and therefore have lower medical expenditures, and (2) immigrants typically pay taxes and health insurance premiums like most citizens, but (3) federal policies make it more difficult for many immigrants, particularly undocumented immigrants, to receive governmental health assistance from programs such as Medicaid, Medicare, and the Affordable Care Act health insurance marketplaces. The net result is that immigrants generally pay more into the health care system through taxes and premiums than they use in the form of expenditures for health care services. Thus, immigrants effectively help to subsidize the costs of health care for US citizens. The Social Security Administration has long acknowledged that the contributions of undocumented immigrants help sustain the Social Security Trust Fund for citizens.

The study by Ommerborn et al joins a series of articles by the late Leah Zallman, Steffie Woolhandler, David Himmelstein, and colleagues that analyze immigrants’ health care expenditures and payments. Their inquiries assess beliefs proffered by former President Trump and others that immigrants, particularly undocumented immigrants, take resources such as health care from citizens without paying for them. These beliefs are part of a broader set of disproven myths that include assertions that undocumented immigrants are criminals, immigrants harm the economy, and so on. Ommerborn et al provide empirically based data that may contribute to public debates about the role of immigrants in US society and public health policy.

The researchers have carefully pieced together estimates across multiple data sources to address issues of tax and premium payments and expenditures for private, public, and uncompensated medical care. They have been thoughtful in assembling the data for their estimates, although the findings need to be interpreted with some caution because of the inherent challenges in estimating total payments and health care costs for these populations.

Accurate data about undocumented immigrants are notoriously hard to find; the marginalized nature of this population makes data collection difficult. Surveys generally do not ask all of the necessary questions about immigration status, in part because asking these questions could cause respondents to incriminate themselves, posing legal and ethical challenges, and because asking detailed questions likely jeopardizes response rates from some populations. Thus, Ommerborn et al, like other researchers, impute legal status based on responses to other questions. However, the imputation process may be biased and weaken the estimates. For example, the lack of Medicaid coverage can be interpreted as evidence that a person is undocumented, although many documented immigrants also do not participate in Medicaid. Similar problems confound other estimates, such as the costs of uncompensated care, used in this analysis. Nevertheless, the broad findings of this study are meaningful, even if there are issues about the accuracy of each component.

This research establishes a better basis for public understanding and public policies on a topic that is politically controversial and often leads to polarization. Recent changes, such as the revisions to the Department of Homeland Security public charge regulations or the expansions of adult immigrants’ Medicaid eligibility in California, are signs of gradual progress in establishing greater equity in immigrants’ access to benefits.
ARTICLE INFORMATION
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