TENDENCIAS
Revista de la Facultad de Ciencias
Económicas y Administrativas.
Universidad de Nariño
Vol. XIII. No. 2 - 2do. Semestre 2012,
Julio - Diciembre - Páginas 52-83

THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) ON LATINO IMMIGRANTS IN THE STATE OF MINNESOTA

Implicaciones de la ley de protección al paciente y de acceso a cuidados (PPACA) en los inmigrantes latinos del Estado de Minnesota

By: Diego Mauricio Díaz Velásquez[1]

ABSTRACT

This paper analyzes how the reform in the health system of the United States of America presented in the year 2012 also known as Patient Protection and Affordable Care Act (PPACA), would impact the foreign born Latino Community in the State of Minnesota.

Key words: Patient protection and affordable care act –PPACA–, Minnesota, latino community, immigrants, health care, health insurance.

RESUMEN

El presente artículo analiza el impacto de la reforma en el sistema de salud de los Estados Unidos de América, también conocido como el Patient

1. Economist and Finance Specialist Universidad de Nariño. Project Manager and Developer in Health Services – Hospital Infantil los Ángeles Pasto. Lecturer in Public Policy Fundación Universitaria San Martín. Legislative Fellow U.S. State Department – Partners of the Americas. I would like to express my gratitude to: Diego Osuna Intern executive Director of CLUES, José William Castellanos mentor for the U.S. State department fellow at CLUES and Senior Director of the Family Centric and Health Promotion Program (FCHPP), Brenna Ouedraogo the Human Resources Director and Carla Kohler the FCHPP manager. Also, special thanks are expressed to Partners of the Americas especially the job done by Theresa McMenomy and Gabrielle Equale, also to Fundación Universitaria San Martín and especially to Juan Felipe Llovera Dean of the Finance and International Relations program as well as Ximena Ortega and Lyda María. Also special thanks to Universidad de Nariño and the editor of the TENDENCIAS Magazine Mrs. Ana María Córdoba Barahona and the University of Minnesota Health Inequalities research group of the Public Health program.

Fecha de recepción: 14 de mayo de 2012. Fecha de aprobación final: 10 de septiembre de 2012.

Protection and Affordable Care Act (PPACA), sobre las vidas de los inmigrantes nacidos en Latinoamérica y que viven en el Estado de Minnesota.

Palabras clave: Protección al paciente y cuidado de salud asequible, –PPACA–, Minnesota, comunidad latina, inmigrantes, cuidado de la salud, seguro de salud.

Clasification JEL: I10, I18

INTRODUCTION

The purpose of this paper is to illustrate how the new health reform in the United States, also known as the Patient Protection and Affordable Care Act (PPACA) could impact foreign born Latino communities living in the state of Minnesota. PPACA is the first step of the United States government to implement a universal healthcare system, where people regardless of their economic situation, social, pathologic or cultural background, could access to health services economically and efficiently.

At the same time, this paper is the result fulfilled as beneficiary of the Legislative Fellows program sponsored by the U.S. State Department. The results are intended to be delivered to the communities of Nariño, Colombia and Minnesota, United States. This document was possible through the guidance of the Latin based organization Comunidades Latinas Unidas en Servicio (CLUES) located in the Twin Cities (Minneapolis, St. Paul) in the state of Minnesota and Partners of The Americas, the partner organization with the U.S. State Department. This study would never been possible with the energetic and open team work environment that CLUES enhanced.

1. UNIVERSAL HEALTHCARE

It is important before focusing the discussing on the impact of PPACA to foreign born Latino community in Minnesota to acknowledge what Universal Healthcare means. Essentially, universal healthcare relates to the possibility of every citizen in a country to receive high quality health services. In the case of the United States, PPACA will allow universal healthcare coverage through a combined public-market approach (HEALTH PACK, 2012).

Literature suggests that universal healthcare began in Germany with Otto Von Bismarck's, a statesman who led the formal unification of Germany in the late eighteen hundreds. This unification was possible through a series of social ideas which promoted legislation to health insurance to all citizens by the government (Originality, 2012). Even though, universal

health coverage in Germany has been considered a Bismarck's political maneuver (Richard, 2008), it established a successful health system for all Germans until present days.

Otto Von Bismark's crafted the law to legitimate universal health insurance, but the system in Germany began earlier to Bismark proposal. In fact, before the law was implemented in Germany, workers of related activities joined together in groups to provide solutions to health problems (Richard, 2008). Workers joined to provide quotas to establish funds in order to facilitate health access or funeral services to group members. Usually, those groups were created within factories and other companies; with time, the company's owners also took responsibility in providing additional benefits, beginning what is now called today as employer-sponsored coverage.

By the beginning of the twentieth century, Britain was the other European country that began providing universal healthcare through the National Insurance Act in 1911, which was considered as the foundation of the social welfare in the United Kingdom. This act crafted the insurance contributory system in Britain for all citizens. The provision focused in helping sick and unemployed people (Politics, 2012).

After the Second World War, most European countries followed a healthcare reform in order to guarantee health services as a right for their population as well as to fulfill the 25th article of the Universal Declaration of Human Rights. The United States was the only developed country who signed but did not ratify the social and economic rights (Nations, 1948). Thereafter, most European countries implemented government based health systems to guarantee health rights to citizens and residents. On the other hand, the United States of America based the provision of healthcare services through the market system.

2. INSIGHT OF THE HEALTH SYSTEM IN THE UNITED STATES AND THE STATE OF MINNESOTA

2.1 The United States

The United States allows the market system as a mechanism for people to obtain health services. This means people on their own choice, could buy health insurance from a health providing company also called health insurer. Even though, the system is basically driven by the laws of supply and demand, the government has a significant influence in the health sector through two different schemes called Medicaid and Medicare. Medicaid is

a program funded between the federal government and the states to provide health services to low-income families which are citizens or legal residents who live in poverty and have not been able to purchase health insurance. In order to know when a person or household lives in poverty, the federal government through the Department of Human Health Services has established a poverty guidelines table where associates the number of people in a household and income earnings. Table 1 shows the Department of Health and Human Services (HHS) poverty guidelines by 2011.

Table 1. HHS Poverty guidelines related to income in the United States

Persons in Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270
For each additional person, add	3,820	4,780	4,390

Source: *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638.

On the other hand, Medicare is a program for people of 65 years or older, funded by the federal government covering health services to guaranty better life quality. Younger individuals with disabilities and terminal renal diseases could benefit from the program. Regularly, this plan does not fully cover all costs of health services; therefore, a person who receives services has to pay the part which is not guaranteed. Medicare is divided into two important categories known as the Original Medicare Plan and the Medicare Advantage Plan. Each category has 4 subcategories called "Parts" and each part is assigned an alphabetical letter from A to D.

When getting the Original Medicare, the person immediately receives Part A coverage. Part A provides hospital insurance and home care. Part A typically is provided free to people, for the reason people have been providing taxes to fund the program during their productive lives. Nevertheless, in the case a person does not qualify to receive free Medicare services there is

the option to buy Medicare coverage. When someone will buy Part A, also is required to buy Part B, then an individual has to pay a premium (The amount of money charged by an insurance company or the government to people and business for health coverage) for the two coverage plans (Human and health services, 2012).

Part B of Medicaid covers doctor services and it is also called medical insurance. Part B also covers outpatient care, durable medical equipment, and home health services. Part B is usually available to people who already have Part A. Alternatively, Part C is also called Medicare Advantage Plan and belongs to the main categories discussed before. Part C of Medicare is usually provided by private health insurers and most of the time includes Part A (Hospital Insurance), Part B (Medical Insurance) and Part D (Drug Insurance).

Part C will provide more services that are not contemplated in other Medicare parts. Part C Medicare, will provide money to health insurers to cover some of the services, but also will require the person to cover certain out-pocket costs.

Medicare Part D could be obtained either through Part C Medicare or as a standalone service providing coverage to prescription drugs. In order to get this plan, a person is required to sign up for a health policy offered by a private insurer which is approved by Medicare (HUMAN AND HEALTH SERVICES, 2012).

The mixed government-market healthcare system in the United States, even though has expanded in time, it has had issues regarding its effectiveness in allowing people to access affordably to health services. In fact, the United States is the country within the Organization for Economic Cooperation and Development (OECD) that holds the first place in spending most financial resources in healthcare compared to the percentage of Gross Domestic Product (15.2% of GPD in 2008). (WORLD HEALTH ORGANIZATION, 2009), nevertheless, the overall system has been ranked 37th place in the world in aspects of health provision, responsiveness and financing fairness (TANDON, 2008).

One of the problems with the healthcare system in the United States is the rising costs in providing services compared to any other country in the developed world. This problem causes premiums to go up, avoiding legal residents or citizens in the middle-class to obtain healthcare. One of the reasons behind the rising cost behavior is that new technology for treatment

is increasing the costs of services instead of reducing as normally expected. In fact, when a new technology is introduced in any other industry, (e.g. agriculture, aviation) the prices of finals goods and services lower down, because there is an increase in productivity originated by the implementation of new technology; however, this economic rationale appears not to be working within the health sector in the United States (Krugman & Well, 2006).

Another problem that explains the rising costs in healthcare in the United States is increase of chronic illnesses. The cases of heart disease or diabetes have risen in the last decade causing higher costs and leading to high premiums charged to people (Krugman & Well, 2006). One of the reasons that chronic illnesses have increased, is low investment in preventive healthcare. For example, cardiovascular diseases (e.g. heart disease, stroke) are the leading causes of mortality in the United States, and usually are expensive to take care of. Frequently, these types of diseases could easily be prevented through series of screenings to treat obesity risk factors. In fact, just 60% of adults undergoing obesity in the United States were counseled to exercise (Nebraska, 2009).

Furthermore, another problem that increases the costs of healthcare leading to increments in premiums is the administrative costs of insurers. The health insurers are organizations that obtain their benefits and profits between the money charged to people in their premiums and the expenses they incur while providing health services2. Insurance companies have a screening system which allows them to set the value of the premium. The screening system consists of examining historical and statistical information on habits and other types of illnesses of each individual, this information could be provided either by the person or the company the individual works for in order to establish a premium. When the screening results say that a person has a pre-existing condition (A health problem that existed before applying to the insurance plan) there are different outcomes that could occur.

Usually, the health insurance company will not provide health insurance to a person with a pre-existing condition, for the reason they have to spend more money on a health treatment for this individual probably for a long period of time. This factor shows the inequality in accessing to the healthcare system in the United States. When a person has a pre-existing condition, He/she is either denied of health services by the insurance com-

2. By law, in Minnesota is prohibited for private for profit institutions to provide health insurance. Just non-profit insurers are permitted.

pany or he/she is remitted to a waiting list where the insurance company could analyze better the case and see if any services could be provided.

Also, the increasing prices in drugs has been another factor that has incremented the costs of the healthcare in the U.S. As a matter of fact, 90% of seniors and 58% of non-elderly who have health coverage through a private insurance rely at least in a prescription drug in daily basis to keep healthy. Even though, such expenses just represent 10% of the whole healthcare expenditures done by insurance companies, the costs are significant. One of the reasons why prescription drugs have impacted health costs is the increasing demand they have gained in the last decade. By 2009, the percentage increase in prescription drugs was higher than the increase in population. Physicians tend to recommend newly prescription drugs that usually are more expensive than the ones they replace generally producing the same effects. Parallel to this, the investment in research and development done by the pharmaceutical companies, as well as the marketing campaigns they organize to promote the new medicines, have increased prices in a faster rate than any other product in the market (Kimbuende, Ranji, & Salganicoff, 2010).

Additionally to the factors mentioned above, the problem in high prices for prescription drugs and their rigidity to decline in time comes with the property rights on the drug. When a pharmaceutical company has invented a new drug, and the drug has fulfilled the controls undergone by the Food and Drug Administration (FDA) in order to offer the medicine to the marketplace, the company is given a patent of 20 years counting from the time the company fills for the rights, making it the only producer of the medicine. During this period of time, no other competitor is able to manufacture the drug, limiting the possibilities of creating a generic version of the medicine that could induce prices down. By the time the property right expires, it is known that the company fills for another property right on the drug with a new enhancement to continue holding the patent on the medicine (Kimbuende, Ranji, & Salganicoff, 2010).

Finally, another issue that arises with healthcare in the United States is the employment based insurance. There are two different ways how the healthcare works in order to provide health insurance in America. One way is for individuals to buy their own insurance; the other, is when a company hires people and pays the health insurance for workers. In the second option, the company puts the group of workers (also referred as pool) in a health insurance policy or plan with a defined premium which is covered by the company. Even though, this seems to be fair or reasonable, the problem about

it is that it limits individual choice. An individual when is subscribed to a group insurance plan does not have illegibility to choose what insurance package wants to have. The other problem that comes up with this type of insurance, is the link it has to employment, so in the case a person loses a job he/she will also lose healthcare, facing a double difficult situation.

2.2 Minnesota's healthcare

The federal government system in the United States of America, allows the country's states to design their own laws in order to guarantee more opportunities to people, in this case healthcare is included. Whatever it is necessary to do on healthcare, the states have freedom to do it. By 2012 the state of Minnesota has passed a health reform where it tries to improve community health, patient experience and affordability (Department of Human Services, 2012). There are two main important health programs offered by the state of Minnesota to their population, those programs are the following:

1. **Medical Assistance (MA).** It is Minnesota's Medicaid program. In the Fiscal Year 2011, MA provided services to 666.000 people. The population who benefited was low income senior citizens, children, parents and people with disabilities. As it was mentioned before, the Medicaid program is funded by the federal government and local states, but in Minnesota there is county participation in funding the program. In 2011, Minnesota's budget for the MA program was of 7.5 billion dollars and the participation share in the budget was mostly predominant by the federal government, Figure 1 shows the participation.

   In order to access this program, it is important for people in Minnesota to meet the poverty guidelines and a certain limit of assets. Minnesota has implemented its own assets guidelines which are subtly different to the ones designed by the federal government[3].

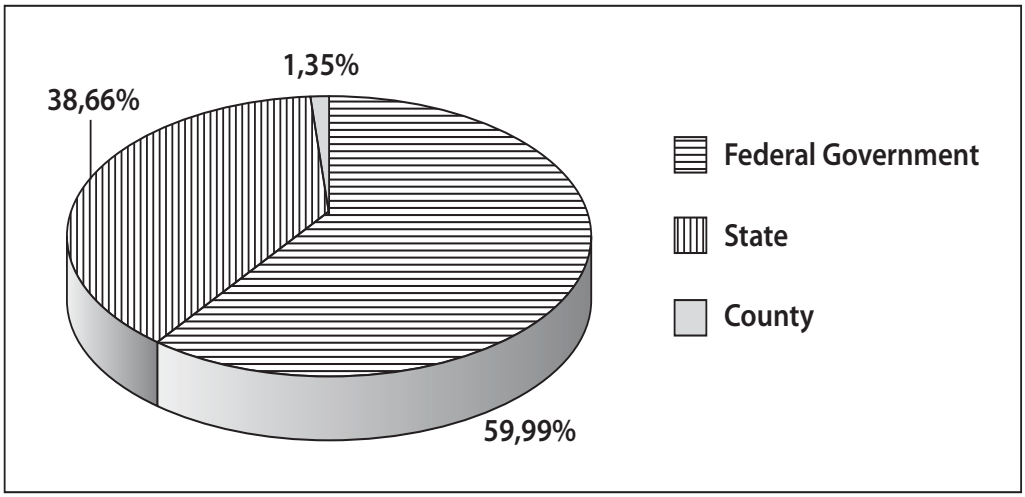
2. **Minnesota Care.** Minnesota Care is a program designed to allow Minnesotans (people who officially live in Minnesota) to access healthcare services when they are not able to afford it. Minnesota Care has become the most important safety-net for people in Minnesota when they are laid-off from work and they do not receive health coverage any longer.

3. Federal Income Guidelines are not usually limitations or boundaries for states to follow, they just provide a general perspective on how the low income range level is. The income guidelines for the state of Minnestoa could be found at: Minnesota Department of Human Services https://edocs.dhs.state.mn.us/lfserver/public/DHS-3182-ENG

The program is financed in this way: 68% by a tax charged to hospitals and healthcare providers, 27% of Medicaid Matching Funds[4], and 5% of enrollee premiums[5]. The program includes coverage for consulting a physician, access to preventive care and rehabilitation services.

Figure 1.

Budget participation in 2011 for funding the Medical Assistance Program (MA)



Source: Minnesota Department of Human Services.

MinnesotaCare is provided to individuals who at least have lived in Minnesota 180 days prior requesting services, be a United States citizen or a qualifying non-citizen, and meet all the income and assets limits established by the state. The income and assets limits are different from the ones implemented for Minnesota Assistance (MA)[6].

4. A matching fund are resources provided by a third-party entity (e.g. federal government) expecting other members or parts (e.g. states) to finance remaining resources.
5. Premiums are the small part for financing this program for the reason it is known people would not have sufficient funds to buy private insurance plans. Nevertheless, the program still charges to people, making the program not free. There are exceptions for people to not pay the premiums. Exceptions are made to military people or American Indians. More information about the premium policy could be found at: Minnesota Department of Human Services https://edocs.dhs.state.mn.us/lfserver/public/DHS-3182-ENG
6. For family units who have children under 21 years old and it size ranges between 2 to 3 people, the monthly wage upper limit in order to get services is $3,378 and $4,248 for each. There are other limits for those who are adults and do not have children. For further information go to Minnesota Department of Human Services: https://edocs.dhs.state.mn.us/lfserver/public/DHS-3182-ENG

Minnesota's Emergency medical assistance (EMA). It is a state funded medical program which allows non-citizens who are not eligible for medical assistance, to get medical services in the case of an emergency. An emergency is described by the state of Minnesota as a *"Sudden onset of physical or mental conditions which causes acute symptoms causing severe pain or has a chronic medical condition which in either case, the absence of immediate medical attention could cause the following: Place the person's health in serious jeopardy, Cause serious impairment of body functions, causes serious dysfunction of bodily organs or parts"*[7].

3. THE PATIENTE PROTECTION AND AFFORDABLE CARE ACT (PPACA) AND ITS IMPLICATIONS ON THE HEALTHCARE SYSTEM (Kaiser Family Foundation, 2011)

In 2010, President Barack Obama introduced into law a reform to the healthcare system in America. This reform was called the Patient Protection and Affordable Care Act (PPACA). This new law was meant to reduce disparities in access to health services in the United States. According to the Nobel Prize winner economist Kenneth Arrow, there are certain aspects in the United States healthcare that makes this service something completely different than any other product or service when is provided just through the market forces of supply and demand. First, the demand for healthcare is uncertain. It is difficult to predict an individual's demand for healthcare allowing extensive price discrimination for a single service in order to allocate resources to treat illnesses (Arrow, 1963).

Price discrimination indeed provides healthcare to people that needs it but usually at a high cost, neglecting people from receiving this type of services when they have income restrictions. Also, there are difficulties in market entry, either in the production of medication (pharmaceutical companies fill for patent protection) and the provision of services (the requirement of licenses); therefore, healthcare is a service which considerably deviates from a competitive market model (Arrow, 1963).

In order to amend these market circumstances and allow people with different incomes to receive affordable healthcare, the Obama administration put into law the Patient Care and Affordable Care Act reform which not

7. Hennepin County, Minnesota. Emergency Medical Assistance (EMA). Retrieved from: http://hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=af59873435b04210VgnVCM10000049114689RCRD

only intended to make healthcare economically accessible, but also wants improve health prevention and quality. In addition, the Affordable Care Act tries to deal with difficulties that some people have had in accessing healthcare because of having a pre-existing conditions. Also, it prevents the cost of healthcare to become unmanageable and tries to implement more efficiency allowing it to do more with the same resources[8].

The most important aspects that the Patient Protection and Affordable Care Act intended to reform the health system in America are the following[9]:

- ***Expanding Coverage.*** Require all citizens and legal immigrants to have health insurance. In this case insurance will be: employer-provided insurance, private coverage (healthcare coverage paid by the individual), and Medicaid or Medicare. People exempt will be:

- Undocumented immigrants
- People who are restricted to religious circumstances
- People who are imprisoned
- Individuals who belong to Native-American tribes
- People that would require spending more than 8% of their income to pay health insurance, or those who do not meet the income threshold required to fill for taxes.

  To expand coverage, each state is required to do what it is called an American Health Benefit Exchange. These "exchanges" are health insurance marketplaces which gather insurance companies to present their health options to people. This will emphasize the introduction of easy-to-comprehend information about health policies and guarantee best quality in services. In the case a state does not design an exchange

8. Most European countries see that United States has long overdue the right for its citizens to have full healthcare coverage. For more information see: E.U. Gloats Over Belated U.S. Healthcare Reform, available at: http://www.time.com/time/world/article/0,8599,1974424,00.html
9. The Patient Protection and Affordable Care Act (PPACA) it is still being discussed in the United States Supreme Court and the final verdict will be provided in June 2012. The discussion on this law is on regard of its compliance with the dispositions presented by the Constitution of the United States. For more detailed information about the different provisions assigned by the law go to: Focus on Health Reform. The Henry Kaiser Family Foundation Summary of the New Health reform law. The document could be obtained at: http://www.kff.org/healthreform/upload/8061.pdf

the federal government would intervene to provide it[10]. Along with the exchange will operate individual and group insurance markets.

The exchange will offer four different plans, these are: Bronze, which represents the minimum coverage, Silver that provides essential coverage and covers up to 70% of the benefit costs, Gold which covers up to 80% of the benefits cost and also provides basic coverage, and a Platinum coverage fulfilling up to 90% of the costs. Also there is a separate catastrophic plan which is a *"type fee-for-service health insurance policy"*[11], this will be available to low income people who would have immediate access to health services in a catastrophic event. This plan is especially designed for people with low incomes because they pay lower premiums (usually this individuals are very healthy) but most of the coverage is charged through a deductible (is the amount ought to be paid out-of-pocket before the insurance company incurs in expenses).

In every exchange it will also be a "Public Option" which would be administer by the Office of Personnel Management. The Public Option is a government run healthcare plan within the health benefit exchanges. The public option has the goal to lower insurance prices and expand the provision of health services. In addition, there would be income and cost-sharing credits to people who earn between 133-400% of the federal poverty level according to family size. These income and cost-sharing programs work through tax credits to people who meet the requirements[12].

- ***Requirement for healthcare coverage.*** All United States residents and all legal residents are required to have coverage. A person or family that does not get health coverage will have to pay a penalty that could represent up to 2.5% of the household income. The penalty will be gradually increased from 2014 to 2016. Since 2016, the penalty fee will be adjusted by costs of living in each year. Exceptions could be made to people in hardship, religious restrictions, American Indians, certain

10. The federal government has designed different types of parameters that each state Exchange should meet.
11. Catastrophic insurance TLC. Discovery Channel. All right reserves, visit at: http://tlc.howstuffworks.com/family/catastrophic-insurance.htm
12. The requirements for people to receive income and cost-sharing credits will depend on earnings, age, geographic area etc. For more information go to: http://www.acponline.org/advocacy/where_we_stand/access/internists_guide/vi2-health-insurance-tax-credits-individuals-families.pdf

immigrants, imprisoned individuals, and those without health coverage in the last three months. On the side of employers, all employees have to be offered health coverage (Kaiser Family Foundation, 2011).

According to the White House, it is necessary to implement the requirement for all people to get a minimum essential coverage in order to prevent insurance companies of not providing services to people with pre-existing conditions[13]. This point of the law has become a difficult issue and has led the United States Supreme Court to assess this disposition if it does complies with the constitution, especially the fifth and tenth amendments which promote individual liberty[14].

- ***Expansion of public programs.*** PPACA will expand Medicaid to all eligible individuals under 65 years old. These individuals have to earn an income around 100 and 133% of the established Federal Poverty Line to receive health insurance through the expanded Medicaid. In other words, Minnesota Assistance (MA), the state's Medicaid program, will expand through this initiative.

  This provision will start in 2014. From this year, the federal government will fund 100% of the expansion program in each state and will continue to decrease its investment until it reaches 90% by the year 2020. Moreover, states will be required to maintain income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019, and funding will be extended to later program until 2015.

- ***Premium Credits and Cost-sharing subsidies.*** It is a way how PPACA will try to reduce health insurance costs to clients to broader coverage. The premium credits relates with government money provided to people who cannot afford to pay a full health insurance premium. The cost-sharing subsidies have the goal to protect families with health insurance of high out-of-pocket costs that could arise while receiving health services[15]. All subsides would be provided only to U.S. citizens or legal immigrants (KAISER FAMILY FOUNDATION, 2011).

13. For more information go to: http://www.upi.com/Top_News/2009/09/09/Obama-Basic-health-coverage-a-requirement/UPI-62861252544116/
14. For more information on this issue go to: http://www.washingtonpost.com/business/on-small-business/as-supreme-court-weighs-health-care-reform-state-contractors-await-their-fate/2012/04/11/gIQApbCIBT_story.html
15. For more information about Premium credits and cost-sharing subsidies go to: Focus on Health Reform. The Kaiser Family Foundation, 2009. http://www.kff.org/healthreform/upload/7962.pdf

The subsidies are prohibited for abortion practices. Moreover, employers with no more than 25 employees and provide an average annual wage of $50.000 to its employees, will receive a tax credit. From 2010 and later, companies with no more than 50 employees would receive a tax credit up to 50% if the company pays up to 50% of the worker's health insurance premium costs. A company could receive a full tax credit if it employs just 10 people and the average wage provided to workers is $25.000 (Kaiser Family Foundation, 2011).

- ***Changes to private insurance.*** PPACA will create a temporary high-risk pool in order to provide health insurance to people with preexisting conditions. The main people who would benefit of the program are U.S. citizens and legal immigrants. All people to enroll in the high-risk pool would receive a subsidy for their premium. Exclusions to health insurance to people with pre-existing conditions are prohibited. Furthermore, health plans need to report the expenses of premiums on clinical services, quality and other services. States have to review premiums trends to see their increases and request exclusion of certain health plans if their premium increases are no appropriate justified (Kaiser Family Foundation, 2011).

  At the same time, PPACA extends dependent coverage to children up to 26 years old who either are insured by individual or group policies (Before PPACA insurance coverage was until 21). It will also prohibit the practice of lifetime limits on health plans (Lifetime limits are a cap on lifetime health benefits), therefore an insurance company could not assign a ceiling on the amount of dollar(s) benefits for lifetime, or a service a person could obtain. (E.g. a person could get a 2 million lifetime cap for health practices during his/her life or a $300.000 cap on heart bypasses or other specific service) In addition, PPACA prohibits annual limits of dollar value on medication coverage. For example, a person could get $10.000 limit in a year for prescription drugs (Kaiser Family Foundation, 2011).

  People who already have a health plan and want to keep it because it is good they are able to do so under a "grandfathered rule". This rule, will allow people to keep their health insurance and obtain the consumer benefits the law offers. Furthermore, the plan should not be able to reduce benefits to different types of diseases, cannot increase co-insurance charges, raise copayments, raise deductibles, and lower employer contribution to the health plan. Additionally, grandfathered

plans have to eliminate lifetime and annual limits on coverage since 2014. Likewise, grandfathered plans eliminate pre-existing condition exclusions for children and adults (Kaiser Family Foundation, 2011).

- ***Consumer Protection.*** PPACA will establish a website to help individuals indentify health coverage options. It will develop a standard format for insurers to present information on their health insurance plan and it will set up an office of health insurance consumer assistance which will advocate for people in the individual and small group exchange markets (Kaiser Family Foundation, 2011).

- ***Improving the System's Quality and Performance.*** PPACA establishes a non-for profit research institute to do studies on comparative effectiveness on medical practices and clinical effectiveness across health institutions in the United States. Through PPACA, the federal government will provide grants to states that have implemented or proposed a program that will allow significant progress in reducing medical errors, adverse events and patient safety (Kaiser Family Foundation, 2011).

  For the Medicare program, PPACA implements the independence at home demonstration program. This program will provide primary care services at home to highly-need Medicare beneficiaries in order to reduce hospitalization costs. Moreover, PPACA will start an initiative to reward hospitals for the quality of care given to people enrolled in Medicare and the help they could do in reducing healthcare costs (Kaiser Family Foundation, 2011).

  On the side of Medicaid, there will be a public option to permit Medicare enrollees with two chronic conditions to designate a health insurer as provider of health services at home. PPACA will increase the Medicaid payments in fee-for-service and manage primary care services. In addition, the government has develop a national strategy to improve the delivery of healthcare services and establish a community based collaborative care network program, in order to coordinate health services for low income and uninsured people.

  PPACA also will require the disclosure of financial relationships between the different stakeholders of the healthcare system, such as hospitals, insurers, clinics, physicians, pharmacists, providers and manufacturers of medical supplies (Kaiser Family Foundation, 2011).

- ***Health prevention.*** PPACA will establish a council for Health Prevention and Promotion. Also, it will set up a health fund for prevention, wellness and public health initiatives, where it will be financed prevention research activities, health screenings and immunization programs. It will also institute a grant based program to support community and evidence projects in health prevention and wellness services. In the Medicare program, all cost-sharing preventive services would be eliminated and everything will be converted with federal funds, also personalized preventive services for Medicare beneficiaries will not be denied (Kaiser Family Foundation, 2011).

- ***Wellness.*** PPACA will deliver grants to small employers to establish wellness programs. Also, it will facilitate resources and technical assistance for employers to establish their wellness programs and will allow employers to provide rewards to employees (e.g. discounts on health insurance premiums) if they participate to wellness programs and meet health parameters. All food chains and vending machines have to provide information on nutrition facts to consumers (Kaiser Family Foundation, 2011).

- ***Long-Term Care.*** It is a voluntary program where people with functional limitations would receive medical services and support in order to live a better quality of life and could achieve the most independence as possible doing daily activities. PPACA will extend the Money Follows the Person Rebalancing Program (MFP), an initiative designed to aid states to fund the long-care system and help people from Medicare who have been in rehabilitation institutions, to enter to their community successfully. PPACA will promote more options for states to provide more community-based services through Medicaid (Kaiser Family Foundation, 2011).

  In addition, PPACA will establish the community first option program to provide community-based services to people when they require institutional support and enhance the federal payments funds to aid states in the provision of non-institutional long-term care services.

- ***Other Investments.*** PPACA will provide rebates up to $250 to prescription drugs requested through Medicare Part D coverage. It will provide subsidies to prescription on generic drugs and will request pharmaceutical companies to make discounts up to 50% on the prescription drugs. PPACA will allow people to receive full benefit of home and

community-based services to dual eligible beneficiaries (Low income elder people beneficiaries of Medicare and Medicaid). Also, it will expand coverage to people exposed to environmental hazards and provide bonus to primary health workers or doctors who provide services in areas with professional shortage.

Likewise, it will establish a committee in order to improve workforce supply especially related with healthcare professionals. Therefore, there are plans to open more educational programs related to health promotion and medical services, in order for people to get more opportunities to prepare. Furthermore, people will have access to scholarships and loans to access education.

Additionally, the government will promote the establishment of more primary health centers within communities and schools, strengthen emergency centers, implement a Regulars Corps or Ready Corps service in case of national emergencies and require non-profit hospitals to do more community assessment every three years and meet identified needs (Kaiser Family Foundation, 2011).

4. THE PROBLEM OF THE PERSONAL MANDATE

Even though the reform advocates for health coverage to the entire population of the United States, by mid 2012 it has faced opposition for its implementation because of the constitutional validity of the Personal Mandate, the pillar of the PPACA. The problem arises because, in the United States Healthcare is a service that a person has to afford by him/herself and it is not a constitutional right.

The opposite happens in countries that have established healthcare as a right in their constitution; Colombia for instance is a good case. In Colombia, healthcare is a right constitutionally recognized. Therefore, the government intervenes aggressively in the system to fulfill this commitment. The way in how the Colombian government intervenes in healthcare is subsidizing the demand side of the market through issuing health insurance to vulnerable people. The health insurance is paid by the government to a health insurance company that is responsible to administer the money. The condition of the health insurance in order to administer the money is to be a non-for-profit organization.

The health insurance paid by the government is known as Régimen Subsidiado. With the subsidized health insurance, a person could receive

health services according to a general service plan called Plan Obligatorio de Salud (POS). If a person is suffering from an illness he/she could receive treatment to the disease according to the services been covered by the POS, if the person requires a more comprehensive treatment which usually is not listed among POS procedures, the individual has to pay the treatment out-of-pocket or implement a legal disposition called "TUTELA", to obtain all the services needed[16].

In the United States, it is mandatory to employers to guarantee health insurance to employees, but individuals are not required to get health insurance, because it is the right of the individual to decide if he/she wants health insurance. The problem of *individual choice* is what has been discussed on PPACA, because the United States constitution has established this notion (individual choice) as a human right, therefore, if PPACA is implemented, individual choice could be weaken.

According to experts on constitutional law in the United States, individual choice was among the most important foundations in which the American democracy was built on; therefore, it is considered as important as any other dispositions such as individual freedom for religion and political beliefs and the individual's pursue of happiness.

On June 2012, the PPACA was upheld by the Supreme Court of the United States making the piece of law constitutional. The argument of the Supreme Court on the law's constitutionality was the power of congress to tax rather than the Personal Mandate implemented. Considering this, when a person does not obtain health insurance, according to PPACA, he/she has to pay a tax penalty which the congress is fully competent to charge, making the law legal (Reforms, 2012).

5. THE BENEFITS OF PATIENT PROTECTION AND AFFORDABLE CARE ACT TO LATINO IMMIGRANTS IN THE STATE OF MINNESOTA

Hypothesis established and verification techniques

After discussing the main reforms introduced by PPACA, it is necessary to know how the law will impact the Latino population in the state of Minnesota. Therefore, the following study established the following preliminary hypothesis: PPACA will benefit 80-90% of the foreign born Latino community in the state of Minnesota. In order to confirm it, it was important to obtain updated data related to the size of immigrant Latino community

16. Tutela: is a judicial remedy for the purpose of protecting constitutional human rights and freedoms.

within the state. First of all, it is essential to define which type of Latino population will be studied. This study will emphasize its analysis in foreign born Latino community in Minnesota, therefore, it is acknowledged with this, that only will be examined the people who have migrated from other regions of the American continent to the state of Minnesota.

The foreign born Latino population analysis is conducted in the following structure:

Demographics

Marital Status and Education

Citizenship Status, Income and Poverty

Once the information is structured as the way presented before, it will be related with the information about the provisions of the Patient Protection and Affordable Care Act.

Demographics of Foreign Latino Population

In the state of Minnesota the most updated data available regarding population is the last census undertaken by the U.S. Census Bureau called "Census 2010". The Census in the United States is conducted every 10 years and it is a mandatory constitutional disposition. From the U.S. Census, the following data analysis was performed to get the necessary demographic information: a) Obtain the report on the total population within the state of Minnesota including everyone, b) acknowledge the total population of foreign born immigrants in Minnesota, regardless the region they come from. c) From the data of foreign born immigrants in Minnesota, obtain the number of foreign-born Latinos and establish their percentage representation within the total immigrant population and the entire state's population.

The results of this data analysis are shown in Table 2.

According to Table 2, the entire population in the state of Minnesota was 5,310,584 habitants by 2010. Within this population, 378,483 people or 7.12% were foreign born immigrants. Within the population of foreign born immigrants, there were 103,622 Latinos which represented 1.95% of Minnesota's entire population and 27.37% of the whole foreign born immigrant community. Table 2 allows determining the high percentage representation of the Latino population within the foreign born immigrant community, nevertheless, still remains small while comparing it to Minnesota's total population.

Table 2. General population and latino population in the state of Minnesota

Topic	Estimate	Percentages	
Total Population in Minnesota	5,310,584	100 %	
Total Population of Foreign Born Immigrants in Minnesota	378,483	7,12% (Related to the total population)	
Population of Foreign Born Latino Immigrants in Minnesota	103,622	Related to entire state's Population	Related to the total immigrant population
		1,95%	27,37%

Source: U.S. 2010 Census

In-depth demographic information of the foreign born Latino immigrant community according the U.S census is shown in Table 3.

Table 3. Foreign latino population in Minnesota – General demographics

CONCEPT	Population By 2010	Percentage
Foreign Born Latino Immigrant Population	103,622	*100%*
Mexico	65,700	*63.40%*
Other Central America Countries	14,561	*14.05%*
Caribbean	4,867	*4.70%*
South America	18,494	*17.85%*
POPULATION BY AGE		
Under 5 years old	1,243	***1.20%***
5 to 17 years old	9,948	***9.60%***
18 to 24 years old	15,129	***14.60%***
25 to 44 years old	56,888	***54.90%***
45 to 54 years old	11,813	***11.40%***
55 to 64 years old	5,803	***5.60%***
65 to 74 years old	1,969	***1.90%***
75 to 84 years old	518	***0.50%***
85 years old and over	311	***0.30%***
Median Age	**32,7**	
POPULATION BY RACE		
Male	56,163	*54.20%*
Famale	47,459	*45.80%*

Source: U.S. 2010 Census

According to Table 3, the most representative population of the Latino community come from Central America, just Mexicans represent 63,40% of the entire Latino community. Adding Mexicans with people of other Central American countries, the representation of Latino foreign born immigrants that have come from Central America reaches 77.45%.

The second most important representation of the foreign born Latino community is from South America, representing 17.85% of the entire foreign born Latino population. These inhabitants surpass the quantity of immigrants of Central America if Mexico is not included. The Caribbean has the smallest representation in the entire foreign born Latino community with just 4.70% of the entire population17. It is important to realize that the foreign born Latino population is young. The median age for the entire community is 32.7 years. The most representative age range in the community goes from 25 to 44 years old. The elder people are not as representative as the young population; in fact, Just 2.7% of people in the foreign born Latino community are 65 years old and older.

If the Latino foreign born population is analyzed according to sex, the most represented are men with 54.20% of the population; meanwhile, women represent the 45.80%. With this in mind, comparing this situation of the foreign born Latino community in Minnesota with the entire United States demographics, the trend is backward. While in Minnesota the foreign born Latino men have a considerable representation, in the whole country, only 49.2% are defined as male meanwhile, females represent 50.8% (CENSUS 2010, 2011).

Marital Status and Education

In relation to marital status, the Bureau of the U.S. Census has established the threshold for marriage from 15 years old and older. In education, the table will emphasize the level of education attained by the foreign born Latino immigrants from 25 years old and older. Table 4 provides all the information just described.

17. From Central America, aside of Mexico, the countries that have the most representation are: El Salvador: 5533; Guatemala: 4760; Honduras: 2290. In the case of South America, the countries that have the most population are: Ecuador: 5963; Colombia: 4042; Guyana: 2708; Peru: 1584. From the Caribbean the most represented countries are: Jamaica: 1400 and Cuba: 937. Source: U.S. 2010 Census.

Table 4. Marital status and education data of foreign born latino community

MARITAL STATUS	DATA
Population over 15 years old and over	95,811
Never Married	39.7%
Now Married, except separated	50.4%
Divorced or separated	8.1%
Widowed	1.8%
EDUCATION ATTAINMENT	
Population of 25 years old and over	77,259
Less than high school graduate	49.40%
High school graduate (Includes Equivalency)	25.50%
Some college or associate's degree	15.20%
Bachelor's Degree	6.00%
Graduate or Professional Degree	3.90%
ENGLISH KNOWLEDGE	
Percentage of people who speak English less than "Very Well"	63.2%

Source: U.S. Census 2010

50.4% of the total population up to 15 years old is already married, but almost 40% never have. It is also important to notice that a small percentage of foreign born Latino community had separated, have gotten divorced or have widowed (9.9%). In addition, almost 50% of the foreign born Latino community in Minnesota has not achieved high school education. In fact, just 3.9% of the population has obtained graduate studies making them the only professionals in this community.

Educational statistics show the high percentage of foreign born Latino immigrants who have not been able to attain high school. This is explained by the high percentage of Mexicans and other Central American citizens of not finalizing their education. In fact, 59.9% of most Mexicans over 25 years old, just have attained some level of high school, but never have finished it. The same is for the 44.4% of the Central American people who come to the United States. In contrast, those people who come from other regions of Latin-America such as the Caribbean and South America, the level of high school attainment is higher (People with no high school education from these regions: 21.8% and 24.3% respectably). Therefore, Latinos in Minnesota who have come from the Caribbean and South America have most likely finished high school education (Census 2010, 2011).

On the side of the professional preparation of the foreign born Latino community, South-America is the region that has provided the most qualified people to Minnesota; in fact, 11.3% of these immigrants are professionals or have achieved graduate level degrees. The other region that follows is the Caribbean with 5.0%. Only 3.0% of Central Americans not including Mexico are professional; meanwhile, only 1.9% of the Mexicans that have come to Minnesota are professional educated (Census 2010, 2011).

Most South Americans have more educational advantages than immigrants from other American regions. One of the reasons is because people from South-America who come to the United States and especially to Minnesota, have incurred in air travel expenses only achievable by either saving almost all money when a person is paid a minimum wage, or obtaining a level of education that could guarantee access to better income. Nevertheless, this it is not a generalization because there have been cases where people from South America have managed to immigrate to the United States illegally especially through shipping boats. Generally, people who have travelled this way cannot afford immigration documents and airfare[18].

Another important aspect is the level of English the community knows. The 2010 U.S. Census has found that 63.2% of foreign born Latino communities speak English less than very well. Probably, it is the most difficult problem facing the community, for the reason that even though Minnesota has not established English as the official language, it is widely used for communication purposes.

Citizenship status, income and poverty

Other important factors that should be analyzed in the Foreign Latino population are the citizenship status, income level and poverty. These factors are important elements to relate with the provisions of PPACA. Data about citizenship is presented in Table 5. Table 6 provides the statistical information related to income and poverty for the community.

Table 5 shows the legal reality of the Latino Born immigrants in Minnesota. 57.1%, reside in the state as undocumented individuals, meanwhile, 42.9% have obtained legal status or citizenship.

18. More research should be done in this topic to prove the points made in the paragraph in order to generalize this conclusion. The ideas in the paragraph are drawn by the author analyzing simple patterns about the immigration process from South America in a personal and empirical experience.

Table 5. Citizenship status of foreign born latinos in Minnesota

TOTAL FOREIGN BORN LATINO POPULATION	103.622
CITIZENSHIP STATUS	**% Proportions for each population**
Naturalized Citizens	23,4
Not a Citizen	76,6
Legal Residents (On regard of Non-citizen population)	25,4%*
Undocumented Aliens (On Regard of Non-Citizen Population)	74,5%*
CITIZENSHIP STATUS	**% General Data**
Naturalized Citizens (On regard of total Latino foreign born population)	23,40%
Not a Citizen	
Legal Residents (On regard of total Latino foreign born population)	19,50%
Undocumented Aliens (On regard of total Latino foreign born population)	57,10%
	100,00%

Source: U.S. Census 2010. *Author's statistical estimations[19].

19. The U.S. Census Bureau has not provided an estimate in the compositions of people who are legal residents or illegal immigrants. Therefore, it was necessary to perform a preliminary estimation for acknowledging the quantity of people who could be without documentation. This is possible to do, because the 2012 U.S. Census included illegal immigrants in the counting. The percentage estimation of the illegal immigrants was performed under the following logical framework: Table 4 gave the information about education background of the Foreign Born Latino community which was 77,259 people. According to Table 4, 49.4% of the population was not able to finish high school and 25.50% have only obtained a high school diploma. This represents 57,867 individuals. The 57,867 individuals represent 55.84% of the entire foreign born Latino population in Minnesota. The U.S. Census says 76.60% of the Latino foreign born immigrants are non-citizens, and if it is put into consideration the assumption that all those who just have earned some high education or only have achieved high school are undocumented immigrants, it is possible to say that 57.10% individuals are undocumented. The rest of non-citizens are legal residents, this percentage was obtained through direct subtracting conclusion. The reason to establish the assumption that most undereducated immigrants are undocumented, is because in Latin America individuals who have not finished high school are more likely to earn a salary lower than the minimum legal wage established by law in each country. High school graduates are destined to earn the minimum wage or slightly higher wages, but it is difficult to see this people surpassing earnings of college graduates. Research done in this topic has been performed by: DURYEA, Suzanne, PAGES, Carmen. Interamerican Development Bank, 2000. GASPARINI, Leonardo; GALIANI, Sebastian; CRUCES, Guillermo; ACOSTA, Pablo. Therefore, all the people who have received basic education, it is very likely that will not have the sufficient financial resources that would require them to obtain legal documents such as a VISA or permits to cross the border. For example, a basic educated Mexican (a person who just finished some high school level or earned a high school diploma) it is most likely that he will find a job that would pay in average 60.66 pesos daily by 2012. In a month, this person would receive 1,516.5 pesos (60.66 multiplied to 25 regular working days) in American

Table 6. Poverty and income within foreign born latino community in Minnesota

Median Earnings (dollars) For full-time year round workers	Earnings
Male	$25,004
Female	$23,361
Unemployment Rate	7.0%
# of Households	34,673
Average household size	3.92
Households with earnings	96,6%
Mean earnings	$47,709
Population for whom poverty status was determined	101,558
Below 100% of the Poverty Level	22,0%
100 to 199% of the Poverty Level	35,6%
200% and more of the poverty level	42,5%

Source: U.S. Census 2010

Table 6 offers the following important information: Men earn 7.03% more in their activities than women do. In average, the foreign born Latino population has earned 213.46% above the Federal Poverty Line (FPL) for a household of 4. In a population of 101,558 foreign born Latino communities, 22% do not earn an income equal at least to FPL, 35.6% of population earns within the range of 100-200% of the FPL. Lastly, 42.5% of the foreign born Latinos in Minnesota earn above 200% of FPL. Also, unemployment rate within the population is 7% of the total labor force (Labor force = 71.978 individuals by 2010 (Source: U.S. Census 2010).

Associating Information of Foreign Born Latino Community and PPACA

According to the information gathered, most of PPACA provisions will provide more coverage to Foreign Born Latinos who are U.S. citizens and legal residents. Therefore, the improvements on affordability and health

dollars, the person would earn 115.63 USD a month, and the costs of obtaining legal documents to be admitted to the United States from Mexico by April 2012, in average, surpass 200 USD (For more information on costs of U.S. documents from the U.S. embassy in Mexico go to: http://mexico.usembassy.gov/visas.html) Then it becomes impossible for people who earn a minimum wage to afford the required documents to be admitted legally in the United States. However, research should be done with more evidences in order to provide a better approximation of foreign-born Latino community and their undocumented status.

access will be mostly enjoyed by those who are "*legal*" according to immigration law. With respect of undocumented immigrants, the most evident result is that they will not receive as much benefits. According to PPACA, it did not try to expand coverage to illegal immigrants. In fact, the Congressional Research Service (CRS) in a studied published in August 2009 realized that if illegal immigrants meet the *"substantial presence test"*[20] under the Internal Revenue Service (IRS) code, they will be required to pay the penalty tax for not purchasing either individual or family medical insurance, for the reason healthcare *requires* individuals to obtain health insurance. Even, though the law does not require undocumented individuals to buy health insurance, they will be charged by the IRS if they avoid doing so (CRS, 2009).

Even if a non-documented immigrant wants to obtain health insurance, he/she will be able to obtain it but not within the "exchange mechanisms" established by the states. Immigrants have the possibility to buy medical insurance in the private parallel market. However, the difficulties will be that most of these options might have higher premiums or deductibles because there is not price regulation. In this case, people will pay themselves for health policies and other services not included in the insurance meeting them with out-of-pocket expenditures.

Undocumented immigrants will not receive tax credits or subsidies for premiums or deductibles when buying a health insurance, because they are illegal aliens and will not be able to receive public funds coming from state and federal government. Every individual, lawfully present in a state of the United States will be able to obtain the subsidies or tax credits; but, people who are lawfully residents but have undocumented family members will not (CRS, 2009).

Elder people who are undocumented and reside in the state of Minnesota, will not be eligible to Medicare insurance with neither allowed providers. Additionally, foreign born Latino immigrants who are undocumented in the state Minnesota and with insufficient income, will have restrictions

20. The substantial presence test is a mechanism implemented by the Internal Revenue Service (IRS) to estimate if an immigrant could be considered as U.S. resident for tax purposes. To meet the test, the person should be present in the United States on at least:
31 days of the current year
183 days during the 3-year period that includes the current year, and two years immediately before that, counting is the following way:
- All days a person was present in the current year.
- 1/3 of the days a person was present in the first year before the current year, and
- 1/6 of the days a person was present in the second year before the current year.

on the access to Minnesota Assistance (Minnesota's Medicaid program) the program financed between the state and federal government.

Minnesota's health reform to amplify reach, created a mechanism to provide medical assistance to immigrant people with financial difficulties who meet the following conditions: pregnant women, Children and people who are receiving rehabilitation services through the Center of Victims and Torture (State, 2011).

PPACA will allow access to the 74.5% non-citizen Latino immigrants to receive the Emergency Medicaid coverage when required. This right for emergency care to illegal immigrants has been provided since the Emergency Medical Treatment and Active Labor Act signed by President Ronald Regan. This part importantly helps pregnant women either legal resident or undocumented and provides all the basic pre-natal care and other services related with delivery (State, 2011).

In addition to the PPACA provisions in restricting undocumented citizens in obtaining the privileges of medical programs and tax credits or subsidies, Minnesota's healthcare law restricts the provision of public sponsored services in the first five years to people who are legal residents. At the same time, equal treatment would receive all family members brought by legal residents. Consequently, this people will need to find important sources of income to afford healthcare for themselves and the entire family. Low income legal residents will have problems with health access in the first five years until they receive more rights[21] (State, 2011).

PPACA will prohibit the access to illegal residents to expansion of Children's Health Insurance Program (CHIP). PPACA will expand children's health coverage through Medicaid to those who are just 133% and lower of the Federal Poverty Line and who are 18 years old and younger. Foreign born Latino children do not receive the benefits of service expansion. It is noteworthy to say that children between 0-17 years old represent 10.8% of the foreign born Latino Population in Minnesota or around 11.191 children.

Additionally, children up to 26 years who could be covered by a family health insurance sponsor or an employer family sponsored, insurance will not be able to obtain the benefits if they are illegal. The same will happen to foreign born Latino adults who are interested in accessing to health promotion services and the educational opportunities available in PPACA in order

21. August 31, 2011.

to strengthen the supply of professionals in the healthcare sector, especially oriented to provide services to long term care in rural areas.

Just around 42.9%[22] of the foreign born Latino population community or 44,439 are eligible to receive the benefits of PPACA. However, from this population a more thoroughly analysis should be done in order to know how many people have been living in the state of Minnesota for less than 5 years, which is the time residence requirement for the Minnesota Assistance program to provide benefits to legal residents.

All in all, 59,181 undocumented foreign born Latino immigrants who live in the state of Minnesota[23] will not receive any benefits of the Patient Protection and Affordable Healthcare Act. In this population the ones who will have more issues, will be those over 85 years old and low income households. Things are particularly more difficult for senior citizens because they have more difficulties to work in order to afford healthcare. It will be most likely that they will have pre-existing conditions that would make prohibiting the costs of health insurance for them and family members. Also, undocumented elders will not be allowed to participate in the high-risk pool insurance system that will be setup by PPACA.

Around 4.356 households of foreign born Latino immigrants, earn less than 100% of the federal poverty guidelines. This people will not be able to obtain the benefits of Medicaid extension implemented through PPACA because they are undocumented aliens. Thus, most of this people will not have the sufficient health services because their financial resources are already insufficient to adequately satisfy normal necessities such as accommodation, transportation, clothing and food.

With all the information gathered, it is possible to say in a preliminary way that the hypothesis established could be rejected, PPACA will just benefit

22. The percentage is presented as preliminary. It is estimated through the following process: On the total population of foreign Latino Immigrants (103,622) it was obtained the amount of individuals who do not have resident status (79,374), then it was obtained the number of residents who have legal status (79.374 x 24.4% = 20.192) The amount of individuals estimated was added to the number of Naturalized Citizens (24,247) obtaining 44,439 people. Dividing this last quantity with the total population it is possible to obtain the 42.9% which is an estimated percentage of the people between citizens and legal residents.
23. This population was estimated through the following process: The population of foreign born Latinos 103,622 multiplied by 76.6%, which is the percentage of people who are not citizens, and multiplied by the 74.6% which is the percentage of foreign born Latinos who non citizens and are undocumented.

CONCLUSIONS

This paper allowed obtaining the following conclusions:

- Universal healthcare is a policy which Europe began to implement in the late 19th century, making it an old initiative rather than a new one. Universal Healthcare service in Europe and other developed countries is provided by a single payer system which generally is the government. In the case of the United States of America, healthcare provision has been entirely driven by market forces of supply and demand. Nevertheless, there is an important government intervention to allow seniors and low income families to obtain healthcare coverage through federal funded programs called Medicare and Medicaid. Nonetheless, the last two programs are not entirely subsidized and require people to cover certain out-of-pocket costs.

  The Patient Protection and Affordable Care Act (PPACA) is a law which tries to expand healthcare in order to reach universal coverage. This law should be fully implemented in the United States by 2019. PPACA will advance in health coverage through a combined government-market solution rather than assigning the coverage function entirely to the government. In order to do this, the law contains a "Personal Mandate" or a provision which requires all individuals to obtain coverage in order to allow citizens with pre-existing conditions to enter the healthcare system without been dismissed. People who do not buy health insurance will be penalized through tax measures. All the benefits of law will essentially be provided to U.S. citizens and Legal residents.

  PPACA will expand coverage of Medicaid to citizens who earn less or equal to 133% of the Federal Poverty Line. It will extend funding to other services which before needed to be funded by the individuals. It will also provide tax credits and subsidies to people who are not able to afford prescription drugs or other services not covered by an insurance policy.

  Furthermore, PPACA will establish the health benefits exchange initiative in every state of the U.S., which consists in a marketplace that gathers insurance companies and consumers. In this marketplace information should be standardized to allow people to have the same information when buying health policies. Also, children up to 26 years old are covered through parent's health plan which could be sponsored either by the family or the employer. Parallel to the exchanges, there will be private individual insurance markets, which provide a coverage solution to undocumented immigrants.

PPACA also offers a consumer support mechanism in order to ensure insurers to provide the services described in their insurance plans and they are not charging arbitrary expensive premiums or deductibles. PPACA emphasizes on the provision of extensive preventive care. It will try to provide home services to seniors and disable elders to gain independence in activities. Also, PPACA will try to enhance patient safety, higher quality services and increase education opportunities to those interested in working for the healthcare sector especially in rural areas.

- PPACA has been considered a constitutional Law by the United States Supreme Court, therefore, it does not violate individual choice and it has to be implemented entirely according to its planned timetable.
- On the side of Foreign Born Latino demographics in the State of Minnesota, according to the U.S. Census 2010, there are 103,622 individuals in this community where 23.40% are naturalized citizens and 76.60% are non citizens. The representation of Latinos in the foreign born population in Minnesota is 27.37%, whereas, for the Minnesota's entire population represents only 1.9%. According to this study, on the side of the non-citizen population, about 74.5% of the individuals are undocumented workers, while just 25.4% are legal residents. The region that provides most of foreign Latinos is Central America with 77.4% of total Latino immigrants.

  49.4% of the foreign Latino Population has received some schooling and 25.50% have finished high school. This means that 74.9% of the foreign Latino population is not professional or qualified workforce. Just 3.9% of foreign born Latinos have obtained graduate degrees; this population is almost entirely configured by South-American immigrants. Moreover, 63.2% of immigrants have problems to speak English the predominant language in Minnesota and the United States.
- According to demographic statistics, PPACA will not provide benefits to almost 59,181 individuals or 57.1% of the entire foreign Latino Population, for the reason they are undocumented aliens. From this population, 22% earn fewer than 133% of the Federal Poverty Line. Unfortunately, their residence status does not make them eligible to expanded government sponsored health Services. Questions remain in the quantity of people residing in poverty levels. Therefore, more statistical data should be analyzed or constructed.

  With the statement just made, the preliminary hypothesis provided in the following study *should be rejected*, where it is presumed that between 80 to 90% of the foreign born Latino community would receive

the benefits of the PPACA law. The statistical data in this report shows with significant consistency that Foreign Latino Population does not obtain the benefits from PPACA. PPACA on the other hand will have an impact on their income for the reason the federal government will penalized undocumented immigrants if they do not have health insurance.

The penalty will happen because it depends upon the *"substantial presence test"* implemented by the Internal Revenue Service (IRS) to all citizens and immigrants. Another difficulty is that undocumented foreign born Latino immigrants cannot buy health insurance through the market exchange, but could do it in individual markets where there is less regulation; therefore, it is more likely that premiums or deductibles could be higher than those offered in the exchange.

- The benefits of PPACA will be essentially enjoyed for the 42.9% Latinos who are citizens or legal residents of the United States, and is more likely it will provide most of the advantages to those who speak English. Therefore, the benefits of the law will just be available for few people.
- It will be important for Non-for-profit organizations such as Comunidades Latinas Unidades en Servicio (CLUES) to teach relevant aspects of the Patient Protection and Affordable care act to people who are eligible for benefits but might not understand the law. This process should be considered after knowing the final verdict of the Supreme Court of the U.S. on the approval of this legislative initiative.

  In addition, non-profit organizations involved in the education sector in Minnesota should find a legislative way to allow immigrants who are 16 years old and older, to access to high school education and attain their diploma in short periods of time. This type of schools in Colombia have allowed people coming from poverty to improve income opportunities by working in fields they have become suited to, or be able to get into college and obtain more qualifications. Improving education to the vast majority of undocumented foreign born Latino population would allow them to earn better income and to afford health insurance until a legislative solution arises to manage their citizenship status.

REFERENCES

Arrow, K. (1963). December. Uncertainty and the welfare economics of health care.

Census 2010, U. S. (2011, May). Age and sex composition: 2010. Washington D.C., Distric of Columbia, United States of America.

CRS (2009, August). *Treatment of noncitizens in HR 3200*. Retrieved 4 24, 2012, from Congresional Research Service: http://www.cis.org/articles/2009/CRS_Report_on_HR3200.pdf

Department of Human Services, M. (2012). *Health reform Minnesota*. Retrieved April 8, 2012, from State of Minnesota: http://mn.gov/health-reform/health-reform-in-Minnesota/index.jsp

Health Pack, O. (2012). Universal health care. United States of the America.

Human and Health Services, D. (2012). The Officional U.S. Government site for Medicare. Washington, D.C., United States of America.

Kaiser Family Foundation, F. (2011, April 15). *Focus of Helth Reform. Summary of new health reform law.* Retrieved April 10, 2012, from http://www.kff.org/healthreform/upload/8061.pdf: http://www.kff.org/healthreform/upload/8061.pdf

Kimbuende, E., Ranji, U., & Salganicoff, A. (2010, February). *Kaiseredu.* Retrieved April 7, 2012, from kaiseredu.org:http://www.kaiseredu.org/Issue-Modules/Prescription-Drug-Costs/Background-Brief.aspx

Krugman, P., & Well, R. (2006, February 22). *The health care crisis and what to do about it*. Retrieved april 06, 2012, from http://www.nybooks.com/articles/archives/2006/mar/23/the-health-care-crisis-and-what-to-do-about-it/?pagination=false

Nations, U. (1948). *The Universal Declaration of Human Rights*. Retrieved april 5, 2012, from http://www.un.org/en/documents/udhr/index.shtml#a25

Nebraska, A. S. (2009). *Heatlh reform*. Retrieved april 6, 2012, from Healthreform.gov: http://www.healthreform.gov/reports/success_nebraska/nebraskasuccesstory.pdf

Originality, G. (2012). *German inventions*. Retrieved 4, 4, 2012, from German Originality: http://germanoriginality.com/madein/inventions.php?id=38

Politics, U. (2012). *National insurance*. Retrieved 4 6, 2012, from Politics website: http://www.politics.co.uk/reference/national-insurance

Reforms, H. (2012, June). *PPACA Passes Supreme Court Judicial Review*. Retrieved August 27, 2012, from http://healthcarereforms.org/ppaca-passes-us-supreme-court-judicial-review/

Richard, K. (2008, July 3). *National Public Radio*. Retrieved April 4, 2012, from History Of Tinkering Helps German System Endure: http://www.npr.org/templates/story/story.php?storyId=92189596

State, M. (2011, 9). Retrieved 4 25, 2012, from State of Minnesota : http://www.house.leg.state.mn.us/hrd/pubs/ncitzhhs.pdf

Tandon, A. (2008). Measuring overall health system performance for 101 countries.

World Health Organization, W. (2009). *World health statistics*. Retrieved april 5, 2012, from http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf