ACP®

American College of Physicians

internal medicine | *Doctors for Adults*

National Immigration Policy and Access to Health Care

American College of Physicians

A Position Paper

2011

National Immigration Policy and Access to Health Care

A Position Paper of the
American College of Physicians

This paper, written by Michelle Kline, was developed for the Health and Public Policy Committee of the American College of Physicians: Richard L. Neubauer, MD, FACP, Chair; Robert McLean, MD, FACP, Vice Chair; Vineet Arora, MD, FACP; Jay D. Bhatt, DO, Associate; Robert M. Centor, MD, FACP; Jacqueline W. Fincher, MD, FACP; Luke O. Hansen, MD; Richard P. Holm, MD, FACP; Celine Goetz, Student; Mark E. Mayer, MD, FACP; Mary Newman, MD, FACP; P. Preston Reynolds, MD, FACP; and Wayne Riley, MD, MBA, MACP with contributions from J. Fred Ralston, Jr., MD, FACP (ACP President, ex-officio); Robert G. Luke, MD, MACP (Chair, ACP Board of Regents, ex-officio), and Donald W. Hatton, MD, FACP (Chair, ACP Medical Service Committee). It was approved by the Board of Regents on 4 April 2011.

How to cite this paper:

American College of Physicians. National Immigration Policy and Access to Health Care. Philadelphia: American College of Physicians; 2011: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

For questions about the content of this Position Paper, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 700, 25 Massachusetts Avenue NW, Washington, DC 20001-7401; telephone 202-261-4500. To order copies of this Policy Paper, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

Executive Summary

This position paper highlights the need for national legislation to address access to health care for immigrants. There has been recent debate about immigration reform in the U.S., and the College believes that access to health care must be addressed. Currently, many immigrants do not have health care insurance coverage and face other barriers to accessing health care. As the immigrant population grows in the U.S., it will be imperative to address this issue. The current system is unsustainable and is inadequate to meet the needs of the immigrant population.

The American College of Physicians (ACP) is the nation's largest specialty society, representing 130,000 internal medicine physicians (internists) and medical students. Internists specialize in the prevention, detection, and treatment of illness in adults. Our membership includes physicians who provide comprehensive primary and subspecialty care to tens of millions of patients, including taking care of more Medicare patients than any other physician specialty. This paper discusses the issues and provides background information concerning access to health care for immigrants. The College calls for a national immigration policy on health care that balances the needs of the country to control its borders, provides access to health care equitably and appropriately, and protects the public's health. The paper presents the following public policy positions:

Access to care

1. **Access to health care for immigrants is a national issue and needs to be addressed with a national policy. Individual state laws will not be adequate to address this national problem and will result in a patchwork solution.**

2. **Access to health care should not be restricted based on immigration status, and people should not be prevented from paying out-of-pocket for health insurance coverage.**

3. **U.S.-born children of parents who lack legal residency should have the same access to health coverage and government-subsidized health care as any other U.S. citizen.**

Delivery of Care

4. **National immigration policy should recognize the public health risks associated with undocumented persons not receiving medical care because of concerns about criminal or civil prosecution or deportation.**

    a. **Increased access to comprehensive primary care, prenatal care, injury prevention initiatives, toxic exposure prevention, and chronic disease management may make better use of the public health dollar by improving the health status of this population and alleviating the need for costly emergency care.**

    b. **National immigration policy should encourage all residents to obtain clinically effective vaccinations and screening for prevalent infectious diseases.**

5. **The federal government should develop new and innovative strategies to support safety-net health care facilities, such as community health centers, federally qualified health centers, public health agencies, and hospitals that provide a disproportionate share of care for patients who are uninsured, covered by Medicaid, or indigent. The federal government should also continue to help offset the costs of uncompensated care provided by these facilities and continue to support the provision of emergency services. All patients should have access to appropriate outpatient care, inpatient care, and emergency services, and the primary care workforce should be strengthened to meet the nation's health care needs.**

Eliminating discrimination in health care and professionalism

6. **Physicians and other health care professionals have an ethical and professional obligation to care for the sick. Immigration policy should not interfere with the ethical obligation to provide care for all.**

7. **Immigration policies should not foster discrimination against a class or category of patients in the provision of health care.**

Call for action

ACP is calling for a national immigration policy on health care that balances:

A. **The need for a country to have control over whom it admits within its borders and to enact and implement laws designed to reduce unlawful entry.**

B. **The need for the U.S. to differentiate its treatment of persons who fully comply with the law in establishing legal residency from that of persons who break the law in the determination of access to subsidized health coverage and treatment.**

C. **The concern that unlawful residents may not pay state or federal income taxes but could receive care that is subsidized by legal residents who lawfully pay their income taxes.**

D. **Recognition that residents who lack legal documentation are still likely to access health care services when ill, especially in emergency situations, and that hospitals have an ethical and legal obligation under Emergency Medical Treatment and Active Labor Act (EMTALA) to treat such persons, and physicians are ethically responsible to take care of them.**

E. **Recognition that society has a public health interest in ensuring that all residents have access to health care, particularly for communicable diseases, and that delayed treatment for both communicable and noncommunicable diseases may be costly and can endanger the rest of the population.**

F. **Recognition that persons who delay obtaining care because they cannot document legal residency are likely to generate higher health care costs that are passed onto legal residents and taxpayers, through higher premiums and higher taxes.**

G. Recognition that any policy intended to force the millions of persons who now reside unlawfully in the U.S. to return to their countries of origin through arrest, detention, and mass deportation could result in severe health care consequences for affected persons and their family members (including those who are lawful residents but who reside in a household with unlawful residents—such as U.S.-born children whose parents are not legal residents), creates a public health emergency, results in enormous costs to the health care system of treating such persons (including the costs associated with correctional health care during periods of detention), and is likely to lead to racial and ethnic profiling and discrimination.

Introduction

Immigration law is very complex, and there are many steps on the road to U.S. citizenship. Legal distinctions are made among different types of immigrants, including naturalized citizens, noncitizens, and undocumented immigrants. Naturalized citizens are foreign-born individuals who have lawfully become U.S. citizens and have all the rights of U.S.-born citizens (except eligibility to be President or Vice President). Noncitizens are foreign-born individuals lawfully residing in the U.S. who have not obtained citizenship (including legal immigrants, legal permanent residents, refugees, asylees, and lawfully present temporary immigrants). Undocumented immigrants are foreign-born individuals illegally residing in the U.S. or who lack acceptable documentation to verify their legal status. Undocumented immigrants include those who enter the U.S. without authorization as well as those who have stayed after their visa has expired.[1] In 2006, there were 37 million foreign-born immigrants living in the U.S. from all over the world. Although most undocumented immigrants enter the U.S. from Mexico, others come from El Salvador, Guatemala, Philippines, Honduras, Korea, China, Brazil, Ecuador, and India.[2] Overall, immigrants make up about 13% of the total U.S. population. Approximately 69% of U.S. immigrants are here legally. Although there are no data that provide a direct count of undocumented immigrants, researchers estimate that about 11-12 million are undocumented.[1] In a recent study, researchers at the Pew Hispanic Center found that the number of illegal immigrants living in the U.S. has decreased by 8% since 2007.[3]

Noncitizens and undocumented immigrants are more likely to lack health insurance than citizens. There is little evidence that public benefits, such as public health insurance, draw immigrants into the country or particular states. Rather, it is believed that economic opportunity and the U.S. demand for workers is the primary driver of immigration. Noncitizens tend to be employed in low-wage labor or service jobs that often do not offer health insurance.[1] Furthermore, low-income immigrants face increased federal restrictions on eligibility for Medicaid. Following the 1996 welfare reform law, almost all legal immigrants became ineligible for federally matched Medicaid coverage during their first 5 years of residence in the U.S. After 5 years, they become eligible if they meet the programs' other eligibility requirements. Undocumented immigrants are generally ineligible for Medicaid regardless of their length of residence.[4] Only about 40% of noncitizens have private coverage. This leaves the other 60% of noncitizen immigrants without options for health care coverage (except emergency care) and may preclude regular access to physicians and other health professionals. When they do receive care, noncitizen immigrants often rely on safety-net facilities, such as clinics and health centers. However, these facilities tend to be limited in the smaller urban and rural areas that are experiencing some of the most rapid influx of immigrants. As immi-

gration populations grow, these health centers are becoming overcrowded and are strained to provide adequate care. Even with access to safety-net medical care, the immigrant population receives less primary care than citizens. In addition, noncitizens and particularly undocumented immigrants are less likely than citizens to use the emergency department for care.[5] Emergency treatment is available to all immigrants, regardless of their status. The EMTALA requires hospitals to screen and stabilize all individuals, including immigrants, who seek care in an emergency room, regardless of their ability to pay. In addition, undocumented and recent legal immigrants can receive Emergency Medicaid, which pays for emergency treatment, if they meet the program's other eligibility requirements.[1] Health coverage patterns for naturalized citizens are very similar to those of native citizens, with the majority covered through employer-sponsored or other private coverage.[5]

Even though noncitizens are less likely to be insured than citizens, they are not the primary factor driving the nation's uninsured problem or the main cause of our nation's increased health care spending costs. Noncitizens and undocumented immigrants accounted for 22% of the nonelderly uninsured in 2006, but citizens still made up the bulk of the uninsured (78%). Most (76%-80%) of the growth in the number of uninsured persons between 2000 and 2006 occurred among citizens, with both noncitizens and undocumented immigrants accounting for the remaining 20%-24% of the growth of uninsured persons. In addition, noncitizens and undocumented immigrants tend to have poorer access and receive less care than citizens, even when they have health insurance. As a result of their lower use of care, noncitizens and undocumented immigrants have significantly lower per capita health care expenditures than citizens. In 2005, average annual per capita health care expenditures for noncitizens and undocumented immigrants were $1,797 versus $3,702 for citizens. These differences in expenditures persist among the privately and publicly insured and the uninsured.[1]

Access to care

1. **Access to health care for immigrants is a national issue and needs to be addressed with a national policy. Individual state laws will not be adequate to address this national problem and will result in a patchwork solution.**

The federal government needs to enact national legislation that will address access to health care for noncitizens and undocumented immigrants. Researchers have estimated that the U.S. population will increase by 120 million people over the next 50 years; 80 million will be the direct or indirect consequence of immigration. In addition, studies have found that the gap in insurance coverage between immigrants and natives persists even after health status, employment sector, occupation, and a limited set of other socio-economic variables are controlled for.[6] Health care access for immigrants is an issue that will only be exacerbated in the future if it is not addressed today.

Since 1996, legal immigrants (noncitizens) have not been eligible for federal funding under government programs during their first 5 years of U.S. residency. The passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states the option to provide coverage, with federal funding participation, to children and pregnant women of documented status in their first 5 years in this country. The "safety-net" facilities, particularly Federally Qualified Health Centers (FQHCs), provide

direct access to health services for immigrants where available. CHIPRA also expanded safety-net services in an effort to address some of the difficulties in health care services. Policies regarding state funding of health care for immigrants and availability of safety-net services are quite variable across the nation. Several states have continued to provide immigrants with health coverage using state-only dollars. However, each state handles coverage of immigrants differently. For example, the states with the largest immigrant populations are Arizona, California, Florida, Illinois, New Jersey, New York, and Texas. Three of these states—California, New York, and Illinois—are in the forefront of coverage for immigrants. Illinois has a unified program to cover all children; California and New York cover low-income immigrants through a patchwork of programs.[7] Some states cover adults, whereas others cover only children.[7] Some states choose not to allocate any additional resources to covering immigrants (legal or illegal) beyond the minimum required by federal law. This patchwork solution is inadequate to face the growing issue in our country.

In addition, the current state-by-state policies to cover immigrants create another barrier for obtaining health coverage and accessing health care services. Differing policies create confusion among those trying to obtain health care. As is, the U.S. health care system is very confusing and daunting to many immigrants trying to obtain access to health care. Many new immigrants are not aware of the need for health insurance in the U.S., as many come from countries where the various forms of government provided medical care.[7] Differing state policies could also result in varying population growth among states due to job opportunities and differences in health insurance coverage. States that offer more generous health insurance coverage could become inundated with new immigrants, overburdening the system and reducing its ability to offer quality care because of a lack of resources (both financially and workforce shortages to meet the new demand). In Massachusetts, more than 20,000 of the state's immigrants may lose their health care benefits due to budget cuts.[8] Even such states as California and Illinois, which have created policy to meet the needs of their state's population of immigrants, could be overwhelmed by an influx of more immigrants.

The federal government needs to develop a national policy that outlines how funding should be allocated to ensure health care access for immigrants. A patchwork of state and local immigration policies disrupts federal immigration enforcement and becomes counterproductive. States should cooperate with the federal government in enforcing national immigration laws, but immigration policy should not be enacted at the state level. It also will be important to consider strategies to foster private job–based health insurance for immigrant workers and their families, as immigrants are far more likely to work in food and agriculture, personal services, or textiles— industries known to be less likely to offer health insurance to their employees.[6]

2. Access to health care should not be restricted based on immigration status, and people should not be prevented from paying out-of-pocket for health insurance coverage.

The College is strongly committed to advocating for increased access to quality health care for all, regardless of race, ethnicity, socioeconomic status, or other factors. Accordingly, the mission of ACP is, "To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine." The College supports policies that increase access to health care for all, invest in preventive care, and address societal determinants

of health. Accordingly, strategic objectives of the College include "improving access to care and eliminating disparities, with a focus on expanding health insurance coverage."[9]

The U.S. has made a great effort to improving access to health care through the passage of the Affordable Care Act (ACA). Under this new law, naturalized citizens will have the same access and requirements for affordable coverage as U.S.-born citizens. However, legal immigrants were granted limited federal coverage. Lawful resident immigrants may purchase coverage from the state insurance exchanges; are eligible for premium tax credits, coverage in temporary high-risk pools, and basic health plans offered by a state; are subject to cost-sharing reductions, the individual mandate, and related tax penalty; and will not have waiting periods for enrollment. Existing federal immigrant eligibility restrictions in Medicaid remain in effect, including the 5-year-or-more waiting period for most lawful resident adult immigrants with low income.

Under the ACA, undocumented immigrants will not receive any federally subsidized health care coverage. They also will not be eligible for Medicare, nonemergency Medicaid, or CHIP. In addition, the law does not allow undocumented immigrants to purchase coverage in the newly created purchasing pools (exchanges), even if they pay entirely with their own funds, leaving most without a group purchasing option to obtain health care coverage. Although undocumented immigrants will remain able to purchase health care coverage outside of the exchanges through the open (individual and small group) market, they may have fewer options as coverage migrates to plans offered only through the exchanges. They will, however, be exempt from the mandate for all individuals to have health insurance. Undocumented immigrants also remain eligible for emergency care under federal law and may seek nonemergency health services at community health centers or other facilities that offer care to all, regardless of immigration status.[10] Restricting undocumented immigrants from having health insurance will not prevent them from falling ill and needing health care.

Access to needed and appropriate health care should not be restricted. Undocumented immigrants should not be able to receive public subsidies to purchase health care, but they should be allowed to purchase health care coverage using their own funds. Health care systems in which health care is restricted have poorer outcomes for those without access to a physician or to health care insurance.[11] In addition, since undocumented immigrants have lower medical expenses than citizens[12], it would be beneficial for them to participate in the health insurance exchanges because their participation would lower average medical costs, therefore enabling the insurance exchanges to offer lower premiums, benefiting both citizens and immigrants alike. The College opposes policies that prohibit persons, regardless of their residency status, from paying out-of-pocket for health insurance coverage.

3. U.S.-born children of parents who lack legal residency should have the same access to health coverage and government-subsidized health care as any other U.S. citizen.

As outlined by the 14th Amendment to the U.S. Constitution, all persons born or naturalized in the U.S. and subject to the jurisdiction thereof are citizens of the U.S. and of the state wherein they reside. This means that a child born in the U.S. to immigrant parents automatically becomes a citizen. Children of immigrants are the fastest-growing component of the child population. Almost all (93%) children of immigrants, who are under the age of 6, are

U.S. citizens. Many of these U.S.-born children younger than 6 years of age live in mixed-status families, with one or more noncitizen parent; 29% live in families with one or more undocumented parent. These legal and undocumented immigrant parents may be reluctant to approach public or publicly funded institutions for services despite their children's citizenship and eligibility. As a result, many children of immigrants use public funding less often than children of natives, despite higher rates of economic hardship. These children remain twice as likely to lack health care insurance than natives, despite expansion of coverage for low-income children through Medicaid and other public programs.[13] In addition, insurance coverage of immigrant children has declined since 1996, while it has improved for citizen children due to differential eligibility for immigrant children in Medicaid and CHIP.[14] National policy should encourage parents to take their children to receive care and other benefits to which they are entitled, by removing the fear of reprisal when trying to access care for their citizen children. U.S.-born children should not be at a disadvantage from receiving the benefits of U.S. citizenship because of their parents' immigrant status and fear of deportation.

Delivery of Care

4. **National immigration policy should recognize the public health risks associated with undocumented persons not receiving medical care because of concerns about criminal or civil prosecution or deportation.**

    a. **Increased access to comprehensive primary care, prenatal care, injury prevention initiatives, toxic exposure prevention, and chronic disease management may make better use of the public health dollar by improving the health status of this population and alleviating need for costly emergency care.**

The College has long supported access to primary care for patients in an effort to enhance coordination of care, prevent unnecessary hospitalization, improve patient health outcomes, and therefore reduce costs. In 2008, ACP released a comprehensive, annotated summary[15] of more than 100 studies, conducted over the past two decades in the U.S. and abroad, that shows that the availability of primary care is consistently associated with better outcomes and lower costs of care. Patients without adequate health insurance often forgo needed care, endure preventable illnesses, suffer complications that could have been avoided if diagnosed and treated earlier, accumulate medical debt (the leading cause of bankruptcy[16], and are at risk for premature mortality.[17-19]

Immigrants do not always have consistent access to a primary care physician, often due to a lack of health insurance. It has been shown that having insurance significantly improves patients' access to care and increases their likelihood of receiving preventive care.[4] Federal law excludes undocumented immigrants, as well as legal immigrants who have been in the U.S. for less than 5 years, from Medicaid eligibility. These individuals can, however, receive Emergency Medicaid coverage for emergency medical services if they are in a Medicaid-eligible category. Federal funds cannot be used for medical services that fall outside of emergency care as defined by federal guidelines. When noncitizens, who are working in the U.S. legally in low-wage jobs that do not offer private insurance, become seriously ill and are not able to access care through Medicaid, their options are either to leave their family and return to their country of

origin for care and then start the process again for entering the U.S., or to forgo treatment. Families can thus face the prospect of being torn apart even if the spouse and children are U.S. citizens. Consequently, people in this situation may go without care.

As of 2007, a total of 23 states had chosen to use state funds to provide additional coverage for recent immigrants or for undocumented children and pregnant women. Some states that have decided to provide additional coverage for the immigrant population have seen the financial benefit. In California, for example, a study in 2000 concluded that elimination of public funding for prenatal care of undocumented immigrants would prove far more expensive for taxpayers by substantially increasing low birthweight, prematurity, and postnatal costs, thereby increasing medical care for the infant.[20]

Emergency Medicaid primarily fills 3 gaps in the health care needs of the immigrant population: childbirth-related costs, emergency care of sudden-onset problems, and emergency care for severe complications of chronic diseases. However, many of these conditions could be prevented through early detection, primary care, and public health educational campaigns. Outside of pregnancy, one prominent reason for Emergency Medicaid is debilitating symptoms that result in a diagnosis of a chronic disease, such as chronic renal failure, cerebrovascular disease, or heart disease. This suggests unmet need for preventive and primary care for risk factor identification and management. Lack of coverage for nonemergency primary and preventive care, and lack of coverage for medical care after discharge may prolong hospitalizations or result in readmissions for chronic or disabling conditions, also resulting in increased hospitalization costs. Case management of uninsured immigrants with chronic disease would be a useful strategy toward addressing both financial and nonfinancial barriers to ongoing care. In addition, a recent study found that many hospitalizations were for major injuries, including workplace injuries and motor vehicle accidents. This study found that immigrants, and particularly Hispanic immigrants, account for a disproportionate number of workplace injuries and fatalities in the U.S.[20] These results suggest a dire need for injury prevention interventions, including working with immigrant health advocates that target the new immigrant population in an effort to reduce hospitalizations and injuries.

In our current system, society already pays to treat the uninsured (both citizens and noncitizens). For example, an uninsured patient who goes to the hospital with pneumonia is required by law to be treated. The costs of the uninsured patient are passed along to other patients in the form of higher prices, which can lead to higher insurance premiums and, in the case of Medicaid and Medicare, higher taxes. If these patients had insurance and access to a primary care doctor, they could see their physician at the first signs of illness and potentially prevent the expensive hospital treatment.[21]

The College continues to support national policies to increase access to comprehensive primary care in order to improve the health status of the population and reduce health care spending. The College encourages the federal government to develop policies to ensure that immigrants are able to access comprehensive primary care.

b. National immigration policy should encourage all residents to obtain clinically effective vaccinations and screening for prevalent infectious diseases.

The U.S. has worked hard to eradicate many communicable diseases and prevent new outbreaks of previously eradicated diseases to keep the population healthy and safe. As such, a medical examination is mandatory for all refugees coming to the U.S. and all applicants outside the U.S. applying for an immigrant visa. Aliens in the U.S. who apply for adjustment of their immigration status to that of permanent resident are also required to be medically examined. The Division of Global Migration and Quarantine (DGMQ) is responsible for providing the Technical Instructions to civil surgeons and panel physicians (see Glossary for definition). DGMQ also provides the technical instructions and guidance to physicians conducting the medical examination for immigration. These instructions are developed in accordance with Section 212(a)(1)(A) of the Immigration and Nationality Act (INA), which states those classes of aliens ineligible for visas or admission based on health-related grounds. The health-related grounds include persons who have a communicable disease of public health significance, who cannot present documentation of having received vaccination against vaccine-preventable diseases, who have or have had a physical or mental disorder with associated harmful behavior, and who are drug abusers or addicts. During the medical examination each patient is assessed for vaccine-preventable diseases, including mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, Haemophilus influenzae type B, rotavirus, hepatitis A, hepatitis B, meningococcal disease, varicella, influenza, and pneumococcal pneumonia. Patients must provide vaccination records during the examination and are required to be vaccinated for any diseases that they may be missing, as well as any others recommended by the Advisory Committee for Immunization Practices.[22] Patients are also responsible for paying the appropriate fee for all vaccinations directly to the civil surgeon.[23] Persons who enter the country illegally are not subject to a medical examination and therefore are not checked for communicable diseases and vaccination history. National policy needs to address this issue and recognize that society has a public health interest in ensuring that all persons within our borders have access to health care, particularly for communicable diseases, such as drug-resistant tuberculosis.

In addition, it is important for the U.S. population and residents to be vaccinated against diseases because we live in a world where diseases can be easily reintroduced and spread among the population through travel. Some believe that previously eradicated diseases are resurfacing due to a lack of vaccination among both children and adults.[24] Public health officials fear that sporadic vaccination practices may be contributing to dangerous cases of preventable diseases.[24] Persons who do not have regular access to health care or who are uninsured will most likely not be able to receive or afford these important vaccinations. It is especially important for pregnant women to receive clinically effective vaccinations to protect high-risk infants from contagious childhood diseases. Restricting access to health care, especially for immigrants, could pose a larger public health threat in the long run. National policy needs to address this issue and ensure that all people living in the U.S. have access to vaccinations and treatment for communicable disease in an effort to keep the public safe.

5. **The federal government should develop new and innovative strategies to support safety-net health care facilities, such as community health centers, federally qualified health centers, public health agencies, and hospitals that provide a disproportionate share of care for patients who are uninsured, covered by Medicaid, or indigent. The federal government should also continue to help offset the costs of uncompensated care provided by these facilities and continue to provide emergency services. All patients should have access to appropriate outpatient care, inpatient care and emergency services, and the primary care workforce should be strengthened to meet the nation's health care needs.**

Safety-net health care facilities are an important aspect of our health care system. These health care facilities provide care to both the insured and uninsured, and they treat patients regardless of their ability to pay. The safety net includes health centers; public hospitals systems; and state, local, tribal, and territorial health departments. They may also include school and church-based health clinics, private physicians, and nonprofit hospitals committed to serving vulnerable patients.[25]

Located in medically underserved communities, safety-net health care centers offer primary care services to people who often have difficulty accessing medical care. These health centers have significantly improved access to primary and preventive care for vulnerable populations, including immigrants. Safety-net health centers are able to tailor their services to the health, social, and cultural needs of their patients (including language services), resulting in high-quality care. However, many health centers struggle with not having enough health care professionals, including a shortage of doctors, nurse practitioners, or physician assistants. Many health care centers are unable to provide even basic health screening tests. In order to offer preventive screening, health care centers need regular paid staff to coordinate care, ensuring that patients are contacted and appropriately advised about their test results.[25] In addition, there is often very little specialist care or surgical inpatient care available for patients who seek care at safety-net health care facilities.[7]

It is important to recognize that rising health care costs in recent years threatens safety-net health care facilities that have slim operating margins and are often reliant on government sources of funding. The payer mix at safety-net health care facilities is switching to more uncompensated care, which is causing funding problems.[7] Medicaid dollars are their single largest source of revenue, providing over a third of public hospitals' and community health centers' revenues. However, as states have struggled with budgets and increased Medicaid enrollment, they have cut provider payments and raised eligibility levels, both of which directly affect the operations of these facilities. Likewise, increases in beneficiaries' co-payments by some states are often absorbed by safety-net health care facilities because the poor are least able to afford these payments.[25]

Without health insurance, patients often turn to safety-net facilities for affordable care. These facilities should not be a replacement for the security and portability that health insurance coverage affords; however, the College recognizes the important role of these centers in delivering care to the uninsured and urges the federal government to develop new and innovative strategies to financially support safety-net health care facilities. Without sustained financing, largely through public funding, the safety net will not be able to continue its mission to the poor and uninsured. It will also be important to maintain funding for these facilities as they adapt their systems to the requirements set forth by the ACA.

To be federally qualified (and to receive federal funding), health centers must deliver the full range of services set by the government, including preventive, diagnostic, laboratory services, dental care, case management, and health education. Numerous studies have found that besides providing affordable services, FQHCs provide quality care—improving preventive care, decreasing preventable hospitalizations, and maintaining high patient satisfaction.[25] According to Kaiser Family Foundation's State Health Facts, 17,122,535 patients were served by FQHCs in 2008 and had 66,924,192 patient encounters/visits.[26]

Disproportionate Share Hospital (DSH) adjustment payments provide additional help to hospitals that serve a significantly disproportionate number

of low-income patients; eligible hospitals are referred to as DSH hospitals. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other health insurance.[27] Even though health insurance will become expanded under the ACA, DSH payments will still be necessary to support care for those who will remain uninsured (including many immigrants) and to subsidize the relatively low Medicaid reimbursement rates for 15 million new Medicaid patients.[28] It will be imperative to support DSHs and other safety-net care facilities because even when fully implemented in 2019, the CBO estimates that 23 million nonelderly residents will remain uninsured.[29]

As another part of the safety-net system, under current law immigrants can receive care in a hospital under EMTALA or Emergency Medicaid. Currently, hospitals are obligated to provide care to anyone needing emergency health care treatment regardless of citizenship, legal status, or ability to pay. As outlined by CMS:

> In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests a transfer, an appropriate transfer should be implemented.[30]

EMTALA is used by all uninsured patients upon entering the emergency department. The program, however, is not fully funded by the federal government and ultimately the costs of care for the uninsured are shifted to the public through higher hospital charges. In addition EMTALA places a large responsibility on hospitals and emergency physicians to provide health care and shoulder the financial burden of providing EMTALA related medical care. For example, according to a May 2003 American Medical Association study, each emergency physician on average provided $138,300 of EMTALA-related charity care yearly, and one third of emergency physicians provide more than 30 hours of EMTALA-related charity care each week.[31]

Noncitizens can receive Emergency Medicaid coverage for emergency medical services if they fit in a Medicaid-eligible category, such as children, pregnant women, families with dependent children, elderly or disabled individuals, and meet state income and residency requirements. Emergency Medicaid is only available to individuals—regardless of immigration status—who are so acutely ill that the failure to receive medical attention would place their health in serious jeopardy. Recently, the U.S. Government Accountability Office has reported that states with high immigration rates have experienced a rapid rise in Emergency Medicaid expenditures in recent years.[20] A study published in the Journal of the American Medical Association analyzed administrative claims data from 2001 to 2004 related to Emergency Medicaid program in North Carolina.(North Carolina's total foreign-born population grew by 274% during the 1990s and included an estimated 300,000 undocumented immigrants by 2004.) The researchers found that despite a steady increase in

Emergency Medicaid use, the 16,106 patients served by Emergency Medicaid in 2004 represented only 5% of the total estimated undocumented immigrant population and remained less than 1% of the total state Medicaid budget.[20] It is interesting to note that although this is available, immigrants use emergency care less and spend less on emergency care than citizens (both insured and uninsured). According to a 2007 analysis by the Kaiser Commission on Medicaid and the Uninsured, uninsured, adult, low-income noncitizens were the least likely to use emergency departments, with only about 1 in 10 reporting a visit in the past year. Adult noncitizens most often rely on clinics and health centers, many of which are funded by charities as well as hospitals seeking to unburden their emergency departments.[4]

Neither EMTALA nor Emergency Medicaid provides preventive care. Both programs focus on providing care only when patients are at their sickest and when the cost of treatment is at its highest. National policy needs to address this issue both from a health and financial standpoint to ensure that undocumented immigrants are able to access preventive care in order to minimize development of diseases and ease the burden borne by hospitals.

As the College has discussed in previous policy papers and earlier in this paper, the U.S. needs to strengthen its primary care workforce in order to meet the needs of the population. Patients with consistent access to primary care have better outcomes and lower costs of care. In addition, as the College outlined in a policy paper, *Racial and Ethnic Disparities in Health Care*, Updated 2010,[32] a diverse health care workforce that is more representative of those it serves is crucial to promote understanding among health care professionals and patients, facilitate quality care, and promote equity in the health care system. As the nation's population grows more diverse, we will need a workforce that reflects the country's racial and ethnic diversity to close the disparity gap. The College recognizes the need for an overall national workforce policy and emphasizes the need to assure an adequate supply of primary care physicians. In the policy paper, *Creating a National Workforce for Internal Medicine*,[33] the College calls on the federal government, large employers and other purchasers, health plans, and the medical profession itself, to take immediate action to create a comprehensive national health care workforce policy. In addition, the College notes that this policy must include a goal of substantially increasing the number of trained and practicing primary care physicians as a proportion of the total physician population. A national workforce policy will not be effective in assuring an adequate supply of physicians—specifically, internists who practice in office-based general internal medicine practices—without changes in reimbursement policies, student debt, and other factors that discourage physicians from going into primary care and encourage those who already are in practice to leave.

Eliminating discrimination in health care and professionalism

6. Physicians and other health care professionals have an ethical and professional obligation to care for the sick. Immigration policy should not interfere with the ethical obligation to provide care for all.

Physicians are bound by ethics, professionalism, and tradition to provide care for the sick. The fundamental principles of medical ethics apply to all patients and include beneficence, the duty to promote good and act in the best interest of the patient and the health of society; nonmalfeasance, the duty to do no harm to patients; respect for patient autonomy; the duty to protect and foster

a patient's free, uncoerced choices; and justice.[34] The health of patients and the public relies on fulfillment of these obligations to care for all patients by physicians, without restriction based on the ability to pay or patient characteristics, including decision-making capacity or social status.

Trust is central to the patient–physician relationship. Patients must be able to feel confident that the information they share with their physicians during the clinical encounter will remain confidential and that physicians will not betray them to authorities. Immigration policy must be consistent with the physician's obligation to respect the privacy and confidentiality of patients, including disclosure of information unrelated to an individual's medical condition.[35] Language and cultural barriers may magnify fears that seeking health care services will result in exposure of immigration status. Patients need to know that they can seek medical attention without fear of being reported to the authorities, regardless of whether reporting is actually required. Such fears can result in increased pain and suffering due to delay in treatment until patients are acutely ill, and ultimately places a greater burden on the health system. Fear of detection and deportation can also lead to patients avoiding preventive care, such as immunizations and screenings for infectious disease, which risks the spread of disease to others.[36]

Also, any law that might require physicians to share confidential information, such as citizenship status to the authorities, that was gained through the patient–physician relationship conflicts with the ethical and professional duties of physicians. National immigration policy should respect the boundaries of this relationship and the ethical obligations of physicians and not require physicians to reveal confidential information. Therefore, federal policies should not intrude upon a physician's obligation to treat patients, regardless of legal status, and physicians should not be required to report on the immigration status of patients.

7. Immigration policies should not foster discrimination against a class or category of patients in the provision of health care.

The ACP Ethics Manual states that "The physician must respect the dignity of all persons and respect their uniqueness" and "may not discriminate against a class or category of patients." Immigration policies that promote or may be seen to encourage ethnic profiling and discrimination raise concerns that patients will be deterred from seeking needed health care and will have a detrimental influence on patient–physician relationships. Such approaches would also be inconsistent with the College policy that physicians "should work toward ensuring access to health care for all persons; act to eliminate discrimination in health care; and help correct deficiencies in the availability, accessibility, and quality of health services... The denial of appropriate care to a class of patients for any reason is unethical."[34]

Conclusion

Access to health care for the immigrant population is important to the overall population of the U.S. This paper sets forth the policy positions of the American College of Physicians concerning access to health care for immigrants and will serve as the basis for ACP public policy advocacy. The paper highlights the major issues concerning health care for immigrants. It also calls for a national immigration policy on health care that balances legitimate needs and concerns to control our borders and to equitably differentiate in publicly supported services for those who fully comply with immigration laws and those who do not, while recognizing that society has a public health interest in ensuring that all resident persons have access to health care. It is hoped that this paper will help influence the national immigration policy discussion and lead to a policy that balances the countervailing needs of individuals and society and is in accord with standards of medical ethics and professionalism.

Glossary

ACA: The Patient Protection and Affordable Care Act that was signed into law by President Barack Obama on March 23, 2010. This Act and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010) constitute the federal health care reform legislation of 2010.

CHIPRA: Children's Health Insurance Program Reauthorization Act of 2009, gave states the option to provide coverage, with federal funding participation, to children and pregnant women of documented status in their first 5 years in this country.

Civil Surgeon: A physician who has been designated by the U.S. Citizenship and Immigration Services to conduct the medical examination in the U.S. during the application process for adjustment of status.[37]

DSH: Disproportionate Share Hospital: A hospital that provides uncompensated care and serves a disproportionate share of care to poor and indigent patients.

EMTALA: Emergency Medical Treatment & Labor Act.

FQHC: Federally Qualified Health Centers.

Immigrant: A foreign-born individual residing in the U.S; includes naturalized citizens as well as noncitizens who fall into a number of different immigration categories.[1]

Naturalized citizen: A foreign-born individual who has lawfully become a U.S. citizen and has all the rights of a U.S.-born citizen, except for being eligible to be President or Vice President of the U.S.[1]

Noncitizen: A foreign-born individual residing in the U.S. who has not obtained citizenship.

- Over half (56%) of noncitizens are legal immigrants, including legal permanent residents (those with "green cards"); refugees, asylees, and other humanitarian immigrants; and lawfully present temporary immigrants.
- It is estimated that the remaining 44% of noncitizens are undocumented immigrants.[1]

Panel physician: Physicians that conduct medical examinations outside of the U.S. during the application process for adjustment of status. Physicians are selected by Department of State consular officials.[22]

Undocumented immigrant: A foreign-born individual residing in the U.S. who is not a legal resident.

- Undocumented immigrants include those who entered the U.S. without authorization, as well as those who were admitted temporarily and have stayed after their visa expired. Individuals who overstayed their visas are estimated to account for 25% to 40% of undocumented immigrants.
- Additionally, an estimated 1 to 1.5 million undocumented immigrants fall into a "quasi-legal" category, such as people with temporary protective status, those with extended voluntary departure, those who have applied for asylum, and those waiting for "green cards" or legal permanent resident status.[1]

References

1. **Summary: Five Basic Facts on Immigrants and Their Health Care.** *Kaiser Commission on Medicaid and the Uninsured.* March 2008. Accessed July 20, 2010 www.kff.org/medicaid/upload/7761.pdf.
2. **Demographics of Unauthorized Immigrants in the US: Countries of Origin, States of Residence, and Employment Data, 2000-2008.** ProCon.org, Accessed February 23, 2011 http://immigration.procon.org/view.resource.php?resourceID=000845#graphs.
3. **Passel J, Cohn, D.** *U.S. Unauthorized Immigration Flows are Down Sharply Since Mid-Decade.* The Pew Hispanic Center. Accessed September 10, 2010 http://pewhispanic.org/reports/report.php?ReportID=126.
4. **Artiga S, Schwartz, K.** Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Children. *Kaiser Commission on Medicaid and the Uninsured.* May 2007. Accessed July 20, 2010 www.kff.org/medicaid/upload/7643.pdf.
5. **Artiga S, Tolbert, J.** Immigrants' Health Coverage and Health Reform: Key Questions and Answers. *Kaiser Commission on Medicaid and the Uninsured – Focus on Health Reform.* December 2009. Accessed July 20, 2010. www.kff.org/healthreform/upload/7982.pdf.
6. **Goldman D, Smith J, Sood N.** Legal Status and Health Insurance Among Immigrants. *Health Affairs.* 24, no. 6 (2005): 1640-1653. Accessed July 21, 2010 http://content.healthaffairs.org/cgi/content/full/24/6/1640?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=legal+status+and+health+insurance&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.
7. **Rosenthal M.** State Practices in Health Coverage for Immigrants: A Report for New Jersey. Rutgers Center for State Health Policy. Accessed July 21, 2010 http://njcitizenaction.org/hcstatepractices.pdf.
8. **Bierman N.** Legal Immigrants could lose out on care. *The Boston Globe*, June 25, 2010. Accessed July 15, 2010. www.boston.com/news/local/massachusetts/articles/2010/06/25/legal_immigrants_could_lose_out_on_care/.
9. **American College of Physicians.** Strategic Plan., Strategic Themes and Objectives. July 2009. Accessed at July 26, 2010 N:\RPE\Online Documents\Planning\Strategic Plan\2009-10.pdf.
10. **How Are Immigrants Included in Health Care Reform?** National Immigration Law Center. Accessed February 28, 2011 at www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf.
11. **Ayanian J, Weissman J, Schneider E, Ginsburg J, Zaslavsky A.** Unmet Health Needs of Uninsured Adults in the United States. JAMA 2000;284:2061-2069. Accessed September 10, 2010 http://jama.ama-assn.org/cgi/content/full/284/16/2061?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=ginsburg%2C+jack&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.
12. **Goldman D, Smith J, Sood, N.** Immigrants and the Cost of Medical Care. Health Affairs, 25, no. 6 (2006): 1700-1711. Accessed February 23, 2011 http://content.healthaffairs.org/content/25/6/1700.full?sid=d2917bdd-40a5-4729-9d9f-02323362c18a.
13. **Capps R, Fix M, Ost J, Reardon-Anderson J, Passel J.** *The Health and Well-Being of Young Children of Immigrants.* Urban Institute 2004. Accessed August 4, 2010 www.urban.org/UploadedPDF/311139_ChildrenImmigrants.pdf.
14. **Ku L.** Restoring Medicaid and SCHIP Coverage to Legal immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens. Department of Health Policy, George Washington University School of Public Health and Health Services. Accessed February 23, 2011 www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A61E7016-5056-9D20-3DB38C7EC7B0B408.pdf.

15. **American College of Physicians.** How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?. Philadelphia: American College of Physicians; 2008: White Paper. Accessed July 28, 2010 www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf.
16. **Himmelstein DU, Thorne D, Warren E, Woolhandler S.** Medical Bankruptcy in the United States, 2007: Results of a National Study. *American Journal of Medicine*, 2009;122(8):741-46.
17. **Tu HT, Cohen GR.** Center for Health Systems Change. Tracking Report: Financial and Health Burdens of Chronic Conditions Grow, Results From The Community Tracking Study • NO. 24 • April 2009.
18. **Fronstin P.** "Sources of Health Insurance and Characteristics of the Uninsured: Updated Analysis of the March 2006 Current Population Survey," EBRI Issue Brief no. 305, p. 4, 2007. Accessed May 13, 2010 www.ebri.org/pdf/briefspdf/EBRI_IB_05-20074.pdf.
19. **Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky A.** Unmet health needs of uninsured adults in the United States. JAMA, 2000; 284:2061-69.
20. **DuBard CA, Massing M.** Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants. JAMA. 2007; 297(10)"1085-1092. Accessed July 28, 2010 http://jama.ama-assn.org/cgi/content/full/297/10/1085.
21. **Beam C.** The Economic Case for Insuring Undocumented Immigrants. *Slate Magazine July 30, 2009*. Accessed July 28, 2010 www.slate.com/id/2223912.
22. **Medical Examination of Immigrants and Refugees.** Center for Disease Control and Prevention. Accessed August 10, 2010 www.cdc.gov/immigrantrefugeehealth/exams/medical-examination.html.
23. **Vaccination Requirements.** U.S. Citizenship and Immigration Services. Accessed August 10, 2010 www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=3384cc5222ff5210VgnVCM100000082ca60aRCRD&vgnextchannel=6abe6d26d17df110VgnVCM1000004718190aRCRD.
24. **Landau E.** Vaccination role unclear in Whooping Cough Outbreak. *CNN*. Accessed July 28, 2010. www.cnn.com/2010/HEALTH/06/28/california.whooping.cough/index.html.
25. **Hoffman C, Sered S.** *Threadbare: Holes in America's Health Care Safety Net*. The Kaiser Commission on Medicaid and the Uninsured. November 2005. Accessed August 18, 2010 www.kff.org/uninsured/upload/Threadbare-Holes-in-America-s-Health-Care-Safety-Net-report.pdf.
26. **Statehealthfacts.org.** The Henry J Kaiser Family Foundation. Accessed August 18, 2010 www.statehealthfacts.org/comparetable.jsp?ind=427&cat=8&sub=99&yr=63&typ=1&sort=a.
27. **Disproportionate Share Hospitals.** Health and Human Services. Accessed August 18, 2010 www.hhs.gov/recovery/cms/dsh.html.
28. **McKethan A, Chen C, Nguyen N, Kocot, L.** Reforming the Medicaid Disproportionate Share Hospital Program. Engelberg Center for Health Care Reform at Brookings. Accessed August 18, 2010 www.brookings.edu/~/media/Files/rc/reports/2010/0121_medicaid_DSH_program/DSH%20011910%20FINAL.pdf
29. **Congressional Budget Office.** H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation) Accessed August 28, 2010 www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.
30. **EMTALA.** Centers for Medicare and Medicaid Services. U.S. Department of Health & Human Services. Accessed August 17, 2010 www.cms.gov/EMTALA/.
31. **EMTALA.** American College of Emergency Physicians. Accessed August 17, 2010 www.acep.org/PrintFriendly.aspx?id=25936.
32. **American College of Physicians.** *Racial and Ethnic Health Care Disparities, Updated 2010*. Accessed August 13, 2010 www.acponline.org/advocacy/where_we_stand/access/racial_disparities.pdf.
33. **American College of Physicians.** *Creating a New National Workforce for Internal Medicine*. Philadelphia: American College of Physicians; 2006: Position Paper. Accessed August 27, 2010 www.acponline.org/advocacy/where_we_stand/policy/im_workforce.pdf.

34. **American College of Physicians.** ACP Ethics Manual: Fifth Edition. Ann Intern Med 2005;142:560-82. Available at: www.acponline.org/ethicsmanual.
35. Checking up on immigrants: a job for physicians? available at: www.acponline.org/running_practice/ethics/case_studies/care_imm.pdf.
36. **Okie S.** Immigrants and health care—at the intersection of two broken systems. N Engl J Med. 2007;357(6):525-9.

ACP®
American College of Physicians
internal medicine | *Doctors for Adults*

Product #510110110