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Introduction by Ann Weilbaecher[*]

I. INTRODUCTION

Immigrants' access to health care is at the forefront of the nation's political debates. Dr. José A. Pagán addressed this widely contested issue at the First Annual Beazley Symposium on Access to Health Care at Loyola University Chicago School of Law. Dr. Pagán is a professor of economics and Director of the Institute for Population Health Policy in the Department of Economics and Finance at the University of Texas-Pan American, in Edinburg, Texas. Dr. Pagán is also a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. He received B.S. and M.A degrees in mathematics and economics from Ohio State University, and a Ph.D. in economics from the University of New Mexico. Dr. Pagán was a Fulbright Scholar in Mexico, a consultant for the World Bank and the Inter-American Conference on Social Security, and a Robert Wood Johnson Health and Society Scholar at the University of Pennsylvania. As the recipient of a 2007 Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation, he has researched and published in the areas of economics and immigration, the impact of health status on employment and productivity, health care access, and population health consequences and community effects of uninsurance.

Dr. Pagán introduced his talk by arguing that it is in the "enlightened self interest" of communities to provide health care to immigrants. His research with colleague Dr. Mark Pauly, a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania, demonstrated that there are monetary and non-monetary spillovers to providing healthcare access to the uninsured, including immigrants (both documented and undocumented). Dr. Pagán's research indicated that making health care accessible to the uninsured actually improves the overall

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quantity and quality of healthcare services for the insured.[1] These spillovers lower the burden on the charity care system because the uninsured will be less likely to go to the emergency room for preventable illnesses.[2] There are also a number of non-pecuniary benefits to the community which include increasing the availability of specialists, lowering the rate of unmet medical needs among the insured, and improving the overall satisfaction with healthcare providers.[3]

In addition to the spillover effects detailed in Dr. Pagán's talk, Dr. Pagán has also conducted research analyzing data on 4920 physicians who provide services to communities with a high number of uninsureds.[4] This research indicates that physicians working in uninsured communities have lower career satisfaction, more difficulties communicating with specialists, and less ability to provide high quality care without facing financial difficulties compared to counterparts in the areas with few uninsured individuals.[5]

Despite convincing economic and non-economic arguments supporting the increase access to health care for immigrants, legislative and policy makers are reluctant to act. Indeed, government funding of immigrant health care is a hotly debated issue.[6] According to the National Immigration of Law Center, "[t]he hostility in the state and local debates, however, fueled a climate that deters lawfully present immigrants and their family members from securing critical services and impedes access to the few critical services that remain available regardless of immigration status."[7] The debates are particularly volatile around the provision of health care to undocumented immigrants.[8] Due to political pressure, even the politicians who encourage comprehensive health care coverage omit undocumented immigrants in their proposals.[9]

This introduction will (1) detail the scope and consequences of uninsurance among immigrants; (2) discuss the difficulties of obtaining publicly funded health care for documented and undocumented immigrants

1. *See* Mark V. Pauly & José A. Pagán, *Spillovers and Vulnerability: The Case of Community Uninsurance*, 26 HEALTH AFFAIRS 1304, 1307-13 (2007).

2. *Id.*

3. *Id.* at 1309.

4. José A. Pagán, Lakshmi Balasubramanian & Mark V. Pauly, *Physicians' Career Satisfaction, Quality of Care, and Patients' Trust: The Role of Community Uninsurance*, 2 HEALTH ECON., POL'Y & L. 347, 349 (2007).

5. *Id.* at 358-59.

6. Richard Wolf, *Rising Health Care Costs Put Focus on Migrants: Tension Over Uninsured Sparks Curbs on Benefits*, USA TODAY, Jan. 22, 2008, at 1A.

7. TANYA BRODER, NAT'L IMMIGRATION LAW CTR., STATE AND LOCAL POLICIES ON IMMIGRANT ACCESS TO SERVICES: PROMOTING INTEGRATION OR ISOLATION? 2 (2007), http://www.nilc.org/immspbs/sf_benefits/statelocalimmpolicies06-07_2007-05-24.pdf.

8. Wolf, *supra* note 6, at 1A.

9. *Id.*

with special attention to the ambiguities in interpreting what kinds of emergency medical conditions are covered by Medicaid; and (3) describe possible solutions to increasing healthcare access for immigrants.

II. LACK OF HEALTH INSURANCE AMONG IMMIGRANT GROUPS

More than forty-six million U.S. children and adults lack health insurance.[10] Native U.S. citizens are three times more likely to have health insurance than documented and undocumented immigrants.[11] While native or naturalized citizens are uninsured at a rate of 15%, non-citizens are uninsured at a rate of 47%.[12] Although immigrants are just as likely to be employed as non-immigrants, they are more likely to work in low paying jobs that do not offer health insurance.[13]

The disproportionately high rate of uninsurance among immigrant populations leads to reduced access to health care and poor health outcomes. Nearly half of uninsured adults have a chronic condition, and 11% of uninsured adults are in fair to poor health compared to 5% of individuals with private insurance.[14] An Institute of Medicine report indicates:

> Uninsured people are more likely to receive too little medical care and to receive it too late, to be sicker and to die sooner. They are reluctant to use health services, often waiting until there is a crisis. They receive fewer preventative services, less regular care for chronic disease, and poorer care in the hospital.[15]

Furthermore, uninsured individuals are more likely to be hospitalized for avoidable health problems and receive fewer diagnostic and therapeutic services once hospitalized.[16]

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10. KAISER COMM'N ON MEDICAID & THE UNINSURED, COVERING THE UNINSURED: GROWING NEED, STRAINED RESOURCES 1 (2007), http://www.kff.org/uninsured/upload/7429-02.pdf.

11. CATHERINE HOFFMAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 5-6 (2007), http://www.kff.org/uninsured/upload/7451-03.pdf. For the purposes of this Introduction, documented immigrants refer to non-U.S. citizens who have entered the country legally. Undocumented immigrants refer to individuals entering the country illegally or legal immigrants who have violated the terms of their immigration status.

12. *Id.*

13. ANDREA B. STAITI, ROBERT E. HURLEY & AARON KATZ, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, STRETCHING THE SAFETY NET TO SERVE UNDOCUMENTED IMMIGRANTS: COMMUNITY RESPONSES TO HEALTH NEEDS, ISSUE BRIEF NO. 104 1 (2006), http://www.hschange.com/CONTENT/818/818.pdf.

14. HOFFMAN ET AL., *supra* note 11, at 6.

15. INST. OF MED., A SHARED DESTINY: EFFECTS OF UNINSURANCE ON INDIVIDUALS, FAMILIES, AND COMMUNITIES 2 (2003), http://www.iom.edu/Object.File/Master/5/883/Uninsured4final.pdf.

16. HOFFMAN ET AL., *supra* note 11, at 8.

Cost plays a tremendous role in health outcomes for the uninsured. Nearly 25% of uninsured adults report postponing or forgoing treatment because of cost compared to roughly 5% of insured adults.[17] Similarly, almost a quarter of uninsured adults report not filling drug prescriptions because they cannot afford them and the anticipation of high medical bills prevent them from following up with recommended care.[18] Furthermore, medical bills for uninsured immigrants can have a serious financial impact on their families and can lead them to spend less on basic needs in order to pay for health care.[19]

Immigrants often do not have the financial resources to obtain private health insurance and are frequently barred from government insurance programs.[20] Even immigrants who are eligible for public programs frequently are not enrolled because of either linguistic and cultural barriers or lack of awareness about their eligibility.[21] Further, undocumented immigrants' fear of deportation due to their illegal status prevents them from seeking publicly funded medical services.[22]

III. PUBLIC FUNDING FOR IMMIGRANT HEALTH CARE

Both documented and undocumented immigrants have disproportionately greater barriers to publicly funded healthcare services than U.S. citizens. Documented immigrants are prohibited from enrolling in Medicaid or State Children's Health Insurance Program ("SCHIP") for the first five years that they reside in the United States, and undocumented immigrants are only eligible for emergency services under Medicaid.[23]

Undocumented immigrants face even greater difficulties in access to health care services. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") terminated the eligibility of undocumented immigrants for Medicaid and other federally-funded social services.[24] Title XIX of the Social Security Act, specifies that "no payment may be made to a State under this section for medical assistance furnished

17. *Id.* at 7.

18. *Id.*

19. *Id.* at 9.

20. STAITI, HURLEY & KATZ, *supra* note 13, at 1.

21. *Id.* at 3; VIRGINIA BRENNAN, NAT'L LIBR. OF MED., FACTLINE: TRACKING HEALTH IN UNDERSERVED COMMUNITIES, J. OF HEALTHCARE FOR THE POOR AND UNDERSERVED, http://www.mmc.edu/www.meharry.org/Fl/Access_to_Health_Care/Barriers_to_Care_for_Immigrants.html(last visited Mar. 31, 2008).

22. Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden it Places on Hospitals*, 7 J.L. SOC'Y 146, 148 (2005).

23. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS 1-2 (2006), http://www.kff.org/medicaid/upload/7492.pdf.

24. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law."[25] Undocumented immigrants only qualify for coverage under the federal Medicaid Assistance program if they have an "emergency medical condition."[26]

Both documented and undocumented immigrants may qualify for Emergency Medicaid because immigration status is not a factor in eligibility requirements.[27] Similarly, the Emergency Medical Treatment and Active Labor Act ("EMTALA") prohibits hospitals from transferring unstable patients for purely economic reasons.[28] Under EMTALA, emergency departments are required to provide medical screening examinations for any individual who comes to an emergency department requesting treatment.[29] An "emergency medical condition" is defined under Medicaid and EMTALA as:

> [A] medical condition . . .manifesting itself by acute symptoms of sufficient severity . . .such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patients' health in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.[30]

The definition of "emergency medical condition" under Medicaid and EMTALA has been subject to conflicting interpretations in different states.[31] The ambiguity of the phrase "emergency medical condition" can lead to the denial of treatment for many immigrants who suffer from emergency conditions.[32] Physicians and hospitals must make decisions to determine whether a patient is suffering from an emergency medical condition with the knowledge that Medicaid may not reimburse all treatment costs.[33] For instance, courts are varied in their assessment of whether an "emergency medical condition" includes situations where a patient who is not suffering from acute systems still needs life sustaining

25. 42 U.S.C. § 1396b(v)(1) (2000).
26. 42 U.S.C. § 1396b(v)(2)(A) (2000).
27. STAITI, HURLEY & KATZ, *supra* note 13, at 1.
28. 42 U.S.C. § 1395dd(c)(1) (2000).
29. 42 U.S.C. § 1395dd(a) (2000).
30. 42 U.S.C. § 1396b(v)(3) (2000); 42 U.S.C. § 1395dd(e)(1) (2000).
31. Michael J. McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard that Governs Undocumented Immigrants' Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL'Y 391, 404 (2007).
32. *Id.* at 391.
33. Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 475 (2007).

treatment.[34] For example, in *Diaz v. Division of Social Services*, the North Carolina Supreme Court concluded that an undocumented immigrant's acute lymphoblastic leukemia was not an "emergency medical condition."[35] As a result, Medicaid did not cover the treatment because the immigrant's condition was stable at the time of hospital admittance.[36] However, in *Szewczyk v. Department of Social Services*, the Connecticut Supreme Court concluded that an undocumented immigrant's acute myelogenous leukemia was covered under Emergency Medicaid because an "emergency medical condition" does not focus only on the immediate condition of the patient.[37] Rather, the court held that the determination should focus on whether the absence of immediate medical attention could reasonably be expected to result in adverse consequences.[38] The inconsistencies in how courts and agencies determine what qualifies as an "emergency medical condition" can lead to decreased delivery of emergency health care services to immigrants.

IV. POSSIBLE SOLUTIONS

Dr. Pagán suggests an incremental approach to solving the immigrant access to health care problem by including state and community support and not relying solely on federal funding. He suggests implementing "immigrant friendly" approaches that have a chance for broad-based appeal.[39]

For legal immigrants, one such "immigrant friendly" approach involves tax credits or subsidies targeted towards workers in small businesses, the self-employed, or ranchers to purchase health insurance coverage. Dr. Pagán contends:

> [I]f tax credits or targeted subsidies permit the uninsured to buy mainstream insurance and use mainstream medical services, this will also improve quality for the insured. Paradoxically, the insured may gain the most from helping the uninsured if that assistance is not targeted specifically at providing services to the uninsured only.[40]

Moreover, these credits and subsidies can be structured so that the funds are provided directly to individuals or to employers.[41] Providing tax credits or

34. McKeefery, *supra* note 31, at 400.

35. Diaz v. Div. of Soc. Serv., 628 S.E.2d 1, 5 (N.C. 2006).

36. *Id.*

37. Szewczyk v. Dep't of Soc. Serv. ,881 A.2d 259, 270-71 (Conn. 2005).

38. *Id.*

39. José A. Pagán, Dir., Inst. for Population Health Pol'y, Dept. of Econ. & Fin., Univ. of Texas-Pan American, Panel Speech at the First Annual Beazley Symposium on Access to Health Care: Solving the Problem of Immigration and Health Care (February 8, 2008).

40. Pauly & Pagán, *supra* note 1, at 1312.

41. *See id.* at 1312-13.

subsidies directly to employers would appeal to the business community. The strengths of this approach include eliminating the need to create a new bureaucracy and allowing for flexibility in adjusting the funds if the demand is low.

For undocumented immigrants, the political volatility of the topic makes it harder to seek federally funded health care. Dr. Pagán recommends circumventing the federal political system and taking care of undocumented immigrants through the safety net of community health centers.[42]

Dr. Pagán has also written about access to health care for migrants returning to Mexico. He recommends that the U.S. and Mexico coordinate policy initiatives to offer portable health insurance to Mexican migrants which will benefit both the migrants and the social security systems in both countries.[43] Dr. Pagán suggests, "A guest worker program with portable social security and health insurance benefits will allow the U.S. to fulfill its labor needs while providing immigrant workers with the flexibility to move in and out of the country without being a threat to national security."[44]

V. CONCLUSION

Access to health care for immigrants in the U.S. is not only a heated political issue, but also one that has ramifications for the overall health of the immigrant populations and the communities in which they live. In the following transcript, Dr. Pagán provides an overview of the geographic distribution of immigrants in the U.S., the community and economic arguments for improving health care access for immigrants, and policy recommendations for increasing immigrant access to health care.

42. Pagán, *supra* note 39.

43. Sara J. Ross, José A. Pagán & Daniel Polsky, *Access to Health Care for Migrants Returning to Mexico*, 17 J. HEALTH CARE FOR THE POOR AND UNDERSERVED, 374, 383 (2006).

44. José A. Pagán, Immigration Reform and Health 33 (Dec. 2007), http://www.reforminstitute.org/uploads/publications/JoseAPagan.pdf.