

2008

Transcribed Speech of Sonal Ambegaokar

Sonal Ambegaokar
National Immigration Law Center

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Sonal Ambegaokar *Transcribed Speech of Sonal Ambegaokar*, 17 Annals Health L. 301 (2008).
Available at: <http://lawcommons.luc.edu/annals/vol17/iss2/8>

This Colloquium is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Annals of Health Law by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

Transcribed Speech of Sonal Ambegaokar

MS. AMBEGAOKAR: Good morning everybody. I want to thank Professor Yearby, her staff, and the Beazley Institute for the invitation, and I'm really excited that we're having this discussion [on immigrant access to health care]. I was talking to a lot of the speakers last night, [and] we're all working on these issues. It's great to have a forum to be able to discuss it amongst peers and figure out where the intersections are and what we can keep doing to move forward, so thank you.

My name is Sonal Ambegaokar and I work primarily on access to health care for low-income immigrants. A lot of [the] topics we are going to cover are around the public coverage programs—Medicaid and SCHIP—but we're seeing also the issues come up in state programs so I'm going to touch upon that as well.

The National Immigration Law Center is a non-partisan, non-profit entity that works on federal policy for immigration. We have worked a lot on comprehensive immigration reform. We also work in the area of public benefits, so in addition to the health care programs I just mentioned, we work on [Temporary Assistance for Needy Families] (“TANF”), food stamps, and access for immigrants.

What I'm going to talk about this morning, just to sort of set the background for today, . . . is to provide you with an overview of the barriers that immigrants face. As I said, my focus is on the low-income immigrants. There are primarily legal barriers, but there are a lot of non-legal barriers that you'll see. I'm going to throw out a couple of ideas of how we start tackling it; just really broad strokes, and I know we have a great panel this afternoon to talk a little bit more about [the details].

So again, I'm going to just touch upon the barriers for both private and public health care coverage that immigrants face. As I was talking to one of the speakers just now, [we noted that] a lot of these barriers are very common for U.S. citizens. We have a high number of uninsured[in our] population, and as the movie “Sicko” indicated, even if you have insurance you don't really have access. The coverage versus access issues are always out there. A lot of the issues are—even if you don't have coverage you don't get in the door—kind of issues. So how does immigration status impact the fact that you can't even get covered, let alone, the issues [associated with accessing treatment] when you enter the system?

So [let's look at] the barriers to health care, and again, this is mainly now addressing coverage issues. Systemically as we all know, we don't have a

really good health care coverage system. We don't have a universal health care or a single payer system. We have a patchwork [system of coverage], right? We have an employer based [coverage system], based on your work status.

[Then we have] public coverage. A lot of us in the room know this, but the common misperception out in the mainstream is that public coverage is available to anyone who's poor. If you understand even just the Medicaid eligibility rules, we have the issue of Medicaid being available [only] to the deserving poor. [For example,] you [may] have a pregnant woman, child, disabled, or elderly [person covered, but] single adults, even parents [are left out]. Also, parents are covered but only at very low-income levels. So we don't really have a good safety net system even under our public coverage system. So where do they all end up? As [the] uninsured and at the safety net hospitals.

There is quite a bit of disparity between how different safety net hospitals actually treat the uninsured. I know they have their obligations, but as I do my work we find certain county hospitals, Cook County, or others in L.A., they face financial stress. They're actually cutting back a lot of services for everybody, but in very anti-immigrant communities they've already made the decision years ago to only provide services to certain indigent folks. We already have that great disparity that the safety net is actually not available to everybody, contrary to the misperception about [it].

Employer based coverage. The other misperception is that immigrants don't work and they're just getting free care. A lot of immigrants do work. They unfortunately work for employers that either can't provide or just choose not to provide employer-based coverage. We all face this issue now, even US citizens and middle-income families, where the employers are cost shifting. The premiums are getting too high for [employers] so they expect the employee to put in for that. We're seeing that as far as affecting immigrants as well; so even if [employer coverage] is offered, [employees] can't afford it. [But primarily we find that [most] working immigrants do not even have access to employer based coverage, despite the fact they're working. They're working in industries like construction, agriculture, and all the service industries, like restaurants. If employer-based coverage is our system currently [within which we must work], the issue is how do we get [better] employer-based coverage? Are there opportunities there to expand employer based coverage so that it can cover working immigrant families?

And then of course we have the issue of once you actually have coverage the barriers of cultural and linguistic access is huge. I'm not going to touch on that because that could be a whole other presentation. I know that's a field that a lot of people are working on and [is] really challenging. I know [good] models are out there, but [lack of language access is] still an issue.

Even when you talk about coverage, like if you think of a private insurance company, we hear a lot about them marketing to the Spanish community or the Latino community because they know that's a big consumer market for them. But then, when they actually get those consumers, how do they treat them? They don't provide the materials in Spanish all the time and they don't have Spanish-speaking doctors. So, that's sort of like [setting up] a false hope of "sign-up for insurance and you'll get access," and that doesn't really happen either.

[There are] other environmental issues that are [affecting] access to treatment [for immigrants], as well. Even if we had a system where we have more eligibility for public coverage, there's all [of] these other factors that are preventing families from getting health coverage, or even accessing treatment when you tell [immigrants] they can go to any emergency room.

As I mentioned, first we have the eligibility restrictions in Medicaid, SCHIP and Medicare. [I] touched upon the general rules about Medicaid, but there is another layer there [as to] which immigrants are eligible for Medicaid, SCHIP and Medicare. Again, everybody who's here legally does not have access to Medicaid, SCHIP, and Medicare. There is what we call a five-year bar. Basically, . . . let's say today I got my green card, I still can't access Medicaid and Medicare today, and that's a federal rule. We still have restrictions based on legal immigrants, and then we can't even begin the discussion about undocumented immigrants for all those other reasons.

Even [if an individual says,] "I'm a U.S. citizen but I might have a family member who's not, and [thus] I don't want to apply," there are other issues for her as a U.S. citizen and as an immigrant family that may [deter her from entering] into a public coverage program. So the issue is about where that information, when I apply for Medicaid or KidCare or family care, where does that information go? There are issues about [whether] you [are] going to take that information and report it to immigration authorities. So they don't [apply], and then if they go to the emergency room, [they worry] is someone going to report [them]? There is always a story of the rogue county worker that takes it upon himself to say, "Well I need to report this person, they're here illegally." So [once] this is out there in the community, even though you've made your hospital or clinic a very safe place and you have policies [in place to protect patient privacy], there is a chilling effect of immigrants [not] accessing emergency room[s] because of a fear of being reported.

The other issue that we're seeing in the last couple of years, because of the failure of federal immigration reform, [is] a lot of state and local cities actually taking it upon themselves to work on immigration reform. Legally, I'm not going to get into [whether] there [are] federal preemption issues about the state or locality trying to enforce immigration law. It's a federal

issue, so there have been legal challenges to it. Even when the legal challenges are successful and the ordinances or the state law fails, there is still the confusion and chilling effect of that rhetoric out there. Just the knowledge that a bill passed [that] maybe really didn't restrict access to health care, [creates] the misperception in the community or among health care providers that, "Oh, I can't see immigrants anymore."

Some of these ordinances are just basically restricting access to certain state and local benefits, or [require] you to prove up your citizenship. I think some of the issues are like getting a driver's license. What documentation would you have to provide to get a driver's license now? So if you add more barriers and layers on that [process], even though it's not directly related to health care, it is causing confusion. Also, again, just sort of on a side note, these anti-immigrant ordinances and laws are targeting immigrants but they actually have a very harmful effect on citizens. If you read a lot of the news stories, just for example, the driver's license issue is actually more harmful to those lawfully here and citizens who have to actually prove more documentation than was [previously] required. It's just adding more administrative costs and barriers on things we actually don't need, in the hope of creating this very anti-immigrant environment, in the hope that people will just leave. It's very troubling that this is our solution. Even if it's not addressing health care, it is causing a chilling effect on [immigrants'] access [to] treatment.

Very quickly, I just wanted to say when I used to be on the ground helping people get enrolled into public coverage programs, [a] lot of the issues were just very common, and [even] common to U.S. citizens, where they're not even told that they're eligible. [For example, if] I walk into the hospital, I should be getting screened somehow. If I'm low-income and eligible for Medicaid, instead of just going right into the indigent care program, I should be getting screened for something that I might be eligible for; so we have that [same] issue among immigrants. They're never told that they could get even Emergency Medicaid and all the fears are there, but we don't even educate them.

[When] you tell [immigrants] they're eligible, [there are] all the complex rules about our public coverage and, again, the systemic problem. We don't make our public coverage programs very simple for citizens even, let alone if we're trying to include immigrants. To have very restrictive rules and very punitive rules, like the five-year bar, a very punitive rule, that prevents access.

Emergency Medicaid. So I just want to throw out that in Emergency Medicaid there is this misperception in the anti-immigrant rhetoric that immigrants come here and get free care and can get any care. This gets the confused with the public coverage restrictions, the EMTALA obligation, and Emergency Medicaid eligibility. So how many of you are familiar with

the Emergency Medicaid rules? Okay. So can any undocumented immigrant get Emergency Medicaid? Is that a yes or a no? Actually a no. Just because you're undocumented, you can't get Emergency Medicaid. Emergency Medicaid follows the Medicaid eligibility rules. So I have to be a "deserving [poor]", undocumented immigrant. I can't be a childless adult. I have to be a child, a parent with very low-income, pregnant, disabled, or elderly. [As a result,] we still have a very huge population of undocumented adults that are not even eligible for Emergency Medicaid. That is different from the obligation to treat them at the hospital. So if I walk into the emergency room, yes, the hospital would have an obligation to treat me if I'm undocumented. So how does that play out then? Those undocumented immigrants are actually often billed for their service in the emergency room. Now, the hospital understandably wants to get paid. If immigrants are not eligible for Emergency Medicaid then they have to figure out what else to do.

Oftentimes [when I was working in L.A. County] we had the issue where even though the hospital knew they should be screening after the fact, to find out if someone is eligible for Emergency Medicaid if they're undocumented, they often didn't do that. So [the hospital] is actually losing revenue by not screening people that were eligible. Those immigrants that are not eligible for Emergency Medicaid are often billed for services, and they end up as self pay [patients]. There's also this misperception that all that care is uncompensated. A lot of immigrants are actually in medical debt. They have huge medical bills and they are trying to pay, and they don't want [the bill] to be just written off. They are trying to make good [on] their obligations. [Even with] all these barriers, [immigrants] don't have the [understanding] that, "If I go to the emergency room, I'm going to get [free care or my bill will be] written off." They think they're going to get billed and they are going to actually ruin their credit, and so there's also this fear of going to the emergency room for that [reason]. [Immigrants] are getting billed; they go into collections. We've had [debt] collection lawsuits against undocumented immigrants, so that is happening.

At some point, obviously, the hospital has to choose how much of [the debt] they have to write-off, and there is the uncompensated care issue. However, there is a misnomer that all that care is free and actually the hospital also has limits; they don't have to give continuing treatment. The acute episodic treatment happens. Once [the hospital] stabilizes a patient [its] obligation to treat sort of ends. I know there are a lot of ethical issues about how you discharge the patient, what is the follow-up care needed, but a lot of that doesn't get discussed. Then the immigrant is left to figure out: where can [I] go for follow-up care; [for example, to] whom do I go to after my heart attack; can I see a cardiologist? We have issues of specialty care being completely off limits to even uninsured citizens, let alone uninsured

immigrants. All [of] these are systemic problems. They are all factors in [the system], and definitely affect immigrants, but it's not unique to immigrants. It just plays out a little differently.

State replacement programs. The federal rules are out there but states have come in, like Illinois, to fund lawfully present immigrants beyond what the federal guidelines are. That's a really great state investment. We're actually preventing people from going into the emergency room and getting them [care] in sooner. So that's an investment we're seeing [nationally]. About half the states are [providing state-funded coverage to immigrants] already, and we're hopefully going to see more trends that way. But any budgetary crisis that comes up—I think a lot of the states are now facing that—they first will start cutting back on these kinds of programs, and then we get into the issue of the cost saving measures, now versus later. Where is the benefit in [cutting those programs]?

Mixed status families. We have the issue of two undocumented parents, one citizen child, one sibling who is in the process of adjusting or has their green card. So because of all the restrictions and the different public coverage programs, as far as who is eligible and who is not, it's very hard to then tell a family [they] should [only] apply for the citizen child. I think a lot of children's groups are always [saying things] like, "Let's get as many [eligible] children as we can [enrolled]." But if the parents have to choose between the undocumented child and the legally [documented] child, they are forced to sort of pick and say, "Well, maybe I won't enroll either one of those children." We always talk about the eligible but not enrolled number of kids that are out there in the Medicaid [or other public coverage] programs. This is [one] of the barriers [that] comes up when you talk about mixed status families as preventing people from enrolling in programs.

I'm running out of time so I'm just going to say when [immigrants] apply there are all these other issues that come up. We encourage people to look at their state applications and see if there are questions that are being asked that are unnecessary, that are preventing immigrant families from getting onto public programs, or even accessing care at the hospital or safety net clinics. A lot of times intake forms may ask for Social Security numbers that aren't necessary, so even just asking very innocently, these questions prevent people from accessing treatment. There just are, like I said, myths and misnomers about what's available; Emergency Medicaid, for example. Still, people think it's available for everybody, and so that causes a lot of confusion.

The concerns about being deported or harming your [immigration] status, your family's status, are out there and so we do a lot [of] education with immigrant communities about the immigration concerns, about public charge, and sponsorship, and I'll go into it real quick. Public charge is an

immigration test, it's not a health care test, and it doesn't apply to everybody. If a citizen child applies for Medicaid, that should not harm [the immigrant parent applying for their child] in any way. There is still the confusion that if my citizen child applies it will harm me, and I don't want to get any public benefits for that reason.

The public charge test basically says, "If you are going to [emigrate], you have to be financially able to live here in the U.S." We only want healthy, working and educated immigrants to come, so this public charge test is out there. However, we realize we don't want to prevent people from getting public health. [For example,] if you have TB you want [people with TB] to get treatment, so [the government] exempted health care from the public charge test. You can apply for Medicaid [and] Medicare, if you're eligible, without it harming your immigration status. There [is] still is a lot of misinformation about that. We have some more information on public charge on our web site, [and] at the end of the presentation you'll have the link.

Sponsorship. I'm not going to have time to go [into] this, but basically if I'm an immigrant, I need a sponsor, and the sponsor has to say I'm going to be financially liable for that person. Sometimes we have issues of sponsors actually telling people, "Don't apply for benefits [or seek treatment] or don't get in trouble in any way."

Confidentiality. This is a huge issue that's coming up and, basically, there are no mandated reporting requirements on hospital providers. There is this fear in the community that hospitals will do that, or there is the one worker that decides to do it, and it create[s] a chilling effect. Non-profit organizations are not required to check immigration status, but again, how their intake form is developed is really critical. If you have a clinic and you're a non-profit, you don't have to ask immigration status questions, and if you start doing so, it can create a chilling effect.

Immigration enforcement. Just a quick thing on the [authority of immigration enforcement officers]. I just wanted to make sure if you are a clinician, you know that you have the same Fourth Amendment rights to prevent somebody from coming in. They need reasonable cause. I'm not going to get into this. I already mentioned it. Real quick, the two solutions that I was going to throw out there [are] basically when we talk about the coverage expansions, we need to talk about it in a very comprehensive way. We need to talk about [it] in a very inclusive way. So creating special programs for immigrants actually is not what we advocate for. We don't want a special program for undocumented immigrants. We want coverage for all because when you talk about mixed status families, that makes sense. [W]e just really need to focus on the system, not creating this special program for immigrants while all these uninsured citizens are out there too. The system needs to be more inclusive and not pick and choose.

Immigration reform. The reason, in addition to legalizing everybody for the sake of [addressing] the “illegal immigration” [issue], we find that it actually helps people get into better jobs and higher wages and have access to employer based coverage. So [there]’s another issue that supports immigrant reform. [W]e don’t talk about immigration reform as the health care solution. We definitely need a [separate] health care solution.

Thank you very much.