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International Examples of Undocumented Immigration and the Affordable Care Act

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Undocumented Immigration is a Global and Local Issue

Undocumented immigration has become a dauntingly complex challenge for community, state, federal, and global governing bodies. Western nations, particularly the United States (US), Spain, The United Kingdom (UK), and Germany, are home to the majority of the undocumented individuals. While calculating the number of undocumented immigrants is very difficult, the best estimates indicate that the US is currently home to 11.2 million undocumented immigrants, while the European Union (EU) hosts between 5.6 and 8.4 million undocumented immigrants (1). In the United States the number of undocumented immigrants will continue to grow due to two major factors. First, preventing the entry of all undocumented persons is not economically or procedurally feasible; many immigrants continue to enter the US without documents or overstay visas (2). Second, thousands of citizen children are born to noncitizens in the US each year. For example, 91% of children under 6 born to undocumented immigrants are US citizens by birth. The multigenerational nature of Latino families suggests that noncitizen parents are likely to remain in the US indefinitely with their citizen children (3). The increasing numbers of undocumented immigrants along with this population's growing medical needs necessitates further examination into how to best provide medical care to this group. Immigrants generally arrive in good health; however, their health deteriorates dramatically while living in the US (4). Additionally, because the majority of undocumented immigrants are Hispanic, they are at increased genetic and environmental risk for chronic diseases such as diabetes, obesity, and stroke (5). Thus, the American health care system will confront a large, permanent, aging, and chronic disease laden undocumented population. Unfortunately, even in light of this increased need, the Affordable Care Act (ACA) has failed to provide a viable insurance/health care option for undocumented immigrants (6). As the US health care system is transformed by the ACA, it is essential that we examine international examples of health care for undocumented immigrants so that we can incorporate policies that have been positive and avoid those which have been problematic. The goals of this paper are to: 1) examine how undocumented immigrant care will change under the ACA, 2) examine undocumented immigrant care in the UK and Germany; and 3) using international examples examine potential repercussions of state law limiting the healthcare of undocumented immigrants.

Health Care of the Undocumented and Uninsured

Lack of primary care often leads to expensive emergency room care (7). Immigrants use emergency departments less frequently than American born individuals; however, they present after prolonged periods of time without primary care, leading to decompensated states of manageable chronic diseases. Costs associated with emergency department management of chronic disease exacerbations are three times higher than American born individuals visits to the emergency room (8,9). The expense of emergency room care for low income undocumented immigrants leads to lack of provider compensation, which is reflected in rising insurance premiums and federal Disproportionate Share Hospital (DSH) funding (7).

Prior to the ACA, undocumented immigrants obtained medical care at safety net organizations such as community health centers, free clinics, and public and academic medical centers. Two major factors have stressed medical center budget margins. First, state Medicaid programs have traditionally under compensated health care centers for services they provide. Second, uninsured individuals often could not pay their bills even after adjustments for income. These two factors have created serious financial problems for health care organizations that provide care to large numbers of Medicaid and uninsured patients. The federal government created the DSH program to financially compensate organizations to care for large numbers of Medicaid and uninsured patients, including citizens, legal immigrants, and undocumented immigrants. The issue is with the anticipated increases in number of insured individuals under the ACA there will be a decreased necessity for the DSH program. Therefore, the ACA plans to cut DSH funding by up to 75%, which would leave undocumented immigrant health care uncompensated.

Reimbursement is the major problem in the provision of health care for undocumented individuals. Unfortunately, the ability of undocumented immigrants to pay for their health care is unlikely to improve with the implementation of the ACA. The Health Care and Education Reconciliation Act of 2010 barred undocumented immigrants, regardless of qualification criteria, from enrolling in government services, such as Medicaid, SCHIP and health insurance exchanges. Private insurance options for undocumented immigrants are limited by nature of their employment and lack of funds (2). Undocumented immigrants will lack employer provided insurance since unofficial employment arrangements will not be included in the ACA mandates. Many undocumented immigrants work for small companies that will be exempt from the ACA's employer sponsored health care insurance policy. Most undocumented immigrants work in low paying jobs in agriculture, construction, and service industries. These jobs are also associated with high rates of work place injury (2,11,12). Moreover, a Pew Hispanic Center survey that found over a quarter of Hispanic undocumented immigrants attributed lack of insurance to financial limitations (2).

This is a critical time for legislation regarding the relationship between undocumented immigrants and the health care industry. Many of the recent state immigration bills originally had stipulations pertaining to health care professionals' relationship with undocumented immigrants. These stipulations were ultimately removed from the final version of proposed bills, but it is important to realize that legislators at both the state and

local levels are discussing physician-patient relationships when the patients are undocumented immigrants. Thus, US policy makers and physicians should benefit from an examination of international physicians' experiences with laws regulating their relationship with undocumented immigrants.

International Examples of Undocumented Immigrant Health Care

In 2004 the UK amended the National Health Service's (NHS) Charges to Overseas Visitors regulations to prevent undocumented immigrants from receiving any non-urgent care unless they can deposit funds equivalent to the estimated full cost of treatment (14). More radically, the act requires health professionals to determine the level of public threat of the undocumented immigrant patient and report patients who may pose a threat to immigration services. While the general UK population finds these policies acceptable, British doctors and health institution managers have voiced their disagreement with these regulations. They protest that it is not a physician's job to act as a 'social police force' to determine who is eligible for NHS funded care and who should be reported. Overall this amendment has been troublesome for British physicians since only 46% reported that they understood the system and 84% want a better system to handle undocumented immigrants. Furthermore, only 20.7% reported that the decision to treat patients is exclusively theirs (15).

In another example of an exclusionary policy, the German Ausländergesetz, sections 92a and 92b stipulate that any member of an official board who has information on an individual without a valid residence permit must report the information to the Ministry of the Interior. Although these laws exist, there are avenues for undocumented immigrants in Germany to access health care services. A survey of undocumented individuals administered by Heidelberg University in 2010 identified health care choices from most popular to least popular include self-medication, medical students, traditional healers, doctors recommended by friends, or of similar ethnic background, nongovernmental organizations, and lastly hospitals. While government officials generally quietly tolerate these avenues, they are certainly not ideal. Decreased use of appropriate health care resources may result from instances in which individuals have been deported directly from hospitals (16). While these events are rare, they are more than enough to instill fear of the health care system that prevents undocumented immigrants from seeking medical attention (16). Although tolerated, undercover avenues for care are not ideal; they make undocumented immigrants afraid of contacting physicians. Physicians find themselves forced to work with limited or no compensation, and/or to personally help immigrants navigate the complicated and disjointed non-governmental health care system (16). In summary, exclusionary policies in the UK and Germany have made undocumented immigrants afraid to approach health providers and placed physicians in awkward, confusing, and frustrating situations when providing health care for patients who are undocumented immigrants.

Discussion: Implications for the US

While no health care program created by another country could easily be implemented in the United States, there are three important points to be made. First, physicians must be aware of the potential for repercussions from proposed immigration reform legislation. These new

laws have the potential to limit a physician's ability to treat undocumented immigrants and may require physicians to report undocumented immigrants to immigration services. Physicians must be aware of and willing to take action regarding proposed health care and immigration reform legislation. Political action by physicians could prevent situations similar to those in the UK and Germany in which physicians are confused and frustrated with the law and reimbursement system surrounding undocumented immigrant health care. Further complicating matters in the US is that policies would vary among states. Many unfortunate and destructive repercussions would arise from a maze of individual state policies. These policies would be confusing and frustrating for physicians. The cost of providing care would increase since sorting through state required documentation, billing, and potential reporting of undocumented immigrants would require additional staff time. In addition, variation in state policies could result in state-to-state migration of undocumented individuals based on the openness of a state's health care system. Such a migration would lead to an unequal distribution of undocumented immigrant health care expenses and place a serious financial burden on those states with more open policies. This burden would provide state representatives with an incentive to enact exclusionary health care policies, which have been proven to be ineffective and dangerous. Thus, federal level policy limiting state governments' ability to alter undocumented immigrants' relationship with health care providers is a necessity.

Second, in combination with the lack of an appropriate international example, there is very a limited amount of research pertaining to how to effectively deliver care to undocumented populations. The situation in the US is further complicated by an extremely high prevalence of mixed status families, an issue which European studies and policy has not addressed. Furthermore, a high prevalence of mixed status families suggests undocumented immigrants will remain in the US for longer periods of time. Thus, extensive efforts must be made to expand this area of research to find a viable model for delivery of health care to undocumented immigrants. Additionally, blindly implementing policies without quality research will likely lead to expensive policies that place undocumented immigrants at high risk for poor health outcomes.

Third, health care options for undocumented immigrants are frighteningly unstable. The ACA anticipates increased numbers of insured individuals will decrease the necessity for the DSH program and plans to cut its funding by up to 75%. Additionally, Hall (2011) argued that the ACA will drastically alter the function, patient demographics, and public perception of health care safety net organizations. The concern is that safety net organizations would facilitate illegal activity by providing care to individuals who do not purchase health care coverage. If the public believes that this is true, the result will be decreased private donations and loss of adequate funding to maintain safety net health centers (17). The Urban Institute estimates that following the full implementation of the ACA the number of adults without health insurance will be reduced by 60%. Ideally this reduction in the number of uninsured American citizens will provide enough funds to adequately compensate for the health care of those who remain uninsured. However, in light of decreased DSH funding and private donations the adequacy of funding would be impossible to predict.

A source of health care dollars for the uninsured has been built into the ACA. To accommodate for dramatic increases in the number of insured individuals, and consequent increased access to health care, the ACA allocates 8 billion dollars over 5 years to expand Federally Qualified Health Centers (FQHC) in 2014. This spending is meant to cover increased costs associated with anticipated increases in FQHC patient load. However, this increase in funding was based on anticipated numbers of newly insured individuals and does not necessarily provide for those who are uninsured. At this point it is impossible to assure that increases in the number of insured Americans and increased federal FQHC funding will be enough to cover the cost of health care for uninsured undocumented immigrants.

Conclusion

Lack of ability to compensate health care providers has led the many undocumented immigrants to lack primary care. Even more worrisome is that the ACA simply does not address health care for undocumented immigrants. Furthermore, lack of a federal plan to provide primary care dollars for undocumented immigrants will lead state governments to create policies which attempt to reduce health care spending by limiting undocumented immigrants' access to care. Such policies will interrupt a physician's ability to provide care to certain patients, as occurred in the UK and Germany. Exclusionary state policies will also incentivize intra-country migration, financially stressing states without exclusionary policies. Most importantly exclusionary state policies limit an individual's ability to obtain health care, undoubtedly contributing to poor health outcomes. Based on the Health Care Reconciliation Act (2010) and the nature of the free market, undocumented immigrant access to government-led health insurance exchanges or affordable private insurance in unlikely to improve. Thus, federal action is essential to ensure effective spending of money on undocumented immigrant health care. First, the federal government ought to be required to prevent state laws that limit or eliminate health care resources for undocumented immigrants. Second, once accurate estimates of spending on undocumented immigrant health care can be made following the implementation of the ACA, FQHC funding must be reevaluated. DSH funding or another source of federal funding must continue to compensate FQHCs for primary care provided to undocumented immigrants beyond the 8 billion dollars over 5 years provided by the ACA. Third, efforts must be made on behalf of physicians to reach out to the undocumented community to ensure they are aware of and utilize their health care resources.

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