Invited Commentary

Undocumented Immigrants and Access to Health Care

Alicia Fernández, MD; Rudolph A. Rodriguez, MD

But the stranger that dwelleth with you shall be unto you as one born among you, and thou shalt love him as thyself; for ye were strangers in the land of Egypt.
Leviticus 19:34

The United States has increased access to insurance for millions of people through the implementation of the Affordable Care Act (ACA). But one group is still firmly outside the insurance coverage wall: the ACA states that an undocumented immigrant "shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange." In 2014, the Pew Research Center[1] estimated that about 11.1 million undocumented immigrants lived in the United States, and nationally, undocumented immigrants now make up about 15% of the uninsured who are younger than 65 years, a proportion that varies greatly by state: from 7% in Pennsylvania, to 24% in California and Texas, and 28% in New Jersey. As the country debates whether to dismantle the existing ACA health reform expansion, prospects for a federal expansion that encompasses the undocumented seem dim in the short term.

Related articles pages 529 and 579

Undocumented immigrants with routine health needs who are not covered through family members' insurance currently obtain care from a patchwork of Federally Qualified Health Centers, private charities, and hospital emergency departments, or go without. Access to care varies enormously by region, and also over time, as some clinics close their doors to undocumented patients during economically difficult times, while other communities choose to provide consistent, high-quality primary care.[2] In some states, undocumented immigrants with catastrophic illnesses, such as end-stage renal disease (ESRD), malignant neoplasm, or traumatic brain injuries, are covered by Emergency Medicaid during the initial life-threatening stage of the illness.[3] Coverage for the sometimes equally life-threatening chronic treatment phase of the illness has been defined variously by the states, and some states with large immigrant populations, like Texas, Colorado, and Florida, do not allow Emergency Medicaid coverage for ongoing care despite the suffering and possible fatal consequences. Owing to these policy differences, undocumented immigrants with catastrophic illnesses receive care that can range from excellent to care that is substandard and often irrational.

In this issue of *JAMA Internal Medicine* there are 2 articles that highlight the health care difficulties of ill, undocumented immigrants.[4,5] The study by Cervantes et al[4] detailing the experience of undocumented immigrants with ESRD in Colorado is extremely important. Many publications have described the economic, legal, regulatory, and clinical challenges associated with caring for undocumented immigrants with ESRD. The study by Cervantes et al[4] is the first to clearly document the physical and psychological suffering associated with the practice of emergent dialysis. This practice, characterized by intermittent admission of patients every few days to weeks for emergent dialysis, is unsafe and inferior compared with the standard of care, which is scheduled, outpatient, 3-times-weekly hemodialysis. Emergent dialysis also burdens the hospitals and clinicians caring for them, who are well aware that the care provided is substandard and also necessarily detracts from the care of other acutely ill patients.

The second study, by Gray et al,[5] reports on a national survey on hospice care. They found that 32% of hospices limited or did not enroll undocumented immigrants as patients. In their multivariable analysis, a higher likelihood of offering unrestricted enrollment to hospice was found in those organizations with a larger average daily census, not-for-profit status, and no chain affiliation. Traditionally, nonprofit hospice organizations maintained a goal of serving patients regardless of ability to pay, which may explain the survey findings. It is distressing that some undocumented immigrants with treatable major illnesses, like ESRD, are unable to receive standard treatment or appropriate palliative and hospice care to address their pain and suffering.

In California, undocumented immigrants with ESRD receive scheduled dialysis paid for by Emergency Medicaid. As described herein, other states, like Colorado, have interpreted Emergency Medicaid coverage differently and allow coverage only when the patient is at imminent risk of death. It is not unreasonable for a state to consider tradeoffs between quality of care and costs when creating health care policy. However, often missing from a cost analysis is the fact that many studies have found that immigrants contribute more via nonincome taxes than the cost of the benefits they obtain. For example, 1 estimate of Medicare contributions over a 7-year period found that undocumented immigrants supplied $115 billion more than what they took out in benefits.[6] However, the emergency dialysis strategy in Texas was estimated to be 3.7 times more expensive than scheduled 3-times-weekly dialysis.[7] The emergent dialysis strategy is illogical by any metric: it is less efficient, provides inferior care, and costs more. States that allow only for emergency dialysis penalize not only the patient but health care systems, health care personnel, and budgets.

Even when undocumented immigrants are eligible for government-sponsored health care, many delay seeking health care for fear of immigration repercussions. This occurs even in cities where the health care system is legally barred from cooperation with immigration authorities because these policies may not be known or believed. Policies that discourage undocumented immigrants from obtaining health care, particularly more cost-effective outpatient care, can both increase costs and have serious public health effects. It is easy to imagine the pub-

lic health consequences had the US index patient with Ebola been undocumented, with no health care options.

The wide variation in local and state policies vividly demonstrates that access to care for undocumented immigrants is driven by politics, and not by cost consideration or concerns for public health. For some communities, including Los Angeles, San Francisco, and New York, which provide care for undocumented immigrants via a variety of local mechanisms, the human imperative to care for the biblical stranger prevails. Not that undocumented immigrants are strangers. The Pew Research Center reports that over 60% of undocumented immigrants have lived in the United States for at least a decade.[8] In 2014, 4.7 million US-born children (<18 years old) were living with undocumented immigrant parents.[8] Undocumented immigrants represent more than 5% of the civilian workforce and more than 20% of the workers in farming and construction.[8] Undocumented children go to local schools, protected by court cases that found a compelling state interest in educating children. Many states cover undocumented children for health care for the same reason.

There have been some positive developments. Twenty-two years ago, California passed proposition 187, which would have denied care to undocumented immigrants had it not been held by the courts in 1994. In June 2016, California passed a law that would allow undocumented immigrants to purchase nonsubsidized private insurance through its exchange, Covered California, if issued an ACA waiver, which is still pending. In some states, nonprofit organizations have stepped forward and have paid insurance premiums for undocumented immigrants with ESRD. Policies emphasizing the primacy of patient welfare are supported by many medical professional societies. The Renal Physicians Association Position Statement on undocumented immigrants and dialysis, for example, states that "The federal government has an ethical and fiscal responsibility to provide care for patients within our borders."[9]

Comprehensive immigration reform is needed to address national policies so that clinicians and health care systems can deliver standard of care to patients without regard to their immigration status. Until then, state and local health care leaders must find creative solutions to alleviate the pain and suffering of the patients we serve, regardless of their immigration status.

ARTICLE INFORMATION

Author Affiliations: Division of General Internal Medicine, San Francisco General Hospital, San Francisco, California (Fernández); Department of Medicine, University of California at San Francisco, San Francisco (Fernández); Center for Vulnerable Populations, San Francisco General Hospital, San Francisco, California (Fernández); Division of Nephrology, Department of Medicine, University of Washington, Seattle (Rodriguez).

Corresponding Author: Alicia Fernandez, MD, DGIM, Zuckerberg San Francisco General, UCSF Box 1364, 1001 Potrero Ave, Building 10, Ward 13, San Francisco, CA 94143 (alicia.fernandez@ucsf.edu).

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