Undocumented Immigrants and Healthcare Access:
What Can We Do?

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Table of Contents

Abstract

There are approximately 11.1 billion undocumented immigrants who live in the United States. They pay taxes and have integrated themselves into their communities. Nonetheless, they are largely ignored by federal healthcare programs such as Medicare and Medicaid. Even healthcare reform such as the Affordable Care Act do not allow undocumented immigrants to purchase subsidized health insurance. This work examines the limited access of healthcare for undocumented immigrants and their economic, societal and public health consequences. Reasons for increasing access to healthcare for undocumented immigrants are proposed. Recommendations for how they may be achieved are proposed are explored through the perspective of the federal government, state government, and institutions.

Introduction

Undocumented immigrants are at the intersection of two contentious debates in the United States: immigration and healthcare. This places them in a precarious legal situation which raises important questions about citizenship, welfare and the state. While undocumented immigrants remain as one of the main topics of the immigration debate, their place in healthcare is largely ignored. Moreover, the future of undocumented immigrants under Trump is unpredictable. Trump's inconsistent policies and reversal of his stance on the Obama era Deferred Action for Childhood Arrivals (DACA) executive order make it difficult to predict how the president will address immigration reform. Meanwhile, undocumented immigrants continue to be victim of accidents and diseases. They live their lives in the fringes of the healthcare system and are kept out of the healthcare reform discussions.

This work examines the access of undocumented immigrants to healthcare in the United States. In the first part, the study explores the regulatory framework and policies established under which undocumented immigrants receive care, as well as the financial and societal costs of these policies. Based on the findings established in the first part, an argument for why undocumented immigrants should have broader access to health care is discussed. Recommendations will be made for what the federal government, state government and institutions can do to help increase access to healthcare for undocumented immigrants.

Part One: Undocumented Immigrants and Healthcare

The Undocumented Population

Demographics

An examination of the undocumented population is needed to understand their place in healthcare. As of 2014, approximately 11.1 million undocumented immigrants reside in the United States, accounting for 3.5 % of the population. Estimates suggest that the undocumented population has been steadily declining. Despite the decrease, the population remains relatively stable in contrast to previous periods. Between 1990 to 2007, the undocumented population rose from 3.5 million to its peak at 12.2 million (Pew Research Center, 2016).

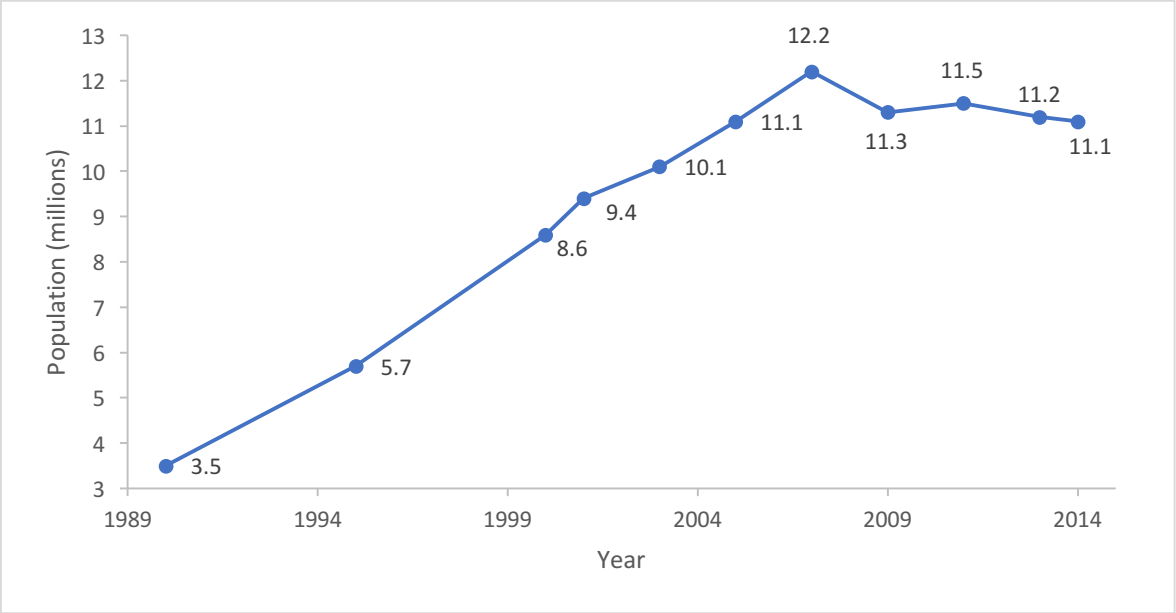

Figure 1. Undocumented immigrant population. Estimated population of undocumented immigrants in millions from 1990-2007. Reprinted from *Pew Research Center*, by J. Passel and D. Cohn. Retrieved from http://www.pewhispanic.org/2016/09/20/overall-number-of-u-s-unauthorized-immigrants-holds-steady-since-2009. Copyright 2016. Reprinted with permission.

Most undocumented immigrants are from Mexico, followed by El Salvador, Guatemala, India, Honduras, China and the Philippines. While Mexico is the leading birthing nation of undocumented immigrants, the total undocumented immigrant population from Mexico has declined by 8% or 500,000 between 2010-2013 (Warren and Kerwin, 2015).

Undocumented immigrants are more likely to live in poverty in comparison to U.S citizens. For example, the mean household income of citizens is $50,000, which is significantly higher than that of undocumented workers at $36,000. Specifically, a third of undocumented children and a fifth of undocumented adults have income at federal poverty level. These statistics are nearly double that of poverty rates for U.S-born children and adults. Escaping poverty is also difficult for undocumented immigrants. They are less likely to attain higher incomes the longer they live in the United States, unlike other immigrant groups (Passel and Cohn, 2009). Interestingly, undocumented immigrants are just as likely as citizens and lawfully present immigrants to have at least one full-time worker in the household. However, as seen Figure 2, undocumented immigrants are nonetheless more likely to be low income and live on an income that is less than 200% of the federal poverty level (FPL). A family of 4, four example, would have a household income of $49,200 or less (Artiga *et al*, 2016).

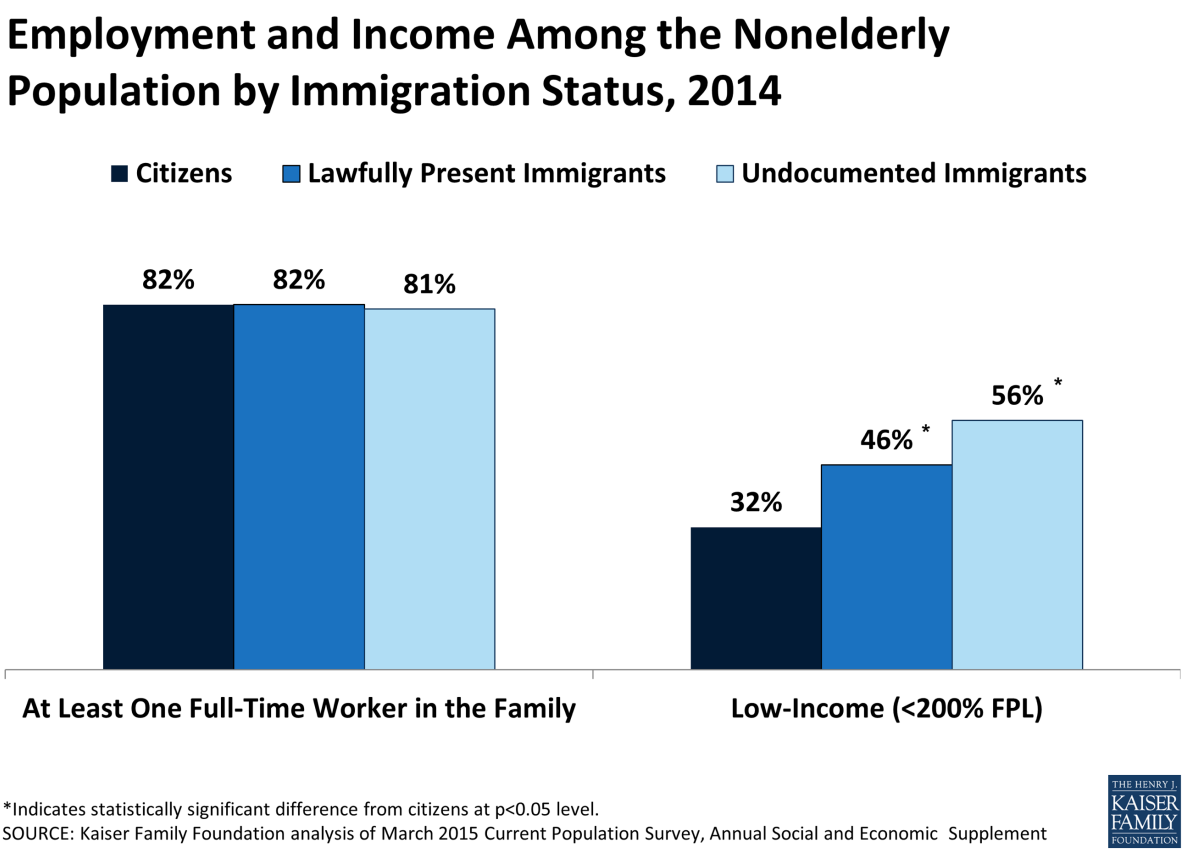

Figure 2. Employment and income by citizenship. Undocumented immigrants are just as likely as lawfully present immigrants and U.S citizens to have at least one full time worker in the family. But, they are more likely to be low income in comparison to other groups. Reprinted from *Kaiser Family Foundation,* by S. Artiga *et al*. Retrieved from http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/. Copyright 2016. Reprinted with permission.

In 2014, undocumented adults have lived in the United States for a median of 13.6 years. In other words, more than half of undocumented immigrants have been living in the country for a decade and have integrated themselves into American society. More than half, specifically 59.2%, of undocumented immigrants reside in six states: California, Texas, Florida, New York, New Jersey and Illinois. While they primarily reside in six states, undocumented immigrants

compromise 40% or more of the immigrant population in some states: 48 % in Arkansas, 42% in Idaho and 43% in North Carolina (Pew Research Center, 2016).

The gender and distribution of undocumented immigrants is unlike the legal immigrant or U. S citizen population. Most undocumented immigrants are adult males, where "adult" is defined as 18 years or older, followed by adult women and children. Undocumented males ages 18-39 make up 35% of the undocumented population (Passel and Cohn, 2009). This statistic is unsurprising given the hard labor most undocumented immigrants do in the United States.

Sources of Undocumented Immigration

The two primary sources of undocumented immigration include unauthorized entry and visa overstays. Every year, the United States issues noncitizens with nonimmigrant temporary visas. Those who remain in the country past their visa expiration date violate their visa terms and are considered part of the undocumented population. Between 1982-2000, the number of undocumented immigrants who crossed from Mexico to the United States has exceeded those who overstayed their visa. Recently however, in 2008, the number of immigrants who overstayed their visa has exceeded the number who crossed the southern border from Mexico. In fact, since 2000, the number of undocumented immigrants who crossed the border without authorization has declined from 675,000 in 2000 to 150,000 in 2012. Moreover, since 1982, the percentage of undocumented immigrants whose visa were overdue has been increasing from 30 % to 58% in 2012 (Warren and Kerwin, 2015).

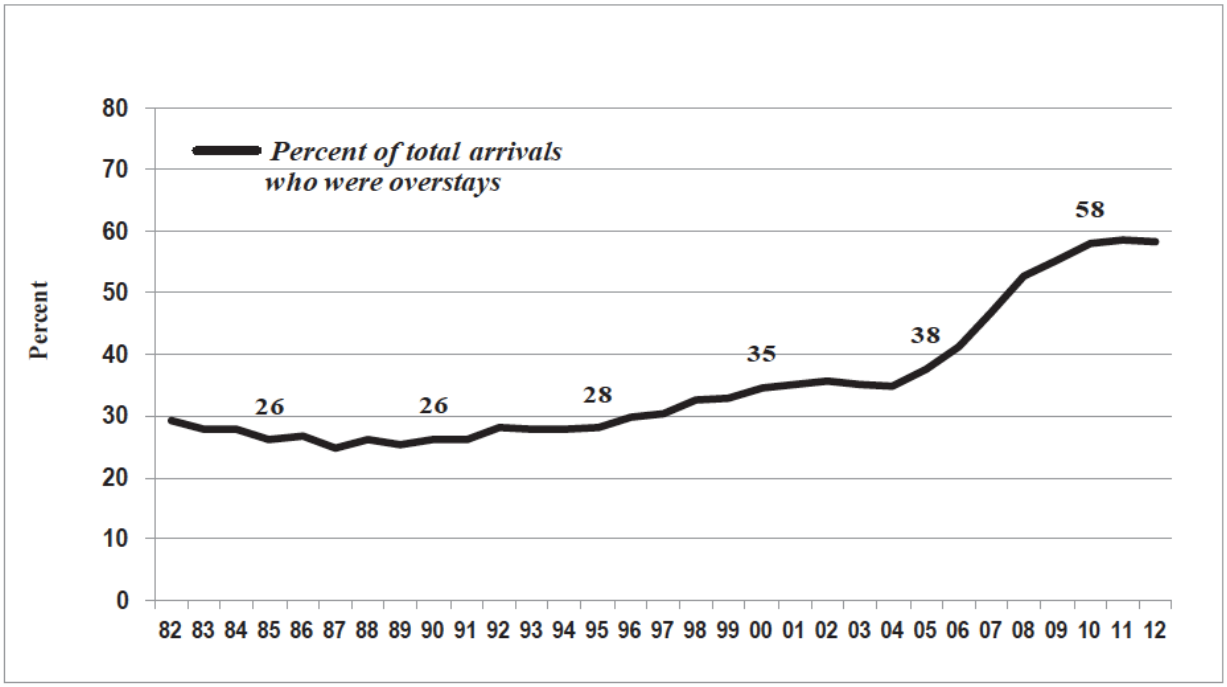

Figure 3. Percentage of undocumented immigrants with visa overstays. Today, visa overstays is the most prevalent source for undocumented immigration. Reprinted from "Beyond DAPA and DACA: Revisiting Legislative Reform in Light of Long-Term Trends in Unauthorized Immigration to the United States," by R. Warren and D. Kerwin, 2015, *Center for Migration Studies of New York, 3*(1), p. 93. Copyright 2015 by the Center for Migration Studies of New York.

Healthcare Policies

Laws

The ineligibility of undocumented immigrants from social programs can be traced back to 1996 when the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was signed into law. The act changed the eligibility rules for public assistance. It declared that undocumented immigrants are ineligible to receive retirement, welfare, health or disability payments. Except for emergency situations and public health assistance with respect to immunizations for communicable disease, undocumented immigrants receive no public health

treatment. States are still allowed to provide public benefits for undocumented immigrants; however, they have no coverage under federal legislation. PRWORA aimed to reduce unauthorized immigration, protect public resources and remove any undue burden on the healthcare system (Kullgren, 2003)

Paradoxically, despite lack of eligibility for public aid programs, federal law still requires that Medicare-participating hospitals treat all patients regardless of citizenship, ability to pay, and insurance status in case of an emergency. In particular, the Emergency Medical Treatment and Active Labor Act (EMTALA) establishes that any patient arriving at an emergency department demanding immediate medical attention must be treated until their condition is stable (Gusmano, 2012). Under EMTALA, an "emergency condition" is defined as:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part

EMTALA was passed to prevent the practice of "patient dumping," the act of refusing to treat uninsured emergency room patients and instead transferring them elsewhere prior to stabilization (Zuber, 2012). EMTALA effectively banned "patient dumping" and has become a safety net for all patients, undocumented or not. However, EMTALA does not require hospitals

to treat life-threatening conditions that are not emergencies or continue to treat complications after patients are stabilized

Moreover, this law doesn't stop hospitals from billing undocumented patients (Sommers, 2013). Thus, these loopholes place undocumented immigrants in a complex legal situation. Although EMTALA forces hospitals to treat undocumented immigrants in emergency conditions, it doesn't cover preventative care services that can potentially stop their health from deteriorating to an emergency situation to begin with. Instead, undocumented immigrants must wait until they are in an emergency situation before a hospital must treat them.

The mandatory need for hospitals to treat all emergency patients led to the creation of Emergency Medicaid, a part of Medicaid that pays for the treatment of people in emergency and acute inpatient care situations. Annually, about $2 billion is spent on Emergency Medicaid by the federal government. According to hospitals' databases, a large portion of undocumented immigrants are recipients of Emergency Medicaid (Galewitz, 2015). Most of the Emergency Medicaid funding is used to reimburse hospitals for delivering babies. In one study of Emergency Medicaid use by undocumented immigrants in North Carolina, most funding was used to pay for childbirth and pregnancy complications (Dubard and Massing, 2007). While this study is only representative of one state, additional research is needed to fully understand Emergency Medicaid uses across the country.

Interestingly, the definition of "emergency" varies by state. The Center for Medicare and Medicaid Services (CMS) has ruled that chemotherapy does not constitute an emergency treatment (Antoniadis and Boxer, 2017). Thus, states need to provide funding for such grey areas. For example, Emergency Medicaid can be used for cancer treatments only in New York and dialysis treatments only in California, North Carolina and New York. In fact, there is no

clear court ruling on when an "emergency condition" ends for the purposes of Emergency Medicaid funding. In *Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System*, an undocumented immigrant was stabilized and transferred to a rehabilitative ward. The court determined that even though the initial injury had been stabilized, the absence of continued medical treatment could place the patient's health in danger. However, in *Greenery Rehabilitation Group, Inc. v. Hammon*, after a patient suffered traumatic brain injury, ongoing care for his chronic conditions did not qualify under Emergency Medicaid statues. Thus, there is no clear judgement on what constitutes an "emergency condition." In many cases, it is state dependent and makes healthcare delivery for undocumented immigrants inconsistent across the country.

Unfortunately, even recent healthcare reform policies such as the Affordable Care Act (ACA) continue to turn a blind eye to the undocumented population. Although the ACA increases funding for safety net clinics by $11 billion over 5 years, an act that can benefit undocumented patients, the ACA still does not allow undocumented immigrants to participate in the health insurance marketplace (Sommers, 2013). Ironically, recent events illustrate that undocumented immigrants are in critical need of federally subsidized healthcare. 150,000 members attempted to register for health insurance through the insurance program Humana, however, their membership was ultimately terminated following verification by CMS. The Center cited termination due to lack of "proper immigrant documentation and/or income status" (Japsen, 2015). This specific Humana example is only one example of undocumented immigrants being barred from receiving the healthcare insurance they need.

Undocumented immigrants may find hope in state reform. Recently, the California Senate passed SB 562, a bill that would allow for a statewide single-payer healthcare system.

Every Californian, regardless of immigration status, will be eligible for coverage without premiums, copayments, or deductibles (Terhune, 2017). The bill still has several hurdles to pass such as determining how the state will pay for it, and passing the California State Assembly and obtaining approval by Governor Jerry Brown.

Federal, State and Private Programs

Undocumented Immigrants do not qualify for federally funded programs such as Medicare or Medicaid with the exception of emergency Medicaid and the Children's Health Insurance Program (CHIP). CHIP is an insurance program for children whose families earn above Medicaid income guidelines. It allows federal funding to be used for children in emergencies and treatment of pregnant women. Because undocumented women give birth to U.S citizens, care for those unborn children is required. However, some states may choose to allocate their own funds to provide extra care to undocumented children. For example, San Francisco's "Healthy Kids" program supports uninsured children under the age of 19 (Healthy Kids, 2016). Illinois has a similar program with "All Kids" which covers uninsured children, regardless of citizenship, who meet income requirements (About All Kids, 2015). In addition to California and Illinois, New York, Massachusetts, Washington and the District of Colombia participate in similar programs offering undocumented children and pregnant women with healthcare (Fremstad and Cox, 2004).

Undocumented immigrants can also receive care through the United States' safety net system which include Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC), and Migrant Health Centers (MHC). DSHs provide care to indigent populations. These hospitals are provided with additional reimbursement from Medicare and

Medicaid, allowing them to provide care to undocumented immigrants. FQHCs are non-profit organizations which give primary care services to low income patients regardless of immigration status. Services provided by FQHCs are free or offered on a sliding scale depending on income and family size. Fees can range from $5 to $24 for patients with income at poverty level and up to $87 for patients with income twice the poverty level (Darnell, 2010). MHCs are similar in structure to FQHC, with the distinction that they provide healthcare to seasonal and migrant farm workers and their families.

Free clinics also provide free healthcare to millions of uninsured patients, including undocumented immigrants. 1007 free clinics operate in the United States providing services such as disease management for chronic conditions, physical examinations, urgent and acute care and medications (Darnell, 2010).

Economics

Medicare and Medicaid Funding

Medicaid health coverage is funded jointly by the state and federal governments. Figure 4 displays how different states pay varying amounts into the program. The federal government subsidies a specific percentage of Medicaid costs in each state known as the Federal Medical Assistance Percentage (FMAP).

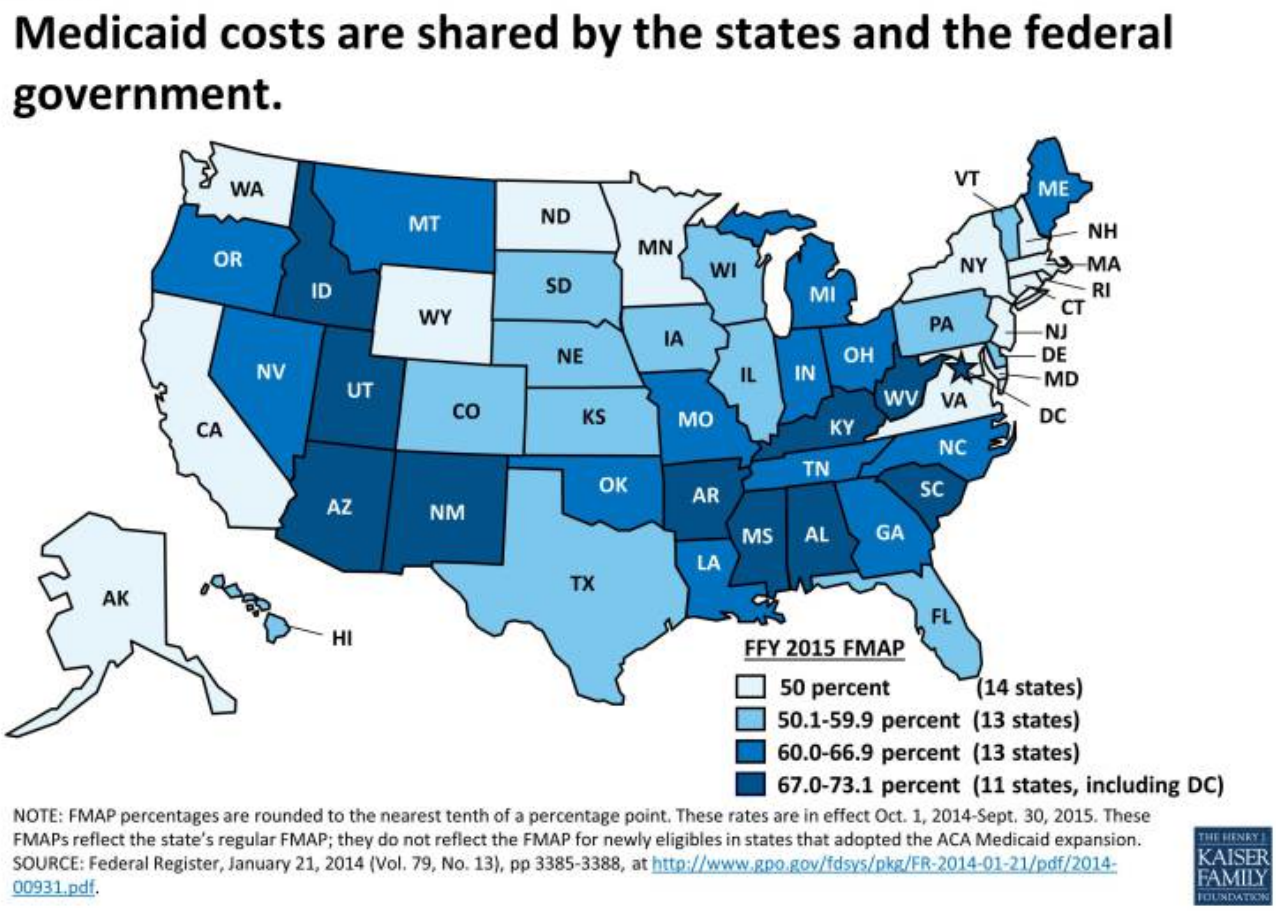

Figure 4. State Medicaid cost according to each state. Each state is responsible for financing a certain percentage of Medicaid. Reprinted from *The Kaiser Commission on Medicaid and the Uninsured*, 2014. Retrieved from http://www.kff.org/medicaid/slide/medicaid-costs-are-shared-by-the-states-and-the-federal-government. Copyright 2014 by The Kaiser Family Foundation. Reprinted with permission.

Federal law dictates that at least 40% of non-federal Medicaid spending comes from state funds. The state finances Medicaid through general fund appropriations, local government funding and revenue from provider taxes and fees (Rudowitz and Snyder, 2015). The general fund is the primary state fund which pays for most of the state government's expenses. Approximately 80% of the general fund is paid through sales taxes, income taxes, gross receipts and compensating taxes. In addition to paying for health services, this fund finances public

schools, higher education, human services and public safety. In comparison, Medicare is funded through the federal government. Payroll taxes are paid by employers and employees, and income taxes are paid through Social Security benefits.

Like Medicaid, CHIP is financed jointly by the state and federal governments. As a block grant, the federal government provides states with a set amount that is matched by the state. The federal government has, on average, a 15% higher match rate for CHIP in comparison to the Medicaid matching rate (Financing Medicaid, 2017).

Taxes

In 2014, approximately 8 million of the 11.1 undocumented immigrants were in the workforce (Gee *et al*, 2016). About half of the working undocumented paid Social Security taxes by filing income tax returns using Individual Tax Identification Numbers (ITINs). ITINS enable undocumented immigrants to pay their taxes as contractors. Another method undocumented immigrants pay taxes is by purchasing unofficial Social Security cards and presenting them to employers. The employers still file W-2 and the federal government receives payroll taxes, even if the Social Security numbers are false. Many undocumented immigrants believe that paying taxes is important while they wait for comprehensive immigration reform. Past reform efforts required undocumented immigrants to prove the length of their residence in the United States and pay owed taxes prior to receiving legal status. As many have noted, paying taxes is one of the pathways to gain legal status in the future.

Additionally, undocumented immigrants pay $11.74 billion every year in state and local taxes each year. Broken down, they pay more than $7 billion in sales and excise taxes, $3.6

billion in property taxes and $1.1 in personal income taxes. Nationwide, about 8% of their total income is used to pay taxes (Gee *et al*, 2016).

Cost of Health Policies

As previously mentioned, $2 billion of Emergency Medicaid is used to pay for EMTALA. To put this into perspective, that amount is less than 1% of Medicaid funding. Overall, approximately $6 billion is spent on providing healthcare to undocumented immigrants every year (Martin and Ruark, 2009).

In several cases, hospitals are responsible for picking up the costs of undocumented immigrants who seek emergency medical treatment. In one report examining uncompensated costs in Southwest Border Counties, it was estimated that hospitals incurred about $190 million in caring for undocumented immigrants in 2000. This accounts for about 25% of the $832 million in compensated care in the region (Meija, 2007). As a response to this, Congress approved $250 million in funding to reimburse hospitals for uncompensated care. However as of 2016, federal funding for reimbursements ended.

Health Outcomes

Health Disparities

In comparison to citizens and lawfully present immigrants, undocumented immigrants are more likely to be uninsured. Among the nonelderly, about 40% of undocumented immigrants are uninsured whereas only 23% and 10% of lawfully present immigrants and citizens are uninsured, respectively. This trend remains consistent in other age groups, as seen in the nonelderly adults and children groups in Figure 5.

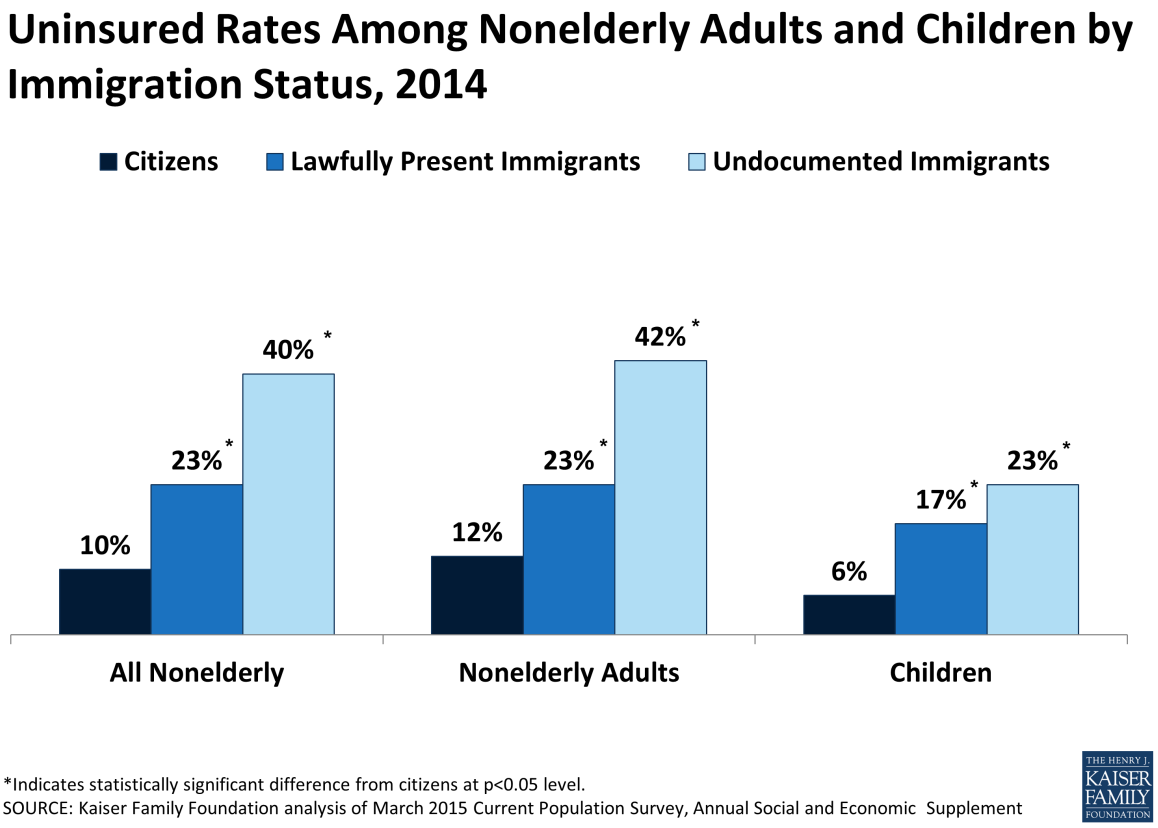

Figure 5. Uninsured rates by age groups and citizenship. In all age groups, undocumented immigrants are more likely to be uninsured in comparison to U.S citizens and legally present immigrants. Reprinted from *Kaiser Family Foundation,* by S. Artiga *et al*. Retrieved from http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/. Copyright 2016. Reprinted with permission.

All those who are uninsured, regardless of citizenship, only utilize medical services about half of the time. Interestingly, even if undocumented immigrants have medical insurance, they are less likely than lawfully present immigrants and citizens to utilize medical services. Figure 6 illustrates how undocumented immigrants have disproportionate access to care.

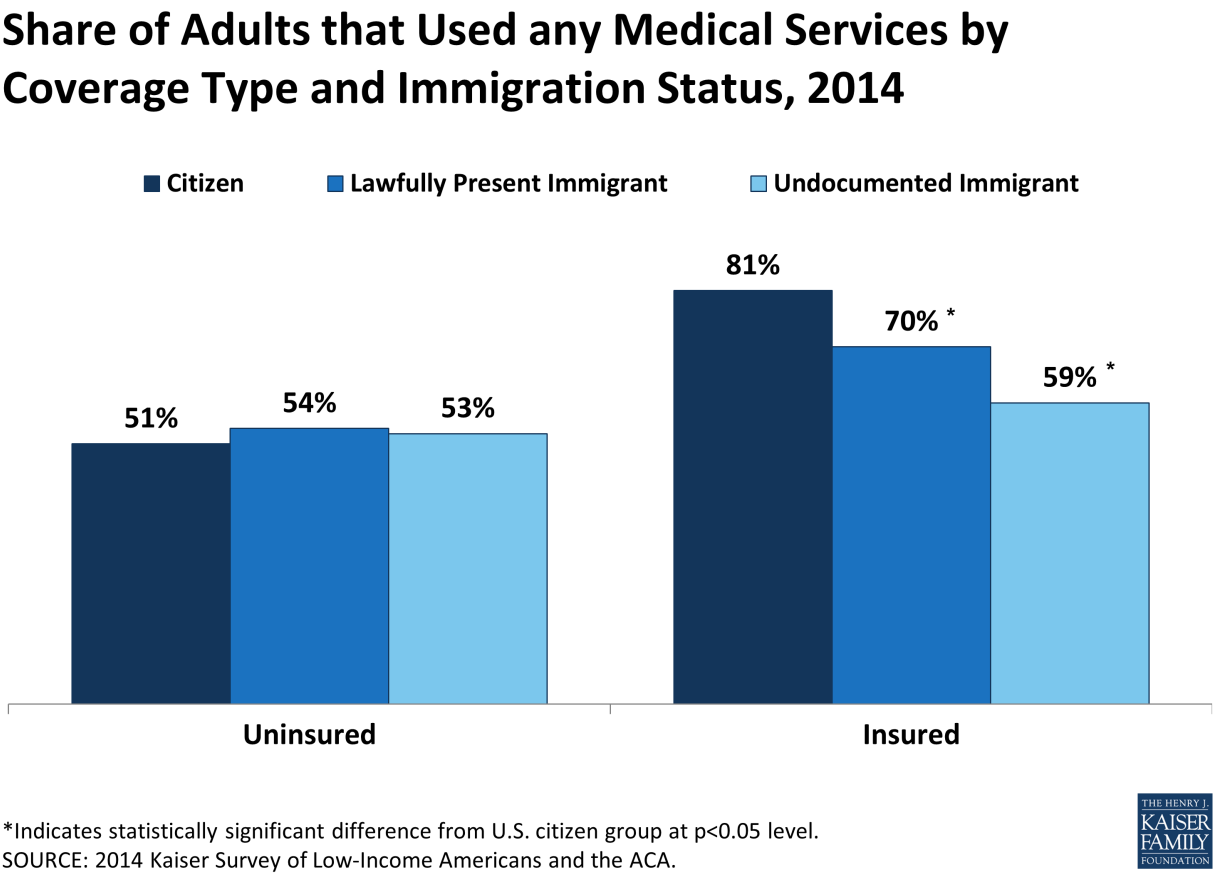

Figure 6. Share of medical services by immigration status. All uninsured, regardless of citizenship, is approximately 50% likely to use medical services. Insured undocumented immigrants, however, are less likely to utilize medical services. Reprinted from *Kaiser Family Foundation,* by S. Artiga *et al*. Retrieved from http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/. Copyright 2016. Reprinted with permission.

Restricting undocumented immigrants' access to healthcare has reverberating impacts on the health of their children. Undocumented immigrants give birth to U.S-born citizens. Although these children qualify for health insurance through the government, many do not receive the benefits. With many language and cultural barriers, immigrants are often confused about state-specific and federal laws that determine eligibility for healthcare services for their children. (Brenner, 1999). Consequently, their children are less likely to see a doctor. In fact, children with undocumented parents are more likely to be uninsured than children with parents who are

citizens (Sanchez and Sanchez-Youngman, 2013). Limiting undocumented parents from seeing a doctor thus also impacts the long-term health of their child.

Reasons for Health Disparities

Evidently, the main reason for the health disparities within the undocumented population is their exclusion from federal and state healthcare policies. In addition, undocumented immigrants' poverty status makes purchasing private health insurance overwhelmingly expensive. Without access to federal subsidies through the ACA or access to Medicaid and Medicare, undocumented immigrants are left to pay for the full price of private insurance. They are also more likely to work in low-income jobs that do not provide employer benefits such as medical insurance (Sanchez and Sanchez-Youngman, 2012). In addition to financial constraints, undocumented immigrants face language limitations. Communication between patients and physicians is a factor of positive health outcomes. Language limitations can cause undocumented immigrants to feel uncomfortable at the doctor's office, which lowers their chances to seek medical treatment.

Undocumented immigrants also face more barriers to accessing healthcare, in comparison to documented immigrants. They report fear of deportation as a main reason for not seeing health treatment. An overall lack of knowledge about the U.S healthcare system and misinformation about what data is collected and how it is used also contribute to the health disparities (Bustamante *et al*, 2012).

Chronic Conditions and End of Life Care

Undocumented immigrants who have chronic conditions such as cancer or renal disease illustrate the critical consequences of the current state of health policies concerning the lack of coverage for the undocumented population. As mentioned previously, undocumented immigrants are eligible to receive chemotherapy and dialysis for these chronic conditions under Emergency Medicaid depending on what state they live in. In addition, they can also receive treatment as charity patients through pharmaceutical donations.

For patients with renal disease, a kidney transplant is the most effective course of treatment. However, transplant patients need to take anti-rejection medication for the remainder of their lives. Without insurance, anti-rejection medication for livers cost more than $1,000 per month (Grubbs, 2014). Due to this, undocumented immigrants are often denied organ transplants even if they have family members who are willing to donate an organ. Justifiably, organ organizations would rather choose an insured patient who is more likely to live longer because organs are a scarce resource. Thus, undocumented immigrants are resigned to live with renal disease and manage their conditions with ongoing dialysis. Notwithstanding, Illinois is the first state to allow undocumented immigrants to receive transplants and provide coverage under the Comprehensive Medicaid Legislation bill (Ansell *et al*, 2015).

An estimated 6,000 undocumented immigrants are living with end-stage renal disease (Ansell *et al, 2015)*. Undocumented immigrants who live in states which do not cover non-emergency dialysis under EMTALA are forced to wait until their symptoms exacerbate into an emergency. Only when their symptoms are severe enough that they qualify as an emergency condition under EMTALA do they go to the emergency department to receive dialysis. In one

study of undocumented patients with end-stage renal disease, patients describe how they feel well for 2 days and then their lives are interrupted by weekly hospital admissions to receive emergent-only dialysis. Because of waiting too long to receive emergent-only dialysis, some undocumented immigrants experienced cardiopulmonary resuscitation and severe arrhythmia (irregular heartbeat). Ironically, many undocumented immigrants can legally donate their own organs, despite being ineligible to receive a transplant themselves. In interviews, many undocumented immigrants even expressed that they want to donate their own organs to help others. In fact, an estimated 3.3% of diseased organ donors between 2012 and 2013 were undocumented (Glazier *et al*, 2014).

An option for undocumented immigrants facing chronic illnesses is medical repatriation. Many undocumented immigrants choose to go back to their home country to receive treatment. For undocumented patients with end stage diseases, hospice care in the United States is unlikely without a hospice willing to take them in as charity patients. Otherwise, some seek medical repatriation for palliative care services. Hospitals in areas with many immigrants work in conjunction with the home consulates of undocumented immigrants to arrange for their travel back to their country. This survival strategy has become so common that the hospitals have developed relationships with consulates. Patients may pay for their travel back own; other times the home government funds transportation (Nuila, 2012).

Part Two: What Can We Do?

In the second part of this work, arguments for increasing access to healthcare for undocumented immigrants are discussed. Afterwards, recommendations as to what the federal government, state government, and institutions can do to improve access to healthcare for undocumented immigrants are explored.

Reasons for Providing Undocumented Immigrants with Healthcare

Arguably, health care is a right and all individuals, including undocumented immigrants, should have access to affordable healthcare. The United States has recognized this idea in several international agreements. For example, the United States adopted the Constitution of the World Health Organization (1946) which establishes:

> The enjoyment of the highest attainable standard of care [as] one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The WHO constitution also acknowledges that the health of the nation is fundamental to the "happiness, harmonious relations and security of all peoples" and the protection of health benefits all of society. The right to health is also established in the Universal Declaration of Human Rights, the International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Economic, Social and Cultural Rights—international treaties all signed by the United States.

An argument against honoring the right to healthcare for undocumented immigrants is that they lose their rights by entering the country illegally. This argument supposes that membership in a country provides citizens with rights while denying noncitizens of those rights. The problem with this notion is that protecting certain rights for all, regardless of citizenship, benefits all of society. For example, sanctuary cities allow undocumented immigrants to call the police without fear of compromising their immigration status. Despite using public funds for the police, it is for the advantage of everyone in society that a crime does not go unpunished or unreported. Many cities also allow undocumented immigrants to have a driver's licenses to promote road safety and education for everyone. Moreover, public education is free for everyone to create an educated country. In the landmark case which established free public education for everyone, regardless of immigration status, the Supreme Court (1982) wrote:

> It is difficult to understand precisely what the State hopes to achieve by promoting the creation and perpetuation of a subclass of illiterates within our boundaries, surely adding to the problems and costs of unemployment, welfare, and crime. It is thus clear that whatever savings might be achieved by denying these children an education, they are wholly insubstantial in light of the costs involved to these children, the State, and the Nation.

The idea of providing undocumented immigrants with affordable healthcare should be seen in the same way. That is, providing them with affordable healthcare benefits not just them, but everyone. This is particularly true for public health. Transmissible diseases have long been a public health issue. Undocumented immigrants who enter the country in an unauthorized manner

are more likely to bring transmissible diseases. Unlike undocumented immigrants who overstay visas or documented immigrants, they are not subject to rigorous medical screenings. Many undocumented immigrants can bring diseases that have been eradicated in the United States such as polio, dengue, tuberculosis or malaria (Cosman, 2015).

Tuberculosis is an airborne disease caused by bacterial infection of the lungs. It is deadly because it can infect other organs and has historically caused endemics because it is easily transmittable. Most tuberculosis cases in the United States have been linked to foreign born individuals. In 2015, the Centers for Disease Control and Prevention (CDC) estimated that approximately two thirds of tuberculosis cases were foreign born (Tsang *et al,* 2017). While not all foreign-born individuals are undocumented, they are more at risk to develop the multidrug resistant-strains due to lower frequencies of doctor visits and lower utilization of medical services (Glen, 2012).

Additionally, in comparison to other industries in the economy, the United States food system is the most dependent upon immigrants. Approximately 1.1 million undocumented immigrants, which is about half of all hired farm workers, perform farm work. It is not sustainable nor is it safe for such a large population of the workers who deal with the country's food to have difficulties accessing healthcare. If sick, these workers could unintentionally spread infectious and communicable diseases to the community (Wainer, 2011). Thus, it is in the interest of everyone in society that undocumented immigrants receive better access to healthcare.

Critics also argue that providing undocumented immigrant's social and health services would incentivize more immigration—both legal and illegal— to the United States. Some claim that removing such social services for the undocumented would decrease any burden on the healthcare system. However, these public opinions are missing the primary reason that many

immigrants come to the United States: employment and social and economic mobility. Immigrants are more likely to come to the United States to be with family, find better job opportunities and avoid violence and war. Many studies reflect this sentiment, and in fact, a study of illegal immigrants who applied for citizenship found that social services did not influence their decision to come to the United States (Chavez *et al*, 1997). Consequently, providing health and social services to undocumented immigrants would not attract more migrants to the United States than the amount that are currently coming seeking economic mobility.

In the current system, undocumented immigrants have disproportionate access to care because of their legal status compared to U.S citizens and documented immigrants. Citizenship and legality should not dictate whether an individual receives life-saving treatment. While EMTALA ensures that everyone is *eventually* treated by a physician, undocumented immigrants are nonetheless subjected to life threatening situations by placing their health on hold until an emergency arises.

Federal Government

Recommendation: Allow undocumented immigrants into federal programs such as Medicaid, Medicare and the ACA

Providing undocumented immigrants with access to federal programs such as Medicare and Medicaid, and letting them participate in federally subsidized insurance through the ACA can help reduce health disparities and increase access to care for the undocumented.

Including undocumented immigrants into federal programs is not only morally responsible, but also fair. Critics often argue that undocumented immigrants are a financial

burden on the United States economy. As previously mentioned, however, undocumented immigrants pay both federal and state taxes. These funds are used together to pay for Medicare and Medicaid. In fact, in one study, it was calculated that undocumented immigrants utilize fewer federal funds than they pay in federal taxes (Androff *et al*, 2012). For example, the chief actuary of Social Security Stephan Goss estimates that undocumented paid $13 billion into the program but only received $1 billion of benefits, netting in $12 in unused funds (Goss et al, 2013).

There is also a fiscal advantage to providing undocumented immigrants with access to federal healthcare programs. Namely, waiting for an emergency to visit a doctor is not a sustainable nor cost effective way to manage health. As mentioned previously, approximately $2 billion is spent every year on Emergency Medicaid. Instead of waiting for an emergency, these funds can be used for preventative care services. Health screenings and regular doctor checkups are a more cost-effective way to maintain a healthy population.

Additionally, including undocumented immigrants into federal programs help subsidize insurance costs. The goal of health insurance is to spread the risks of an individual person across the entire population. The addition of a relatively young and healthy population, such as undocumented immigrants, into insurance programs helps mitigate the risks for everyone. In other words, the healthy lowers the cost of care for the sick. Having a larger population in the insurance pool is desirable because they reduce spending and make premiums more stable (Gostin and Conners, 2010).

Productivity is also lost when healthcare professionals spend time having to organize and coordinate the care of uninsured undocumented immigrants. For example, professionals and social workers help undocumented immigrants receive charity care and organize medical

repatriations. The time and money spent on these services can be avoided if undocumented immigrants have access to federally funded healthcare programs.

Including undocumented immigrants into federal programs can also help alleviate the uncompensated costs absorbed by local hospitals. Allowing low income undocumented immigrants into federal programs will allow these hospitals to be reimbursed by the federal government for the care they provide. The problem with the current system is that undocumented immigrants are paying too much taxes into the federal government while underutilizing the funds. Permitting undocumented immigrants into federal programs can fix the inequality by using those currently underutilized funds to reimburse local hospitals.

State Government

Recommendation: Provide funds to enable undocumented children and pregnant women to participate in CHIP

As previously discussed, only five states and D.C provide children with healthcare through state funds. Providing undocumented children is particularly important because they interact with other children during school. Vaccinating undocumented children is important to prevent the spread of communicable diseases as previously discussed. Providing healthcare for undocumented children may also be easier to justify to the public. Similar to the argument behind DACA, undocumented children were brought to this country as minors. They should not be excluded from healthcare because of the choices of their parents.

Additionally, prenatal care is extremely important for a woman and her unborn child. Studies show that prenatal care reduces costs and adverse outcomes such as premature birth. During one study of undocumented pregnant women, researchers calculated that every dollar

spent on prenatal care results in a $3 and $4 in post-natal and long-term care, respectively. The authors examined California as a case study and predicted that while the state would save $58 million by eliminating pre-natal care for undocumented immigrants, it would result in an addition $194 million for post-natal care (Lu *et al*, 2000). Thus, there is financial incentive for states to provide prenatal care for undocumented pregnant women.

Institutions/Organizations

Medical Schools

Recommendation: Invest in graduating DACA physicians.

In 2015, only 50 of the 142 surveyed medical schools in the United States admitted that they were willing to accept DACA students (Foley, 2016). The major challenge for DACA students is their ineligibility to qualify for federal loans. Thus, it is a financial burden for undocumented students to afford medical schools. In response to this, Loyola University Chicago Stritch School of Medicine has offered loans to DACA medical students. As of 2016, Stritch had 20 DACA medical students enrolled.

DACA medical students represent an untapped potential workforce for diversifying medicine. Currently, African Americans and Hispanics makeup 25% of the population but only 6% of physicians. Studies show that minority patients favor physicians of the same race because of personal and language preferences (Saha *et al,* 2000). Making patients more comfortable with their doctors is particularly important, especially for undocumented patients who already disproportionately have lower access to care. Making medical school more accessible for DACA physicians can also help teach other medical students of the struggles of uninsured

undocumented immigrants. DACA medical students can share their personal perspective on the issue and help their classmates be more aware of it.

Additionally, undocumented students demonstrate high levels of civic engagement and show commitment to giving back to their communities (Perez *et al,* 2010). In interviews, DACA medical students echo this sentiment as well. Personal experiences with their families having trouble accessing healthcare motivate them to work with underserved communities (Foley, 2016).

Research Institutions

Recommendation: Invest in researching the healthcare experiences of undocumented immigrants

Research into how undocumented immigrants receive healthcare is difficult, which arguably makes identifying and amending health disparities challenging. Hospitals aren't required by law to document the citizenship status of their patients. Instead, studies utilize proxy measures such as lack of a permanent address and self-pay status to identify undocumented patients. Thus, many studies express that their statistics are limited by this fact. Moreover, more statistical data needs to be collected on the experiences of undocumented immigrants who receive health treatment. For example, most articles on medical repatriation simply include individual stories and case studies. Studies with larger sample sizes are needed to attain a broader understanding of medical repatriation. Understanding how undocumented immigrants receive care and the quality of care they receive will be important in guiding policies to help them achieve better access to care.

Conclusion

Undocumented immigrants must learn to navigate the bureaucratic policies of both the immigration and healthcare systems. Without immigration reform and a pathway to citizenship, they live every day in uncertainty. Limited access to healthcare further complicates their lives because they are ineligible for federal healthcare programs as Medicare, Medicaid and the ACA. When most undocumented immigrants fall ill, they rely on the mercy of emergency rooms and charity of hospitals and clinics. Due to these systemic limitations, undocumented immigrants have lower access to care in comparison to U.S citizens and documented immigrants, despite paying the same taxes.

Allowing undocumented immigrants access to federal healthcare programs is one way to reduce the disparities in health which undocumented patients face. However, this would only be one progressive step in addressing their overall lack of rights. Long term and permanent solutions to addressing the systematic barriers to healthcare would have to come from meaningful immigration reform policies.

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