A Health Care Problem the Supreme Court Can’t Solve
Dissecting Obamacare’s Troubly Exclusion of Undocumented Immigrants
By Max Hadler
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LOS ANGELES – A white canvas sign tied to a fence on South Alvarado St. in Los Angeles reads, “Clinica Romero remains open and offers the same low-cost or free services as always.” The sign is a reference to the stunning rumors that reverberated through the city not long ago suggesting that the community health center, a mainstay of LA’s MacArthur Park neighborhood since its founding in 1983, was on the verge of bankruptcy and would soon be shuttering its doors. Reports of the clinic’s demise now appear to be greatly exaggerated, but the stir that the rumors caused gave pause to a poor, immigrant community that leans heavily on the clinic’s mostly free health care services. On a larger scale, Clínica Romero’s brush with death is the kind of news that makes health care experts ponder how a health care system can function when a single clinic’s struggles mark the potential difference for thousands of people between having a regular place to get care and being relegated to the hospital emergency room.

Clinica Romero is a federally qualified health center (FQHC), meaning that it receives grants from the federal government to offer services without regard to insurance coverage or ability to pay. In many cases, its patients have nowhere else to turn for preventive care. It is, in the truest sense of the phrase, a safety net. It is no coincidence that the prevention-oriented Patient Protection and Affordable Care Act, more recognizably known as health care reform, increases funding for FQHCs in recognition of their invaluable place at the base of the U.S. health care pyramid. But health care reform also contains a poorly-kept secret that threatens the ability of FQHCs to attend to their most needy clients. It is a secret that is couched, ironically, in one of the most public aspects of the health care reform debate – the almost complete exclusion of undocumented immigrants from any of the law’s benefits.

Until the Supreme Court decides the fate of health care reform sometime next year, most headlines will focus on if, how, and how much the law will solve the country’s health care crisis. Even if the Court upholds the law exactly as it is currently written, there will still be a huge amount of uncertainty about who gets what. But for undocumented immigrants, the answer will be the same no matter the Court’s decision. As a result of anti-immigrant rhetoric promulgated by the likes of South Carolina Congressman Joe Wilson (he of the infamous, ‘You lie!’ cry), undocumented immigrants were so marginalized from the health care debate that they will not even be allowed to spend their own money to obtain insurance through the exchanges that are to be created across the country by 2014.
The link between health care reform’s immigration status regulations and the standing of a safety net provider like Clínica Romero may seem tangential (indeed, many of the rumors about the clinic’s financial troubles pointed to failed and possibly corrupt administration), but it represents the relationship between the people left out of reform and the only places likely to continue to serve them. Like most community health centers of its kind, Clínica Romero does not collect information on its patients’ immigration status. Such data would be useful for a clinic that expends a sizable portion of limited resources trying to channel patients into public programs that make the clinic eligible for reimbursement for treating them. If the clinic knew which patients were undocumented, it would almost automatically save itself the trouble of searching for applicable programs, for which there are almost none that benefit undocumented immigrant adults (children have a different set of benefits). However, asking patients about their immigration status could chase away weary community residents and would go against the FQHC mission of serving anyone regardless of their background. So the clinics rely on anecdote and limited eligibility information to guess how many of their patients are undocumented. The conclusions are grim.

“As it is now, health care reform won’t really do anything for our current patients at any point in their lifetimes,” says Alicia Wilson, the executive director of La Clínica del Pueblo, a FQHC in Washington, D.C. that, like Clínica Romero, was founded in 1983 to serve Central American refugees fleeing civil wars. Both clinics continue to care for the mostly Central American and Mexican residents of their urban environs. Wilson’s conclusion refers to the fact that most of her clinic’s patients, in her estimation, are undocumented immigrants who do not stand to benefit from the expansion of Medicaid or the exchanges that would ostensibly lower the cost of insurance for larger pools of people. Some optimistic early analyses of health care reform suggested that FQHCs would benefit from the fact that more of their near-poor patients would be eligible for Medicaid with the proposed increase in the program’s income cap, which would make FQHCs eligible for more reimbursable care. La Clínica del Pueblo provides an early indication that this is not true because Washington, D.C., trying to get ahead of the 2014 requirements, has already raised its Medicaid cap. According to Wilson, the increase in the clinic’s Medicaid reimbursements have “barely been a blip.”

Wilson has a bigger concern, though, and it is one that is likely to affect people well beyond the confines of her clinic. In addition to FQHCs like La Clínica del Pueblo, Washington, D.C.-area residents are eligible for a program called DC Healthcare Alliance. The Healthcare Alliance is funded by the city government and covers any uninsured individual who makes less than about $22,000 a year, regardless of their immigration status. The program has been credited with being the biggest reason that 95 percent of Washington, D.C. residents are insured, well above a national average that struggles to surpass 80 percent. While the program has been a success, it is a strain on the city government’s budget. Wilson fears that any
opportunity to cut the program will be taken seriously. Health care reform may provide just
that opportunity because it will offer coverage to many of the more than 50 million people in
the U.S. who are currently uninsured. In Wilson’s reading of the situation, if enough people who
rely on the DC Health Care Alliance are covered by Medicaid and the health insurance
exchanges, the city will seriously consider cutting the program. The people who are left out will
seek care in community health centers, which will find themselves more stretched than ever
trying to accommodate a group that, at least in Washington, D.C., has been more evenly spread
across the city’s health care outlets since the Alliance’s inception in 2001. The clinics will
respond by turning people away when they reach capacity and, even more likely, having to
diversify their patient base to ensure that some insured patients cover the increasing cost of
unreimbursed care for the people on the margins of the new health care system. Either way,
the result is the same – less access to care for people who can least afford to see their few open
channels narrowed further.

Figuring out who will remain uninsured after health care reform has been implemented
is a bit like shooting at a moving target, but it has not stopped some experts from trying to do
so. “It’s guesswork because so few states have implemented anything... but immigration status
is very important,” says Matthew Buettgens, a researcher at the Urban Institute. According to a
recent study Buettgens did with Mark Hall from Wake Forest University, 18.6 million people will
still be uninsured after health care reform is in place.1 About 25 percent of those people will
be undocumented immigrants. Nearly seven million of the uninsured will be people who are
eligible for some sort of benefit under reform and could ostensibly be enrolled through
outreach. Removing those seven million people from the equation, fully 40 percent of the
remaining uninsured would be undocumented immigrants, by far the biggest single group of
uninsured people. Absent the possibility of effective outreach for these 4.7 million people, the
obvious solution is a change in policy. However, immigration is about as toxic an issue as exists
in Washington these days, and we just finished reforming a health care system that decisively
declared that it is not interested in undocumented immigrants. In this context, a change in
policy seems unlikely. Nonetheless, it is worth confronting the question that most
fundamentally stands in the way of a truly universal system for a country that is home to more
than ten million people without authorization to be here – why should U.S. citizens and
permanent residents care about the health care access of people whose right to even be in the
country, let alone use its services, is questionable?

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1 Buettgens, M (2011). “Who Will be Uninsured Following Health Insurance Reform?” Presentation at the Annual
Meeting and Exposition of the American Public Health Association.

* Only academic articles or presentations are cited here in trying to stay as close to journalistic form as possible
while also recognizing published work (i.e., personal interviews are not cited in footnotes because they are a
standard part of background reporting).
Moral arguments aside, people should care because the plight of undocumented immigrants affects everyone. To understand how undocumented immigrants affect the bottom line of places like La Clínica del Pueblo in Washington, D.C., or Clínica Romero in Los Ángeles, is to begin to understand how their exclusion represents a problem for a revamped health care system built on the premise that everyone be insured and yet leaves nearly five million people without viable coverage options. The classic argument against health care services for undocumented immigrants – that they already fill up emergency rooms with minor issues that create bankrupting costs for hospitals and prevent them from handling real emergencies – is greatly exaggerated. There is no question that cost shifting, the practice of increasing the cost per service of insured patients to buffer the expense of treating uninsured people, takes place, but studies across the country have found that emergency department expenditures on immigrants are exponentially lower than those for U.S. citizens. Still, that emergency rooms are used as primary care clinics is a fact that is problematic for a system hell-bent on reducing costs. The real issue, though, lies in the shortsighted view that undocumented immigrants generate costs for services without providing anything in return.

Undocumented immigrants are in fact important contributors to the U.S. economy. The difference between a path to legalization and a path back to immigrants’ countries of origin is on the order of $1.5 trillion, according to a 2010 study by the Center for American Progress. That is, the U.S.’ gross domestic product, the number one indicator of economic health, would be buffered $1.5 trillion over ten years if immigrants were offered an opportunity to normalize their legal status. A study by the same organization using advanced economic modeling at the state level showed that Arizona, in the aftermath of Senate Bill 1070, the infamous anti-immigrant law that has been stalled by a Justice Department injunction, stood to lose $48.8 billion and 581,000 jobs if it succeeded in deporting all undocumented immigrants (not an explicit goal, but certainly one in spirit). States that have tried to copy or, in the case of Alabama, one-up Arizona have already seen anecdotal evidence of the disappearance of immigrant labor. It took mere weeks for Alabama to feel the effects of passing the most vicious of all U.S. anti-immigrant laws in October. By the end of the month, Sean Sellers and Greg Asbed were already writing in this magazine’s pages about watermelons and tomatoes rotting in unpicked fields in Alabama and Georgia, another state that has aggressively pursued the expulsion of immigrants without regard to their role as the backbone of the agriculture industry. The loss of farm productivity is not just an indication that draconian laws succeed in chasing immigrants away; it also debunks the myth that immigrant workers are taking jobs from U.S. citizens. Indeed, when these workers leave, jobs disappear with them, the spillover effects of

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which increase economic stagnation and joblessness for U.S. laborers at a time when unemployment is at near-record levels in the post-war era.

There are indications that the recoil from the anti-immigrant fire is even entering the political sphere, with the architect of Arizona’s law losing a recall vote in November elections and the Obama administration, despite its spotty immigration record, doing everything possible to prevent obviously detrimental bills from becoming law. Though he is now out of politics, former senate majority leader Tom Daschle of South Dakota recently said that “every person in this country deserves health care.” It is a subtle distinction, but given politicians’ weakness for words like “Americans” and “U.S. citizens,” Daschle’s choice of terminology is notable for its inclusionary implication. Granted, he was speaking at a conference of the American Public Health Association, a sympathetic crowd if ever there was one, but the tone is still instructive.

The damage, though, may already be done, and this is where health care reform and piecemeal immigration reforms cross paths. Immediately after Alabama’s bill was passed by the state’s legislature, the federal government temporarily blocked a part of the law that would have required public schools to check the immigration status of their students. Nonetheless, school attendance has already fallen amid fear and confusion in immigrant communities. Similarly, a recent study in the Stanford Journal of Public Health shows that immigrants and refugees in the United Kingdom often do not seek care for their health problems despite acknowledged need. This may not seem surprising in a system like the U.S.’s, where attrition has become an afterthought, but the U.K.’s National Health Service is designed to serve everyone, everywhere, without financial or geographic obstacles. And yet immigrants consider confusion about the system’s functionality and communication troubles to be insurmountable barriers.

The implication of these instances is that rhetoric, rumor and confusion can have a strong impact even if they don’t reflect reality. When the target of the rhetoric is a vulnerable group of people that already faces barriers to services, the effect can be absolute: school or no school; health care or no health care. In the case of the latter, the issue at hand in reviewing health care reform’s effect on immigrants brings back one of the underlying questions in the reform debate, namely what happens to people who do not have insurance.

Health researchers have long focused on the relationship between being insured, having a regular source of health care, and eventual health outcomes. The connections are astounding. Despite former President George W. Bush’s musings on the ease of seeking care in an emergency room, uninsured people are substantially worse-off than their insured counterparts. A California study that measured the health care access of children of immigrants found that
those who were uninsured were significantly less likely to have a regular source of care.\(^4\) Other studies on chronic diseases such as hypertension and diabetes indicate that not having a regular source of care is strongly associated with an inability to obtain medications or receive timely follow-up appointments.\(^5\) When people do not have a general clinician, they seek care in other places, such as emergency rooms that are required by federal law to treat anyone who walks in the door. In this sense, the worn-out narrative of immigrants filling up hospitals is not entirely wrong, nor are its concerns about the spillover effects of cost-shifting; they simply exaggerate the relative cost.

One reason that anecdotal, anti-immigrant scare-mongering does not match up with actual health care expenditures is because immigrants are, in the aggregate, an exceptionally healthy group of people. They have less heart disease, cancer and hypertension than the U.S.-born population, and they tend to be younger than the average U.S. citizen.\(^6\) In nearly every sense they are the ideal population to enroll in pooled health insurance schemes like the soon-to-be-formed exchanges. In theory, immigrants would lower the cost of insurance for everyone. However, the longer immigrants spend in the U.S., the less healthy they get. Theories about why this happens are myriad, but most suggest it is a combination of the inability to get needed health care and lifestyle changes that increase the probability of chronic disease.

The increase in chronic conditions is obviously not unique to immigrants. U.S.-born people are at the root of the ballooning obesity epidemic, and the retirement of the baby boom generation has led to an aging of society that challenges the health care system to keep up with the exploding elder care costs. As is often the case when labor shortages threaten an industry in the U.S., the long-term care sector is now leaning on the same immigrants who are not able to access care themselves to provide for baby boomers. A 2009 Georgetown University study found that one in five direct long-term caregivers for elderly and disabled people were immigrants.\(^7\)

Whether they are working in nursing homes, watermelon fields, or the construction of new houses, immigrants provide services that others are often unwilling to offer. The more time they spend in the U.S., the less healthy they become and the less access to care they enjoy.

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suggesting that the health care system is contributing to a downgrading of the workforce’s labor capacity. If the economic effect of removing immigrants from the workforce is clear, the economic effect of not providing them preventive care is just as obvious. Perhaps the best example comes from California, the state with the largest undocumented immigrant population in the country. The Golden State has had its share of immigration battles since it nearly set a precedent that would have outdone even Alabama’s new law when it passed Proposition 187 in 1994. In the throes of one such fight in 2000, over the state’s provision of prenatal care to undocumented immigrant women, the renowned *American Journal of Obstetrics and Gynecology* published a study about the program’s effect on the state economy. Using risk ratios associated with births by women who did not receive prenatal care and the resultant cost of treatment for low birth weight and preterm infants, who as low-income children would likely fall under the state’s purview, the authors calculated it would cost the state $194 million in health care expenditures. Cutting the program, meanwhile, would save the state $58 million in prenatal care costs. Eleven years later, undocumented immigrant women in California still receive care.

Indeed, many of them receive it at Clínica Romero.