REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-07

Subject: Financial Impact of Immigration on the American Health System (Resolution 235, A-06)

Presented by: William A. Dolan, MD, Chair

Referred to: Reference Committee A (Virginia E. Hall, MD, Chair)

At the 2006 Annual Meeting, the House of Delegates referred the first resolve of Resolution 235, which was submitted by the Organized Medical Staff Section and calls for the AMA to "ask the United States Department of State to include on applications for visas to the US, a requirement mandating that visitors carry adequate health insurance valid during their stay in the US." The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2007 Annual meeting.

Although the first resolve of Resolution 235 (A-06) is limited to visitors, the underlying concern of the resolution is immigration, and specifically the assumed financial burden on the US health system created by uninsured undocumented immigrants. This report discusses the influence of immigrants on the US health care system, includes an overview of existing federal laws affecting immigrant health care coverage, summarizes AMA policy on immigrant care, as well as general policy on coverage for the uninsured, and considers the appropriate role for the AMA in national discussions about both immigration and health care coverage for the uninsured.

US DEPARTMENT OF STATE VISA INFORMATION

The US Department of State has the responsibility for issuing visas to citizens of foreign countries who wish to travel, work, or take up permanent residence in the US. According to the State Department, visas themselves do not permit entry to the US. Rather, they are attached to passports and indicate that a US consular officer at an American embassy or consulate has reviewed a foreign traveler's application and determined that the traveler is eligible to travel to the port-of-entry for a specific purpose. At the port-of-entry, a US immigration officer of the Department of Homeland Security decides whether to allow the traveler to enter and determines the length of stay for any particular visit. Despite these procedures, an estimated 40% of the undocumented people living in the US originally entered the country with non-immigrant visas have become "undocumented" by overstaying their visas.

INTERNATIONAL HEALTH INSURANCE REQUIREMENTS

On the Web site of the National Academies: Advisors to the Nation on Science, Engineering and Medicine, foreign travelers to the US are advised of the following: "Medical care in the US can be very expensive. All visitors should carry adequate health insurance valid for the duration of their stay in the United States."

For US citizens traveling to foreign countries, the State Department provides summaries of the entry requirements for foreign countries. For example, every visitor entering Austria, the Czech Republic, Estonia, Greece, Germany, Latvia, Lithuania, Montenegro, the Netherlands, New Zealand, the Slovak Republic, Sweden, and the Ukraine, are required to provide proof of sufficient health insurance, although some of these countries may only require health insurance for stays of a certain length. In comparison to the US, these countries have more nationalized systems of health care.

The State Department also is responsible for the "J" exchange visitor program, which is designed to promote the interchange of persons, knowledge, and skills in the fields of education, arts and sciences. In the US, J-1 exchange visitors and J-2 visitors (the spouses and minor children of J-1 visitors) must carry health insurance. Government regulations stipulate that if visitors willfully fail to carry health insurance, then the J-1 sponsor must terminate the visitor's participation in the program. While the "J" visitor program is an example of how the US has been able to require health insurance for entry into the country, it is unclear how well the US has monitored and enforced this requirement.

FEDERAL LEGISLATION RELATED TO THE HEALTH CARE OF IMMIGRANTS

Although most immigrants are in working families, a disproportionate number of immigrants work in low wage jobs that are less likely to offer private health insurance. The eligibility of documented non-citizens for federal means-tested public benefits, including Medicaid and the State Children's Health Insurance Program (SCHIP), is limited. With enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), only permanent residents, refugees/asylees, persons paroled to the US, and battered spouses and children admitted to the US, qualify for Medicaid.

Undocumented immigrants and legal immigrants residing in the United States less than five years, with the exception of limited coverage for emergency conditions, are ineligible for Medicaid. Prior to the enactment of PRWORA, immigrants admitted to the US with documentation were eligible for benefits under the Medicaid program on the same terms as US citizens. A June 2005 Employee Benefit Research Institute study found that between 1998 and 2003, growth in the uninsured increased by 86%, likely a result of the enactment of PRWORA.

More recently, Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P. L. 108-173) (MMA), mandated the distribution of federal funding for the emergency care of undocumented immigrants to the states between May 2005 and 2008. A total of $1 billion in federal funds were appropriated to help hospitals and certain other providers cover their otherwise non-reimbursed costs of providing emergency services required under the 1986 Emergency Medical Treatment and Labor Act (EMTALA) to undocumented immigrants. Since the passage of EMTALA, hospitals with dedicated emergency departments have been required to provide an appropriate medical screening examination to any person, regardless of ability to pay or citizenship status. If the examination reveals an emergency medical condition, the hospital is required to stabilize or arrange for an appropriate transfer to another medical facility.
To address the concern that EMTALA constitutes an "unfunded mandate," Section 1011 of the MMA provides for direct payments to eligible providers for EMTALA-related care to undocumented immigrants that was not otherwise reimbursed. Hospitals, qualifying physicians, and ambulance providers need not be enrolled in the Medicare program to be considered eligible providers. The Centers for Medicare and Medicaid Services (CMS) does not require hospital staff

to ask patients directly about their citizenship or immigration status. Instead, CMS developed a form that instructs providers to ask or research some basic questions (e.g., whether the patient is enrolled in Medicaid). It is the provider's responsibility to make a reasonable determination of patient eligibility based on that information.

Section 1011 of the MMA provides funds for FY 2005 through FY 2008, with $250 million appropriated per fiscal year. Each year, two-thirds of this $250 million, or $167 million, is allocated to the states based on their relative percentages of undocumented immigrants. The remaining $83 million is allotted to the six states with the highest number of undocumented immigrant apprehensions for each fiscal year. In FY 2005 and FY 2006, Arizona, Texas, California, New Mexico, Florida, and New York were the six states determined to have the highest number of undocumented immigrant apprehensions. Payments to providers may be reduced in the case of multiple providers, and payments may only be made to the extent that care was not otherwise paid for through insurance or other sources. Funds are state-specific, and any unused portion allocated in one year may be rolled over to the state's allocation for the following year, for use by that state.

In FY 2005, approximately $192 million allocated for providers for care to immigrants under MMA, Section 1011, were not accessed by physicians. One likely reason that physicians face considerable challenges in accessing payment is because while the provider payment determination form states that physicians should not ask the patient if he or she is documented, it does ask the provider to indicate whether the patient is undocumented if this information is revealed.

RELATED AMA POLICY

Policies H-270.961 and H-440.876 (AMA Policy Database) state that our AMA strongly opposes any federal legislation requiring physicians to establish the immigration status of their patients or collect and report data regarding an individual patient's legal resident status. Policy H-160.987 reaffirms the dedication of physicians to serving those in need of medical care and their commitment to the principle that no one shall be denied necessary medical care because of inability to pay. Policies H-130.967 and D-440.985 support payments to physicians for care given to undocumented immigrants, specifically for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in an undocumented immigrant presenting to hospital emergency departments for treatment. Similarly, Policy H-160.956 favors lobbying Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. Policies H-290.983 and H-440.903 support restoring and maintaining funding for public health care benefits for all documented immigrants. Finally, Policy H-165.848 supports a requirement that individuals and families earning greater than 500 percent of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care.

IMMIGRANTS AND HEALTH INSURANCE

In 2006, an estimated 12 million undocumented immigrants were living in the United States. Over the last 20 years, increases in the number of undocumented immigrants have made immigration an increasingly important matter of national concern, particularly with respect to health care. Recent studies indicate that undocumented immigrants account for one in four of the uninsured population. Comprehensive analyses regarding health care costs and the fiscal benefits or burdens of undocumented immigrants are not widely available. There are no national surveys, administrative

data, or other sources of information that directly provide accurate health cost estimates of this population. However, the unauthorized immigrant population has been estimated using certain assumptions and by combining data that measure events with those that measure populations. The emerging picture from these data seem to indicate that immigrants are disproportionately low users of the health care system.

For example, a November/December 2006 article in *Health Affairs* by Dana P. Goldman, et al., "Immigrants and the Cost of Medical Care," found that in Los Angeles County, California (the state with the largest immigrant population in the country), immigrants use disproportionately less medical care than indicated by their representation in the US population. The study indicated that immigrants account for 86% of the growth in the uninsured; however, the correlation between the growth of the immigrant population and their proportionate contribution to medical costs is questionable because foreign-born are predominately young and relatively healthy. In addition, they often have less access to health insurance and correspondingly are lower users of medical care. Extrapolating data from Los Angeles County, California to the nation, total spending by undocumented immigrants is $6.4 billion, of which 17% ($1.1 billion) is paid for by public sources. Goldman asserts that immigrants' health care costs are only half as large as their representation in the US population and since immigrants are less likely than US natives to use public funds, their impact on public spending is even smaller.

A March 2007 article in *JAMA* by C. Annette DuBard, MD, MPH, et al, found that between 2001 and 2004, the state of North Carolina spent less than 1% of its total $7.5 billion Medicaid budget on care for recent immigrants. While undocumented immigrants are not able to access traditional Medicaid, children, elderly or disabled, families with dependent children and pregnant women do have some access to care in emergency situations with Emergency Medicaid, as long as they meet residency and state income requirements. In 2004, approximately 82% of Emergency Medicaid spending ($43.4 million) was for childbirth and complications related to pregnancy. These data suggest that the Emergency Medicaid programs in states with growing immigrant populations, such as North Carolina, are mainly geared to providing childbirth coverage.

DISCUSSION

Implicit in the implementation of a requirement for visas to indicate health insurance coverage is a requirement for documentation. Such a request may contribute to further increases of undocumented immigrants, as uninsured immigrants may opt to enter the country without documentation rather than meet the health insurance requirement that would be required for documented entry. In addition, enforcing a documentation requirement is currently a source of considerable controversy regarding US immigration policy reform.

There are nearly 45 million uninsured Americans and expanding affordable medical coverage to patients is a primary goal of the AMA. The Council is concerned that advocating for required health insurance for US visa applicants would insinuate the AMA in the broader national immigration debate, at a time when the AMA is attempting to focus its advocacy on extending health insurance coverage to the nearly 45 million Americans who are uninsured.
In contrast to countries with nationalized systems of health care, the US health system is dominated by an employer-based method of insuring citizens which disproportionately fails those with low-wage, minimal benefit jobs. Council on Medical Service Report 8 (A-01), "Uninsured Immigrants," detailed the barriers to access and insurance coverage faced by immigrants. The report concluded that there is an opportunity for the AMA proposal for health system reform to fill

the gaps in coverage between the public and private sector for documented immigrants. The AMA continues to advocate a system of refundable tax credits for individuals directly related to income, as a means to address the health insurance needs of the documented immigrant population.

Meanwhile, physicians are in the tenuous position of mediating the costs of providing care to patients who are unable to obtain public health insurance due to their immigration status. AMA policy opposes any requirement that physicians establish the documentation status of their patients. As the US faces a dilemma in how it will mitigate the tradeoffs between low-wages to immigrants and healthy citizens, documented, undocumented, and native, the Council believes that the AMA should continue to advocate that physicians receive payment for the care that they provide, and that individuals obtain health insurance. Rather than asking the State Department to require that visitors carry adequate health insurance valid during their stay in the US as requested in Resolution 235 (A-06), the Council recommends the establishment of new policy to support the legislative and regulatory changes that would require the federal government to provide reasonable payment to physicians for federally mandated care, regardless of the immigration status of the patient.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of the first resolve of Resolution 235 (A-06); and that the remainder of this report be filed:

> That our American Medical Association support legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient. (New HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Support legislative and regulatory changes to require the federal government to make reasonable payments for the federally mandated care they provide at an estimated total staff cost of $1,840.