CITIES, IMMIGRATION, AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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The Patient Protection and Affordable Care Act (ACA) has transformed the U.S. health care system. It expanded health insurance to millions of Americans and has provided U.S. health care safety-net institutions, including public hospitals and clinics that provide health care to a disproportionate share of low-income people, with crucial funds. In theory, poor residents of rural areas could benefit from the ACA’s insurance expansion even more than residents of cities, but city residents have gained more from the ACA than their rural counterparts. This is due, in part, to the fact that most uninsured residents who live in rural areas live in states that have refused to implement the ACA’s expansion of the Medicaid program. Despite the law’s considerable success, it remains politically controversial. Republican leaders remain committed to repealing it, and there are questions about its future.

In this chapter, I provide a brief overview of the ACA, discuss the political struggle that led to its uneven implementation, and then discuss one of the largest gaps in the ACA—coverage for undocumented immigrants (Joseph 2017a, 2017b; López-Sanders 2017; Sanchez et al. 2017). The ACA is limited in its ability to address the needs of city residents because, like other public insurance programs in the U.S., the ACA excludes undocumented immigrants. More than 61 percent of the 11.1 million undocumented immigrants in the U.S. live in the country’s 20 largest metropolitan areas (Passel and Cohn 2017). The failure of the federal government, and most state governments, to adequately address the needs of undocumented patients means that local governments and local health care organizations are left to grapple with this problem. The efforts I describe below are important, but they are limited in their reach. Equally important, because cities are not equally willing or able to address the needs of this population, relying on local governments reinforces the large geographic inequalities in the U.S.

What Is the Affordable Care Act (ACA)?

After a century of failed efforts, President Barack Obama signed the ACA into law on March 23, 2010. The health reform law regulates private health insurance and extends public and private insurance to millions of Americans. The ACA represents the largest expansion of government in health care since the adoption of Medicare and Medicaid in 1965 and the first time the federal government adopted a law with the goal of providing (nearly) all citizens with health insurance. Although it closes many of the gaps in health insurance coverage, the ACA leaves the basic patchwork nature of the insurance system in place and has not controlled health care costs. The law offers important insurance
protection to millions of Americans without insurance and helps to minimize regional inequalities in access to public insurance for the poor, but it has been continually under attack from the Republican Party since its adoption. Despite the failure of the Congress to adopt a bill to repeal the ACA in 2017, the adoption of the new tax law, which eliminated the financial penalties enforcing the individual mandate starting in 2019, and the Trump administration’s efforts to undermine the implementation of the ACA continue to threaten insurance coverage.

**What Does the ACA Do?**

The ACA is a complex law, but it includes three main components. The first is an expansion of health insurance. It accomplished this expansion in two ways (Marmor and Gusmano 2018). First, the law dramatically expanded Medicaid, the jointly financed and jointly administered federal-state program for low-income individuals. About half of the new coverage offered by the ACA resulted from expansion of the Medicaid program (Garfield and Damico 2017; Obama 2016). Established in 1965, Medicaid is the largest grant program to the states, providing health insurance to over 65 million low-income people. The ACA initially mandated that all nonelderly, non-disabled people with incomes up to 138 percent of the federal poverty level (FPL) would qualify for Medicaid. The federal government would pay 100 percent of the costs for the newly eligible for three years starting in 2014. In 2017, this federal match started to decline and was due to level off at 90 percent in 2020 (Thompson and Gusmano 2014). According to the law signed by President Obama, states that refused to comply with this mandate risked having funding for their existing Medicaid program reduced, but a Supreme Court ruling converted the Medicaid expansion from a mandate to a state option (Thompson and Gusmano 2014).

Second, it created new, subsidized health exchanges (later dubbed “marketplaces”) of Americans insured against health costs. It required all Americans who were not covered by other health insurance programs to purchase health insurance through one of the new exchanges or pay a penalty, but the law provided subsidies for those with incomes between 138 and 400 percent of the federal poverty level.

The second component of the law involved new federal health insurance regulations. Before the adoption of the ACA, private health insurance companies were permitted to impose lifetime expense limits on clients and could refuse to sell insurance to people with “pre-existing” conditions. The ACA made these insurance provisions unlawful. It also included a rule that children can continue to be covered by their parents’ health insurance to 26 years of age. Finally, the ACA includes a mix of different policy initiatives explained as cost control, but not providing much of it (Gusmano 2011; Marmor and Gusmano 2018; Marmor et al. 2009; Oberlander 2011). The result was a confusing patchwork built on existing programs, but one that expanded public and private insurance coverage in the United States to more than 25 million people (Marmor and Gusmano 2018).

**The ACA’s Bumpy Implementation: State and Local Variation**

The ACA was historic for many reasons. Not only did it represent the first successful effort to adopt a comprehensive national health insurance program, but it was notable for an almost complete lack of Republican support in Congress. From the moment President Obama signed the law in 2010, Republican leaders have been trying to undermine or eliminate it. The members of the so-called “Tea Party” led the attack on the ACA.

The Tea Party, which emerged as a new force in American politics in 2009, pointed to the ACA as an example of what was wrong with government and used anger about the law to increase turnout among conservative activists in the 2010 mid-term elections. The success of the Tea Party in the
2010 mid-term elections and their intense dislike of the law referred to derisively as “Obamacare” have encouraged Republicans to continue their attacks on the law (Gusmano 2012).

One strategy by opponents of the ACA has been to challenge the constitutionality of the law in court. The Supreme Court has twice upheld the law’s constitutionality, but in the first Supreme Court case, National Federation of Independent Business v. Sebelius, the U.S. Supreme Court limited the federal government’s forcing states to expand Medicaid by threatening to withhold Medicaid matching funds. Some commentators predicted that the Court might overturn the law’s minimum essential coverage provision, known as the “individual mandate” (Tau 2012). This provision requires most people to purchase a minimum level of health insurance for themselves and their dependents, starting in 2014. Under the law individuals who do not purchase insurance must pay a tax (or, as the law described it, a “penalty”). Since Congress has the power to levy taxes, Chief Justice Roberts argued that the mandate is constitutional. The decision by the Chief Justice to accept this line of argument from the government surprised some. The claim that the federal government could not force states to expand Medicaid by threatening cuts to their Medicaid matching funds was an even more unexpected dimension of the majority opinion. There is a long history of the federal government making funding for programs conditional on changes in state law. The adoption of state seatbelt and minimum drinking age laws, for example, happened after the federal government threatened to withhold federal interstate highway funds. Roberts justified this decision by arguing that the ACA’s Medicaid expansion was really the creation of a new program. In his view, it was too coercive for the federal government to threaten funding for the original Medicaid program to pressure states to adopt

![Figure 6.1](image_url)  
**Figure 6.1** Current status of state Medicaid decisions.  
*Source: Kaiser Family Foundation, 2017.*
this “new” Medicaid program. Threatening states with existing federal Medicaid funds, according to Chief Justice Roberts, would have put “a gun to the head” of states and was an unconstitutional exercise of federal government authority.

Some thought that Republican states would not be able to resist the attraction of new federal money and would eventually implement the Medicaid expansion. This assumption failed to account for the degree to which partisan opposition to the ACA drove health policy in many states with Republican governors and Republican-controlled state legislatures. Even though the ACA covered 100 percent of the costs of Medicaid expansion in 2014–2016, and in 2019 covered 90 percent of such costs, 19 states (Figure 6.1) have refused to expand Medicaid (Marmor and Gusmano 2018). Although 16 states with Republican governors have expanded their Medicaid programs, the governments in all of the states that have refused to participate in the Medicaid expansion are controlled by Republicans (Thompson and Gusmano 2014).

Did the ACA Expand Access to Care?

Despite claims by President Trump and other critics that the ACA is a failure and about to implode, there is overwhelming evidence that the law has improved insurance coverage and access to care since its full implementation in 2014. Data from the Kaiser Family Foundation, which is one of several organizations that track the implementation of the ACA, indicates that the law has increased insurance coverage dramatically (Figure 6.2). Between 2013, the year before the law’s insurance expansion provisions were implemented, and 2016, the percentage of Americans without insurance fell from 13.3 to 10.3 percent (Figure 6.2). Overall, the ACA is credited with reducing the number of uninsured by about 20 million people (Garrett et al. 2017). Not surprisingly, states that implemented the Medicaid expansion experienced larger increases in insurance coverage (Garrett et al. 2017). In addition, adults between 18 and 64 with incomes below 138 percent of FPL are more likely to have insurance if they live in a county within a state that expanded Medicaid (Figure 6.3). Thanks to the insurance subsidies from the federal government for people to purchase non-group coverage through the ACA marketplaces, even non-expanding states experienced gains in insurance coverage. Yet, because non-expanding states were also less likely to invest in outreach to encourage people to sign up for insurance through the marketplaces, adults between 18 and 64 with incomes between 138 and 400 percent of FPL are less likely to be insured if they live in the non-expanding states (Figure 6.4).

There is also evidence that the expansion of insurance due to the ACA has improved access to care. In 2016, Sommers and colleagues compared self-reported access to care during the first year of ACA implementation in three states (Arkansas, Kentucky, and Texas). Both Arkansas and Kentucky, which expanded Medicaid under the ACA, experienced great improvements in insurance coverage and access to care (Sommers et al. 2016) compared with Texas, which did not expand Medicaid. Also in 2016, the Kaiser Family Foundation conducted a survey of people who had signed up for insurance through the ACA “marketplaces.” Although the results highlight partisan disagreements about the law, they indicate that the majority of those surveyed believe they have benefited from the ACA. The majority of those who identified as Republicans (57 percent) indicated that they had not benefited from the law, but overall 54 percent of the respondents offered a positive assessment of the ACA (Figure 6.5). It is important to note that Republicans are less likely to live in states that expanded Medicaid, so it is possible that these poll results reflect this.

The ACA and Cities

Although the ACA has improved access for care among all demographics and in all regions of the country, the law has been particularly beneficial to America’s cities. The disproportionate gain in
Figure 6.2  Uninsurance rate among the nonelderly population, 1972–2016.

Figure 6.3  Health insurance coverage estimates, percentage uninsured, living at or below 138 percent FPL, working age adults aged 18–64.
Figure 6.4  Health insurance coverage estimates, percentage uninsured, living between 138 percent and 400 percent FPL, working age adults aged 18–64.


Figure 6.5  People in ACA marketplaces who say they benefited or were negatively affected by the ACA.

coverage among people living in urban areas reflects the politics of the ACA and state-level decisions about expanding Medicaid, because about two-thirds of uninsured people in rural areas live in states that have refused to expand the Medicaid program (Newkirk and Damico 2014). This means that a larger portion of people in rural areas fall into a coverage gap because their incomes are too high to qualify for their state’s Medicaid program, but they do not qualify for the ACA’s insurance subsidies, which start at 138 percent of the federal poverty level. About 16 percent of people in rural areas fall into a coverage gap, but only 9 percent of those living in urban areas (Newkirk and Damico 2014).

Even within states that did not expand Medicaid there are important urban–rural differences in access to insurance. Barker and colleagues found that between 2012 and 2015 Medicaid growth rates in metropolitan counties were twice as large as in rural counties (10 percent compared to 5 percent) (Barker et al. 2017). The authors suggest that, because there are fewer ACA “navigators” to help people understand benefits under the program in rural areas, many people may be unaware that they are eligible for Medicaid (Barker et al. 2017).

**Ongoing Challenges Facing the ACA**

The ACA does face challenges (Obama 2016). Health insurance premiums have continued to increase, and several large health insurance companies have decided to leave the marketplaces. Fortunately, the ACA subsidies, which have been threatened by the Trump administration and congressional Republicans, have protected most people from significant out-of-pocket cost increases. Nevertheless, the absence of serious cost control provisions does threaten the long-term stability of the program. With regard to choice of insurer, this is primarily a problem faced by residents of rural areas (Altman 2016). In most cities, people who purchase non-group coverage through one of the ACA marketplaces have a choice of multiple insurers. Even in cities, however, these choices are threatened by efforts to undermine the ACA. Even though the Congress has not yet repealed the law, the new tax law did repeal penalties for failing to comply with the individual mandate, and this may have resulted in a decline in insurance coverage. In addition, the Trump administration has engaged in efforts, including the administration’s decision not to fund advertisements during the 2017 open enrollment period. One of the most significant threats to the stability of the law is the threats by the Trump administration and Republicans in Congress to withhold the ACA’s cost-sharing reduction (CSR) payments. These are monthly payments made to insurers to subsidize the deductibles, coinsurance, copayments, and other out-of-pocket payments by individuals with incomes between 100 and 250 percent of the federal poverty level (Jost 2017). In 2014 the House of Representatives sued the Secretary of Health and Human Services because she claimed that the Congress never appropriated money for this purpose. The House was successful in a federal district court, but the court stayed its order pending an appeal. If Secretary Clinton had won the 2016 presidential election, she would have appealed the decision, but President Trump decided to drop the appeal and suspend the CSR payments. To date, this has not resulted in a dramatic decrease in insurance coverage, but it has contributed to increases in premiums on the ACA marketplaces (Congressional Budget Office 2017).

**The Limits of the ACA: Access to Care for Undocumented Immigrants**

There are approximately 11.1 million undocumented immigrants living in the United States (Passel and Cohn 2017). In the United States and worldwide, most immigrants settle in cities (Passel and Cohn 2017). Twenty American cities are home to more than 60 percent of the nation’s foreign-born population, including 65 percent of authorized immigrants and 61 percent of unauthorized (undocumented) immigrants. Most undocumented immigrants have been settled for more than a decade,
and one-third of their households include children who are U.S. citizens by birth, according to the nonpartisan Migration Policy Institute.

This low-income population is excluded from key federal benefits such as Medicare, Medicaid, the Child Health Insurance Program, and Affordable Care Act insurance subsidies (National Immigration Law Center 2014). Health care access beyond sliding-scale primary care via public or nonprofit clinics, or specialty care beyond emergency interventions reimbursed by a state’s Emergency Medicaid program, often varies significantly based on organizational charity care investments and local and state safety-net provisions (Cervantes et al. 2017; Joseph and Marrow 2017). Although the U.S. is a nation of immigrants, throughout much of its history it has projected fears onto immigrants. One way that fears about immigrants and immigration have been articulated in the U.S. is through the language of public health (Markel and Stern 1999). Some Progressive-era reformers, many of whom were women, held more positive attitudes toward immigrants and created forms of assistance to help immigrants integrate into American society. The Settlement House Movement was an important development in these efforts. Settlement houses were communal residences in poor urban, often immigrant, neighborhoods in which middle-class, well-educated people would live to help improve the lives of local residents by providing recreational and social services, with the goal of mutual learning and benefit across classes and cultures (Skocpol 1992). The first settlement house in London, Toynbee Hall, founded in 1884, became the model for Chicago’s Hull House, founded by Jane Addams in 1889, and New York City’s Henry Street Settlement, founded by Lillian Wald in 1893. These and other leaders of the Settlement House Movement in the U.S. also advocated for public programs to improve the health and well-being of women and children. Lillian Wald advocated to create the New York City Bureau of Child Hygiene, whose motto was “Better mothers, better babies, and better homes” (Skocpol 1992), and with Jane Addams and Florence Kelley, a reformer for child welfare and labor protections, supported the creation of a federal-level Children’s Bureau (Skocpol 1992). The emphasis of the Settlement House Movement leaders on mothers and children as a group deserving of assistance is a theme that is reflected throughout the history of American social policy (Schneider and Ingram 1993; Weir et al. 1988) and continues to influence federal, state, and local policy toward pregnant women who are undocumented, and to some extent toward undocumented children.

National debates over eligibility for public assistance have intersected with federal immigration law through the concept of “public charge,” first introduced in the 1882 Immigration Act (Park 2011). According to this and subsequent laws, immigrants are denied entry to the United States if they are deemed to be a likely public charge, defined as “someone who cannot provide for himself and thus relies on public assistance for a substantial part of his livelihood; it is someone who is a charge, or responsibility, of the public” (Edwards 2001). A finding of public charge can be considered grounds for deportation to this day, and foreign nationals seeking reentry may be required to pay back public assistance and health care costs incurred on prior visits before being considered for visas.

In 1996, Congress further eroded access to care for undocumented patients and other immigrants when it enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). The federal law scaled back welfare state provisions and devolved federal authority for social services to the states. PRWORA (Title IV) rendered two groups of immigrants ineligible for federally financed Medicaid: lawfully present immigrants (“qualified aliens”) who have held green cards for less than five years, and unauthorized immigrants (“non-qualified aliens”) who are considered to be permanently residing under color of law (PRUCOL). PRUCOL is a public benefits eligibility category for individuals who are in the U.S. with the knowledge of immigration services and are not likely to be deported. Before PRWORA, legal immigrants were eligible for Medicaid under the same rules as native-born Americans, and people with PRUCOL status were also eligible for Medicaid. PRWORA (Title VIII, Sec. 1621) further required states to “affirmatively” declare,
through new law, that persons “not lawfully present in the United States” after August 22, 1996 would be excluded from “any state or local public benefit,” including Medicaid.

New York State complied with PRWORA by passing Social Services Law 122, which terminated public benefits, including Medicaid, for “unqualified aliens” and instituted a five-year waiting period for public benefits for “qualified aliens” who had entered the U.S. after August 22, 1996. Advocates filed a lawsuit (Aliessa et al. v. Novello) against the state on behalf of 12 immigrants who had been denied coverage for the treatment of “potentially life-threatening illnesses” under Law 122. The New York State Court of Appeals ruled that denying access to Medicaid violated the equal protection clauses of the New York and U.S. constitutions. Article XVII of the state constitution holds that “the aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature from time to time may determine,” and PRUCOL was defined in the decision as “aliens of whom the INS is aware, but has no plans to deport.” The decision by Judge Albert Rosenblatt also notes the importance of “ongoing medical care.”

The Aliessa v. Novello decision in 2001 was a landmark in case law, creating a legal mandate in one state for health care access, via insurance coverage, for certain populations of immigrants excluded from public insurance by federal law. As Deborah Bachrach and Karen Lipson (2002) have noted, the court followed long-established New York State precedent when it ruled that the legislature may not refuse “to aid those whom it has classified as needy.” Because the state had deprived legal immigrants of “an entire category of otherwise available basic necessity benefits” based on “an overly burdensome eligibility condition having nothing to do with need,” the court held that the state had violated the mandate of Article XVII.

(Bachrach and Lipson 2002)

As a result of Aliessa v. Novello, undocumented immigrants with PRUCOL status, and lawfully present immigrants who have held green cards for less than five years, are eligible for state-funded Medicaid in New York State if they meet income requirements. Fifteen states now offer at least some state-only funded health insurance coverage for immigrants with PRUCOL status (ASPE 2012).

Public Health Law and Safety-Net Health Care Access for Undocumented Immigrants

Undocumented immigrants often obtain access to some forms of health care through provisions for populations recognized as lacking health care access for a range of reasons, including geography, lack of a fixed address, limited time to attend to personal needs, lack of transportation, lack of information about where to seek health care, difficulty communicating about health care needs, or lack of a means to pay for health care. Over the past 50 years, public health law and related financing mechanisms have shaped the two major safety-net systems—community health centers and emergency medical treatment—that serve these populations.

The Migrant Health Act was enacted in 1962. This legislation provided federal funding to every state to support primary health care and preventive health services for migrant farmworkers and their families. The migrant health centers created through this legislation are not-for-profit organizations funded by the federal Health Resources and Services Administration (HRSA) (National Center for Farmworker Health 2014). They offer low-cost primary care to migrant and seasonal farmworkers and their families, regardless of immigration status. Other types of not-for-profit community health centers, such as federally qualified health centers (FQHCs), were subsequently created based on this model. FQHCs are funded by HRSA grants to support primary care on a sliding fee scale to
populations that lack access to primary care. FQHCs are an important source of accessible primary health care for undocumented immigrants owing to their low cost, community locations, and attention to issues of language, lack of time, and reluctance to engage with perceived authorities that are among the barriers to health care access for this population (Berlinger et al. 2014).

In addition to these federally subsidized clinics, local public and not-for-profit (or “voluntary”) hospitals concerning undocumented immigrants who are unable to pay for their own health care are determined in part by the 1986 Emergency Medical Treatment and Leave Act (EMTALA), also known as the “anti-dumping law.” EMTALA requires hospitals with public emergency departments (EDs) to provide appropriate medical screening for every patient arriving in the ED. Other sources of reimbursement for uncompensated care include Medicaid payments to “disproportionate share hospitals” (DSH) that treat higher than average percentages of low-income and uninsured patients (Gusmano and Thompson 2012), state- and county-level funding for safety-net hospitals, and a hospital’s own charity care resources.

Medicaid for the Treatment of Emergency Conditions (Emergency Medicaid)

Hospitals may seek to recover the costs of providing emergency medical treatment to undocumented immigrants and other uninsured patients through state-funded Medicaid for the Treatment of Emergency Conditions, commonly known as “Emergency Medicaid.” This provision defines “emergency conditions” as those that seriously jeopardize a patient’s health, put the patient at risk of bodily dysfunction of a major organ, or cause severe pain; each state sets its own policy concerning income limits and which services will be reimbursed. Emergency Medicaid often excludes treatments that constitute appropriate medical care for specific life-threatening conditions. For example, this provision may reimburse hospitals for the cost of providing chemotherapy to an uninsured patient but fail to provide reimbursement for medications that are typically ordered for a patient receiving chemotherapy. Emergency Medicaid provisions exclude post-discharge services such as skilled nursing care, home care, physical therapy, medical equipment, and medical transportation. These exclusions create immense and expensive barriers to the implementation of “safe and effective” discharge plans when a hospitalized patient is undocumented and has no prospect of obtaining insurance coverage.

“Universal” Medicare Entitlements and Undocumented Immigrants

The basic exclusion of undocumented immigrants from “public benefits,” including insurance, means that this population is excluded from several Medicare provisions that are commonly described as “universal” entitlements for which people qualify based on diagnosis and related medical criteria. Analysis of Medicare data for the period 2000 through 2011 suggests that payroll contributions from undocumented immigrants using false Social Security numbers to satisfy E-Verify or other employment requirements contributed a total surplus of $35.1 billion to the Medicare Trust Fund during this period (Zallman et al. 2016). Because undocumented immigrants are excluded from Medicare insurance, the notion that this population has not “paid into the system” is false. In fact, contributions from undocumented immigrants are paying for health care for current and future Medicare recipients.

Patient Protection and Affordable Care Act (ACA) of 2010 and Undocumented Immigrants

The ACA excludes undocumented immigrants from its federal insurance provisions—notably, the expansion of Medicaid—and prohibits undocumented immigrants from purchasing federally subsidized private insurance through the federal or state marketplaces. Section 1312 of the Act states:
If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual 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.


Although the health reform law provides direct funding for safety-net organizations, it also called for reductions in funding to Medicare and Medicaid DSH programs in anticipation of projected new revenues from newly insured patients. Because of the refusal of the governors of 19 states, mostly in the South, to expand their Medicaid programs, an estimated 3 million low-income people remained uninsured who would have been eligible for the Medicaid expansion (Garfield and Damico 2017). This refusal ensures continued economic pressure on safety-net organizations that also care for the undocumented uninsured, for legally present immigrants who are not yet eligible for ACA provisions, and for other populations who continue to lack access to health care.

**Local Initiatives to Improve Health Care Access for Undocumented Immigrants**

Health care access is always a local issue, because that is where most people seek care, especially if they depend on safety-net organizations. Efforts to improve health and health care for immigrants are also often local efforts, grounded in specific cities or neighborhoods, as in the Settlement House Movement, and reflect local perceptions and priorities about what a community should do for new arrivals as well as poorer citizens. Local initiatives to improve health care access for undocumented immigrants using local policy mechanisms often take the form of supporting “direct access” to primary and preventive health care, through subsidized low-cost services and through local financing for health care personnel and facilities. These initiatives coexist with safety-net programs such as Medicaid, the Child Health Insurance Program (CHIP), Emergency Medicaid, and prenatal care coverage that are financed and regulated at the state level and to which undocumented immigrants may have access at a state’s discretion.

Local direct access programs are usually associated with county-level programs for the indigent. In Texas, mid-20th century revelations about poor conditions in charity hospitals led to the creation of “hospital districts” with their own financing systems, like school districts. County-level hospital districts in major cities in Texas operate public hospital systems and may also choose to invest in services that are usually funded by public insurance to provide access to these services for patients ineligible for public insurance. Levying taxes to support health care for uninsured county residents is typically described as public financing; in Houston, this is construed as “taking care of our own,” distinct from “government” funding (Nuila 2012). Houston’s Harris Health system’s financial assistance program offers discounted health care to uninsured county residents with incomes less than 300 percent of the FPL regardless of immigration status at primary, surgical, specialty, and dental clinics. This hospital district also operates a scheduled dialysis clinic for uninsured patients; because most patients with ESRD are eligible for the Medicare entitlement covering this diagnosis and treatment, patients without coverage for dialysis tend to be undocumented. Houston’s approach and scope of services is similar to that of New York City’s Health and Hospitals Corporation (HHC), the nation’s largest public hospital system, which offers discounted health care to uninsured city residents, including undocumented immigrants, with incomes up to 400 percent of the FPL.

Two major cities in California have undertaken direct access programs that coexist with a range of progressive state-level efforts to improve health care access for undocumented immigrants.
Since 1993, Healthy San Francisco has offered low-cost health care for residents of San Francisco County with incomes up to 500 percent of the FPL, financed through county funds, California’s 1115 Medicaid waiver (which allows a state to implement its Medicaid redesign plan), and a spending requirement for local employers to support employees’ health care benefits (Katz and Bingham 2011). Patients also pay a participation fee and point-of-service fees unless they are under 100 percent of the FPL or are homeless. Healthy San Francisco offers access to a care network that includes public and nonprofit hospitals, FQHCs, county clinics, and for-profit providers; patients receive a card with the name of their primary care medical home. The program reflects multimillion dollar investments by Kaiser Permanente, and from other non-public providers. Innovative aspects of Healthy San Francisco include its use of eReferral, developed at San Francisco General Hospital, to link primary care providers with specialists for timely web-based consultations to determine whether a condition can be managed in the primary care setting (Narang 2015). This helps reduce clinic wait times and avoids unnecessary appointments, both of which present barriers to health care for low-wage workers, including undocumented immigrants, who lack paid sick days. Healthy San Francisco’s approach, including multiple points of entry, care coordination through a medical home, public and private providers, specialty access, predictable fees, and centralized eligibility and records-keeping systems, have informed the design of similar direct access programs in the nation’s second largest city (Katz and Bingham 2011). In October 2014, My Health LA, a no-cost health care program for uninsured Los Angeles County residents at or below 138 percent of the FPL, was launched under the leadership of the former director of Healthy San Francisco. My Health LA offers a network of primary care medical homes, based in FQHCs and in county-run clinics, supported by other county facilities providing diagnostic, emergency, inpatient, pharmacy, and specialty services.

In October 2015, New York City, the nation’s largest city and longstanding immigrant gateway, announced the creation of Direct Access, a program modeled on the successful efforts of Los Angeles and San Francisco to improve health care access for remaining uninsured populations, including undocumented immigrants. The pilot phase of New York City’s program was launched in Spring 2016 with 1,000 patients and an initial investment of $6 million from the Robin Hood Foundation and other funders. Data from the one-year pilot was used to design a citywide model to provide reliable, coordinated access to low-cost health care for immigrants who were excluded from federal and state insurance programs such as Medicare and Medicaid (Mayor’s Task Force on Immigrant Health Care Access 2015; Office of the Mayor 2015). This effort to improve immigrant health access using local policy mechanisms and investment in the coordination of existing HHC and FQHC facilities to create networks of primary care medical homes was developed through a public task force process, augmented by the involvement of City stakeholders in an independent process focused on policy solutions to the needs of the undocumented uninsured. It was also informed by the successful launch, in 2014, of New York City’s municipal ID card (ID NYC), which has proven popular among immigrants and may help support health care access for this population.

Other jurisdictions that use direct access approaches to improve health care access for undocumented immigrants and other uninsured populations include Nevada’s nonprofit Access to Healthcare Network, which links low-income individuals who are ineligible for public insurance with discounted health care services and care coordination, supported by a monthly membership fee. Massachusetts’s longstanding commitment to universal health insurance coverage uses a single application to match people without insurance with mechanisms for which they qualify. For undocumented immigrants, these include: Mass Health Limited, for services covered under Emergency Medicaid; the Health Safety Net, which uses indigent care pool funds to pay for hospital and community clinic services for individual patients with incomes of 200–400 percent of the FPL; and the Children’s Medical Security Plan, which provides health insurance for children ineligible for Medicaid. The District of Columbia’s Healthcare Alliance offers insurance
coverage, modeled on Medicaid Managed Care, to Washington, DC residents who are ineligible for Medicaid and have incomes below 200 percent of the FPL.

Conclusions

Common features of existing and forthcoming approaches to improving health care access for undocumented immigrants through local-level or state-level policy solutions include upfront and continuing political support, access to a strong primary care network, an emphasis on care coordination, and eligibility by income and residence rather than immigration status so that they are inclusive of low-income uninsured populations. While the financing mix of each program differs, all existing programs rely on the continued availability of DSH payments to safety-net organizations; this is a potential weakness owing to the uncertain effects of pending DSH cuts. As the relatively new direct access programs in New York City and Los Angeles evolve, potentially encouraging other major cities to take similar action, there will be an ongoing need to track and study these programs in terms of their costs, and their effects on population health.

Health care access for undocumented immigrants clusters around the ends of a spectrum, with many gaps between the “emergency” access facilitated by EMTALA and financed by Emergency Medicaid and the “primary care” orientation that may be traced from the era of settlement houses, through health services for migrant workers, community health centers, and financing for prenatal care programs. Despite the federal impasse over comprehensive immigration reform needed for undocumented immigrants to resolve their legal status, the undocumented population of the U.S. is becoming an ever more settled population, with a broader range of health care needs, including for treatment for chronic, age-associated conditions. As major cities, and some states, devise policy solutions to ensure access to primary care and avoid defaulting to EDs, it is time for focused attention to sustainable mechanisms for effective treatment for conditions such as ESRD, hepatitis C, cancer, and mental illness, which are life-threatening and potentially curable, or manageable as chronic conditions. These conditions require specialty care and usually cannot be managed at the primary-care level, and they are poorly suited to management as emergent conditions. Managing more complex conditions with a patient who is a low-wage immigrant, often with limited proficiency in English and with little time to attend to health care needs, also requires that health care professionals and organizations acquire a deep understanding of this patient population’s day-to-day economic realities. These range from expectations concerning the support of family members in the United States and in the patient’s home country, to perceptions and access concerning eligibility for charity care, to economically driven decisions patients may make concerning adherence when time and funds are limited (Costas-Muniz et al. 2015; Gany et al. 2014).

Efforts by the Trump administration and Congressional Republicans’ efforts to repeal the Patient Protection and Affordable Care Act (ACA) and cap the federal government’s commitment to the Medicaid program threatened to reduce the capacity of local safety-net institutions to provide needed health care to undocumented patients. At the same time, the increase in the number of arrests and deportations of undocumented immigrants without criminal records under the Trump administration has increased fears among immigrants, triggering a “chilling effect” on health-seeking behaviors that has been observed by public health officials and safety-net clinicians (Pedraza et al. 2017). Furthermore, because many undocumented immigrants live in “mixed status” households that include authorized immigrants or citizens, immigrant enforcement policies targeting undocumented immigrants also affect health care access for others, notably U.S.-born children (Castañeda and Melo 2014; Hoffman 2017). Together, current federal health and immigration policies have the potential to significantly undermine public health goals. In the face of these federal policy changes, many local governments are taking the lead on developing solutions to address the health care needs of this large, low-income population, but the funding and political support for these efforts are fragile and endangered.
References

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132


