

Immigrants and Health Care Access: Where's the Safety-net?

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Recent immigrants to the United States face numerous challenges in obtaining quality, affordable health coverage, including limited access to employer-based health insurance, lower rates of job security, and language barriers. Immigrants are often left to deal with their health care needs without access to the safety-net programs designed to assist their citizen neighbors in poverty. This brief article will articulate how immigrants in poverty face barriers to health care access. Next it will examine some of the ethical issues raised by the inequities in our health care system. It will show how Catholic Social Teaching can provide a framework to address some of these issues. Lastly, the article will suggest ways in which the Catholic health care community might respond to this expanding need in our communities.

Immigrants and Access to Health Care

In 2008 there were 39 million immigrants in the United States accounting for about 13 percent of the population. Of this group, about seven out of ten were either naturalized citizens or lawfully-residing non-citizens. The Pew Hispanic Center estimates that undocumented immigrants make up about four percent of the nation's total population and roughly 5.4 percent of the work force.¹ Many immigrants work in industries that traditionally do not provide health care insurance to their work force.

A June, 2009 Kaiser Family Foundation issue brief estimates that 63 percent of nonelderly immigrant adults living in the U.S. for less than five years are uninsured.²

Lack of insurance is not the only barrier to health care access for immigrants. Language barriers, cultural traditions that support alternative medical practices, and for the undocumented, fear of exposure to the government contribute to delay in seeking treatment. The fear of exposure to government prohibits some undocumented immigrant parents from enrolling their citizen children in Medicaid and other programs designed to assist them. Immigrants also delay emergency medical treatment and actually are less likely than citizens to use emergency rooms.³

Lawfully Present Immigrants and Benefits

Medicaid is the nation's primary safety net program to assist those in poverty who cannot afford health care insurance. Immigrants, depending on their status or length of stay, may or may not qualify for this program. Since 1996, states may not use federal Medicaid funds to provide assistance to most lawfully present immigrants for the first five years they reside in the U.S., even though these immigrants are taxed like every other American. Their sponsors are tasked with responsibility for paying for their health care needs. Under new health care reform

legislation, lawfully present immigrants may purchase insurance on the new exchanges and are eligible for the same subsidies as citizens; however, those who are eligible for Medicaid will continue to be subject to the five-year bar.

Many lawfully-residing immigrant children also lack access to the safety net programs available to their citizen neighbors. The Children's Health Insurance Program (CHIP) is designed to cover the children of the working poor. The CHIP Reauthorization Act of 2009 (CHIPRA) rescinded the five-year federal Medicaid and CHIP bar for children and pregnant women, but Congress left it to the states to decide whether to cover this population. As many as 400,000 lawfully present immigrant children of the working poor are affected by this inequity. To date, only 20 states have elected to fund health care for their lawfully residing immigrant children and 17 states will cover pregnant women under this new option.⁴ CHIPRA does not authorize the use of federal monies to states to provide this coverage to immigrant adults or those who reside in the U.S. without authorization.

Another category of lawfully residing immigrants is refugees. Refugees make up about seven percent of the foreign born persons in the United States. They face fewer restrictions to health care access than other immigrants because they are exempt from the five-year waiting period. Since most single adults without disabilities cannot qualify for Medicaid (even though they may be in poverty), these adult refugees can qualify for special Refugee Medical Assistance for the first eight months they reside here. Medicaid and CHIP benefits are also immediately available to refugees, and in most states endure for 18 months. After that, they may re-apply for benefits. If they meet income eligibility requirements, they may qualify for the benefit

extension. Many refugees come to the United States after having suffered serious trauma encountered in war or as victims of human trafficking. Refugees often need special medical and mental health services to help them heal from the events that brought them here.⁵

Eligibility for benefits is not the only barrier to health care access for immigrants. Complex eligibility formulas such as sponsor deeming (the act of combining the income of one's sponsor in addition to the immigrant's to determine financial eligibility), strict verification rules, language barriers that prevent immigrants from knowing their rights and eligibility for important programs, and fear of being declared a "public charge" which could jeopardize their ability to eventually become a citizen, all play a part in making immigrants less likely to use safety-net services.

The Undocumented Immigrant

Nearly 30 percent of all non-citizens living in the United States today do so without authorization from the federal government. The last decade has seen an increase in the number of undocumented persons in states which did not previously see them in significant numbers. Traditionally only six states (California, Texas, Illinois, Florida, New York, and New Jersey) were home to more than 60 percent of the population living here without authorization.⁶ In this decade, some 17 states have seen significant growth in the number of unauthorized immigrants. Among the new destination states is Arizona, which has become ground zero for the debate on immigration policy and law enforcement. Many states lack the social infrastructure to deal with these newcomer populations, and the problems are exacerbated by the clandestine nature of the unauthorized group.⁷

U. S. policy prohibits states from using federal dollars for unauthorized immigrants in TANF, CHIP, Medicaid, Medicare or other safety-net programs. Some federal Emergency Medicaid money is available to treat those who present at the emergency department of a hospital and are treated, regardless of status. Some states have chosen to cover undocumented immigrant children residing in the state using state-only funding in order to maintain better public health. To underscore the commitment of the federal government to deny benefits to “illegal aliens,” new health care insurance exchanges forbid 11 million undocumented persons from using their own money to purchase insurance even at full price. In a cynical nod to strict justice, these same undocumented persons are exempt from the mandate that they purchase health insurance.

Access to Health Care for Immigrants: Ethical Considerations

Does the accessibility of the nation’s safety net programs, dependent on an immigrant’s personal “status,” satisfy society’s duty to provide for the wellbeing of its members? Is it ethical to share a limited good, such as health care, to undocumented persons who are living in the country illegally? What justification can be made for the participation of immigrant persons in all the goods of society? Can a society claim a legitimate right to deny its goods to immigrants? Ethicists are asked to answer these questions in the context of hospital policy, limited budgets, shrinking resources, and uncompensated care that concretely impacts patient care. Lack of sound policy has led to extreme solutions to immigrant health crises by mandatory repatriation after some patients’ medical bills reached over a million dollars in

uncompensated care. Difficult questions regarding the just distribution of a society’s resources can be answered, I suggest, by using a framework provided by Catholic Social Teaching.

The Right to Health Care

Every immigrant is a person. Every person is an absolute good and created in the image of God. No person can ever be used as a mean to another’s end, even an immigrant. In his major encyclical, *Pacem in Terris*, Pope John XXIII teaches that a person possesses rights that flow from one’s nature: rights and duties are universal and inviolable, and are therefore inalienable. One has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services (no.11). As such, every immigrant person arrives on our shores with his or her rights intact. A person has a right to leave one’s country if goods are not sufficiently available in one’s country of origin for human flourishing. A person’s human dignity is the source of both rights and duties. Rights are the moral claims to goods that are required to promote human dignity. Rights are the basic requirements needed for a person to participate fully in society. Whether one is a person, therefore, is the only “status” by which every good in our society would be either made available to an immigrant or denied.

Catholic Social Teaching uses individual rights language to justify claims by individuals to society’s goods, but tempers these claims by due regard for the common good. In this way, a balance is sought between an individual’s needs and the realization that we live in society and are social by nature.

Further, it is incumbent on nations to welcome émigrés and limit immigration only when it is proved actually harmful to the common good, since the goods of the earth are to be shared in by all. The common good must be seen as having a global relevance, and not simply determined by local communities. The struggle that immigrants face in accessing health care raises fundamental questions of justice. In a just society, the common good is perfected when access to the good (in this case, health care) is manifest through the ordered relationships of contributive justice, distributive justice, and social justice.⁸ Fundamental goods are essential for human persons to live in dignity. Among these goods is access to quality health care. Contributive justice concerns the need we have to build up those institutions that promote these goods in a manner consistent with our abilities. All of us have a duty to make health care and other social goods available to members of society. Distributive justice is concerned with how we share the goods our life together makes possible. It is concerned with the distribution of the common good. It ensures that one's claim to a shared good is based on a proportionate share, and not on a kind of mathematical equality. In the arena of health care, therefore, those who are sick should get more care than those who are well. Social justice is achieved when every member of society is able to participate in the common good. A society can be determined to be just when each of these forms of justice is achieved. This vision of justice is impossible to achieve if we marginalize immigrants and deny them access to the common good. I believe that only full participation in the common good by every member of society is essential in order for us to become true communities. Solidarity is the virtue that makes community possible.

Solidarity

The notion that immigrants are a fundamental good for America is one of the strongest pillars of our culture. We look back with pride at our immigrant heritage and the unique character of a “melting-pot” America. As a nation, we boast of our capacity to help immigrants achieve the “American dream.” As individuals, no one is able to economically advance, stay healthy, and prosper without the aid of others. Our interdependence on one another for both our personal development and our economic strength forms the commonweal that binds us as a community. Solidarity becomes a virtue when habitually we seek the good of the other and never allow any member of society to be denied participation in the common good. Everyone in society is called upon to make a proportional contribution to society according to his or her abilities. Society has a duty never to exclude its members from those goods necessary for their dignity. It is spurious to assume that we can be successful as a nation without account for one another's welfare. After all, community is created when we become our brothers' and sisters' keepers. Lawfully present immigrants face significant barriers to health care access primarily because our current system of safety-net programs is made available based on length of stay in country, and not on individual need. This is a policy which creates marginalization that fails to account for the contributions that immigrants make to the common good. Undocumented immigrants face discrimination and scorn because as a society we citizens have failed to embrace the virtue of solidarity. We must acknowledge that much of the affluence we enjoy as a society can be attributed to the contribution of immigrants. The quantity of taxes paid by an individual is

not a strong enough measure of one's contribution to society. In a just community, we could never exclude immigrant persons from health care because we felt they didn't pay enough in taxes.

Contribution of Catholic Health Care Institutions

Catholic health care institutions were founded primarily to serve the immigrant community. Heroic efforts were made by many prophetic women religious who faced considerable obstacles in a society that did not provide health care to immigrant communities. Today, Catholic health care institutions continue the tradition of caring for the marginalized and those in poverty. Special programs which uphold the dignity of every person and demonstrate a preferential option for the poor are in the best tradition of Catholic health care institutions.

Immigrant communities can be found in every place there is a Catholic hospital, and meeting their culturally specific needs should remain a high priority. Those who need special language assistance, have diverse cultural needs or live in the most remote areas of the country can be effectively served by special clinics, often sponsored by Catholic hospitals. Some hospitals today sponsor satellite clinics or in-house clinics to meet the needs of immigrants living in their local communities.⁹ All of this bears witness to a belief that human dignity requires recognition of the right to health care beyond care provided in an emergency room.

The measure of a great society is how it treats its most vulnerable. Now that health care reform law has determined that 11 million undocumented persons will not participate in the new exchange system for the uninsured, those of us who uphold the right to health

care must act in solidarity with these immigrants. Leaders in health care institutions should continue advocacy efforts for those who are left behind. Systemic change does not happen quickly, but persistence over time has proven effective in changing attitudes toward the marginalized in the past. Universal health care access is the only goal consistent with our beliefs as men and women of faith.

This brief article has shown that immigrants in poverty face significant barriers to access to health care. These barriers are not adequately addressed under current systems.

Undocumented immigrants are most marginalized since they qualify for no federal safety-net health care programs, except emergency Medicaid funding. Catholic Social Teaching instructs that human dignity and participation in society require respect for an immigrant's right to migrate and right to health care. Further, society cannot be considered just if participation in the common good is not afforded every member of society. The virtue of solidarity compels us to recognize the interdependence we have with immigrant persons living in our society.

¹ J. Passel and D. Cohn, "A Portrait of Unauthorized Immigrants in the United States," Pew Hispanic Center. April 14, 2009.

² Peter Cunningham and Samantha Artiga, "How Does Health Coverage and Access to Care for Immigrants Vary by Length of Time in the U.S.?" Henry J. Kaiser Family Foundation. <http://www.kff.org/uninsured/7916.cfm>. June, 2009.

³ Samantha Artiga and Jennifer Tolbert, "Immigrants' Health Coverage and Health Reform: Key Questions and Answers." Henry J. Kaiser Family Foundation. Publication #7982. www.kff.org.

⁴ Jennifer Sullivan, "Expanding Coverage for Recent Immigrants; CHIPRA Gives States New Options." Families USA. March, 2010. p. 7.

⁵ A brochure on benefits for refugees is available from the U.S. Committee for Refugees and Immigrants. www.refugees.org.

⁶ Jeffrey S. Passel, "Background Briefing Prepared for Task Force on Immigration and America's Future." Pew Hispanic Center. Unauthorized Migrants: Numbers and Characteristics. June 14, 2005. P. 15.

⁷ Ibid.

⁸ David Hollenbach, *The Common Good and Christian Ethics*. Cambridge Press. New York, (2002). pp. 196-200.

⁹ Elzbieta M. Gozdzia and Micah N. Bump, *New Immigrants Changing Communities: Best Practices for a Better America*. Lexington Books. New York, 2008. pp. 55-71.

Post a Comment

To foster continued dialogue around this important issue for the ministry, we invite you to let us know what you think and/or share examples of how your organization is addressing this situation. E-mail your comments to hceusaeditor@chausa.org

For additional information about immigrants and health reform legislation enacted in 2010, see an informative resource, "[How Are Immigrants Included in Health Care Reform?](#)," from the National Immigration Law Center, www.nilc.org, April 2010.