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The Migrant Crisis and Access to Health Care

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> "It is a great satisfaction to do something for ourselves, but it is a privilege, an honor and a much greater satisfaction to do something meaningful for someone else in need"

Most people in the world have had to leave the place where they were born or grew up. Some people move as far as the next town or city. Other people will need to leave for more pressing reasons– sometimes for a short time, but sometimes permanently.

More often than what we know, millions of people make one of the most difficult decisions in their lives: to leave their homes and loved ones looking for a better life, to seek a new job, higher wages or seek better education. Unfortunately, many people are forced to flee their country to escape prosecution or human rights violations such as torture. Other people are forced to leave their hometowns because they no longer feel safe, for being targeted because of who they are, personal choices, or different beliefs (ethnicity, religion, sexuality and/or political opinions, etc.).

However, these journeys in hope for a better life are not always safe, and can be full of traumatizing experiences, danger and fear. Some people risk falling prey to some form of exploitation, such as human and drug trafficking.

In the event they legally settle in their new community, many migrants face challenges of being accepted by new host communities, disrupting communal integration, and harmonious living. They face barriers based upon their cultural practices, religious beliefs, language, discrimination and racism.

As a result of their migration, people lose their support networks. Like an invisible "force field," support networks are the people who surround and share your life—that you can turn to for encouragement, support and personal growth. Having a good support network is a vital tool in maintaining wellbeing—and most times something that we are so used to that we take them for granted. Losing this network can lead to people ending up feeling alone and isolated, or victims of depression, anxiety and substance abuse.

Are All Immigrants the Same?

The terms *migrant*, *refugee*, and *asylum seeker* are often used interchangeably, but it is important to distinguish between them as there is a legal difference.

Migrants can return home if they wish, unlike refugees or asylum seekers who cannot safely return home. This distinction is important for governments, since countries handle migrants under their own immigration laws and processes.

The main difference is choice. Simply speaking, a migrant is someone who chooses to move, and a refugee or an asylum seeker is someone who has been forced from their home.

However, there is no internationally accepted legal definition of a migrant. Most agencies and organizations define migrants as people staying outside their country of origin, who are not asylum-seekers or refugees.

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Some migrants leave their country because they want to work, seek better wages, study or join family, for example. Others feel they must leave because of poverty, natural disasters, political unrest, gang violence or other serious circumstances that exist in their home country.

Refugees are people who have fled war, violence, conflict, or persecution and have crossed an international border to find safety in another country. The risks to their safety and life were so great that they felt they had no choice but to leave and seek safety outside their country because their own government cannot or will not protect them from those dangers. Refugees have a right to international protection.

An *asylum-seeker* is a person who has fled their home in search of safety and protection in another country. Because he or she cannot obtain protection in their home country, they seek it elsewhere. Asylum seekers have left their country and are seeking protection from persecution and serious human rights violations. They have not yet been legally recognized as a refugee and are waiting to receive a decision on their asylum claim. Seeking asylum is a human right. Therefore, anyone is allowed to enter another country to seek asylum.

Many of those crossing the U.S. border from Central American countries—El Salvador, Guatemala and Honduras—are in fact asylum seekers, not migrants. They have a well-founded fear of persecution if they were to return home.

It is important to understand that just because migrants do not flee persecution, they are still entitled to have all their human rights protected and respected, regardless of the status they have in the country they moved to. Governments must protect all migrants from racist and xenophobic violence, exploitation and forced labor. Migrants cannot be detained or forced to return to their countries without a legitimate reason.

Refugees and asylum seekers are employment eligible and are authorized to work indefinitely because their immigration status does not expire.

The other important category refers to *undocumented immigrants*, who are foreign-born individuals residing in the U.S. without authorization. This group includes individuals who entered the country without authorization and individuals who entered the country lawfully and stayed after their visa or status expired.

The United States government processes migrants through the United States' Customs and Border Protection (CBP) agency.[1] Founded on May 28, 1924, the United States Border Patrol is a federal law enforcement agency under the United States' Customs and Border Protection and is responsible for securing the borders of the United States.

In the last year, U.S. Customs and Border Protection logged more than 2.3 million illegal border crossings. This has led to not only a humanitarian crisis, but also a dire security breakdown. We have our border patrol agents spending most of their time processing and helping immigrants settle instead of patrolling the border. This creates a gateway for dangerous drugs and criminals to enter our country: in the past year, CBP has seized more than 645,000 pounds of illegal drugs, including nearly 13,600 pounds of the deadly synthetic opioid fentanyl.[1]

Access to Health Care Is Not a Privilege But a Human Right

Like any US citizen, migrants will require access to health care. The countries most current migrants come from, along with the living circumstances they were facing in their home country, puts them at a higher risk of a suboptimal health status. Chronic conditions like diabetes, high

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blood pressure, heart disease, and malnutrition are prevalent among migrants. In addition, their current situation puts them at higher risk of mental health illnesses, such as depression, anxiety, post-traumatic stress disorder and substance abuse.

Undocumented immigrants are not eligible for federally funded public health insurance programs, including Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

To care for the lower income residents, including undocumented immigrants, the U.S. relies on a patchwork system of safety-net providers, including public and not-for-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") states that only "qualified aliens" are allowed access to federal and state public benefits, including Medicaid. A qualified alien is one who falls into one of the following categories[2]:

- Lawful permanent resident (LPR or green card holder);
- Refugee;
- Asylee;
- Cuban/Haitian entrant;
- Paroled into the U.S. for at least one year;
- Conditional entrant granted before 1980;
- Granted withholding of deportation;
- Battered noncitizen, spouse, child, or parent;
- Victims of trafficking and his/her spouse, child, sibling, or parent or individuals with pending application for a victim of trafficking visa;
- Member of a federally recognized Indian tribe or American Indian born in Canada; and
- Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants).

Effective December 27, 2020, COFA migrants are considered "qualified noncitizens" and are eligible for Medicaid, if they meet all of the eligibility criteria for their state.

Other lawfully Present Immigrants:

- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT);
- Individual with Non-Immigrant Status, includes worker visas, student visas, U-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau;
- Temporary Protected Status (TPS);
- Deferred Enforced Departure (DED);
- Deferred Action Status, except for Deferred Action for Childhood Arrivals (DACA) who are not eligible for health insurance options;

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- Lawful Temporary Resident;
- Administrative order staying removal issued by the Department of Homeland Security;
- Resident of American Samoa;
- Applicants for certain statuses; and
- People with certain statuses who have employment authorization.

Undocumented immigrants are considered "non-qualified aliens," and therefore can only receive limited federal and state public benefits. Undocumented immigrants may be eligible for "Emergency Medicaid" benefits for services needed for the treatment of an emergency medical condition (excluding organ transplants). They still need to meet all other general Medicaid requirements except those related to immigration status.

An emergency medical condition is defined at §1903(v)(3) of the Social Security Act ("SSA")[3] as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy,

(2) serious impairment to bodily functions, or

(3) serious dysfunction of any bodily organ or part.

Although the PRWORA severely limits what public benefits a state can provide to non-qualified aliens, it allows states to provide additional state funded benefits if state laws enacted after August 22, 1996 affirmatively provide for such eligibility.

There is also a federal rule requiring that the condition must have had a "sudden onset," however, the Medicaid Act does not contain this language. There is no definitive rule on when an emergency condition ends for the purposes of cutting off emergency Medicaid. In addition, what defines "acute" or "sudden onset" can be misleading as well. A person can have a chronic condition, but in the absence of treatment can result in either placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

In addition, in 1986 the Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272).[4] This law prevents hospitals that participate in the Medicare program from denying care to unstable patients that could not afford to pay for their care. It requires hospitals covered by the law to provide patients with an emergency medical condition with "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (EMC) exists."

In Delaware, neither legally residing noncitizens nor illegally/undocumented residing immigrants are eligible for full Medicaid coverage, but remain eligible for emergency services and labor and delivery only.[5]

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To be eligible for Emergency Medicaid, the individual must meet all eligibility requirements for a specific Medicaid eligibility group. The individual does NOT have to meet the requirement concerning a declaration of satisfactory immigration status and verification of that status.[6]

Delaware Medical Assistance Program (DMAP) defines an emergency as:

- a sudden serious medical situation that is life threatening; OR
- a severe acute illness or accidental injury that demands immediate medical attention or surgical attention; AND
- without the treatment a person's life could be threatened or the person could suffer serious long-lasting disability.[7]

Medically necessary physician (surgeon, pathologist, anesthesiologist, emergency room physician, internist, etc.) or midwife services rendered during an emergency service that meets the above criteria are covered. Ancillary services (laboratory, x-rays, pharmacy, etc.) rendered during an emergency service that meets the above criteria are also covered. Emergency ambulance services to transport these individuals to and from the services defined above are also covered.

The following services are not covered:[8]

- Any service delivered in a setting other than an acute care hospital emergency room or an acute care inpatient hospital. The only exception is that labor and delivery services may be rendered in a birthing center.
- Any service (such as pharmacy, transportation, office visit, lab or x-ray, home health) that precedes or is subsequent to a covered emergency service. The only exception is that ambulance transportation that is directly related to the emergency is covered
- Organ transplants
- Long term care or rehabilitation
- Routine prenatal and post-partum care

Unfortunately, many lawfully present immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges.

In addition to their own health risks, migrants are at risk of:

- Health disparities: this can lead to suboptimal care and poorer health outcomes, when compared to the medical care other groups in the same community receive.
- Inequities: refers to differences which are unnecessary, avoidable and are considered unfair and unjust. Health equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage, related to economic status, positions of power or prestige.

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- Different Social Determinants of Health (SDOH): refer to environmental conditions where people live, study, work, worship that affect a wide range of health conditions, care for the conditions and outcomes.

How is Health Equity Achieved?

According to the CDC, Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[9]

The COVID-19 pandemic has contributed to increased health, social and financial needs and declines in health coverage among the immigrant population. Immigrants' work (such as crowded spaces), living (such as sharing housing), and transportation situations put them at increased risk for potential exposure to coronavirus. Noncitizen immigrants also faced risk of financial difficulties due to the pandemic, as many work in service industries, such as restaurants, poultry farms and food services, that suffered cutbacks during the early phases of the pandemic. At the same time, immigrants have had more limited access to COVID-19 financial relief. Immigration-related fears may have contributed to reluctance accessing COVID-19 vaccines.

How is The Government Addressing This Problem?

Recent federal and state activity has focused on expanding access to health care for immigrants. At the federal level, legislation has been proposed that would expand eligibility for health coverage for immigrants.

Some states take up federal options to expand Medicaid and CHIP coverage for lawfully present immigrant children and pregnant women. In addition, several states have recently proposed or taken action to expand state-funded coverage to low-income people regardless of immigration status.

The Biden-Harris Administration has proposed new public rules in an attempt to help reduce fears among immigrants and encourage them to participate in non-cash assistance programs, including health coverage. Funding for Navigator programs has been increased, which provides enrollment assistance to individuals. However, even with these actions, it will likely take time and sustained efforts to rebuild trust and reduce fears about the use of services among immigrant families.

The Administration has also increased funding for outreach and enrollment assistance, which may help eligible immigrant families enroll and stay enrolled in coverage, including awarding CMS $80 million in funding for 60 Navigator programs in 30 states with Federally-Facilitated Marketplaces for the 2022 plan year.

Navigator programs must provide information that is culturally and linguistically appropriate, and can assist individuals with renewing Medicaid coverage and help those who are no longer eligible for Medicaid transition to coverage through the marketplaces. This assistance may be particularly important for helping immigrant families enroll in and maintain coverage given the complex eligibility requirements for immigrants and potential linguistic barriers and fears of negative immigration consequences.

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In 2021, the Health Equity and Access Under the Law (HEAL) Act[10] and Lifting Immigrant Families Through Benefits Access Restoration Act (LIFT the BAR) Act[11] were introduced into Congress. The intention is to remove the five-year waiting period for health coverage and other assistance programs that currently apply to many lawfully present immigrants under the 1996 PRORWA rules. These acts would expand the definition of lawfully present immigrants to include Deferred Action for Childhood Arrivals (DACA) recipients and certain other immigrants who are authorized to be in the U.S., so that they could qualify for federally funded health care programs. In addition, the HEAL Act would allow undocumented immigrants to access health insurance coverage through the ACA Marketplaces and to be eligible for subsidies to offset the cost of this coverage. Both acts also would ensure that lawfully present immigrants with incomes below 100% Federal Poverty Level (FPL) may receive subsidies if they are ineligible for Medicaid based on immigration status if they live in a state that has not expanded Medicaid.

Several states have proposed or taken action to expand coverage for immigrant children and pregnant individuals. Currently, six states (California, Washington, DC, New York, Oregon and Washington state) provide comprehensive state-funded coverage to all income-eligible children, regardless of immigration status.

The American Rescue Plan Act[12] gives states the option to extend Medicaid postpartum coverage from 60 days to 12 months beginning in April 2022. Five states—California, Connecticut, Massachusetts, Minnesota, and Washington—that are planning to take up this option will also extend the coverage to postpartum individuals who are not eligible due to immigration status. California[13] and Illinois[14] recently implemented 12 months postpartum coverage regardless of immigration status through CHIP Health Services Initiatives amendments.

Some states are also taking action to expand fully state-funded coverage to adult immigrants. California Governor Gavin Newsom's 2022-2023 proposed budget would provide fully state-funded Medicaid coverage to all income-eligible adults, ages 26 to 49, regardless of immigration status, no sooner than January 1, 2024. The state previously extended state-funded Medicaid coverage to young adults ages 19-26 regardless of immigration status, and adults ages 50 and older will become eligible on May 1, 2022.

As of July 1st, 2022, In Oregon, the Cover All People Act (now known as "Healthier Oregon"), extends state-funded coverage to all low-income adults who are not eligible due to immigration status.[15] Prior to this recent state activity, only the District of Columbia's locally-funded Healthcare Alliance program, created in 1999, provided health coverage to low-income residents regardless of immigration status.[16] States can also provide state-funded premium subsidies to immigrants who are ineligible for federal premium subsidies in the Marketplace due to their immigration status. In Colorado, beginning in 2023, state residents with income up to 300% FPL who do not qualify for health insurance under the Affordable Care Act or other public programs because of their immigration status will be eligible for state-funded premium subsidies to assist them in purchasing individual coverage.[17]

The Biden-Harris Administration has proposed changes to public charge policies that are intended to reduce fears of enrolling in health coverage and accessing care. As noted, after taking office, the Administration reversed public charge policies implemented by the Trump Administration that had made some immigrant families more reluctant to access health coverage and care for themselves and their children.

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The Biden-Harris Administration's changes to public charge policy and increased funding for outreach and enrollment assistance may help increase access to health coverage for immigrant families. However, no matter what the government efforts are, they will not reach maximum success unless we put efforts to rebuild trust and reduce fears in the migrant community.

Is There a Solution on The Horizon?

The short-term solution to the migrant crisis and access to health care will entirely rest on the hands of the federal and local governments. The immigrant people are not the problem. Rather, the causes that drive families and individuals to cross borders and the short-sighted and unrealistic ways that politicians respond to them are the problem. The crisis situation is not the number of migrants seeking protection, but the government system's failure to respond in an orderly way.

The cost of not providing health care to immigrants is big, but not as bad as many think. A study by Fernando A. Wilson et al in 2020 showed that the annual expenditures per person were $1629 for unauthorized immigrants and $3795 for authorized immigrants compared with $6088 for US-born individuals.[18]

In a recent publication by Steven A. Camarota et al on October 10, 2019, it was estimated that allowing uninsured, low-income illegal immigrants access to Federally funded programs would likely cost taxpayers around $10 billion per year, assuming many chose not to enroll, with costs potentially rising as high as $23 billion.[19]

As of today, the majority of the healthcare to be provided to migrants will rest on the hands of safety-net providers, including public and not-for-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers.

Federally Qualified Health Centers (FQHCs)

FQHCs play a pivotal role in the short-term solution.

Jack Geiger and Count D. Gibson Jr. pioneered the founding of the first two health centers in the nation at Columbia Point, Dorchester MA, and Mound Bayou, Mississippi, launching a movement in urban and rural areas across the country in 1965.

Delaware's three health centers—La Red Health Center (mostly serving Sussex County), Henrietta Johnson Health Center and Westside Health Center (both serving mostly New Castle county)—operate 14 sites across the state and provide care for vulnerable patient populations, many of whom have no other options for care. Community Health Centers provide comprehensive services including primary care, dental services, behavioral health care, prenatal services, substance abuse treatment, STD counseling and education and pharmacy.

Since its inception over twenty years ago, La Red Health Center has served an estimated 20,000 unduplicated Hispanic patients. The Center currently provides prenatal services to over 500 Hispanic women every year. La Red Health Center has implemented the nationally recognized evidence-based Navigator outreach program, "The Promotoras," that has built a defacto support network and through culturally sensitive outreach services, has earned the trust of the local immigrant population. All these efforts are some unique examples of what FQHCs can do to improve the health of an underserved population.

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By mission and design, FQHCs exist to serve those who have limited access to healthcare, although all are welcome. We take pride on serving populations that may otherwise find barriers to healthcare in other medical practices.

FQHCs help improve the quality of life for millions of their underserved patients, including immigrants. Their preventative care is cost efficient and allows many patients to have access to affordable immunizations, mammograms, Pap smears, health education, and other preventative services.

FQHCs deliver culturally competent, comprehensive primary care. Thanks to Federal financial support, FQHCs have the ability to provide additional supportive services such as health education, case management, translation, and transportation that promote access to care and break barriers migrants face, that otherwise would result in poor health outcomes.

This makes immigrants a logical population to be served by FQHCs.

There are several challenges that FQHCs might face when delivering charitable healthcare to immigrant populations. Some examples of these challenges include sensitivity to cultural norms, trouble securing financial support, promoting a safe environment, community and patient rejection and lack of financial resources to address more expensive medically necessary procedures or invasive interventions, such as surgeries, dialysis, organ transplants, etc.

Staff members that work in a FQHC are, by the nature of their daily job and training, culturally sensitive and trained to interact in the world of cultural diversity. Therefore, FQHCs are more open to accommodate and understand different cultural norms pertinent to their immigrant population.

People in the community might have different levels of acceptance to the FQHCs attending to the needs of migrants. FQHCs must be prepared to be celebrated or rejected because of this service.

During times of heightened political sensitivity around immigration issues, a FQHC must create an environment that is “safe” for those whose immigration status is questionable. FQHCs must be diligent in reassuring patients and immigrant communities that they will be safe in seeking service from their facilities. Any FQHC that serves an immigrant population should have protocols in place on how to respond should immigration official appear at the clinic to check credentials. Remember – it is difficult to build trust, but very easy to lose it.

Culturally sensitive health care will help bring about positive health outcomes for diverse populations. It can help narrow the gap in health care outcomes and promotes health equity, which must remain as the ultimate goal of our efforts. We must always remember that dignity and quality of health care are rights of all and not the privileges of a few.

Long-Term Solutions

The long-term solution lies far beyond the efforts of local FQHCs, hospitals and migrant health centers. Powerful and financially strong nations must put pressure on foreign governments to honor their responsibility to protect every single person’s rights. They must make sure that refugees, asylum-seekers and migrants are safe, and are not tortured, discriminated against or left living in poverty.

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Migration is often driven by the search for better livelihoods and new opportunities. Indeed, global and regional social and economic inequalities are expressed most powerfully through the figure of the migrant, as one who crosses borders in search of work, education and new horizons.

Highly developed nations should help less fortunate countries stop conflicts, increase average wealth levels, improve education opportunities, improve social security and health insurance, fight extreme poverty, stop discrimination, among other actions to encourage their citizens to remain in their land and be part of future progress.

In order to mitigate the migration issue, it is crucial to stop conflicts and wars so that people are not forced to leave their homes. Governments of developed countries all over the world should work together and should implement financial sanctions to countries which engage in conflicts.

It is imperative that the financial stability in poor countries improves so that people have an incentive to stay home rather than to migrate to other countries in search for better wages and financial opportunities. Rich developed countries should provide not only financial assistance to less fortunate countries but also scientific support so that poor countries can progress and develop by increasing their knowledge, which in turn should translate to progress, better financial stability and higher living standards.

Education is indirectly proportional to level of poverty and it is directly connected to job opportunities. Low levels of education often lead to higher levels of unemployment and poverty.

It is equally important that poor countries have enough government support in case their citizens urgently need it.

We need to guide our efforts to eradicate extreme hunger and poverty. Poverty is the principal cause of global hunger. Many people migrate to a wealthier country just because they are no longer able to survive in their home countries due to extreme poverty.

People all over the world have to become more tolerant towards minorities and have to accept their lifestyles, gender, race and literacy. Discrimination is one of the leading causes of migration.

If we increase overall living conditions in poorly developed countries, people would be less likely to migrate. This includes better access to better wages, health insurance, better access to education, better social security support and overall safer conditions.

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