Category Justification: Special request for established investigator’s pilot project

I am requesting funding to collect pilot data for a project involving a new research direction with strong future external funding possibilities. This study focusing on medical deportations following the implementation of the Affordable Care Act raises important questions regarding health care policy as it intersects with immigration politics.

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Present Status of Knowledge

This proposed study focuses on legal decision-making by health care providers who care for unauthorized (i.e., undocumented or recently arrived documented persons ineligible for public health insurance) immigrants. This project is particularly timely given the profound changes in federal health care policy instituted with the Affordable Care Act, which explicitly curtails health care access for low-income undocumented immigrants. And, at the same time, immigration enforcement has become increasingly dispersed to nongovernmental agencies, including health care providers who find themselves in a liminal state of legal ambiguity in which there are no clear rules of engagement. To do this, I will focus on medical deportations – the forced removal of chronically ill or disabled immigrants to other nations – as a strategic location from which to understand how hospitals negotiate this liminal site in which health care law intersects with immigration law to create a legal vacuum.

As the political and financial pressures of immigration strain their role as health care providers, some hospitals have quietly employed medical deportations as a solution. A recently released report (December 2012) by the Seton Hall University School of Law and the New York Lawyers for the Public Interest documented over 800 immigrant patients who have been involuntarily repatriated from hospitals in 15 different states. This is assumed to be a severe undercount given that there is no legal requirement that hospitals report medical deportations. One hospital in Phoenix alone reportedly “repatriates” approximately 100 patients a year (Sontag 2008). These deportations carried out by hospitals are conducted without the same procedural protections required under international law and the U.S. constitution, which are provided during formal removal proceedings when initiated by the federal government. Currently, hospitals can independently decide to deport patients with minimal risk of legal repercussions since there is no formal system in place to regulate such practices. Federal immigration authorities have remained silent regarding this practice despite the fact that alien removals, or deportations, are solely within their jurisdiction. And, because this process is outside of the federal immigration process, there are no avenues for redress even for those who can prove that the hospital failed to obtain consent to transfer the patient abroad.

To begin, this study examines the decision-making process within individual hospitals in determining whether or not to deport immigrant patients in need of long-term health care. A policy gap exists in the care of such patients. Federal law (Emergency Medical Treatment and Active Labor Act of 1986 – EMTALA) requires hospitals to treat all patients in emergency medical conditions regardless of the patient’s ability to pay or citizenship status. And, once the patient is stabilized, EMTALA also requires hospitals to ensure adequate follow-up care. This law was enacted in response to “patient-dumping” practices by hospitals that literally discharged low-income and uninsured patients onto the street without adequate follow-up care. This latter legal obligation, however, is an unfunded mandate that has placed health care providers in a
difficult position in which the hospital must incur the costs of care for patients who may never fully recover and no other facility will accept them. The financial strain of long-term health care costs, coupled with the ambiguity in immigration law and its uneven enforcement, results in a gap in policy in which medical deportations are possible.

And, with the enactment of the Patient Protection and Affordable Care Act (ACA) and (as of this writing) potential passage of major federal immigration legislation, the factors promoting medical deportations may actually increase. Beginning in 2014, the federal government will dramatically reduce Medicaid Disproportionate Share Hospital (DSH) payments, which are provided to hospitals that care for large numbers of patients who are on Medicaid or who are uninsured. While millions of previously uninsured patients will become eligible for Medicaid under this new health law, undocumented and many newly arrived immigrants will not (NILC 2010; Jerome-D’Emilia and Suplee 2012). Federal immigrant eligibility restrictions in Medicaid, including the five-year or more waiting period for most lawfully residing, low-income immigrant adults continue to apply. Undocumented immigrants, on the other hand, are not only ineligible for public health insurance but are restricted from purchasing private health insurance at full cost in state insurance exchanges. They are also ineligible for Medicare, nonemergency Medicaid, or the Children’s Health Insurance Program (CHIP). For undocumented immigrants, health care access is restricted to emergency care and nonemergency health services at community health centers or safety-net hospitals. Currently, an estimated 10 million of the 47 million uninsured people in the U.S. are non-citizens. Of this number, approximately 5.6 million are undocumented immigrants. Legal scholars predict that immigrants could become the largest segment of the population without health insurance after ACA is implemented (Irshad 2012).

Finally, the new immigration legislation currently being debated in the U.S. Congress may bring another layer of complexity. Should this legislation pass with a defined route towards citizenship for undocumented immigrants, it is expected that increasingly more aggressive methods of homeland security and border enforcement will likely accompany it (Preston 2013). As part of the bipartisan senate bill, a new wave of border security programs will be initiated first before any of the estimated 11 million undocumented immigrants will be allowed to apply for citizenship. And, proof that the applicant will not become a public charge is explicitly noted as one of the requirements of gaining Registered Provisional Immigrant status, which places undocumented persons on the path to citizenship (NCSL 2008). This process is expected to take 13 years. In this long, winding scenario, medical deportations may flourish as a cost effective form of forced repatriation of public burdens. What, then, happens to those immigrants excluded from health insurance who need long-term health care? What are the options for hospitals that care for them?

To answer these questions, I will examine: 1) the decision-making process by hospital personnel regarding long-term health care of uninsured low-income immigrants, 2) hospital personnel’s reaction to medical deportations specifically, and 3) responses from immigrant legal advocates. Toward this end, I will interview key health care providers and legal immigrant advocates within three border states: California, Arizona, and Texas.

This study is situated at the intersection of two of the most salient political controversies today – health care and immigration – and the ensuing consequences of the blurring of their respective societal roles. To date, there are few empirical studies of medical deportation. Its near total absence in the social scientific literature is a result of its relatively recent origins and no formal accounting of this practice. This study will be one of the first systematic research efforts to
provide an in-depth, interdisciplinary exploration of this practice. The innovative aspects of this research project, then, include not only shedding light on the little known practice of medical deportations, but also linking this phenomenon to larger issues surrounding the often conflicting roles of health care providers within changing immigration policies.

**Plan of Work**

The main components of the research design include a thorough policy analysis of the various health care and immigration related legislations that culminate to produce this phenomenon, and interviews with health care providers and immigrant legal advocates in three large metropolitan areas (Houston, Phoenix, and San Diego) near the U.S.-Mexico border.

California, Arizona, and Texas all hold opposing policy views regarding immigrants and their access to health care. California has the largest number of foreign-born residents (27%) and is deemed exceptional in its decision to provide some level of health care access to new and undocumented immigrants. However, this was a hard fought result from decades of political disputes over immigration. Currently, California has agreed to implement all the major components of the federal Affordable Care Act. Arizona, ranked 13th in percentage of foreign-born residents, on the other hand, is notable for passing one of the nation’s broadest and strictest immigration enforcement measures in 2010 (Archibold 2010). However, Arizona’s Republican governor recently surprised some of her constituents by supporting Medicaid expansion, a central pillar of President Obama’s new health care law.

Texas, ranked 7th in percentage of foreign-born residents, remains firm against Medicaid expansion and opposes establishing a state-based health insurance exchange as part of the ACA. Given the impending complex and varied changes in health care access, a comparison across states is necessary to understand hospital responses to uninsured low-income immigrants in need of long-term care and whether or not they engage in medical deportations as a result.

The private, unregulated nature of medical deportations makes systematic documentation difficult. As a consequence, the methods for this study are somewhat exploratory – meaning, flexibility in its interview structure and sampling is required. An initial pilot study is necessary to develop a research design that is effective in elucidating potentially sensitive information. I will begin with a broad approach focusing on individual hospitals’ responses to immigrant health care provision after ACA. We will identify three hospitals (one public, one private, and a third can be either but excluding Veterans’, Children’s, Psychiatric, and other specialty hospitals) in each of the three targeted metropolitan areas that serve large numbers of immigrant patients. Total number of hospitals = 9.

From this sample, we will interview key informants identified as knowledgeable about the hospitals’ policy and practice dealing with long-term health care for uninsured immigrants. We expect to conduct approximately 5 in-depth, in-person individual interviews at each hospital (n = 45). According to media reports, both private and public hospitals have engaged in medical deportations. And, given the potentially sensitive nature of medical deportations, the interviews will begin with questions regarding the larger issue of long-term care of uninsured immigrants. The interviews will be semi-structured guided by specific core questions. Our interview instrument at this initial stage will focus on: 1) how individual hospitals address the problem of long-term care for uninsured and low-income immigrant patients, and 2) what strategies they have devised to prepare for ACA with respect to immigrant long term care.

Then, we will make specific inquiries into their response to medical deportations and whether or not their hospital engages in this practice. We will ask about: 1) the hospitals’
position or response to medical deportations, and 2) their personal reaction to this practice given their role in the hospital. Subsequent questions, probes, and prompts will be addressed in an open-ended format. Interviews are expected to last an hour. We will ensure the respondents’ anonymity and, in general, only identify the respondents by job title, state/city, and type of hospital (public vs. private), unless the interviewee tells us otherwise. We will audio-record the interviews, with the permission of the interviewees, to supplement our notes and for data coding and analysis purposes.

Finally, I will contact key local immigrant advocates to document their responses to medical deportation. These interviews (both telephone and in-person, depending upon respondents’ preference) will provide important information regarding the concerns of their respective constituents as well as assist us in documenting other cases of medical deportations that may have eluded the scattered media reports. My objective is to outline the presence (or absence) of different strategies these important stakeholders draw on to address medical deportation within the three targeted metropolitan areas. We expect to conduct in-person and telephone interviews (whichever the respondent prefers) with representatives from three different organizations in each city. Total number of organizations = 9.

Timeline: July – December 2014 (IRB application will be submitted in April 2014)
July – Preparation for interviews
  • Review local immigrant and health policy issues in each site
  • Identify interview sites & individual respondents
  • Make individual contact and get permission for individual interviews
  • Schedule interviews in each metropolitan area
August – Conduct interviews (one week in each of the three cities)
September – Transcribe interviews
October – Analyze interviews
November – Revise grant proposals to reflect new pilot data
December – Prepare to submit to NSF, RWJ, and other funding possibilities

[Word count of ‘present status of knowledge’ and ‘plan of work’: 1956]

Need Justification

This past year, my research team and I developed this project and submitted two grant proposals to external funders – Robert Wood Johnson (RWJ) Investigators Award and the National Science Foundation’s (NSF) Law and Social Sciences program. Our proposal was not awarded but we received very positive feedback and were encouraged to resubmit. The central (and only) concern expressed was how we will gain access to hospital personnel and will they be willing to discuss the issues central to this study. This pilot study would directly address these questions.

Currently, I have no other sources of support for this project other than a portion of my start-up funds, which I received upon arrival at UMN six years ago. I will use most of these funds ($13,000) to provide summer support for two of the three graduate students who will assist me on this study. Grants-in-Aid funding would cover: 1) the third graduate student’s summer RA-ship and 2) travel expenses. With this pilot study, I feel confident in resubmitting a stronger proposal to NSF and RWJ.
REFERENCES CITED


