**Excerpts- Undocumented Immigrants in the United States: Access to Care**

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**With the exception of emergency medical care**,

(Emergency Medical Treatment and Active Labor Act [EMTALA] –which requires access to emergency medical care to prevent hospitals from dumping unstable patients who cannot afford to pay for their care.…“(any patient arriving at an Emergency Department (ED) of a hospital that participates in the Medicare program must be given an initial screening, and if found to be in need of emergency treatment or in active labor, must be treated until stable”)

**federal funds may not be used** to provide non-emergency health care to undocumented immigrants.

The **ACA/Obama Care** does not provide undocumented immigrants with eligibility for public insurance programs because undocumented immigrants are not regarded as “qualified individuals” under the law. Consequently, undocumented immigrants are not eligible to purchase health insurance through the state health exchanges even if they are able to do so with their own money.

Some states and local governments use their own funds to offer coverage to undocumented children. For example, the Healthy Kids program in San Francisco covers uninsured children under the age of 19, including undocumented children. Similarly, the All Kids program Illinois covers all children under the age of 19 who meet program income requirements, regardless of immigration status.

In about half of the U.S. states, immigrant children under the age of 21 and pregnant women who have been granted deferred action on their immigration status are allowed to apply for Medicaid and the CHIP or enroll in their state’s high risk insurance pool. An exception to this, however, are the so-called “dreamers” – the estimated 1.7 million undocumented teenagers and young adults granted deferred action do not meet the definition of being “lawfully present” and are ineligible for Medicaid, the CHIP in addition to the insurance benefits of the ACA.

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. Since the Omnibus Budget Reconciliation Act of 1981, a hospital recognized as “disproportionate share hospital” (**DSH**) with respect to the percentages of low-income and uninsured patients it treats receives additional payments from Medicaid to support uncompensated care.

Federally Qualified Health Centers (FQHCs) and Migrant Health Centers are not-for-profit organizationsfunded by the federal Health Resources and Services Administration (**HRSA**). Both offer comprehensive primary care to vulnerable populations that include Medicaid patients, uninsured patients, and patients in underserved urban, suburban, and rural areas. They provide care regardless of ability to pay, insurance status or immigration status. Both types of health centers are required to use a sliding fee scale.

As of 2010 (most recent statistic available), there were 1,214 FQHCs operating more than 8,000 service sites and were 159 federally funded migrant health center sites, operating more than 700 service sites.