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JOURNAL DISCUSSION
Use of Emergency Medicaid by Undocumented Immigrants
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DuBard CA, Massing MW. Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *JAMA*. 2007;297(10):1085-1092.

The question of whether or not to provide health care for immigrants, especially those who are undocumented, has been hotly debated in the national arena in recent decades, but few studies have actually attempted to explore how members of this population use health care. In their *Journal of the American Medical Association* article, "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants," C. Annette DuBard and Mark Massing examined how Emergency Medicaid was used by recent, undocumented immigrants in North Carolina, a state that has experienced a surge in its immigrant population in the past few years [1]. The authors' laudable goals are to "improve knowledge of the health care needs of this population and permit better identification of conditions that are preventable or treatable in the primary care setting, or amenable to other public health interventions" [2]. The authors hope their insights will "lead to more effective use of available resources and improved health care for this population" [2].

Methods and Results
DuBard and Massing chose to study expenditures related to Emergency Medicaid because, although federal law does not provide Medicaid coverage to those who are in the country unlawfully or to legal immigrants who have lived in the United States for less than 5 years, it does provide coverage in emergency situations to adults, children, pregnant women, families with dependent children, and elderly or disabled individuals who meet state income and residency requirements [3].

Using Emergency Medicaid claims data for almost 50,000 patients who received coverage between 2001 and 2004, the authors described the sociodemographic trends of health care spending, and the most frequent diagnoses were broken down by cost and frequency of hospitalization [2].

There were four main findings from this study. First, the authors found that patients receiving Emergency Medicaid were most likely to be between the ages of 18 and 40 (almost 90 percent), female (95 percent), pregnant (90 percent), undocumented immigrants (greater than 99 percent), and Hispanic (93 percent) [2]. Second, although North Carolina Emergency Medicaid spending rose by about 30 percent during the study's time period, this amount "represented less than 1% of total North

Carolina Medicaid spending each year" [4]. Third, about 82 percent of 2004 Emergency Medicaid spending was related to pregnancy and childbirth [5]. Finally, although injury was the most common reason for hospitalization across all ages (not including pregnancy) when acute cerebrovascular disease, congestive heart failure, and acute myocardial infarction were grouped together, they accounted for more hospitalizations in the older age group [5].

DuBard and Massing conclude that "Emergency Medicaid is primarily filling 3 gaps in the health care needs of this population: child-birth related costs, emergency care of sudden-onset problems, and emergency care for severe complications of chronic disease" [6]. The authors go on to make several suggestions for change. First, they say that it may be more cost-effective to provide coverage for contraceptive and prenatal care, given the major toll that pregnancy and postpartum complications take on Emergency Medicare spending, and it is in everyone's best economic interest that the children are born healthy, given that they are U.S. citizens and eligible for Medicaid. Second, the authors argue that, since major injuries rank second behind pregnancy as the cause of both hospitalization and Emergency Medicaid spending, injury-prevention education and interventions should be developed, especially in the areas of worker and motor vehicle safety. Finally, the authors note that the prominence of chronic renal failure, cerebrovascular disease, and heart disease reveals the need to identify risk factors for these diseases and suggests that case management of uninsured immigrants with chronic diseases may be a partial solution to this problem [7].

DuBard and Massing also note three potential obstacles to improving health care for immigrants in areas with new growth in this population sector. The first is the need for culturally and linguistically appropriate care that is readily accessible and affordable. Second, immigrants are "vulnerable to the local political climate and availability of funds during state budget crises" because the bulk of the money for covering them is allocated at the state level [7]. Finally, hospitals continue to have a rising number of unsustainable, uncompensated care cases because of federal or state nonpayment, which threatens funding for prenatal and preventive care.

In summary, DuBard and Massing have used the findings from the analysis of the 2001 to 2004 expenditures under the North Carolina Emergency Medicaid program to highlight some thought-provoking and important immigrant health care challenges. Their work has brought us one step closer to their stated goal of better understanding the health care needs of recent and undocumented immigrants and identifying areas for effective public health interventions. Unfortunately, their study is narrow in scope, as it looks at only emergency services provided under the umbrella of Emergency Medicaid to immigrants whose status was determined by social services workers in one state in the nation. To explore these issues more deeply, more studies on a broader scale are needed.

References

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