feasibility of the Medicaid expansion, or controversy over the conscience clauses, much has been said and written both in support of and against the legislation. And unless the entire law is invalidated by the Supreme Court, much more will be written before key components of the ACA are implemented in 2014.

In my practice in the teaching clinic of a family medicine residency program, I see many patients who are expected to benefit from the expansion of insurance access. Working-class people with costly chronic illnesses who do not qualify for Medicaid and have not reached the Medicare eligibility age will be ushered into the insurance pool and removed from our health care system’s list of charity cases. In our practice, there is hope that it will become easier to serve patients who are currently uninsured.

However, there is one sizable segment of my patient panel — undocumented immigrants — for whom the ACA is a mere abstraction. Their stories are familiar ones in my clinic, perhaps best illustrated by describing a representative composite family. Ms. R., let’s say, is a 34-year-old woman with impaired glucose tolerance, whom I see regularly for sundry symptoms that I suspect are related to depression. She lives with her two children, 12 and 9 years of age, and her husband, whom I treat for hypertension. He works in construction for a contractor that is currently building a six-story hospital addition. Ms. R. and her family came to this country from Central America 7 years ago. Her husband does not receive health insurance benefits, and their children’s undocumented status bars them from Medicaid. Their family gains access to my services through the hospital system’s program for the indigent.

Proponents of the ACA tout the dramatic effect the law will have on the estimated 50 million Americans who are currently un-
Perspective

Barack Obama, in his attempt to win bipartisan support for the ACA, declared that it would not expand coverage to undocumented immigrants, who would be barred from purchasing coverage in health insurance exchanges. For advocates of a more patient-driven health care system, what happens to undocumented immigrants will be a story worth following. Putting aside the issue of illegal immigration, it is clear that undocumented immigrants’ access to care is in jeopardy under the ACA. Deliberately excluded from insurance access, they are forced to fend for themselves in an artificial market system where inflated charges are set by insurance and governmental third parties, with fees for basic services beyond the reach of most working people. Economics notwithstanding, many physicians are willing to treat the undocumented, who remain outside the purview of the new law, as a means to provide the best hope for meeting patients’ needs. Although some dispute the prediction of a shortage, the Association of American Medical Colleges has stated that the burgeoning demand created by the newly insured and the swell of new Medicare enrollees will create a shortage of primary care physicians of about 39,800 in 2015 and about 65,000 by 2025.

Which brings me back to Ms. R. and her family. In this brave new world of expanded insurance access and shrinking subsidies for uncompensated care, where will the undocumented go when safety-net providers struggle to accommodate newly paying customers? Will they show up in emergency rooms in greater numbers? Will they simply go without care?

Could millions of people legally excluded from the insurance mandate prompt the emergence of new markets to meet their needs? Might providers respond by providing services according to how much patients are willing and able to pay, as in other sectors of the economy? Perhaps, over time, these market-oriented health care providers will control the cost of medical services in the same way that large retailers (such as Target and Wal-Mart) have by implementing $4 prescription formularies for generic drugs. It is not infeasible that the undocumented, who remain outside the law, may attract the attention of care providers who yearn for a simpler, leaner practice that responds not to bureaucratic prescriptions but to patients’ needs and values. Practice models that cater to the need for responsive, patient-centered care are likely to be both financially and professionally rewarding.

The ACA has provoked visceral responses from both those who are opposed to its means and those who support its ends. Irrespective of the Supreme Court’s decision regarding its constitutionality, the ACA is emblematic of the nation’s lack of will to provide a means for the undocumented to meet their health care needs. Market-based arrangements developed around the needs of individual patients may provide the best hope for meeting the basic health care needs of the United States’ 11 million undocumented immigrants — and may conceivably end up producing examples of ways to provide more efficient and cost-effective primary health care than centrally managed systems can.
Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1202039) was published on May 16, 2012, at NEJM.org.


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