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## The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP

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# The Consequences of Restricted Health Care Access for Immigrants:

## Lessons from Medicaid and SCHIP

Janet M. Calvo \*

### I. INTRODUCTION

Health care access reform is again at the forefront of public concern. State governments and presidential candidates are proposing various approaches to change the healthcare system.<sup>1</sup> These proposals recognize the serious individual, public health, and health system consequences of a society with up to fifty million uninsured and increasing numbers of underinsured.<sup>2</sup> However, current proposals to reform health care do not directly address the issue of health care access for noncitizens, particularly those in the United States without status (sometimes labeled undocumented, unauthorized, or illegal immigrants). The exclusion of noncitizens from these healthcare models is in part attributed to Congress' failure to address another area in need of substantial reform: the immigration system.<sup>3</sup> This omission leaves approximately twelve million residents in the United States without a legal status.<sup>4</sup>

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\* Professor, City University School of Law. Many thanks for the comments of Ruthann Robson and Andrea McArdle, the research assistance of Johan Bysainthe, and the typing assistance of Rosa Navarra.

1. See Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1 (discussing proposals by state politicians). See also HENRY J. KAISER FAMILY FOUND., 2008 PRESIDENTIAL CANDIDATE HEALTH CARE PROPOSALS: SIDE-BY-SIDE SUMMARY (2008), <http://www.health08.org/sidebyside.cfm> [hereinafter 2008 PRESIDENTIAL CANDIDATE HEALTH CARE PROPOSALS] (explaining the proposals of various presidential candidates).

2. See Barry R. Furrow, *Symposium: The Politics of Health Law: Access to Health Care and Political Ideology: Wouldn't You Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 406-07 (2007) [hereinafter *The Politics of Health Law*] (discussing the problem of healthcare costs for uninsured and underinsured individuals).

3. See Dr. Juan Hernandez, *Introduction* to MANY VOICES, ONE DREAM: A COLLECTION OF INSIGHTS AND RECOMMENDATIONS FOR ACHIEVING MEANINGFUL IMMIGRATION REFORM 1, 1-2 (2007), available at <http://www.reforminstitute.org/DetailPublications.aspx?pid=130&cid=7> [hereinafter MANY VOICES] (highlighting the need for immigration reform).

4. See Douglas Massey, *America's Unfolding Human Rights Crisis*, in MANY VOICES, *supra* note 3, at 6. See also *Comprehensive Immigration Reform: Government Perspectives on Immigration Statistics Before the Subcomm. on Immigration, Citizenship, Refugees, Border*

To be effective, any health care access reform proposal must address the noncitizen members of this society, rather than focusing merely on which individuals are “entitled” to be included. There are significant public health and health system consequences to restricting health care access, particularly for this minority segment of the U.S. population. This article will discuss these consequences that arise from the exclusion of noncitizens from health care access reform.

Among the programs that have limited immigrants’ access to health care, the Medicaid and State Children’s Health Insurance Program (“SCHIP”) initiatives have placed various restrictions on health care access of noncitizens. This article analyzes the public health and health system consequences of the limitations on immigrants’ access to the Medicaid and SCHIP programs to illustrate the issues that arise in the consideration of immigrant status in any healthcare system. Attention to the Medicaid and SCHIP programs is also important because these programs are poised to remain as the stop gap programs in most of the reform proposals advanced by the 2008 presidential candidates.<sup>5</sup>

Medicaid and Child Health Insurance through SCHIP are federal programs designed to fill the gaps in health care access for low-income individuals. However, qualification for these programs is severely restricted based on citizenship status. This article explains how these restrictions pervert the concept and provision of emergency care. It further discusses how they undermine public health objectives that protect the public at large, limit access to eligible citizens, and also impede the effective and economic functioning of the healthcare system. The restrictions on health care access for noncitizens undermine public health policies relating to the control of contagious diseases like tuberculosis (“TB”), severe acute respiratory syndrome (“SARS”), and pandemic influenza, all of which require access to medical care for early detection and response. Additionally, the Medicaid and SCHIP restrictions impede the reduction of infant mortality and morbidity, the promotion of child health, and the control of chronic disease.

This article further demonstrates how concern about enforcing the restrictions on health care access through Medicaid for noncitizens has created significant barriers for citizens as well. Citizens now have to prove their status with particular forms of documentation not easily accessible to many low-income individuals. The perceived and actual adverse

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*Security, and International Law of the H.R. Comm. on the Judiciary*, 110th Cong. 42 (2007) (testimony of Ruth Ellen Wasem, Specialist in Immigration Policy, Congressional Research Service), available at <http://judiciary.house.gov/media/pdfs/Wasem070606.pdf> [hereinafter Wasem Testimony] (noting that one-third of the thirty-six million foreign-born residents are unauthorized residents and legal temporary residents).

5. See 2008 PRESIDENTIAL CANDIDATE HEALTH CARE PROPOSALS, *supra* note 1.

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immigration consequences of obtaining health care also discourage those noncitizens who may have access from getting the health care they need.

Furthermore, the restrictions to health care access wreak havoc on the administrative and fiscal underpinnings of health care programs and frustrate medical and health administration professionals. Determining eligibility for care on the basis of immigration status requires difficult analysis and shifts a significant amount of resources away from providing health care. Moreover, immigrants have been made scapegoats in a system of conflicting local, state, and federal responsibilities that have inflicted fiscal strains on public hospitals, clinics, and state budgets for Medicaid. The restrictions shift costs to local government and not-for-profit entities that have no control over immigration policy.

Finally, this article discusses the consequences of the lack of provision of health care in the context of the American healthcare system. It addresses the opposition to coverage for noncitizens, based on a desire by some to implement restrictive immigration policy through health care policy. This article concludes that limiting health care access for legal permanent residents and other aliens permanently residing in the United States does not make sense from a public health or health system perspective. Although providing health care access to those without documented status is a controversial issue, health care reform would be most effective if all persons residing in the United States were included in health care access programs. At the very least, healthcare services that have major public health consequences and fiscal implications must be provided without regard to citizenship status in any system reform plan.

## II. MEDICAID AND SCHIP IN THE CURRENT AMERICAN HEALTHCARE SYSTEM

### *A. Overview*

The American healthcare system, unlike those in many other industrialized nations, is not a national system of comprehensive health care access. Rather, the American system relies predominantly on health insurance from employers for workers and their families.<sup>6</sup> Yet, the United States does not require employers to provide insurance to their employees.<sup>7</sup> As a result, there are millions of people in the United States who are employed but without healthcare coverage.<sup>8</sup> Moreover, America's

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6. See *The Politics of Health Law*, *supra* note 2, at 407-09.

7. See *id.* at 409-10.

8. See *id.* at 407-09. See also ROBIN A. COHEN ET AL., CTR. FOR DISEASE CONTROL, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY 1-5 (2006), available at [www.cdc.gov/nchs/data/nhis/earlyrelease/insur200706.pdf](http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200706.pdf).

immigration laws do not require healthcare coverage by employers who seek employment-based visas for employees as permanent residents or on long-term work-related visas.<sup>9</sup>

A variety of federal, state, and local government programs support—and some would say subsidize—the employer choice health insurance system. The primary government programs are Medicare, Medicaid, and SCHIP. Medicaid supplies federal matching money for states to provide health care to persons deemed to have inadequate economic resources to obtain health care.<sup>10</sup> SCHIP, an initiative focused on child health, provides federal grants to states to assist in providing healthcare coverage to low-income children.<sup>11</sup> Medicare is a federally run program that administers subsidized health insurance for the aged and disabled that is supplemented by the Medicaid program.<sup>12</sup>

Medicaid and SCHIP are funded in part by the federal government and in part by states and localities. These programs have income and resources eligibility criteria.<sup>13</sup> Thus, many uninsured workers who do not have sufficient resources to purchase private health insurance are denied assistance because they have too much income to qualify for the government-sponsored programs. In addition to income and resources requirements, noncitizens face barriers based on immigration status. Under the current system, the noncitizen population contains many individuals who clearly meet economic criteria for the government programs, but who are barred because they cannot meet immigration status criteria.<sup>14</sup>

Thus, the underlying problems and issues of the healthcare system become more intense and complicated when health care access of noncitizens is considered. The dependence on an employer-based insurance

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9. See Labor Certification for the Permanent Employment of Aliens in the United States, 72 Fed. Reg. 27,904, 27,904-05 (May 17, 2007) (to be codified at 20 C.F.R. pt. 656) (omitting healthcare coverage as a requirement in the process for U.S. employers to obtain permanent alien workers).

10. Social Security Act, 42 U.S.C. § 1396 (2000) (providing medical assistance to the poor, the disabled, and other needy individuals).

11. NAT'L CONFERENCE OF STATE LEGISLATURES, STATE CHILDREN'S HEALTH INSURANCE PROGRAM, [www.ncsl.org/programs/health/chiphome.htm](http://www.ncsl.org/programs/health/chiphome.htm) (last visited Apr. 12, 2008) (noting that the SCHIP program targets low-income children who are not eligible for Medicaid and are uninsured).

12. See HENRY J. KAISER FAMILY FOUND., INTERACTION BETWEEN MEDICARE AND MEDICAID, [www.kff.org/medicare/upload/Navigating-Medicare-and-Medicaid-2005-Interaction-Between-Medicare-and-Medicaid-Section-4.pdf](http://www.kff.org/medicare/upload/Navigating-Medicare-and-Medicaid-2005-Interaction-Between-Medicare-and-Medicaid-Section-4.pdf).

13. 3 Medicare and Medicaid Guide (CCH) ¶ 14,311 (2007). See also NEIGHBORHOOD LEGAL SERVICES, INC., MEDICAID FINANCIAL ELIGIBILITY LEVELS FOR NEW YORK (2007), available at <http://www.nls.org/medichrt2007.htm> (noting that Medicaid financial eligibility differs from state to state and also by family size; for example, a single person in New York State would be eligible with a monthly income of \$700 or less, and a family of four would be eligible with a monthly income of \$1109 or less).

14. See 3 Medicare and Medicaid Guide (CCH) ¶ 14,341 (2007).

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system is problematic for many noncitizen workers who are employed in industries that usually do not provide health insurance, such as agriculture, cleaning, and food services.<sup>15</sup> Moreover, in recent years and especially since 1996, the federal government has imposed restrictions on noncitizen participation in Medicaid and SCHIP.<sup>16</sup> Additionally, states and localities bear the brunt of federal policies that attempt to promote immigration policy through programs designed to achieve public health objectives. As a result, states and localities have borne the fiscal and societal costs of federal non-participation in funding health care for noncitizens.<sup>17</sup>

### *B. The Federal Limitations on Medicaid and SCHIP*

Under the sweeping and controversial changes brought about by the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA"), many legal permanent residents and all aliens permanently residing in the United States under color of law were deemed ineligible for most forms of public benefits, including Medicaid and SCHIP.<sup>18</sup> Noncitizens with no form of immigration authorization continued to be ineligible. Otherwise ineligible noncitizens could receive care under a few exceptions, the most important being treatment for an emergency medical condition under Medicaid.<sup>19</sup> SCHIP mirrored Medicaid eligibility but nonetheless permitted for some prenatal care through a subsequent regulatory interpretation.<sup>20</sup>

Prior to 1996, aliens who were legal permanent residents were fully Medicaid-eligible on the same basis as citizens.<sup>21</sup> Also prior to 1996, aliens

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15. See JEFFREY S. PASSEL, PEW HISPANIC CTR., UNAUTHORIZED MIGRANTS: NUMBERS AND CHARACTERISTICS 26-27 (2005), available at <http://pewhispanic.org/reports/report.php?ReportID=46> (statistics regarding unauthorized individuals in lower wage occupations).

16. Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the "Contract with America" Congress*, 90 KY. L.J. 1043, 1052-53 (2002) (noting that while undocumented immigrants are generally eligible for emergency Medicaid, they are ineligible for non-emergency federal public benefits under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996).

17. See, e.g., Nathanael J. Scheer, *Keeping the Promise: Financing EMTALA's Guarantee of Emergency Medical Care for Undocumented Aliens in Arizona*, 35 ARIZ. ST. L.J. 1413, 1413-14 (2003) (discussing this issue as it applies to the state of Arizona).

18. See Costich, *supra* note 16, at 1052-53. See also TANYA BRODER, NAT'L IMMIGRATION LAW CTR., OVERVIEW OF IMMIGRANT ELIGIBILITY FOR FEDERAL PROGRAMS 4.1-4.10 (2007), [http://www.nilc.org/immspbs/special/pb\\_issues\\_overview\\_2007-10.pdf](http://www.nilc.org/immspbs/special/pb_issues_overview_2007-10.pdf).

19. 8 U.S.C. § 1611(b)(1)(A) (2000).

20. See Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537, 559-563, 589-591 (2006) (noting that state-sponsored insurance was expanded to cover pre-natal care).

21. Janet M. Calvo, *Alien Status Restrictions on Eligibility for Federally Funded Assistance Programs*, 16 N.Y.U. REV. L. & SOC. CHANGE 395, 402 (1988) [hereinafter *Alien*

otherwise permanently residing in the United States under color of law qualified for Medicaid as well.<sup>22</sup> This group included aliens residing in the United States with the knowledge and acquiescence of the immigration service, as well as numerous categories of aliens who specifically met the criteria, including an open-ended category through which individuals could demonstrate that they were permanently residing under color of law.<sup>23</sup>

The “permanently residing under color of law” category reflected the complicated reality of immigration status. Particularly with regard to Medicaid eligibility, Congress intended a broad interpretation of this category that included those residing in the country pursuant to immigration law, policy, and practice.<sup>24</sup> The legislature and subsequently the judiciary acknowledged that the immigration system included diverse categories that afford an ability to live in the United States.<sup>25</sup> Further, the “permanently residing under color of law” category recognized the complexity of the process of changing immigration status and the numbers of noncitizens who find themselves in a bureaucratic limbo while they try to provide the documents and demonstrate they meet the criteria for a status that would allow continued residence in the United States.<sup>26</sup>

Since 1996, however, the federal government has withheld eligibility to both legal permanent residents and aliens permanently residing under color of law.<sup>27</sup> Medicaid eligibility initially depends on whether an alien has been classified as a “qualified alien.”<sup>28</sup> “Qualified aliens” include legal permanent residents, refugees, asylees, aliens granted withholding, conditional entrants, Cuban/Haitian entrants, aliens paroled into the United States for at least one year, and certain abused spouses and

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*Status Restrictions*]. Under current law, Medicare is limited to legal permanent residents who have been in the United States for at least five years. See 8 U.S.C. § 1613(a) (2000). See also *Matthews v. Diaz*, 426 U.S. 67, 67 (1976) (holding that Congress may condition an alien’s eligibility for participation in a federal medical insurance program on continuous residence in the U.S. for a five-year period).

22. *Alien Status Restrictions*, *supra* note 21, at 412.

23. See *id.* at 412-15.

24. H.R. REP. NO. 99-727, at 111 (1986).

25. See, e.g., *Holley v. Lavine*, 553 F.2d 845, 849 (2d Cir. 1977), *cert. denied sub nom.*, *Shang v. Holley*, 435 U.S. 947 (1978); *Berger v. Heckler*, 771 F.2d 1556, 1574-75 (2d Cir. 1985).

26. See, e.g., *Berger*, 771 F.2d at 1571-75.

27. See 3 Medicare and Medicaid Guide (CCH) ¶ 14,341 (2007).

28. 8 U.S.C. §§ 1611(a), 1641(b)-(c) (2000). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”) implemented the federal restrictions. States operating designated federal programs such as Medicaid are required to follow federal law to receive federal financial contributions. 8 U.S.C. §§ 1601-46 (2001). The provisions of PRWORA have been upheld by federal courts applying a rational basis review. See *Kiev v. Glickman*, 991 F.Supp. 1090, 1100 (D. Minn. 1998); *Abreu v. Callahan*, 971 F.Supp. 799, 818 (S.D.N.Y. 1997).

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children of U.S. citizens or legal permanent residents if there is a substantial connection between the abuse and the need for Medicaid.<sup>29</sup>

However, even some “qualified” aliens are not eligible because of their date of entry into the United States. Persons who become legal permanent residents after August 22, 1996, are barred from receiving non-emergency Medicaid for five years beginning on the date they obtained their status.<sup>30</sup> After five years, a permanent resident can still be barred by the sponsor deeming provisions if the alien had a sponsor who signed an affidavit of support.<sup>31</sup> States may opt to cover permanent residents who have been in the United States on or before August 22, 1996, and legal permanent residents who have been in the United States for more than five years.<sup>32</sup> However, all otherwise eligible aliens qualify only for treatment of an emergency medical condition covered by Medicaid.<sup>33</sup>

### C. Coverage for Pregnant Women and Children under Medicaid

Medicaid eligibility for pregnant women<sup>34</sup> and children was expanded during the 1980’s and 1990’s.<sup>35</sup> Pregnant women and children are eligible for Medicaid at higher incomes than other Medicaid applicants.<sup>36</sup> States that participate in Medicaid must provide certain services for children: Early and Periodic Screening, Diagnostic, and Treatment Services (“EPSDT”).<sup>37</sup> However, Medicaid excludes some pregnant women and children based on alien status, even if they would otherwise be eligible based on income.

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29. 8 U.S.C. § 1641(b)–(c) (2000).

30. 8 U.S.C. § 1613 (2000).

31. See 8 U.S.C. § 1183a(a) (2000 & Supp. V 2005) (sponsor deeming provisions attribute a sponsor’s income and resources to noncitizen in determining the eligibility for and amount of federal benefits, indicating that noncitizen may be barred from receiving benefits on basis of sponsor’s income and resources).

32. OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING & EVALUATION, SUMMARY OF IMMIGRANT ELIGIBILITY RESTRICTIONS UNDER CURRENT LAW (2004), <http://aspe.hhs.gov/hsp/immigration/restrictions-sum.htm#sec 6>.

33. 42 U.S.C. § 1396b(v)(2)(A) (2000).

34. For example, in 1986, Congress allowed states to enroll all pregnant women with incomes up to 100% of the federal poverty level in Medicaid. This increased the number of pregnant women eligible to receive pre- and post-natal care. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401(b)(2), 100 Stat. 1874 (1986). See also GENERAL ACCOUNTING OFFICE, PRENATAL CARE: EARLY SUCCESS IN ENROLLING WOMEN MADE ELIGIBLE BY MEDICAID EXPANSIONS 7 (Feb. 1991), available at <http://www.gao.gov/docsearch/beta>.

35. Ian T. Hill, *The Role of Medicaid and Other Government Programs in Providing Medical Care for Children and Pregnant Women*, 2 No. 2 THE FUTURE OF CHILDREN: U.S. HEALTH CARE FOR CHILDREN 134, 134-35 (Winter, 1992).

36. See, e.g., NEIGHBORHOOD LEGAL SERVICES, INC., *supra* note 13.

37. HENRY J. KAISER FAMILY FOUND., EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES 1 (2005), <http://www.kff.org/medicaid/upload/Early-and-Periodic-Screening-Diagnostic-and-Treatment-Services-Fact-Sheet.pdf>.



A controversial interpretation of SCHIP allows the provision of health care to “a child from the time of conception.”<sup>38</sup> Theoretically, this allows states to choose to provide some prenatal care to a pregnant woman for the benefit of the fetus regardless of the woman’s citizenship status.<sup>39</sup> However, the care provided is limited and the efficiency of providing appropriate prenatal care through this approach has been criticized.<sup>40</sup>

#### D. Emergency Care Under EMTALA and Medicaid

##### 1. EMTALA

Congress passed the Emergency Medical Treatment and Labor Act (“EMTALA”)<sup>41</sup> to guarantee emergency health care to every individual and to prevent patient dumping by hospitals and providers.<sup>42</sup> EMTALA’s approach reflects the current system of handling medical emergencies in the United States, which involves taking a patient to a hospital emergency room. EMTALA requires that any hospital with an emergency room provides emergency care without regard to the patient’s ability to pay.<sup>43</sup> Further, the act penalizes hospitals or physicians who fail to provide care by imposing fines and terminating their participation in the Medicare system.<sup>44</sup> Under EMTALA, if a person comes to a hospital that has an emergency department, the hospital must provide an appropriate medical screening examination to determine whether an emergency medical condition or active labor exists.<sup>45</sup> If the patient has an emergency medical condition, the hospital must administer any necessary stabilizing treatment or transfer the person to an appropriate medical facility.<sup>46</sup> The act defines an emergency medical condition as a medical condition that manifests itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her

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38. Diana O. Aguilar, *Using SCHIP to Offer Prenatal Care to Undocumented and Non-Qualified Immigrants in Wisconsin: The Benefits, Risks, and Shortcomings*, 20 WIS. WOMEN’S L.J. 263, 269-70 (2005).

39. *Id.*

40. *See id.* at 281-86. *See also* Fentiman, *supra* note 20, at 589-93.

41. 42 U.S.C. § 1395dd (2000 & Supp. IV 2004).

42. *See* Scheer, *supra* note 17, at 1415.

43. William P. Gunnar, *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 171 (2006); Beverly Cohen, *Disentangling EMTALA from Medical Malpractice*, 82 TUL. L. REV. 645, 655 (2007); 42 C.F.R. §489.24 (2007).

44. Gunnar, *supra* note 43, at 172. *See* 42 U.S.C. § 1395dd(d)(1)(B) (2000 & Supp. IV 2004).

45. *See* 42 U.S.C. § 1395dd(a) (2000).

46. *See* 42 U.S.C. § 1395dd(d)(B)(i) (2000).

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unborn child) in serious jeopardy, inflict serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.<sup>47</sup>

Despite EMTALA's noble goal of preventing hospitals from refusing to treat patients because they are unable to pay, the act's effectiveness suffers from a lack of funding.<sup>48</sup> Consequently, hospitals must provide these required services without regard to the patient's ability to pay, causing hospitals to increasingly struggle with the costs of uncompensated care. Hospitals may bill the patients for the emergency services, but if the patients do not have insurance or sufficient economic resources, the government does not compensate the hospital for the care.<sup>49</sup>

However, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA") allows providers to recoup some of the costs of caring for uninsured, undocumented aliens who could not afford emergency care.<sup>50</sup> The MMA funds are distributed among states on the basis of their relative undocumented alien populations.<sup>51</sup> Payments can be made directly to hospitals and certain physicians for unreimbursed costs under EMTALA.<sup>52</sup> This provision, however, does not effectively address uncompensated care outside of the hospital, particularly for noncitizens because they are less likely to use emergency rooms than citizens.<sup>53</sup>

## 2. Care for Emergency Medical Conditions Under Medicaid

All otherwise eligible aliens are entitled to Medicaid coverage for "such care and services [as] are necessary for the treatment of an emergency medical condition of the alien."<sup>54</sup> An "emergency medical condition" is a

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47. 42 U.S.C. § 1396b(v)(3) (2000). See also Marcela X. Berdion, *The Right to Health Care in the United States: Local Answers to Global Responsibilities*, 60 SMU L. REV. 1633, 1644-48 (2007) (for a discussion of EMTALA's limitations).

48. See Tianna Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 166 (2004). See also Dean M. Harris, *Symposium: The Future of Medicare, Post Great Society and Post Plus Choice: Legal and Policy Issues: Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals*, 60 WASH. & LEE L. REV. 1251, 1279 (2003) (EMTALA referred to as an "unfunded mandate").

49. See David Hyman, *Patient Dumping on EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 50-53 (1998).

50. See generally Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

51. Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMG), 70 Fed. Reg. 25,578 (May 13, 2005).

52. Ice Miller, *Survey of Recent Developments in Health Law*, 39 IND. L. REV. 1051, 1092 (2006).

53. See HENRY J. KAISER FAMILY FOUND., SUMMARY: FIVE BASIC FACTS ON IMMIGRANTS AND THEIR HEALTH CARE (2008), <http://www.kff.org/medicaid/upload/7761.pdf> [hereinafter FIVE BASIC FACTS ON IMMIGRANTS].

54. 42 U.S.C. § 1396b(v)(2)(A) (2000).

medical condition (including emergency labor and delivery) that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy; inflict serious impairment to bodily functions; or cause serious dysfunction of any bodily organ or part.<sup>55</sup> As will be discussed more fully below, what meets this definition has been hotly contested in the courts and between states and the federal government.

### III. RESTRICTIONS ON ALIEN ELIGIBILITY FOR HEALTH CARE DISTORT THE PROVISION OF APPROPRIATE AND EFFECTIVE CARE FOR EMERGENCY MEDICAL CONDITIONS

Under Medicaid, those who do not fit into an eligible immigration status or who cannot prove their citizenship status are limited to treatment for an emergency medical condition. There has been confusion and controversy about what constitutes treatment for an emergency medical condition. Moreover, the limitation of noncitizen access to care for emergency medical conditions has undermined the ability of medical professionals to prevent emergencies and to treat medical conditions in a manner consistent with their obligations to save lives and prevent damage to health.

Individuals in need of care and providers have argued for the definition of an emergency medical condition that reflects the reality of how conditions and illnesses are treated in the healthcare system. State and federal courts have divergently interpreted the statutory definition of treatment for an emergency medical condition.<sup>56</sup> Moreover, some view the outcome of court interpretations as inconsistent even when the courts apparently apply the same legal standard.<sup>57</sup> Courts' varying interpretations of what constitutes treatment for an emergency medical condition have created negative consequences not only for the individuals in need of care, but also for the providers of emergency services.

#### A. *Initial Interpretations Respected Medical Judgment*

Initially, the interpretation of the statutory language defining an "emergency medical condition" recognized a myriad of situations and

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55. 8 U.S.C. § 1369(d) (2000).

56. See, e.g., *Greenery Rehab. Group, Inc. v. Hammon*, 150 F.3d 226, 231-33 (2d Cir. 1998); *Szewczyk v. Dep't of Soc. Servs.*, 881 A.2d 259, 265-74 (Conn. 2005); *Diaz v. Div. of Soc. Servs.*, 600 S.E.2d 877, 879-81 (N.C. Ct. App. 2004); *Luna v. Div. of Soc. Servs.*, 589 S.E.2d 917, 919-25 (N.C. Ct. App. 2004); *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 94-99 (Ariz. 2003).

57. See Michael McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard that Governs Undocumented Immigrants' Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL'Y 391, 404 (2007).

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conditions, and relied on professional medical judgment in the context of consistent and appropriate medical care.<sup>58</sup> In adopting a regulation regarding emergency conditions,<sup>59</sup> the federal department of Health and Human Services (“HHS”) acknowledged that the term should be construed broadly and consistently with medical judgment in the context of the variety of conditions, illnesses, and treatments that affect diverse individuals.<sup>60</sup> The statement reads, “[w]e believe the broad definition [of emergency medical condition] allows States to interpret and further define the services available to aliens . . . .”<sup>61</sup> HHS also recognized the need for deference to medical judgment by defining these services as “necessary to treat an emergency medical condition in a consistent and proper manner supported by professional medical judgment.”<sup>62</sup> The explanation further addressed the complex individual decisions that needed to be made with medical judgment, stating that “the significant variety of potential emergencies and the unique combination of physical conditions and patient’s response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions.”<sup>63</sup>

Following this regulation, some state courts took an approach that respected the physician’s judgment, viewing treatment for an emergency medical condition along a continuum.<sup>64</sup> As described below, the Second Circuit subsequently took a more restrictive approach that approved treatment for stabilization and acute symptoms, but not treatment to respond to serious health and life threatening conditions.<sup>65</sup> State courts then struggled to respond to this more restrictive standard while trying to reflect the realities of medical practice and the consequences of failure to provide treatment.<sup>66</sup>

In the 1995 case of *Gaddam v. Rowe*, a Connecticut court interpreted the Medicaid statute to provide for care and services necessary for the treatment of an emergency medical condition with deference to medical judgment about the consequences of a condition that initially presented as an emergency.<sup>67</sup> The patient was hospitalized at the outset with acute

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58. Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36,813, 36,816 (Sept. 7, 1990) (to be codified at 42 C.F.R. pts. 435, 436, and 440).

59. See generally *id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. at 36,816.

64. *Gaddam v. Rowe*, 684 A.2d 286 (Conn. Super. Ct. 1995).

65. *Greenery Rehab. Group, Inc. v. Hammon*, 150 F.3d 226 (2d Cir. 1998).

66. E.g., *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259 (Conn. 2005).

67. *Gaddam*, 684 A.2d at 288.

symptoms of kidney failure and was subsequently put on a course of outpatient dialysis.<sup>68</sup> The court found that the patient continued to have the life threatening medical condition of last stage renal disease,<sup>69</sup> thus Medicaid coverage existed for outpatient dialysis treatment necessary to keep the patient alive.<sup>70</sup> Further, the court stated that the statute providing for treatment of an emergency medical condition did not require medical “Russian roulette” of stopping the treatment, waiting a short time for symptoms to recur, and then rushing the patient to the hospital to restart treatment before the patient dies.<sup>71</sup> It rejected the notion that the medical treatment will not be covered once the acute symptoms dissipated if the symptoms would quickly return after the medical treatment was halted.<sup>72</sup>

An Arizona court focused on the consequences described in the statute of failure to provide medical care.<sup>73</sup> In *Mercy Healthcare Arizona, Inc. v. Arizona Health Care Cost Containment System*, the court addressed the emergency medical care needed by a car accident victim who suffered a severe head injury that left him unable to speak, paralyzed in his lower extremities, and dependant on a feeding tube.<sup>74</sup> The court held that the statute defining an emergency medical condition does not limit coverage to treatment services while acute symptoms continue.<sup>75</sup> The court concluded that once a medical condition manifested itself through acute symptoms, covered services for the treatment of that condition may continue, so long as the absence of immediate treatment could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of an organ or body part.<sup>76</sup>

### B. More Restrictive Interpretations Followed

The Second Circuit’s decision in *Greenery Rehabilitation Group, Inc. v. Hammon* presented a more restrictive interpretation that did not view medical care along a continuum and did not focus on the consequences of removal of care.<sup>77</sup> The court found that care provided to two patients did

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68. *Id.* at 286.

69. *Id.* at 287.

70. In *Crespin v. Kizer*, 226 Cal. App. 3d 498, 510 (Cal. Ct. App. 1990), the court noted that the California Department of Health Services “acknowledges that in most cases renal dialysis does constitute ‘emergency treatment’ for which federal financial participation is available.”

71. *Gaddam*, 684 A.2d at 288.

72. *Id.*

73. *Mercy Healthcare Ariz., Inc. v. Ariz. Health Care Cost Containment Sys.*, 887 P.2d 625 (Ariz. Ct. App. 1994).

74. *Id.* at 627.

75. *Id.* at 628-29.

76. *Id.* at 629.

77. See *Greenery Rehab. Group, Inc. v. Hammon*, 150 F.3d 226, 232 (2d Cir. 1998).

not meet the definition of emergency medical care, because the patients had been stabilized and their acute symptoms treated; thus, the court viewed them as suffering from chronic conditions.<sup>78</sup> The court did not sufficiently consider that the withdrawal of the continuous medical attention could reasonably be expected to place the patients' health in serious jeopardy.<sup>79</sup>

In *Greenery*, both patients were placed in a rehabilitation facility after sustaining severe head injuries, one from an automobile accident, and the other from a gun shot wound.<sup>80</sup> The first patient was a bedridden quadriplegic with a feeding tube; the second was unable to walk and required monitoring and medication for seizures.<sup>81</sup> The treating physicians at their rehabilitation facility believed the patients were receiving care for an emergency medical condition because their continuous medical care was necessary to prevent serious risks to their health.<sup>82</sup> The circuit court found that the initial treatment for the head injuries was covered, but that the continuous treatment after the patients had been stabilized was not covered.<sup>83</sup> The court concluded that stabilization ended the emergency; thus, subsequent care addressed a chronic condition that did not meet the statute's definition of an emergency medical condition.<sup>84</sup> The court stated that to meet the statutory definition, the patient had to be suffering from acute symptoms that coincided in time with the medical condition.<sup>85</sup> Further, the court stated that for a medical condition to be an emergency, the medical condition had to be a sudden, severe, and short lived illness or injury that required immediate treatment to prevent further harm.<sup>86</sup>

After *Greenery*, state courts struggled to interpret the statute providing for treatment of an emergency medical condition. A Connecticut court, asserting that it was bound by *Greenery*, held that continued and regimented care by dialysis was not treatment for an emergency medical condition.<sup>87</sup> The court made the chilling statement: "The fatal consequences of the discontinuance of such ongoing care does not transform into emergency medical condition care."<sup>88</sup>

However, the Supreme Court of Arizona in *Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System Administration* disagreed in

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78. *Id.*

79. *Id.* at 233.

80. *Id.* at 228.

81. *Id.* at 228-29.

82. *Greenery*, 150 F.3d at 230.

83. *Id.* at 232-33.

84. *Id.*

85. *Id.* at 232.

86. *Id.*

87. *Quiceno v. Dep't of Soc. Servs.*, 728 A.2d 553, 555 (Conn. Super. Ct. 1999).

88. *Id.*

part with the approach taken in *Greenery*.<sup>89</sup> The court rejected the reliance on the notion of stabilization and stated that it was not practical to focus on whether the initial injury was stabilized or the type of ward in which the patient received treatment.<sup>90</sup> However, the court did concur with *Greenery* in finding that the patient's current medical condition must manifest through acute indications of injury or illness such as to qualify as an emergency medical condition.<sup>91</sup> The court stated that this determination was one of fact and remanded the case to the trial court.<sup>92</sup>

In *Scottsdale*, the court pointed to one of the patients as an example of factual determinations that had to be made.<sup>93</sup> The patient was a gunshot wound survivor.<sup>94</sup> The bullet hit a major artery causing extensive damage, for which his hospital treatment spanned multiple surgeries over the course of eleven months.<sup>95</sup> While hospitalized, the patient was occasionally moved from an acute care bed to a sub-acute unit.<sup>96</sup> The state agency had determined that the care in the sub-acute unit was not covered care thus focusing only on the place in which the treatment was provided.<sup>97</sup> The court, however, indicated that fact finding was necessary because the condition the patient suffered in a sub-acute unit could have continued to manifest itself by acute symptoms of sufficient severity that medical attention was required to prevent placing his physical well-being in serious jeopardy.<sup>98</sup>

### C. Controversy Developed in the Context of Cancer and Chemotherapy

Questions about what constitutes an emergency medical condition have also arisen in several cases involving treatment for cancer, especially chemotherapy. In *Szewczyk v. Department of Social Services*, the Supreme Court of Connecticut applied the more restrictive *Greenery* standard to treatment for acute myelogenous leukemia and found that it met the statutory criteria of treatment for an emergency medical condition.<sup>99</sup> The patient first sought care when he was in intense pain and near collapse.<sup>100</sup>

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89. *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91 (Ariz. 2003).

90. *Id.* at 96-97.

91. *Id.* at 97.

92. *Id.* at 98.

93. *Id.* at 97.

94. *Scottsdale*, 75 P.3d at 97.

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Szewczyk v. Dep't of Soc. Servs.*, 881 A.2d 259, 261 (Conn. 2005).

100. *Id.* at 262.

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After a diagnosis he was admitted to a hospital and treated for approximately one month with surgery, biopsies, and chemotherapy.<sup>101</sup> The court found that the *Greenery* standard had been met because the patient sought coverage for “the finite course of treatment of the very condition that sent him to the emergency room and not for long-term or open-ended nursing care.”<sup>102</sup> In reaching its conclusion, the court noted that the treating physician had stated that acute myelogenous leukemia is a rapidly fatal disease unless treated aggressively with chemotherapy administered in a hospital and in the absence of the therapy the patient probably would have likely died.<sup>103</sup>

A North Carolina appellate court in *Luna v. Division of Social Services* also found that chemotherapy qualified as treatment for an emergency medical condition.<sup>104</sup> The patient underwent a three month course of treatment for primary central nervous system lymphoma and a spinal cord tumor.<sup>105</sup> The state agency had denied coverage for the intravenous chemotherapy treatments provided in the hospital’s oncology unit.<sup>106</sup> The treating physician explained that this type of cancer had a rapid life-threatening progression requiring immediate treatment and that the surgery and cycles of chemotherapy were best considered a single course of treatment.<sup>107</sup> The court found the approach of the Arizona courts to be most applicable and remanded the case to resolve the factual issues of whether the patient’s condition was manifesting itself by acute systems and whether the absence of immediate medical treatment could reasonably be expected to place his health in serious jeopardy or result in serious impairment to bodily functions or serious dysfunction of an organ or body part.<sup>108</sup>

However, in *Diaz v. Division of Social Services*, the Supreme Court of North Carolina denied coverage to chemotherapy treatments for acute lymphocytic leukemia.<sup>109</sup> In the court’s view, the leukemia was not an emergency medical condition when the patient received the chemotherapy because when the chemotherapy was administered, the patient’s condition had improved and was stable.<sup>110</sup> The court acknowledged that the patient would have regressed into a state of emergency had he not received the chemotherapy.<sup>111</sup>

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101. *Id.*

102. *Id.* at 272.

103. *Id.* at 262.

104. *Luna v. Div. of Soc. Servs.*, 589 S.E.2d 917, 922 (N.C. Ct. App. 2004).

105. *Id.* at 918-19.

106. *Id.* at 919.

107. *Id.* at 921.

108. *Id.* at 924-25.

109. *Diaz v. Div. of Soc. Servs.*, 628 S.E. 2d 1, 5 (N.C. 2006).

110. *Id.*

111. *Diaz v. Div. of Soc. Servs.*, 600 S.E.2d 877 (N.C. Ct. App. 2004).



### D. *Conflicts Between State and Federal Authorities*

The definition of emergency medical condition under Medicaid has been an area of contention not only in the courts, but also between state and federal authorities.<sup>112</sup> Frequently, the controversy revolves around whether a person in need of medical care is eligible and can obtain the care. However, the source of funding also contributes to this controversy. Hospitals and providers, confronted with what they view as an emergency, have legal and ethical obligations to expeditiously provide and continue necessary medical care.<sup>113</sup> Further, they may provide the care with an understanding that the person is Medicaid eligible, but then must confront whether government officials will agree with their assessment of what constitutes appropriate treatment of an emergency medical condition. State Medicaid programs decide whether the provider of health services will be reimbursed for the health care provided to patients claiming Medicaid eligibility.<sup>114</sup> States, particularly those with significant immigrant populations, face federal rejection of their determinations, subjecting them to loss of federal dollars for reimbursement of Medicaid expenses.<sup>115</sup>

New York is one such state that had to fight for federal reimbursement for medical services rendered to Medicaid eligible patients. After a federal audit, the Federal Center for Medicaid Services challenged determinations made by the state of New York.<sup>116</sup> Because of the audit, New York will not receive millions of dollars in federal reimbursement for Medicaid expenses.<sup>117</sup> More specifically, one chief source of conflict between state and federal governments concerns whether the provision of chemotherapy can be considered emergency care.<sup>118</sup> New York State takes the position that what constitutes an emergency is a factual issue that should be determined by treating doctors who must submit written certifications stating that the treatment provided is for an emergency medical condition.<sup>119</sup> Further, state officials assert that chemotherapy can cure and control cancer and thus, functions as treatment for an emergency medical condition.<sup>120</sup>

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112. See *infra* notes 113-120 and accompanying text.

113. See Barry Furrow, *Forcing Rescue: The Landscape of Health Care Provides Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 43-46 (1993) [hereinafter *The Landscape of Health Care*].

114. Gunnar, *supra* note 43, at 166 (noting that states reimburse the health care services covered by Medicaid).

115. See Sarah Kershaw, *U.S. Rule Limits Emergency Care for Immigrants*, N.Y. TIMES, Sept. 22, 2007, at A1.

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. Kershaw, *supra* note 115, at A1.

### E. Further Adverse Consequences

The conflicts and cases described above demonstrate the negative consequences that result from the failure to define an emergency medical condition in the context of the realities of health care. However, there are additional adverse and detrimental effects that result. For instance, the discourse regarding the term's meaning takes time away from actually responding to medical conditions. Moreover, it puts medical judgment and good medical practice at odds with the applicable legal standard. Consequently, medical providers cannot meet their ethical obligations nor act in accord with the standard required to avoid medical malpractice if the law compels them to engage in the "Russian roulette" approach to treatment by consistently withdrawing treatment until a patient reaches a crisis level or discharging a patient without an appropriate treatment plan.

Hospitals and doctors are obligated to pursue certain courses of action. To illustrate, hospitals must have adequate discharge plans for patients to meet legal and accreditation standards.<sup>121</sup> Physicians have a duty of continuous care and can be liable for patient abandonment or lack of due diligence in caring for a patient.<sup>122</sup> The duty of continued care is not dependent on the patient's ability to pay for the care.<sup>123</sup> Further, the duty of continued care may be breached by premature discharge from a hospital or termination of treatment.<sup>124</sup> Once a physician undertakes treatment, ordinary skill and care is necessary to determine when to discontinue treatment.<sup>125</sup> Thus, it is imperative that physicians maintain the ability to determine the type of care needed by their patients.

As illustrated above, the current healthcare system fails to provide adequate treatment for many patients. This egregious condition of the system is further negatively impacted when noncitizens are added to the equation. For example, limiting health care for noncitizens to emergencies leads to inappropriate and more costly care in addition to the unnecessary escalation of diseases and conditions to dangerous levels. While emergency care is most often provided in hospitals, medical care can be less costly when patients are treated at an earlier stage of an illness or condition in an outpatient setting.<sup>126</sup> In situations

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121. Olga Cotera-Perez-Perez, *Discharge Planning in Acute and Long Term Facilities*, 26 J. LEGAL MED. 85, 85-86 (2005).

122. See *The Landscape of Health Care*, *supra* note 113, at 43-45; Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians*, 45 RUTGERS L. REV. 1, 45 (1992).

123. *The Landscape of Health Care*, *supra* note 113, at 45.

124. *Id.* at 43-45.

125. *Id.* at 55.

126. INST. OF MED., FUTURE OF EMERGENCY CARE: HOSPITAL BASED EMERGENCY CARE AT THE BREAKING POINT 2-3 (Nat'l Acad. of Sciences 2007), available at <http://www.nap.edu/catalog/11621.html>.

where emergency care is unavoidable, a patient is often admitted to the hospital for continuation of acute care. Acute care facilities are designed to provide limited care and therefore seek to transfer patients to other, more appropriate treatment facilities or wards when there is a need for continuation of health care. However, medical providers cannot release patients until they are placed in a setting appropriate to their health care needs.<sup>127</sup> Lack of access to alternative appropriate care leads to inappropriate and more costly continuation of acute care. This results in inefficient use of scarce medical resources and subjects patients to unnecessary health risks in acute care facilities, such as infections.<sup>128</sup> This then results in additional illnesses, with their attendant costs.<sup>129</sup>

#### IV. RESTRICTIONS ON IMMIGRANT ACCESS TO HEALTH CARE UNDERMINE PUBLIC HEALTH GOALS

The public health consequences of the restrictions on noncitizens' health care access raise public health concerns. Contagious disease control is one of the primary concerns of the field of public health.<sup>130</sup> However, this objective is undermined when restrictions on access limit immunization, prevent early detection and diagnosis, and impede the control of contagion through appropriate isolation and quarantine.<sup>131</sup> Restrictions on health care access for noncitizens also undermine the essential public health goals of diminishing infant mortality and morbidity, promoting child health, and effectively managing chronic disease.

##### *A. Restrictions on Alien Eligibility for Health Care Undermine Contagious Disease Control*

Federal law allows public health programs to immunize and treat immigrants for contagious diseases.<sup>132</sup> However, because the federal programs are limited in scope, many individuals must rely instead on immunization through private and not-for-profit providers that rely on public and private health insurance.<sup>133</sup> If noncitizens are precluded from

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127. *The Landscape of Health Care*, *supra* note 113, at 43-44.

128. *See infra* note 96.

129. *See* INST. OF MED., A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE (Nat'l Acad. of Sciences 2003), *available at* <http://books.nap.edu/openbook/0309087260/html/index.html> [hereinafter A SHARED DESTINY]. *See also* INST. OF MED., CARE WITHOUT COVERAGE TOO LITTLE, TOO LATE (Nat'l Acad. of Sciences 2002), *available at* <http://www.nap.edu/books/0309083435/html/>.

130. *See infra* note 128.

131. *See infra* notes 132-174.

132. *See* 8 U.S.C.A. § 1611(b)(A)(C) (2000). *See also* Mee Moua et al., *Immigrant Health: Legal Tools/Legal Barriers*, 30 J.L. MED. & ETHICS 189, 192 (2002).

133. *See The Politics of Health Law*, *supra* note 2. *See also* Costich, *supra* note 16.

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that insurance, their access to care is limited. Additionally, symptoms of contagious disease often go undetected until the individual is tested and diagnosed through a medical care provider.

### 1. Restrictions Undermine Prevention Through Immunization

The need of the United States to maintain high immunization rates creates a public health concern.<sup>134</sup> The infectious agents of vaccine or toxoid-preventable diseases have not yet been eradicated. Thus, any decline in immunization rates can be expected to increase the risk of new outbreaks of these diseases, resulting in an increase in unnecessary disability and deaths.

Health care access, particularly for children, is important in keeping immunization rates high because children are particularly vulnerable to diseases such as measles, mumps, and diphtheria.<sup>135</sup> Further, they frequently interact with other children in playgrounds and schools. While providing programs which focus exclusively on immunization may be helpful to some, a well child program provided through routine health care access is most important to assuring that children receive recommended vaccinations over time, thereby protecting not only their health but the public's health as well.<sup>136</sup> Immunization for children depends on the ability of their parents or other caretakers to obtain health care, but the restrictions on health care access lead to confusion and fear in immigrant communities, discouraging parents from obtaining needed health care for their children.<sup>137</sup>

Although immunization for children is of the utmost importance, the immigrant population as a whole is in dire need of immunization. Immunization of adults is also a high priority because many immigrants come from countries in which they were not immunized.<sup>138</sup> Adults need access to health care to be assessed for and provided with necessary immunizations. Further, immunization for women in childbearing years is critical; not only for their health, but also for the health of the children they bear.<sup>139</sup> If the system is structured to address the immunization needs of immigrants thereby protecting those individuals from contagious diseases, then the risk to the general population of becoming infected is minimized.

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134. See HEALTHY PEOPLE 2010, IMMUNIZATION AND INFECTIOUS DISEASES, *available at* <http://www.healthypeople.gov/Document/HTML/Volume1/14Immunization.htm>.

135. See *id.*

136. See, e.g., AMERICAN ACAD. OF PEDIATRICS, CATCH-UP IMMUNIZATION SCHEDULE (2008), *available at* [http://www.idph.state.il.us/about/2008\\_catch-up\\_schedule.pdf](http://www.idph.state.il.us/about/2008_catch-up_schedule.pdf).

137. Shari B. Fallick, *Health Care for Illegal Aliens: Why It Is a Necessity*, 19 HOUS. J. INT'L L. 951, 969-80 (1997) (pointing out that scaring immigrants away from receiving medical care only exacerbates the health problems for all).

138. *Id.* at 970.

139. See *id.* at 969-72.

Vaccinations for influenza are important to addressing public health concerns, because influenza epidemics occur almost annually.<sup>140</sup> During severe outbreaks, influenza has been associated with thousands of deaths in the United States.<sup>141</sup> The vaccine available is not always effective—it might not have a similarity to the influenza strain that attacks the public.<sup>142</sup> However, the vaccine is still the most effective means to diminish the disease and protect the public health.<sup>143</sup> The Centers for Disease Control (“CDC”) estimates that a moderately severe influenza pandemic could cause between 89,000 and 207,000 deaths and cost \$71 to \$166 billion.<sup>144</sup> Thus, access to vaccination for influenza for individuals is important for the health of the public.

## 2. Restrictions Undermine Efforts to Prevent Spread of Disease Through Early Detection and Diagnosis

Another important element of communicable disease control is the early detection and treatment of contagious diseases, such as SARS, TB, influenza, hepatitis, and venereal disease. For such diseases, access to primary care is essential to contain the risk of contagion for the larger community. These diseases may be asymptomatic and can only be detected through primary care screenings, particularly sexually transmitted diseases.<sup>145</sup> Moreover, contagious diseases may have common symptoms that require careful medical screening to assess.<sup>146</sup> Influenza is an example. Influenza, or the “flu”, is transmitted by respiratory secretions, direct contact, and contact with infected surfaces and objects.<sup>147</sup> Its symptoms and severity vary; they can be non-specific and include fever, chills, cough, and headache.<sup>148</sup> The challenge to those in public health is that the “flu” may be minor or it may be caused by a new respiratory pathogen that can

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140. AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE, EXPERT GUIDE TO INFECTIOUS DISEASES 424 (James S. Tan et al. eds., American College of Physicians Press 2d ed. 2008).

141. *Id.*

142. *Id.* at 424.

143. *Id.*

144. U.S. DEP’T OF HEALTH & HUMAN SERVS., PROGRESS REVIEW, IMMUNIZATION AND INFECTIOUS DISEASES (2007), <http://www.healthypeople.gov/Data/2010prog/focus14/>.

145. CTR. FOR DISEASE CONTROL, HIV PREVENTION THROUGH EARLY DETECTION AND TREATMENT OF OTHER SEXUALLY TRANSMITTED DISEASES 17-20 (1998), <http://www.cdc.gov/mmwr/PDF/rr/rr4712.pdf>.

146. CTR. FOR DISEASE CONTROL, INFLUENZA SYMPTOMS, <http://www.cdc.gov/flu/symptoms.htm> (last visited Apr. 12, 2008).

147. AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE, *supra* note 140, at 423.

148. *Id.* at 418.

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lead to an epidemic if not detected and controlled.<sup>149</sup> With proper primary care, these diseases can be treated during their early stages, thereby reducing, containing, and eliminating their risks.

### 3. Restrictions on Noncitizen Access to Health Care Particularly Undermine the Effort to Limit and Control TB, Especially Drug-Resistant Strains

TB is a serious, worldwide contagious disease.<sup>150</sup> TB has the potential to do great harm as it is spread from person to person through the air.<sup>151</sup> Once an individual is infected, the disease usually affects the lungs but also can affect other parts of the body.<sup>152</sup> It is a serious condition that can lead to death, but can be controlled with proper diagnosis and treatment.<sup>153</sup> Persons who become infected can have a latent or an active condition.<sup>154</sup>

Control of TB necessitates screening. Screening is especially important for at-risk groups, which include foreign-born persons. Treatment of latent TB is recommended to decrease the risk of the development of active TB.<sup>155</sup> However, active TB can also be treated.<sup>156</sup> A fully administered drug treatment results in cure rates of 95%, but because treatment is specific and sometimes lengthy, it must be supervised and facilitated by a healthcare worker.<sup>157</sup> While TB has been on the decline in the United States, it continues to increase in foreign-born persons.<sup>158</sup> In the United States in 2006, the number of TB cases among foreign-born persons increased. The TB rate in foreign-born persons in the United States in 2006 was 9.5 times greater than that of native-born

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149. CTR. FOR DISEASE CONTROL, TYPES OF INFLUENZA VIRUSES, <http://www.cdc.gov/flu/about/viruses/types.htm> (last visited Apr. 12, 2008).

150. INST. OF MED., ENDING NEGLECT: THE ELIMINATION OF TUBERCULOSIS IN THE UNITED STATES 1 (Lawrence Geiter ed., Nat'l Acad. Press 2000), *available at* <http://www.nap.edu/catalog/9837.html> [hereinafter THE ELIMINATION OF TUBERCULOSIS].

151. *Id.* at 15.

152. *Id.*

153. CTR. FOR DISEASE CONTROL, MULTIDRUG-RESISTANT TUBERCULOSIS (2007), <http://www.cdc.gov/tb/pubs/tbfactsheets/mdrtb.htm> [hereinafter MULTIDRUG-RESISTANT TUBERCULOSIS].

154. *See id.* at 14.

155. CTR. FOR DISEASE CONTROL, THE DIFFERENCE BETWEEN LATENT TB INFECTION AND ACTIVE TB DISEASE (2007), <http://www.cdc.gov/tb/pubs/tbfactsheets/LTBlandActiveTB.htm> (last visited Apr. 13, 2008) [hereinafter THE DIFFERENCE BETWEEN LATENT TB INFECTION AND ACTIVE TB DISEASE].

156. *Id.*

157. CTR. FOR DISEASE CONTROL, THE TREATMENT OF TUBERCULOSIS, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm> (last visited Apr. 12, 2008).

158. Francesca M. Gany et al., *Drive-by Readings: A Creative Strategy for Tuberculosis Control Among Immigrants*, 95 AM. J. OF PUB. HEALTH 117, 117 (2005).

persons.<sup>159</sup> These numbers illustrate that it is crucial for noncitizens to have access to screening.

Elimination of TB is an important public health goal.<sup>160</sup> In the 1960's and 1970's, declining TB rates in the United States led to a dismantling of prevention and treatment programs.<sup>161</sup> The consequence was increased TB infection rates with drug-resistant strains emerging.<sup>162</sup> It was estimated that the monetary costs of losing control of TB exceeded one billion dollars in New York City alone.<sup>163</sup>

Of particular current concern is the control of multidrug-resistant and extensively drug-resistant TB,<sup>164</sup> which are significantly more difficult to treat. Others can become infected by breathing in the air containing these TB germs.<sup>165</sup> Multidrug-resistant TB disproportionately affects foreign born persons. They accounted for 81.5% of these cases in 2005.<sup>166</sup> From 2000-2006, 73% of the extensively drug-resistant TB cases occurred in foreign-born persons.<sup>167</sup>

Control of multidrug-resistant TB first requires appropriate testing and screening. The treatment of the disease requires appropriate medication and monitoring to assure that the therapy is completed.<sup>168</sup> Access to health care for prevention, screening, early diagnoses, and treatment are necessary to prevent the increase of drug-resistant TB and the associated costs. Drug-resistant TB also occurs in patients with active TB who are initially treated with medication, but do not get their full course of treatment.<sup>169</sup> When drug-resistant TB develops, the treatment required is much more extensive and expensive. Treatment for multidrug-resistant TB requires a minimum of eighteen to twenty-

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159. CTR. FOR DISEASE CONTROL, TRENDS IN TUBERCULOSIS INCIDENCE—UNITED STATES, 2007, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5611a2.htm> [hereinafter TRENDS IN TUBERCULOSIS INCIDENCE].

160. See THE ELIMINATION OF TUBERCULOSIS, *supra* note 150.

161. *Id.*

162. *Id.*

163. See *id.*

164. MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 153; CTR. FOR DISEASE CONTROL, EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS (2007), <http://www.cdc.gov/tb/pubs/tbfactsheets/xdrtb.htm> [hereinafter EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS].

165. MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 153; EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS, *supra* note 164.

166. TRENDS IN TUBERCULOSIS INCIDENCE, *supra* note 159.

167. *Drug Resistant TB: CDC's Public Health Response Before the Subcomm. on Africa and Global Health of the H.R. Comm. on Foreign Affairs*, 110th Cong. 2 (2008) (testimony of Julie L. Gerberding, Dir., Ctr. for Disease Control), available at <http://foreignaffairs.house.gov/110/ger022708.htm> [hereinafter Gerberding Testimony].

168. MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 153.

169. *Id.*

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four months; in-patient costs for someone with extensively drug-resistant TB can be \$600,000.<sup>170</sup>

Providing health care access to noncitizens is therefore important in meeting the public health goal of controlling and hopefully eliminating this disease. While treatment programs are targeted to help treat and curtail the spread of TB, general health care access is essential. As with many diseases, TB presents with common symptoms such as a cough and fatigue at the early stages when it is easiest to treat and contagion can be best controlled.<sup>171</sup>

#### 4. Restrictions Undermine the Ability to Control Contagion Through Appropriate Isolation and Quarantine

The CDC has recognized that controlling contagion through isolation and quarantine ultimately depends on the cooperation of those who are infected.<sup>172</sup> However, the lack of health care access and the immigration consequences of seeking medical care are significant barriers to access. A recent case involving an Atlanta teen illustrates this concept. In this instance, the local public health authorities discovered that a young Mexican immigrant had a variation of drug-resistant TB.<sup>173</sup> Instead of treating the young man and his family and friends in an appropriate outpatient or inpatient setting, the authorities incarcerated him and contacted the immigration authorities.<sup>174</sup> These actions undermined cooperation by the terrified young man and his family. Instead of promoting the public health by eliciting cooperation, threats of incarceration and deportation undermine it. There can be no realistic expectation that a noncitizen will come forward for a diagnosis and cooperate in the treatment of a serious contagious disease when the consequences of coming forward are being jailed and reported to immigration authorities.

#### 5. Exclusion of Some Noncitizens from Health Care Programs Limits the Ability of the Government and the Healthcare System to Respond to Public Health Emergencies

There is a public health concern about the potential of widespread pandemic in addition to concerns about contagious disease control for individuals and

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170. Gerberding Testimony, *supra* note 167.

171. THE DIFFERENCE BETWEEN LATENT TB INFECTION AND ACTIVE TB DISEASE, *supra* note 155; MULTIDRUG-RESISTANT TUBERCULOSIS, *supra* note 153; EXTENSIVELY DRUG-RESISTANT TUBERCULOSIS, *supra* note 164.

172. See, e.g., Ctr. for Disease Control, *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities*, 1994, 43 No. RR-13 AND MORBIDITY AND MORTALITY WEEKLY REPORT 1, 28 (Oct. 28, 1994).

173. Craig Schneider & Jim Galloway, *Teen Jailed in Gwinnet in Another Case of TB*, ATLANTA JOURNAL-CONSTITUTION, Aug. 26, 2007, at J1, available at [http://www.ajc.com/metro/content/metro/atlanta/stories/2007/08/26/tbcase\\_0826.html](http://www.ajc.com/metro/content/metro/atlanta/stories/2007/08/26/tbcase_0826.html).

174. *Id.*



population pockets. For example, many are concerned about a potential flu pandemic.<sup>175</sup> A potential flu pandemic and other public health emergencies raise concerns about whether the American healthcare system is prepared for public health emergencies.<sup>176</sup> Healthcare systems that provide access to early screening and diagnosis for potential public health threats are essential for effective management of an emergency.<sup>177</sup>

The potential for pandemic is illustrated by SARS, a highly contagious new strain of viral pneumonia for which there is no vaccine.<sup>178</sup> Its symptoms are common such as fever and fatigue.<sup>179</sup> Preventing a disease like SARS from becoming a pandemic depends on individuals' access to health care for early diagnosis and treatment.<sup>180</sup> SARS, like other highly contagious diseases, is controlled by rapid detection, contact investigation, and quarantine.<sup>181</sup> An adequate response to a public health emergency, especially a pandemic, requires immediate health care access for the affected population as a whole, but particularly for vulnerable populations. Access not only protects particular populations but prevents spread of contagion to the larger population.<sup>182</sup> If a noncitizen population is denied health care access, rapid detection and control of a highly contagious disease will be undermined.

*B. Restrictions on Alien Eligibility for Health Care Undermine  
Diminishment of Infant and Mother Mortality and Morbidity*

Improving the health of women and children is an important public health objective as indicated by its inclusion in the HHS's Healthy People 2010 goals, a set of health objectives for the nation.<sup>183</sup> Medicaid coverage

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175. COUNCIL OF STATE GOVERNMENTS, THE COUNCIL OF STATE GOVERNMENTS RESOLUTION OF PANDEMIC FLU PREPAREDNESS 2006, <http://www.csg.org/policy/documents/ResolutiononPandemicFluPreparedness.pdf>.

176. See Eleanor D. Kinney, *Can the Medicare, Medicaid, and SCHIP Programs Meet the Challenges of Public Health Emergencies?*, 58 ADMIN. L. REV. 559, 567-69 (2006) (noting that while the sources generating natural disasters, catastrophic accidents, terrorist attacks, and epidemics differentiate the types of events, they all may cause disease and injury and therefore must be addressed as public health emergencies).

177. See generally Sara Rosenbaum et al., *Public Health Emergencies and the Public Health/Managed Care Challenge*, 30 J.L. MED. & ETHICS 63 (2002) (discussing tension between public health goals in the face of public health emergencies and fiscal constraints of insurance structure).

178. AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE, *supra* note 140, at 427, 430.

179. *Id.* at 428.

180. *Id.* at 427-30.

181. *Id.* at 428.

182. See *id.* at 427.

183. HEALTHY PEOPLE 2010, MATERNAL, INFANT AND CHILD HEALTH, available at <http://www.healthypeople.gov/document/html/volume2/16mich.htm>.

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of pregnant women was expanded to meet the public health goal of promoting better birth outcomes.<sup>184</sup> The provision of prenatal health care is also economically sensible—money spent on relatively inexpensive prenatal care prevents much more expensive neonatal care.<sup>185</sup> The receipt of adequate prenatal care thus contains health care costs by preventing conditions that require expensive treatment. Prenatal care can also reduce the costs for future medical care, special schooling, and social services by ensuring that infants are healthy.

Women comprise 55% of the legal permanent residents entering the United States and an increasing number of those labeled as unauthorized.<sup>186</sup> Moreover, female immigrants tend to be young adults and thus of child-bearing age.<sup>187</sup> The foreign-born population is 49.7% female, and among foreign-born females ages fifteen to fifty, 7.1% gave birth between 2005 and 2006.<sup>188</sup> Therefore, women's health, and particularly pregnancy-related health, is important.<sup>189</sup> The children born to noncitizens in the United States are United States citizens under the Fourteenth Amendment to the U.S. Constitution.<sup>190</sup> Thus, denial of prenatal health care to noncitizens has serious negative consequences for their citizen children.<sup>191</sup>

A study reported in the *American Journal of Obstetrics and Gynecology* demonstrated the cost effectiveness of prenatal health care for undocumented women.<sup>192</sup> It found that without prenatal healthcare, undocumented women were four times more likely to have low birth weight babies and seven times more likely to have premature babies.<sup>193</sup>

184. U.S. GEN. ACCOUNTING OFFICE, *PRENATAL CARE: EARLY SUCCESS IN ENROLLING WOMEN MADE ELIGIBLE BY MEDICAID EXPANSIONS 7* (1991), available at <http://archive.gao.gov/d21t9/143346.pdf>.

185. Michael C. Lu et al., *Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A Cost/Benefit Analysis*, 182 AM. J. OBSTETRICS & GYNECOLOGY 233, 237 (Jan. 2000).

186. See DEPT. OF HOMELAND SECURITY, *YEARBOOK OF IMMIGRATION STATISTICS—2006*, <http://www.dhs.gov/ximgtn/statistics/publications/LPR06.shtm>.

187. MIGRATION POLICY INST., *FACT SHEET ON THE FOREIGN BORN DEMOGRAPHIC & SOCIAL CHARACTERISTICS*, <http://www.migrationinformation.org/DataHub/acscensus.cfm> (last visited Feb. 8, 2008) (selecting any state will produce that state's data as well as national statistics for comparison).

188. *Id.*

189. See generally Janet M. Calvo, *Health Care Access for Immigrant Women*, in *MAN-MADE MEDICINE, WOMEN'S HEALTH, PUBLIC POLICY, AND REFORM* 161 (Kary L. Moss ed., Duke Univ. Press 1996).

190. See U.S. CONST. amend. XIV, § 1.

191. NAT'L CONFERENCE OF STATE LEGISLATURE, *FUNDING PRENATAL CARE FOR UNAUTHORIZED IMMIGRANTS*, <http://ncsl.org/programs/immig/prenatal.htm> (last visited Apr. 12, 2008).

192. See generally Lu et al., *supra* note 185.

193. *Id.* at 237.

Further, for each dollar spent on prenatal care, three dollars were saved in the short term and four dollars for longer term costs of medical care.<sup>194</sup>

However, provision of pre-natal health care is not covered by Medicaid for an unqualified alien.<sup>195</sup> It is also not available to legal permanent residents for five years from entry into the United States.<sup>196</sup> The Second Circuit held that Medicaid coverage for pre-natal health care of noncitizen women, whose unborn children will be citizens, may be properly denied under the Constitution.<sup>197</sup>

In spite of this court holding, a controversial interpretation of SCHIP allows the provision of health care to pertain to “a child from the time of conception,” thereby allowing certain limited care to be provided to the woman carrying the fetus regardless of the mother’s citizenship status.<sup>198</sup> Some states have implemented this interpretation, but many others have not.<sup>199</sup> Some advocates and commentators viewed this interpretation as limiting reproductive health choices by imposing legal recognition of fetuses.<sup>200</sup> Other scholars have expressed concern about the ethical and practical problems with providing pre-natal but not post-partum care, thus undermining the health of the mother and the infant.<sup>201</sup>

HHS provides funding to local health departments to provide prenatal services, for which non-qualified aliens are eligible.<sup>202</sup> However, because of the Medicaid eligibility restrictions on non-qualified aliens, there are uncompensated costs which impose a strain on state and local governments.<sup>203</sup> The public health goal of providing prenatal health care to promote infant health and save neonatal costs is thus undermined by the lack of consistent prenatal health care for noncitizen pregnant women.

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194. *Id.*

195. Cindy Chang, *Health Care for Undocumented Immigrant Children: Special Members of an Underclass*, 83 WASH. U. L.Q. 1271, 1274 (2005) (noting that unqualified individuals are ineligible for all non-emergency public benefits).

196. 8 U.S.C. § 1613 (2000).

197. *Lewis v. Thompson*, 252 F.3d 567, 591 (2d Cir. 2001).

198. 42 C.F. R. § 457.10 (2006). *See* State Children’s Health Insurance Program: Eligibility for Prenatal Care and Other Health Services for Unborn Children, 67 Fed. Reg. 61,955 (2002) (to be codified at 42 C.F.R. pt. 457).

199. *See generally* Aguilar, *supra* note 38.

200. *See generally* Fentiman, *supra* note 20.

201. *Id.* at 561-62.

202. Michelle Weinberg et al., *Migration Law and the Public’s Health*, 33 J.L. MED. & ETHICS 109, 110 (2005).

203. *Id.*

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*C. Restrictions on Alien Eligibility for Health Care Undermine Healthy Child Care*

Another important indicator of public health is the health of children. Health care provided to children is often focused on preventative care, assuring the health of children at a cost much less than the consequences of childhood illness. Further, another consequence of denying primary and preventive child care is the limitations on the social and economic contributions these children may make in the future.<sup>204</sup>

Uninsured children have less access to health care and are less likely to have a regular source of primary care.<sup>205</sup> They are less likely to have received medical care for common childhood diseases such as ear infection and asthma.<sup>206</sup> Uninsured children often receive no care or late care.<sup>207</sup> Moreover, children are at higher risk for (1) hospitalization for conditions that should be treated in an outpatient setting and (2) missed diagnosis of serious conditions.<sup>208</sup> Conditions such as asthma, anemia, and otitis media can be prevented or cured, but if not addressed, affect a child's life-long functioning.<sup>209</sup> Immigrant children have a high risk of being uninsured and face additional barriers to appropriate health care.<sup>210</sup> Uninsured citizen children of immigrants are less likely to see a doctor.<sup>211</sup>

Medicaid and SCHIP programs increased access to health care for children in recognition of the important public health objective of improving the health of children.<sup>212</sup> However, the programs restrict the eligibility of children who are legal permanent residents for five years from date of their entry. Five years is a particularly long time for children, because the limitations deny health care during crucial developmental phases.<sup>213</sup> Further, other children who are not considered "qualified" are denied health care access. Medicaid coverage makes a difference in health care access. Forty-three percent of uninsured immigrant children had not seen a doctor in a year, while only 16% of those with Medicaid had not.<sup>214</sup>

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204. See generally Chang, *supra* note 195.

205. INST. OF MED., HEALTH INSURANCE IS A FAMILY MATTER 111 (Nat'l Acad. Press 2002) [hereinafter HEALTH INSURANCE IS A FAMILY MATTER].

206. *Id.* at 112.

207. *Id.*

208. *Id.* at 2.

209. *Id.*

210. HEALTH INSURANCE IS A FAMILY MATTER, *supra* note 205, at 118.

211. *Id.*

212. *Id.* at Appendix B, 155-56.

213. *Id.* at 118 (noting that adolescents encounter new and challenging health care needs).

214. *Id.*

*D. Restrictions on Noncitizens' Health Care Access Limit the Ability to Coordinate Chronic Disease Care*

Lack of medical care access for immigrants makes chronic disease care more difficult and costly due to delayed detection and treatment or inappropriate treatment. This is of particular concern with regard to common chronic diseases such as diabetes, asthma, and heart disease. The lack of access to primary or preventive care means that certain diseases or conditions will go undetected and untreated until they have advanced to more serious stages.<sup>215</sup> The cost of treating the disease or condition will almost invariably be much higher than treating the disease or condition at an earlier, more appropriate state.<sup>216</sup>

According to one study, lack of health care access may lead to decreased use of health care services for diabetes management, asthma control, reduction of cardiovascular disease risk, and cancer prevention.<sup>217</sup> Appropriate medicine and health promoting practices obtained through primary health care can help avoid painful and harsh consequences of disease.<sup>218</sup>

Unnecessary hospitalizations for chronic conditions come at a high price by imposing unnecessary costs and inefficiently utilizing scarce medical care resources. The price of maintaining patients in acute hospitals is considerably higher than the cost of more appropriate lower levels of and approaches to care.<sup>219</sup> The community pays these costs through increased tax dollars, hospital bills, or health insurance rates.<sup>220</sup> Moreover, inappropriate hospitalization may subject patients to unnecessary health risks, and may therefore create additional illnesses that will cost more to treat.

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215. INST. OF MED., *INSURING AMERICA'S HEALTH* 42-43 (Nat'l Acad. Press 2004) [hereinafter *INSURING AMERICA'S HEALTH*].

216. See, e.g., *id.* at 43.

217. See generally Jack Hadley, *Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income* 60 No. 2 Supp. Med. Care Res. & Rev. 3S (2003).

218. See Amy L. Fairchild & Ava Alkon, *Back to the Future? Diabetes, HIV, and the Boundaries of Public Health*, 32 J. HEALTH POL. POL'Y & L. 561 (2007).

219. ALLISON RUSSO ET AL., *HEALTHCARE COST AND UTILIZATION PROJECT*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *TRENDS IN POTENTIALLY PREVENTABLE HOSPITALIZATIONS AMONG ADULTS AND CHILDREN, 1997-2004* (2007), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb36.pdf>.

220. See A SHARED DESTINY, *supra* note 129, at 121-22 (discussing the economic and social implications of uninsurance within communities).

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V. RESTRICTIONS ON IMMIGRANT ACCESS TO HEALTH CARE LIMIT  
HEALTH CARE ACCESS OF ELIGIBLE CITIZENS AND IMMIGRANTS*A. Denial of Health Care to Noncitizen Family Members Undermines the  
Health of Citizen and Legal Immigrant Family Members*

Immigrants are integrated in society even down to the level of the nuclear family. It is not uncommon for a grandparent, a spouse, or a sibling in a family to be a noncitizen while the other family members are citizens. An analysis of the noncitizen population specifically looked at families and children associated with the “unauthorized” population. The study reported that 6.6 million families included a head of the household or spouse who was “unauthorized” and labeled these families as “unauthorized families.”<sup>221</sup> Thirty percent of these families had United States citizen children (1.96 million families).<sup>222</sup> The study labeled these families as “mixed status” families, which encompassed five out of six “unauthorized” families with children.<sup>223</sup> Twenty-three percent (1.5 million families) had only citizen children, while seven percent included citizen and unauthorized children (460,000 families).<sup>224</sup> A total of 3.1 million citizen children lived in families in which the head of household or spouse was “unauthorized.”<sup>225</sup>

Limitations on health care access to the noncitizen family members have a direct negative effect on the citizen family members. Their health is undermined if the health of a close family member is threatened. The citizen children of immigrants are particularly at risk for illness if their parents do not receive proper health care.<sup>226</sup>

Moreover, fears about contact with authorities deter noncitizens from obtaining health care for themselves or for their citizen relatives. This fear is rooted in two concerns. First, immigrants frequently fear that contact with any authority will increase the risk of being reported to immigration authorities, who can force removal from the country.<sup>227</sup> Second, immigrants often believe that obtaining medical care may undermine their ability to qualify for permanent resident status or naturalization.<sup>228</sup>

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221. JEFFREY S. PASSEL, PEW HISPANIC CTR., THE SIZE AND CHARACTERISTICS OF THE UNAUTHORIZED MIGRANT POPULATION IN THE U.S. BASED ON THE MARCH 2005 CURRENT POPULATION SURVEY 7 (Mar. 7, 2006), <http://pewhispanic.org/files/reports/61.pdf>.

222. *Id.* at 7-8.

223. *Id.* at 8.

224. *Id.*

225. *Id.*

226. INSURING AMERICA’S HEALTH, *supra* note 215.

227. Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 468-69 (2007).

228. *Id.*

*B. Documentation Requirements to Limit Alien Eligibility Result in Denials of Needed Care to Eligible Citizens*

Even individual citizens unrelated to immigrants are hurt by eligibility restrictions based on alien status. If citizenship is an eligibility criterion, then citizens can be required to prove their status and demonstrate that they are not ineligible aliens. Recent changes in Medicaid eligibility require that citizens produce certain documents to prove both their citizenship and their identity.<sup>229</sup> This legislation was purportedly for the purpose of preventing undocumented immigrants from obtaining Medicaid.<sup>230</sup> However, those most harmed by the rule are eligible citizens, particularly citizen children.<sup>231</sup>

Under the Deficit Reduction Act, individuals who claim U.S. citizenship, but are unable to produce acceptable documentation of both their citizenship and their identity, are denied Medicaid benefits.<sup>232</sup> Citizenship documentation to prove citizenship includes passports and birth certificates, while identity documents include driver's licenses, school identification cards, and other special documents.<sup>233</sup> Congress enacted the law with the objective of preventing noncitizens from making false claims of citizenship.<sup>234</sup> However, there was no empirical support for the proposition that individuals were making false claims of citizenship to gain Medicaid eligibility.<sup>235</sup> Many citizens, particularly those poor enough to qualify for Medicaid, do not have or have difficulty obtaining the requisite documentation.<sup>236</sup>

The act exempted children in foster care, individuals enrolled in Medicare, and individuals who receive Supplemental Security Income ("SSI") or Social Security Disability from the proof of citizenship requirements.<sup>237</sup> Yet, this still left large numbers of Medicaid-eligible citizens with a proof requirement they could not meet. As a consequence, citizens face difficulties and delays in obtaining health care for themselves and their children, health care providers confront an increase in uncompensated care, and states bear the financial and administrative burden of determining citizenship status.<sup>238</sup>

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229. Jacob Press, *Poor Law: The Deficit Reduction Act's Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. PA. J. CONST. L 1033, 1037 (2006).

230. *Id.* at 1039-41.

231. DONNA COHEN ROSS, CTR. ON BUDGET & POL. PRIORITIES, MEDICAID DOCUMENTATION REQUIREMENT DISPROPORTIONATELY HARMS NON-HISPANICS, NEW STATE DATA SHOW 1 (July 10, 2007), <http://www.cbpp.org/7-10-07health.htm>.

232. Deficit Reduction Act of 2005, § 6036 amending 42 U.S.C. § 1396b.

233. Ross, *supra* note 231, at 1.

234. *Medicaid Citizenship Guidelines Revised*, 17 No. 1 Healthcare Registration 7 (Oct. 2007).

235. *See id.*

236. *Id.*

237. *Id.*

238. *Id.*

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## VI. RESTRICTIONS ON IMMIGRANT ACCESS TO HEALTH CARE UNDERMINE THE FUNCTIONING OF HEALTHCARE SYSTEM AS A WHOLE

### *A. Determining Eligible Statuses Involves Complicated Analysis that is Inappropriate for Healthcare Personnel and Diverts Resources from Provision of Service*

The process of determining immigration status is complicated. Labeling noncitizens as legal or illegal or undocumented does not accurately reflect the complex realities of immigration status, and the determinations that immigration authorities make that allow noncitizens to reside and work in the United States. Understanding those realities involves a sophisticated knowledge of immigration law and policy. This level of immigration expertise should not be expected from healthcare providers or administrators. Moreover, determining eligibility on the basis of immigration status requires time and resources that are better spent by healthcare professionals in providing care.

The intricacies of immigration status are reflected in the categories of “qualified” aliens currently recognized as eligible for Medicaid and in the prior eligibility criterion of permanently residing under color of law. “Qualified” alien includes persons in classifications that only an individual well versed in immigration law would recognize, including asylee, refugee, parolee, conditional entrant, Cuban/Haitian entrant, and those granted withholding of removal.<sup>239</sup> HHS previously classified numerous categories of aliens as “permanently residing under color of law,” an understanding of which also required an in depth knowledge of immigration law and policy. For example, some of the categories of immigrants permanently residing under color of law included: aliens with indefinite stays of deportations or indefinite voluntary departure; aliens for whom immediate relative petitions had been approved and families covered by those petitions; and aliens who had filed applications for adjustments of status, registry-eligible aliens, and aliens granted suspension of deportation, etc.<sup>240</sup>

Further, when eligibility rules involve immigration status, even supposed experts have difficulty making the correct determinations. As a result, health agencies and other entities have difficulty setting up systems to effectuate accurate determinations. Demonstrating this difficulty, New York City and State were found by a federal court to have erroneously denied access to a class of immigrant applicants entitled to Medicaid.<sup>241</sup>

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239. 8 U.S.C. § 1641(b) (2006).

240. Medicaid Program: Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36,813, 36,819-36,820 (Sept. 7, 1990) (to be codified at 42 C.F.R. pts. 435, 436, and 440).

241. See *M.K.B. v. Eggleston*, 445 F. Supp. 2d 400, 435-36 (S.D.N.Y. 2006).



The class included persons in deep need of health care, abused spouses, and children.<sup>242</sup> While the court determined that the city did not intentionally deny benefits to this population, it nonetheless granted a preliminary injunction.<sup>243</sup> The court concluded that the defendants denied benefits because the employees making determinations did not understand the eligibility rules or know which documents were necessary for verification of status.<sup>244</sup> The court found that the training materials and manuals were inadequate, the computer system did not contain the necessary fields, and the notices of determination did not explain the eligibility of individual members of households whose members were in different immigration classifications.<sup>245</sup> The state, the city, not-for-profit organizations, and the court devoted significant time and resources to assure accurate eligibility determinations. Those resources would have been better spent providing health care access for abused children and spouses in general, thus addressing domestic violence, a major public health concern.

*B. Restrictions on Noncitizen Health Care Access Shift Costs to Local Government and Not-For-Profit Entities That Have No Expertise in or Control Over Immigration Policy From the Federal Government*

The economic benefits of immigration generally flow to the federal government, but the costs of new and increased populations are often absorbed by states and localities as they are primarily responsible for their residents' health and welfare. Federal law and practice inhibit states' ability to obtain federal financial contributions for immigrant health care through Medicaid and SCHIP.<sup>246</sup> The controversies about the definition of emergency care described above illustrate this idea; promised federal funds for state Medicaid programs have been revoked because the federal authorities disagreed with the states on the definition of an emergency medical condition.<sup>247</sup>

State and federal governments have clashed over health care access for noncitizens. On a policy level, states and localities can argue that health care for noncitizens is ultimately a federal responsibility because the federal government can decide which noncitizens can enter and stay in the country. Within the current Medicaid system, states contend that the federal government should pay a share of healthcare costs for noncitizens and should not impede state and local public health

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242. *Id.*

243. *Id.* at 443.

244. *Id.* at 434.

245. *Id.* at 434-37.

246. See Weinberg et al., *supra* note 202.

247. HHS Departmental Appeals Board Decision, Appellate Division, No. A-96-118, Dec. No. 1583, June 24, 1996, reported in Medicaid and Medicare Guide (CCH) ¶ 44,505.

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objectives by forcing state and localities to solely bear the expense of providing for noncitizens.<sup>248</sup>

Examples from New York, Texas, and Colorado illustrate some of the conflicts between federal standards and state and local requirements. In New York, for example, an interpretation of federal legislative restrictions on noncitizen eligibility for Medicaid by the Second Circuit resulted in the dissolution of a long-standing injunction in that state, which had protected access to pre-natal health care and required federal funding regardless of the immigration status of pregnant women.<sup>249</sup> At about the same time, the New York Court of Appeals interpreted the state and federal constitutions to require state medical assistance for several categories of noncitizens.<sup>250</sup> The State of New York therefore had an obligation to provide medical care without receiving federal contributions.

In a Texas community, doctors included all residents in a preventive medical program designed to improve public health and limit emergency room costs.<sup>251</sup> The State Attorney General asserted that this program violated federal law because it did not restrict the access of undocumented aliens.<sup>252</sup> Legal scholars, however, asserted that the federal law violated the Tenth Amendment.<sup>253</sup> The doctors argued that restrictions would undermine the public health and fiscal objectives of the program.<sup>254</sup>

The State of Colorado responded to the pressure of state budget restrictions for Medicaid by excluding all immigrants from the Medicaid program, even those allowed to be included by federal law.<sup>255</sup> However, in 2005, the Colorado legislature passed a bill that restored Medicaid eligibility for several categories of immigrants.<sup>256</sup>

Lifting the restrictions based on noncitizen status in the current Medicaid/SCHIP system would relieve states and localities of some burdens and would enable them to obtain federal financial contribution for

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248. JONATHAN BLAZER, NAT'L IMMIGRATION LAW CTR., IMMIGRATION REFORM AND ACCESS TO PUBLIC BENEFITS: AN UNEASY COUPLING 1-2 (2006), [http://www.nilc.org/immlawpolicy/cir/cirandbenefits\\_2006-5-15.pdf](http://www.nilc.org/immlawpolicy/cir/cirandbenefits_2006-5-15.pdf).

249. *Lewis v. Thompson*, 252 F.3d 567, 569 (2d Cir. 2001).

250. *Aliessa ex rel. Fayad v. Novello*, 96 N.Y.2d 418, 436 (N.Y. 2001).

251. *Texas AG Issues Opinion that County Hospitals Not Allowed to Serve "Not Qualified" Immigrants*, IMMIGRANTS' RIGHTS UPDATE (Nat'l Immigration Law Ctr.), Aug. 31, 2001, available at <http://www.nilc.org/immspbs/health/health012.htm>.

252. *Id.*

253. *Id.*

254. *See id.*

255. *Soskin v. Reinertson*, 353 F.3d 1242, 1244 (10th Cir. 2004).

256. *Colorado Legislature Votes to Restore Medicaid Eligibility for Immigrants*, IMMIGRANTS' RIGHTS UPDATE (Nat'l Immigration Law Ctr.), Feb. 10, 2005, available at <http://www.nilc.org/immspbs/health/health032.htm>.

the health services they provide. In the broader context of health care reform, inclusion of noncitizens is necessary to avoid similar federal-state conflicts.

Further, limitations on immigrants' access to health care also make the job of healthcare providers much more difficult. It is very frustrating for people whose life work is to heal and care for the sick to be blocked in affording appropriate and timely health care. Eventually these healthcare providers have to deal with the medical consequences of barriers to access to health care. Because of these barriers, the resulting medical conditions are then much more severe and difficult to treat.

#### VII. DENIAL OF HEALTH CARE TO NONCITIZENS IN THE CONTEXT OF THE DEFICIENCIES IN THE AMERICAN HEALTH CARE SYSTEM

The consequences of the denial of health care access for noncitizens need to be examined in the context of the deficiencies of the overall American healthcare system. The difficulties with the current American healthcare system would continue to exist even if the noncitizen population disappeared. The minority noncitizen population has not caused the system's problems. Yet, the exclusion of the members of this population contributes to and exacerbates the negative public health and health system consequences as described above.

The problems of the American healthcare system are massive. There are significant negative consequences associated with the large number of uninsured and underinsured people.<sup>257</sup> The Institute of Medicine undertook an exhaustive and extensive multi-year, multi-volume study of the consequences of uninsurance in the United States. It concluded that the lack of health insurance for millions of Americans had serious negative consequences and economic costs for the uninsured, their families, the communities in which they live, and the country as a whole.<sup>258</sup> Uninsured children and adults do not receive the care they need and suffer from poor health.<sup>259</sup> One uninsured family member can impose a risk to the health of the whole family.<sup>260</sup> A high uninsured rate can affect the overall health status of a community and undermine its healthcare institutions and providers.<sup>261</sup>

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257. THE COMMONWEALTH FUND, FRAMEWORK FOR A HIGH PERFORMANCE SYSTEM FOR THE UNITED STATES (Aug. 2006), available at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=387153](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=387153).

258. INSURING AMERICA'S HEALTH, *supra* note 215, at 1.

259. *Id.* at 2.

260. *Id.*

261. *Id.*

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As reported by the Institute of Medicine, when people lack health coverage, society's costs are substantial.<sup>262</sup> The uninsured lose their health and die prematurely. Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated. Families lose peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of serious illness or injury. Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in public health programs like communicable disease surveillance. These consequences can affect everyone, and the economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers. Much of the societal cost is in the form of poorer health for the uninsured, because they frequently receive too little care, too late.<sup>263</sup>

The relatively small size of the noncitizen population precludes any notion that difficulties within the American healthcare system are caused by the noncitizen population. The American population in 2005 was almost three hundred million.<sup>264</sup> According to the Congressional Research Service, the census data as of 2005 revealed that the foreign-born comprise 12.4% of the U.S. population.<sup>265</sup> However, 34.7% of the foreign-born population were naturalized citizens.<sup>266</sup> Thus, naturalized citizens comprised 4.3 % of the U.S. population while the total noncitizen population comprised 8.1%,<sup>267</sup> a significant but not overwhelming minority. Further, the majority of the uninsured are citizens. In 2006, U.S. citizens constituted 78% of the non-elderly uninsured while noncitizens were 22%.<sup>268</sup> Additionally, the growth in the number of uninsured from 2000 to 2006 occurred predominately among citizens.<sup>269</sup>

Moreover, regardless of whether they have health insurance, immigrants overall have much lower per capita healthcare expenditures than native-

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262. See generally INST. OF MED., HIDDEN COSTS, VALUE LOST- UNINSURANCE IN AMERICA (Nat'l Acad. of Sciences 2003).

263. *Id.*

264. See PEW HISPANIC CTR., A STATISTICAL PORTRAIT FOR THE FOREIGN-BORN POPULATION AT MID DECADE, (2006) <http://pewhispanic.org/factsheets/factsheet.php?FactsheetID=36> (noting that the American population in 2005 was 288,398,819 people).

265. Wasem Testimony, *supra* note 4.

266. *Id.*

267. A study from the RAND Corporation estimated that undocumented adult immigrants, who make up about 3.2% of the population, account for only about 1.5% of U.S. medical costs. See Dana P. Goldman et al., *Immigrants and the Cost of Medical Care*, 25 HEALTH AFF. 1700, 1709 (Nov./Dec.2006).

268. FIVE BASIC FACTS ON IMMIGRANTS, *supra* note 53.

269. *Id.*

born Americans.<sup>270</sup> Recent analyses indicate that they contribute more to the economy in taxes than they receive in public benefits.<sup>271</sup> Accusations that immigrants use healthcare services for which they are not eligible, or use them more often than the average person, are based on uninformed assumptions that are rarely substantiated.<sup>272</sup> Healthcare expenditures in the United States are lower for immigrants than for native-born residents, and immigrants use less health care services overall than citizens.<sup>273</sup>

Yet, lack of health insurance coverage is a serious issue for noncitizen populations, particularly those with lower incomes who often also have an irregular immigration status. In 2001, 60% of low-income noncitizens did not have health insurance and only 13% received Medicaid.<sup>274</sup> This is in contrast to 28% of low-income citizens who were uninsured and 30% that had Medicaid.<sup>275</sup>

After its exhaustive study, the Institute of Medicine concluded that to achieve the goals of health care access reform, universal coverage is essential.<sup>276</sup> The Institute of Medicine specifically researched and analyzed the issue of inclusion of noncitizens. It concluded that the “analysis of the extensive body of literature concerning access to health services and health outcomes provides no evidence to support the notion that coverage should be limited based on citizenship or immigration status.”<sup>277</sup> Further, the Institute of Medicine found that it is advantageous to provide coverage to immigrants.<sup>278</sup> Overall, the value of providing health coverage across the U.S. population is greater than the additional cost of services to those who lack coverage.<sup>279</sup>

Further, restriction on health care access for noncitizens as a means of immigration control is misguided. Studies indicate that health care is not a major motivating factor in migration decisions. Immigrants come to the United States for family, employment, and to seek refuge from persecution and disaster.<sup>280</sup> The objective of improving public health through expanding access has been undermined by the attempt to regulate

270. Sarita A. Mohanty et al., *Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis*, 95 AM J. PUB. HEALTH 1431, 1431-38 (2005).

271. Susan Okie, *Immigrants and Health Care – At the Intersection of Two Broken Systems*, 357 N. ENGL. J. MED. 525, 526 (Aug. 9, 2007).

272. CAL. IMMIGRANT POL’Y CTR., IMMIGRANTS AND THE U.S. HEALTH CARE SYSTEM (2006), [http://www.nilc.org/immspbs/health/Issue\\_Briefs/imms&ushealthcare\\_2007-01.pdf](http://www.nilc.org/immspbs/health/Issue_Briefs/imms&ushealthcare_2007-01.pdf).

273. *Id.*

274. HENRY J. KAISER FAMILY FOUND., IMMIGRANTS’ HEALTH CARE COVERAGE AND ACCESS (2003), <http://www.kff.org/uninsured/upload/Immigrants-Health-Care-Coverage-and-Access-PDF.pdf>.

275. *Id.*

276. INST. OF MED., CONSEQUENCES OF UNINSURANCE, available at <http://www.iom.edu/uninsured>.

277. INSURING AMERICA’S HEALTH, *supra* note 215, at 112.

278. *Id.* at 112.

279. *Id.* at 3.

280. Fallek, *supra* note 137, at 967-69.

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immigration through restricting access to health programs based on immigration status. There is no indication that the goal of immigration restriction is being met. The public health and health system objectives that are the main focus of Medicaid, SCHIP, and similar programs need to be predominant. Germs, accidents, and disease do not pick their victims based on citizenship status. A community's health depends on the health status of each of its members.

Ultimately, as concluded by the Institute of Medicine, for health reform to be effective, everyone residing in the United States including noncitizens must be included.<sup>281</sup> Yet providing health care for noncitizens particularly the undocumented has been a controversial issue. If the goal of coverage for all those residing in the United States is not politically achievable, then an alternative that at least mitigates the adverse societal consequences should be considered. Any health reform proposal must provide full eligibility for legal permanent residents and other noncitizens permanently residing in the United States under color of law. If the federal government does not pay all or part of the cost of care for these long-term residents, the states and localities will have to bear the fiscal and public health consequences. While coverage for other noncitizens residing in the United States would be best, at the very least, healthcare access must be provided without regard to immigration status for services that have major public health consequences and fiscal implications. These include contagious disease prevention, detection and treatment; pre-natal health care; preventive health care for children; treatment for emergency conditions and outpatient treatment to avoid emergency hospitalization. Further, the full medical course of treatment must be provided in response to an emergent situation or illness to avoid a "Russian roulette" approach to health care.

## VIII. CONCLUSION

The consequences of denying health care access to immigrants are one aspect of the massive challenges posed by the American healthcare system in which a significant segment of the total population is uninsured. Yet, negative consequences are exacerbated when noncitizens are involved and have an impact on the public health of the society as a whole. Providing health care access for noncitizens would promote public health goals and assist in implementing a more rational and cost-effective healthcare system.

Restrictions on health care access are not a viable means to implement immigration policy. Immigration policies are most effectively implemented directly, through measures that affect the major motivating factors for migration: employment, family reunification, and seeking refuge. Any healthcare system reforms need to include provision of care to the

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281. See INST. OF MED., UNINSURANCE FACTS & FIGURES (Nat'l Acad. of Sciences 2001).

noncitizen population if the reforms are to protect the public health and provide a rational, humane, and cost-effective approach to health care delivery. Any health care reform that does not take the noncitizen population into account will not be complete and will result in the continuation of serious adverse public health and healthcare system consequences.