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Left Out in the Cold: How the United States' Healthcare System Excludes Immigrants

*Introduction by Tamara Forys**

I. INTRODUCTION

As the number of uninsured Americans rises each year, the discourse on how to ensure better access to the United States' healthcare system has intensified. This debate has been raging since Hillary Clinton first advocated universal coverage in the early 1990's. In this debate, the U.S. immigrant population has often been overlooked. Solving the plight of both documented and undocumented immigrants living and working in the United States is essential to ensuring that all have access to health care. If the issue of immigrant¹ care is not addressed, the financial strains on the healthcare system may be too great for future reforms to succeed.

Dr. E. Richard Brown, the founder and director of the University of California Los Angeles Center for Health Policy Research, spoke about the effects of citizenship status on healthcare coverage at the First Annual Beazley Symposium on Access to Health Care at the Loyola University Chicago School of Law. He addressed how the employer-based insurance system fails both immigrants and natives in the United States. Dr. Brown also highlighted California's solutions to the problem of providing healthcare services to the immigrant population.

As the director of the Center for Health Policy Research, Dr. Brown focuses his research on healthcare disparities experienced by immigrants and the disadvantaged. Additionally, Dr. Brown serves as the principle investigator of the California Health Interview Survey. This ongoing survey covers an expansive array of health issues affecting Californians, such as health status and the ability of different populations to access

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1. For the purpose of this article, any reference to "immigrants" means people living or working in the United States who are not citizens.

quality health care. Public health agencies and policymakers have used data from this survey to develop California's public healthcare programs.

There are different options available to documented and undocumented immigrants seeking health care and health insurance in the United States. Non-citizens tend to be underserved by the employer-based insurance system because even though immigrants could qualify for employer-based health insurance, many do not work in industries that offer this insurance.² Furthermore, immigrants often do not have sufficient access to public health insurance programs such as Medicare, Medicaid, and SCHIP.³ Additionally, documented immigrants may fear that utilizing government-funded services will have a negative impact on their citizenship applications if they utilize government-funded health services.⁴ Undocumented immigrants face additional challenges accessing the few public services available to them due to fear of deportation.

II. EMPLOYER-BASED INSURANCE

Healthcare coverage in the United States is primarily based on employer-funded private insurance. During World War II, employer-funded health insurance became the basis of the U.S. system.⁵ Wartime wage controls forced employers who were competing over a shrinking workforce to provide non-monetary incentives to attract employees.⁶ This resulted in employers offering workers private employer-funded health insurance.⁷ This system has continued into the present day, and in 2004 about 60% of the U.S. population was insured under an employment-sponsored plan.⁸

2. E. Richard Brown, Director, UCLA Ctr. for Health Policy Research, Panel Speech at the First Annual Beazley Symposium on Access to Health Care: Solving the Problem of Immigration and Health Care (February 8, 2008) (transcript published in the Summer 2008 Issue of *Annals of Health Law*).

3. See KAISER COMM'N ON MEDICAID & THE UNINSURED, IMMIGRANTS AND HEALTH CARE COVERAGE: A PRIMER 2 (2004), <http://www.kff.org/uninsured/upload/Immigrants-and-Health-Coverage-A-Primer.pdf> ("Medicaid and SCHIP play an important role in covering some low-income immigrants, but federal legislation restricts many immigrants, particularly recent immigrants, from qualifying for or enrolling in this coverage. As a result of low-paying jobs without health insurance and restrictions on public coverage, immigrants are significantly more likely to be uninsured than citizens.") [hereinafter PRIMER].

4. SHAWN FREMSTAD & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS' ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 32 (2004), <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>.

5. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 10 (2005).

6. *Id.*

7. *Id.*

8. *Id.* at 6.

However, the number of Americans utilizing employer-based health insurance has been declining. Between 2001 and 2004, five million fewer jobs provided health insurance to their workers.⁹ Low-income workers are the least likely to have employer-based health insurance and the construction and service industries have been the targets of the greatest cuts in employer-provided health insurance.¹⁰

Most low-income non-citizens, including documented and undocumented immigrants, do not have access to employer-based health insurance. About 73% of uninsured non-citizen non-elderly adults are considered to be low-income because they live below 200% of the federal poverty level.¹¹ Out of this vulnerable population, roughly 71% live in a family where there is at least one full-time worker.¹² However, these adults often do not have health insurance because they work in industries where employers customarily do not offer health insurance.¹³ For example, about half of low-income non-citizens are employed in agriculture, construction, or the service industry.¹⁴ These three industries have the lowest rates of employer-based insurance coverage.¹⁵ Thus, even though most low-income immigrant families contribute to the workforce, they do not receive the benefits of employer-funded health insurance. If the employer-based system is to be successful in assuring access to health care, then more workers should be covered. In particular, non-citizens are negatively affected by the present system because they often work in industries that do not provide coverage and are often ineligible for federal assistance.

The employer-based health insurance system is not a good fit for the immigrant population. Too many immigrants work in industries where employer-funded insurance is not offered, cannot afford private health insurance on their own, and are ineligible for federal health programs. These factors create an entire population that must either pay for health services out of pocket or forgo medical care altogether. The entire health system suffers from immigrants' inability to access health care. If immigrants are only able to access emergency care, the resulting costs will be higher and will be passed along to the entire system, making health care more expensive for everyone.

9. *Health Insurance Costs Rising as Fewer Jobs Offer Coverage*, NATION'S HEALTH, Nov. 2004, at 6.

10. LISA CLEMANS-COPE & BOWEN GARRETT, KAISER COMM'N ON MEDICAID & THE UNINSURED, CHANGES IN EMPLOYER-SPONSORED HEALTH INSURANCE, SPONSORSHIP, ELIGIBILITY, AND PARTICIPATION: 2001 TO 2005 17, 27 (2006), <http://www.kff.org/uninsured/upload/7599.pdf>.

11. KARYN SCHWARTZ & SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE CONVERGE AND ACCESS TO CARE FOR LOW-INCOME NON-CITIZEN ADULTS 1 (2007), <http://kff.org/uninsured/upload/7651.pdf>.

12. *Id.* at 3.

13. *Id.*

14. *Id.*

15. *Id.*

III. ACCESS TO FEDERAL AND STATE FUNDED INSURANCE

A. Medicaid

Since 1996, most documented immigrants arriving in the United States have been prohibited from receiving public health benefits for the first five years that they reside in the country.¹⁶ Before the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”), Medicaid was available to lawful permanent residents and to those permanently residing in the United States under color of law.¹⁷ However, currently some specific categories of documented immigrants do qualify for benefits during the first five years of residence, and, in addition, emergency Medicaid is available to all immigrants regardless of how long they have been in the U.S.¹⁸ Refugees and other humanitarian immigrants are not subject to the five-year residency requirement to receive federally-funded Medicaid.¹⁹ Lawfully present immigrants are usually not eligible for Medicaid unless they are granted asylum or some other humanitarian status.²⁰ However, an immigrant that gains legal permanent resident (“LPR”) status will still be barred for the first five years that they are in the United States.²¹

Some states have chosen to provide healthcare coverage under state-funded programs to immigrants ineligible for Medicaid due to their immigration status or length of residency in the United States.²² States have the option of either expanding coverage with their own funds or excluding more immigrants than required by federal regulations from Medicaid by imposing more restrictive eligibility requirements.²³ Under PRWORA, states can deny Medicaid eligibility to certain legal permanent residents even if they have lived in the United States for longer than five years.²⁴ Only Colorado and Wisconsin have chosen to further limit the ability of immigrants to access Medicaid; however, Colorado has since repealed that measure as it relates to legal immigrant children.²⁵

The five-year ban under PRWORA perpetuates the theory that only the

16. PRIMER, *supra* note 3, at 3.

17. Steven M. Dawson, *The Promise of Opportunity and Very Little More: An Analysis of the New Welfare Law's Denial of Federal Public Benefits to Most Legal Immigrants*, 41 ST. LOUIS U. L.J. 1053, 1058 (1997).

18. *Id.* at 3.

19. FREMSTAD & COX, *supra* note 4, at 11.

20. *Id.*

21. *Id.*

22. PRIMER, *supra* note 3, at 3.

23. FREMSTAD & COX, *supra* note 4, at 12.

24. *Id.* at 11.

25. *Id.* at 20.

deserving poor should be given government aid. In this respect, the U.S. welfare system arguably reflects the Elizabethan Poor Laws passed in England during the 16th century.²⁶ Those 16th Century laws only provided assistance to the poor who were deemed deserving and those who were poor and physically able to work were not considered deserving.²⁷

Under current law, only those immigrants who have lived in the United States for five years are considered deserving of public assistance. The five-year Medicaid waiting period is a prime example of the unfair treatment of immigrants who pay taxes, but are unable to claim benefits from the healthcare system. Just as certain people were arbitrarily deemed undeserving of public assistance during Elizabethan times, the current federal health assistance programs similarly block access to government health assistance for certain immigrants.

LPRs with sponsors also face additional barriers to obtaining Medicaid. Sponsors agree to help LPRs adjust to life in the United States and must sign an affidavit of support on behalf of the new immigrants.²⁸ The purpose of the affidavit is to assure “the U.S. Government that the person(s) named . . . will not become a public charge in the United States.”²⁹ Under this agreement, the assets of a sponsor may be counted towards determining whether a LPR’s income qualifies them for Medicaid.³⁰ Therefore, even when a sponsored immigrant’s income is low enough to qualify him for Medicaid, he may still be ineligible for Medicaid due to the sponsor’s assets.³¹ Even though this problem is limited to a small number of immigrants, it exemplifies the additional administrative barriers that immigrants face when trying to obtain healthcare coverage.

B. Emergency Medicaid and EMTALA

Even though some new documented immigrants and almost all undocumented immigrants are ineligible for federal coverage under Medicaid, both of these populations are guaranteed emergency care through Emergency Medicaid.³² Under the Emergency Medical Treatment and

26. Joseph P. Rompala, “*Once More Unto the Breach, Dear Friends*”: Recurring Themes in Welfare Reform in the United States and Great Britain and What the Principle of Subsidiary Can Do to Break the Pattern, 29 J. LEGIS. 307, 308-10 (2003).

27. *Id.* at 318.

28. FREMSTAD & COX, *supra* note 4, at 13.

29. Dept. of Homeland Security, U.S. Citizenship and Immigration Services, I-134, Affidavit of Support, OMB No. 1615-0014, Exp. 4-30-07, <http://www.uscis.gov/files/form/I-134.pdf> (last visited February 19, 2007).

30. FREMSTAD & COX, *supra* note 4, at 13.

31. *Id.*

32. PRIMER, *supra* note 3, at 3.

Active Labor Act (“EMTALA”),³³ all hospitals receiving federal funds must treat and stabilize anyone who is experiencing a medical emergency and goes to an emergency room to seek care.³⁴ This federal mandate applies to both documented and undocumented immigrants.³⁵ The ability to pay for emergency care, however, is another issue. Under EMTALA, hospitals may not delay treatment due to a patient’s inability to pay, but the law does not forbid hospitals from billing patients and holding those patients responsible for the cost of their care.³⁶

An immigrant’s cost of emergency treatment may be covered by Emergency Medicaid regardless of immigration or residency status if he or she falls within the income eligibility requirements of Medicaid; however, coverage does not extend to preventative or routine services.³⁷ Immigrants who are otherwise ineligible for publicly-funded health services must then pay for those services on their own.

Defining “emergency care” has proven to be a problem. The State of New York has funded chemotherapy for any immigrant regardless of status and has requested reimbursement from the federal government for the cost of this treatment under Emergency Medicaid.³⁸ In September of last year, the Centers for Medicare and Medicaid Services (“CMS”) told New York State that it would no longer cover the cost of chemotherapy because it did not consider it to be emergency care under Emergency Medicaid.³⁹ CMS has not yet decided whether it will attempt to recover the money spent on chemotherapy for undocumented immigrants by New York between 2001 and 2006.⁴⁰ Despite CMS’s recommendations, the governor of New York has pledged to continue to fund chemotherapy.⁴¹ The argument over whether chemotherapy should be covered under Emergency Medicaid highlights the problem of only offering financial assistance for “emergencies.” Immigrants who are diagnosed with cancer will likely suffer emergencies as the disease takes its course; any emergency care given will ultimately do an immigrant little good if she cannot obtain necessary follow up treatment. Most immigrants are unlikely to be able to afford to pay for cancer treatment on their own. Emergency care can save

33. The Emergency Treatment Act was passed as part of the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) of 1986, Pub. L. No. 99-272, § 9121 (effective August 1, 1986) (codified as amended at 42 U.S.C. § 1395dd (2000)).

34. 40 AM. JUR. 2D *Hospitals and Asylums* § 12 (2007).

35. FREMSTAD & COX, *supra* note 4, at 14.

36. 42 U.S.C. § 1395dd(h) (2000).

37. See SCHWARTZ & ARTIGA, *supra* note 11, at 3.

38. Sarah Kershaw, *New York, Faulting U.S., Says It Will Pay for Cancer Care for Illegal Immigrants*, N.Y. TIMES, Sept. 26, 2007, at B3.

39. *Id.*

40. *Id.*

41. *Id.*

lives, but patients who cannot obtain public assistance for further treatment may be unable to pay for necessary life saving treatment.

C. SCHIP

In 1997, the State Children's Health Insurance Program ("SCHIP") was created to give federally funded insurance to those children whose families did not qualify for Medicaid but could not afford private health insurance.⁴² Each state has its own SCHIP plan, but SCHIP is governed by PRWORA restrictions, which prevent some immigrant children from accessing the program.⁴³ SCHIP provides coverage for "targeted low-income children."⁴⁴ In 2002, the Department of Health and Human Services decided to include unborn children in the definition of low income children.⁴⁵ This means that states can provide SCHIP coverage for prenatal care to pregnant women, regardless of their immigration status.⁴⁶ This decision has sparked criticism because the benefits were actually granted to unborn children who will become citizens at birth, not to the immigrant mothers carrying these children.⁴⁷ Pro-choice groups have protested this regulation because it may "advance the rights of a fetus in a way that threatens a woman's reproductive freedom."⁴⁸

D. Medicare

Immigrants who are permanent residents qualify for Medicare coverage if they have lived in the United States for five years and meet Medicare's age requirements.⁴⁹ However, most older immigrants did not work or pay Federal Insurance Contributions Act ("FICA") taxes in the United States, and therefore are not eligible for Social Security benefits.⁵⁰ Therefore, when a LPR meets Medicare's age and residency requirements, she may enroll, but must pay requisite premiums to be covered under the program.⁵¹ In 2007, these premiums were \$410 per month for Medicare Part A, which

42. Hyejung Janet Shin, Note, *All Children Are Not Created Equal: PRWORA's Unconstitutional Restriction on Immigrant Children's Access to Federal Health Care Programs*, 44 FAM. CT. REV. 484, 488 (2006).

43. *Id.* at 488-89.

44. Diana O. Aguilar, Comment, *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, 268 (2005).

45. *Id.* at 269.

46. *Id.* at 270.

47. *Id.* at 264.

48. *Id.* at 265.

49. The Eldercare Team, "Medicare for Non-Citizens," <http://www.eldercareteam.com/resources/articles/alien-medicare.htm> (last visited Feb. 20, 2008).

50. *Id.*

51. *Id.*

covers hospitalization and \$93.50 for Part B, which covers physician visits.⁵²

E. State-Funded Programs

Many states provide health coverage for low income immigrant residents who are ineligible for federal programs.⁵³ In 2006, twenty-two states provided state-funded health coverage for some immigrants who were not eligible for federal assistance.⁵⁴ These state-funded programs are less expansive than their federal counterparts, but are a start to ensuring that everyone in the United States has adequate health coverage. Using state funds, Florida, Massachusetts, Rhode Island, and Washington, D.C. cover all children, no matter their immigration status.⁵⁵ California covers roughly one million noncitizens, most of whom do not qualify for federal aid.⁵⁶

California and other states that fund immigrant health care began doing so shortly after the 1996 passage of PRWORA.⁵⁷ This occurred during a time that most states had strong economies and budget surpluses; however, state-funded care for immigrants has been among the first programs cut as states went into debt due to the recession.⁵⁸ Under current state budget constraints, state governments cannot adequately provide for the healthcare needs of the immigrant population without more federal assistance.

IV. CONCLUSION

Most U.S. immigrants are unable to gain health insurance coverage through the employer-based private system and are often ineligible for federally-funded coverage. States have attempted to cover these ineligible immigrants, but with recent budget constraints, immigrants are inadequately covered by these programs. Since federal funding covers only emergency care for new and undocumented immigrants, some states have attempted to expand the meaning of emergency to better aid sick undocumented immigrants. Other states have begun to cover undocumented children with state funds and to provide prenatal care for undocumented mothers and their unborn children. Despite different programs designed to assist

52. *Id.*

53. FREMSTAD & COX, *supra* note 4, at 16.

54. KARYN SCHWARTZ & SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE CONVERGE AND ACCESS TO CARE FOR LOW-INCOME NON-CITIZEN CHILDREN 2 (2007), <http://www.kff.org/medicaid/upload/7643.pdf>.

55. FREMSTAD & COX, *supra* note 4, at 17.

56. E. Richard Brown, *supra* note 2. California's efforts to cover its immigrant population were discussed by Dr. Brown during the 2008 symposium and his remarks are printed after this introduction.

57. FREMSTAD & COX, *supra* note 4, at 18.

58. *Id.*

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immigrants in obtaining health care, there are huge gaps in federal and state coverage for the immigrant population, which is the most underserved by the private sector.

In the following transcript, Dr. Brown addresses the divide that citizenship status creates between the insured and uninsured. He focuses on the plight of immigrants and their ability to access health services in California and the policy that California has taken with regard to immigrant health care, while also offering solutions to the problems faced by uninsured immigrants.