

# UNIVERSITY *of* PENNSYLVANIA

## JOURNAL *of* LAW & PUBLIC AFFAIRS

---

Vol. 4

Jan. 2019

No. 2

---

### HEALTH JUSTICE FOR IMMIGRANTS

*Medha D. Makhoul*\*

INTRODUCTION .....	236
I. IMMIGRANT ACCESS TO PUBLICLY FUNDED HEALTH CARE.....	241
A. <i>Immigrant Health Disparities and Access to Care</i> .....	243
B. <i>The Legal Framework</i> .....	247
C. <i>Rationales for Restriction</i> .....	264
1. Cost and Deterrence .....	266
2. Deservingness .....	267
II. THE SHIFT TO COLLECTIVISM IN HEALTH CARE FINANCING.....	274
A. <i>The Health Justice Model</i> .....	276
1. Universal Access to Protect Collective Interests .....	278
2. Collective Responsibility for Distributing Public Resources ....	281
B. <i>A Health Justice Analysis of Immigrant Access to Publicly       Funded Health Care</i> .....	283
1. The Health Justice Model's Contribution .....	283
2. Question Left Unanswered: Are All Immigrants Included? .....	285

---

\* Assistant Professor of Law; Director, Medical-Legal Partnership Clinic, Pennsylvania State University – Dickinson Law. For generous and insightful comments and helpful advice, I sincerely thank Lindsay Wiley, Sidney Watson, Liz McCuskey, Rob Gatter, Govind Persad, Matt Lawrence, Jason Parkin, Ann Shalleck, and participants in the 2017 ASLME Health Law Scholars Workshop at SLU Law, the *Clinical Law Review* Writers' Workshop at NYU Law, the ASLME Health Law Professors Conference, and the AALS Clinical Legal Education Conference Works-in-Progress Program. I am grateful to the editors of the *University of Pennsylvania Journal of Law & Public Affairs* for their editorial assistance, and to Jessica Lambert and Lindsay Daniels for their research assistance.

III. HEALTH JUSTICE FOR IMMIGRANTS: A FRAMEWORK.....	287
A. <i>Including Immigrants in the Health Care Collective</i> .....	290
1. Foundations for Solidarity with Immigrants.....	292
2. Health Care Norms Supporting Inclusion.....	295
a. <i>Providers and the Principle of Need</i> .....	295
b. <i>Payers and Mutual Aid</i> .....	297
B. <i>Discouraging Biased or Fear-Based Arguments</i> .....	299
C. <i>Linking Health Advocacy with Immigration Advocacy</i> .....	301
D. <i>Expanding Individual Rights to Access</i> .....	303
CONCLUSION.....	304

## INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was conceived as a progressive project to expand access to affordable health insurance and promote greater health care equity, but it largely left out the 23 million noncitizens living in the United States.<sup>1</sup> Excluding immigrants from some of the key benefits of the ACA actually *increased* the disparity in access to health care between U.S. citizens and immigrants.<sup>2</sup> The ACA entrenched the

<sup>1</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1302(b)(1), 2707(a) (2010) (codified in 42 U.S.C. § 18022(b)(1) (2012)). This Article refers to the consolidated act, with amendments, as the Affordable Care Act or ACA.

<sup>2</sup> See, e.g., Randy Capps & Michael Fix, *Immigration Reform: A Long Road to Citizenship and Insurance Coverage*, 32 HEALTH AFF. 639, 639 (2013) (noting that although the ACA expands coverage to millions, “unauthorized immigrants will still be frozen out”); Tiffany D. Joseph, *Still left out: healthcare stratification under the Affordable Care Act*, 43 J. ETHNIC & MIGRATION STUD. 2089, 2089 (2017) (arguing that the “stratification” created by the ACA may “worsen existing disparities in healthcare coverage and access” in the United States); Helen B. Marrow & Tiffany D. Joseph, *Excluded and Frozen Out: Unauthorised Immigrants’ (Non)Access to Care after US Health Care Reform*, 41 J. ETHNIC & MIGRATION STUD. 2253, 2254 (2015) (discussing the ACA’s creation of “an even stronger and clearer separation of unauthorised immigrants from the rest of the morally ‘deserving’ US body politics in the health care domain”); Benjamin D. Sommers, *Stuck between Health and Immigration Reform—Care for Undocumented Immigrants*, 369 N. ENGL. J. MED. 593, 594–95 (2013) (warning that the ACA may decrease support and resources for local programs that largely help uninsured individuals, making “access to care for this population potentially even worse than it is now”). In this article, I use the terms “immigrant” and “noncitizen” interchangeably to mean any person present within the United States who is not a U.S. citizen. This includes persons lawfully admitted for permanent residence, holders of temporary visas, refugees, and undocumented people. Although the term “immigrant” has a more technical and limited definition in the Immigration and Nationality Act, it is often used by academics, politicians, and the general public in the more colloquial sense in which I use it here.

categorical exclusion of immigrants from access to important parts of the health care safety net, and further legitimized the consideration of immigration status among the factors determining health care access rights.<sup>3</sup> Immigrants are now the largest segment of the uninsured population in the United States, and the only community that includes members who are barred by federal law from receiving health care subsidies regardless of medical need or income. As such, they represent a uniquely marginalized population with respect to health care access.

The ACA's failure to address the health care access needs of all immigrants jeopardizes its own progressive efforts to encourage social solidarity and an ethos of mutual aid in debates about how to pay for health care. Systems based on solidarity and mutual aid create obligations for members of a community to contribute to the common good and create the possibility of subordinating individual interests to the community's interests. By excluding large numbers of immigrants from the imagined community that "deserves" access to affordable health care, the ACA undermines its goals of ensuring universal, affordable access to health care, improving population health, and increasing efficiency in the health care delivery system. It also reinforces restrictionist political and ethical norms that exclude immigrants, and therefore threatens efforts by progressive advocates to encourage solidarity with immigrants in support of humane immigration reform.

Consider the following real-world examples of the immigrants whom the ACA left out. All of these immigrants are ineligible for publicly funded health insurance programs like Medicaid and the Children's Health Insurance Program (CHIP), and for federal tax credits to subsidize premiums for health insurance purchased in the Health Insurance Marketplaces that were created by the ACA.<sup>4</sup> They are ineligible for these programs solely due to their lack of citizenship or immigration status. In all relevant ways—namely, their medical needs and income levels—they are identical to the populations that the ACA intended to benefit.

---

<sup>3</sup> See Donald Light & Mélanie Terrasse, *Immigrant access in the Affordable Care Act: legacies of the Confederacy*, 43 J. ETHNIC & MIGRATION STUD. 1985, 1988–98 (2017) (explaining that the ACA, by categorically excluding immigrants from certain benefits, reinforced a strategy dating back to the Civil War era).

<sup>4</sup> Part I of this Article describes in detail the federal laws governing immigrant eligibility for various publicly funded health care programs. Some states provide health coverage for a broader group of immigrants, but the immigrants in these scenarios live in states that do not provide such coverage. See *Table 3: Medical Assistance Programs for Immigrants in Various States*, NAT'L IMMIGR. L. CENTER, <https://www.nilc.org/issues/health-care/medical-assistance-various-states/> [<https://perma.cc/BW6Y-WP4X>] (last revised Jan. 2018) (outlining states' policies of health care coverage for immigrants).

1. Miguel, a 26-year-old gas-station attendant from Mexico, crossed the border into Texas with his parents when he was nine years old and has lived in El Paso ever since. In 2013, he obtained permission to live and work in the United States through the Deferred Action for Childhood Arrivals (DACA) program.<sup>5</sup> Although he had been suffering from severe stomach pain for months, Miguel avoided the doctor because he did not have health insurance and could not afford to pay the out-of-pocket cost of a doctor's visit. One day, the pain became unbearable. Miguel went to the hospital emergency department and learned that he had stage IV stomach cancer, too late for lifesaving treatment. He was referred to hospice care, which he could not afford. For the next few months, he went to the hospital emergency department whenever he experienced severe pain, was admitted for a week until he stabilized, and was then discharged to begin the cycle all over again until he died.
  
2. Claudia, a recent college graduate living in central Pennsylvania, sought prenatal care after learning she was pregnant. She had entered the United States with a student visa that had since expired, and was in the process of applying for lawful permanent residence based on her marriage to a U.S. citizen. She did not have health insurance to defray the costs of prenatal care, so she went without, despite a history of hypertension. Claudia went into labor five weeks before her due date and went to a hospital emergency department to deliver her baby. Due to Claudia's untreated hypertension, the baby was born with serious developmental delays and is expected to require a lifetime of special education and other services.
  
3. Elena, a line worker at a poultry processing plant in Iowa, has had a bad cough and has lost several pounds over the last few weeks. She came to the United States from Guatemala with her husband and young children to escape gang violence that had

---

<sup>5</sup> Memorandum from Jeh Charles Johnson, Sec'y of Homeland Sec., to León Rodriguez et al., Dir., U.S. Citizenship & Immigration Serv. (Nov. 20, 2014) [https://www.dhs.gov/sites/default/files/publications/14\\_1120\\_memo\\_deferred\\_action\\_2.pdf](https://www.dhs.gov/sites/default/files/publications/14_1120_memo_deferred_action_2.pdf) [<https://perma.cc/8UPQ-K2S9>] (expanding certain parameters of DACA); Memorandum from Janet Napolitano, Sec'y of Homeland Sec., to David V. Aguilar et al., Acting Comm'r, U.S. Customs & Border Prot. (June 15, 2012) <https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf> [<https://perma.cc/4SA9-U2HN>] (establishing the DACA program).

devastated their community. In desperation, they had borrowed money to pay smugglers to bring them across the U.S.-Mexico border, and applied for asylum. Both Elena and her husband work full-time, but they struggle to manage their debts and keep their household afloat. Elena wants to see a doctor, but her family cannot afford the \$80 fee, in addition to the loss of her daily pay. Elena learns that she has active tuberculosis from a Public Health Nurse who is dispatched to the plant after one of Elena's coworkers was diagnosed with this highly infectious disease. The delayed screening and treatment of active tuberculosis put more than one hundred of Elena's friends, family members, and coworkers at risk of infection.

This Article makes the case for a more inclusive health law and policy that addresses disparities in immigrants' access to affordable health care. Health Justice is an emerging model of health law that reflects important changes in our health care system that both drive and amplify health care reform.<sup>6</sup> Although Health Justice provides a framework for understanding how universal access to affordable health care protects collective as well as individual interests, it does not address whether immigrants should be included in that "universe." Indeed, one formulation of the Health Justice model's ideal vision of access to health coverage describes access as a "right of citizenship."<sup>7</sup> This Article questions the assumption that the ideal of universal access is based on a health care collective that excludes noncitizens, and that access to affordable health care should be understood as an entitlement of political citizenship, as opposed to some other characteristic of community membership. It draws on the philosophical underpinnings of the Health Justice framework in order to answer the difficult ethical and political question about the extent to which immigrants should be included in the national health care collective.

---

<sup>6</sup> Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 *CARDOZO L. REV.* 833, 837–39 (2016). These influences include: a shift from private to public law governance of health care, a growing emphasis within bioethics on reconciling collective and individual interests, increased overlap in the work of health care and public health practitioners, and modified health care reimbursement policies that recognize the importance of primary care in relation to specialty care. *Id.* at 854–73. See also Lindsay F. Wiley, *Health Law as Social Justice*, 24 *CORNELL J. L. & PUB. POL'Y* 47, 47 (2014) (arguing that the health justice framework calls for greater public awareness of health care access as a social determinant, for further research into the effects of social biases on health inequality, and for a "collective action grounded in community engagement and participatory parity").

<sup>7</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 888.

The ACA's efforts to address health care access disparities in marginalized subpopulations has generated a substantial body of scholarship.<sup>8</sup> Yet barriers specifically related to citizenship or immigration status are often left out of these important conversations. This Article illustrates how recognizing immigrant populations can strengthen both health care policy and theory. Understanding how and why immigrants have been largely left out of progressive efforts to subsidize health insurance coverage can help to illuminate the fundamental defects in our health care system that perpetuate these and other inequities. While a significant body of scholarship has turned to the theory of Health Justice to address various health inequities,<sup>9</sup> the theory remains incomplete as it applies to immigrant populations. Inclusion of immigrant health care rights refines and fortifies the Health Justice framework as a tool for influencing progressive legislation, doctrine, scholarship, and advocacy.<sup>10</sup>

---

<sup>8</sup> See, e.g., Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 HOUS. J. HEALTH L. & POL'Y 183 (2017); Keegan Warren-Clem, *Unnecessary, Avoidable, Unfair, and Unjust: [En]gendered Access to Care in the PPACA Era and the Case for a New Public Policy*, 13 IND. HEALTH L. REV. 119 (2016); Wiley, *Health Law as Social Justice*, *supra* note 6, at 49 (referring to the reduction of racial and ethnic disparities as “a central—and deeply controversial theme—of the American health reform agenda”); Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 HOW. L.J. 887, 921-22 (2012) (discussing the expected impact of the ACA's coverage expansion on disparities in mortality rates for racial and ethnic minorities); Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 LOY. L. REV. 655, 683 (2012) (same). For a comprehensive overview of ACA provisions that are expected to reduce health disparities, see DENNIS P. ANDRULIS, ET AL., JOINT CTR. FOR POL. & ECON. STUD., PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010: ADVANCING HEALTH EQUITY FOR RACIALLY AND ETHNICALLY DIVERSE POPULATIONS (2010).

<sup>9</sup> See generally ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, *ESSENTIALS OF HEALTH JUSTICE: A PRIMER* (2019); see also Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 275–278 (2015) (recommending a health justice framework to improve social and health inequality); Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489, 491–93 (1988) (discussing the increasingly common incorporation of social justice concepts into determining health care distribution); Sidney D. Watson, *Health Law, Public Law, and Social Justice*, 61 ST. LOUIS U. L. J. 391, 391–393 (2017) (describing health care law as an effective way to explore larger issues of social inequality). The theme of the 2018 Public Health Law Conference, which brings together leading public health law scholars from around the country, is Health Justice. *Health Justice: Empowering Public Health and Advancing Health Equity*, THE NETWORK FOR PUBLIC HEALTH LAW (Oct. 31, 2018), [https://www.networkforphl.org/2018\\_conference/phlc18/](https://www.networkforphl.org/2018_conference/phlc18/) [<https://perma.cc/3W9A-7ATS>].

<sup>10</sup> Academic framing can play an influential role in shaping public debate about controversial topics. See Dennis Chong & James N. Druckman, *Framing Theory*, 10 ANN. REV. POL. SCI. 103,

Part I of this Article provides an overview of the laws governing immigrant access to publicly funded health care. Part II describes the Health Justice framework, which views health law as a vehicle for social justice. When applied to the issue of immigrant access to publicly funded health care, Health Justice raises but does not answer the fundamental question of whether immigrants are included in the health care collective. Part III draws on the communitarian social justice roots of the Health Justice framework in order to fill this gap, and to complete the Health Justice vision of universal access to affordable health care. I argue that the ethical norms underlying access to health care—the principle of need, which directs health care providers to offer care to those in need, and the principle of mutual aid, which dictates that health care resources should be distributed based on medical need—support the inclusion of immigrants in publicly funded health care programs.

## I. IMMIGRANT ACCESS TO PUBLICLY FUNDED HEALTH CARE

In the United States and in most high-income countries today, immigration status is a major factor in determining noncitizen residents' eligibility for publicly funded health care. In countries that provide at least some public funding for health care benefits to some portion of the population, there is a range of possibilities for structuring health care benefits eligibility for noncitizens. One theoretical extreme is to provide no publicly funded health coverage to noncitizens; the other is to provide them with equal access to the publicly funded health coverage available to similarly situated citizens. Within this range of theoretical extremes, the United States and other high-income countries are located somewhere in the middle, allocating public funds for health care for some noncitizens under certain circumstances.<sup>11</sup> In the United States, there are sharp distinctions in legal access rights to publicly

---

103 (2007) (explaining that academic studies have shown public opinion is influenced by the framing effect on a number of different issues); Lynn H. Fujiwara, *Immigrant Rights are Human Rights: The Reframing of Immigrant Entitlement and Welfare*, 52 SOC. PROBS. 79 (2005) (discussing how scholarly work influenced public opinion during the passage of the Personal Responsibility Work Opportunity Reconciliation Act); Anahí Viladrich, *Beyond Welfare Reform: Reframing Undocumented Immigrants' Entitlement to Health Care in the United States*, A CRITICAL REVIEW, 74 SOC. SCI. & MED. 822, 824 (2012) (noting the impact of academic framing on public opinion during the passage of the Personal Responsibility Work Opportunity Reconciliation Act).

<sup>11</sup> See, e.g., Mark A. Hall & Jacob Perrin, *Irregular Migrant Access to Care: Mapping Public Policy Rationales*, 8 PUB. HEALTH ETHICS 130, 130–31 (2015) (explaining that irregular migrants only have access to select publicly funded health care services in the United States and Europe).

funded health coverage among various categories of immigrants, with relatively few resources devoted to health care for undocumented immigrants.<sup>12</sup> In other countries, a broader range of noncitizens have access to publicly funded health care, although it may not be as comprehensive as the level of coverage to which citizens are entitled.<sup>13</sup>

There are a variety of criteria that may be used to ration health care based on citizenship and immigration status, all of which are typically related to the precariousness of the noncitizen's situation. These criteria might include a noncitizen's actual presence within the nation's territory, which necessarily requires a precise delineation of where that territory begins and ends; his manner of entry into the territory; whether he holds or has ever held a valid immigration status, and the nature of that status; how long he has resided in the country; and his positive and negative contributions to society. One might consider additional rationing criteria that are identical to those already commonly used to allocate public health care dollars among the general population, such as the nature of his medical need and whether he is considered a categorically needy or vulnerable person. These rationing criteria reflect and reinforce national values about the extent to which health—and even health care—are considered public goods.<sup>14</sup> They also reflect and reinforce divergent conceptual portraits of noncitizens as unwelcome outsiders or as neighbors.<sup>15</sup>

---

<sup>12</sup> For example, certain types of lawfully present immigrants, such as refugees, have immediate access to federally funded health coverage through Medicaid on the same terms as U.S. citizens. Other lawfully present immigrants gain such access after a five-year waiting period. Still others will never qualify for such access so long as their status does not change. Undocumented immigrants generally have access to Medicaid for emergency care only. In some states, Medicaid provides health coverage for children and prenatal care for pregnant women, regardless of immigration status. *See generally* KAISER FAM. FOUND., FACT SHEET: HEALTH COVERAGE OF IMMIGRANTS 3–4 (2017) (explaining the different levels of Medicaid coverage by states). The legal access rights of noncitizens are described in detail in this Part.

<sup>13</sup> *See* PATRICIA ILLINGWORTH & WENDY E. PARMET, THE HEALTH OF NEWCOMERS: IMMIGRATION, HEALTH POLICY, AND THE CASE FOR GLOBAL SOLIDARITY 102–10 (2017) (surveying the difference in health care coverage for citizens and noncitizens in Canada, the U.S., and Western Europe).

<sup>14</sup> *Id.* at 171; Wendy K. Mariner, *Health Insurance is Dead; Long Live Health Insurance*, 40 AM. J. L. & MED. 195, 199 (2014) (“Despite many who treat healthcare to be a commercial good that should be allocated through commercial markets, most Americans treat healthcare like a necessity and a public good.”).

<sup>15</sup> Stephen H. Legomsky, *Portraits of the Undocumented Immigrant: A Dialogue*, 44 GA. L. REV. 65, 70 (2009); *see also* Brietta R. Clark, *The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 263–64 (2008) (describing how the public debate commonly portrays immigrants as a vulnerable group of victims or as a dangerous group threatening other citizens).



### A. Immigrant Health Disparities and Access to Care

In the U.S. public health community, the term “health disparity” means more than a difference in health status among population groups. Rather, it is used to refer to “a particular type of health difference between individuals or groups that is unfair because it is caused by social or economic disadvantage.”<sup>16</sup> This Section provides an overview of health disparities among immigrants living in the United States, and explains the relationship between these disparities and access to affordable health care.

There are approximately 14.3 million lawfully present noncitizens and 10.7 million undocumented noncitizens living in the United States.<sup>17</sup> Among the general public, there is often confusion over who undocumented immigrants are, and how they became undocumented. There is no statute that defines the term. Generally, it is used to refer to people who do not have a valid federal immigration status because they either (1) entered the country without inspection, or (2) entered legally but then overstayed or otherwise violated the terms of their visa.<sup>18</sup> It is also important to note that undocumented status is not static: many immigrants who eventually obtain legal status or U.S. citizenship have been undocumented for some period of time, and those who are currently undocumented have often held legal status at some point in the past.<sup>19</sup> For example, it is estimated that up to forty percent of undocumented people residing in the United States entered the country with a valid visa.<sup>20</sup> Some common pathways by which undocumented people obtain legal status include spousal or family sponsorship, asylum, deferred action, temporary protected status, and parole.<sup>21</sup>

---

<sup>16</sup> U.S. DEP’T OF HEALTH & HUMAN SERV., SECRETARY’S ADVISORY COMM. ON NAT’L HEALTH PROMOTION & DISEASE PREVENTION OBJECTIVES FOR 2020, PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020 28 (2008).

<sup>17</sup> Gustavo Lopez et al., *Key Findings about U.S. Immigrants*, PEW RESEARCH CTR.: FACT TANK - NEWS IN THE NUMBERS (Nov. 30, 2018), <http://www.pewresearch.org/fact-tank/2018/11/30/key-findings-about-u-s-immigrants/> [<https://perma.cc/P45N-FSA5>].

<sup>18</sup> See, e.g., Geoffrey Heeren, *The Status of Nonstatus*, 64 AM. U. L. REV. 1115, 1126 (2015) (describing undocumented immigrants as those who have overstayed legal visas or entered the country without inspection); Peter L. Markowitz, *Undocumented No More: The Power of State Citizenship*, 67 STAN. L. REV. 869, 873, n.14 (2015) (same); Legomsky, *supra* note 15, at 68–69 (same).

<sup>19</sup> MICHAEL A. RODRÍGUEZ, ET AL., CREATING CONDITIONS TO SUPPORT HEALTHY PEOPLE: STATE POLICIES THAT AFFECT THE HEALTH OF UNDOCUMENTED IMMIGRANTS AND THEIR FAMILIES 3 (2015).

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

Studies have found various health disparities among immigrant populations living in the United States, including increased stroke risk,<sup>22</sup> higher rates of hypertension and diabetes,<sup>23</sup> and higher rates of vaccine-preventable disease.<sup>24</sup> Biological and non-biological factors can account for disparities. Among the non-biological factors are the social determinants of health (SDOH), which the World Health Organization defines as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”<sup>25</sup> These include “economic, cultural, societal, environmental, and social conditions.”<sup>26</sup> The SDOH have a significant effect on individual and population health, and are widely acknowledged as the root causes of major health inequities in the United States and around the world.<sup>27</sup> Access to health care is one of the SDOH. In the United States, the major barrier to health care access is the cost of care.<sup>28</sup> This is true for U.S. citizens and immigrants alike. Health insurance plays an important role in enabling people to access health care in a timely and efficient manner.<sup>29</sup> Under the ACA, people living in the United States are generally required to

---

<sup>22</sup> Mark Fort Harris, *Access to Preventive Care by Immigrant Populations*, 10 BMC MED. 55, 55 (2012).

<sup>23</sup> *Id.*

<sup>24</sup> Namratha R. Kandula, et al., *Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us*, 25 ANN. REV. PUB. HEALTH 357, 367 (2004).

<sup>25</sup> *Social Determinants of Health*, WORLD HEALTH ORG., [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/) [<https://perma.cc/Y7XZ-HYPN>] (last visited Nov. 21, 2018).

<sup>26</sup> Benfer, *supra* note 9, at 279.

<sup>27</sup> See *Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020*, U.S. DEP’T OF HEALTH & HUMAN SERV. (July 26, 2010), <http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm> [<https://perma.cc/N8BP-XP74>] (explaining that because many diseases and health issues stem from societal determinants, improving social inequalities can significantly alleviate health inequities as well); WORLD HEALTH ORG., RIO POLITICAL DECLARATION ON SOCIAL DETERMINANTS OF HEALTH ¶ 4 (Oct. 21, 2011) (calling for global action for a social determinants of health approach reducing health inequities).

<sup>28</sup> See, e.g., TOBIN-TYLER & TEITELBAUM, *supra* note 9, at 67 (“For most low- and moderate-income Americans, the out-of-pocket costs for health care are prohibitively expensive, and thus having adequate insurance coverage for both preventive and catastrophic care is *required* to access needed health care services.”) (emphasis added).

<sup>29</sup> *Id.* Sarita A. Mohanty, *Unequal Access: Immigrants and U.S. Health Care*, 5 IMMIGRATION POL’Y IN FOCUS 5 (2006) (explaining why many immigrants forgo medical care- due to costs from not being insured); HEALTH ACCESS FOUNDATION, CALIFORNIA’S UNEVEN SAFETY NET: A SURVEY OF COUNTY HEALTH CARE 2 (2013) (“People who are uninsured typically delay and are some-times denied care because of lack of insurance.”); KAISER FAM. FOUND., FACT SHEET: KEY FACTS ABOUT THE UNINSURED POPULATION 5 (2017) (finding those without insurance are more likely than those with insurance to postpone or not receive treatment).

purchase health insurance or pay a penalty.<sup>30</sup> Publicly funded health insurance subsidizes health care costs for people who do not have access to affordable private health insurance.

Numerous studies show that both lawfully present and undocumented noncitizens living in the United States have poorer access to health insurance than U.S. citizens.<sup>31</sup> Among lawfully present nonelderly adults, 18% lacked health insurance coverage in 2015, compared with 11% of citizens.<sup>32</sup> Lawfully present immigrant children fared slightly better, with only 13% lacking coverage, but the disparity with citizen children—only 5% of whom were uninsured—is stark.<sup>33</sup> Among the undocumented, 42% of nonelderly adults and 25% of children were uninsured.<sup>34</sup> It is estimated that undocumented immigrants could represent one-third of the uninsured population by 2019.<sup>35</sup> A critical factor contributing to these disparities is that the federal government restricts eligibility for public health insurance programs on the basis of citizenship or immigration status.<sup>36</sup> This leaves many immigrants without access to affordable health insurance, which serves as an effective barrier to health care.<sup>37</sup>

It is important to note that these restrictionist laws do not only affect access to care among immigrants; they also have spillover effects on U.S. citizens. This is because mixed-status families—in which some members may

---

<sup>30</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 42 U.S.C. § 18091. The general requirement applies to all U.S. taxpayers, but immigrants who are not lawfully present in the United States are exempt. § 1501(b), 26 U.S.C. § 5000A(d)(3). There are several additional categories of exemptions for individuals, including categories based on religious conscience, hardship, and membership in an established religious sharing ministry, as well as for incarcerated individuals, Native Americans, people uninsured for less than a three-month period, and expatriates. 26 U.S.C. § 5000A(d), (e), (f)(4).

<sup>31</sup> See, e.g., Jim P. Stimpson & Fernando A. Wilson, *Medicaid Expansion Improved Health Insurance Coverage for Immigrants, But Disparities Persist*, 37 HEALTH AFF. 1656 (2018).

<sup>32</sup> SAMANTHA ARTIGA & ANTHONY DAMICO, KAISER FAM. FOUND., ISSUE BRIEF: HEALTH COVERAGE AND CARE FOR IMMIGRANTS 3 (2017).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Marrow & Joseph, *supra* note 2, at 2255 (internal citations omitted).

<sup>36</sup> Karen Hacker, et al., *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 RISK MGMT. & HEALTHCARE POL'Y 175, 178 (2015) (finding, in a literature review, that exclusionary laws were the most commonly cited barrier to health care for undocumented immigrants).

<sup>37</sup> See, e.g., Arjumand Siddiqi, et al., *The Role of Health Insurance in Explaining Immigrant Versus Non-Immigrant Disparities in Access to Health Care: Comparing the United States to Canada*, 69 SOC. SCI. & MED. 1452, 1457–58 (2009) (arguing health insurance coverage is a critical cause of disparities in access to primary care between immigrants and non-immigrants in the United States).

be U.S. citizens, some have another lawful immigration status, while others are undocumented—are very common.<sup>38</sup> They are estimated to account for nearly half of all families with undocumented adults, and approximately four million U.S. citizen children have an undocumented parent.<sup>39</sup> Studies have found that undocumented parents of U.S. citizen children avoid applying for health coverage or seeking health care for their children because of the perceived or actual need to show documentation of immigration status for themselves.<sup>40</sup>

Progressive efforts to reduce health disparities have focused on improving access to affordable health coverage with the goal of improving access to health care, despite the relatively modest role that it plays in improving overall health.<sup>41</sup> In recent years, there has been a growing recognition of the need to address the broader SDOH, especially non-financial barriers to health care, in order to achieve health equity.<sup>42</sup> Although non-financial barriers are important determinants of health in immigrant populations,<sup>43</sup> I focus on financial access to health coverage in this Article for the following reasons: First, effective strategies to address health disparities among immigrants must consider the interrelated roles of immigration status, socioeconomic status, and access to health care. Health care *is* still essential to achieving good health outcomes, and immigration status is a SDOH that directly impacts access to affordable health care.<sup>44</sup> Second, after the passage of

---

<sup>38</sup> See, e.g., SILVA MATHEMA, KEEPING FAMILIES TOGETHER: WHY ALL AMERICANS SHOULD CARE ABOUT WHAT HAPPENS TO UNAUTHORIZED IMMIGRANTS 2 (2017) (reporting the results of an analysis showing that 16.7 million people live in mixed-status families in the United States).

<sup>39</sup> MICHAEL A. RODRÍGUEZ, ET AL., CREATING CONDITIONS TO SUPPORT HEALTHY PEOPLE: STATE POLICIES THAT AFFECT THE HEALTH OF UNDOCUMENTED IMMIGRANTS AND THEIR FAMILIES 4 (2015) (providing estimates on the amount of undocumented immigrants in the United States).

<sup>40</sup> Hacker et al., *supra* note 36, at 178; Rodríguez et al., *supra* note 19, at 8.

<sup>41</sup> See Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUBLIC HEALTH REP. 19, 20 (2014) (reviewing the evidence of the impacts of social factors on most health outcomes).

<sup>42</sup> See HARRY J. HEIMAN & SAMANTHA ARTIGA, KAISER FAM. FOUND., ISSUE BRIEF: BEYOND HEALTH CARE: THE ROLE OF SOCIAL DETERMINANTS IN PROMOTING HEALTH AND HEALTH EQUITY 1 (2015) (noting the importance of studying non-financial barriers to healthcare which continue to trouble U.S. healthcare).

<sup>43</sup> Non-financial barriers to accessing health care are also significant among immigrants, but they are not the main subject of this Article. See, e.g., Hacker et al., *supra* note 36, at 177, Table 1.

<sup>44</sup> See, e.g., Sanjay K. Pandey et al., *Immigrant Health Care Access and the Affordable Care Act*, 74 PUB. ADMIN. REV. 749, 757 (2014) (describing a finding that “provides support for the perspective that public coverage, by and large, has been a force for leveling access gaps” for immigrant groups). I hope to more fully explore the topic of immigration status as a SDOH in depth in future

the ACA, immigrants are disproportionately represented among those who are left without access to affordable health coverage and are therefore uniquely disadvantaged among people residing in the United States. This result is an inequity in the health care system that the federal government, given its outsized role in financing U.S. health care, should correct.

### *B. The Legal Framework*

In this section, I describe the laws that govern immigrants' access to publicly funded health care, focusing on legal restrictions that apply exclusively to immigrants.

Health care in the United States is financed through a patchwork system of health coverage that includes employer-based insurance (covering 55.7% of the U.S. population in 2016); direct-purchase insurance (16.2%); federal government insurance programs such as Medicaid (19.4%), Medicare (16.7%), and the Children's Health Insurance Program (CHIP); and additional state-funded insurance programs.<sup>45</sup> Virtually all hospitals are required to provide treatment to stabilize patients in emergency situations, and if such patients are uninsured, emergency Medicaid, a federal benefit, may be an option to cover the cost of treatment.<sup>46</sup> Safety net health care providers, such as public hospitals and community health centers, are committed to providing some access to care regardless of a patient's ability to pay for it. They typically rely on subsidies in order to maintain financial viability.<sup>47</sup> The federal government also funds the

---

work, as it is beyond the scope of this article. The concept of immigration as a SDOH was analyzed from an anthropological and public health perspective in Heide Castañeda et al., *Immigration as a Social Determinant of Health*, 36 ANN. REV. PUB. HEALTH 375, 375–76 (2015). They note that restrictionist laws are structural factors that impede immigrants' ability to obtain health-protective resources. *Id.* at 381. Immigrants face other unique and disproportionate barriers related to language and cultural differences, discriminatory treatment by health care providers, fear of deportation or other immigration consequences, lower likelihood of being offered health insurance by an employer, shame or stigma related to being “a burden on the system,” lack of familiarity with the U.S. health care system, and related uncertainty about their potential financial liability for medical treatments. See generally Geraldine Dallek, *Health Care for Undocumented Immigrants: A Story of Neglect*, 14 CLEARINGHOUSE REV. 407, 409 (1980); Hacker et al., *supra* note 36, at 178; H. Russell Searight, *Bosnian Immigrants' Perceptions of the United States Health Care System: A Qualitative Interview Study*, 5 J. IMMIGRANT HEALTH 87, 90 (2003).

<sup>45</sup> JESSICA C. BARNETT & EDWARD R. BERCHICK, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016 1 (2017).

<sup>46</sup> See *infra* text accompanying footnotes 76–85 for a discussion of EMTALA and emergency Medicaid.

<sup>47</sup> See Dave A. Chokshi et al., *Health Reform and the Changing Safety Net in the United States*, 375 N. ENG. J. MED. 1790, 1790 (2016) (stating healthcare providers who serve as a safety-net rely on subsidies).

direct provision of health care through the Veteran's Health Administration, the Indian Health Service, and in prisons. Finally, patients themselves are often responsible for significant out-of-pocket health care expenses, whether or not they have insurance. If they are unable to pay their medical bills, they may be eligible for financial assistance ("charity care") from the health care provider to which they owe a debt, or it is categorized as "bad debt" by the provider.<sup>48</sup> Out of these major sources of financing, private health insurance paid for the largest share of health expenditures (34%), followed by Medicare (20%), Medicaid (17%), and households (11%).<sup>49</sup>

There are no citizenship or immigration status-based restrictions on eligibility for employer-based or direct-purchase insurance, or coverage offered through colleges or universities for enrolled students. However, these options are unavailable to many immigrants for other reasons. In order to obtain employer-based insurance, an employer must offer it, and immigrants are disproportionately likely to be employed in jobs and industries that do not offer health coverage.<sup>50</sup> Direct-purchase insurance is typically unaffordable

---

<sup>48</sup> Charity care and bad debt are the major types of hospital uncompensated care, which constitutes a significant portion of costs in the healthcare system. Patrick Glen, *Health Care and the Illegal Immigrant*, 23 HEALTH MATRIX 197, 219 (2013).

<sup>49</sup> *National Health Expenditures 2016 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

<sup>50</sup> See Fatma Marouf, *Alienage Classifications and the Denial of Health Care to Dreamers*, 93 WASH. U. L. REV. 1271, 1285 (2016) (describing lack of access to employer-based health insurance for the demographic of most DACA recipients, who are treated as undocumented immigrants for ACA purposes); Thomas C. Buchmueller et al., *Immigrants and Employer-Provided Health Insurance 2* (Econ. Res. Initiative on the Uninsured, Working Paper 38, Aug. 2005), <http://www.rwjf-eriu.org/pdf/wp38.pdf> (arguing the difference between immigrant and U.S. citizen insurance rates is almost entirely due to employer-sponsored insurance disparities); KAISER FAM. FOUND., HEALTH COVERAGE OF IMMIGRANTS (2017) (noting the increased likelihood that undocumented immigrants' employers do not provide health insurance compared to those of the general population). Undocumented immigrants are more likely than other types of workers to get injured on the job. See Pia M. Orrenius & Madeline Zavodny, *Do Immigrants Work in Riskier Jobs?*, 46 DEMOGRAPHY 535, 536 (2009). Although undocumented immigrants are generally eligible for medical coverage to diagnose and treat job-related injuries through their employers' workers' compensation insurance, these benefits are limited, and some workers forgo even this limited right because they fear that claims information could be used for immigration enforcement purposes. See Michael Grabell & Howard Berkes, *They Got Hurt at Work. Then They Got Deported.*, PROPUBLICA (Aug. 16, 2017), <https://www.propublica.org/article/they-got-hurt-at-work-then-they-got-deported> [<https://perma.cc/B96J-DDY8>] (reporting an example of an undocumented immigrant deciding not to take advantage of his workers' compensation in order to avoid deportation). In recent years, several states have introduced but failed to enact legislation excluding undocumented workers from workers' compensation medical benefits. See Deborah Berkowitz & Hooman Hedayati, *Unintended Consequences of*

and is often less comprehensive than plans offered through ACA Marketplace.<sup>51</sup> School health insurance policies are limited to enrolled students, and are therefore only temporary solutions for a small percentage of immigrants.<sup>52</sup>

Eligibility for most federal public benefit programs—including the major health care programs—is limited to U.S. citizens and certain “qualified aliens,” who constitute a minority of immigrants living in the United States. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 marked a shift in the treatment of immigrants with respect to eligibility for federal public benefit programs.<sup>53</sup> Prior to the passage of this welfare reform legislation, federal public benefits were generally available to lawful permanent residents and other immigrants who were permitted to remain in the United States indefinitely on the same terms as U.S. citizens.<sup>54</sup> PRWORA limited

---

*Limiting Workers' Comp Benefits for Undocumented Workers*, NAT'L EMPLOYMENT L. PROJECT (May 23, 2017), <https://s27147.pcdn.co/wp-content/uploads/Unintended-Consequences-Limiting-Workers-Comp-Undocumented-Workers.pdf>.

<sup>51</sup> See, e.g., The Editorial Board, *California's Nifty Idea on Immigrant Health Care*, N.Y. TIMES (Sept. 17, 2016), <https://www.nytimes.com/2016/09/18/opinion/californias-nifty-idea-on-immigrant-health-care.html?smid=tw-nytopinion&smtyp=cur> (claiming that directly purchasing health-care often leaves undocumented immigrants with less coverage than they would have received from an ACA marketplace plan); Lisa Zamosky, *Healthcare Options for Undocumented Immigrants*, L.A. TIMES (Apr. 27, 2014), <http://www.latimes.com/business/la-fi-healthcare-watch-20140420-story.html#page=1> [<https://perma.cc/78QR-NUH9>] (stating private health insurance is often too expensive for undocumented immigrants).

<sup>52</sup> See Jie Zong & Jeanne Batalova, *International Students in the United States*, MIGRATION POL'Y INST. (May 9, 2018), <https://www.migrationpolicy.org/article/international-students-united-states> [<https://perma.cc/E9JF-HL2A>] (citing the United States hosted 1.1 million international students in 2017). There are more than 43.7 million immigrants residing in the United States. Jie Zong et al., *Frequently Requested Statistics on Immigrants and Immigration in the United States*, MIGRATION POL'Y INST. (Feb. 8, 2018), <https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states> [<https://perma.cc/7TSJ-6X6V>].

<sup>53</sup> Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104–193, 110 Stat. 2105 (Aug. 22, 1996) (codified as amended in scattered sections of 42 U.S.C.); Illegal Immigration Reform and Immigrant Responsibility Act of 1996, enacted as Division C of the Defense Department Appropriations Act, 1997, Pub. L. No. 104–208, 110 Stat. 3009 (Sept. 30, 1996) (codified as amended at 8 U.S.C. § 1101 et seq.). Some of the harshness of PRWORA was alleviated through subsequent legislation that permitted states to expand Medicaid and CHIP eligibility to certain types of immigrants, discussed below. For an overview of immigrant access to publicly funded health coverage prior to PRWORA, see David C. Warner, *Access to health services for immigrants in the USA: from the Great Society to the 2010 Health Reform Act and after*, 35 ETHNIC & RACIAL STUD. 40, 41–44 (2012) (arguing the ACA of 2010, which was designed to ensure all Americans could obtain health insurance, may actually reduce immigrants' access by isolating them from the general population).

<sup>54</sup> Tanya Broder et al., *Overview of Immigrant Eligibility for Federal Programs*, NAT'L IMMIGR. L. CTR. 1, <https://www.nilc.org/wp-content/uploads/2015/12/overview-immeligfedprograms-20>

immigrants' access to many types of public benefits that help families meet basic needs, and therefore have a positive impact on health.<sup>55</sup> This legislation both reflected and influenced the rise of anti-immigrant attitudes in discussions around the government's obligations to maintain a social safety net for individuals living within its territory.<sup>56</sup> The current policy framework that excludes most categories of immigrants from the major publicly funded health care programs is based on PRWORA.

The definition of a "qualified alien" under PRWORA is complex. It includes lawful permanent residents, refugees, people granted asylum, people granted parole by the U.S. Department of Homeland Security (DHS) for a period of at least one year, people granted withholding of deportation/removal, people granted conditional entry, Cuban and Haitian entrants, certain survivors of trafficking, and certain abused immigrants, their children, and their parents.<sup>57</sup> All other immigrants are considered "non-qualified aliens," and are generally ineligible for federal public benefits.<sup>58</sup> However, even qualified

---

15-12-09.pdf (last revised Dec. 2015); 45 C.F.R. § 248.50 (1974) (setting guidelines for state plans under the Social Security Act which include citizens or lawfully admitted aliens).

<sup>55</sup> PRWORA restricted immigrant eligibility in federal programs that provide "any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit . . ." The Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, § 401(c)(1)(B), 110 Stat. at 2113 (codified in 42 U.S.C. § 601). Other agencies issued their own interpretations of the programs they administer that are subject to PRWORA. *See, e.g.*, Dep't of Health & Human Servs., PRWORA, "Interpretation of 'Federal Public Benefit,'" 63 Fed. Reg. 41,658-41,661 (Aug. 4, 1998) (including services offered through the Child Care and Development Fund, the Low Income Home Energy Assistance Program (LIHEAP), and Temporary Assistance for Needy Families (TANF)); Personal Responsibility and Work Opportunity Reconciliation Act of 1996: Federal Means-Tested Public Benefits Paid by the Social Security Administration, 62 Fed. Reg. 45,284 (Aug. 26, 1997) (including the Supplementary Security Income (SSI) program); Food and Nutrition Service, Federal Means-Tested Public Benefits, 63 Fed. Reg. 36,653 (July 7, 1998) (including the Food Stamp Program, which is the predecessor of the Supplemental Nutrition Assistance Program (SNAP)).

<sup>56</sup> *See* Anahí Viladrich, *Beyond Welfare Reform: Reframing Undocumented Immigrants' Entitlement to Health Care in the United States, a Critical Review*, 74 SOC. SCI. & MED. 822, 823 (2012) (arguing that PRWORA ushered in a new American culture of distrust of foreigners who were perceived to be coming to America to take advantage of federal and state benefits, often illegally).

<sup>57</sup> The Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, § 431(b), 110 Stat. at 2274 (codified in 8 U.S.C. § 1641(b)); *see also* William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. No. 110-457, 122 Stat. 5063 § 211 (Dec. 23, 2008) (adding certain survivors of trafficking to the definition of "qualified alien").

<sup>58</sup> Although the term "non-qualified" does not appear in PRWORA, HHS has used it in regulations interpreting the statute. *See* Personal Responsibility and Work Opportunity



aliens face restrictions on their eligibility for federal public benefits.<sup>59</sup> An eligibility determination for a noncitizen applicant can involve consideration of numerous criteria beyond the applicant's current immigration status, including whether the applicant entered the United States or received benefits prior to PRWORA's enactment on August 22, 1996; any work history or military connections; number of years with qualified status; and how states have exercised their discretion within PRWORA to permit noncitizen participation in federal public benefit programs.<sup>60</sup>

The federal government has the authority to exclude noncitizens from public benefit programs. In constitutional challenges to Congress' disparate treatment of citizens and noncitizens with respect to eligibility for public benefits, the Supreme Court has upheld the political branches' right to discriminate.<sup>61</sup> These decisions are based on the plenary power doctrine, which gives the legislative and executive branches great discretion over the establishment of laws and policy relating to immigration. The Supreme Court precedents applying the plenary power doctrine to legislation relating to public benefits eligibility criteria establish the federal government's right to discriminate on the basis of citizenship or immigration status so long as the decision has a rational basis. In Equal Protection challenges to laws restricting immigrant access to public benefits, federal courts have consistently found that these laws easily satisfy rational basis review, for purposes related to deterrence of illegal immigration and cost savings.<sup>62</sup>

The following paragraphs broadly summarize noncitizen eligibility for the major federal health care benefit programs for low-income people that existed before the ACA: Medicaid and the Children's Health Insurance Program

---

Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit," 63 Fed. Reg. 41,658, 41,659, 41,660 (Aug. 4, 1998).

<sup>59</sup> These restrictions are described in detail in relation to immigrant eligibility for federally subsidized health care programs, below.

<sup>60</sup> See ALISON SISKIN, CONG. RESEARCH SERV., RL33809, NONCITIZEN ELIGIBILITY FOR FEDERAL PUBLIC ASSISTANCE: POLICY OVERVIEW (2016).

<sup>61</sup> See *Mathews v. Diaz*, 426 U.S. 67, 78–84 (1976) (holding that Congress' broad power over naturalization allows it to engage in disparate treatment between citizens and immigrants that is not necessarily invidious); *Lewis v. Thompson*, 252 F.3d 567, 582 (2d Cir. 2001) (upholding PRWORA's denial of prenatal care to non-qualified immigrants and reiterating the federal government's "broad power over naturalization and immigration"); *Lake v. Reno*, 226 F.3d 141, 148 (2d Cir. 2000) (holding that a highly deferential standard is appropriate in immigration cases).

<sup>62</sup> *Lewis v. Thompson*, 252 F.3d 567, 583 (2d Cir. 2001) (denial of Medicaid); *Aleman v. Glickman*, 217 F.3d 1191 (9th Cir. 2000) (denial of Food Stamps); *City of Chicago v. Shalala*, 189 F.3d 598, 609 (7th Cir. 1999) (denial of Food Stamps, Supplemental Security Income, and other income benefits); *Rodriguez v. U.S.*, 169 F.3d 1342, 1353 (11th Cir. 1999) (denial of Food Stamps and Supplemental Security Income).

(CHIP). Both Medicaid and CHIP are jointly funded by the federal government and states, with the federal government paying states for a specified percentage of Medicaid expenditures ranging from 50% to 74%, depending on the state's per capita income.<sup>63</sup> A chart describing immigrant eligibility for federally funded health care programs for a variety of individual circumstances is at Appendix 1.

Contrary to what one might expect, not all immigrants who are *qualified* for Medicaid and CHIP are *eligible* to receive them. In general, qualified immigrants are ineligible for these programs for a period of five years, beginning on the date they become qualified.<sup>64</sup> However, there are several categories of immigrants who are exempt from this five-year bar, including humanitarian immigrants such as refugees and asylees; trafficking survivors; certain Amerasian immigrants; grantees of Iraqi or Afghan special immigrant status; certain American Indians born in Canada; individuals receiving Foster Care; and permanent resident veterans or active duty military members and their spouses and unmarried dependent children.<sup>65</sup> In addition, most immigrants who were lawfully residing in the United States prior to August 22, 1996, which was the date PRWORA was enacted, are eligible for Medicaid and CHIP, and are not subject to the five-year bar.<sup>66</sup>

Under PRWORA, all nonqualified immigrants were ineligible for Medicaid and CHIP.<sup>67</sup> However, in the years thereafter, Congress twice

---

<sup>63</sup> ROBIN RUDOWITZ, KAISER FAM. FOUND., MEDICAID FINANCING: THE BASICS 2 (2016) (the federal government pays for a larger share of program costs for certain services or populations).

<sup>64</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 431, 110 Stat. 2105, 2274 (codified in 8 U.S.C. § 1641).

<sup>65</sup> 8 U.S.C. § 1612. Six states—Wyoming, Alabama, Mississippi, North Dakota, Texas, and Virginia—elected to provide Medicaid to a more limited group of qualified immigrants who have completed the five-year bar. So, although federal funds are available to provide health care to *all* qualified immigrants who have completed the five-year bar, these states have chosen to pass on this opportunity for some noncitizen residents. Refugees who are ineligible for Medicaid or CHIP receive health coverage for up to eight months after they are initially resettled in the United States through a 100% federally funded benefit called Refugee Medical Assistance. 8 U.S.C. § 1522(e)(5); 45 C.F.R. § 400.100 (describing general eligibility requirements for refugee medical assistance); 45 C.F.R. § 400.211 (describing the methodology to be used to determine the annual time-eligibility period for refugee medical assistance). The same benefit is also available to asylum recipients, Cuban and Haitian entrants, certain Amerasians, and certain humanitarian parolees, and to trafficking victims beginning on the date such status was granted. 45 C.F.R. § 400.43(a); OFF. OF REFUGEE RESETTLEMENT, FACT SHEET: VICTIM ASSISTANCE (2012) (describing eligibility for trafficking victims).

<sup>66</sup> Providing Medicaid to this population was an option under PRWORA. Only Wyoming declined this option. Broder et al., *supra* note 54, at 4, n.23.

<sup>67</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2113 (codified in 42 U.S.C. § 601).

expanded the categories of immigrants eligible for federal Medicaid and CHIP. In 2002, states were permitted to use CHIP funds to provide prenatal care for pregnant women without a waiting period, regardless of their immigration status; sixteen states plus the District of Columbia have elected to do so.<sup>68</sup> In 2009, Congress gave states the option to provide Medicaid or CHIP to nonqualified children and/or pregnant women who are “lawfully residing” in the United States and who otherwise would be eligible for those programs, without a waiting period.<sup>69</sup> The term “lawfully residing,” as it relates to immigrant eligibility for Medicaid and CHIP, has the same meaning as “lawfully present” in the context of eligibility for other federal public benefits.<sup>70</sup> This category includes all qualified aliens, as well as persons with a variety of humanitarian statuses or circumstances, valid non-immigrant visas, and legal statuses conferred by other laws.<sup>71</sup> More than half of the states have elected the option to expand Medicaid or CHIP to lawfully present immigrant children, and nearly half of the states have elected it for lawfully present pregnant women.<sup>72</sup>

Although nonqualified immigrants who are not lawfully present remain ineligible for full-scope Medicaid benefits, a separate provision provides coverage of emergency treatments for uninsured patients regardless of citizenship or immigration status.<sup>73</sup> Emergency Medicaid is available to all immigrants who would meet the requirements of the state’s Medicaid program but for their immigration status.<sup>74</sup> Federal funds may be used under this

---

<sup>68</sup> Broder et al., *supra* note 54, at 5.

<sup>69</sup> Children’s Health Insurance Program Reauthorization Act of 2009 (H.R.2), Pub. L. No. 111–3, § 214, 123 Stat. 56 (2009); 42 U.S.C. § 1396b(v)(4)(A)(Medicaid); 42 U.S.C. 1397gg(e)(1)(N) (CHIP).

<sup>70</sup> See Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials 3–4 (July 1, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf> (explaining the definition of “lawfully present” as related to other federal public benefit programs); 8 C.F.R. 103.12(a) (defining “lawfully present”).

<sup>71</sup> *But see* Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials and Medicaid Director 1 (Aug. 28, 2012), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-002.pdf> (excluding DACA recipients from the definition of “lawfully residing” children or pregnant women who states can elect to cover under Medicaid or CHIP). The exclusion of DACA recipients from the major federally funded health care programs is discussed in detail later.

<sup>72</sup> See *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html> [<https://perma.cc/2FMV-FFG3>] (last visited Dec. 27, 2018).

<sup>73</sup> 42 U.S.C. § 1396b(v)(2)(A)-(C).

<sup>74</sup> 8 U.S.C. § 1611(b)(1)(A); U.S. GENERAL ACCOUNTABILITY OFF., GAO–04–472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED

provision to cover the treatment of an “emergency medical condition,” which is defined as “a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient’s health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.”<sup>75</sup> Covered services are limited to those required “after the sudden onset” of a medical condition; therefore, applicants cannot apply for coverage in advance.<sup>76</sup>

Emergency Medicaid works in tandem with a federal law, the Emergency Medical Treatment and Labor Act (EMTALA), which requires virtually all hospitals to provide treatment to stabilize patients who have an emergency medical condition.<sup>77</sup> This obligation applies regardless of a patient’s citizenship or immigration status.<sup>78</sup> The definition of “emergency medical condition” under EMTALA is almost identical to the term used to qualify services for coverage under emergency Medicaid.<sup>79</sup> Generally, health care providers are not obligated to treat patients who do not have proof of insurance or other ability to pay, so EMTALA represents a major exception to the rule that a provider has no duty to accept a new patient, regardless of the patient’s condition.<sup>80</sup> Congress

---

CARE COSTS, 9 (2004) (noting that undocumented aliens eligible for or enrolled in Medicaid can receive only emergency medical services). Emergency Medicaid is available to uninsured U.S. citizens, but there is evidence that the majority of Medicaid expenditures are for services provided to immigrants—and, in particular, undocumented immigrants. *Id.* at 10.

<sup>75</sup> 42 U.S.C. § 1396b(v).

<sup>76</sup> 42 C.F.R. § 440.255(c)(1).

<sup>77</sup> 42 U.S.C. § 1395dd(a) (“In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists.”); *id.* at § 1395dd(b) (describing hospital’s obligation to provide necessary stabilizing treatment for emergency medical conditions and labor).

<sup>78</sup> *See* 42 U.S.C. § 1395dd(a) (stating that the obligation applies to “any individual”); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (holding states must provide emergency medical services to undocumented people as a condition of receipt of Medicaid funding).

<sup>79</sup> *Compare* 42 U.S.C. § 1395dd(e)(1) (including harm to both the mother and child if the condition is not immediately treated in the definition of “emergency medical condition”) with 42 C.F.R. § 489.24(b) (defining emergency medical condition as in the EMTALA statute, with the addition of “psychiatric disturbances or symptoms of substance abuse,” and without a “sudden onset” requirement).

<sup>80</sup> The seminal case stating this rule is *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901). However, there are certain situations in which courts have held health care providers have a

was motivated to approve emergency Medicaid funding for patients who would otherwise burden hospitals with uncompensated care costs.<sup>81</sup> Together, EMTALA and emergency Medicaid provide universal access to care for the stabilization of emergency medical conditions, and near-universal access to publicly funded coverage of such treatment for low-income uninsured people.

However, EMTALA and emergency Medicaid are not, in any way, a true health care safety net for uninsured immigrants. Treatment and coverage limitations result in hospitals denying treatment to patients that go beyond stabilization of an emergent condition.<sup>82</sup> Moreover, different state interpretations of “emergency medical condition” result in big differences in access to lifesaving health care for immigrants. Depending on the state in which he resides, an uninsured immigrant may or may not receive coverage for treatment of cancer, kidney failure, or traumatic brain injuries.<sup>83</sup> The practical consequences of this patchwork of interpretations are potentially severe for uninsured immigrants with serious medical conditions. For example, in a state that does not consider renal failure to be an emergency medical condition, an uninsured immigrant would be eligible for coverage of dialysis only once he goes into diabetic shock.<sup>84</sup> Similarly, states may deny payment for medically indicated, scheduled Cesarean deliveries for pregnant women based on the reasoning that the need for this procedure does not arise from the “sudden onset” of a condition.<sup>85</sup> In addition, some states have successfully

---

duty to treat under common law. *See, e.g.*, *Wilmington General Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (finding a hospital has a duty to treat in cases of “unmistakable emergency”); *Guerrero v. Cooper Queen Hosp.*, 537 P.2d 1329, 1330 (Ariz. 1975) (implying an expansive duty “to provide emergency care to *all* persons presenting themselves for such aid”); *Thompson v. Sun City Community Hosp.*, 688 P.2d 605, 611–12 (Ariz. 1984) (holding hospitals may not transfer emergency patients for economic reasons).

<sup>81</sup> *See, e.g.*, Phil Galewitz, *Medicaid Helps Hospitals Pay for Illegal Immigrants’ Care*, KAISER HEALTH NEWS (Feb. 12, 2013), [https://www.dhs.gov/sites/default/files/publications/14\\_1120\\_memo\\_deferred\\_action\\_0.pdf](https://www.dhs.gov/sites/default/files/publications/14_1120_memo_deferred_action_0.pdf) [<https://perma.cc/9AV7-XLTH>] (explaining Congress approved the funding after “lawmakers required hospitals to screen and stabilize all emergency patients” leaving hospitals with a deficit if the patient then could not pay).

<sup>82</sup> *See, e.g.*, HEALTH ACCESS FOUNDATION, *supra* note 29, at 2 (“While many consider hospital emergency rooms as the nation’s safety net, the only requirement is that a hospital must stabilize a patient in in an emergent [sic] situation,” so, for example, “a severe asthma attack will be treated, but care to manage asthma” is not provided).

<sup>83</sup> *See* Jane Perkins, *Medicaid Coverage of Emergency Medical Conditions*, 38 CLEARINGHOUSE REV. J. POVERTY L. & POL., 384, 389–90 (2004) (explaining that brain trauma, renal failure and cancer treatment are the conditions most likely to result in denial of Medicaid coverage once immigrant patients stabilize).

<sup>84</sup> Rodriguez et al., *supra* note 5, at 15.

<sup>85</sup> Perkins, *supra* note 83, at 388 (citing Letter from Andrew A. Fredrickson, Associate Regional Administrator, Div. of Medicaid, Dallas Regional Office, Ctrs. for Medicare &

defended their exclusion of certain classes of noncitizens from eligibility for emergency Medicaid based on interpretations of their Medicaid residency requirements.<sup>86</sup>

When a patient's treatment for an emergency medical condition under EMTALA is not covered by health insurance or emergency Medicaid, hospitals bill patients for all services received. Attempts to extract payments from low-income, uninsured patients are typically unsuccessful. For this reason, hospitals that serve a disproportionate number of low-income patients are eligible to receive Medicaid Disproportionate Share Hospital (DSH) payments to subsidize their operations.<sup>87</sup> DSH payments can help to offset the cost of treating undocumented immigrants.<sup>88</sup> On two occasions, Congress has authorized the distribution of additional funds for the specific purpose of subsidizing emergency care provided to uninsured immigrants. In 1997, Congress recognized that states with the greatest numbers of undocumented residents incur disproportionate costs for the provision of uncompensated emergency care, and authorized an additional \$25 million in funding to be split among twelve states, for each fiscal year from 1998 to 2001.<sup>89</sup> In 2003, Congress once again authorized additional funding—\$250 million for each fiscal year from 2005 to 2008—to reimburse health care providers nationwide for the cost of emergency health services to undocumented immigrants and other noncitizens whose care was not covered.<sup>90</sup>

---

Medicaid Servs., to Don Hearn, Medical Advocacy Services for Healthcare, Fort Worth, Tex. (Dec. 9, 2002) (on file with Jane Perkins)).

<sup>86</sup> See, e.g., *Clark v. Div. of Social Services*, No. COA02-1278, 2003 N.C. App. LEXIS 1855 at \*5–6 (N.C. Ct. App. 2003), *review denied*, 358 N.C. 153 (N.C. 2004) (denying coverage of the cost of a noncitizen's dialysis treatment because she entered the country with a tourist visa, which presumably contradicted her claim, as the evidence showed she intended to reside in the state); *Okale v. N.C. Depts. of Health & Human Servs.*, 570 S.E.2d 741, 744–45 (N.C. Ct. App. 2002) (denying coverage of the cost of a noncitizen's childbirth because she had an unexpired tourist visa); *Salem Hosp. v. Comm'r of Public Welfare*, 574 N.E.2d 385, 386–89 (Sup. Jud. Ct. 1991) (denying coverage of treatment for applicant who was visiting relatives in Massachusetts on a valid visitor's visa).

<sup>87</sup> See, e.g., U.S. GENERAL ACCT. OFFICE, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS' UNCOMPENSATED CARE COSTS 13 (May 2004) (“In general, a hospital qualifies for DSH payments on the basis of the relative amount of Medicaid service or charity care it provides.”).

<sup>88</sup> *Id.* (explaining this determination includes care to undocumented immigrants).

<sup>89</sup> See Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4723, 111 Stat. 251, 515 (1997) (authorizing 25 million dollars for uncompensated care). The states that qualified for the additional funding were California, Texas, New York, Florida, Illinois, New Jersey, Arizona, Massachusetts, Virginia, Washington, Colorado, and Maryland. 63 Fed. Reg. 10402 (Mar. 3, 1998).

<sup>90</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, § 1011, 117 Stat. 2066, 2432 (codified in 42 U.S.C. 1395(d)(d)).

Coverage options for immigrants vary significantly depending on the state in which they reside, based on whether the state has decided to take advantage of options to use federal funding to cover specific subpopulations (discussed above), or to use state funds to cover immigrants who do not qualify for federally funded health care programs. For example, children under the age of nineteen, regardless of status, may access subsidized coverage through state-funded programs in California, the District of Columbia, Illinois, Massachusetts, and New York.<sup>91</sup> Many states also subsidize coverage of qualified immigrants who have not completed five years in that status. Coverage options can even vary within a state. For example, Maryland funds limited coverage for children, regardless of immigration status, if they reside in Montgomery County or Prince George's County.<sup>92</sup> However, throughout most of the country, many immigrants—and undocumented immigrants, in particular—are unable to access publicly funded health coverage.

In the absence of publicly funded health insurance options, many immigrants rely on safety net providers, such as federally qualified health centers (FQHCs), which were created to attend to the primary health care needs of medically underserved populations. The federal government funds the operation of FQHCs through grants under Section 330 of the Public Health Service Act.<sup>93</sup> Health insurance is not necessary to receive services at FQHCs, and patients pay for services on a sliding scale based on their income. FQHCs treat patients regardless of their citizenship or immigration status.<sup>94</sup> However, undocumented immigrants may still fear being on the hook for costs or exposing their lack of status, and these fears discourage many from accessing preventive health care. Also, FQHCs only provide primary care services, meaning that patients who are referred for specialist care must figure out a way to pay for these services or go without. Care provided at safety-net hospitals and clinics has been described as “categorically unequal” to care provided at private health care institutions.<sup>95</sup> In

---

<sup>91</sup> NILC, *supra* note 4, Table 3 (illustrating that these states offer medical assistance programs to some children regardless of immigration status).

<sup>92</sup> *Id.* at 2 (stating that coverage of immigrant children in Maryland differs by county in some cases).

<sup>93</sup> See CMS, FEDERALLY QUALIFIED HEALTH CENTER 3 (Jan. 2018), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf> (stating that FQHCs must receive a section 330 grant under the Public Health Service Act).

<sup>94</sup> Services provided by FQHCs are not considered to be federal public benefits subject to PRWORA. See ALISON SISKIN, *supra* note 60, at i (stating FQHCs are not federal public benefits).

<sup>95</sup> See, e.g., Marrow & Joseph, *supra* note 2, at 2255 (describing care at clinics and safety-net hospitals as categorically unequal).

addition, it is widely acknowledged among health policy experts that the health care safety net, in which FQHCs play an important role, is inadequate to provide health care to all those who qualify for services.<sup>96</sup>

There are a few other limited contexts in which immigrants of all types may access federally funded health care services. Through the Public Health Service, immigrants have access to immunizations and treatment of communicable disease symptoms, whether or not a communicable disease is actually causing those symptoms, on the same terms as U.S. citizens.<sup>97</sup> Similarly, during federally declared disasters, the government provides short-term, in-kind emergency disaster assistance to residents of disaster areas without consideration of citizenship or immigration status.<sup>98</sup> This assistance includes medical, public health, and mental health services necessary to protect life or safety, which includes treatment of mental illness and substance abuse.<sup>99</sup> Finally, the U.S. Immigration and Customs Enforcement Health Service Corps (IHSC), provides direct care to immigrants in its custody.<sup>100</sup>

---

<sup>96</sup> See, e.g. SARA ROSENBAUM ET AL., KAISER FAM. FOUND., COMMUNITY HEALTH CENTERS: RECENT GROWTH AND THE ROLE OF THE ACA 2 (2017) (explaining the decision to make Medicaid expansion optional has kept 19 states from providing the coverage); ANDREA B. STAITI, ROBERT E. HURLEY & AARON KATZ, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, ISSUE BRIEF NO. 104: FINDINGS FROM HSC 2 (Feb. 2006) (describing providers' difficulty with referring undocumented immigrants for specialty care); James Hennessy, *FQHCs and Health Reform: Up to the Task?*, 9 NW. J. L. & SOC. POL'Y 122, 131 (2013) ("Some communities have relatively extensive FQHC capacity for their Medicaid and uninsured populations, while others have lagged substantially in such growth by comparison."); Ileana Najarro & Jenny Deam, *Fearing Deportation, Undocumented Immigrants in Houston are Avoiding Hospitals and Clinics*, HOUSTON CHRONICLE (Dec. 27, 2017), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Fearing-deportation-undocumented-immigrants-are-12450772.php> [<https://perma.cc/A9KS-MMYF>] (describing how one mother avoided seeking treatment for cancer out of fear that if she went to the hospital "someone will call immigration and she will be taken away from her daughters"); Michael K. Gusmano, *Lack of Coverage for Undocumented Patients Puts Pressure on the Health Care Safety Net*, ROBERT WOOD JOHNSON FOUND. CULTURE OF HEALTH BLOG (Sept. 26, 2014, 9:00 AM), [https://www.rwjf.org/en/culture-of-health/2014/09/lack\\_of\\_coveragefor.html](https://www.rwjf.org/en/culture-of-health/2014/09/lack_of_coveragefor.html) [<https://perma.cc/LK7Z-8KRY>] (calling the current safety net "unraveling" due to the demands).

<sup>97</sup> 8 U.S.C. § 1611(b)(1)(C); Broder et al., *supra* note 54, at 3 (noting immunization services are available through public assistance regardless of immigration status).

<sup>98</sup> 8 U.S.C. § 1611(b)(1)(B); Broder et al., *supra* note 54, at 4 ("Short-term noncash emergency disaster assistance remains available without regard to immigration status.").

<sup>99</sup> 8 U.S.C. § 1611(b)(1)(D); U.S. DEP'T OF JUSTICE, A.G. ORDER NO. 2353-2001, FINAL SPECIFICATION OF COMMUNITY PROGRAMS NECESSARY FOR PROTECTION OF LIFE OR SAFETY UNDER WELFARE REFORM LEGISLATION (published in 66 FR 3613-16 (Jan. 16, 2001)) (promulgating the Attorney General's interpretation of programs, services and assistance pursuant to 1611(b)(1)(D)).

<sup>100</sup> See Immigration Enforcement, *ICE Health Service Corps*, DEP. OF HOMELAND SEC., <https://www.ice.gov/ice-health-service-corps> [<https://perma.cc/LA57-YTNR>] (last updated Dec. 12, 2018) (describing ICE Health Core Services' commitment to providing health care to detained persons).



The passage of the ACA in 2010 made health insurance more accessible for millions of people living in the United States. It created new responsibilities and benefits for most people living in the United States through three major changes: requiring all U.S. residents to have a minimum level of health coverage; creating federal tax credits to subsidize health insurance purchased on a federal or state-run insurance “Marketplace;” and expanding eligibility for Medicaid.

The ACA created new responsibilities and benefits for most people living in the United States. Generally, all immigrants who are “lawfully present in the United States,” and who do not otherwise qualify for an exemption, share in these new responsibilities and benefits.<sup>101</sup> The term “lawfully present” was not defined in the ACA itself and is not a term that has a precise definition in the immigration laws.<sup>102</sup> Ultimately, the Department of Health and Human Services (HHS) issued regulations defining the term to include qualified aliens under PRWORA,<sup>103</sup> as well as individuals who have been paroled into the United States for less than a year; who have a valid nonimmigrant status; who were granted withholding of removal under the Convention Against Torture, temporary protected status (TPS), deferred enforced departure (DED), deferred action, family unity, or temporary resident status; who have an approved visa petition and have filed an application to adjust to lawful permanent residence; who were granted employment authorization based on an application for asylum or withholding of removal (or, if under fourteen years old, have had such an application pending for more than 180 days), TPS, registry, legalization under the Immigration Reform and Control Act (IRCA) of 1986, adjustment under the Legal Immigration Family Equity (LIFE) Act, suspension of deportation or cancellation of removal, or based on an order of supervision; and applicants for Special Immigrant Juvenile Status.<sup>104</sup>

---

<sup>101</sup> See 26 C.F.R. § 1.5000A-3(c)(2)(ii)(B) (describing noncitizens who are exempt from the individual mandate as “not lawfully present”); 26 C.F.R. § 1.36B-2(b)(4) (describing noncitizens who are not lawfully present as ineligible to enroll in health coverage through a Marketplace); 26 C.F.R. § 1.36B-2(b)(5) (describing noncitizens who are lawfully present as eligible for premium tax credits).

<sup>102</sup> See ALISON SISKIN & ERIKA K. LUNDER, CONG. RESEARCH SERV., R43561, TREATMENT OF NONCITIZENS UNDER THE AFFORDABLE CARE ACT 2–3 (2016) (noting the definition for lawfully present was provided by regulatory agencies after the ACA was passed, rather than in the legislation itself).

<sup>103</sup> The definition of “qualified alien” under PRWORA is found at 8 U.S.C. § 1641 (“[T]he term ‘qualified alien’ means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit” falls under one of the seven categories described in § 1641(b)). See also App. 1 (including qualified aliens).

<sup>104</sup> See 45 C.F.R. § 152.2 (2016) (defining “lawfully present” for the purpose of eligibility to enroll in the Pre-Existing Condition Insuring Plan (PCIP) program, an ACA program that is

The individual mandate requires every person residing in the United States to have health insurance, or pay a tax penalty, unless they are eligible for an exemption.<sup>105</sup> Generally, all immigrants who are lawfully present in the United States are subject to the individual mandate.<sup>106</sup> Those who are not lawfully present are exempt from the individual mandate. However, in mixed-status households, exempt noncitizen parents are still responsible for obtaining health coverage for their non-exempt children.<sup>107</sup>

In order to make health coverage more affordable for lower-to-middle income households who are subject to the individual mandate, the ACA created a new system of subsidizing the purchase of private health insurance plans that meet the ACA's definition of minimal creditable coverage. It consists of two types of federal tax credits for households with incomes at or below 400 percent of the federal poverty level that purchase health insurance on a health insurance exchange and file a federal tax return.<sup>108</sup> The first type, a "premium tax credit" reduces the out-of-pocket cost of health insurance premiums for plans offered through a federal Marketplace.<sup>109</sup> The second type, "cost-sharing reductions," subsidizes the cost of copayments, coinsurance, and deductibles.<sup>110</sup> The amount

---

not a focus of this Article); 26 C.F.R. § 1.36B-1(g) (2012) (implementing the premium tax credits and cross-referencing the PCIP definition of "lawfully present"), § 1.5000A-3(c)(2)(ii)(B) (describing noncitizens who are not exempt from the individual mandate and cross-referencing the same definition); 45 C.F.R. § 155.2 (2012) (implementing the Exchanges and cross-referencing the same definition).

<sup>105</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(b) (codified at 26 U.S.C. § 5000A (a), (g)) (establishing the individual mandate and its associated penalty for non-compliance).

<sup>106</sup> See Patient Protection and Affordable Care Act § 1501(b) (codified at 26 U.S.C. § 5000A(d)(3); 26 C.F.R. § 1.5000A-3(c)(2)(ii)(B) (defining individuals not lawfully present). The individual mandate only applies in months in which a noncitizen is lawfully present for the entire month. Patient Protection and Affordable Care Act § 1501(b) (codified at 26 U.S.C. § 5000A-3(c)(2)). Also, there are certain noncitizens who fall under the definition of lawfully present, but who qualify as "nonresident aliens" under the tax laws; they are also exempt from the individual mandate. 26 C.F.R. § 1.5000A-3(c)(2)(ii)(A).

<sup>107</sup> See NAT'L IMM. L. CTR., *THE AFFORDABLE CARE ACT & MIXED-STATUS FAMILIES* 3 (2014) (stating that exempt parents may still be assessed a penalty for not insuring their non-exempt children).

<sup>108</sup> See I.R.C. § 36B(c)(1)(A) (defining applicable taxpayers who are eligible for ACA tax credits); 26 C.F.R. § 1.36B-2 (2016) (stating the conditions for premium tax credits for eligible taxpayers); 45 C.F.R. § 155.305(f) (2016) (stating the conditions for advance payment of the premium tax credit).

<sup>109</sup> See I.R.C. § 36B (2014) (defining a premium tax credit for applicable taxpayers which offsets premium costs).

<sup>110</sup> See 42 U.S.C. § 18071 (2014) ("The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit..." which includes copayments, coinsurance and deductibles).

of subsidy each household receives is based on a sliding scale pegged to household income. Immigrants must be lawfully present in the United States in order to be eligible for a Marketplace health plan and to receive tax credits to subsidize that purchase under the ACA.<sup>111</sup> For eligibility purposes, “lawfully present” has the same meaning as “lawfully residing” with respect to eligibility for Marketplace health plans and tax credits.<sup>112</sup> The major noncitizen beneficiaries of this reform are qualified immigrants who are ineligible for Medicaid and CHIP due to the five-year ban, and nonqualified but lawfully present immigrants.<sup>113</sup>

Under the ACA, states may expand Medicaid eligibility to a much broader group of potential recipients. Prior to health care reform, states were limited to using federally funded Medicaid for certain categories of low-income people, such as the aged, blind, disabled, or members of families with dependent children. The ACA expanded eligibility for Medicaid by increasing the maximum income with which one could qualify for the benefit, and by eliminating the categorical restrictions on qualified recipients. Specifically, it enabled states to expand Medicaid coverage to all otherwise eligible people with incomes under 138% of the federal poverty level. Immigrants and U.S. citizens alike who reside in states that chose not to expand Medicaid did not reap any of these benefits. Currently, thirty-six states and the District of Columbia have expanded Medicaid coverage.<sup>114</sup>

In states that expanded Medicaid, immigrants who did not qualify for Medicaid prior to the ACA because of their income or a categorical restriction are now eligible to qualify. On account of this change in the eligibility criteria

---

<sup>111</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1411(a)(1) (describing eligibility for the health insurance exchanges and the related premium tax credits), § 1312(f)(3) (codified at 42 U.S.C. § 18032(f)(3)) (2017); I.R.C. § 36B(e)(2) (2017); 42 U.S.C. § 18032(f)(3) (2017); 42 U.S.C. § 18071(e)(2) (2017); *see also* 42 U.S.C. § 18082(d) (2017) (“No Federal payments for individuals not lawfully present.”).

<sup>112</sup> *See* Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials 3–4 (July 1, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SM-DL/downloads/SHO10006.pdf>.

<sup>113</sup> Although eligibility for ACA premium tax credits helps lawfully present immigrants overcome financial barriers to accessing health insurance—an important social determinant of health that is the focus of this Article—lawfully present immigrants face non-financial barriers that can hinder their ability to obtain coverage. *See* Hacker et al., *supra* note 36, at 178 (summarizing non-financial barriers to access that immigrants often encounter).

<sup>114</sup> *Status of State Action on the Medicaid Expansion*, KAISER FAM. FOUND. (Nov. 26, 2018), <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-1> [<https://perma.cc/UQZ6-VSW3>].

for Medicaid, a broader range of uninsured citizens and immigrants (in terms of income and categories) also became eligible for emergency Medicaid. This is because eligibility for emergency Medicaid is based on the state's eligibility criteria for the general Medicaid program. For example, a non-pregnant, non-elderly, non-disabled, undocumented adult with an income at 125% of the federal poverty level may not have been eligible for emergency Medicaid prior to the ACA on account of her income, and the fact that she did not fall within one of the eligible categories; after expansion, she is eligible for emergency Medicaid.

The ACA also increased funding for FQHCs, which are important providers of health care services to immigrant communities.<sup>115</sup> The Community Health Center Fund (CHCF) both mandated and increased grant funding for FQHCs under Section 330 of the Public Health Service (PHS) Act.<sup>116</sup> This supplementary funding, along with increased revenues derived from insurance payments due to Medicaid expansion, has bolstered the budgets of many existing health centers, enabling them to expand primary care capacity and the range of services they offer.<sup>117</sup> Immigrants are undoubtedly among those who benefitted from this expansion of services, as FQHCs are one of the only sources of affordable primary care for uninsured immigrants.

Despite its achievements in expanding access to health coverage and improving health outcomes for millions of people living in the United States, scholars have characterized health care reform as “largely a missed opportunity” to change the status quo for immigrants.<sup>118</sup> The ACA did not

---

<sup>115</sup> Sonal Ambegaokar, *Opportunities for Maximizing Revenue and Access to Care for Immigrant Populations*, P'SHIP FOR PUB. HEALTH L.1, <http://www.astho.org/Public-Policy/Public-Health-Law/Access-to-Care-for-Immigrant-Populations-Overview>.

<sup>116</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as § 5601(a)). The ACA funded the CHCF for FY2010-15, and Congress subsequently extended funding through FY2019. See ELAYNE J. HEISLER & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., IN10804, TWO-YEAR EXTENSION OF THE COMMUNITY HEALTH CENTER FUND 3 (2018) (citing Bipartisan Budget Act of 2018, Pub. L. No. 115-123) (discussing specific mandates of the Affordable Care Act).

<sup>117</sup> See JULIA PARADISE ET AL., KAISER FAM. FOUND., COMMUNITY HEALTH CENTERS: RECENT GROWTH AND THE ROLE OF THE ACA 5-6 (2017) (discussing the impact of increased funding because of the ACA on health centers).

<sup>118</sup> Kinsey Hasstedt, *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*, 16 GUTTMACHER POL'Y REV. 2, 3-4 (2013). See also Pandey, *supra* note 44, 757 (explaining why the ACA fails to reach the health care needs of a large proportion of immigrants); David C. Warner, *Access to Health Services for Immigrants in the USA: from the Great Society to the 2010 Health Reform Act and After*, 35 ETHNIC AND RACIAL STUD. 40, 47-48 (2012) (providing a past and present analysis of the impact of health reforms on immigrants); Donald Light & Melanie Terrassee, *Immigrant Access in the Affordable Care Act: Legacies of the Confederacy*, 43 ETHNIC AND MIGRATION

change the eligibility criteria related to citizenship or immigration status for Medicaid or CHIP. These programs continue to be limited to qualified aliens, with states permitted to extend coverage to noncitizen children and pregnant women who are non-qualified but “lawfully residing in the United States.”<sup>119</sup> The ACA also left the five-year ban intact, which means most qualified immigrants must accrue five years of qualified immigration status before they are eligible for Medicaid or CHIP. Undocumented immigrants continue to be completely excluded from eligibility for non-emergency Medicaid and are ineligible to receive premium tax credits or even to purchase health insurance from the Marketplace at full price.

During the highly contested passage of the ACA, the issue of subsidizing undocumented immigrants’ purchase of health insurance was never seriously on the table.<sup>120</sup> Even the idea of expanding access for authorized immigrants was controversial.<sup>121</sup> Nevertheless, political opponents of the bill made this issue a centerpiece of their opposition. One has only to recall Rep. Joe Wilson’s outburst during President Obama’s speech to a joint session of Congress in 2009.<sup>122</sup> “You lie!” Wilson shouted, in response to the President’s statement that undocumented immigrants would not be insured under the proposed health care reform plan. Initially, at least one health care reform-related legislative proposal sponsored by Democrats permitted undocumented immigrants to purchase unsubsidized insurance in the Marketplace.<sup>123</sup> However, even this provision was abandoned in the compromises that followed—particularly after President Obama made it clear that he did not support it. In limiting eligibility for the new premium tax credits to “lawfully

---

STUD. 1985, 1994–1995 (2017) (explaining that the ACA did not address the needs of undocumented immigrants).

<sup>119</sup> Social Security Act, 42 U.S.C. § 1903(v)(4) and § 1397(gg) (1996).

<sup>120</sup> See, e.g., Erica Werner & Ricardo Alonso-Zaldivar, *Senate Health Talks Focus on Illegal Immigrants*, BOSTON GLOBE (Sept. 12, 2009), [http://archive.boston.com/news/health/articles/2009/09/12/senate\\_health\\_talks\\_focus\\_on\\_illegal\\_immigrants/](http://archive.boston.com/news/health/articles/2009/09/12/senate_health_talks_focus_on_illegal_immigrants/) [<https://perma.cc/AU65-A834>] (reporting on congressional debate over whether undocumented immigrants would receive benefits under the ACA); Marrow & Joseph, *supra* note 2, at 2257–58 (2015) (discussing the ACA and its treatment of undocumented immigrants).

<sup>121</sup> *Id.* at 2257.

<sup>122</sup> See, e.g., Carl Hulse, *In Lawmaker’s Outburst, a Rare Breach of Protocol*, N.Y. TIMES (Sept. 9, 2009), <https://www.nytimes.com/2009/09/10/us/politics/10wilson.html> [<https://perma.cc/4XGM-75RY>] (reporting on Representative Joe Wilson’s outburst during President Obama’s speech on health care reform).

<sup>123</sup> See SISKIN & LUNDER, *supra* note 104, at 4 (“H.R. 3200 does not contain any restrictions on noncitizens—whether legally or illegally present, or in the United States temporarily or permanently—participating in and paying for coverage available through the Exchange.”).

present” immigrants, the ACA further entrenched the political status quo that excludes undocumented immigrants from publicly funded health coverage.<sup>124</sup>

The confluence of anti-immigrant sentiment and intense opposition to health care reform resulted in political compromises that left one group of lawfully present immigrants uniquely disadvantaged.<sup>125</sup> Deferred Action for Childhood Arrivals (DACA) is a program that was established by President Obama in 2012 in order to provide work authorization for undocumented young people who entered the United States as children. DACA recipients are not qualified for federal public benefits and were specifically carved out of the group of lawfully present immigrants who were included in important ACA programs designed to improve access to medical care. Additionally, while other recipients of deferred action are eligible for premium tax credits and cost-sharing reduction to subsidize private health coverage purchases from the Marketplace, DACA recipients are excluded.<sup>126</sup> They are also excluded from the definition of “lawfully residing” immigrant children and pregnant women who states can elect to cover under Medicaid or CHIP.<sup>127</sup> DACA recipients are effectively in the same position as undocumented immigrants in terms of access to publicly funded health care.<sup>128</sup>

### C. Rationales for Restriction

In the Introduction to this Article, three vignettes illustrated the consequences of the ACA’s exclusion of undocumented immigrants and DACA recipients from the new health insurance exchanges and subsidies, and its maintenance of the immigration status-based restrictions for Medicaid and CHIP. Ineligibility for publicly funded health coverage can be, in effect, a complete barrier to hospice care for end-stage cancer patients, prenatal care for women with pregnancy complications, mental health care for survivors of

---

<sup>124</sup> See Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials 3-4 (July 1, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SM DL/downloads/SHO10006.pdf> (providing guidance on the implementation of the Children’s Health Insurance Program Reauthorization Act of 2009).

<sup>125</sup> See Light & Terrasse, *supra* note 118, at 1995–96 (explaining how the ACA excluded specific groups of immigrants).

<sup>126</sup> 45 C.F.R. § 152.2(4)(vi), (8) (2016) (listing the exception to eligibility for Marketplace purchases and tax credits for DACA recipients).

<sup>127</sup> Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials and Medicaid Dirs. (Aug. 28, 2012), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-002.pdf>.

<sup>128</sup> See Fatma Marouf, *Alienage Classifications and the Denial of Health Care to Dreamers*, 93 WASH. U. L. REV. 1271, 1279–83 (2016) (explaining how recipients of DACA were excluded from ACA benefits).

torture, early diagnosis of serious medical conditions in children, and treatment of infectious disease. Millions of long-time residents of the United States who live, work, learn, and worship alongside U.S. citizens are subject to these exclusions.

The main rationales for excluding immigrants from most publicly funded health care programs are: (1) it would be too costly to cover immigrants, and (2) it is contrary to immigration policy to reward immigrants with free health care if they enter or remain in the country without authorization. However, it is not certain whether restrictionist policies actually reduce health care costs or deter immigrants from illegal entry. Nevertheless, supporters may still appreciate the expressive value of such policies and any indirect effects on curbing immigration they may have. Another rationale for restriction that is sometimes put forth is that immigrants are “less deserving” recipients of publicly funded health care, compared with citizens.

Arguments invoking each of these rationales are attempts to achieve immigration policy goals through social welfare policy. History teaches that exclusionary laws and policies based on immigration concerns make bad health policy.<sup>129</sup> From a population health perspective, to ignore policies that reduce the public accessibility of health services is to ignore a major determinant of inequity.<sup>130</sup> For example, restrictionist laws that require applicants for benefits to show proof of citizenship or immigration status prevent those without the means to procure such documents from obtaining timely care. This is inefficient from the perspective of the health care system and can create unnecessary risks to both individual and public health.<sup>131</sup> These laws also create legal, ethical, and administrative dilemmas for providers who care for uninsured immigrants.<sup>132</sup> They introduce a new level of complexity into the determination of health care

---

<sup>129</sup> See, e.g., Tiffany D. Joseph, *supra* note 2, at 2099–2100 (analyzing the ACA’s exclusion of certain immigrant groups from health coverage and the negative repercussions therein).

<sup>130</sup> Richard B. Warnecke et al., *Approaching Health Disparities From a Population Perspective: The National Institutes of Health Centers for Population Health and Health Disparities*, 98 AM. J. PUB. HEALTH 1608, 1610 (2008). See also *Determinants of Health*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health#health%20services> (last visited Oct. 19, 2018) (reporting how lack of access to health care can affect people’s lives).

<sup>131</sup> Hacker et al., *supra* note 36, at 176. See also Najarro & Deam, *supra* note 96 (reporting on how fear in the immigrant community has impacted interactions with public health systems).

<sup>132</sup> Hacker et al., *supra* note 36, at 178 (describing “extensive paperwork requirements” for providers); Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS OF HEALTH L. 175, 184 (2008) (describing providers’ ethical “obligation to save lives and prevent damage to health”).

benefits eligibility for state agencies, imposing hefty administrative burdens and increased risk of erroneous denials of benefits to legal immigrants and even U.S. citizens.<sup>133</sup> There is evidence that these laws disproportionately impact Medicaid enrollment among black children, thereby undermining the ACA's goal of reducing racial disparities in health care access.<sup>134</sup> Finally, when a health care benefits eligibility determination process excludes applicants on the basis of immigration status, it takes on a punitive character.<sup>135</sup> As a result, members of immigrant communities—even those with legal status—may become wary of interacting with the health care system more broadly.<sup>136</sup> These reasons alone make a compelling case for severing policy decisions about access to health care from policies designed to effectuate immigration enforcement goals. And yet, they have failed to capture popular or political sentiment. The following sections describe each of the common rationales for excluding immigrants from most publicly funded health care programs in further detail.

### 1. Cost and Deterrence

Controlling costs is a perennial goal of health care policy and reform efforts, and concerns about immigrants burdening the health care system have been the major rationale for restrictionist policies. This argument is closely linked with the deterrence rationale, which is based on the idea that restrictive benefits laws act as a deterrent to foreigners who would come to the United States for the purpose of accessing such benefits, and discourage undocumented immigrants from staying in the United States long-term. Both rationales were invoked by supporters of California's Proposition 187, a 1994 ballot measure that was a precursor to PRWORA. Concern over spending on social services and increasing anti-immigrant sentiment created widespread support for Proposition 187, which denied virtually all medical and social services to undocumented immigrants, and required government agencies to verify the citizenship or legal status of a person before providing publicly

---

<sup>133</sup> Calvo, *supra* note 132, at 204–205.

<sup>134</sup> DONNA COHEN ROSS, CTR. ON BUDGET & POL. PRIORITIES, MEDICAID DOCUMENTATION REQUIREMENT DISPROPORTIONATELY HARMS NON-HISPANICS, NEW STATE DATA SHOW, 3–4 (2007).

<sup>135</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 70 (describing the coercive qualities of public laws affecting immigrants).

<sup>136</sup> See SAMANTHA ARTIGA & PETRY UBRI, KAISER FAM. FOUND., ISSUE BRIEF: LIVING IN AN IMMIGRANT FAMILY IN AMERICA: HOW FEAR AND TOXIC STRESS ARE AFFECTING DAILY LIFE, WELL-BEING, & HEALTH 15 (2017) (describing the worries of immigrant families and its effect on inter-actions with health care systems).



funded services.<sup>137</sup> In support of Proposition 187, its author, California State Assemblyman Dick Mountjoy, invoked the cost rationale, writing, “It has been estimated that ILLEGAL ALIENS are costing taxpayers in excess of 5 billion dollars a year. While our own citizens and legal residents go wanting, those who choose to enter our country ILLEGALLY get royal treatment at the expense of the California taxpayer.”<sup>138</sup> The ballot pamphlet also contained arguments that were based on the deterrence rationale: “Welfare, medical, and educational benefits are the magnets that draw these ILLEGAL ALIENS across our borders . . . . It is the role of our government to end the benefits that draw people from around the world who ILLEGALLY enter our country. Our government actually entices them.”<sup>139</sup> Likewise, PRWORA dramatically scaled back immigrant eligibility for federal health care programs in an effort to reduce federal government spending and deter immigration.<sup>140</sup>

The cost and deterrence rationales are evident in the current administration’s immigration and social welfare policy agenda, which has linked the crackdown on immigration enforcement with the receipt of public benefits, including health care. In January 2017, a draft executive order, titled “Protecting Taxpayer Resources by Ensuring Our Immigration Laws Promote Accountability and Responsibility,” was leaked to the media but was never signed or released.<sup>141</sup> The order proposed a change to the way in which the federal

---

<sup>137</sup> See ATTORNEY GENERAL OF CALIFORNIA, ILLEGAL ALIENS INELIGIBILITY FOR PUBLIC SERVICES. VERIFICATION AND REPORTING INITIATIVE STATUTE CALIFORNIA PROPOSITION 187 51 (1994) [hereinafter “Proposition 187 Ballot Pamphlet”] (detailing the proposed initiatives under California’s Proposition 187); Audrey Singer, *Welfare Reform and Immigrants: A Policy Review*, IMMIGRANTS, WELFARE REFORM, AND THE POVERTY OF POLICY 26 (Philip Kretsedemans & Ana Aparicio, eds. 2004) (focusing on the historic developments of the Work Opportunity Reconciliation Act and related legislation).

<sup>138</sup> Proposition 187 Ballot Pamphlet, *supra* note 137, at 54.

<sup>139</sup> *Id.*

<sup>140</sup> Congress described the two main objectives of the PRWORA restrictions as follows: “to assure that aliens be self-reliant in accordance with national immigration policy . . . [and] to remove the incentive for illegal immigration provided by the availability of public benefits.” H.R. Rep. No. 104-430, at 161 (1995), reprinted in 1996 U.S.C.C.A.N. 2105, 2260. See Aaron L. Schwartz & Benjamin D. Sommers, *Moving For Medicaid? Recent Eligibility Expansions Did Not Induce Migration From Other States*, 33 HEALTH AFF. 88 (2014) (describing theme of cost-cutting in the legislative history of welfare reform). See also Singer, *supra* note 137, at 25) (describing how cost-savings motivated policymakers to exclude noncitizens from eligibility for federal means-tested benefits in PRWORA). PRWORA may have reduced costs for the federal government in the short-term, but it likely increased its costs in the long-term; and it certainly shifted costs to state governments with large immigrant populations.

<sup>141</sup> See, e.g., Matthew Yglesias & Dara Lind, *Read Leaked Drafts of 4 White House Executive Orders on Muslim Ban, End to DREAMer Program, and More*, VOX (Jan. 25, 2017, 5:43 PM), <https://www.vox.com/policy-and-politics/2017/1/25/14390106/leaked-drafts-trump-immigrants>

government conducts its “public charge” assessment of immigrants. The federal government has the authority to bar immigrants from entering the country or obtaining lawful permanent resident status if they are likely to become public charges, or persons who are dependent on the government for subsistence. Under current policy, officials could take into consideration the likelihood that an immigrant would rely on public benefits in the future. However at this point in time, only two types of public benefits matter for this purpose: monthly cash assistance for income maintenance and Medicaid for long-term care services.<sup>142</sup> The proposed order would permit the federal government to consider all means-tested public benefits—including health care benefits—in its public charge assessment.<sup>143</sup>

In line with the intent of the draft executive order, in January 2018, the U.S. Department of State revised its Foreign Affairs Manual to permit its officials abroad to consider use of all public benefits by the applicant or her dependent family member in their public charge assessment.<sup>144</sup> In October 2018, DHS released a proposed public charge rule that would consider a broader range of health-supporting public benefits in the public charge determination, including non-emergency Medicaid and the Medicare Part D Low-Income Subsidy Program.<sup>145</sup> The proposed rule, if finalized as written, would dramatically expand the number of immigrants who would be excluded as public charges. The Trump administration’s policy position regarding the public charge assessment is one of many that promise to further marginalize immigrants as health care consumers by deterring them from accessing benefits to which they are legally entitled.<sup>146</sup>

---

-executive-order [<https://perma.cc/XB46-X5LH>] (revealing the Trump administration’s plan to address immigration).

<sup>142</sup> Gabrielle Lessard, *Five Things You Should Know About the Draft Executive Order on Public Benefits*, NAT’L IMMIGR. L. CTR. (Feb. 16, 2017), <https://www.nilc.org/news/the-torch/2-16-17/> [<https://perma.cc/AD5Y-6NQY>]. The order would permit officials to consider all means-tested public benefits in their public charge assessment. Under longstanding policy, officials considered only monthly cash assistance for income maintenance and Medicaid for long-term care services.

<sup>143</sup> See, e.g., Memorandum from Andrew Bremburg for the President, Executive Order on Protecting Taxpayer Resources by Ensuring Our Immigration Laws Promote Accountability and Responsibility 3–4 (Jan. 23, 2017), [https://cdn3.vox-cdn.com/uploads/chorus\\_asset/file/7872571/Protecting\\_Taxpayer\\_Resources\\_by\\_Ensuring\\_Our\\_Immigration\\_Laws\\_Promote\\_Accountability\\_and\\_Responsibility.0.pdf](https://cdn3.vox-cdn.com/uploads/chorus_asset/file/7872571/Protecting_Taxpayer_Resources_by_Ensuring_Our_Immigration_Laws_Promote_Accountability_and_Responsibility.0.pdf) (detailing President Trump’s initiatives to reduce taxpayer expenses on health care).

<sup>144</sup> *Access to Health Care, Food, and Other Public Programs for Immigrant Families under the Trump Administration*, NAT’L IMMIGR. L. CTR. (Feb. 8, 2018), <https://www.nilc.org/issues/health-care/exec-orders-and-access-to-public-programs/> [<https://perma.cc/L6Z7-P2BN>].

<sup>145</sup> Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114, 51159 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

<sup>146</sup> See ARTIGA & UBRI, *supra* note 136, at 2 (describing the fears that President Trump’s immigration policy has instilled in immigrants and how this has led to decreased health care

Some scholars have addressed the cost and deterrence rationales for restrictionist laws head-on, questioning whether they actually achieve their goals. For example, several scholars have argued that expanding immigrants' access to preventive health care could actually result in cost *savings* to the health care system.<sup>147</sup> This is based, in part, on findings that patients without access to primary care delay seeking health care until their medical problems are so severe that they require expensive emergency care.<sup>148</sup> Most hospitals are obligated under EMTALA to provide emergency care to patients regardless of their ability to pay for it. When patients do not have health coverage and are unable to pay their medical bills, hospitals incur uncompensated care costs, which include "charity care," or "care for which the hospital never expected to receive payment because of the patient's inability to pay," and "bad debt," or patients' nonpayment for services for which the hospital expected to be paid.<sup>149</sup> "Uncompensated care"—which is health care that is not paid for by patients out-of-pocket or by public or private insurance coverage—constitutes a significant portion of costs in the health care system.<sup>150</sup> Additional costs attributed to uncompensated care include taxpayer-funded programs, such as emergency Medicaid, designed to financially protect health care providers that serve the uninsured; and rate increases by physicians and hospitals designed to recoup losses from the provision of uncompensated care.<sup>151</sup> Expanding immigrants' access to relatively inexpensive primary care through insurance coverage could decrease such costs.

---

access); Najarro & Deam, *supra* note 96 (reporting on how fear in the immigrant community has impacted interactions with public health systems).

<sup>147</sup> See, e.g., Arijit Nandi et al., *Expanding the Universe of Universal Coverage: The Population Health Argument for Increasing Coverage for Immigrants*, 11 J. IMMIGRANT & MINORITY HEALTH 433, 435 (2009) (arguing that reduced health care access for immigrants may adversely impact general health and the economy); Glen, *supra* note 47, at 221–39 (analyzing how increased access to health care for undocumented immigrants reduces net costs); Clark, *supra* note 15 at 259 (pointing out the flaws of health policy rationalized on the basis that undocumented immigrants increase costs).

<sup>148</sup> Helen B. Marrow, *Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Healthcare Model*, 74 SOC. SCI. & MED. 846, 848–49 (2012) (laying out the arguments made in the debate over health care access for undocumented immigrants). See generally Calvo, *supra* note 132, at 210 (discussing the impact of reduced health insurance coverage of immigrants on the United States); Mohanty, *supra* note 29, at 2 (reporting that concerns that immigrants place an undue burden on the U.S. health system are largely unsubstantiated).

<sup>149</sup> U.S. GENERAL ACCT. OFFICE, UNDOCUMENTED ALIENS, *supra* note 87, at 1.

<sup>150</sup> Glen, *supra* note 48, at 219.

<sup>151</sup> See BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., RL32237, HEALTH INSURANCE: A PRIMER 8 (2009) (reporting generally on the status quo of health care insurance); Glen, *supra* note 48, at 221.

Another way in which expanding immigrants' access to publicly funded health care could decrease costs to the health care system is based on the same logic as the ACA's individual mandate, the purpose of which was to increase enrollment of lower-risk individuals in insurance coverage.<sup>152</sup> Enabling a broader group of immigrants, who tend to use fewer health care services than citizens, to join insurance enrollee pools should help to spread risks across a broader population and therefore improve the stability and predictability of risk pools. This, in turn, should enable insurers to lower premiums for all participants, thereby lowering costs for privately insured individuals.<sup>153</sup>

Also, excluding certain classes of immigrants from publicly funded health care benefits definitely *creates* some often overlooked systemic costs that should be taken into account. These include an increased administrative burden for government agencies and publicly funded health care facilities that must determine a person's citizenship or immigration status during the eligibility determination process; delays or denials of care if proof of eligibility cannot be obtained immediately, which is especially likely for children, the mentally ill, and people with dementia; increased risk of the spread of infectious disease if care is denied or delayed; and preventable harm to fetuses whose mothers were denied prenatal care.<sup>154</sup>

Empirically, it is difficult to predict whether expanding immigrants' access to health care would increase or decrease costs to the health care system overall in the short and long term.<sup>155</sup> There is significant uncertainty about the actual costs of providing uncompensated care to immigrants, the potential savings in premium reductions for privately insured individuals if more immigrants were enrolled, and the potential cost of subsidizing immigrants' coverage of non-emergency health care. Therefore, it is not certain that expanding immigrant access to publicly funded health care would result in a net savings to the system. The studies predicting cost savings, however, weaken the argument that expanded access would undoubtedly increase costs.

Regarding the deterrence rationale, studies show that immigration to the United States increased in the years following the enactment of PRWORA, suggesting that restricting public benefits eligibility does not change decisions to immigrate. Also, numerous studies show that the opportunity to access more generous publicly funded health care benefits does not play a large role in

---

<sup>152</sup> ANNIE L. MACH, CONG. RES. SERV., R44438, THE INDIVIDUAL MANDATE FOR HEALTH INSURANCE COVERAGE: IN BRIEF 1 (2018) (reporting on the requirements of the Affordable Care Act).

<sup>153</sup> Glen, *supra* note 48, at 222.

<sup>154</sup> Tal Ann Ziv & Bernard Lo, *Denial of Care to Illegal Immigrants: Proposition 187 in California*, 332 NEW ENG. J. MED. 1095, 1095–97 (1995); Glen, *supra* note 48, at 227–28.

<sup>155</sup> See, e.g., Glen, *supra* note 48, at 224; Hall & Perrin, *supra* note 11, at 130, 134.

motivating either citizens or immigrants to migrate *within* the United States.<sup>156</sup> From these studies, one might infer that access to publicly funded health care is not a major driver of migration across international borders. Rather, the desire to secure gainful employment, to reunite with family members, or to avoid political or other forms of persecution are likely to play a more significant role in motivating immigrants to come to the United States.<sup>157</sup> It is also “highly speculative” whether the denial of access to publicly funded health care inspires many immigrants to return to their native countries for medical treatment.<sup>158</sup>

The actual consequences of dramatically expanding immigrant access to publicly funded health care are unknown. It is possible, especially in the short term, that costs could increase; that certain population health outcomes could worsen (e.g. due to iatrogenic illness, prescription errors, culturally incompetent care, and acculturation leading to decline in the “healthy immigrant effect”); and that there could be an increase in the number of immigrants who come to the United States for the primary purpose of seeking health care. Proponents of the ACA also had to address such effects, and point to the predicted long-term effects of increasing access to health insurance. But the possibility of these undesirable short-term consequences makes it even more important to challenge the normative arguments for restricting immigrants’ access to publicly funded health care.

## 2. Deservingness

The third major rationale for excluding immigrants from eligibility for public benefits is that they do not “deserve” access to the limited public funding for health care that is available. This is a normative argument that

---

<sup>156</sup> See, e.g., Lucas Goodman, *The Effect of the Affordable Care Act Medicaid Expansion on Migration*, 36 J. POL’Y ANALYSIS & MGMT. 211, 212 (2016) (analyzing the effect of expanded Medicaid under the Affordable Care Act on migration patterns within the U.S.); Aaron L. Schwartz & Benjamin D. Sommers, *Moving for Medicaid? Recent Eligibility Expansions Did Not Induce Migration from Other States*, 33 HEALTH AFF. 88, 92 (2014) (arguing that expanded Medicaid in individual states does not trigger significant populations to migrate in search of coverage); Joshua S. Yang & Steven P. Wallace, *Expansion of Health Insurance in California Unlikely to Act as Magnet for Undocumented Immigration*, UCLA: HEALTH POLICY 3–4 (July 2007) (discussing the welfare magnet theory); Marc L. Berk et al., *Health Care Use Among Undocumented Latino Immigrants*, 19 HEALTH AFF. 51, 56 (2000) (discussing the reasons why undocumented Latinos immigrate to the U.S).

<sup>157</sup> INT’L ORG. FOR MIGRATION, INTERNATIONAL MIGRATION, HEALTH AND HUMAN RIGHTS (2013) (discussing a data-driven analysis of whether undocumented Latinos immigrate to the U.S. for health care).

<sup>158</sup> *Lewis v. Grinker*, 965 F.2d 1206, 1214 (2d Cir. 1992) (recognizing undocumented immigrants as eligible for Medicaid-funded prenatal care).

considers immigrants living in the United States to be outside of the community that merits the receipt of publicly funded health care, a community defined by citizenship.<sup>159</sup> According to this reasoning, undocumented immigrants are considered the “least deserving” type of immigrant because they are morally culpable and blameworthy for their lack of status.<sup>160</sup> Ineligibility for publicly funded health care becomes a form of punishment for civil immigration violations.

There have been three main progressive arguments against the use of the punitive rationale as a basis for the restrictionist provisions of PRWORA. First, it is misguided, because while the intent is to punish undocumented immigrants, the actual effect is to restrict access for immigrants with lawful status as well. Second, it is motivated by animus, because PRWORA was enacted during a period of heightened anti-immigrant sentiment, when Congress began to dramatically increase the number of immigration-related criminal offenses. Third, it is unfair to punish people who violate immigration laws by forcing them to suffer physically through the denial of access to affordable health care.<sup>161</sup>

However, these objections have done little to erode restrictionist political and ethical norms in health care, and may even have reinforced the idea that punitive social welfare policies are appropriate for certain categories of immigrants. For example, the first objection, that restrictionist laws are misguided because they punish lawful immigrants as well as undocumented immigrants, implicitly accepts the notion that there are “good” and “bad” types of immigrants. In doing so, it threatens the case for universal health care by affirming that there are people living in the United States who deserve health care, and those who do not. The second objection, that the restrictionist provisions in PRWORA were motivated by extreme and ahistorical anti-immigrant sentiment, and have now become entrenched, merely points out that political tides—and therefore attitudes toward immigrants—can change, and does not identify any enduring principles that support a commitment to the health care access rights of immigrants or uninsured people in society generally. Also, it is not difficult for supporters of restrictionist laws to point to legitimate social purposes for drawing a distinction between citizens and noncitizens in the provision of public benefits.<sup>162</sup> The third objection, that it

---

<sup>159</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 168 (noting that conceptual arguments for discrimination assert that citizenship is a morally relevant categories).

<sup>160</sup> Clark, *supra* note 15, at 259; ILLINGWORTH & PARMET, *supra* note 13, at 173.

<sup>161</sup> See, e.g., James Dwyer, *Illegal Immigrants, Health Care, and Social Responsibility*, 5 HASTINGS CTR. REP. 34, 36 (2004) (“Nothing about access to health care follows from the mere fact that illegal aliens have violated a law. Many people break many different laws.”).

<sup>162</sup> OWEN FISS, *THE IMMIGRANT AS PARIAS*, in *A COMMUNITY OF EQUALS: THE CONSTITUTIONAL PROTECTION OF NEW AMERICANS* 1, 9–10 (Joshua Cohen & Joel Rogers, eds., 1999).

is unfair to punish people for violating immigration law by denying them access to health care, begins with the premise that immigration violators deserve to be punished in some way, as opposed to simply being removed from the country. It reinforces the idea of immigration violators as criminals, for whom punitive measures are justified.

The issue of whether or how much access to publicly funded health care immigrants should have involves two issues—health care and immigration—over which there are deep divisions in U.S. society. An indication of this divisiveness is the remarkably different state policies on immigrant access to publicly funded health care.<sup>163</sup> On one side of the divide, people think of health care resources as more like public goods. In economic theory, a public good is “one which is available for consumption to anyone regardless of whether or not one is able to pay for it.”<sup>164</sup> A public good is non-excludable, meaning that people cannot be efficiently excluded from using it, and non-rivalrous, meaning that consumption of the good by one person does not reduce the ability of others to use it.<sup>165</sup> In the United States, emergency health care services and treatment for symptoms of communicable disease possess some of the characteristics of public goods, in that they are generally available to all regardless of ability to pay, and consumption of these types of services up to a certain capacity is non-rivalrous.<sup>166</sup> In countries where the government subsidizes health care or coverage that is generally available to the public, health care services and coverage begin to look more like public goods.

On the other side of the divide are those who conceive of health care resources as more like private goods, which are both excludable and rivalrous. In this view, a person who cannot pay for a health care service or health insurance does not receive it, and any person’s use of health care resources prevents another person from consuming the same. Therefore, it is natural to be protective of health care resources, and to reserve them for the “most

---

<sup>163</sup> See NILC, *supra* note 4, Table 3 (describing state policies for providing health coverage to immigrants).

<sup>164</sup> Siegfried G. Karsten, *Health Care: Private Good vs. Public Good*, 54 AM. J. ECON. & SOC. 129, 136 (1995).

<sup>165</sup> See, e.g., Sandro Galea, *Dean’s Note: Public Health as a Public Good*, B. U. SCH. OF PUB. HEALTH (Jan. 10, 2016), <https://www.bu.edu/sph/2016/01/10/public-health-as-a-public-good/> [<https://perma.cc/8Z2S-JBCP>]. However, few goods are completely non-excludable or non-rivalrous. See, e.g. *Universal Health Insurance is a Common Good*, THE ECONOMIST (Oct. 8, 2009), <https://www.economist.com/democracy-in-america/2009/10/08/universal-health-insurance-is-a-common-good> [<https://perma.cc/8Z2S-JBCP>].

<sup>166</sup> Mariner, *Health Insurance is Dead*, *supra* note 14, at 199.

deserving” members of society. It is difficult to come up with eligibility criteria based on “deservingness” that are non-controversial; fine distinctions in status can result in very different outcomes, which might seem irrational or unfair. Certainly, drawing up such eligibility criteria is complicated. Where health care or coverage are considered private goods, restricting immigrants from eligibility for most publicly funded health care programs is one way to ration limited resources. Whether this form of rationing seems reasonable or not depends largely on one’s conception of immigrants as either members of the community, defined by their individual contributions and family ties (“residents”); or infiltrators of the community, who have yet to earn their keep or who collectively violate its norms (“lawbreakers”) in the case of undocumented immigrants.<sup>167</sup>

In order to bridge the divide in opinions about immigrant access to publicly funded health care, it is necessary to address the values that motivate each side to believe that its choice is the “right” one. Therefore, a moral philosophical approach that provides a framework for determining what is “right” is useful. Part II explores the utility of Health Justice, one such framework, for analyzing the issue of immigrant access to publicly funded health care.

## II. THE SHIFT TO COLLECTIVISM IN HEALTH CARE FINANCING

As a field, health law has been the subject of considerable scholarly debate over its scope, its theoretical orientation, and its values.<sup>168</sup> Models of health law describe the “assumptions, values, background norms, orientations, etc., of private and governmental decision-makers.”<sup>169</sup> They are the “lenses[] through which policymakers, judges, practitioners, scholars, and teachers view the field.”<sup>170</sup> The philosophical underpinnings of different models of health law serve as frameworks for answering difficult ethical and political questions. In each model, the answer to the question of what justice requires may be defined differently. Historically, new models of health law have emerged with each dramatic shift in health law and policy.<sup>171</sup>

---

<sup>167</sup> Legomsky, *supra* note 15, at 70.

<sup>168</sup> See, e.g., Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 347 (2006) (relaying the historical underpinnings that make up health law in the U.S.); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 157–58 (2004) (discussing the past, present and future of direction of health law).

<sup>169</sup> *Id.* at 162.

<sup>170</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 834.

<sup>171</sup> *Id.*



Prior to the passage of the ACA, existing models of health law were based on professional autonomy, patient rights, market power, and health consumerism.<sup>172</sup> One thing that all of these models have in common is their individualistic bias, i.e., they view the health system as serving primarily private interests.<sup>173</sup> The liberal egalitarian “patient rights” model of health law has strongly influenced how progressive scholars and governmental decision-makers approach problems in health care.<sup>174</sup> This model seeks to liberate and empower patients through the realization of individual rights.<sup>175</sup> Individual patients’ medical needs play a major role in determining who is entitled to access health care. Respect for human dignity and autonomy drives the patient’s right to health care, regardless of whether health care services would actually improve the patient’s health outcomes.<sup>176</sup> Because of the normative focus on personal autonomy in defining what it means to have a good life, “the public’s” ideas about the common good are not important. Some rationales for expanded access based on the patient rights model acknowledge the impact of expanded access on population health outcomes, but the interests of the public are not typically highlighted.<sup>177</sup>

The passage and subsequent implementation of the ACA signaled a fundamental transformation in health care policy.<sup>178</sup> In particular, “the ACA cemented a broader social function for health insurance, employing it to serve the goal of access to affordable healthcare for all.”<sup>179</sup> It did this by creating new subsidies for purchasing health insurance, expanding the pool of people who are eligible for public health insurance, requiring insurers to cover certain preventive interventions, and limiting risk-based underwriting, such as by prohibiting health insurance issuers from imposing preexisting condition exclusions.<sup>180</sup> Together, these reforms changed the way that health insurance is regulated, moving it from a system that is based on the principle of actuarial fairness toward a system based on the principle of solidarity.<sup>181</sup> This shift is

---

<sup>172</sup> *Id.* at 839–53 (describing the evolution of these health law models).

<sup>173</sup> *Id.* at 855; William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 500 (2008).

<sup>174</sup> *See, e.g.*, Rosenblatt, *supra* note 168.

<sup>175</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 843.

<sup>176</sup> *Id.* at 879.

<sup>177</sup> *Id.* at 872–73.

<sup>178</sup> *See id.* at 854–72 (describing four factors that reflect the ACA’s transformation of the health care system); Wendy K. Mariner, *Health Insurance is Dead*, *supra* note 14, at 195 (discussing the new era of health law ushered in by the Affordable Care Act).

<sup>179</sup> Mariner, *Health Insurance is Dead*, *supra* note 14, at 201.

<sup>180</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 859.

<sup>181</sup> *Id.* at 854.

one of several that reflect health law and policy's evolution from a field that focuses mainly on relational issues involving patients, physicians, and payers, to one that recognizes collective problems and solutions as critical.<sup>182</sup>

Health Justice is an emerging model of health law that reflects and reinforces these important changes by “address[ing] the increasingly social, collective nature of health law institutions, instruments, and norms.”<sup>183</sup> This Section will explore the ways in which Health Justice is helpful for understanding and guiding discussions about public subsidization of health coverage for immigrants. Like others who have written about Health Justice, I anticipate that my analysis will mainly be of interest to progressive-minded scholars, advocates, legislators, and judges who have adopted the patient rights model, and who view health equity as an important goal of health law and policy.<sup>184</sup> However, I am hopeful that some aspects of my analysis will resonate with those who are skeptical of progressive health care reform by building consensus around society's moral obligation to finance a broader range of health care services for immigrants.

#### A. *The Health Justice Model*

In a series of articles, Professor Lindsay F. Wiley has developed the Health Justice model as an alternative or supplement to the dominant progressive approach to various problems in health law and policy.<sup>185</sup> Health Justice, like

---

<sup>182</sup> *Id.* at 855; Sage, *supra* note 173, at 502.

<sup>183</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 872.

<sup>184</sup> *Id.* at 837–38; Benfer, *supra* note 9, at 277.

<sup>185</sup> Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 MARQUETTE BENEFITS & SOC. WELFARE L. REV. 203, 209 (2017); Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 101, 107 (2017); Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 838 (articulating health justice as a model of health law for examining issues of health care quality and access); Wiley, *Health Law as Social Justice*, *supra* note 6, at 52 (describing a health justice approach to eliminating health disparities). *See also* LAWRENCE O. GOSTIN & LINDSAY F. WILEY, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 531–50 (Regents of U.C., 3d ed. 2016) (arguing that social justice is foundational to public health law). Political philosophers, advocacy groups, lawyers, and other scholars have also used the term “health justice,” but this Article builds on the model developed by Professor Wiley. *See, e.g.*, SRIDHAR VENKATAPURAM, *HEALTH JUSTICE: AN ARGUMENT FROM THE CAPABILITIES APPROACH* (2011); Benfer, *supra* note 9, at 277–78; *Mission, LEGAL COUNCIL FOR HEALTH JUSTICE*, <http://legalcouncil.org/mission-vision/> [<https://perma.cc/85TT-EAZD>] (last visited July 16, 2018); *Mission & Approach*, PRAXIS PROJECT, <https://www.thepraxisproject.org/who-we-are/mission-approach/> [<https://perma.cc/LRP3-72NU>] (last visited July 16, 2018) (describing itself as an organization that works to “achieve health justice for all communities”); THE HEALTH JUSTICE LAB, <https://www.healthjusticelab.org/> [<https://perma.cc/4EKG-Y84U>]; Loy. U. Chi.,

other contemporary justice movements, is rooted in a communitarian conception of social justice.<sup>186</sup> Its approach is distinct from existing models of health law and policy in that it shifts the focus from “legal duties rooted in concern for particular individuals” to the broad social concerns of people as interdependent members of communities.<sup>187</sup> The model acknowledges that social choices—rather than merely economics or human nature—drive the design of the health care system, and that social choices can include both aggregated individual preferences and collective choices based on need and equity.<sup>188</sup> It seeks to balance the individual and collective interests of community members, rather than *a priori* privileging either set of interests.<sup>189</sup>

Health Justice consists of a set of commitments that reflect a collectivist approach to analyzing issues of health law and policy: (1) recognition of the collective interests that are protected when there is universal access to affordable health care; (2) collective responsibility for ensuring that state resources are distributed in a way that provides the essential conditions for well-being; (3) recognition of collective interests in decisions about medical treatment; and (4) prioritization of community and primary prevention strategies and the integration of health care and public health.<sup>190</sup>

As Part I described, debates about the types of people who should be eligible to receive public health care resources and the types of health care

---

HEALTH JUSTICE PROJECT, <https://www.luc.edu/law/centers/healthlaw/hjp/index.html> [<https://perma.cc/5N9W-RF3S>] (a medical-legal partnership); GEO. U. HEALTH JUSTICE ALLIANCE, <https://www.law.georgetown.edu/health-justice-alliance/> [<https://perma.cc/PSJ3-P5K8>] (a medical-legal partnership); DUKE LAW HEALTH JUST. CLINIC, <https://law.duke.edu/healthjustice/> [<https://perma.cc/9BJT-SHTS>] (provides legal assistance to “low-income clients with HIV . . . and cancer”); UNIV. OF MINN. HEALTH JUSTICE RESEARCH CIRCLE, <https://cla.umn.edu/rigs/research/research-circles/health-justice> [<https://perma.cc/XVC6-6S2N>] (“a cross-collegiate, multi-disciplinary group focused on critical race theory, health equity, and health disparities research”); CTR. FOR HEALTH JUST., <http://www.centerforhealthjustice.org/staff/mission> [<https://perma.cc/P6T4-K3Y2>] (providing health education and support to people impacted by incarceration).

<sup>186</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 837–38; Wiley, *Health Law as Social Justice*, *supra* note 6, at 52 (describing a health justice approach to addressing social disparities in health that builds on lessons from other recent social justice movements as well as the work of political philosophers and ethicists on health and social justice).

<sup>187</sup> Sage, *supra* note 173, at 500. See Wiley, *Health Law as Social Justice*, *supra* note 6, at 55 (comparing the social justice model’s focus on collective responsibility with the progressivist focus on individual rights).

<sup>188</sup> See Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489, 491–93 (1988) (describing three pedagogical models of health law that focus on economics, self-determination, and social justice respectively).

<sup>189</sup> Amitai Etzioni, *On a Communitarian Approach to Bioethics*, 32 THEORETICAL MED. & BIOETHICS 363, 364 (2011).

<sup>190</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 874.

services that should be provided using these resources have been highly divisive. The first two Health Justice commitments are particularly useful for guiding these debates.

Despite reported dissatisfaction with the ACA among the public, and repeated attempts by its opponents to repeal it or undermine its effectiveness, the basic tenets of the ACA appear to have become politically entrenched.<sup>191</sup> A recent poll found that a majority of Americans support universal health coverage, and a strong role for the government in ensuring such coverage.<sup>192</sup> Newfound support for universal coverage could reflect Americans' understanding of how expanded access to affordable health care has positive spillover effects on the general U.S. population; similarly, support for a stronger government role in health care reflects trust in public management of health care resources.<sup>193</sup>

### 1. Universal Access to Protect Collective Interests

The Health Justice model builds on the progressive ideas that motivated the ACA's goal of providing universal access to affordable health care. The ACA's approach to health care financing shifted the balance toward more public financing of health care, and emblemized the logic of mutual aid.<sup>194</sup> Mutual aid systems provide a model for distributive justice in that they are "based on a shared definition of the legitimate reasons for redistribution—why, in what circumstances, and to whom people should give something up

---

<sup>191</sup> See Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 860-61 (describing the shift towards viewing healthcare like the ACA as a form of mutual aid); Abbe R. Gluck, *Obamacare as Superstatute*, BILL OF HEALTH (July 31, 2017), <http://blogs.harvard.edu/bill-of-health/2017/07/31/obamacare-as-superstatute/> [<https://perma.cc/GEW4-WWUW>] (observing that the ACA represents a normative transformation of our collective understanding of "what a health care system should be and what the government's role in it should look like," by emphasizing the norm of solidarity over individual responsibility).

<sup>192</sup> See, e.g., Ricardo Alonso-Zalvidar & Laurie Kellman, *62 Percent of U.S. Want Federal Government to Ensure Health Care for All*, *Poll Says*, PBS NEWSHOUR (July 20, 2017, 8:52 AM), <https://www.pbs.org/newshour/health/62-percent-u-s-want-federal-government-ensure-health-care-poll-says> [<https://perma.cc/2UMY-C9G4>] (reporting that 62% of Americans polled by AP-NORC Center in 2017 thought that the federal government should be responsible for ensuring universal health coverage); Sarah Kliff, *An Astonishing Change in How Americans Think about Government-Run Health Care*, VOX (Aug. 16, 2017, 5:10 PM), <https://www.vox.com/policy-and-politics/2017/8/16/16158918/voxcare-poll-government-run-health-care> [<https://perma.cc/9KCR-FMDY>] (reporting that 60% of Americans polled by Pew Research Center in 2017 believed the federal government had an obligation to ensure universal health coverage as compared to only 43% of Americans in 2013).

<sup>193</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 884-88.

<sup>194</sup> *Id.* at 854-55; Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 290-91 (1993).

of their own and offer help.”<sup>195</sup> The distribution of health care resources in mutual aid systems is primarily based on “medical need or the ability of the individual to benefit from medical care.”<sup>196</sup>

All health insurance plans can be characterized as mutual aid systems to an extent, because distribution of medical care is based, at least in part, on medical need; many health insurance plans actually began as mutual aid societies. However, the private insurance industry is built on the concept of actuarial fairness, i.e., “each person should pay for his own risk.”<sup>197</sup> By contrast, a mutual aid system built on the concept of solidarity “creates an obligation to act for the sake of others and creates a possibility that individual interest may need to be subordinated to community interest.”<sup>198</sup> Actuarial fairness and solidarity are two different principles upon which a mutual aid system can be organized, and represent “alternative visions of distributive justice.”<sup>199</sup>

Both the patient rights model and Health Justice view the ACA’s goal of universal access to affordable health care as the government fulfilling its duty to assure one of “the essential conditions for human well-being.”<sup>200</sup> However, a Health Justice approach differs from a patient rights approach because it “takes communities as the starting point of analysis” and intervention, rather than individuals.<sup>201</sup> While a patient rights approach focuses on individuals’ needs and choices, a Health Justice approach focuses on the social, economic, and political context of those needs and choices. This is the sense in which Health Justice aligns with the social philosophy of communitarianism. Health Justice is not “communitarian” in the strict, ideological sense; rather it uses principles of communitarianism to critique the individualistic bias of the existing models of health law and policy.<sup>202</sup>

In making the case for universal access to affordable health coverage, the Health Justice approach emphasizes how such coverage protects the collective interests of community members, such as reducing the threat of infectious disease, preventing antibiotic resistance, and ensuring workforce productivity.<sup>203</sup> Universal coverage can also reduce wasteful spending and transaction costs in

---

<sup>195</sup> Stone, *supra* note 194, at 289.

<sup>196</sup> *Id.* at 291.

<sup>197</sup> *Id.* at 290.

<sup>198</sup> ILLINGWORTH & PARMET, *supra* note 13, at 174–75.

<sup>199</sup> Stone, *supra* note 194, at 290.

<sup>200</sup> Wiley, *Health Law as Social Justice*, *supra* note 6, at 56.

<sup>201</sup> Mark G. Kuczewski, *Who is My Neighbor? A Communitarian Analysis of Access to Health Care for Immigrants*, 32 THEORETICAL MED. & BIOETHICS 327, 328 (2011).

<sup>202</sup> The basic tenets of responsive communitarianism are described in Part III.

<sup>203</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 878–79.

the health care system.<sup>204</sup> The Health Justice approach highlights evidence that disparities in access to health care do not merely affect the individuals or populations with restricted access; they can also have negative spillover effects in the general community. For example, in its comprehensive study of uninsurance, the Institute of Medicine (now called the National Academy of Medicine) found that the number of uninsured persons living in an area contributes disproportionately to a community's burden of disease and disability, due to the uninsured residents' poor health and to spillover effects affecting other residents.<sup>205</sup> In summary, the Health Justice approach frames "access to health care [as] primarily a means to an end," rather than an end in itself.<sup>206</sup> This reasoning complements, rather than replaces, justifications for universal access based on the protection of an individually held human right to health care.

Health Justice also brings attention to how a universal, mutual aid system built on solidarity protects collective interests that go beyond improved population health outcomes and improved efficiency, such as reducing health disparities and encouraging fellow-feeling among community members. The logics of actuarial fairness and solidarity in health insurance provide two different visions of "how Americans should think about what ties them together and to whom they have ties."<sup>207</sup> In a seminal article, *The Struggle for the Soul of Health Insurance*, Deborah Stone argues that actuarial fairness as a method of organizing mutual aid "leads ultimately to the destruction of mutual aid," because it encourages the fragmentation of communities.<sup>208</sup> When health care is treated like a market commodity, and different classes of people contribute different amounts of money depending on their risk of incurring medical expenses, the system reinforces the notion that group members are only responsible for bearing costs for others in their group—in other words, the people who are most like themselves. Health care financing systems that are based on actuarial fairness—like systems that emphasize personal responsibility—exacerbate disparities because, by requiring each person to be responsible for his or her own risk, they impose greater obligations on those who have little to no control over their exposure to health risks. These tend to be disadvantaged populations.<sup>209</sup> This, in turn, influences the way that society

---

<sup>204</sup> *Id.* at 861 (citing Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1995–96 (2011)).

<sup>205</sup> INST. OF MED., A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE 12 (2003).

<sup>206</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 879.

<sup>207</sup> Stone, *supra* note 194, at 289. Social insurance is a paradigmatic example of a system based on the logic of solidarity. *Id.* at 290–91.

<sup>208</sup> *Id.* at 290.

<sup>209</sup> Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 224 (2008).

views certain health conditions and groups of people, reinforcing previously existing class and racial biases and holding members of disadvantaged groups personally responsible for poor health status based on perceived lifestyle choices, bad morals, lack of self-control, or other negative stereotypes.<sup>210</sup> This type of thinking is antithetical to the communitarian conception of social justice upon which Health Justice is based because it neglects to take into account the larger context in which individual, health-harming choices are made.

In more collective systems of public health care finance, solidarity derives from acknowledgement of the common vulnerability to illness and death. It “implies a communitarian understanding of the human situation, a need for social interdependence, and a lively awareness of the ways in which disease and illness can overcome our individual economic and social resources.”<sup>211</sup> Health care systems built on solidarity can operate to bring “outsiders” of all kinds into the societal fold. Scholars of policy inclusion have argued that the political and policy environment in which people live profoundly influences their sense of membership in a community.<sup>212</sup> In an inclusive policy environment, members of formerly marginalized groups are more likely to adopt the values of the mainstream community.<sup>213</sup> Universal access to health insurance can reinforce social bonds and mutual trust in a community by signaling that all members are worthy of health care resources, which are “generally valued as essential to a dignified and secure life.”<sup>214</sup> These observations reflect a communitarian perspective, which recognizes “that the collective action of ensuring health care access for all plays a constitutive role in defining mutual obligations that reflect and reinforce the community’s values.”<sup>215</sup>

## 2. Collective Responsibility for Distributing Public Resources

The second Health Justice commitment of interest emphasizes collective responsibility for ensuring that state resources are distributed in a way that provides the essential conditions for well-being.<sup>216</sup> Different models of health law suggest different ways of allocating limited health care resources. In the patient rights model, physicians’ expert opinions about patients’ medical needs

---

<sup>210</sup> *Id.* at 224–26.

<sup>211</sup> DANIEL CALLAHAN & ANGELA A. WASUNNA, *MEDICINE AND THE MARKET: EQUITY V. CHOICE* 114 (2006).

<sup>212</sup> Meghan Condon et al., *Immigrant Inclusion in the Safety Net: A Framework for Analysis and Effects on Educational Attainment*, 44 *POL’Y STUD. J.* 424, 428 (2016).

<sup>213</sup> *See, e.g., id.* (explaining that immigrants who live in inclusive communities are likelier to identify as American and adopt mainstream American culture and values).

<sup>214</sup> *INST. OF MED.*, *supra* note 205, at 133.

<sup>215</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 879.

<sup>216</sup> *Id.* at 838–39.

typically drive allocation decisions relating to health care resources. In addition to citizenship and immigration status-based criteria, which were described in detail in Part I, the health care and financial needs of individual patients generally determine their ability to access publicly funded health insurance. Examples of groups with special health care needs who have historically had special access to publicly funded health care programs include children, pregnant women, the elderly, and people with disabilities. Income-based eligibility criteria are a feature of all such programs, because they exist to enable people to access health coverage when they would not otherwise have the financial means to do so. However, the details of how these eligibility criteria come to be are typically decentralized and hidden from public view.<sup>217</sup>

Health Justice supports transparency and public engagement in the resource allocation process.<sup>218</sup> Specifically, health insurance is viewed as “a common-pool resource regarding stewardship” via public governance, as opposed to case-by-case determinations made by the judiciary or private contractors.<sup>219</sup> In countries with public health care financing systems that resemble social insurance, the political branches play a greater role in making resource allocation decisions.<sup>220</sup> Likewise, in the Health Justice model, collective deliberation about the content of the right to access publicly funded health coverage is considered “an expression and obligation of citizenship.”<sup>221</sup>

### *B. A Health Justice Analysis of Immigrant Access to Publicly Funded Health Care*

In this Part, I apply the Health Justice lens to the issue of immigrant access to publicly funded health care. Although the Health Justice model provides some insight into whether and how the government should distribute health care resources to noncitizens, it does not answer the fundamental question of whether noncitizens should be included in the community whose collective interests are important to protect, and in the collective deliberation over the appropriate distribution of public health care resources. Nevertheless, the Health Justice model begins to make the case for why a communitarian conception of social justice is a good foundation for analyzing problems of access and equity in the U.S. health care system.

---

<sup>217</sup> *Id.* at 885–87.

<sup>218</sup> *Id.* at 885.

<sup>219</sup> *Id.* (quoting William M. Sage, *Should the Patient Conquer?*, 45 WAKE FOREST L. REV. 1505, 1510 (2010)).

<sup>220</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 885.

<sup>221</sup> *Id.* at 888.



## 1. The Health Justice Model's Contribution

Framing the issue of immigrant access to publicly funded health care through the Health Justice lens helps to highlight the collective benefits of expanding access as well as the drawbacks of restricting access, which are typically described as the positive or negative “spillover effects” of health policies. It provides support for the position that policy decisions about access to health care should be severed from policies designed to effectuate immigration enforcement goals.

From a health policy perspective, emphasizing an inclusive health care collective makes sense.<sup>222</sup> In 2004, the leading policy research organization on issues of health and medicine in the United States specifically examined the issue of health care coverage for immigrants and found “no evidence to support the notion that coverage should be limited based on citizenship or immigration status.”<sup>223</sup> Scholars have identified the potentially disastrous public health consequences of making decisions about health policy based on immigration policy.<sup>224</sup> For example, if immigrants perceive a link between health care access and immigration enforcement, immigrants may be dissuaded from accessing health care—or, by implication, the means of paying for health care.<sup>225</sup>

---

<sup>222</sup> Leaders in the health care industry understand this intuitively. *See, e.g.*, Najarro & Deam, *supra* note 96 (explaining the potential consequences of health policies that exclude immigrants, such as the spread of communicable diseases and HIV). Immigrants constitute 7% of the U.S. population. *Population Distribution by Citizenship Status*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/distribution-by-citizenship-status/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/6U2N-UMAX>] (last visited Dec. 20, 2018). Therefore, any effort to improve population health must specifically address this subpopulation. *See* ILLINGWORTH & PARMET, *supra* note 13, at 206 (noting that inclusive health policies make sense if you view health as a global public good).

<sup>223</sup> INST. OF MED., *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* 112 (2004).

<sup>224</sup> Calvo, *supra* note 132, at 192–202 (surveying the adverse effects on public health that would be caused by restrictions on access to health care by undocumented immigrants); Karen Hacker et al., *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 RISK MGMT. & HEALTHCARE POL'Y 175, 176 (2015). *See also* Najarro & Deam, *supra* note 96 (explaining that denying undocumented immigrants access to health care could lead to the spread of communicable diseases or HIV).

<sup>225</sup> *See, e.g.*, Leighton Ku & Mariellen Jewers, *Health Care for Immigrant Families: Current Policies and Issues*, MIGRATION POL'Y INST. 11 (2013) (explaining that undocumented immigrants avoid using healthcare services out of fear that their legal status will be exposed); Marrow & Joseph, *supra* note 2, at 2265 (correlating decreased access to health care by undocumented immigrants and their documented family members to reports about raids and detentions by immigration officials); Marcella Alsan & Crystal S. Yang, *Fear and the Safety*

Several of the community benefits of expanding access were described in a previous subsection: reducing the threat of infectious disease, preventing antibiotic resistance, ensuring workforce productivity, reducing wasteful spending and transaction costs, eliminating health disparities, and encouraging fellow-feeling among community members.<sup>226</sup> These benefits are the inverse of the negative spillover effects that result from restrictionist policies.

Another tangible benefit of expanding access to currently ineligible immigrants would likely accrue to patients and providers at safety net institutions: When levels of uninsurance decrease in a population, health care providers serving that population see increased revenues that can pay for additional staff and services to meet the demands of insured and uninsured patients.<sup>227</sup> Safety net health care institutions often play an important role in local communities, and their economic vitality contributes to the overall well-being of these communities.<sup>228</sup> Expanding access to affordable health care for immigrants who are members of these communities would also have some less tangible but nonetheless important benefits, such as helping to build social cohesiveness, mutual trust, and a “stock of social capital,” i.e. perceived confidence that one would be able to obtain health care if one were to fall ill or become injured.<sup>229</sup> This is the very essence of community: “[m]utual aid among a group of people who see themselves as sharing common interests.”<sup>230</sup>

As these examples show, expanding immigrant access to publicly funded health care serves the interests of the community in many ways, while restricting access can result in neutral or negative spillover effects. Recognition of these interests may provide the foundation upon which people with some

---

Net: Evidence from Secure Communities 1–4 (June 2018) (unpublished manuscript) (on file with author) (presenting evidence that fear of immigration enforcement drives avoidance of the social safety net); Najarro & Deam, *supra* note 96 (reporting anecdotal evidence of an undocumented mother who deferred medical treatment that could prevent cancer out of fear that she will be deported). This is a phenomenon I am exploring in a work in progress on potential legal, policy, and institutional solutions to the problem of health care system avoidance among immigrants, from the perspective of those who are concerned about access to health care for vulnerable populations.

<sup>226</sup> See *supra* Section II.A.1.

<sup>227</sup> See, e.g., Peter Shin et al., *Kentucky’s Medicaid Work Requirements: The Potential Effects on Community Health Centers*, HEALTH AFF. BLOG (Apr. 12, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180412.955253/full/> [<https://perma.cc/ZP5T-FWWB>] (describing the positive spillover effects of Medicaid expansion in Kentucky for safety-net health care providers).

<sup>228</sup> INST. OF MED., *supra* note 205, at 2.

<sup>229</sup> *Id.* at 133–34.

<sup>230</sup> Stone, *supra* note 194, at 289.

power to inform the debate—legislators, regulators, policymakers, judges, voting citizens, and other residents of the United States—can begin to make the case for expanding access. In addition to highlighting collective interests, the Health Justice model also highlights collective obligations, i.e. what each member of the community owes to the other members. This is the norm of reciprocity, which is described as “the heart of the communitarian understanding of social justice.”<sup>231</sup> Reciprocity would require that immigrants with newly expanded access to publicly funded health care would also become subject to the ACA’s individual mandate to obtain health coverage. Just like all others who are subject to the mandate, immigrants would thereby contribute to risk pooling, equity, and the idea of health coverage as a shared, public good.

## 2. Question Left Unanswered: Are All Immigrants Included?

The Health Justice model was developed to reflect and reinforce the transformative effects of the ACA on health law and policy. Given its foundation in a communitarian conception of social justice, it “takes communities as the starting point of analysis,” and as the source of values from which collective interests emerge.<sup>232</sup> Assuming that “health” is considered a collective interest, a communitarian approach should seek to advance the health of all members of the community. In an analysis of immigrant access to affordable care, Health Justice raises—but does not answer—the important question of whether immigrants must be included in the community of relevance. The Health Justice model “avoids the big issue of whether . . . immigrants should be considered part of the public and whether public institutions should serve their health needs.”<sup>233</sup>

If the ACA is taken as an example of a Health Justice approach, it seems that not all immigrants are considered part of the “health care collective” whose interests should be protected through the expansion of access to affordable health coverage. After all, expanding access to affordable health care for all U.S. citizens and select groups of noncitizens still promises to improve population health outcomes, improve the efficiency of the health care system, and encourage fellow-feeling among members of the community. Examples of solidarity-based national health care systems that nevertheless exclude immigrants abound in Europe. In these “universal” health care systems, robust health care benefits are available to citizens only—the majority

---

<sup>231</sup> *The Responsive Communitarian Platform*, THE COMMUNITARIAN NETWORK, <https://communitariannetwork.org/platform> [<https://perma.cc/Z6NK-LL3B>].

<sup>232</sup> Kuczewski, *supra* note 201, at 328.

<sup>233</sup> Dwyer, *supra* note 161, at 37–38.

of whom share a common history, culture, and language, thereby reinforcing fellow-feeling—and citizenship is relatively difficult to acquire.<sup>234</sup> The political divisiveness of health care reform and the rising tide of anti-immigrant sentiment likely led supporters of the ACA to make the strategic decision to sacrifice the expansion of immigrant access for the success of the bill.<sup>235</sup>

However, by expanding coverage for and imposing a new obligation to purchase insurance on U.S. citizens and certain legal immigrants, while leaving out other categories of noncitizens, the ACA legitimized the consideration of citizenship or immigration status in determining membership in the new, progressive health care collective.<sup>236</sup> U.S. citizens and immigrants who became insured through ACA benefits were transformed into “insiders,” and non-citizens who were left out of these benefits—particularly undocumented immigrants—became highly visible “outsiders.”<sup>237</sup> The law brightened the symbolic and social exclusion of the newly constituted group of outsiders, intensifying the perception that they are undeserving of state resources designed to serve the common good.<sup>238</sup> Indeed, some scholars have argued that by failing to address the health coverage needs of undocumented immigrants, the ACA further entrenched their alienation as members of the health care collective,<sup>239</sup> and actually decreased their access to health care.<sup>240</sup>

---

<sup>234</sup> See, e.g., David Abraham, *Recognizing the Problem of Solidarity: Immigration in the Post-Welfare State*, 55 WAYNE L. REV. 1641, 1646–47 (2009) (describing the arguments that “the extension of [the] principles of trust and solidarity cannot be endless and cannot be predicated on simple humanity” when debating the level of inclusion and integration of immigrants).

<sup>235</sup> Marrow & Joseph, *supra* note 2, at 2258 (“Unauthorised immigrants have so little legitimacy in prevailing American political discourse today . . . that policy-makers working to craft and pass the ACA likely had to . . . exclude them from its most visible provisions. In the controversial context of health care reform, any attempt to include them may have been accurately perceived as a danger to its supporters’ legitimacy and ultimate chances for success.”).

<sup>236</sup> See Light & Terrasse, *supra* note 3, at 1998 (“[B]ecause the ACA reinforced the diverse categories of inequality applied to immigrants, it partly served as an obstacle of the vision of access to health care and insurance as a right.”).

<sup>237</sup> See Marrow & Joseph, *supra* note 2, at 2257 (emphasis omitted) (arguing that “the symbolic and social boundaries excluding unauthorized immigrants . . . have become ‘brighter’ since the passage of the ACA. . . . because of an important boundary expansion [that] has occurred for many citizens and long-term legal immigrants . . . who previously did not have access to affordable insurance.”).

<sup>238</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 114 (“The denial of immigrants’ right to health . . . helps to sustain the illusion that health care benefits are available only to those who are ‘deserving’ of them.”).

<sup>239</sup> See Light & Terrasse, *supra* note 3, at 1995 (“[T]he ACA up through 2015 further legitimized a political environment which marginalized undocumented immigrants . . .”).

<sup>240</sup> The ACA decreases DSH payments to safety-net hospitals based on the assumption that they will have increased revenues due to a higher proportion of insured patients; however,

The Health Justice model is a useful methodological jumping-off point for analyzing the problem of immigrants' access to affordable health care because it draws attention to the collective interests that may be protected when immigrants are included in the health care collective. However, it does not provide clear guidance on whether immigrants *should* be included. Therefore, it is necessary to excavate the principles of communitarianism at the model's core in order to fully articulate a vision of Health Justice for Immigrants.

### III. HEALTH JUSTICE FOR IMMIGRANTS: A FRAMEWORK

In Part II, I identified an unresolved issue with the Health Justice framework's approach to the problem of immigrants' access to affordable health care: whether immigrants must be included in the "health care collective," which I define as the group of people whose interests should be protected by health law and policy and who bear some responsibility for ensuring the just distribution of public health care resources. The individual mandate provision of the ACA created a concept of a national health care collective that was largely based on one's presence in the United States, notwithstanding its exceptions and the fact that it stopped short of applying to all noncitizens living in the country. Membership in the national health care collective is no longer based primarily on one's relationship with one's employer. This represents a shift in notions of membership, obligation, and belonging with respect to the health care collective.

In this Part, I describe a vision of Health Justice for Immigrants by drawing on the model's foundation in the social philosophy of responsive communitarianism. My hope is that these proposals will inspire constructive debate about health care access policies for immigrants, with the goal of creating durable, politically viable legal change toward a more inclusive system of public health care finance.

The Health Justice framework's vision of social justice builds on principles espoused by one branch of communitarianism, called "responsive communitarianism."<sup>241</sup> Communitarianism is variously described as a freestand-

---

this may result in fewer resources to provide specialty and emergency care to undocumented immigrants, who make up a significant proportion of the uninsured. Other scholars have expressed concern that increased funding for FQHCs under the ACA may spotlight their treatment of undocumented immigrants and stimulate "greater public scrutiny and political backlash." See Marrow & Joseph, *supra* note 2, at 2259.

<sup>241</sup> See Wiley, *Health Law as Social Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, *supra* note 6, at 54–55 (citing *The Responsive Communitarian Platform*, THE COMMUNITARIAN NETWORK, <https://communitariannetwork.org/platform> [<https://perma.cc/Z6NK-LL3B>]).

ing philosophy, or as a critical extension of the liberal tradition.<sup>242</sup> Like other extralegal frameworks, it can help to guide debate on difficult ethical and political questions, such as whether and how much to subsidize health coverage for immigrants. In general, communitarians look to the community as the main source of values from which collective interests emerge.<sup>243</sup> Practically, communitarianism favors policies that emphasize “collective responsibility and action,” in contrast with progressivism, which “maintains a central focus on individual rights.”<sup>244</sup> A communitarian perspective illuminates the ways in which dominant models of health law and policy, with their individualistic bias and focus on the pursuit of private interests, can overlook population-level health concerns related to social determinants of health, and in particular, inequitable health outcomes for vulnerable members of the community.<sup>245</sup>

Responsive communitarianism is a branch of communitarianism that considers “both individual rights and the common good [to be] major sources of normativity;”<sup>246</sup> that is, it is a framework that seeks to balance individual interests/autonomy with the interests of all.<sup>247</sup> A health care system built on principles of responsive communitarianism could prioritize the health of the community over an individual’s freedom to opt out of contributing to this common good, as the ACA’s individual mandate did.<sup>248</sup> In contrast, a health care system based on “authoritarian communitarianism,” would always privilege the needs of the community over the needs of individuals.<sup>249</sup>

---

<sup>242</sup> Daniel Bell, *Communitarianism*, THE STANDARD ENCYCLOPEDIA OF PHILOSOPHY, <https://plato.stanford.edu/entries/communitarianism/> [<https://perma.cc/GE6A-4VQX>] (last visited Dec. 20, 2018).

<sup>243</sup> See Etzioni, *supra* note 256, at 1 (“Communitarians examine the ways shared conceptions of the good are formed, transmitted, justified, and enforced. Hence, their interest in communities (and moral dialogues within them), the historical transmission of values and mores, and the societal units that transmit and enforce values – such as the family, schools, and voluntary associations (including places of worship), which are all parts of communities.”).

<sup>244</sup> Wiley, *Health Law as Social Justice: Securing the Public’s Interest in Affordable, High-Quality Health Care*, *supra* note 6, at 59.

<sup>245</sup> See Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 845 (noting that in the patient rights model, “courts routinely neglect the population perspective, overlooking the interests of society as a whole”); *id.* at 878-79 (describing how a Health Justice perspective, based in communitarianism, justifies access to health care as a means to improving population health outcomes, rather than as a human right); Benfer, *supra* note 9, at 341 (proposing that Health Justice requires evaluation of laws’ “potential health effects on the entire population, paying special attention to marginalized individuals”).

<sup>246</sup> Etzioni, *supra* note 256, at 1.

<sup>247</sup> Etzioni, *supra* note 189, at 364.

<sup>248</sup> Alena M. Buyx, *Personal Responsibility for Health as a Rationing Criterion: Why We Don’t Like It and Why Maybe We Should*, 34 J. MED. ETHICS 871, 871 (2008)

<sup>249</sup> Amitai Etzioni, *Authoritarian versus Responsive Communitarian Bioethics*, 37 J. MED. ETHICS 17, 17 (2011).

A responsive communitarianism approach identifies shared values within a community, and builds on them to come to a consensus on controversial issues before passing laws that affect the status quo.<sup>250</sup> It invites those with differing opinions to engage in a moral dialogue in order to come to “new shared moral understandings” among members of the community.<sup>251</sup> To this end, state involvement “is best used as the last, rather than the first, resort.”<sup>252</sup> For example, by the time EMTALA was enacted in 1986, there was widespread consensus over hospitals’ duty to provide lifesaving care to anyone who needs it.<sup>253</sup> In the debate over immigrant access to publicly funded health care, a responsive communitarian approach points to existing, shared norms about the embeddedness of immigrants in the health care sphere and in the broader community.

A responsive communitarian approach helps to make a moral case for expanding immigrant access to publicly funded health care, even if the population health-based arguments are not ironclad. Population health analyses synchronize with the extralegal framework of utilitarianism, which says that the right choice is the one that provides the greatest good for the greatest number of people. A person’s citizenship or immigration status is, in theory, irrelevant in the moral calculus.<sup>254</sup> As applied to the question of whether inclusive or restrictive policies are the more ethical choice, one must consider the health impact of such policies, but also the fact that public dollars for subsidizing health care are limited. Utilitarianism supports truly universal access to immunization and treatment for communicable diseases, because citizens and noncitizens alike benefit from a reduction in the threat of infection, and the cost of these services is minimal compared with the cost of an outbreak of infectious disease. However, it is less supportive of universal access to other types of care, particularly preventive care. As described in Section I.C., although there are some potential efficiency gains and cost reductions that may come from expanding immigrant access to treatment for chronic conditions, these benefits are relatively intangible. The potential benefits from expanding immigrant access to preventive care

---

<sup>250</sup> See Etzioni, *supra* note 256, at 4 (“Responsive communitarians seek to build communities based on open participation, dialogue, and truly shared values.”).

<sup>251</sup> Etzioni, *supra* note 189, at 369.

<sup>252</sup> *Id.* at 366.

<sup>253</sup> See Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFF. 2075, 2075 (2013) (“Far from being a dramatic departure from prior law, EMTALA was the culmination of a generational shift in how courts and legislatures viewed hospitals’ emergency care obligations, not only toward their established patients but, just as important, to people who had not yet been accepted into care.”).

<sup>254</sup> See Daniel S. Goldberg, *Universal Health Care, American Pragmatism, and the Ethics of Health Policy: Questioning Political Efficacy*, 7 PIERCE L. REV. 183, 188 (2009) (“[U]tilitarians typically reject the notion that our intimates have a greater moral claim on us than strangers.”).

are even less tangible and are not well-supported by evidence. Therefore, from a utilitarian perspective, restricting immigrants from eligibility for comprehensive, publicly funded health coverage may be a reasonable way to ration limited resources, and therefore adopting criteria that discriminate on the basis of citizenship or immigration status is also reasonable.

A responsive communitarianism approach would support expanding immigrant access to publicly funded health care even if the population health or health system benefits of doing so are somewhat intangible. This is because concern for the common good, from this perspective, includes protection of a community's shared assets as well as the social norms around which the community has achieved consensus. Even if individual members of the community cannot know if contributing to the common good of public health will ever benefit them or their offspring, it is still worthwhile if it is considered "the right thing to do" based on the community's moral norms.<sup>255</sup> By applying a responsive communitarian lens to the concrete issue of immigrant access to affordable health care, this Part begins to make the case for why communitarianism is a good framework for analyzing problems in health law. The following sections propose four commitments for completing the vision of Health Justice for Immigrants.

#### *A. Including Immigrants in the Health Care Collective*

The problem of defining the community that "matters" has emerged as a criticism of communitarianism generally.<sup>256</sup> Scholars of political communitarianism have offered some responses to the critique that the concept of "community" is employed too loosely to make sense of it as a normative ideal. Amitai Etzioni, a founder of the responsive communitarian movement, has put forth a definition of community that is based on two characteristics: "first, a web of affect-laden relationships among a group of individuals, relationships that often crisscross and reinforce one another (as opposed to one-on-one or chain-like individual relationships); and second, a measure of commitment to a set of shared values, norms, and meanings, and a shared history and identity – in short, a particular culture."<sup>257</sup> Etzioni also writes that individuals are frequently members of multiple communities that are limited to particular spheres in scope and reach.<sup>258</sup>

---

<sup>255</sup> Etzioni, *supra* note 189, at 365.

<sup>256</sup> See Amitai Etzioni, *Communitarianism*, in THE ENCYCLOPEDIA OF POLITICAL THOUGHT 4 (Michael T. Gibbons ed. 2015) ("[C]ritics have accused communitarians not merely of overlooking the less attractive features of traditional communities, but of longing to revive these features.").

<sup>257</sup> *Id.*

<sup>258</sup> *Id.* at 3.



In the health care context, an important question to ask in defining the relevant community is: What purpose does the health care system serve? If the purpose is to promote the communal good of “health,” laws and policies should be designed to preserve that good. The ACA’s individual mandate and commitment to ensuring affordable health coverage were based on the understanding that a person who does not have health coverage “lives sicker, dies younger, and is one emergency away from financial ruin,” and that these consequences have negative spillover effects to the larger community.<sup>259</sup> The national health care collective created by the ACA could be considered one of the overlapping communities that Etzioni describes. This Part builds on Etzioni’s definition of community by describing the important roles that immigrants play in the U.S. health care system and in society more generally. It then explores how important ideas underlying the culture of health care—the principle of need and the concept of mutual aid—support the inclusion of immigrants in publicly funded health care programs.

### 1. Foundations for Solidarity with Immigrants

In an analysis of immigrant access to publicly funded health care, the responsive communitarian perspective looks to the place of immigrants within the community. In *The Health of Newcomers*, a comprehensive analysis of the ways in which immigration policy has undermined public health, Professors Patricia Illingworth and Wendy E. Parmet observe, “An underlying assumption of the view that citizenship triggers solidarity is that people are only able to have fellow feeling toward citizens.”<sup>260</sup> This analysis asks whether citizens’ interactions with immigrants are a more important consideration than formal legal status in determining access to publicly funded health care.<sup>261</sup> The degree to which immigrants are embedded in the community influences the extent to which they may be included in a health care system built on the concept of solidarity.<sup>262</sup>

The challenge of engendering solidarity among citizens and non-citizens should not be discounted. Solidarity develops most easily among members of groups with common, strongly held values and histories. Social

<sup>259</sup> HEALTH ACCESS FOUNDATION, *supra* note 29, at 1–2.

<sup>260</sup> ILLINGWORTH & PARMET, *supra* note 13, at 175.

<sup>261</sup> See Kuczewski, *supra* note 201, at 335 (“[T]he important questions should not focus on whether immigration laws have been broken but on what roles in the life of the community such [immigrants] play and whether immigration laws should be adjusted to accommodate these roles.”).

<sup>262</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 175 (“Solidarity is understood to have prescriptive qualities. It creates an obligation to act for the sake of others and creates the possibility that individual interest may need to be subordinated to community interest. That is, solidarity triggers a duty to carry costs for other people.”).

insurance systems in the United States, such as Social Security retirement benefits, operate primarily by the logic of a solidarity based on U.S. citizenship, with exceptions for certain types of immigrants who have long contributed to the system.<sup>263</sup> In liberal political theory, citizenship is a commonality that can be invoked to create solidarity among disparate communities that are fragmented by political affiliation, race, ethnicity, religion, class, and other social divisions.<sup>264</sup> In certain contexts, defining the community by drawing a line between citizens and noncitizens makes sense.<sup>265</sup> For some advocates of restrictionist policy, the answer to the question of whether undocumented immigrants should be considered members of the health care collective is simple: they are not, because their physical presence within the country is unauthorized under federal law. According to them, this “illegal” quality should trump all others in a consideration of their rights vis-à-vis the state.<sup>266</sup>

However, making eligibility for publicly funded health coverage contingent on citizenship or immigration status offers a false sense of clarity about who the health care collective considers insiders and outsiders. A person’s immigration status is not always easy to discern, and many immigrants go through frequent changes of status or periods without status during their immigration journeys.<sup>267</sup> The immigration laws are complex, and there are hundreds of possible immigration “statuses” that fall on the spectrum from “permanent” to temporary to quasi-status to undocumented. One scholar suggests referring to “illegal immigrants” as “pre-legal immigrants,” given that there are many ways in which a person without status can gain or regain status, and that a large percentage of immigrants who appear in immigration court ultimately receive legal status.<sup>268</sup> Readers might be surprised to learn that each

---

<sup>263</sup> See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 437 (2011) (“Social insurance was driven by the philosophical idea of solidarity . . .”). Many working immigrants who pay Social Security taxes do not qualify for Social Security retirement benefits, either because of their status or because they have not accumulated the necessary work credits. *Id.*

<sup>264</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 176 (“[C]itizenship can replace kin, clan, and tribe, creating a new liberal, nonnativist national identity.”).

<sup>265</sup> See FISS, *supra* note 162, at 8–9 (“[D]rawing a distinction between aliens and citizens is integral to the effort of any sovereign nation to determine its own membership.”).

<sup>266</sup> See, e.g., ILLINGWORTH & PARMET, *supra* note 13, at 173 (“Some argue that the situation is different for those who enter a country illegally, that by violating a nation’s immigration laws, unauthorized immigrants demonstrate their lack of loyalty to the community and hence lose their claim to participate in the rights it bestows.”).

<sup>267</sup> *Id.* at 174.

<sup>268</sup> Kari Hong, *The Ten Parts of “Illegal” in “Illegal Immigration” That I Do Not Understand*, 50 U.C. DAVIS L. REV. ONLINE 43, 44–45 (2017) (citing Esther Yu Hsi Lee, *Immigrants Are Winning Half of All Deportation Cases So Far This Year*, THINKPROGRESS (Feb. 18, 2014),

of the immigrants profiled in the Introduction to this Article are technically undocumented, whether or not they entered the United States with official documentation, and are in the process of applying for benefits; all could potentially be on the path to citizenship within a year. Making citizenship or immigration status a key determinant of eligibility for publicly funded health care has resulted in an overly complex, error-prone system.<sup>269</sup> It also ignores the reality that there will always be some degree of unauthorized immigration because it is impossible for the United States to enforce immigration laws perfectly.<sup>270</sup> What is clear is that consideration of citizenship and immigration status in the determination of eligibility for public benefits is not inevitable; it is possible to use “inhabitation” as an alternative criterion for inclusion in a health care collective that aims to provide universal affordable coverage.<sup>271</sup>

An understanding of the complexity and fluidity of immigration status helps to make some of the less tangible spillover effects of denying public coverage to immigrants more tangible. Uninsured people tend to use health care less often than insured people (even when they need it), have more trouble finding health care providers who will take them on as patients, and are responsible for a greater proportion of uncompensated care costs for health care providers.<sup>272</sup> A potential ripple effect of restricting immigrants’ access to health coverage is—if lack of health care leads to disability—the necessity of supporting these “Americans in waiting” for years to come through disability benefits or other income supports.<sup>273</sup> For these reasons, adopting increasingly restrictionist social welfare and immigration policies are unlikely to reduce health care-related costs in the long term.

Scholars from several fields of study have described the ways in which immigrants—including undocumented immigrants—are embedded in American society. Immigrants live with and next to U.S. citizens, they attend school with citizens, and they work side by side with citizens.<sup>274</sup> Many citizens once

---

<https://thinkprogress.org/immigrants-are-winning-half-of-all-deportation-cases-so-far-this-year-fe5a58dbd78e> [<https://perma.cc/K42V-LKXP>].

<sup>269</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 78 (describing the “messy and very confusing hodgepodge of exclusions, inclusions, and exceptions” caused by different private and public insurance programs, some of which do not cover certain groups of noncitizens); see also Appendix 1 (providing a chart indicating immigrant eligibility for federally funded health care programs).

<sup>270</sup> Hiroshi Motomura, *Immigration Outside the Law*, 108 COLUM. L. REV. 2037, 2090 (2008).

<sup>271</sup> Tiffany D. Joseph, *What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms*, 41 J. HEALTH POL., POL’Y & L. 101, 111 (2016).

<sup>272</sup> INST. OF MED., *supra* note 201, at 2.

<sup>273</sup> *Id.*

<sup>274</sup> Kuczewski, *supra* note 201, at 334.

were immigrants or have family members who are immigrants. Immigrants pay taxes to fund public programs that promote the common good. These roles contribute to the depth of the “web of affect-laden relationships” that characterizes the place of immigrants within American society.

In the health care context, immigrants already play an important role as caregivers: In 2015, 16.7% of the health care workforce nationally was foreign born, including 27.9% of physicians; 23.8% of nursing, psychiatric, and home health aides; and 15.8 % of registered nurses.<sup>275</sup> In three states and in the District of Columbia, the immigrant share of the health care workforce was greater than 30%.<sup>276</sup> Immigrants also play important roles as caregivers to children, constituting 18.2% of early childhood education and care workers.<sup>277</sup> These numbers almost certainly underestimate the number of immigrants in the caregiving professions, as they do not include undocumented immigrants whose employment is not reported to the government. Credible sources state that “substantial numbers” of domestic workers—such as nannies and caregivers—are undocumented immigrants.<sup>278</sup> Also, of the documented immigrants who work as caregivers, some may have been undocumented for some period prior to gaining lawful status.<sup>279</sup>

The fact that immigrants play such important roles in the U.S. health care system, and that citizens willingly place trust in immigrants as health care workers and caregivers for the most vulnerable members of society, belies the assumption that only citizenship can trigger solidarity.<sup>280</sup> Rather, these caregiving roles can and often do trigger solidarity between citizens and immigrants.<sup>281</sup> Illingworth and Parmet note the ironic trust that citizens place

---

<sup>275</sup> Szilvia Altorjai & Jeanne Batalova, *Immigrant Health-Care Workers in the United States*, MIGRATION POL’Y INST. (June 28, 2017), <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states> [<https://perma.cc/M9FH-GQRX>].

<sup>276</sup> *Id.* (citing statistics of the immigrant share of the health care work force at 37% in New York, 33% in California, 32% in New Jersey, and 37% in the District of Columbia).

<sup>277</sup> MAKI PARK ET AL., MIGRATION POL’Y INST., IMMIGRANT AND REFUGEE WORKERS IN THE EARLY CHILDHOOD FIELD: TAKING A CLOSER LOOK 17 (2015).

<sup>278</sup> *See, e.g.*, LINDA BURNHAM & NIK THEODORE, NAT’L DOMESTIC WORKERS ALLIANCE, HOME ECONOMICS: THE INVISIBLE AND UNREGULATED WORLD OF DOMESTIC WORK 12 (2012) (discussing the penalties that undocumented immigrants, who represent a “significant proportion” of domestic workers, incur in the workforce).

<sup>279</sup> For example, the renowned neurosurgeon Dr. Alfredo Quinones-Hinojosa entered the United States without inspection as a teenager and spent several years as a migrant farmworker. Elizabeth Landau, *From Migrant Worker to Neurosurgeon*, CNN (May 25, 2013, 7:32 AM), <https://www.cnn.com/2013/05/24/health/lifeswork-dr-q/index.html> [<https://perma.cc/5L7M-QLNZ>].

<sup>280</sup> ILLINGWORTH & PARMET, *supra* note 13, at 159 (noting that health care recipients place great trust in immigrants, proving that there can be trust among diverse groups of people).

<sup>281</sup> *Id.* at 180 (showing how immigrant caregivers can bond with native patients).

in immigrants to look after their most intimate and vital needs, coupled with their reluctance to support immigrants' health needs.<sup>282</sup> This highlights the need to redraw the borders of the health care collective in order to adjust the imbalance in access to affordable health care.

## 2. Health Care Norms Supporting Inclusion

Traditional rationales for excluding immigrants from most publicly funded health care programs all rely on the assumption that lack of immigration status is a compelling reason to deny publicly funded health care.<sup>283</sup> In a communitarian analysis of immigrant access to affordable health, I argue that it is worth investigating this assumption by looking to the shared values and ideals—or the “particular culture”—of health care.<sup>284</sup>

Within the health care sphere, I focus on the two most relevant sub-spheres: providers and payers. Health care providers treat patients based on the principle of need. An example of this principle that has been codified in federal law is the Emergency Medical Treatment and Labor Act (EMTALA), which requires nearly all health care institutions to stabilize a patient with an emergency medical condition—no questions asked. Health care financing is based on the concept of mutual aid. Traditionally, health insurance as mutual aid has operated based on a principle of actuarial fairness, meaning those who have greater health care needs bear the heaviest costs. The ACA, by expanding eligibility for publicly funded health coverage and limiting private insurers' ability to charge customers based on past and expected future consumption of health care, marked a shift in health care finance: from a system based on the principle of actuarial fairness toward a system based on the principle of solidarity. I explain how the principles underlying the sub-spheres of both providers and payers, pre- and post-ACA, support the inclusion of immigrants in publicly funded health care programs.

### a. Providers and the Principle of Need

An ethical argument for discounting immigration status as a criterion for publicly funded health care is based in professional ethics in medicine. This argument invokes the physician's ethical duty to act with single-minded

---

<sup>282</sup> *Id.* at 152 (questioning why so many people support restrictive immigration policies, yet trust immigrants to take care of their basic health care needs).

<sup>283</sup> See Linda Bosniak, *Being Here: Ethical Territoriality and the Rights of Immigrants*, 8 THEORETICAL INQUIRIES IN L. 389 (2007) (describing the status-based idea of immigrants' rights).

<sup>284</sup> See generally Glen, *supra* note 48; Clark, *supra* note 15, at 270–71 (discussing what drives the political rhetoric surrounding immigrant health care); Kuczewski, *supra* note 201, at 335 (emphasizing the irrelevancy of a patient's immigration status during health care treatment).

devotion to the well-being of the patient in front of him, often referred to as “the principle of need.”<sup>285</sup> It holds that a patient’s need should evoke a caring response based on sound medical judgment from a physician, without regard to other considerations. To a certain degree, this duty also extends to publicly funded health care institutions, which distribute health care resources primarily on the basis of individual and community need.<sup>286</sup> The principle of need has been recognized as “the particular form of justice in the health care sphere,” one that is already “embedded in law and community institutions.”<sup>287</sup>

When factors other than a patients’ needs enter into medical decision-making, physicians may be unable to treat a patient based on sound medical judgment alone. For example, in a fragmented system of health care finance, providers are compelled to determine patients’ ability to pay for services before providing them. This practice “can distort and even disrupt [the] relationships between health care providers and the people they serve.”<sup>288</sup> When that system takes into account citizenship or immigration status in making coverage determinations, it involves the institutions in “an investigative enterprise that is foreign to [health] care and [that] would undermine its capacity to fulfill the expectations of the community.”<sup>289</sup> Indeed, physicians opposed to Proposition 187—the restrictionist ballot measure in California that was a precursor to PRWORA and that would have required publicly funded health care facilities to deny care to undocumented immigrants and report them to immigration officials—argued that cooperating with the law would erode professionalism and undermine their autonomy.<sup>290</sup> The fact that undocumented immigrants are eligible for emergency Medicaid, a limited form of publicly funded health care, demonstrates that some amount of “health-related solidarity” exists between citizens and immigrants.<sup>291</sup> All categories of immigrants are eligible for some public subsidization of the costs of emergency medical care, presumably based on a moral imperative.<sup>292</sup> This fundamental idea has been termed the “rescue principle,” and has been

---

<sup>285</sup> Kuczewski, *supra* note 201, at 329.

<sup>286</sup> *Id.* at 329 (explaining that nonprofit hospitals adopt the rescue principle in that no one in immediate need of care will be turned away).

<sup>287</sup> *Id.* at 330.

<sup>288</sup> INST. OF MED., *supra* note 201, at 2.

<sup>289</sup> Kuczewski, *supra* note 201, at 330.

<sup>290</sup> Ziv & Lo, *supra* note 154, at 1095–96.

<sup>291</sup> ILLINGWORTH & PARMET, *supra* note 13, at 182 (pointing to the fact that because immigrants are not fully excluded from the health care system, there is at least some health-related solidarity among citizens and noncitizens).

<sup>292</sup> Glen, *supra* note 48, at 229 (discussing the EMTALA and how ethical beliefs about how every person should be treated when medically necessary, regardless of legal status).

codified in EMTALA.<sup>293</sup> It holds that “anyone in immediate distress [should] not suffer and die in the street but has a place where he or she is immediately welcomed and the resources of modern medicine are brought to bear to diagnose and, if possible, stabilize the patient.”<sup>294</sup> In an emergency situation, it is especially clear how requiring health care providers to determine the worthiness of patients in distress would undermine values that health care seeks to foster.<sup>295</sup> Solidarity between citizens and immigrants in health care is derived from humans’ basic vulnerability to illness and death.<sup>296</sup> The moral imperative behind EMTALA, based on the presumption that patients have “intrinsic worth and dignity,” also supports broader integration of immigrants into the national health care collective.<sup>297</sup>

### b. Payers and Mutual Aid

Most health care in the United States is financed through health insurance, and health insurance is based on the concept of mutual aid.<sup>298</sup> A mutual aid system distributes health care primarily based on “medical need or the ability of the individual to benefit from medical care.”<sup>299</sup> In the private insurance industry, the principle of actuarial fairness dominates, meaning that each member of the health care financing collective must “pay for his own risk;”<sup>300</sup> the dominant value could be expressed as “personal responsibility.”

The principle of actuarial fairness largely avoids the dilemma of determining who is a member of the community because community members do not commit to take on great obligations to provide for one another, as they would in a mutual aid system based on solidarity. In theory, a person can participate in such a system if, presumably, he or she can “buy in” to the system. One’s immigration status—not to mention lineage, culture, and native language—should be considered irrelevant to such a notion of membership.

Moreover, the principal of actuarial fairness encourages the participation of healthier people, because this generally translates into less utilization

---

<sup>293</sup> See Kuczewski, *supra* note 201, at 329.

<sup>294</sup> *Id.* at 329.

<sup>295</sup> *Id.* at 329 (pointing out that questioning the immigration status of patients may undermine the status of health care in communities).

<sup>296</sup> See ILLINGWORTH & PARMET, *supra* note 13, at 214 (discussing the ability of health care to bring people together); Kuczewski, *supra* note 201, at 335 (discussing ways in which health care can bring us together as a community).

<sup>297</sup> *Id.* at 332.

<sup>298</sup> See *infra* Section II.A.1.

<sup>299</sup> Stone, *supra* note 194, at 291.

<sup>300</sup> *Id.* at 290.

of health care, and lower costs.<sup>301</sup> As a population, immigrants are generally younger and healthier than citizens. For this reason, they could be considered valuable contributors to the insurance pool. Similarly, inviting a broader range of immigrants to participate in the ACA insurance exchanges could result in savings for the federal government over the long term. Making it easier for currently healthy immigrants to access preventive and primary care now could prevent costly, chronic health problems in the future.<sup>302</sup> This reasoning justifies broader immigrant access to publicly funded health care than is currently permitted. U.S. citizens have an interest in ensuring that immigrant community members can access primary care in order to reduce their future risk of chronic disease, which can lead to socioeconomic disadvantage for all.<sup>303</sup>

Public health insurance is a form of mutual aid that is based on the principle of solidarity. As described in Part II, the ACA's reforms transformed the health insurance system so that it looks less like a system based on the principle of actuarial fairness and more like a system based on the principle of solidarity. Solidarity derives from the norm of reciprocity, and health insurance can be a means for citizens and immigrants to share societal "wins" and "losses"—something that is implied in the concept of mutual aid and reciprocity. Encouraging or mandating that immigrants participate in financing health care is one way of building solidarity between citizens and immigrants. Immigrants already contribute to publicly funded health care programs like Medicare, Medicaid, Title X for family planning, local health departments, and community clinics through the taxes they pay.<sup>304</sup> More widespread and transparent contributions to health care finance by immigrants can help trigger duties to carry costs across lines of nationality and formal status.<sup>305</sup>

A communitarian approach to the question of public financing of health care for immigrants could be considered attractive by those on opposing sides of the debate because it appeals to a shared notion of what constitutes "community"

---

<sup>301</sup> Capps & Fix, *supra* note 2, at 641 (pointing out that immigrants, lacking health care coverage eligibility, will continue to utilize expensive methods of health care such as emergency rooms).

<sup>302</sup> *Id.* (noting that including younger, healthier people in insurance pools will bring the cost of health care down for everyone).

<sup>303</sup> Harris, *supra* note 22, at 2 ("Access to preventive care is particularly important among immigrant populations as it is a determinant of future risk of chronic disease, which in turn may lead to socioeconomic disadvantage").

<sup>304</sup> NATIONAL ACADEMIES PRESS, *THE INTEGRATION OF IMMIGRANTS INTO AMERICAN SOCIETY* 401 (2015) (noting that the taxes immigrants pay help fund Medicaid, Title X for family planning, local health departments, and community clinics that serve all communities).

<sup>305</sup> ILLINGWORTH & PARMET, *supra* note 13, at 174–75 (describing the prescriptive qualities of solidarity, as it creates an obligation to work on behalf of others).



in the health care sphere. Those who typically favor restrictions against noncitizen “outsiders” or “freeloaders” may be drawn to the emphasis on the idea of reciprocity: all members of the community must commit to a set of core values and must contribute to the health care system, regardless of citizenship or immigration status. From this perspective, excluding immigrants from making financial contributions to the health care system in which they will likely participate is irrational.<sup>306</sup> Permitting them to participate is a “means of empowering persons who might present for care to make contributions according to their means.”<sup>307</sup> On the other side, those who already support more inclusive policies would find this approach refreshing because unlike analytical approaches that emphasize individual rights, it does not automatically categorize noncitizens as second-class members of the community. Communitarianism promotes building upon those shared norms to come to a consensus on society’s moral obligation to finance non-emergent types of health care for immigrants, and to then introduce laws to enforce those norms.

### *B. Discouraging Biased or Fear-Based Arguments*

This Article has described a strategy for building solidarity between U.S. citizens and immigrants in health care by raising awareness of the negative spillover effects of excluding immigrants from access to health care.<sup>308</sup> Justifications for public health interventions typically rely on the need for collective action to address a problem that could impact all members of a community. Similarly, progressive scholars and advocates who argue against restrictionist policy have advanced pragmatic arguments warning about threats to public health and the health system when immigrants are excluded from the health care collective.<sup>309</sup> These are likely to be effective arguments for an audience of U.S. citizens because it appeals to their self-interest. Even very privileged members of the community may be persuaded to support expanded access. For example, states that elect the federal option to eliminate the five-year waiting period for lawfully present immigrant children to

---

<sup>306</sup> Kuczewski, *supra* note 201, at 333 (discussing the irrationality of excluding immigrants from contributing financially to the health care system when they will likely use it).

<sup>307</sup> *Id.* at 335.

<sup>308</sup> See Mike Ewall, *Legal Tools for Environmental Equity vs. Environmental Justice*, 13 SUSTAINABLE DEV. L. & POLY 4, 12 (2012) (describing this strategy in the environmental justice context); Kuczewski, *supra* note 201, at 328 (explaining that because the United States does not provide health care to illegal immigrants, these undocumented immigrants avoid medical care until absolutely necessary and, as a result, use emergency rooms more often than primary care physicians).

<sup>309</sup> See Clark, *supra* note 15, at 264 (describing common pro-access arguments that begin with “a fear of what will happen if we do not encourage access”).

access Medicaid or CHIP may reason that such immigrants are likely to become long-term residents of the state, and therefore “[i]ncluding immigrants in safety-net care and coverage is an investment in the future.”<sup>310</sup> These are strong arguments grounded in public health science and a population-based perspective, in which “access to health care is primarily a means to an end.”<sup>311</sup>

From a responsive communitarian perspective, however, strategies that characterize immigrants as a population that must be accommodated lest they become threats to public health or drains on the health care system, are potentially problematic. Some of the most common progressive arguments for expanding access emphasize the increased costs, inefficiency, and frustration in the health care system that result from immigrants’ lack of financial access to health care. Depending on how they are framed and communicated, such arguments can reinforce negative stereotypes about immigrants as infectious agents, excess cost-consumers, or other liabilities.<sup>312</sup>

These arguments can conflict with communitarian values if they are based on or feed into irrational fears of, or biases against, immigrants. For example, communitarianism encourages building on shared norms to come to a consensus about society’s moral obligation to finance health care for immigrants. Fear and bias are poor foundations for policies designed to promote the common good. An immigrant health care policy that is dominated by the frame of immigrants undermining both the health care system and public health could result in a political backlash that includes any of the following: generating anti-immigrant sentiment, supporting efforts to increase immigration enforcement and border security, decreasing legal avenues of immigration, cutting back the already meager funding for health coverage for immigrants, or rolling back laws obligating certain health care providers to treat patients regardless of immigration status.<sup>313</sup>

---

<sup>310</sup> HEALTH ACCESS FOUNDATION, *supra* note 29, at 16.

<sup>311</sup> Wiley, *From Patient Rights to Health Justice*, *supra* note 6, at 879.

<sup>312</sup> See generally Clark, *supra* note 15; Calvo, *supra* note 132, at 177 (illuminating that immigrants are made scapegoats in the realm of health care by those in favor of restricting immigration); Viladrich, *supra* note 10, at 825 (expressing that immigrations should be given health care because they are carriers of disease that could be transmitted to non-immigrant communities).

<sup>313</sup> See, e.g., ILLINGWORTH & PARMET, *supra* note 13, at 176 (recognizing that immigration could undermine social solidarity, support for the welfare state, and incite support for restrictive immigration proposals); Clark, *supra* note 15, at 264; see also Ed Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1, 2-3 (1981) (describing a related phenomenon, in that the more successful pro-access advocates are in obtaining health coverage for low-income populations, the greater the threat of program cutbacks).

Moreover, these pragmatic arguments, while perhaps politically expedient, are also politically vulnerable. If the normative rationale for restricting access—said argument being that immigrants do not deserve access to publicly funded health care—becomes the dominant social opinion, such rationales could stimulate a backlash against immigrants and immigration generally, thereby leading to the fragmentation of the health care collective that advocates seek to build. For this reason, Health Justice for Immigrants requires careful framing and communication of the population health arguments in favor of expanding access, in order to avoid villainizing the population it seeks to include.

### C. *Linking Health Advocacy with Immigration Advocacy*

The Health Justice framework's foundation in communitarian conceptions of social justice includes solidarity with noncitizens. This means that it should explicitly consider all noncitizens within the United States, regardless of status, as members of the health care collective. As a framework for health law that is based in social justice and is committed to addressing the social determinants of health, Health Justice supports the normative goal of encouraging social solidarity and an ethos of mutual aid in debates about both health care and immigration.<sup>314</sup> By including noncitizens within the community that matters in health policy debates, Health Justice can help to foster social solidarity generally, which may encourage the development of more humane immigration policy and create a ripple effect to expand immigrants' access to other health-supporting public benefits.<sup>315</sup> Advocates for humane immigration reform would likely embrace allies who promote policies that “are not explicitly immigration-related, but that create a legal or social environment that is more inclusive and beneficial” to immigrants.<sup>316</sup> This is based on the theory that including immigrants in the health care collective would further integrate them into the nation.

---

<sup>314</sup> Lawrence O. Gostin & Madison Powers, *What Does Social Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 HEALTH AFFAIRS 1053, 1058–59 (2006) (discussing the need to take particular care to account for the health care of the poor and less powerful, and that ensuring fair distribution of resources is not enough).

<sup>315</sup> ILLINGWORTH & PARMET, *supra* note 13, at 178 (explaining that state-funded health care that is blind to immigration status can encourage solidarity and facilitate government action). See Hunter, *supra* note 204, at 1996 (noting that the Patient Protection and Affordable Care Act extends the functional aspects of citizenship to health care for the first time); Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1579–80 (2011) (discussing how the Affordable Care Act creates solidarity by bringing people together through a system of mutual insurance).

<sup>316</sup> Rodríguez et al., *supra* note 5, at 17.

By linking health policy with immigration policy in this way, advocates would be addressing one of the biggest barriers to accessing affordable health care for many noncitizens: exclusion from the major publicly funded health insurance programs based on their immigration status. Legal status is also the basis for exclusion from many other health-supporting public benefits for low-income people, such as food stamps, cash assistance, disability benefits, child care subsidies, energy subsidies, and transportation benefits tied to Medicaid enrollment. Immigration laws and policies have contributed to the creation of a large immigrant underclass in the United States. Lack of legal status or citizenship impacts a person's ability to work in a safe environment, to earn a fair wage, and to plan for the long term—all of which are stressors with the potential to exacerbate existing health conditions. Moreover, immigrants are disproportionately impacted by poverty, a major social determinant of poor health outcomes.<sup>317</sup> To summarize, immigration status itself may be considered a social determinant of health.<sup>318</sup> If lack of immigration status is indeed the major barrier to access in the immigrant community, Health Justice for Immigrants should support a strategy that directs resources toward advocating for immigrants more broadly.<sup>319</sup>

---

<sup>317</sup> Ku & Jewers, *supra* note 225, at 3 (noting that low-income children and adult noncitizens are much less likely to have health insurance than low-income citizens). As of September 2018, the poverty rate of native-born citizens was 12.3%, while the poverty rate of foreign-born noncitizens was 18.7%, and was 10.1% for foreign-born naturalized citizens. *U.S. Poverty Statistics*, FED. SAFETY NET, <http://federalsafetynet.com/us-poverty-statistics.html> [<https://perma.cc/E598-4KVA>] (last visited Dec. 20, 2018).

<sup>318</sup> Heide Castañeda et al., *Immigration as a Social Determinant of Health*, 36 ANNUAL REV. PUBLIC HEALTH 375, 381 (2015) (explaining that immigration status can affect a person's health care because immigrants face challenges such as housing issues, fear of interaction with the government, minority stress, among other issues). Although it is beyond the scope of this article, it is important to note another way in which immigration status functions as a social determinant of health in the current environment of heightened immigration enforcement: Increased fear and stress are causing behavioral issues, psychosomatic symptoms, and mental health issues in children, and making it more difficult for parents to focus on caregiving. ARTIGA & UBRI, *supra* note 136, at 11–13. Pediatricians are also concerned about the potential long-term consequences of toxic stress on children in immigrant families—increased rates of chronic disease and mental health disorders through adulthood. *Id.* at 16–17.

<sup>319</sup> See generally Edna A. Viruell-Fuentes et al., *More than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health*, 75 SOCIAL SCIENCE & MED. 2099 (2012) (describing ways in which anti-immigrant policies can undermine the health and wellbeing of undocumented immigrant communities). For many immigrants, naturalizing or obtaining a more secure status would expand their access to many public benefits under existing laws. Some medical-legal partnerships represent clients in immigration matters for precisely this reason.

#### D. Expanding Individual Rights to Access

An obvious strategy to address the issue of immigrant access to affordable health care is to advocate for the creation of health care entitlements for low-income immigrants that are similar or identical to those enjoyed by U.S. citizens. This effort would build on the history of progressive health care reform efforts that have expanded health care access rights to ever-broader populations by extending already-existing rights to noncitizens.<sup>320</sup> It may be that establishing a universal right to publicly funded health care for low-income immigrants and citizens alike is a necessary step to eliminating the disparities in both access and health status affecting the immigrant community.<sup>321</sup>

Although other social justice movements based in communitarianism have been critical of rights-based movements for various reasons, the unique lack of entitlement and political voicelessness of the immigrant community requires a reassessment of this position.<sup>322</sup> As a health law model emerging in the years following the implementation of the ACA, Health Justice seems to assume near-universal access to affordable health care, especially for very low-income populations within the United States. For example, reliance on this assumption strengthens the argument to shift the focus of health law and policy away from access to health care and toward the social determinants of health. This shift is based on the understanding that access alone is insufficient to ameliorate health disparities. The problem with this assumption is that it ignores the fact that immigrants are automatically categorized as second-class members of the community with respect to publicly funded health coverage. Immigrants are unique among marginalized groups whose needs have been sidelined by rights-based progressive movements aiming to reduce health disparities.

Low-income immigrants represent an intersectional identity with complex barriers to accessing health care, but in contrast to marginalized communities defined by race or gender, one aspect of their identity guarantees that they will suffer from a rights deficit and it is enshrined in the law: their legal status impacts their access to publicly funded health care. Unlike native-born communities whose marginal status prevents them from fully exercising

---

<sup>320</sup> Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 79 (2003) (describing grassroots movements focused on securing benefits for a particular group as “part of the tradition of pluralism or incrementalism in American health politics”).

<sup>321</sup> See, e.g., INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 35 (2003) (noting the health care disparities in minority communities, and how white citizens tend to fare much better than minorities).

<sup>322</sup> For example, rights-based movements can inadvertently create rights only for a privileged segment of society, further marginalizing historically marginalized populations and exacerbating disparities.

their rights, immigrants have been excluded altogether from the community of rights-bearers. The ACA's reforms, while benefiting citizens and certain types of immigrants, had the effect of exacerbating health care access disparities between citizens and noncitizens. The long-term implications of the choice to exclude undocumented immigrants from the benefits of the ACA may be to further entrench their exclusion from the health care collective.

The Health Justice framework must be flexible enough to accommodate rights-based strategies when addressing issues relevant to particularly disempowered groups. A responsive communitarian analysis begins with an analysis of an existing community's conception of the common good, and how it can be served through law and policy.<sup>323</sup> It is not opposed to employing individual rights as a vehicle for promoting compliance with norms that are shared by the community. As described above, EMTALA entrenched the widely shared norm that hospitals must provide lifesaving care to any person who needs it. Efforts to establish a thicker health care safety net for immigrants may have to rely on a similar strategy of first building consensus around society's moral obligation to finance such care, and later enshrining it in the law.

### CONCLUSION

This Article introduces a new paradigm for analyzing the issue of immigrant access to affordable health care. So long as large numbers of immigrants living in the United States remain uninsured, the goals of health care reform will not have been accomplished. Although the Health Justice model provides a framework for understanding how universal access to affordable health care protects collective and individual interests, it does not address the crucial question of whether immigrants should be included in that "universe." I articulate a vision of Health Justice for Immigrants by using the principles of responsive communitarianism to complete the theory. The framework's commitment to collective responsibility requires solidarity with immigrants, avoiding rationales that rely on xenophobic fears and biases, linking health advocacy with immigration advocacy, and seriously considering a rights-based strategy to expand immigrants' access to publicly funded health care.

---

<sup>323</sup> Kuczewski, *supra* note 201, at 328 (explaining that communitarian critiques show how the individual is "conceived as being without content or specific determinations, other than will and choice").

## APPENDIX 1

## Immigrant Eligibility for Federally Funded Health Care Programs

Description of Noncitizen Status / Circumstance	Classification under Federal Public Benefit Laws	Medicaid	CHIP	ACA Premium Tax Credits
Lawful Permanent Resident (LPR) for 5+ years	“Qualified” and “Lawfully Present”	Yes, at the state’s option <sup>324</sup>	Yes	Yes
LPR for fewer than 5 years, generally		No	No	Yes
LPR for fewer than 5 years who is exempt from the 5-year bar <sup>325</sup>		Yes	Yes	Yes
LPR for fewer than 5 years who is not exempt from the 5-year bar, and who is a child		Yes, at the state’s option <sup>326</sup>	Yes, at the state’s option	Yes
LPR for fewer than 5 years who is not exempt from the 5-year bar, and is pregnant		Yes, at the state’s option	Yes, at the state’s option	Yes

<sup>324</sup> Qualified aliens are generally subject to a five-year bar to accessing federal public benefits, including Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 403(a), 110 Stat. 2105, 2116 (codified in 42 U.S.C. § 603). States have an option to provide or deny Medicaid to most qualified immigrants who have completed the five-year bar to federal public benefits.

<sup>325</sup> Lawful Permanent Residents (LPR) who adjusted to LPR from one of the following statuses are exempt from the five-year bar to federal public benefits under PRWORA: refugee, asylee, Cuban/Haitian entrant, grantee of withholding of deportation/removal, Amerasian immigrant, trafficking survivor, Iraqi or Afghan special immigrant status, certain American Indians born abroad, children receiving Foster Care, and veteran or active duty military member and their spouses and unmarried dependent children.

<sup>326</sup> States may elect to provide Medicaid to lawfully present pregnant women and children, without a waiting period. Children’s Health Insurance Program Reauthorization Act of 2009 (H.R.2), Pub. L. No. 111-3, § 214, 123 Stat. 56 (Feb. 4, 2009).

Refugee		Yes	Yes	Yes
Asylee		Yes	Yes	Yes
Cuban/Haitian Entrant		Yes	Yes	Yes
Granted Withholding of Deportation/ Removal under the Immigration Laws		Yes	Yes	Yes
Amerasian Immigrant		Yes	Yes	Yes
Iraqi and Afghan Special Immigrants		Yes	Yes	Yes
Paroled into the U.S. for at least one year		Yes	Yes	Yes
Conditional Entrant		Yes	Yes	Yes
Domestic Violence Survivor with an approved self-petition for an immigrant visa filed under the Violence Against Women Act (VAWA) or a prima facie determination on a self-petition, and his/her parent and/or child		Yes	Yes	Yes
Domestic Violence Survivor with an approved immigrant visa filed for a spouse or child by a U.S. citizen or LPR, and his/her parent and/or child		Yes	Yes	Yes



Domestic Violence Survivor with an approved application for cancellation of removal / suspension of deportation under VAWA, and his/her parent and/or child		Yes	Yes	Yes
Trafficking Survivor certified by HHS's Office of Refugee Resettlement and his/her Spouse, Children, Sibling or Parent		Yes	Yes	Yes
Veterans or Active Duty Military Member and his/her Spouse and Children		Yes	Yes	Yes
Member of a Federally-Recognized Indian Tribe or American Indian Born in Canada		Yes	Yes	Yes
Granted Withholding of Deportation/ Removal under the Convention Against Torture (CAT)		Yes	Yes	Yes

A person who entered the United States prior to Aug. 22, 1996, and is a qualified alien, i.e. any of the statuses listed above		Yes, at the state's option <sup>327</sup>	Yes	Yes
A child or pregnant woman who is nonqualified but lawfully present, i.e. in any of the statuses listed under this category	Nonqualified but "Lawfully Present"	Yes, at the state's option	Yes, at the state's option	Yes
Temporary Protected Status (TPS)		No	No	Yes
Deferred Enforced Departure (DED)		No	No	Yes
Deferred Action (except DACA)		No	No	Yes
Paroled into the U.S. for less than one year		No	No	Yes
Nonimmigrant Visa Holders <sup>328</sup>		No	No	Yes
Citizens of Micronesia, the Marshall Islands, and Palau		No	No	Yes

<sup>327</sup> Under PRWORA, states have an option to provide or deny Medicaid to most qualified immigrants who were in the United States before Aug. 22, 1996. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 402(c)(1)(B), 110 Stat. 2105, 2113 (1996) (codified in 42 U.S.C. § 602).

<sup>328</sup> This category includes individuals with valid worker visas, student visas, U visas (for victims of certain crimes), T visas (for victims of human trafficking), and other visas.

Resident of American Samoa		No	No	Yes
Administrative order staying removal issued by the Department of Homeland Security		No	No	Yes
Lawful Temporary Resident under the Immigration Reform and Immigrant Control Act of 1986 (IRCA)		No	No	Yes
Family Unity		No	No	Yes
Issued an Order of Supervision, and has been granted employment authorization		No	No	Yes
Applicant for LPR with an approved visa petition		No	No	Yes
Applicant for Asylum under the age of 14 whose application has been pending for at least 180 days		No	No	Yes
Applicant for Asylum aged 14 years or older who has been granted employment authorization		No	No	Yes
Applicant for Special Immigrant Juvenile Status		No	No	Yes

Applicant for Victim of Trafficking Visa		No	No	Yes
Applicant for Withholding of Deportation/Removal, under the immigration laws or under the CAT who is under the age of 14 and whose application has been pending for at least 180 days		No	No	Yes
Applicant for Withholding of Deportation/Removal, under the immigration laws or under the CAT aged 14 years or older who has been granted employment authorization		No	No	Yes
Applicant for TPS who has been granted employment authorization		No	No	Yes
Registry Applicant who has been granted employment authorization		No	No	Yes
Applicant for Cancellation of Removal or Suspension of Deportation who has been granted employment authorization		No	No	Yes

Applicant for Legalization under IRCA who has been granted employment authorization		No	No	Yes
Applicant for LPR under the Legal Immigration and Family Equity (LIFE) Act of 1990 who has been granted employment authorization		No	No	Yes
A pregnant woman who is nonqualified and not lawfully present	Nonqualified and Not “Lawfully Present”	No	Yes, for pregnancy related care only, at the state’s option <sup>329</sup>	No
Undocumented		No	No	No
Deferred Action for Childhood Arrivals (DACA)		No	No	No

<sup>329</sup> Children’s Health Insurance Program Reauthorization Act of 2009 (H.R.2), Pub. L. No. 111–3, § 111, 123 Stat. 26 (2009).

\* \* \* \* \*