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# Legislating a Public Health Nightmare: The Anti-immigrant Provisions of the “Contract With America” Congress

BY JULIA FIELD COSTICH\*

It sounds like every public health practitioner’s worst nightmare: Identify a large, rapidly growing population that is known to have high levels of communicable disease and high fertility rates, then deny them access to most health care other than emergency services, and devote as little funding as possible to the few services for which they are eligible.

That is precisely what the 104th Congress accomplished with provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”).<sup>1</sup> Acting in combination with portions of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (“IIRIRA”)<sup>2</sup> and the Balanced Budget Act of 1997,<sup>3</sup> PRWORA has restricted immigrant health care access in most states to an unprecedented extent. The consequences of this public health blunder are difficult to measure because the restrictions on health care access created by the 1996

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<sup>1</sup> Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-93, 110 Stat. 2105 (codified as amended at 8 U.S.C. §§ 1601- 46 (2001)) [hereinafter PRWORA].

<sup>2</sup> Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, §§ 501 - 594, 110 Stat. 3009, 3009-670 to - 688 [hereinafter IIRIRA]. A detailed discussion of the IIRIRA is beyond the scope of this Article; for such a discussion, see Evangeline G. Abriel, *Ending the Welcome: Changes in the United States’ Treatment of Undocumented Aliens (1986 to 1996)*, 1 RUTGERS RACE & L. REV. 1 (1998); Melinda Smith, *Criminal Defense Attorneys and Noncitizen Clients: Understanding Immigrants, Basic Immigration Law & How Recent Changes in Those Laws May Affect Your Criminal Cases*, 33 AKRON L. REV. 163 (1999).

<sup>3</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 5301 - 5305, 111 Stat. 251, 596-601 (1997) (codified as amended in scattered sections of 8 and 42 U.S.C.) (amending 8 U.S.C. § 1612).

laws limit the contact of investigators with the immigrant targets of the legislation. Qualitative research has begun to report, for example, that health care providers fear short-term outcomes that include “increases in communicable diseases, decreases in the use of prenatal and preventive care, compromised health status due to delayed care and lack of preventive/primary care, and complications from chronic conditions that are unattended.”<sup>4</sup>

Public health experts observe that denial of care to new and undocumented immigrants has predictable adverse health consequences for the rest of the population.<sup>5</sup> As some commentators have put it, “improving the health of migrants is at the heart of reducing the public health risk to the international community.”<sup>6</sup> With this obvious connection in mind, why would Congress place such draconian limits on health care access for immigrants? In brief, they were responding to vehement complaints from border states like California and Texas that the cost of medical care for new immigrants, regardless of their status, was impairing the states’ ability to provide necessary services to the rest of their residents.<sup>7</sup>

Anecdotal evidence of immigration motivated by access to the high quality of health care available in the U.S.<sup>8</sup> abounded in the early 1990s and was consistent with the movement of the Republican “Contract with America” towards cutting federal expenditures regardless of the consequences. These scattered anecdotes appear to constitute the only evidence for health services-related immigration. Population-based research indicates exactly the opposite: government-sponsored services are so far down the list of reasons for immigration to the U.S. that they scarcely arise at

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<sup>4</sup> Kathleen Maloy et al., Center for Health Services Research and Policy, George Washington University Medical Center, *Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants’ Ability and Willingness to Access Medicaid and Health Care Services*, at ii (May 2000), at <http://www.gwu.edu/~chsrp/imig/index.html>.

<sup>5</sup> See, e.g., Shari B. Fallek, *Health Care for Illegal Aliens: Why It Is a Necessity*, 19 HOUS. J. INT’L L. 951, 952 (1997); Geri Aston, *Hospitals Join the Fight*, AHA NEWS, Jan. 9, 1995, at 7 (noting that David Langness of the Hospital Council of Southern California has characterized denial of health services to immigrants, specifically in California’s Proposition 187, as “a public health nightmare.”).

<sup>6</sup> Susan Cookson et al., *Immigrant and Refugee Health*, 4 EMERGING INFECTIOUS DISEASES 427 (1998).

<sup>7</sup> See, e.g., Fallek, *supra* note 5, at 955-59.

<sup>8</sup> See generally *id.*

all.<sup>9</sup> Immigrants who use government-sponsored health services do so to a very limited extent;<sup>10</sup> undocumented immigrants who risk identification when they seek service from a government agency are even less likely than others to make use of health services.<sup>11</sup> Indeed, one scholarly article characterizes the motivation behind these statutes as “a replay of the historically recurrent theme of safeguarding national resources from alien freeloaders and preserving them for *real*, deserving members of ‘American’ society.”<sup>12</sup>

Following the enactment of the 1996 restrictions, advocacy groups effectively lobbied for mitigation, and a few of the more devastating provisions were rolled back in the Balanced Budget Act of 1997.<sup>13</sup> However, most of the anti-immigrant text in these 1996 laws is still law four years later, and occasional congressional initiatives to moderate it fall short of addressing its grave potential public health consequences.

This Article reviews the statutory modifications affecting immigrants’ health care access since 1996, their effect on prevention and treatment of communicable disease, prenatal care, and children’s health care, recent litigation arising from the 1996 legislation, and the options available for avoiding the threat these restrictions pose to the health of the whole U.S. population, regardless of immigration status.

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<sup>9</sup> Marc L. Berk et al., *Health Care Use Among Undocumented Latino Immigrants*, HEALTH AFF., July/Aug. 2000, at 51, 56 (examining surveys in El Paso, Houston, Fresno, and Los Angeles and finding that “social services” were a motivating factor behind immigration to the U.S. in less than one percent of cases).

<sup>10</sup> See, e.g., Leighton Ku & Sheetal Matani, *Left Out: Immigrants’ Access to Health Care and Insurance*, HEALTH AFF., Jan./Feb. 2001, at 247.

<sup>11</sup> See Bill Waddell, *United States Immigration: A Historical Perspective*, in HANDBOOK OF IMMIGRANT HEALTH 1, 15 (Sana Loue ed., 1998) (noting the potential “public health crisis if undocumented immigrants refuse to get treatment for fear of being turned over to the INS”); see also Linda S. Bosniak, *Opposing Prop. 187: Undocumented Immigrants and the National Imagination*, 28 CONN. L. REV. 555 (1996); Kevin R. Johnson, *Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class*, 42 UCLA L. REV. 1509 (1995); Jeffrey R. Margolis, Comment, *Closing the Doors to the Land of Opportunity: The Constitutional Controversy Surrounding Proposition 187*, 26 U. MIAMI INTER-AM. L. REV. 363 (1995).

<sup>12</sup> Berta Esperanza Hernandez-Truyol & Kimberly A. Johns, *Global Rights, Local Wrongs, and Legal Fixes: An International Human Rights Critique of Immigration and Welfare “Reform,”* 71 S. CAL. L. REV. 547, 560 (1998).

<sup>13</sup> See *infra* notes 39-41 and accompanying text; see also Lanelle K. Polen, Note, *Salvaging a Safety Net: Modifying the Bar to Supplemental Security Income for Legal Aliens*, 76 WASH. U. L.Q. 1455, 1470-71 (1998) (cataloging the changes).

## I. STATUTORY REGIMES

A. *Before 1996*

The two features of pre-1996 immigration law relevant to this discussion are the Permanently Residing Under Color of Law ("PRUCOL") doctrine<sup>14</sup> and the general non-enforcement of affidavits or bonds indicating a sponsor's willingness to provide financial support for a prospective immigrant. Perhaps more important, there is extensive evidence that nominal statutory barriers to health care for undocumented or non-permanent residents were generally ignored before their existence was forced into public view.

1. *PRUCOL*

Under the PRUCOL doctrine, an immigrant whose status was ambiguous, under consideration, or even clearly irregular, could be eligible for government-sponsored benefits.<sup>15</sup> The only limit was that the immigrant could not be under active Immigration and Naturalization Service ("INS") pursuit for deportation.<sup>16</sup> Regulations incorporating PRUCOL were promulgated by the Health Care Financing Administration in 1990.<sup>17</sup> Although the majority of undocumented immigrants could not benefit from the PRUCOL doctrine because their lack of legal status was clear, a broad category of immigrants had access to publicly-funded health care because of their uncertain legal position.<sup>18</sup> Ellwood and Ku estimate that the loss of access to Medicaid because of change in the PRUCOL doctrine affected 0.3% of total Medicaid enrollees.<sup>19</sup>

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<sup>14</sup> The Second Circuit Court of Appeals detailed the derivation of this doctrine from 45 C.F.R. § 233.50 and its application. *Holley v. Lavine*, 553 F.2d 845, 848-51 (2d Cir. 1977).

<sup>15</sup> *Id.* at 850-51.

<sup>16</sup> *See id.*

<sup>17</sup> 42 C.F.R. § 435.408 (2001).

<sup>18</sup> *See* Michael J. Sheridan, *The New Affidavit of Support and Other 1996 Amendments to Immigration and Welfare Provisions Designed to Prevent Aliens from Becoming Public Charges*, 31 CREIGHTON L. REV. 741, 745 (1998); Daniel Stein & Steven Zanowic, *Permanent Resident Alien Under Color of Law: The Opening Door to Alien Entitlement Eligibility*, 1 GEO. IMMIGR. L.J. 231, 266-67 (1986).

<sup>19</sup> Marilyn R. Ellwood & Leighton Ku, *Welfare and Immigration Reforms: Unintended Side Effects for Medicaid*, HEALTH AFF., May/June 1998, at 137, 148.

## 2. *Affidavits of Support*

Long before the IIRIRA of 1996 went into effect, sponsors of immigrants were required to sign affidavits or bond agreements indicating that they would keep the sponsored immigrant from becoming a “public charge” because of dependence on government benefits.<sup>20</sup> However, the pre-IIRIRA affidavits of support were not viewed as enforceable contracts. This counterintuitive interpretation arose from a number of judicial opinions holding that immigrants were qualified to receive government benefits if the sponsor was unwilling or unable to provide financial resources. In effect, courts found the affidavits to be moral but not legal commitments.<sup>21</sup>

Before the 1996 restrictions, publicly-funded health care providers and practitioners customarily provided necessary health services regardless of immigration status. This simple fact obviously had a far greater influence on immigrants’ access to health care than the legal niceties of PRUCOL or affidavit of support enforcement. One reason for nondiscriminatory provision of health care is its support in the fundamental standards of professional ethics. More specifically, however, in *Plyler v. Doe*<sup>22</sup> the Supreme Court required state and local governments to extend basic public benefits to residents regardless of immigration status. Until 1996, such benefits were presumed to include health care.

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<sup>20</sup> This requirement still exists in 8 U.S.C. § 1183a (2000); however, it is important to note that there are now additional, more stringent, requirements.

<sup>21</sup> The applicable statute, 8 U.S.C. § 1183a(a)(1), has since been amended and now affidavits of support are to be “executed . . . as a contract.” Before the amendment of the statute, the unenforceability of the affidavits was widely criticized. U.S. COMM’N ON IMMIGR. REFORM, 1994 REPORT TO CONGRESS, U.S. IMMIGRATION POLICY: RESTORING CREDIBILITY 24 (1994) [hereinafter 1994 REPORT].

[T]he Commission believes that the affidavits of support signed by sponsors should be legally enforceable, with contingencies made if the sponsor’s financial circumstances change significantly for reasons that occurred after the immigrant’s entry. Mechanisms should be developed that would ensure that sponsors actually provide the support they have promised. This would protect recent immigrants and close a loophole in current policy wherein the sponsor’s income is “deemed,” or taken into account, in calculating the immigrant’s eligibility, regardless of whether such support is actually available to the immigrant.

<sup>22</sup> *Plyler v. Doe*, 457 U.S. 202 (1982).

## B. PRWORA

The following discussion focuses on three groups who are treated differently in the post-1996 statutory context: undocumented immigrants, recent immigrants, and pre-PRWORA immigrants. For these purposes, the term "undocumented immigrants" is used to refer to persons who entered the U.S. legally but subsequently lost legal status (for example, by overstaying a tourist visa), as well as immigrants who entered the U.S. in a manner not sanctioned by the Immigration and Nationality Act ("INA"). The effect of the 1996 statutory restrictions is the same for both groups.

"Recent immigrants" in this context are those who entered the U.S. legally after August 22, 1996, the date of PRWORA implementation, while "pre-PRWORA immigrants" are those who entered legally before the date of statutory implementation. The Select Commission on Immigration, a government-appointed body whose recommendations had been adopted in several previous legislative initiatives, was strongly opposed to the denial of benefits to otherwise eligible legal immigrants, specifically noting that such restrictions impede immigrants' progress towards full social integration.<sup>23</sup>

It is important to recall that under the Fourteenth Amendment to the U.S. Constitution, anyone born in the U.S. and subject to its jurisdiction is a U.S. citizen. A U.S.-born child of undocumented parents, whether born before or after August 22, 1996, is entitled to the same health care access as a child born of U.S. citizens.<sup>24</sup> In contrast, a foreign-born child who entered the U.S. legally after PRWORA implementation must wait at least five years to become eligible for federally-funded health services.

In addition to "ending welfare as we know it," PRWORA had the goal of substantial reduction in the federal social service budget.<sup>25</sup> In the context

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<sup>23</sup> See 1994 REPORT, *supra* note 21, at 128; see also Carlos Ortiz Miranda, *United States Commission on Immigration Reform: The Interim and Final Reports*, 38 SANTA CLARA L. REV. 645, 657-61 (1998).

<sup>24</sup> See, e.g., Christopher L. Eisgruber, *Birthright Citizenship and the Constitution*, 72 N.Y.U. L. REV. 54, 69 (1997) (discussing the concept of "tacit consent" as support for the Fourteenth Amendment "birthplace rule").

<sup>25</sup> "The underlying motive for restricting legal aliens from federal and state benefit programs was economic. Eliminating coverage for aliens will save an estimated \$23.7 billion over the next six years, which represents approximately 44 percent of the total \$53.4 billion savings in the legislation." Charles Wheeler, *The New Alien Restrictions on Public Benefits: The Full Impact Remains Uncertain*, 73 INTERPRETER RELEASES 1245, 1248 (Sept. 23, 1996) (citing correspondence from Congressional Budget Office to Senator Pete Domenici, Chair of the Senate

of public health, it is startling to learn that forty-four percent of the expected savings to the federal government from PRWORA would have resulted from cutting off services for post-enactment legal permanent residents.<sup>26</sup> A report sponsored by the Urban Institute estimated that these provisions, had they been enacted, would have increased the number of persons (mostly immigrants) below the federal poverty level by 1.2 million.<sup>27</sup>

### C. IIRIRA

Under the IIRIRA, the affidavit of support has become a legally enforceable contract.<sup>28</sup> If the sponsored immigrant receives Medicaid or Supplemental Security Income (“SSI”) benefits, for example, an action to obtain reimbursement from the sponsor can be initiated by the agency that provided the benefits. To qualify as the sponsor of a new immigrant, the signer of the affidavit must demonstrate the ability to maintain his or her own household plus the sponsored immigrant at a minimum of 125% of the federal poverty level (100% for sponsors on active military duty).<sup>29</sup> The affidavit must be submitted for family-based immigrants, immediate relatives, and employment-based immigrants who will be working for a business owned by a relative.<sup>30</sup> Others who are required to use it include aliens seeking immigrant visas, adjustment of status, or admission as an immigrant.<sup>31</sup> After the five-year bar, new immigrants with sponsors must include their sponsors’ income when applying for federal means-tested benefits, a mechanism known as “deeming,” until the immigrant attains citizenship or the sponsor(s) complete forty calendar quarters of qualifying work.<sup>32</sup> Because immigrants remain eligible for emergency services regardless of these conditions, another section of the IIRIRA provides for reimbursement to state and local governments for the expenses incurred

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Budget Committee (Aug. 1, 1996)).

<sup>26</sup> *Id.*

<sup>27</sup> Sheila Zedlewski et al., Urban Institute, *Potential Effects of Congressional Welfare Reform Legislation on Family Incomes* (July 26, 1996), at <http://www.urban.org/welfare/pec72696.htm>; see also Liza Cristol-Deman & Richard Edwards, *Closing the Door on the Immigrant Poor: Creating a Permanent Underclass of Immigrants Residing in the U.S.*, 9 STAN. L. & POL’Y REV. 141, 151 (1998).

<sup>28</sup> 8 U.S.C. § 1183a (2000); see *supra* notes 20-21 and accompanying text.

<sup>29</sup> 8 U.S.C. § 1183a(a)(1).

<sup>30</sup> 8 C.F.R. § 213a.2(a)(2)(i) (2000).

<sup>31</sup> *Id.*

<sup>32</sup> Cristol-Deman & Edwards, *supra* note 27, at 143.



providing care to undocumented immigrants, to the extent that other reimbursement is not available.<sup>33</sup>

There are several limited exceptions to the affidavit of support requirement, but two deserve special mention. First, benefits cannot be denied when immigrants are granted permanent resident status as battered children or spouses.<sup>34</sup> As summarized by one commentator, in order to qualify:

[A] battered immigrant must demonstrate that she has a pending or approved [Violence Against Women Act] case or a family-based visa application filed with the INS, that she has been battered or subjected to extreme cruelty, that there is a substantial connection between the need for benefits and the abuse and that she is no longer residing with her abuser.<sup>35</sup>

Second, an immigrant who is battered by her sponsor (who filed an affidavit of support) after immigrating is not required to take the abusive sponsor's income and resources into consideration when her eligibility for means-tested assistance is determined.<sup>36</sup> However, these exceptions do not apply to many common domestic violence scenarios, such as women who are abused by non-spousal partners and children who need services that are not directly related to the abuse.<sup>37</sup>

Another provision of the IIRIRA requires the Attorney General to develop procedures for verifying the immigration status of persons applying for federal public benefits (including Medicaid and SSI) "in a nondiscriminatory manner."<sup>38</sup> Non-profit charitable organizations are exempted from this requirement, including non-profit hospitals.

#### D. Amendments

The Balanced Budget Act of 1997 rolled back some of the more controversial provisions of PRWORA, notably in the area of SSI

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<sup>33</sup> See 8 U.S.C. § 1369(a).

<sup>34</sup> See *id.* §§ 1631(f), 1641(c).

<sup>35</sup> Leslye Orloff, *Lifesaving Welfare Safety Net Access for Battered Immigrant Women and Children: Accomplishments and Next Steps*, 7 WM. & MARY L. REV. 597, 622 n.214 (2001).

<sup>36</sup> 8 U.S.C. § 1631(f)(1)(A).

<sup>37</sup> Nat'l Health Law. Program, *Health Related Provisions in the Illegal Immigration Reform and Immigrant Responsibility Act of 1996* (Oct. 8, 1996), at <http://nhelp.org/pubs/19961008immigrant.html>.

<sup>38</sup> 8 U.S.C. § 1642(a)(2).

eligibility.<sup>39</sup> Under PRWORA, SSI payments to legal immigrants would have been terminated.<sup>40</sup> The apparent motivation for this action was the perception that naturalized citizens were bringing their frail elderly parents to the U.S. so as to enroll them in government-sponsored benefits. A widespread expression of outrage at the harm done to these highly vulnerable persons led to the inclusion of less harsh provisions in the Balanced Budget Act of 1997. PRWORA was amended to allow immigrants to remain on SSI if they were receiving SSI on or before August 22, 1996, and remained otherwise eligible.<sup>41</sup> Other details of this amendment are discussed in Part II.C of this Article.

## II. EFFECT ON BENEFITS

### A. *Emergency Care*

One of the few bright, if ironic, notes in this discussion is the continued availability of emergency Medicaid, regardless of immigration status.<sup>42</sup> Immigrants become eligible for emergency Medicaid if they require emergency care and meet all state eligibility requirements for Medicaid other than verified legal immigration status. Health care providers must follow the same procedure with all emergency cases under the Emergency Medical Treatment and Active Labor Act,<sup>43</sup> and immigration status is no more of an impediment to receipt of emergency care than lack of insurance coverage.

To qualify for emergency Medicaid coverage, an immigrant must have an emergency medical condition, 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>44</sup>

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<sup>39</sup> See *infra* notes 59-61 and accompanying text.

<sup>40</sup> 8 U.S.C. § 1612(a)(1).

<sup>41</sup> See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 5301, 111 Stat. 251, 596 (amending 8 U.S.C. § 1611(b) to allow restoration of SSI to qualified immigrants).

<sup>42</sup> 8 U.S.C. § 1611(b)(1); see also 42 U.S.C. § 1396b(v)(2) (2000) (law governing immigrants' access to emergency treatment).

<sup>43</sup> 42 U.S.C. § 1395dd.

<sup>44</sup> *Id.* § 1396b(v)(3).

The Medicaid regulations require that there have been a "sudden onset" of an illness or injury.<sup>45</sup> Courts have interpreted "sudden onset" to mean that the condition occurred unexpectedly over a short period of time, as in the case of a stroke, heart attack, or an auto accident. However, treatment does not necessarily need to occur immediately after the onset of the illness or injury in order to be covered under emergency Medicaid.<sup>46</sup>

The effect of denying health care access to recent immigrants was evident in emergency departments even before PRWORA. For example, a 1994 analysis reports that "[u]ndocumented individuals continually live with the fear of deportation because of their illegal status. This fear often prevents them from seeking any type of medical care. Therefore, they arrive most often in emergency rooms only after the medical situation has elevated to a crisis."<sup>47</sup> Deferring appropriate preventive care gives rise to avoidable morbidity and mortality and escalates the cost of care for emergency departments and the taxpayers who fund them.

## B. Non-Emergency Medicaid

### 1. Undocumented Immigrants

The PRWORA makes undocumented immigrants ineligible for all non-emergency federal public benefits, including Medicaid, Medicare, and State Children's Health Insurance Programs ("SCHIP").<sup>48</sup> This prohibition holds even when states and localities fund health services without federal dollars,<sup>49</sup> unless the services are authorized by legislation passed after the August 22, 1996, PRWORA enactment date.<sup>50</sup> State-specific legislation

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<sup>45</sup> 42 C.F.R. § 440.255(b)(1) (2000).

<sup>46</sup> See, e.g., *Greenery Rehab. Group v. Hammon*, 893 F. Supp. 1195 (N.D.N.Y. 1995) (requiring Medicaid to pay for nursing facility care for severely disabled undocumented immigrants); *Gaddam v. Rowe*, 684 A.2d 286 (Conn. Super. Ct. 1995) (requiring Medicaid to pay for kidney dialysis necessary for treatment of acute renal failure).

<sup>47</sup> Cynthia Webb Brooks, *Health Care Reform, Immigration Laws, and Federally Mandated Medical Services: Impact of Illegal Immigration*, 17 HOUS. J. INT'L L. 141, 164 (1994).

<sup>48</sup> "Federal public benefit" is a term defined broadly to include any contracts, loans, professional or commercial licenses, retirement benefits, health or disability benefits, food assistance, housing, post-secondary education, or any other "similar" benefits provided by the federal government. See 8 U.S.C. § 1611(c) (2000).

<sup>49</sup> See *id.* § 1621(a).

<sup>50</sup> See *id.* § 1621(d).

funding services regardless of immigration status would thus have to be re-enacted in states where it was already a matter of law.

## 2. *New and Pre-PRWORA Immigrants*

As originally enacted, the PRWORA also made lawful permanent residents ineligible for most forms of federal public benefits. The Balanced Budget Act of 1997 provided some mitigation of these harsh provisions for immigrants who resided in the U.S. at the time the PRWORA was enacted.<sup>51</sup> If states with high numbers of otherwise ineligible immigrants had not opted to cover immigrants without federal matching funds, some 1.5 million immigrants would have lost Medicaid coverage.<sup>52</sup> The Congressional Budget Office estimated that if the PRWORA had been fully implemented, by 2002 the Medicaid bar for new legal immigrants would have resulted in the denial of health care to approximately 260,000 elderly legal immigrants, 65,000 disabled immigrants, 175,000 other adult immigrants, and 140,000 children who would otherwise qualify for Medicaid.<sup>53</sup>

## 3. *Defining "Qualified Aliens"*

The PRWORA defines "qualified aliens"—those eligible for public benefits under certain circumstances—in a manner that abolishes the PRUCOL doctrine. Eligibility is limited to lawful permanent residents; refugees and asylees; certain Cubans, Haitians, and Amerasians; aliens paroled into the U.S. for a period of at least one year; aliens granted withholding of deportation by the INS; aliens granted conditional entry into the U.S.; and certain battered immigrant spouses and children. While the PRUCOL doctrine defined eligibility broadly and excluded only narrowly-defined immigrant categories, the PRWORA takes the opposite approach by excluding all but those who fall within the seven categories of "qualified alien," plus battered women and children who are in the process of acquiring qualified status.<sup>54</sup> The immigrants who were arguably out of status and yet qualified for benefits under the PRUCOL doctrine would not

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<sup>51</sup> See Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, 638-43 (codified as amended in scattered sections of 8 and 42 U.S.C.).

<sup>52</sup> Cristol-Deman & Edwards, *supra* note 27, at 151.

<sup>53</sup> David A. Super et al., Center on Budget and Policy Priorities, *The New Welfare Law*, at 26 (Aug. 13, 1996), at <http://www.cbpp.org/WECNF813.HTM>.

<sup>54</sup> 8 U.S.C. § 1641(b), (c) (2000).

meet the "qualified alien" test and thus would be found ineligible for federally-funded means-tested benefits like Medicaid and SCHIP.

A battered spouse can achieve "qualified" status by presenting a prima facie case for approval of a visa petition or cancellation of removal (formerly known as "suspension of deportation") to the INS as the battered spouse or child of a citizen or resident alien.<sup>55</sup> The agency whose benefits are sought by the battered spouse must find that the immigrant's need for assistance is connected with the abuse.<sup>56</sup> To qualify for this exception, the visa petition or application for cancellation of removal must at a minimum have been filed, but need not have been approved.<sup>57</sup>

Eleven specific social welfare programs are also exempted from the five-year waiting period, including in-kind forms of emergency assistance, Head Start, and the Job Training Partnership Act programs.<sup>58</sup>

### C. SSI

SSI is the part of Social Security that provides cash benefits to persons with serious disabilities. A highly controversial provision of the PRWORA would have terminated SSI payments to legal immigrants.<sup>59</sup> The specter of half a million frail, elderly immigrants being rendered destitute finally overcame congressional anti-immigrant sentiment, and the Balanced Budget Act of 1997 amended the PRWORA to continue eligibility for immigrants who were receiving SSI on or before August 22, 1996, and remained otherwise eligible.<sup>60</sup> Legally present immigrants who were not yet

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<sup>55</sup> *Id.* § 1641(c).

<sup>56</sup> *Id.* § 1641(c)(1)(A).

<sup>57</sup> *Id.* § 1641(c)(1)(B).

<sup>58</sup> *Id.* § 1611(b). The available benefits include medical assistance for emergency medical care (unrelated to organ transplants); short-term, in-kind, non-cash emergency disaster relief; public health assistance related to immunizations and to treatment of the symptoms of a communicable disease (even if the disease did not cause the symptoms); in-kind services (such as soup kitchens) designated by the Attorney General as necessary to the protection of life and safety; and assistance under Housing and Urban Development programs if the alien was receiving the assistance on August 22, 1996. *Id.* § 1611(b)(1). Also available are Social Security benefits that the U.S. must pay under an international agreement or that are based on an application filed on or before August 1996, or that are the result of the alien's lawful employment in the U.S. and certain benefits under the Railroad Retirement and Railroad Unemployment Insurance Acts. *Id.* § 1611(b)(2)-(4).

<sup>59</sup> *Id.* §§ 1611-12.

<sup>60</sup> See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 5561, 111 Stat. 251, 638.

receiving benefits, but were residing in the U.S. as of the enactment date, were eligible for SSI and Medicaid if they became disabled.<sup>61</sup>

The PRWORA established stricter eligibility requirements for “qualified aliens” to receive SSI: a permanent resident must have worked or be credited with forty qualifying quarters, or ten years, of coverage under the Social Security Act.<sup>62</sup> The applicant cannot rely on any quarter of coverage earned after December 31, 1996, if the person received any federal means-tested benefit during that quarter.<sup>63</sup> Spouses may be credited with one another’s qualifying quarters if they were earned during the marriage and the couple remains married.<sup>64</sup> Immigrants are also entitled to rely on the quarters of coverage earned by their parents before the child’s eighteenth birthday.<sup>65</sup> It is thus possible, that five, rather than ten, years of at least part-time employment in the U.S. may relieve married permanent residents and their non-citizen children of the restrictions on eligibility for SSI.

A legally residing immigrant who was receiving SSI on August 22, 1996, remains eligible for SSI.<sup>66</sup> The PRWORA as originally enacted would have denied SSI benefits even to this group. The policymaking process that led to this harsh provision is an enlightening illustration of the way incorrect information takes on a life of its own in political rhetoric. Robert Rector of the Heritage Foundation wrote in 1995 that without reform, *three million* elderly immigrants would be receiving SSI in 2005.<sup>67</sup> However, the INS estimated that the *total* number of elderly immigrants was *less than 2.2 million*. Data from the Congressional Budget Office likewise show that Rector’s estimates of the cost of providing SSI and Medicaid to immigrants in 2006 under pre-welfare law overstated actual costs by more than 200%.<sup>68</sup>

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<sup>61</sup> *Id.*; see also Noncitizen Benefit Clarification and Other Technical Amendments Act, Pub. L. No. 105-306, 112 Stat. 2926 (1998). The exemption from SSI and Medicaid restrictions for refugees was extended from five to seven years.

<sup>62</sup> 8 U.S.C. § 1612(a)(2)(B)(ii)(I).

<sup>63</sup> *Id.* § 1612(a)(2)(B)(ii)(II).

<sup>64</sup> *Id.* § 1645(2).

<sup>65</sup> *Id.* § 1645(1).

<sup>66</sup> *Id.* § 1612(a)(2)(D). There are additional exceptions for certain Native Americans, for “very old applicants,” and for blind or disabled aliens who were residing in the U.S. lawfully on August 22, 1996. *Id.* § 1612(a)(2)(F)-(H). Native Americans and others entitled to receive SSI are also exempt from the restrictions on Medicaid eligibility. *Id.* § 1612(b)(2)(E), (F), (G).

<sup>67</sup> Robert Rector & William F. Lauber, *Elderly Non-Citizens on Welfare Will Cost the American Taxpayer \$328 Billion Over the Next Decade* (Mar. 23, 1995), at <http://www.heritage.org/library/categories/healthwel/fyi54.html>.

<sup>68</sup> JENNIFER DASKAL & DAVID SUPER, *MISPERCEPTIONS AND REALITIES: IMMIGRANTS ON SSI* (1997).

Pressure from immigrant advocates and the Clinton administration led Congress to restore eligibility for SSI and food stamps to some immigrants already in the U.S. But even with these changes, approximately 735,000 immigrants lost eligibility for food stamps, and the restrictions on recent immigrants remain in place.<sup>69</sup>

#### D. State Programs

Some states provide health insurance for legal immigrants who are ineligible for Medicaid or SCHIP.<sup>70</sup> States that offer coverage to these immigrants receive no federal matching funds under Medicaid and SCHIP. Fourteen states<sup>71</sup> extend Medicaid coverage to legal immigrant children who would otherwise not be eligible, and ten<sup>72</sup> serve some recent immigrant children in child health insurance programs funded through SCHIP.

These state-specific programs vary considerably. For example, Washington provides full Medicaid benefits to low-income, post-PRWORA immigrants who have lived in the state for more than a year, while California provides coverage to all legal immigrants. Massachusetts provides full Medicaid benefits to persons who were receiving long-term care at the time of enactment and a reduced benefit package to PRUCOL and post-PRWORA immigrants. Minnesota coordinates state-funded benefits with emergency Medicaid for eligible immigrants who are in the process of becoming citizens, and New York has retained benefits "for PRUCOL immigrants who were in institutions in August 1996."<sup>73</sup>

In July 2001, the Attorney General of Texas found that Harris County (Houston) public health agencies were not authorized by state or federal law to provide outpatient services to allegedly ineligible immigrants.<sup>74</sup> His

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<sup>69</sup> Michael Fix & Wendy Zimmermann, *The Legacies of Welfare Reform's Immigrant Restrictions*, 75 INTERPRETER RELEASES 1577, 1580 (1998).

<sup>70</sup> Balanced Budget Act of 1997, Pub. L. 105-33, § 4901, 111 Stat. 251, 552-62 (codified at 42 U.S.C. §§ 1397aa-1397jj (2000)).

<sup>71</sup> These states are: California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Pennsylvania, Rhode Island, Virginia, and Washington. Leighton Ku & Shannon Blaney, Center on Budget and Policy Priorities, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage* (Oct. 10, 2000), at <http://www.cbpp.org/10-4-00health.htm>.

<sup>72</sup> These states are: California, Connecticut, Florida, Illinois, Maine, Massachusetts, New Jersey, New York, Pennsylvania, and Texas. *Id.*

<sup>73</sup> Ellwood & Ku, *supra* note 19, at 137, 146.

<sup>74</sup> Tex. Att'y Gen. Op. No. JC-0394 (July 10, 2001) (concerning whether the Harris County Hospital District may provide discounted health care without regard to immigration or legal status), at <http://www.org.state.tx.us/opinopen/opinions/>

actions have highlighted the conflict between core public health principles and the PRWORA restrictions. In New York, a similar federal decision<sup>75</sup> has given new momentum to coverage initiatives that comply with the federal restrictions.

Eligibility restrictions under the PRWORA have had the intended effect of shifting costs away from the federal government, generally bringing the financial burden closer to the place where care is delivered. Where states have elected to fund these benefits themselves, costs have been transferred from the federal government to the states. Where state-funded benefits for ineligible immigrants are not available, costs have shifted to the municipal funders of safety net providers such as public hospitals and clinics. This phenomenon, which will increase in the absence of legislative change or effective immigration enforcement, is yet another burden on the increasingly stressed safety net of health services for low-income U.S. residents.<sup>76</sup>

### III. EFFECT ON ACCESS TO CARE

Immigrants are much more likely than citizens to be uninsured, so restrictions of eligibility for government-funded health coverage impair the access of immigrants to health care to a far greater extent than for U.S. citizens. Surveys assessing U.S. residents' health insurance coverage consistently find that the proportion of low-income non-citizen parents who lack health insurance is high and rising.<sup>77</sup> Overall, thirty-four percent of non-citizen immigrants are uninsured, compared with approximately fourteen percent of non-immigrants.<sup>78</sup> Among non-citizens, forty-three percent of children and twelve percent of those sixty-five and older are

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op49cornyn/jc-0394.htm; see also *infra* note 131 and accompanying text.

<sup>75</sup> *Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001); see also *infra* notes 124-30 and accompanying text.

<sup>76</sup> See, e.g., GEN. ACCT. OFF., WELFARE REFORM: MANY STATES CONTINUE SOME FEDERAL OR STATE BENEFITS FOR IMMIGRANTS, GAO/HEHS 98-132 (July 1998) (stating that current welfare reform law constitutes a substantial shift of responsibility from the federal government to the states); Karen C. Tumlin et al., Urban Institute, *State Snapshots of Public Benefits for Immigrants: A Supplemental Report to "Patchwork Policies"* (Oct. 1999), at <http://www.urban.org/UploadedPDF/occa29.pdf>.

<sup>77</sup> See O. Carrasquillo et al., *Health Insurance Coverage of Immigrants Living in the United States: Differences by Citizenship Status and Country of Origin*, 90 AM. J. PUB. HEALTH 917, 918 (2000).

<sup>78</sup> *Id.*



uninsured.<sup>79</sup> Some fifty-five percent of low-income immigrant parents were uninsured in 1999, compared to twenty-eight percent of low-income citizen parents.<sup>80</sup> This finding is hardly surprising, given the tendency of low-income immigrants to be employed in service and construction industries where employer-sponsored health benefits are not widely available.

### A. Communicable Disease

Because immigrants are less likely than U.S. citizens to have health insurance, and because they often come from regions where communicable diseases are more common than in the U.S., denying them access to diagnosis and treatment of these diseases makes it not only likely that they will suffer readily avoidable consequences themselves, but that they will increase citizens' exposure. U.S. immigration policy has traditionally associated immigrants with "germs,"<sup>81</sup> and any discussion that touches on this topic must be carefully constructed to avoid fostering the xenophobia that appears to animate immigration legislation in other areas. The following analysis will focus on tuberculosis because of its prevalence, contagion, and (in most cases) amenity to treatment. However, many of the same findings could be made with regard to other communicable diseases that are more prevalent in third-world countries than in the U.S.

A recent assessment of tuberculosis among foreign-born persons in the U.S. found that 41.6% of U.S. cases in 1998 occurred in immigrants, and that the case rate per 100,000 persons was more than five times as high in foreign-born as in U.S.-born residents.<sup>82</sup> However, other investigators have noted the substantial presence of tuberculosis in the undocumented population and their recourse to treatment strategies that allow the patient to avoid contact with the health care system.<sup>83</sup> The inability of the U.S. public health system to note the precise incidence and prevalence of

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<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> See NANCY TOMES, *THE GOSPEL OF GERMS: MEN, WOMEN & THE MICROBE IN AMERICAN LIFE* (1998).

<sup>82</sup> Elizabeth A. Talbot et al., *Tuberculosis Among Foreign-Born Persons in the United States, 1993-1998*, 284 JAMA 2894, 2895 (2000).

<sup>83</sup> See, e.g., Kimberly A. Johns & Christos Varkoutas, *The Tuberculosis Crisis: The Deadly Consequence of Immigration Policies and Welfare Reform*, 15 J. CONTEMP. HEALTH L. & POL'Y 101, 123-24 (1998); Guido S. Weber, *Unresolved Issues in Controlling the Tuberculosis Epidemic Among the Foreign-Born in the United States*, 22 AM. J. L. & MED. 503 (1996).

tuberculosis among immigrants cannot mask the fact that the immigrant community accounts for a disproportionate share of U.S. tuberculosis cases.

Immigrants suffer respiratory and other infectious diseases because of the concentration of undocumented immigrants among the migrant farm worker population, their substandard living conditions, and the prevalence of infectious disease in their countries of origin.<sup>84</sup> Even when immigrants are given access to tuberculosis screening, the estimated ninety percent who have the latent form of the disease are unlikely to be detected.<sup>85</sup>

While tuberculosis is not contagious unless airborne particles containing viable bacilli are actually expelled,<sup>86</sup> the more important public health issue in tuberculosis care is that well-established treatment regimens can keep patients from reaching the active stage. Nevertheless, multi-drug-resistant tuberculosis patients can continue to transmit the disease for as long as it takes to develop an effective course of treatment, a period which may continue as long as the patient survives.<sup>87</sup>

The increased rate at which immigrants in the U.S. suffer from tuberculosis, despite recent declines among the general population, suggests that denying them access to routine screening and treatment of latent disease creates a serious public health risk.<sup>88</sup> It is difficult enough for public health authorities to convince latent tuberculosis patients to undergo complex six-month drug regimens when they are asymptomatic. By erecting barriers to appropriate testing and treatment for undocumented immigrants and those who arrived after PRWORA enactment, current policies make it highly unlikely that they will receive the care needed to

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<sup>84</sup> See Cynthia Webb Brooks, *Health Care Reform, Immigration Laws, and Federally Mandated Medical Services: Impact of Illegal Immigration*, 17 HOUS. J. INT'L L., 141, 164 (1994); Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 275 (1992); Peter L. Reich, *Jurisprudential Tradition and Undocumented Alien Entitlements*, 6 GEO. IMMIGR. L.J. 1, 3 (1992).

<sup>85</sup> See Loue, *supra* note 84.

<sup>86</sup> Lawrence Gostin, *Tuberculosis and the Power of the State: Toward the Development of Rational Standards for the Review of Compulsory Public Health Powers*, 2 U. CHI. L. SCH. ROUNDTABLE 219, 225 (1995).

<sup>87</sup> *Id.* at 227-28.

<sup>88</sup> Chelsea J. Carter, *TB Cases Fall in U.S., Rise 6 Percent Among Immigrants*, HOUS. CHRON., Apr. 10, 1998, at 13 (noting incidence of TB in immigrants rose by six percent); Ruth Larson, *U.S. Sees Strong Drop in Tuberculosis Cases But Disease Takes Toll on Immigrants*, WASH. TIMES, Apr. 10, 1998, at A6 (noting a thirty-eight percent drop in tuberculosis cases among native-born Americans, but a six percent increase in tuberculosis cases among immigrants).

reduce the danger of transmission. Provisions of IIRIRA that facilitate deportation<sup>89</sup> provide an even greater incentive for undocumented immigrants to avoid revealing their presence to entities that they perceive as agents of the government, meaning that they are unlikely to seek treatment even with active tuberculosis.

Although the PRWORA ban on health care access exempts diagnosis and treatment of communicable diseases,<sup>90</sup> this provision is unlikely to provide much relief. Latent tuberculosis is by definition asymptomatic, and the symptoms of early disease stages are easily overlooked.<sup>91</sup> If treatment is deferred until the patient qualifies for emergency care, many others may have been exposed.

The most extreme example thus far of anti-immigrant legislation, California's Proposition 187 of 1994 ("Proposition 187"), clearly demonstrates the public health consequences of denying health care access to undocumented immigrants. Although legal challenges ultimately kept the law from being enforced, the fear of being identified as undocumented drove immigrants to avoid public health authorities anyway.<sup>92</sup> One observer reports that "the immigrants themselves, fearful of legal repercussions after passage of the law, stayed away from hospitals and clinics until their conditions were dire. Child vaccination rates fell and catastrophic illness rates rose."<sup>93</sup>

The lessons of Proposition 187 carry forward to the PRWORA health care access barriers: concern about revealing immigration status is an even more powerful barrier to access than technical eligibility requirements. Immigrant families with mixed status (e.g., undocumented parents with U.S.-born citizen children) may defer or withhold care for eligible members out of fear that undocumented relatives will be discovered. Care deferred is likely to give rise to much more expensive emergency care needs.

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<sup>89</sup> See, e.g., 8 U.S.C. § 1229(a) (2000) (referencing removal proceedings).

<sup>90</sup> See *id.* §§ 1611(b)(1)(C), 1613(c)(2)(E).

<sup>91</sup> OFF. OF TECH. ASSESSMENT, U.S. CONGRESS, *THE CONTINUING CHALLENGE OF TUBERCULOSIS* 3 (1993).

<sup>92</sup> See Geoffrey Cowley & Andrew Murr, *Good Politics, Bad Medicine*, NEWSWEEK, Dec. 5, 1994, at 31.

<sup>93</sup> LAURIE GARRETT, *BETRAYAL OF TRUST: THE COLLAPSE OF GLOBAL PUBLIC HEALTH* 444 (2000); see also Paul Feldman, *Proposition 187: Measure's Foes Try to Shift Focus From Walkouts to Issues*, L.A. TIMES, Nov. 4, 1994, at A3 ("If we do not immunize undocumented children, we will increase the incidence of measles, whooping cough, mumps, rubella, diphtheria and hepatitis B in all children, not just the undocumented," said Dr. Brian D. Johnston, secretary of the Los Angeles County Medical Ass'n.').

## B. Prenatal Care

While the 1996 welfare and immigrant reform legislation has predictable detrimental effects on the health of immigrants and the public in general, denial of coverage for prenatal care is the most poignant of the barriers imposed by the “reforms” because of the vulnerability of affected mothers and newborns.<sup>94</sup> A recent Second Circuit Court of Appeals decision,<sup>95</sup> while finding that denial of prenatal care to undocumented immigrant women did not violate equal protection rights under the U.S. Constitution, noted:

The New York State Department of Health believes that the costs of furnishing prenatal care for the more than 13,000 annual births to undocumented pregnant women in New York would be almost completely recouped by the savings from the decrease in initial postnatal hospitalizations alone, without even considering the vast savings from not having to treat these children’s lifetime health problems that would have resulted from denial of prenatal care.<sup>96</sup>

Even pregnant immigrant wives of U.S. citizens who legally entered the U.S. after August 22, 1996, are ineligible for publicly funded prenatal care while they have “conditional resident status,” a period that covers the first two years of their stay in the U.S.<sup>97</sup>

From the perspective of public health, denying access to prenatal care for low-income immigrants is as counterproductive as raising barriers to tuberculosis care. Immigrants’ children who are born in the U.S. are

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<sup>94</sup> See, for example, the testimony of Senator Edward Kennedy:

Perhaps the cruelest provision in this bill is the ban on assistance under Medicaid for legal immigrants giving birth. . . . These babies are doomed to unsupervised home deliveries, substandard care, and a lifetime of potential handicaps if they fail to get adequate medical care during birth. If Congress will not strike that shameful provision down, perhaps the Supreme Court will.

142 CONG. REC. S. 9344-01 (daily ed. Aug. 1, 1996).

<sup>95</sup> *Lewis v. Thompson*, 252 F.3d 567, 583-84 (2d Cir. 2001).

<sup>96</sup> *Id.* at 579. The court held that citizen children of undocumented mothers were automatically eligible for Medicaid at birth if they met the same eligibility criteria as children of mothers legally present. *Id.* at 591.

<sup>97</sup> Stacey M. Schwartz, *Beaten Before They are Born: Immigrants, Their Children, and a Right to Prenatal Care*, 1997 ANN. SURV. AM. L. 695, 696; see also 8 U.S.C. § 1613 (2000).

automatically eligible for publicly-funded benefits, so the taxpayer is ultimately responsible for the costs associated with children's health conditions that could have been prevented with appropriate prenatal care.<sup>98</sup> A 1999 study modeling the effects of denying prenatal treatment for sexually transmitted infections alone in undocumented immigrants estimated that treatment for the adverse pregnancy outcomes would offset about one-third of the projected savings from denying all prenatal care.<sup>99</sup>

If the effect of the PRWORA were limited to Medicaid, it would merely codify a 1973 HHS regulation that made undocumented immigrants ineligible for Medicaid-funded prenatal care.<sup>100</sup> However, § 411 of the Act also cuts off undocumented pregnant women's access to health care funded by state and local governments,<sup>101</sup> unless the state legislature passes a new statute for this purpose after the passage of the PRWORA.<sup>102</sup>

Under the PRWORA, persons permanently residing in the U.S. under color of law also lose their eligibility for Medicaid-funded prenatal care except in the highly unlikely event that they receive SSI payments.<sup>103</sup> PRWORA also denies formerly-eligible PRUCOL immigrants prenatal care funded by states or localities,<sup>104</sup> although several states continue to provide state-funded prenatal care benefits to immigrants who meet the PRUCOL definition.<sup>105</sup>

Lawful immigrants who entered the U.S. *before* August 22, 1996, are eligible for Medicaid-funded prenatal care (and other Medicaid benefits)

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<sup>98</sup> See *Lewis v. Grinker*, 965 F.2d 1206, 1223 (2d Cir. 1992) ("Lewis IV").

<sup>99</sup> H. Kuiper et al., *The Communicable Disease Impact of Eliminating Publicly Funded Prenatal Care for Undocumented Immigrants*, 3 *MATERN. CHILD HEALTH J.*, Mar. 1999, at 39.

<sup>100</sup> See *Lewis v. Grinker*, 660 F. Supp. 169, 170 (E.D.N.Y. 1987) ("Lewis I") (citing 42 C.F.R. § 435.402(b) as "establishing alienage requirements for medical eligibility" for Medicaid).

<sup>101</sup> Compare 8 U.S.C. § 1621, with *id.* §§ 1611-12.

<sup>102</sup> See *id.* § 1622 (providing statutory authority for limitation of eligibility). This is obviously not what Congress had in mind, as PRWORA § 400(7) notes: "[A] State that chooses to follow the Federal classification in determining the eligibility of . . . aliens for public assistance shall be considered to have chosen the least restrictive means available for achieving the compelling governmental interest of assuring that aliens be self-reliant in accordance with national immigration policy." PRWORA, *supra* note 1, § 400(7).

<sup>103</sup> Tanya Broder, *State and Local Policies on Immigrants and Public Benefits: Responding to the 1996 Welfare Law*, 31 *CLEARINGHOUSE REV.* 503, 512 (1998).

<sup>104</sup> 8 U.S.C. § 1621(a).

<sup>105</sup> Broder, *supra* note 103, at 512-13.

in states that have chosen to provide these benefits to “qualified aliens.”<sup>106</sup> However, those who entered after PRWORA enactment have no access to federally-funded means-tested programs such as Medicaid and SCHIP for at least their first five years in the U.S.<sup>107</sup> In reality, for those entering after December 1997, the ban is likely to extend for ten years, at least in the case of Medicaid, because income eligibility determinations must include the available income and assets of each qualified immigrant’s sponsor.<sup>108</sup> Because the sponsor must provide evidence of an income above 125% of the federal poverty level in order to qualify,<sup>109</sup> counting the sponsor’s income will raise the immigrant above the Medicaid eligibility level in most states. Fortunately, several states with large immigrant populations provide state or locally funded prenatal care services to recent immigrants who enter the U.S. on or after August 22, 1996.<sup>110</sup>

### C. Public Health Assistance

Immigrants are eligible for public health assistance funded through sources other than the Medicaid program regardless of their status. These services include immunizations, as well as testing and treatment of “apparent” communicable diseases, regardless of whether a communicable disease is ultimately found to have caused the symptoms.<sup>111</sup> As with emergency Medicaid, providers are not required or encouraged to verify patients’ immigration status. Services related to HIV/AIDS, sexually transmitted diseases, and tuberculosis are thus available from safety net providers, but it appears unlikely that immigrants will take advantage of these opportunities in numbers large enough to meet the needs of these providers. A recent study of Latino Hispanic residents of Los Angeles found that lack of access to subsidized preventive services led to low utilization rates and potentially higher incidence of cervical

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<sup>106</sup> Only the state of Wyoming has elected not to continue eligibility for these benefits. *Id.* at 513.

<sup>107</sup> *See* 8 U.S.C. § 1613.

<sup>108</sup> *Id.* § 1631(a). The only exceptions are for immigrants who have worked (or whose parents or spouses have worked) forty qualifying quarters, have need of assistance to avoid hunger and homelessness, or are battered spouses or children. *See id.* § 1631(b)(2)(A), (e), (f).

<sup>109</sup> 8 C.F.R. § 213a.2(b)(2) (2001).

<sup>110</sup> *See* Broder, *supra* note 103, at 513.

<sup>111</sup> *See* 8 U.S.C. § 1611(b)(1)(C).

cancer, a condition that has otherwise been very responsive to early detection.<sup>112</sup>

PRWORA authorized the Attorney General to designate other community programs, services and assistance opportunities that are open to all immigrants. Such offerings must deliver (rather than fund) community-based services regardless of the patient's income level, and the services must be necessary to the patient's life or safety.<sup>113</sup> The August 30, 1996, order designating these benefits covers police, fire, ambulance, transportation, sanitation and other regular, widely available services in addition to:

Crisis counseling and intervention programs, services and assistance relating to child protection, adult protective services, violence and abuse prevention, victims of domestic violence or other criminal activity, or treatment of mental illness or substance abuse;

Medical and public health services (including treatment and prevention of diseases and injuries) and mental health, disability or substance abuse assistance necessary to protect life or safety;

Activities designed to protect the life and safety of workers, children and youths, or community residents; and

Any other programs, services, or assistance necessary for the protection of life and safety.<sup>114</sup>

#### D. Child Health

The American Academy of Pediatrics ("AAP") has consistently advocated the provision of health care to all children, regardless of their immigration status. The official AAP statement on this subject notes:

Public health initiatives by intent and design are universal, and the protection of the public health requires access by the entire community. Restrictions on access to services placed on immigrants would seriously limit the effectiveness of outreach, case finding, and prevention and treatment programs related to infectious diseases. Patients needing

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<sup>112</sup> Judith R. Katzburg, *The Impact of Citizenship on Access to Preventive Care (Pap Smears) for Women Living in Los Angeles County*, ACAD. HEALTH SERVS. RES. & HEALTH POL'Y (1999), at <http://www.academyhealth.org/abstracts/1999/katzburg.htm> (last visited Mar. 24, 2002).

<sup>113</sup> 8 U.S.C. § 1611(b)(1)(D).

<sup>114</sup> 61 Fed. Reg. 45,985 (1996).

prenatal care and family planning services would similarly lose access to important preventive care, resulting in increased risks for poor pregnancy outcomes and the major long-term disabilities associated with such outcomes and their subsequent costs. Denying legal and illegal immigrants access to basic health care would not only deprive them of needed services but also disrupt the provision of services to other children by redirecting resources from providing services to sorting and enforcement of more restrictive eligibility standards.<sup>115</sup>

Undocumented immigrant parents whose children are citizens may be reluctant to apply for aid for their children, since government offices are authorized or even required to report suspected undocumented immigrants to the INS.<sup>116</sup>

Two recent studies using national data sets have noted serious deficiencies in health care access for immigrant children, particularly those born abroad.<sup>117</sup> New immigrants are often employed in low-wage positions that do not offer employer-sponsored health benefits; even with access to group coverage, their income is often too low to pay for dependent coverage. The evidence from both of these national studies clearly supports the conclusion that the PRWORA's denial of eligibility for publicly-funded health programs impairs the access of immigrant children to necessary health services.<sup>118</sup> One of the many chilling effects of U.S. immigration law is the unwillingness of non-citizen or undocumented parents to enroll their U.S. citizen children in programs for which they are eligible, such as Medicaid or SCHIP. Ku and Matani found, as have others,<sup>119</sup> that citizen children of non-citizen parents were significantly less likely than children

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<sup>115</sup> Comm. on Cmty. Health Servs., Am. Acad. of Pediatrics, *Health Care for Children of Immigrant Families*, PEDIATRICS, July 1997, at 153, 154.

<sup>116</sup> See 8 U.S.C. §§ 1373(a), 1644 (2000).

<sup>117</sup> Sylvia Guendelman et al., *Unfriendly Shores: How Immigrant Children Fare in the U.S. Health System*, HEALTH AFF., Jan./ Feb. 2001, at 257; Ku & Matani, *supra* note 10, at 247.

<sup>118</sup> See Guendelman et al., *supra* note 117, at 264 (finding that, when controlling for income, employment status, and other significant variables, "uninsured foreign-born children faced the worst access to health care"); Ku & Matani, *supra* note 10, at 253 ("Being a noncitizen adult or the child of noncitizen parents reduces access to ambulatory medical care and emergency room care, after factors such as health status, income, and race/ethnicity are controlled for.").

<sup>119</sup> See, e.g., Glenn Flores et al., *Access Barriers to Health Care for Latino Children*, 152 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1119 (1998); Maloy et al., *supra* note 4.



of foreign-born citizens to have a regular source of care or to have used health services in the preceding year.<sup>120</sup>

#### IV. ANTI-IMMIGRANT LAWS IN THE COURTS

##### A. *New York*

Two recent decisions from state and federal courts in New York have clarified some of the more ambiguous aspects of the 1996 statutes.<sup>121</sup> In analyzing these decisions, it is important to distinguish between benefits that are partially supported by federal funds and those that are offered on a discretionary basis by the states without federal funding participation. It is also helpful to recall that the INA<sup>122</sup> and the U.S. Constitution<sup>123</sup> grant exclusive authority over policy decisions based on immigration status to the federal government.

In *Lewis v. Thompson*, the Second Circuit Court of Appeals held that the PRWORA's denial of federally-funded prenatal care to undocumented immigrants did not violate the equal protection provisions of the U.S. Constitution.<sup>124</sup> The same decision, however, held that citizen newborns who were otherwise eligible for automatic Medicaid coverage at birth could not be denied coverage merely because their mothers were undocumented.<sup>125</sup> The original case dates from 1979,<sup>126</sup> and the decision retracts a 1987 court order requiring coverage.<sup>127</sup>

*Aliessa v. Novello*, decided by New York's highest court, addressed state-funded Medicaid offered by New York to persons who did not meet federal Medicaid coverage requirements.<sup>128</sup> Because immigration-related decisions are the exclusive province of federal law, the court reasoned that New York's exclusion of certain legal immigrants from federal Medicaid coverage for which they would otherwise be eligible was an unconstitutional exercise of state discretion.<sup>129</sup> The court also found that the provision

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<sup>120</sup> *Ku & Matani, supra* note 10, at 249-50.

<sup>121</sup> *See Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001); *Aliessa v. Novello*, 754 N.E.2d 1085 (N.Y. 2001).

<sup>122</sup> *See* 8 U.S.C. § 1103(a) (2000).

<sup>123</sup> *See* U.S. CONST. art. I, § 8, cl. 4.

<sup>124</sup> *Lewis*, 252 F.3d at 584.

<sup>125</sup> *Id.* at 591.

<sup>126</sup> *Id.* at 572.

<sup>127</sup> *Id.* at 574.

<sup>128</sup> *Aliessa v. Novello*, 754 N.E.2d 1085, 1089 (N.Y. 2001).

<sup>129</sup> *Id.* at 1096-99.

of the PRWORA allowing states to distinguish among categories of immigrants with regard to state-funded benefits violated the equal protection provisions of the U.S. Constitution.<sup>130</sup> Such actions might also be found to be overreaching on the part of states with regard to their jurisdiction over immigration issues.

The obvious resolution of these apparently inconsistent decisions lies in state-sponsored program expansion unless or until the PRWORA restrictions are lifted.

### B. Texas

On July 10, 2001, Texas Attorney General Michael Cornyn issued an opinion stating that PRWORA banned the Harris County (Houston), Texas Hospital District from providing free or discounted care to undocumented immigrants in the absence of a post-PRWORA state law authorizing such activities.<sup>131</sup> The opinion further found that “[t]he requestor has not cited any statute applicable to the Harris County Hospital District expressly stating that aliens unlawfully in the county may receive publicly-funded health care from the district, nor have we identified such a statute.”<sup>132</sup>

A 1999 statute reaffirming the hospital district’s duty to care for Harris County residents regardless of their ability to pay did not meet the PRWORA criterion that post-PRWORA state legislation must “affirmatively” state its applicability to undocumented persons.<sup>133</sup> The opinion also finds that the PRWORA restrictions do not violate the Tenth Amendment to the U.S. Constitution.<sup>134</sup>

Shortly after the opinion was issued, the Harris County District Attorney initiated a *criminal* investigation of the hospital district at the behest of county residents.<sup>135</sup> However, on December 10, 2001, the Harris County District Attorney suspended the investigation indefinitely because

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<sup>130</sup> *Id.* This is not the first time PRWORA provisions have been found unconstitutional. See *Saenz v. Roe*, 526 U.S. 489 (1999) (finding that a provision allowing states to condition benefit eligibility on duration of residence violated the Fourteenth Amendment right to travel); *Maldonado v. Houston*, 157 F.3d 179 (3d Cir. 1998) (holding that the state’s residency requirement, similar to PRWORA’s residency provision, violated the Equal Protection Clause).

<sup>131</sup> Tex. Att’y Gen. Op. No. JC-0394, *supra* note 74.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> Jim Yardley, *Immigrants’ Medical Care is Focus of Texas Dispute*, N.Y. TIMES, Aug. 12, 2001, at 1:18.

the hospital district announced its intention to begin billing all patients on a sliding scale.<sup>136</sup>

## V. POLICY RECOMMENDATIONS

### A. *Proposed Legislation*

Several legislative proposals were introduced in the 106th and 107th Congress to alleviate the hardship imposed by the combination of PRWORA and IIRIRA, although none expressly acknowledged that doing so is in the interest of all U.S. residents, not just immigrants.

House Resolution 5291, one version of the Medicare “give-back” legislation intended to restore some of the draconian Medicare reimbursement cuts of the Balanced Budget Act of 1997, would have restored Medicaid and SCHIP eligibility for legal immigrant children who have been in the U.S. for less than five years.<sup>137</sup> Senate Bill 2668 would have had the same effect.<sup>138</sup> The enacted legislation did not include the mitigating provisions of either of these bills.<sup>139</sup> The Immigrant Children’s Health Improvement Act of 2001<sup>140</sup> enjoyed broad bipartisan support before the events of September 11th cast a harsher light on immigration reform. Meanwhile, five years have passed since the August 22, 1996, enactment of PRWORA, so children whose deemed income<sup>141</sup> does not exceed state-specific eligibility levels will begin to become eligible for federally-funded means-tested benefits such as SCHIP and Medicaid.

In the aftermath of the September 11th terrorist attacks, pro-immigrant legislation that had received strong bipartisan support has been tabled.<sup>142</sup> Stricter enforcement of existing law and rapid expansion of grounds for detention and deportation will exacerbate the tendency of immigrants to keep away from government agencies and programs.

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<sup>136</sup> Steve Brewer, *DA Drops Investigation of Immigrant Health Care*, HOUS. CHRON., Dec. 11, 2001, at 1.

<sup>137</sup> H.R. 3426, 106th Cong. (1999).

<sup>138</sup> S. 2668, 106th Cong. (2000); *see also* Legal Immigrant Children’s Health Improvement Act of 2001, H.R. 1143/S. 582, 107th Cong.

<sup>139</sup> The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, H.R. 3426, 106th Cong.

<sup>140</sup> Legal Immigrant Children’s Health Improvement Act of 2001, H.R. 1143/S. 582, 107th Cong.

<sup>141</sup> *See supra* note 32 and accompanying text.

<sup>142</sup> Mary Beth Sheridan, *U.S. Moves to Tighten Security on Borders; in Wake of Terrorist Attacks, Congress and INS are Changing Their Priorities*, WASH. POST, Oct. 18, 2001, at A08.

### B. Next Steps

Although the relatively short period of time since PRWORA and IIRIRA implementation makes a full evaluation of their impact impossible, there is no reason to demand scientific rigor when the public health implications of the 1996 statutes are so clear and compelling. A George Washington University study found that “[i]mplementation of [the]1996 laws increased the uninsured population, exacerbated demands on the safety net, and heightened fears about using Medicaid.”<sup>143</sup> When the potential consequences to other U.S. resident populations and the children of new immigrants are added to this catalogue of issues, the need for improved immigrant health care access should rise to the level of a national policy priority. Repeal of the restrictive PRWORA provisions is an obvious starting point.

It is clear that health care access is not a significant motivator for immigrants. Despite isolated anecdotes to the contrary, the overwhelming majority of new immigrants, and particularly undocumented persons, enjoy better health than their U.S.-born counterparts, or they would be unable to withstand the physical and mental rigors of immigration. The exception is the group of elderly parents of legal residents or naturalized citizens, whose numbers are far lower than alarmist projections suggested in the mid-1990s.<sup>144</sup>

Denying health care access to children, pregnant women, and persons at risk for serious communicable diseases solely because of their immigration status violates the fundamental principles of public health, which emphasize the improvement of health across communities. States and municipalities (not to mention federal agencies) may resent expenditures for services to new immigrants, but in the absence of draconian changes in immigration law and enforcement, investment in preventive care is definitely preferable to the alternative. The cost to a community of an outbreak of multiple-drug-resistant tuberculosis, for example, far exceeds the cost of providing screening and treatment for persons with latent forms of the disease before they progress to the level of requiring drug regimens that cost thousands of dollars per person.

Repealing statutory bans alone will not link immigrants with the care they must receive to protect themselves and the populations among whom they live. States and the federal government will need to identify resources to fund these services. Active outreach, culturally competent services, and

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<sup>143</sup> Maloy et al., *supra* note 4, at iii.

<sup>144</sup> See *supra* notes 67-68 and accompanying text.

a better-informed practitioner community will be necessary to overcome the accumulated effects of the barriers to necessary health care.