

1-1-2019

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Bethany A. Taylor, *Student Publication: Undocumented, Untreated, Unhealthy: How the Expansion of FQHCs Can Fill the Gaps of Basic Healthcare for Undocumented Immigrants*, 25 Buff. Hum. Rts. L. Rev. 139 (2019).

Available at: <https://digitalcommons.law.buffalo.edu/bhrlr/vol25/iss1/7>

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UNDOCUMENTED, UNTREATED, UNHEALTHY: HOW THE EXPANSION OF FQHCs CAN FILL THE GAPS OF BASIC HEALTHCARE FOR UNDOCUMENTED IMMIGRANTS

Bethany A. Taylor†

INTRODUCTION

The right to health has always been a fundamental part of the human rights framework. The 1946 Constitution of the World Health Organization (WHO) states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being *without distinction of race, religion, political belief, economic or social condition.*”¹ In fact, a study of adults in the United States in 2004 revealed that 76% of adults agreed that access to healthcare should be a right.² In contrast to almost all other industrialized countries in the world, however, the United States has not recognized an affirmative right to healthcare.³ Furthermore, the United States intentionally excludes and imposes barriers upon access to healthcare for some of the nation’s most vulnerable communities: undocumented immigrants.⁴ The right of equal access to health care applies to all persons within a state’s jurisdictional boundaries, irrespective of immigra-

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1. U.N. High Comm’r for Hum. Rts., *The Right to Health: Fact Sheet No. 31* (Jun. 2008), available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (emphasis added).

2. Elizabeth R. Chesler, *Denying Undocumented Immigrants Access to Medicaid: A Denial of Their Equal Protection Rights?* 17 PUB. INT. L.J. 255, 280 (2008).

3. NICOLE HUBERFELD ET AL., *THE LAW OF AMERICAN HEALTHCARE*, 152 (2016).

4. Kaiser Family Foundation, *Health Coverage of Immigrants* (Dec 13, 2017), available at <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants>. In 2016, there were 23 million non-citizens residing in the United States, equaling 7% of the total population. 4 in 10 non-citizens were undocumented immigrants. Two-thirds of undocumented immigrants reside in 8 states: California, Texas, New York, Florida, New Jersey, Arizona, Georgia, and Illinois.

tion status.⁵ This Article addresses this unjustified exclusion. It proposes a way forward, taking into account the national political moment we are in and the general hostility to immigrants from the current federal government. Specifically, it calls on states and localities to take the lead by establishing and expanding the use of federally qualified health centers (FQHCs) to ensure basic preventive care to all underserved communities in the U.S., including undocumented immigrants.

In short, my thesis is that the federal government has failed in honoring the right to health care, requiring states and localities to step in and fill the gaps, and that the expansion of current FQHCs and the establishment of new centers is the best way in which states can fill the gap in the medium-term. This is not to suggest that this is necessarily an ideal long-term solution to the problem of inadequate healthcare access within the U.S. Rather, it is proposed as a workable and practical medium-term path to expanding health care access to the nation's most vulnerable and excluded communities, working within the parameters of the existing federal health care framework, which may open the door to more durable changes when the national political moment becomes more amenable to rights-based change.

This Article proceeds in three parts. Part I examines current federal exclusions that prevent undocumented immigrants from accessing health care, as well as the impact of these exclusions on health outcomes. Part II identifies ways in which various states have stepped up to try to fill the gaps left by these federal exclusions, both by stretching statutory language, and deploying state funds to cover those left outside of federal definitions. Part III then proposes that expansion and establishment of FQHCs is the most appropriate avenue for state action and will produce the most ideal outcomes in terms of providing basic and preventive care for undocumented immigrants.

I. OVERT EXCLUSION: FEDERAL GOVERNMENT FAILURE

The United States not only does not guarantee universal health care to those within its borders, but intentionally excludes undocumented immigrants from accessing healthcare insurance, even on the private market. The result is that undocumented adults are nearly four times as likely as citizen adults to lack health care coverage (39 % vs. 9 %)⁶, while the uninsured rate for undocumented immigrant children is nearly five times the rate for citi-

5. See, e.g., International Covenant on Economic, Social and Cultural Rights, Dec. 16 1966, 993 U.N.T.S. 3. In a human rights framework, under the I.C.E.S.C.R., not only do all humans have the right to basic healthcare, but to the "highest attainable standard of physical and mental health."

6. See Kaiser Family Foundation, *supra* note 4, at 1.

zen children (23 % vs. 5 %).⁷ Exclusion from the normal provision of insurance, though, is not the only barrier to health care that the government has erected.

A. Federal Statutory Exclusions

1. Insurance Barriers: Employment, the ACA, and Medicaid

There are three options for the provision of healthcare insurance in the United States, and undocumented immigrants have significant legal and practical barriers in accessing each one. The first is employer-based insurance. Eighty percent of undocumented adult immigrants are in the labor force, but often in low-income fields that rarely offer health insurance.⁸ Because they often cannot get employer-based insurance, the next stop for many people residing in the United States would be to purchase private insurance through the exchange marketplaces. Undocumented immigrants hit another roadblock here: the Patient Protection and Affordable Care Act of 2010, a comprehensive health care bill passed by the Obama administration, prohibits undocumented immigrants from buying any insurance at all, even private insurance that they can afford.⁹

2. Medicaid Emergency Care

With the first two options rendered unworkable, many would then turn to government health insurance, namely Medicaid. Research suggests that public programs such as Medicaid reduce hardship, improve health and nutrition, and contribute to stability in families' lives and better outcomes for children.¹⁰ Unfortunately, public health coverage is the least likely form of insurance to help undocumented immigrants, even though they are almost

7. *Id.*

8. Benjamin D. Sommers, *Stuck between Health and Immigration Reform: Care for Undocumented Immigrants*, 369 *NEW ENG. J. MED.* 593 (2013); see also Patrick Glen, *Health Care and the Illegal Immigrant*, 23 *HEALTH MATRIX* 197, 222 (2013) (offering that "healthier" means better health outcomes and lower mortality than U.S.-born counterparts).

9. Rayden Llano, *Immigrants and Barriers to Healthcare: Comparing Policies in the United States and the United Kingdom*, 1 *STAN. J. PUB. HEALTH* 14, 15 (2011).

10. Urban Institute, *ASPE Issue Brief: Barriers to Immigrants' Access to Health and Human Services Programs* 1 (2012), available at <https://aspe.hhs.gov/basic-report/barriers-immigrants-access-health-and-human-services-programs>.

twice as likely as the native-born population to have income below the Medicaid 133% federal poverty line threshold.¹¹

For low-income United States citizens and legally present immigrants—who often cannot afford private healthcare and do not receive employer-based insurance—government programs fill the gap; specifically Medicaid. Medicaid is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.¹² Essentially working as a safety net, Medicaid provides health insurance for those who would not be able to receive it elsewhere. As undocumented immigrants usually work in settings where they are not receiving insurance from their employers, and are, as this Article will discuss, barred from purchasing private healthcare, Medicaid seems to be the optimal way to provide health insurance. For undocumented immigrants, few healthcare options are available; options for quality health care even less so. Though Medicaid would logically be the best way to provide basic health coverage for undocumented immigrants, the federal government explicitly excludes them from qualification. The only care that undocumented immigrants can receive is emergency care, which is often too late. The federal Medicaid statute that defines an emergency makes it clear that basic, routine care for illegal immigrants is not covered.¹³ The only procedures it specifically excludes from reimbursement, though, are organ transplants, leaving to the states the task of further defining an emergency.¹⁴

The statute governing Medicaid qualification for undocumented immigrants is 42 U.S.C. § 1396(v), which ambiguously states that undocumented immigrants only qualify for coverage under Medicaid if they are suffering from an “emergency medical condition,” without expressly defining what emergency medical conditions consist of.¹⁵ Section 1396b(v)(3) provides that a medical condition manifesting itself by “acute symptoms of sufficient severity such that the absence of immediate medical attention could be reasonably be expected to result in: (A) placing the patients’ health in serious

11. Stephen Zuckerman et al., *Undocumented Immigrants, Left Out of Health Reform, Likely to Continue to Grow as Share of the Uninsured*, 30 HEALTH AFF. 1997, 2000 (2011).

12. SOCIAL SECURITY ADMINISTRATION, MEDICAID INFORMATION, <https://www.ssa.gov/disabilityresearch/wi/medicaid.htm> (last visited Mar. 8, 2018).

13. Sarah Kershaw, *U.S. Rule Limits Emergency Care for Immigrants*, N.Y. TIMES (Sept. 22, 2007), <http://www.nytimes.com/2007/09/22/washington/22emergency.html>.

14. *Id.*

15. 42 U.S.C. § 1396b(v) (2018).

jeopardy; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part.”¹⁶

3. EMTALA

EMTALA, the Emergency Medical Treatment and Active Labor Act, states that any hospital with an emergency department must provide patients with an appropriate medical screening examination within the capability of the hospital’s emergency department.¹⁷ If it is determined that an emergency condition exists, the hospital must provide for “for such further medical examination and such treatment as may be required to stabilize the medical condition, or . . . for transfer of the individual to another medical facility.”¹⁸ EMTALA also treats giving birth as an emergency medical condition, protecting the right of pregnant women to birthing care.¹⁹ The umbrella of EMTALA and Emergency Medicaid are the only federal doors which are open to care for undocumented immigrants. EMTALA and Emergency Medicaid, though, are insufficient. While these federal laws mandate that hospitals provide emergency medical care for all, irrespective of legal status, they fail to provide the funding necessary to meet this obligation.²⁰ Not only is there insufficient funding, but these statutes provide no comprehensive access to care.²¹

4. PRWORA

Following EMTALA, another federal statute in 1996 severely restricted undocumented immigrants’ access to healthcare. Entitled the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), this statute acknowledged that “it is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.”²² The law then outlines standards regarding undocumented immigrants’ eligibility for services supported by the federal

16. Michael J. McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard that Governs Undocumented Immigrants’ Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL’Y 391, 400 (2007).

17. 42 U.S.C. § 1395dd (2012).

18. *Id.*

19. *Id.*

20. Lindita Bresa, *Uninsured, Illegal, and In Need of Long-Term Care: The Repatriation of Undocumented Immigrants by U.S. Hospitals*, 40 SETON HALL L. REV. 1663, 1667 (2010).

21. Sommers, *supra* note 8, at 595.

22. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, 2260 (1996).

government, distributed by states and localities. With regard to health, PRWORA declares that undocumented immigrants are ineligible for “any retirement, welfare, health, disability . . . or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government,” with the EMTALA exceptions of emergency medical conditions and immunizations.²³ Though PRWORA had a harsher effect on legal immigrants,²⁴ it continued the denial of basic healthcare services to undocumented immigrants. One scholar even framed PRWORA as an equal protection issue, arguing that the law violates undocumented immigrants’ equal protection rights by denying them Medicaid eligibility based on their immigration status.²⁵ The preceding statutes, with the addition of the ACA, are the standing law shaping the federal government’s treatment of undocumented immigrants in the health-care system.

5. DRA

In addition to the restrictions imposed by Medicaid, EMTALA and PRWORA, states experience further restrictions to their desire to provide basic medical care. The Deficit Reduction Act of 2005 (DRA) takes the Medicaid statute one step further, conditioning federal payments to state Medicaid programs on states ability to demonstrate that they have *written proof* of citizenship or legal status for all beneficiaries for whom federal payments are sought.²⁶

B. *Impacts on Health and State Finances*

This exclusionary framework has two distinct and deleterious outcomes. The first is a negative effect on national public health outcomes. The second results in shifting the financial burden of said negative health outcomes to states, particularly those with the highest concentration of undocumented immigrants.

23. *Id.* at 2268.

24. See Neeraj Kaushal & Robert Kaestner, *Welfare Reform and Health Insurance of Immigrants*, 40 HEALTH SERV. RES. 697 (2005). PRWORA altered legal (*i.e.*, legal permanent residents) immigrants’ access to public health insurance by denying Medicaid coverage to immigrants who arrived in the U.S. after August 1996 for all but emergency care in the first five years of their residency.

25. Chesler, *supra* note 2, at 256.

26. Sara Rosenbaum, *Medicaid and Documentation of Legal Status: Implications for Public Health Practice and Policy*, 122 PUB. HEALTH REP. 264, 265 (2007) (emphasis added).

1. Negative Health Impacts

The health of a society is built on the health of its individual members. The intentional exclusion of undocumented immigrants within the borders of the United States from health care access, thereby impacts the health of the nation as a whole. By building an exclusionary healthcare framework, the federal government pushes the basic notion that an individual's health depends on the health of the people around them to the side. Undocumented immigrants' presence and the fact that they are socially integrated into the communities in which they live and work also makes them members of the health care community, entitling them to the same care as other community members.²⁷ Therefore, restrictions to health care based on citizenship status "pervert the concept and provision of emergency care" and "undermine public health objectives."²⁸ Without the voluntary participation of all affected patients, documented and undocumented, public health authorities will struggle to track the transmission of any emerging diseases.²⁹ If they cannot be treated, it is likely that preventable diseases will go undiagnosed, endangering whole communities and populations.³⁰ Since they are already receiving care in some capacity (emergency care), allowing basic and preventive care access would be an extension of existing coverage, not an addition.³¹

The director of the El Paso health district, Dr. Laurence Nickey, stated that "diseases that are generally considered to have been controlled in the United States are readily evident along the border."³² For example, in El Paso, TX, the tuberculosis rate is twice that of the United States as a whole,

27. Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS OF HEALTH L. 175, 176 (2008).

28. *Id.*

29. Kunal Sindhu, *Trump is Creating a Public Health Crisis for Undocumented Immigrants*, TONIC (Jan. 19, 2018), available at https://tonic.vice.com/en_us/article/59w443/trump-is-creating-a-public-health-crisis-for-undocumented-immigrants.

30. Jim P. Stimpson et al., *Unauthorized Immigrants Spend Less than Other Immigrants and US Natives on Health Care*, 32 HEALTH AFF. 1313, 1316 (2013).

31. Glen, *supra* note 8, at 230.

32. Federation for American Immigration Reform (FAIR), *Illegal Immigration and Public Health* (Mar. 2009), available at <https://fairus.org/issue/societal-impact/illegal-immigration-and-public-health>. Here, Dr. Nickey is explicitly referring to the United States border with Mexico, speaking about diseases usually brought from Mexico and Central and South American countries. It must be acknowledged that Latino/a immigrants are not the only undocumented immigrants in the country, and disease can also be spread by those from other parts of the world who, for example, have overstayed tourist visas.

and that dysentery is several times the U.S. rate.³³ Nickey further explained that although undocumented immigrants usually cross the border for economic opportunity, “medical care ha[s] not been made available to them, causing a severe risk to health and wellbeing of people on both sides of the border.”³⁴ As undocumented immigrants can come from countries with lesser developed health care, it is important that they have access to preliminary disease screenings, vaccinations, and treatment. Despite the political rhetoric, major, *treatable*, health risks are freely entering into the general population, and undocumented immigrants have nowhere to turn to protect themselves or their communities from microscopic threats.³⁵

Denying healthcare not only has an impact on undocumented immigrants who cannot receive statutorily covered healthcare, but their children who have been born in the United States. These children can legally receive healthcare by virtue of being born in the U.S. Indeed, excluding undocumented immigrants has had a chilling effect on provision of care to those who are legally entitled by birth: 7 out of every 10 children of undocumented immigrants are U.S. citizens by birth.³⁶ Annual per capita expenses for healthcare were 86% lower for uninsured immigrant children than for their uninsured US born counterparts,³⁷ suggesting that barriers to undocumented adults are creating a perverse incentive avoid exploring the options for healthcare for themselves and their children. For example, on May 12, 2008, ICE agents raided a slaughterhouse in Iowa, arresting 389 undocumented immigrants, which, at the time, became the largest workplace raid in American history.³⁸ In the year after the raid, infants born to Latina mothers had a 24% higher risk of being born with a low birth weight than infants born the year before the raid.³⁹ Since the neurocognitive consequences of being born with a low birth weight persist for years, ICE agents may have forever altered the life trajectories of numerous unborn babies with a single raid.⁴⁰

Additionally, denying healthcare for undocumented immigrants is depriving them not only of care which they cannot pay for, but benefits for

33. *Id.*

34. *Id.*

35. Peter Edelstein, *Do Illegal Immigrants Pose a Health Risk to Us All?*, PSYCHOLOGY TODAY: PATIENT POWER (Jan. 25, 2017), available at <https://www.psychologytoday.com/us/blog/patient-power/201701/do-illegal-immigrants-pose-health-risk-us-all>.

36. *Id.*

37. Llano, *supra* note 9, at 15; see also Glen, *supra* note 8, at 223.

38. Sindhu, *supra* note 29.

39. *Id.*

40. *Id.*

which they *have* paid, and are unable to access. The IRS estimates that undocumented workers pay about \$9 billion in payroll taxes annually, which includes Social Security and Medicare withholdings, yet they rarely qualify to receive those benefits.⁴¹ The federal government's exclusionary framework is therefore unwilling to provide undocumented immigrants services that they are able to afford, allowing them to contribute to the economy, but denying the ability to derive health benefits from it.

2. Financial Burden Shifting

The estimated cost of unpaid emergency medical bills for undocumented immigrants reaches \$2 billion a year,⁴² and is increasingly becoming the problem of the states, whereas the federal government is dodging responsibility. Because of the federal government's exclusionary language, it is the states and localities that are feeling the most pressure to adopt a rights-based approach to healthcare. Doctors in state hospitals which receive federal funding based on government evaluation of whether the treatment given to an undocumented immigrant could be covered by public insurance mechanisms are increasingly finding a conflict between ethics and compliance with federal law.⁴³ "We have people coming to our country in good faith to work, but we have no system in place as a nation as to what to do when these people get sick," said Pat Austin, a spokeswoman for Martin Memorial Medical Center in Florida, "[e]ach hospital is left to kind of figure out what to do for itself."⁴⁴

While doctors feel obligated to give undocumented immigrants the care that they need, hospitals are increasingly struggling with costs of uncompensated care, which is forcing hospitals to take huge deficits in healthcare budgeting.⁴⁵ Federal exclusions and restrictions, then, are cost-shifting the cost of health care from the federal government to state governments and not for profit health centers that have no control over the immigration

41. Alexia Fernández Campbell, *Trump says undocumented immigrants are an economic burden. They pay billions in taxes*, VOX (Oct. 25, 2018, 2:15 PM), available at <https://www.vox.com/2018/4/13/17229018/undocumented-immigrants-pay-taxes>.

42. Phil Galewitz, *How Undocumented Immigrants Sometimes Receive Medicaid Treatment*, PBS NEWS HOUR (Feb. 13, 2013, 11:00 AM), available at <https://www.pbs.org/newshour/health/how-undocumented-immigrants-sometimes-receive-medicaid-treatment>. Estimates aside, calculating the cost of care given to undocumented immigrants is challenging because most hospitals don't ask about citizenship.

43. Calvo, *supra* note 27, at 183; *see also* Bresa, *supra* note 20, at 1672.

44. Dana Canedy, *Hospitals Feeling Strain from Illegal Immigrants*, N.Y. TIMES (Aug. 25, 2002), available at <https://www.nytimes.com/2002/08/25/us/hospitals-feeling-strain-from-illegal-immigrants.html>.

45. Calvo, *supra* note 27, at 183.

policy controlling those costs.⁴⁶ The costs of providing federally mandated emergency healthcare fall disproportionately on states with large undocumented immigrant populations.⁴⁷ Because of EMTALA, when undocumented immigrants need emergency care, the utilization of emergency services rather than preventative medical care is more than twice the rate of the overall U.S. population (29% vs. 11%).⁴⁸

Two examples from Arizona and Florida, both with a high number of undocumented immigrants, illustrate the difficulty that hospitals are having with this cost shifting. In Arizona, the University Medical Center in Tucson wrote off more than \$3 million in costs between July 2000 and June 2001 that it incurred from treating uninsured immigrants.⁴⁹ John Duval, chief operating officer for the center, said that hospitals “are doing an enormous amount of heavy lifting with no compensation.”⁵⁰ In the case of Mr. Jiménez, an undocumented immigrant from Guatemala living in Florida with severe brain damage from a head-on car collision, Martin Memorial Medical Center incurred nearly \$900,000 in expenses for which it has no hope of being paid.⁵¹

This accumulation of money is increasingly debilitating hospitals across the nation. Danny Chun, a spokesman for the Illinois Hospital Association, states that those costs are lumped into bad debt: “For accounting purposes, if a person does not provide financial information and it turns out they can’t pay, that is accounted for as bad debt . . . Knowing if a patient who can’t pay for care is or is not an undocumented immigrant doesn’t really matter . . . because hospitals are absorbing the cost.”⁵²

The lack of political will from the federal government to address this hospital debt is astounding. Senator Max Baucus, head of the Senate Finance Committee from 2007–2014, stated that health care in the United States was “not going to cover undocumented workers, because that’s too politically explosive.”⁵³ This is an issue, though, that is not going to disappear from the nation’s docket. Current projections suggest that almost one

46. *Id.* at 177.

47. Bresa, *supra* note 20, at 1675.

48. See FAIR, *supra* note 32.

49. Canedy, *supra* note 44.

50. *Id.*

51. *Id.*

52. Rodney J. Moore, *Care costs for undocumented immigrants absorbed by hospitals*, HEALTHCARE FINANCE (Nov. 19, 2013), available at <http://www.healthcarefinancenews.com/news/care-costs-undocumented-immigrants-absorbed-hospitals>.

53. Charlene Galarneau, *Still Missing: Undocumented Immigrants in Healthcare Reform*, 22 J. HEALTHCARE FOR POOR & UNDERSERVED 422, 423 (2011).

in five Americans will be a foreign-born immigrant by 2050,⁵⁴ with many coming from undocumented parents. Federal law and practice inhibit states' ability to obtain federal financial contributions for immigrant health care through Medicaid,⁵⁵ and politicians are relieving themselves of accountability for this intertwined health/immigration reform.

Thus, it becomes the responsibility of the state to find creative ways to fund basic health coverage for undocumented immigrants. According to various scholars, "additional policies need to be developed at the local level in cases where . . . federal policy fails to help local communities address the health needs of undocumented immigrants and cover the costs of caring for them."⁵⁶ By failing to protect America's borders, then denying undocumented immigrants federal benefits, the federal government is passing off these costs on the communities with the most immigrants, giving the impression that Congress is not truly concerned about deterring illegal immigration and instead simply wished to defray the costs of illegal immigration on the federal government by passing it onto the states.⁵⁷ What federal restrictions fail to consider is the power and responsibility of state and local governments, and the institutions they fund, to protect the health, safety, and welfare of all who reside within the state's borders.⁵⁸

II. PICKING UP THE PIECES: STATES STEPPING IN

States have responded by seeking to fill in the gaps. They have done this in two ways: one, states have sought to broaden the definition of "emergency care" under Medicaid to allow coverage of more health services, and two, they have begun to fill the gaps by providing health services with state funds, which come without the restrictive strings of federal funding.⁵⁹

54. Llano, *supra* note 9, at 14.

55. Calvo, *supra* note 27, at 206.

56. Stimpson, *supra* note 30, at 1317.

57. Chesler, *supra* note 2, at 286.

58. Jeffrey T. Kullgren, *Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform*, 93 AM. J. PUB. HEALTH 1630, 1631 (2003).

59. There has been a surge in recent years of cities and local governance structures working upwards in terms of promotion of human rights frameworks. Examples include the establishment of sanctuary cities and defining a citizen as a member of a city, state, or jurisdiction, rather than a comprehensive citizen of the United States. All authorities have responsibility for the implementation of human rights, including access to health care, but in the absence of the federal government's cooperation, it is the duty of the state to fulfill the obligations that are going untouched.

A. *State Policies Working Inside the Definition of Emergency Care*

A few states have sought to work within the definition of “emergency medical condition,” to stretch federal Medicaid dollars as far as possible to provide life-sustaining coverage for undocumented immigrants. In fact, in an adoption of regulations on emergency medical conditions, the Department of Health and Human Services (HHS) issued a statement saying that they “believe the broad definition of emergency medical condition allows States to interpret and further define the services available to aliens.”⁶⁰ Granted, in this statement, HHS is speaking about legal aliens who fall within the statutory coverage, but it is an example of the federal government’s desire to place the burden of distribution of healthcare heavily on the state’s shoulders. Working within statutory language comes with limitations. It is a difficult task, and has been predominantly based on case-by-case judicial interpretation at the state level.

The Second Circuit case of *Greenery Rehabilitation Group v. Hammon*, arising out of New York, is an example of the difficulties faced by states in seeking to broaden federal statutory language beyond its plain meaning limits. The corresponding “*Greenery* test” provides that chronic debilitating conditions that result from sudden and serious injuries, were not emergency medical conditions.⁶¹ Instead, in the context of a medical condition, the term “emergency” is defined by focusing on severity, temporality and urgency.⁶² Therefore, under *Greenery*, a condition qualifies as an emergency condition only if the condition is sudden, severe and short-lived, requiring treatment to prevent further harm.⁶³ Scholar Michael McKeefery argues that the *Greenery* test continues to make it virtually impossible for service providers to predict whether undocumented patients are covered by the Medicaid reimbursement program, rendering it completely unworkable.⁶⁴ Despite the possible unworkability, there are some states courts that follow *Greenery*, and do not offer coverage for chronic conditions.⁶⁵

60. Calvo, *supra* note 27, at 185.

61. *Id.* at 187.

62. *Id.*

63. Calvo, *supra* note 27, at 187.

64. McKeefery, *supra* note 16, at 392.

65. *Id.* at 405–06; *see also* Quiceno v. Dep’t of Soc. Servs., 728 A.2d 553, 554–56 (Conn. Super. Ct. 1999) (applying the *Greenery* standard and concluding that chronic conditions cannot be covered under the Medicaid statute); *see also* Diaz v. Div. of Soc. Servs., 628 S.E.2d 1, 5 (N.C. 2006) (applying the *Greenery* test and holding that acute lymphocytic leukemia does not constitute an “emergency medical condition” under the statute.)

However, other states have stretched the meaning of emergency medical condition to include chronic condition care. In *Scottsdale Healthcare, Inc.*, the Supreme Court of Arizona rebuked the *Greenery* rule, stating that “no bright line can be drawn as to what constitutes an emergency medical condition because ‘the unique combination of physical conditions and the patient’s response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions. ““⁶⁶ The court held that the maintenance of head and neck trauma constituted an emergency medical condition.⁶⁷ In North Carolina, the Court of Appeals held that lymphoma management also falls within the limits of an emergency medical condition.⁶⁸ Additionally, the Supreme Court of Connecticut extended management of symptoms deriving from leukemia to fall within the emergency medical condition framework.⁶⁹

New York included dialysis and chemotherapy treatment in its emergency medical condition coverage under Medicaid.⁷⁰ After an audit of New York State’s Medicaid claims, federal health officials told New York State that they would no longer help cover the cost of chemotherapy for undocumented immigrants with cancer because it does not qualify under an emergency Medicaid program.⁷¹ Governor Eliot Spitzer responded that New York would cover all the costs no matter what the federal government does.⁷² Stating that the federal government is “. . . picking on the most vulnerable populations—here immigrants who need chemotherapy, alternately children who are without health insurance” Spitzer challenged the government saying, “It is wrong. It’s a bad policy.”⁷³ Although challenges to the federal government restriction of health care is limited to case-by-

66. *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys.* Admin., 75 P.3d 91, 95 (Ariz. 2003).

67. *Id.*

68. *See Luna v. Div. of Soc. Servs.*, 589 S.E.2d 917, 922–25 (N.C. Ct. App. 2004).

69. *See Szewczyk v. Dep’t. of Soc. Servs.*, 881 A.2d 259, 267–74 (Conn. 2005).

70. N.Y. DEP’T OF HEALTH, OTHER ELIGIBILITY REQUIREMENTS—CITIZENSHIP AND IMMIGRATION STATUS—UNDOCUMENTED/ILLEGAL ALIENS TREATMENT OF AN EMERGENCY MEDICAL CONDITION 458 (Jun. 2010), available at https://www.health.ny.gov/health_care/medicaid/reference/mrg/june2010/page457-460.pdf.

71. Sarah Kershaw, *New York, Faulting U.S., Says It Will Pay for Cancer Care for Illegal Immigrants*, N.Y. TIMES (Sept. 26, 2007), available at <https://www.nytimes.com/2007/09/26/nyregion/26spitzer.html>.

72. *Id.*

73. *Id.*

case state basis, the examples above show states' inclination to fill the healthcare gaps created by the federal framework.

B. *State Policies Working Outside the Definition of Emergency Care*

Given the limitations of working inside federal definitions, some states have sought to increase accessibility to preventive and primary care by paying for such services directly out of state funds. Indeed, by 2004, 23 states used state funds to extend coverage to some or all immigrants eligible for Medicaid.⁷⁴ The focus of many such states is ensuring that undocumented children and pregnant women are cared for first and foremost. New York, Illinois, California, and Washington all use state tax dollars to cover children.⁷⁵ In 2015, California passed the Health for All Kids Act, offering insurance coverage to all undocumented immigrant children.⁷⁶ California has truly been a model for provision of basic care to undocumented immigrants. While most children and pregnant women are covered under state laws, other adults fall to the wayside.

In addition to the Health for All Kids Act, California proposed two similarly situated policies concerning other undocumented adults in the following years. In June 2016, the California legislature enacted a law which allowed undocumented-immigrant adults to participate in the state exchange and purchase private health insurance.⁷⁷ An additional proposed policy, which unfortunately never made it out of committee, but signals a state-based political will to deal with this issue, would have created a program similar to Medicaid for undocumented-immigrant adults.⁷⁸ All three actions provide insight into the current opportunities and challenges for state-level innovation to expand health coverage.⁷⁹ Texas has also been known to experiment with state funding. In one Texas community, doctors included all residents, both legal and undocumented, in a preventive medical program designed to improve public health and lower emergency room costs. The Attorney General filed suit, reasoning that the program violated federal law because it did not restrict undocumented immigrants.⁸⁰ Doctors argued that restrictions undermine the public health objectives of the program.⁸¹

74. Llano, *supra* note 9, at 15. This was due to cuts made by PRWORA.

75. Bresa, *supra* note 20, at 1670–71.

76. N.Y. DEP'T OF HEALTH, *supra* note 70, at 458.

77. Rachel Fabi, & Brendan Saloner, *Covering Undocumented Immigrants—State Innovation in California*, 375 NEW ENG. J. MED. 1913 (2016).

78. *Id.*

79. *Id.*

80. Calvo, *supra* note 27, at 207.

81. *Id.*

Despite the impetus of various state governments to legislatively counteract the federal government and recognize a universal right to health care, they are still overpowered with federal barriers. As mentioned above, states are allowed to pass laws explicitly giving undocumented immigrants access to health care, but that comes with a caveat: under no circumstances can they use federal Medicaid funds for that treatment.⁸² Within the current Medicaid system, states contend that the federal government should pay a share of healthcare costs for non-citizens, and should not impede state and local public health objectives by forcing states and localities to solely bare the expense of providing for non-citizens. That is an ideal which our current political climate is not equipped to realize. The reality is that funding undocumented immigrants is a burden of the state at this point. There are many different routes a state could take, as exemplified by New York's stretching of the emergency Medicaid statute, or California's total establishment of state laws giving access to immigrants. This Article next proposes a way through this dilemma.

III. FILLING THE GAPS: EXPANSION OF FQHCs

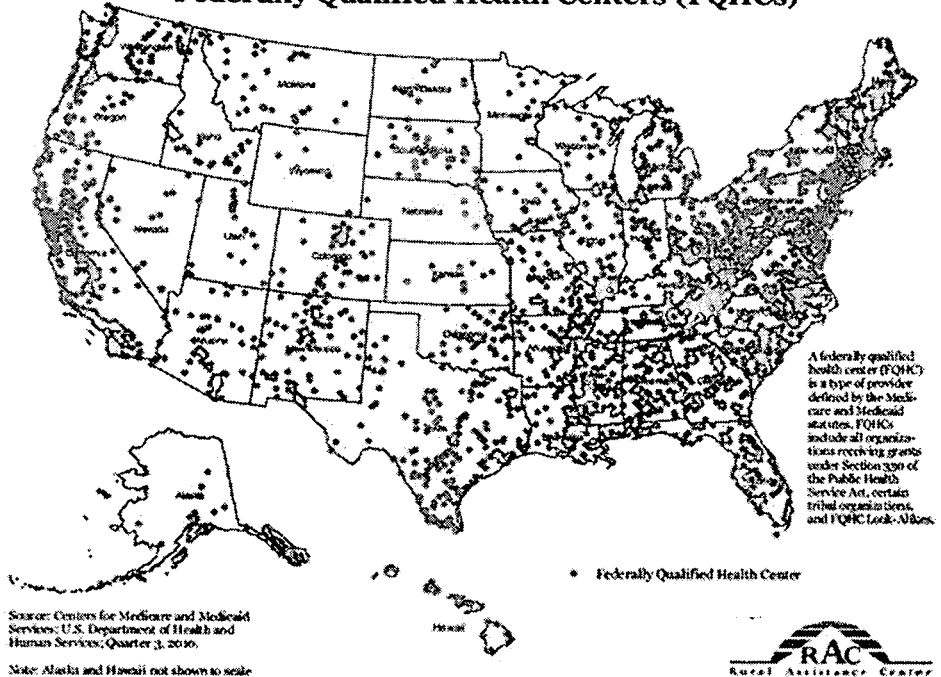
How, then, can the above dilemma be resolved? This Article proposes a way through: federally qualified health care centers, which are community-based organizations that provide comprehensive primary and preventative care regardless of status. Originally founded to reduce hospital loads, FQHCs have taken on the mission of targeting communities with great need, bringing primary healthcare to underserved populations.⁸³ This Article proposes that using state funds to encourage establishment of FQHCs will bring states further in line with the goal of fostering the right to health regardless of immigration status, specifically increasing basic, but quality coverage for undocumented immigrants.

82. Chesler, *supra* note 2, at 257.

83. The Primary Health Network, *What is an FQHC?*, <https://primary-health.net/FQHC.aspx> (last visited Mar. 1, 2018).

FIGURE 1. Location of FQHCs, 2010

Federally Qualified Health Centers (FQHCs)



Since the passage of the ACA, federally qualified health centers (FQHCs) have taken the lead as primary healthcare providers in the U.S.⁸⁴ While the establishment of FQHCs is not new, establishment of new FQHCs may bridge the politically created gap in basic primary care for undocumented immigrants. Medicaid is supposed to be the safety net for these undocumented immigrants, but undocumented immigrants are being denied even that, making FQHCs the “safety net of the safety net.”⁸⁵ Because FQHCs run on a myriad of different funding mechanisms, states are allowed to use funds outside of Medicaid to serve undocumented immigrants so as not to be in violation of Medicaid statute while still receiving incentives such as heightened Medicaid reimbursements for those who do fall within the bounds of the statute.

84. Kathy Poppitt & Sheryl Tatar Dacso, *Federally Qualified Health Centers: A Healthcare Delivery Model for a Newly Reformed Health System*, 23 A.B.A. HEALTH L. SEC. 1 (2010).

85. Bresa, *supra* note 20, at 1674; Stimpson et. al., *supra* note 30, at 1313.

“Successful healthcare reform is tied to lowering barriers, enhancing primary care, and maintaining a strong network of safety net providers.”⁸⁶ Figure 1, above, provides a diagram of FQHC locations in 2010.⁸⁷ Though there are a few densely located hot beds of FQHCs, the gray space, especially shocking in places such as southeastern California and Texas, as well as Illinois (all which are in the top eight states with the highest %age of undocumented immigrants), shows that there are hundreds of thousands of healthcare needs going unmet. While it would be naïve not to acknowledge that money is not free flowing in many states’ budgets, the provision of basic healthcare across the states’ population is well worth the money spent on cost-efficient FQHCs. The purposes, funding mechanisms, and outcomes of FQHCs are the top three reasons why this Article proposes the centers as the best medium-term solution to the problem of undocumented immigrants’ lack of health care accessibility.

A. Purpose

FQHCs are considered “safety net providers.”⁸⁸ The main purpose of FQHCs is to enhance access for underserved populations to primary care services.⁸⁹ While there is no typical model for an FQHC, what they all have in common is the mission of providing high quality, and additionally, culturally competent,⁹⁰ primary and preventive health services to underserved populations. The qualifications and requirements for applications to become federally qualified are governed through Section 330 of the Public Health Service Act.⁹¹ The Public Health Service act requires that all FQHCs provide “primary, preventive, enabling health services,”⁹² which includes care by physicians, nurse practitioners, physician’s assistants, psychologists, social workers, and in some cases, home health services.⁹³ Going beyond traditional notions of private medical care, FQHCs are also involved in the promotion of access to healthcare. This includes translation services, health

86. James Hennessy, *FQHCs and Health Reform: Up to the Task?*, 9 Nw. J. L. & Soc. Pol’y 122, 136 (2013).

87. Michael K. Gusmano, *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care*, THE HASTINGS CENTER (Mar. 15, 2012), available at <http://undocumentedpatients.org/issuebrief/health-policy-and-access-to-care/#footnote-10>.

88. Poppitt & Dacso, *supra* note 84, at 1.

89. *Id.*

90. Sarah Noonan Davis, *Community Health Centers: On the Frontlines of Reform*, DEL. LAW., Spring 2013, at 12.

91. 42 U.S.C. § 254b (2012).

92. Hennessy, *supra* note 86, at 123.

93. Poppitt & Dacso, *supra* note 84, at 3.

education and family planning, and possible transportation to and from medical appointments.⁹⁴

Often interchangeable with community health centers, FQHCs are health centers, but can also include public housing centers, Indian Health Services, outpatient health programs, and health programs that serve migrants and the homeless.⁹⁵ The differentiation lies in the fact that an “FQHC” is not a certain type of health center, but a designation. Any health related center that falls within the stringent guidelines can become federally qualified. To be designated as federally qualified, the health center must meet the following criteria: (1) they must be in an area that is experiencing a shortage in health professionals; (2) they must provide services without regard to patient’s insurance status (which already makes FQHCs the first choice among undocumented immigrants, who, as this Article has explored, fall victim to high rates of being uninsured); (3) they must use a sliding fee discount payment system based on each uninsured patient’s income and ability to pay; and (4) they must operate as a not for profit entity.⁹⁶ As a corollary to the first criteria, in order to gain the status of a federally qualified health center, the center must receive a designation of a “Medically Underserved Area” (MUA) or as serving “Medically Underserved Populations” (MUP).⁹⁷ MUA and MUP designations are based on four factors: (1) the %age of a population with incomes below the Federal Poverty Line, or FPL; (2) infant mortality rates; (3) the %age of a population 65 years of age or older; and (4) as the FQHC criteria lists, the number of primary care physicians per 1000 people.⁹⁸

Most important to the significance of FQHCs for undocumented immigrants is the second and third criteria of federal qualification: the necessity to provide healthcare whether someone is eligible for private insurance, public insurance, or are uninsured, and the offering of a sliding-scale discount fee.⁹⁹ Because undocumented immigrants do not even qualify for the expansion of Medicaid under the ACA, they will join the significant number of individuals that are uninsured, relying on FQHCs as the only option for care.¹⁰⁰ In 2008, FQHCs served 834,000 migrant and seasonal workers and their families,¹⁰¹ a portion of whom were bound to be undocumented.

94. *Id.*; Hennessy, *supra* note 86, 123–24.

95. Poppitt & Dacso, *supra* note 84, at 3.

96. *Id.*

97. Hennessy, *supra* note 86, at 133.

98. *Id.*

99. Poppitt & Dacso, *supra* note 84, at 8.

100. Davis, *supra* note 90, at 14.

101. Poppitt & Dacso, *supra* note 84, at 4.

B. Funding

A trademark of FQHCs is that they are a cost-effective way to treat underserved populations.¹⁰² As the most widely-used source of primary care in medically underserved areas—in 2013, the number of uninsured patients at FQHCs reached upwards of 7.4 million¹⁰³—FQHCs must be able to treat a large capacity of underserved patients with high quality care. Due to the volume of patients and number of services that are offered, FQHCs would be nothing without their myriad sources of funding. As aforementioned, if a health center qualifies under Section 330 of the Public Health Service Act, they receive federal funding, which makes them “federally qualified.”¹⁰⁴

330 funds alone, though, do not fully support the cost of care for the totality of FQHCs patients, so FQHCs rely on revenues from several other sources: some within the federal government, and some outside of it. For insured patients, federally qualified status provides for enhanced Medicaid reimbursement, resulting in higher payments from the government for treatment of Medicaid patients.¹⁰⁵ As previously discussed in this Article, these government insurance reimbursements are in no way to be paid out for treatment to undocumented immigrants. In order to stay true to the mission of providing care to those most underserved, FQHCs also use funding from the following sources: state and local government grants, charitable foundation grants, donations from supporters, fundraising efforts and out of pocket payments by patients.¹⁰⁶

It is precisely because of these supplemental forms of funding that FQHCs are the best way for states and localities to provide care to undocumented immigrants. First, FQHCs are still able to get enhanced Medicaid reimbursements and federal funding, because they do treat insured patients. Because they do not fully rely on federal funding, though, FQHCs are able to skirt federal Medicaid policy for patients that are uninsured, including undocumented immigrants. Through state grants, community grants, and fundraising efforts, local towns, cities, and upwards to states can demonstrate that while the federal government may not honor a right to even the most basic healthcare, they do. Not only is the ability to apply funding

102. Hennessy, *supra* note 86, at 125.

103. *Id.*

104. Poppitt & Dacso, *supra* note 84, at 3. Note that there are health centers that are known as FQHC look-alikes; they retain the same mission and practice of FQHCs, without the federal funding.

105. Davis, *supra* note 90, 13.

106. *Id.*; Bresa, *supra* note 20, at 1679; Deborah A. Boehm, *The Safety Net of the Safety Net: How Federally Qualified Health Centers “Subsidize” Medicaid Managed Care*, 19 *MED. ANTHROPOLOGY Q.* 47, 59 (2005).

outside the federal context, but the sliding scale fee based on income and ability to pay will allow undocumented patients to pay out of pocket for primary care services at a price that they can afford. This provides extra income to the FQHCs, and it effectively drops the immigration debate from the provision of basic healthcare by allowing undocumented immigrants to pay for their services based on ability like any other patient. This way, undocumented immigrants would not need to worry about whether they qualify for Medicaid coverage, because they can make small payments without it, and still receive care.

The establishment of newer FQHCs and the expansion of capacity of current FQHCs are needed for treatment to become a reality for undocumented immigrants; there are just not enough.¹⁰⁷ Nationwide, there are only 1200 FQHCs currently existing, and they alone service over 20 million patients.¹⁰⁸ While larger urban settings like Boston or Miami may have over 100 FQHCs, more rural settings, places that could exhibit a far higher poverty rate and lack of primary care physicians than their urban counterparts, may only have a handful.¹⁰⁹ In addition, there are counties that don't have access to FQHCs simply because they have been classified as an affluent area, and did not receive that MUA or MUP designation. Just because a majority of a certain county may be higher income, it does not automatically mean that no part of the population needs FQHCs.¹¹⁰

Adding to the issue of sheer lack of numbers, since 2011, there have been significant federal budget cuts to the health centers program, creating increased hardships for states and localities to keep FQHCs up and running.¹¹¹ Under the Trump administration, uncertainty continues to remain around continued federal grant funding for FQHCs.¹¹² FQHCs, though, provide a quarter of all primary care visits for the nation's low income population, and are widely viewed as part of the solution in reforming our nation's healthcare system because of their extremely beneficial outcomes in terms of service provision and cost reduction.¹¹³

C. *Outcomes*

Not only do FQHCs continually provide quality and much-needed care to underserved communities, they do it in a way that saves costs for Ameri-

107. Sommers, *supra* note 8, at 594.

108. Hennessy, *supra* note 86, at 130.

109. *Id.* at 132.

110. *Id.*

111. Davis, *supra* note 90, at 15.

112. Kaiser Family Foundation, *supra* note 4, at 4.

113. Davis, *supra* note 90, at 13, 15.

can taxpayers, which was highlighted as a main concern in extending primary care services to undocumented immigrants. In short, FQHCs are cheaper, costing about a dollar less per patient per day than all other physician settings.¹¹⁴ FQHCs reduce the rate of unavoidable hospitalizations and emergency room visits, which in turn minimizes the need for expensive specialty care.¹¹⁵

Improving access to primary care is directly related to lesser utilization of emergency room services. Medical care is markedly less costly when patients are treated at an earlier stage of an illness or condition in an outpatient setting.¹¹⁶ Under current federal regulations of emergency care, undocumented immigrants are getting the most expensive treatment, and taxpayers are paying for it. If avoidable visits to the emergency room were directed towards FQHCs, anywhere between additional \$1.6 and \$8 billion in national health care costs would be saved annually.¹¹⁷ Counties with FQHCs have 25% fewer emergency room visits for potentially preventable conditions than counties without.¹¹⁸ Undocumented immigrants already have a lower utilization rate of emergency rooms; for example, counties with higher populations of undocumented immigrants, such as California's Orange County and Florida's Miami-Dade County have lower rates of emergency room use than counties with lower populations of undocumented immigrants. In fact, counties with the highest emergency room use do not even correlate to a large number of immigrant residents, undocumented or otherwise.¹¹⁹ Because the utilization of emergency rooms is already low, providing preventive care through FQHCs will further diminish emergency room usage, saving money and giving undocumented immigrants access to the healthcare that they need.

Finally, the mission and practice of FQHCs stand starkly opposed to the current national political framework. As community centers, it is understood that the more instances that preventable diseases go undiagnosed, the more communities are endangered. Therefore, with their community based rights approach, no matter who is getting diagnosed, the most important goal is treatment and prevention of danger to the community. As for other barriers to health care deriving from the federal framework, such as the chilling effect on even seeking care to begin with, FQHCs are community

114. Hennessy, *supra* note 86, at 125.

115. *Id.* at 124; Poppitt & Dacso, *supra* note 84, at 1.

116. Calvo, *supra* note 27, at 191.

117. Hennessy, *supra* note 86, at 124.

118. Davis, *supra* note 90, at 13.

119. Samuel Wolbert, *Universal Healthcare and Access for Undocumented Immigrants*, 5 *PRIT. J. ENVTL. & PUB. HEALTH L.* 61, 68 (2011).

based and culturally competent settings where undocumented immigrants can feel accepted, cared for, and comfortable enough to seek potentially life-saving medical care. Because FQHCs provide individualized, comprehensive care that is culturally sensitive, they should be on the front lines of changing the national framework of healthcare from exclusionary to rights-based, exemplifying that preventive and basic care for undocumented immigrants contributes to a healthier general public.

IV: CONCLUSION

This Article addresses the exclusion of undocumented immigrants from basic, preventive healthcare and proposes a way forward within the political and statutory framework that currently exists. This way forward is the expansion of existing and establishment of new federally qualified health centers (FQHCs), which are providing basic preventive care to underserved communities in the U.S. While a significant amount of literature is dedicated to concretely observing what healthcare procedures and services an undocumented immigrant is granted, what services should be granted, and why or why not those services should be granted, this Article goes one step further, not only acknowledging that basic healthcare services should be granted, but providing a way in which to grant them. FQHCs have been a kind of hidden gem in the provision of healthcare; there is literature about what they are, how they run, and who they serve (underserved communities), but the literature has very rarely recognizes them as the vessel that states should be using to promote healthcare services for undocumented immigrants.

The establishment and expansion of FQHCs is a politically workable solution within the short and medium-term. While this Article is not arguing for a change in the federal structure, it acknowledges the necessity for efforts at the national level to create a new framework for discussing health care access as a right for all people within the borders of the United States. While FQHCs allow states to use the current structure to meet the needs of those within our borders that are not receiving healthcare over the medium-term, the United States needs to see a genuine federal commitment to ensure healthcare access for all. The current administration controls how rights-based discussions are framed, and the current administration wants to limit healthcare, creating a harshly exclusionary framework around which it builds its policies. If the federal structure will not change, states and localities will have to operate within it. Until the United States is ready to change the framework around health care as a right for all, states and localities can engage in taking up health care as a right for their own residents, and FQHCs are an already established way in which states have been using

funding to treat mostly those without insurance, or those with Medicaid. As undocumented immigrants are a very clearly underserved population, the use of FQHCs as the establishments through which undocumented immigrants receive basic healthcare is an expansion on an idea that is already present. Of course, there are risks involved to the approach proposed in this Article, the most glaring of which is the seeming absolution of the federal government of their duties to the health and safety of the nation. Until the national political moment aligns with a rights-based approach to the provision of healthcare, though, the expansion and establishment of FQHCs is the most practical and forward looking solution to the inadequacy of healthcare access.

The economic, moral, philosophical, and social issues concerning undocumented immigration range above and beyond the narrow issue which this Article considers. There is a simple fact which this Article hinges on: ignoring undocumented immigrants is not a realistic federal policy, and neither is outright exclusion. There are undocumented immigrants living within the borders of the United States. These undocumented immigrants are human beings with a set of inherent internationally-recognized human rights. While it is not a United States sanctioned constitutional right, health care is an internationally recognized human right. Legal limits do not necessarily represent the best policy, and it is certainly the case with healthcare; while the legal limitations of our current political framework is exclusionary towards undocumented immigrants, a policy of inclusion has farther reaching positive health outcomes for every person residing in the United States.¹²⁰

120. Glen, *supra* note 8, at 218.

