

ANNALS OF HEALTH LAW
Advance Directive

VOLUME 21 FALL 2011 PAGES 109-118

**Waiting Five Years for Healthcare: How Restricting
Immigrants' Access to Medicaid Harms All**

Karla Guerrero

I. INTRODUCTION

Healthcare has historically been afforded to both citizens and non-citizens alike.¹ However, the dwindling economic resources of the federal and state governments, coupled with the influx of immigration in the United States (U.S.), has led to larger numbers of uninsured immigrant populations.² The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) curtailed immigrant eligibility for most federal benefits, such as Medicaid.³ In order to justify the limitations imposed on immigrants, Congress reasoned that the federal government has a duty to regulate immigration so that immigrants rely on their own capabilities instead of public benefits.⁴ Because states receive federal

· Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Ms. Guerrero is a staff member of *Annals of Health Law*.

1. See KIMBERLEY CHIN ET AL., HOW HAVE STATES RESPONDED TO THE ELIGIBILITY RESTRICTIONS ON LEGAL IMMIGRANTS IN MEDICAID AND SCHIP? 1 (2002), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13988>.

2. See KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS 2 (2006) [hereinafter MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS], available at <http://www.kff.org/medicaid/upload/7492.pdf>.

3. *Id.* at 1.

4. See 8 U.S.C. § 1601(2)(A) (stating that the PRWORA's immigrant restrictions are

funding for programs like Medicaid, the PRWORA extended these immigrant restrictions to individual states.⁵ Individual states can extend Medicaid coverage to most legal immigrants if they entered the U.S. before the passage of the PRWORA.⁶ However, if they entered the U.S. after the passage of the PRWORA, states are not permitted to use federal money to provide Medicaid coverage to these immigrants for their first five years in the country (the five-year bar).⁷ In light of these restrictions, several states have undertaken initiatives to provide state-funded replacement programs to some or all legal immigrants during the Medicaid ineligibility period.⁸

First, this article will cover the basics of Medicaid, including the eligibility requirements that have been reformed to limit immigrants' access to coverage. The second part of this article will discuss how some states have chosen to reject the five-year bar and permit eligible legal immigrants to immediately apply for Medicaid or some alternative healthcare program, given that they meet certain other eligibility requirements.⁹ Lastly, this article will discuss the impact the five-year bar has on states, legal immigrants, the healthcare system, and healthcare funding.

II. AN OVERVIEW OF MEDICAID

A. Medicaid for Citizens

Medicaid was enacted by Congress under Title XIX of the Social Security Act of 1965.¹⁰ The Medicaid program was intended as a partnership between federal and state governments that granted states the option to provide a more comprehensive healthcare program for low-

important for fostering self-sufficiency, and that immigrants “within the Nation’s borders [cannot] depend on public resources to meet their needs”); *see also id.* § 1601(2)(B) (stating that a priority of the PRWORA is to ensure that “the availability of public benefits not constitute an incentive for immigration to the United States”).

5. *See* 8 U.S.C. § 1621(a).

6. CHIN ET AL., *supra* note 1.

7. *Id.*

8. *Id.*

9. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 1.

10. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, REPORT TO THE CONGRESS ON

income individuals who were unable to afford the costs of needed medical services.¹¹ Today, Medicaid is a significant component of our healthcare system, covering sixty-eight million people.¹² Income is the predominant factor in determining Medicaid eligibility; Medicaid has provided coverage to “low-income children, their parents, pregnant women, individuals with disabilities, and individuals age 65 and older.”¹³ Under the program, the federal government covers between fifty percent and seventy-six percent of the total state costs for Medicaid,¹⁴ thereby incentivizing the states to comply with federal guidelines and provide healthcare coverage to income-eligible citizens.¹⁵

The federal government also mandates that each state’s Medicaid program cover certain benefits in order to receive matching federal funding for the program.¹⁶ If states do not comply with the federally mandated provisions and services set forth under Medicaid, the federal government will deny funding to the state.¹⁷ However, states may supplement the federally mandated coverage by relaxing eligibility requirements or by extending coverage to additional types of medical services as their budgets see fit.¹⁸ As a result, the Medicaid program does not provide consistent services across the country.¹⁹ Hence, the range and quality of services that an individual receives, as well as his or her eligibility status, depends principally on his or her state of residence.²⁰

MEDICAID AND CHIP 27 (2011).

11. *Id.*

12. *Id.*

13. *Id.*

14. *Extra Federal Medicaid Support Ends. A Temporary Increase During 2009-11 in Federal Medicaid Funding to the States Has Expired. A Crunch Looms*, HEALTH POL’Y BRIEF 1 (2011), <http://www.rwjf.org/files/research/65908.pdf>.

15. See MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 10, at 37-38.

16. 42 U.S.C. § 1396d(a) (enumerating mandatory benefits that states must provide to their residents).

17. See 42 U.S.C. § 1396c.

18. *Id.* at § 1396d(a) (permitting states to provide optional services beyond the minimum federal requirements).

19. See Jon Donenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance With Federal Availability Requirements*, 117 YALE L.J. 1498, 1504-05 (2008).

20. See David M. Herszenhorn, *Medicaid Expansion Poses Test for Some Democrats*,

B. Separate Medicaid Provisions for Immigrants

Title IV of the PRWORA severely reduced immigrants' eligibility for Medicaid.²¹ Under the PRWORA, qualified immigrants are ineligible to receive Medicaid assistance for their first five years of their legal resident status if they entered the U.S. on or after August 22, 1996.²² Prior to the passage of the PRWORA, legal immigrants were able to receive Medicaid benefits using the same eligibility criteria as citizens.²³ Congress justified the change in treatment in §1601 of the PRWORA by explaining that "aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates," and that "[c]urrent eligibility rules . . . have proved wholly incapable of assuring that individual aliens not burden the public benefits system."²⁴ For purposes of the PRWORA, qualified citizens includes lawful permanent residents, refugees, asylees, persons granted withholding of deportation, persons granted conditional entry, and immigrants who have been battered or subject to extreme cruelty in the U.S. and who otherwise satisfy certain federal requirements, or the parents of such immigrants.²⁵ However, some legal immigrants, such as refugees, other humanitarian immigrants, and active duty members or veterans, are exempt from the five-year bar.²⁶ Additionally, the Deficient Reduction Act of 2005 requires all individuals applying for Medicaid to show proof of citizenship in order to determine Medicaid eligibility.²⁷

Additionally, the PRWORA allowed states to limit the eligibility of legal

N.Y. TIMES PRESCRIPTIONS BLOG (Sept. 14, 2009, 12:27 PM) <http://prescriptions.blogs.nytimes.com/> (search "Medicaid Expansion Poses Test for Some Democrats"; then follow "Medicaid Expansion Poses Test for Some Democrats" hyperlink) (showing that eligibility criteria for Medicaid services vary significantly from state to state. In Alabama, for example, the maximum qualifying household income is 12% of the federal poverty level, whereas in Minnesota, it is 275% of the federal poverty level).

21. See 8 U.S.C. §§ 1601, 1611-1613, 1621-1622, 1641 (2006).

22. See 8 U.S.C. § 1613(a).

23. CHIN ET AL., *supra* note 1.

24. 8 U.S.C. § 1601(3), (4).

25. CHIN ET AL., *supra* note 1, at 4-5.

26. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 1.

immigrants to solely state-funded benefits programs.²⁸ Consequently, the PRWORA placed the burden of deciding immigrant eligibility for state-funded benefits on state legislatures.²⁹ In the years immediately following the PRWORA's enactment, states promulgated regulations for their Medicaid programs that conformed to the guidelines of the PRWORA.³⁰ Some states enacted affirmative legislation that created supplemental health insurance programs for certain categories of immigrants, although in some cases the scope of services available to eligible immigrants were made less inclusive than the pre-PRWORA federal Medicaid provisions.³¹ Still, in the midst of any economic instability, state-subsidized programs for legal immigrants have been cut from state budgets.³²

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).³³ The PPACA expands Medicaid eligibility by requiring states to provide Medicaid to any individual or family whose annual income is at or below 133% of the federal poverty level.³⁴ However, Congress declined to repeal many of the immigrant restrictions enacted in the PRWORA, such as the five-year bar for legal immigrants.³⁵ Therefore, state-funded healthcare programs

27. *Id.* at 2.

28. 8 U.S.C. § 1622(a) (“... a State is authorized to determine the eligibility for any State public benefits of an alien who is a qualified alien. . .”).

29. *See id.* § 1622(a).

30. *See* SHAWN FREMSTAD & LAURA COX, KAISER COMM'N ON MEDICAID & THE UNINSURED, COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS' ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 18 (2004), *available at* <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>.

31. *See id.* at ii, 18. (Massachusetts, Rhode Island, Florida, and Washington, D.C. cover all income-eligible children regardless of immigration status; thirteen states provide prenatal care regardless of immigration status.); *Id.* at 17.

32. *See id.* at 18.

33. *See* KAISER COMM'N ON HEALTHCARE & THE UNINSURED, FOCUS ON HEALTH REFORM: SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2010), *available at* <http://www.kff.org/healthreform/upload/8023-R.pdf>.

34. *Id.*

35. *See* NAT'L IMMIGRATION LAW CTR., HOW ARE IMMIGRANTS INCLUDED IN HEALTHCARE REFORM? 1 (2010), *available at* <http://www.nilc.org/immspbs/health>

continue to provide the only source of health insurance for legal immigrants.³⁶

III. UNDERTAKING TO EXPAND MEDICAID TO LEGAL IMMIGRANTS

Although legislation has made it increasingly difficult for legal immigrants to qualify for Medicaid benefits, non-citizens do not remain entirely exempt from ever obtaining coverage.³⁷ States may enact measures to expand coverage of Medicaid through Medicaid-like replacement programs for uninsured immigrants without a five-year waiting period, if the state can finance the program entirely on state funds.³⁸ For example, “[t]he Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides states with an opportunity to provide affordable health coverage with federal funding to ‘lawfully residing’ immigrant children and pregnant women through the Medicaid and Children’s Health Insurance Program (CHIP).”³⁹ This regulation allows individual states the flexibility to provide coverage to pregnant women, children, or both.⁴⁰ States may also choose to extend coverage to Medicaid and/or CHIP if the individuals in question are legally residing immigrants of that state.⁴¹ “CHIPRA officially lifts [the] bar for children and pregnant women, although all other legal immigrants are still ineligible for Medicaid and CHIP during their first five years in the country.”⁴² This new option only affects legally residing

/immigrant-inclusion-in-HR3590-2010-04-19.pdf (noting that legal immigrants may purchase insurance through exchanges, but remain ineligible for Medicaid under previous restrictions).

36. *See id.*

37. KAISER COMM’N ON MEDICAID & THE UNINSURED, SUMMARY: FIVE BASIC FACTS ON IMMIGRANTS AND THEIR HEALTH CARE 6 (2008) [hereinafter FIVE BASIC FACTS], available at <http://www.kff.org/medicaid/upload/7761.pdf>.

38. CHIN ET AL., *supra* note 1, at 6.

39. NAT’L IMMIGRATION LAW CTR., FACTS ABOUT FEDERAL FUNDING FOR STATES TO PROVIDE HEALTH COVERAGE TO IMMIGRANT CHILDREN AND PREGNANT WOMEN 1 (2010), available at <http://www.nilc.org/immspb/cdev/ICHIA/ICHIA-facts-2010-08-06.pdf>.

40. JENNIFER SULLIVAN, EXPANDING COVERAGE FOR RECENT IMMIGRANTS: CHIPRA GIVES STATES NEW OPTIONS 1 (2010), available at <http://www.familiesusa.org/assets/pdfs/chipra/Immigrant-Coverage.pdf>.

41. *Id.*

42. *Id.*

immigrants, while illegally residing immigrants are still ineligible from ever enrolling in Medicaid.⁴³ States that choose to take advantage of CHIPRA receive federal matching funds for the services they provide to pregnant women and children.⁴⁴

In total, forty-two states receive federal funding to provide coverage to legal immigrants who entered this country on or after August 22, 1996, after the immigrant has been in the U.S. for a minimum of five years.⁴⁵ Twenty-two states have elected to offer a state-funded program for immigrants during the five-year bar.⁴⁶ In addition to the extension of Medicaid services offered to legal immigrant pregnant women and children, legal and illegal immigrants are eligible to receive Emergency Medicaid as long as they meet certain eligibility requirements.⁴⁷ Emergency Medicaid covers the costs of emergency medical treatment through the Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, which requires hospitals to treat individuals facing medical emergencies regardless of their ability to pay, their immigration status, or whether the hospital could receive reimbursement for services that went beyond simply stabilizing the patient's medical emergency.⁴⁸

IV. LIMITING LEGAL IMMIGRANTS' ACCESS TO MEDICAID IS DETRIMENTAL

The five-year bar affects immigrants' at the most inopportune time.⁴⁹ Upon arriving into the U.S., immigrants are statistically the least likely to have employer provided coverage⁵⁰ and tend to earn less than citizens or

43. *Id.*

44. *Id.* at 4.

45. CHIN ET AL., *supra* note 1, at 9.

46. *Id.*

47. MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS, *supra* note 2, at 2.

48. See 42 U.S.C. § 1395dd(a), (b)(1) (2006); see also FIVE BASIC FACTS, *supra* note 37.

49. See NAT'L IMMIGRATION LAW CTR., IMPROVING IMMIGRANT ACCESS TO AFFORDABLE HEALTH COVERAGE: ANALYSIS OF THE MASSACHUSETTS HEALTH CARE SYSTEM AS A MODEL 2 (2009) [hereinafter IMPROVING IMMIGRANT ACCESS], available at <http://www.nilc.org/immspbs/health/MA-health-reform-2009-05-26.pdf>.

50. *Id.*

immigrants that have been in the country for longer periods of time.⁵¹ Only California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, Pennsylvania, Rhode Island, Virginia, and Washington allow all legal immigrants access to Medicaid benefits before the five-year bar.⁵² However, as previously stated, some states eliminate the five-year bar of legal immigrants towards pregnant women and children under CHIPRA.⁵³ Both immigrants and natural born citizens suffer when state-funded health care programs restrict access to legal immigrants from an economic as well as a social policy perspective.

Barring healthcare coverage to residents that are permanently residing in the U.S. shifts expenditures from cost-controlled preventive care to expensive emergency room treatment.⁵⁴ The EMTALA mandates that all hospitals treat patients with an emergency medical condition, regardless of their ability to pay or citizenship status.⁵⁵ Therefore, legal immigrants without access to preventive care, such as Medicaid, will still be treated at emergency rooms but at a significantly higher cost.⁵⁶ As a result, immigrant restrictions in state healthcare programs, which have been enacted to reduce costs, actually increase the costs absorbed by states and hospitals in treating legal immigrants.⁵⁷ Treating illnesses with preventive care reduces future costs and are the most economical way to maximize better health.⁵⁸ According to the Executive Director of the Kaiser Family

51. See FIVE BASIC FACTS, *supra* note 37, at 4.

52. USLEGAL, INC., STATE-BY-STATE GUIDE TO GOVERNMENT BENEFITS FOR IMMIGRANTS (2010), <http://immigration.uslegal.com/eligibility/state-by-state-guide-to-government-benefits-for-immigrants/>.

53. SULLIVAN, *supra* note 40, at 1.

54. NAT'L IMMIGRATION LAW CTR., COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS: A SOUND STRATEGY FOR FISCAL AND PUBLIC HEALTH 1 (2004) [hereinafter COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS], http://www.nilc.org/immspbs/health/Issue_Briefs/comphealthcare_0404.pdf.

55. See 42 U.S.C. § 1395dd(a) (2006).

56. See COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54 (arguing that denying immigrants preventive care and relying on emergency room treatment is the least cost-effective strategy).

57. See *id.*

58. IMMIGRATION POLICY CTR., INCLUDING LEGAL IMMIGRANTS IN HEALTHCARE REFORM, JUST WHAT THE DOCTOR ORDERED 2 (2009), available at <http://www.immigration>

Foundation's Commission on Medicaid and the Uninsured, restricting healthcare means that "we are already paying a substantial amount to care for a large uninsured population without any guarantee of coverage," and, "we pay for care in the least efficient way possible— after people get sick and need emergency or hospital care."⁵⁹ Imposing a five-year bar on legal immigrants is economically damaging because legal immigrants are "citizens in waiting," and many will naturalize.⁶⁰ Even if legal immigrants do not naturalize, they become eligible for federal health programs after five years⁶¹ and will delay treatment for potentially serious conditions while they are uninsured, ultimately leading to care that is more expensive and less effective after the five-year bar.⁶²

From a social policy perspective, restricting legal immigrants' healthcare access decreases participation in government programs that are vital to the public interest. Also, many immigrants live in "mixed households," containing both citizens and noncitizens.⁶³ Particularly common are households containing noncitizen adults and citizen children, and these children are adversely affected by their parents lack of access to medical care.⁶⁴ Noncitizen parents are also less likely to enroll their citizen children, who are fully eligible for all government healthcare programs, out of fear and confusion over potential immigration consequences for utilization of public benefits.⁶⁵

Furthermore, legal immigrants pay taxes just as natural born citizens, and it does not make sense to exclude them from a state and federally funded healthcare program, such as Medicaid, for any amount of time when their

policy.org/sites/default/files/docs/Including_Legal_Immigrants_in_Health_Care_Reform.pdf.

59. COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54, at 2.

60. IMMIGRATION POLICY CTR., *supra* note 58, at 1 (citing statistic that between 2006 and 2008, over two million legal permanent residents became U.S. citizens).

61. *See* 8 U.S.C. § 1613(a) (2006) (stating that legal permanent residents are eligible for benefits five years after becoming qualified aliens).

62. COMPREHENSIVE HEALTH CARE FOR IMMIGRANTS, *supra* note 54, at 1-2.

63. IMMIGRATION POLICY CTR., *supra* note 58, at 1.

64. *Id.*

tax dollars are being used to fund the program.⁶⁶ In addition, immigrants are just as likely as citizens to have at least one full-time worker in the family, but they tend to have lower rates of employer-sponsored insurance or have jobs that do not offer health insurance.⁶⁷ These limitations, coupled with the federal restrictions on Medicaid eligibility, severely reduce immigrants' public health coverage.⁶⁸ These immigrants are legally residing within our borders, pay taxes and work the same as citizens, which suggests that the five-year bar is an arbitrary restriction that simply allows states to discriminate against lawfully residing immigrants.⁶⁹

V. CONCLUSION

For the first five years following an immigrants' entrance into the U.S., state-funded healthcare programs remain the only option for legal immigrants who cannot afford the high cost of private health insurance. By providing cost-effective preventive care to legal immigrants, states both respect the rights of these "citizens in waiting" and reduce the large deficits created by the EMTALA mandate. As more states scramble to make additional cuts in their social welfare programs, they must be mindful of the legal and policy ramifications resulting from any potential exclusion of legal immigrants.

65. *Id.*

66. *Id.*

67. FIVE BASIC FACTS, *supra* note 37, at 4.

68. *Id.*

69. *See* IMPROVING IMMIGRANT ACCESS, *supra* note 49, at 2.