



THE HEALTH LAWYER

IN THIS ISSUE

Federally Qualified Health Centers: A Healthcare Delivery Model for a Newly Reformed Health System 1

MS.01.01.01 (formerly known as MS 1.20): The Joint Commission's Standard for Medical Staff Bylaws..... 10

An Obituary for Physician-Owned Specialty Hospitals..... 24

Immigrants and Healthcare: A Voice for Coverage..... 35

“Work-Arounds” for Physician-Owned Hospitals: Are They Workable?..... 44

Updates to EMI 2010 Presentations 51

FEDERALLY QUALIFIED HEALTH CENTERS: A HEALTHCARE DELIVERY MODEL FOR A NEWLY REFORMED HEALTH SYSTEM

Kathy Poppitt, Esq.
Cox Smith Matthews Incorporated
Austin, TX

Sheryl Tatar Dacso, Dr.P.H., Esq.
Seyfarth Shaw
Houston, TX

The Patient Protection and Affordable Care Act of 2010 is a landmark healthcare bill designed to substantially reform how healthcare is financed and delivered in the United States.¹ One of the central funding initiatives in the legislation is the expansion of federally qualified health centers (“FQHCs” or “health centers”) as a means of improving access to primary healthcare services for millions of Americans.

FQHCs also benefited from the enactment of the American Recovery and Reinvestment Act (“ARRA”), which has infused slightly more than two billion dollars to community health centers for capital improvements, expansion (or retention) of personnel and services, and adoption of health information technology.² This amount was intended to offset the double burden of reduced local funding streams and increases in the number of medically underserved individuals.

FQHCs are not new. The FQHC benefit under Medicare was added effective October 1, 1991, when Section 1861(aa) of the Social Security Act (the “Act”) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990.³ FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

In terms of health outcomes, studies have shown that the presence of, or patients’ receipt of care from, FQHCs can reduce rates of avoidable hospitalizations and improve birth outcomes. Other studies have examined the impact of health centers on access to care, measured as having a usual source of care or more physician visits, and found a strong positive relationship.⁴

The purpose of this article is to familiarize the reader with FQHCs as an important player in the healthcare delivery system of the future.

continued on page 3



IMMIGRANTS AND HEALTHCARE: A VOICE FOR COVERAGE

Mercedes Varasteh Dordeski, Esq.
Frank, Haron, Weiner & Navarro
Troy, MI

Kelly N. Steffens
Thomas M. Cooley Law School
Auburn Hills, MI

“Remember, remember always, that all of us, you and I especially, are descended from immigrants and revolutionists.” –Franklin D. Roosevelt¹

The United States has always attracted immigrants with its allure as the “land of opportunity.” However, in the years since President Roosevelt’s address, this welcoming attitude toward immigrants has seemingly waned. Take for example the Arizona state law passed in April 2010,² which gives law enforcement officers broad discretion to accost individuals based on a “reasonable suspicion” that they are “unlawfully present” in the United States, and to check their immigration status.³ Although the Arizona law has been protested by critics who claim that it encourages racial profiling,⁴ the law is part of a growing trend among states to enact legislation placing special restrictions on immigrants.⁵

In the wake of such trends, the topic of immigrant rights remains a debated topic that elicits passionate responses from both sides of the political spectrum – especially with respect to immigrant healthcare. For example, few can forget the outburst that occurred during the September 9, 2009 Joint Session of Congress, when in response to President Barack Obama’s statement that proposed health reforms would not expand coverage for illegal immigrants, Representative Joe Wilson (R-S.C.) immediately shouted “You lie!”⁶

In the quest to attribute fault for the current economy and deficiencies of the healthcare system, even *legal* immigrants are receiving substantial blame for “milking” a system to which the general public believes they do not

contribute.⁷ However, the current – and proposed – restrictions on healthcare eligibility for immigrants are often based on myths. These false beliefs then adversely impact the legally admitted immigrant population, when it is actually vital to expand coverage to legal immigrants, as their lack of coverage creates a greater financial burden on the healthcare system when the uninsured require emergency treatment for preventable conditions.⁸

This article provides an overview of the current system under which immigrants to the United States receive healthcare, with the primary purposes of clarifying common misperceptions about the state of immigration, and highlighting the disparities that exist with respect to healthcare coverage for legally-admitted immigrants as compared to U.S. citizens.

First, this article will provide a summary of the alien population in the United States, along with the path these non-citizens must take to obtain permanent residency and U.S. citizenship. Next, the article reviews the current Medicaid system and the impact of two major laws currently defining the conditions under which non-citizens are eligible for Medicaid benefits: the Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”) of 1996 and the Deficit Reduction Act (“DRA”) of 2005. Finally, the article analyzes legal immigration’s purported impact on the healthcare system and economy in the United States, and the justifications for ensuring healthcare coverage for all legally-admitted immigrants.

Who Are Immigrants?

To begin, it is important to define “immigrant” and “alien”. The Immigration and Nationality Act (“INA”)⁹ classifies an “alien” as, “any

person not a citizen or national¹⁰ of the United States”.¹¹ The term “citizen” applies to individuals, including children, born within the United States (50 states and territories) or those who complete the process of becoming a U.S. citizen through naturalization. In turn, an “immigrant” is defined as every alien, except those listed as nonimmigrant aliens by statute.¹²

The four general classes of aliens who will be referred to throughout this article are as follows:

- Legal Permanent Residents (also known as legal immigrants, or immigrants with green cards): Aliens who have been granted “admission” by the government to make their permanent home in the United States.¹³
- Refugees and Asylees: These include refugees (individuals admitted for humanitarian reasons under the United States Refugee Act of 1980) and asylees who are already present within the United States (or at a land border or port of entry) and claim to be refugees.¹⁴
- Non-immigrants: There are more than 25 subcategories of non-immigrants. These include individuals who are in the United States temporarily and have no plans of permanent residency, such as officials from foreign governments, visitors, foreign students and temporary workers.¹⁵
- Undocumented Aliens (illegal immigrants): This term, which is used interchangeably with the term “illegal aliens,” refers to individuals who are living in the United States without establishing legal residency. Illegal aliens have not been “admitted,” which requires lawful entry into the United States after inspection and authorization by an immigration officer.¹⁶

continued on page 36

Immigrants and Healthcare: A Voice for Coverage

continued from page 35

For purposes of this article, the term “legal immigrant” will refer to aliens who were not born in the United States or who have not become U.S. citizens, but have been legally admitted to the United States. Most legal immigrants living in the United States are adults.¹⁷ However, there are many children (both citizen and non-citizen) who live in a family with at least one legal immigrant parent.¹⁸ A little over half of the legal immigrant population is from Latin America; one-quarter comes from Asia, and the remainder hail from Europe and other regions.¹⁹ Their destinations within the United States are constantly changing, but the 2000 U.S. Census²⁰ disclosed that over one-half of the foreign-born population lives in California, New York and Texas.²¹

When analyzing census data, all immigrants, regardless of their legal status, are referred to as “foreign-born” individuals (those born abroad but who have American citizen parents are not included within this category). In 2008, there were 37.9 million foreign-born individuals in the United States, which was approximately 12.5 percent of the population.²² Additionally, as of 2009 it was estimated that 10.8 million illegal immigrants are present in this country.²³

The notion that the average immigrant easily enters the United States and automatically receives public assistance is erroneous. In fact, the process to become a legal immigrant is often confusing, lengthy, and highly exclusionary. The U.S. immigration system is becoming increasingly complex, with even higher standards to gain entry into the United States and lower standards to trigger an alien’s deportation. Most recently, the post-9/11 emphasis on combating terrorism and protecting U.S. borders led to the creation of legislation such as the Patriot Act,²⁴ which gave the government heightened discretion to interpret and enforce immigration policies. Additional legislation was also suggested, like the Border Protection,

Anti-Terrorism, and Illegal Immigration Control Act of 2005,²⁵ which was passed by the House of Representatives but failed to pass the Senate. This bill, among other things, would have required up to 700 miles of fence along the U.S.-Mexico border and eliminated the Diversity Immigrant Visa.²⁶

Legal immigrants are generally defined as those who can enter with an immigrant visa (not illegal).²⁷ Those seeking to enter the country based on employment transfers, reciprocity, as a government diplomat or belonging to any other class determined to be “non-immigrant alien” status will apply for a Non-Immigrant Visa.²⁸ (These individuals will not be discussed in this article, because they usually arrive in the country for a set period of time with employment opportunities and receive or are able to obtain health coverage).

How Do Immigrants Get Here?

To begin the process of becoming a legal immigrant, an alien must apply at the Consulate (U.S. Department of State) in his or her home country. The Consulate is informed of immigrant preferences by the government, which are allocated based on nationality and status of the alien. This preference system is in place as a method of distributing the limited number of immigrant visas available each year. The burden of showing a right of admissibility into the United States is on the alien. Statutory grounds for inadmissibility include reasons related to health, criminal status, security, likelihood that the alien will become a public charge, labor certifications, fraud or misrepresentation, improper documentation, ineligibility for citizenship, and previous removal from the United States.²⁹

If an alien is inadmissible under any grounds, denial of admission is automatic, except for a narrowly-crafted waiver of inadmissibility. However, the

waiver is typically based on some form of extreme hardship for a U.S. citizen or legal immigrant, not hardship on the applicant as a result of admission being denied.³⁰ (An example would be if a relative has a major medical condition that makes the relative unable to move abroad, and the relative absolutely needs the alien for caretaking purposes.) If this burden of admissibility is met, the alien is issued an immigrant visa and may now go to a port of entry into the United States. A denial of admission is generally non-reviewable and will be upheld unless the Attorney General is satisfied that the person is admissible under any provision of the INA.³¹

Even if an immigrant is issued a visa, this does not guarantee admissibility or actual entry into the United States. This simply allows the immigrant to “knock on the door” of the United States, where the immigrant must again demonstrate eligibility for admission to immigration officers. Once approved, an immigrant may legally enter the country, subject to conditions such as timing restraints and grounds for removal for the entire length of stay, or until he becomes a U.S. citizen.

The U.S. immigration process and statutes are complex and difficult to summarize while still recognizing all of the exceptions and waivers. However, even a brief overview of this rigorous process illustrates how legal immigrants have earned their right to entry.

It is important to note that once these legal immigrants are admitted, they are bound by the same tax rules as U.S. citizens, and are therefore equally contributing to the system.³² Given that the U.S. government has approved the presence of these legal immigrants, and they are expected to abide by the same rules and laws as U.S. citizens, it might be expected that they should be entitled to receive the benefits of health coverage given to similarly situated U.S. citizens. In a nutshell, it can be argued that eligibility for government

programs should not vary based solely on citizenship if an immigrant is in the U.S. legally. However, this is often not the case.

Medicaid

The Medicaid program was enacted in 1965 through Title XIX of the Social Security Act,³³ and is administered by the Centers for Medicare & Medicaid Services (“CMS”).³⁴ The goal of Medicaid is to provide medical benefits to eligible low-income families and long-term care services for the elderly and disabled.³⁵ Individuals eligible under Medicaid may currently have no medical insurance or inadequate medical insurance. Coverage provided by Medicaid has expanded over the years, and now accounts for almost one-sixth of total personal healthcare spending in the United States.³⁶

The federal and state governments jointly finance the Medicaid program by each paying a percentage of the cost to cover individuals enrolled in the program.³⁷ Although percentages vary by state based on per capita income, the federal government currently covers 50 percent to 76 percent of the cost of providing care to Medicaid beneficiaries.³⁸ While each state administers its own individual program and maintains a certain degree of flexibility regarding coverage, state levels of coverage must fall within broad federal guidelines.³⁹ Medicaid-covered services vary by state, but generally include:

- Inpatient and outpatient hospital services;
- Physician, midwife, and certified nurse practitioner services;
- Laboratory and x-ray services;
- Nursing home and home health care for individuals 21 years and older;
- Early and periodic screening, diagnosis, and treatment (“EPSDT”) for children under age of 21;
- Family planning services and supplies;

- Rural health clinic/federally qualified health center services.⁴⁰

Medicaid coverage has also been expanded under the State Children’s Health Insurance Program⁴¹ (“SCHIP”, now “CHIP”), which was created in 1997 and is now administered by the U.S. Department of Health and Human Services.⁴² CHIP is an expansion of the Medicaid program that aims to cover children of parents (and a very limited number of parents) with modest incomes that are above Medicaid eligibility levels, but are still unable to afford health coverage.⁴³ Eligibility for CHIP also requires an individual to meet income and categorical eligibility requirements.⁴⁴

A difference between family cultures in the United States and abroad creates a problem when eligibility criteria are based on parent and child relationships. For Medicaid purposes, the Social Security Act defines a “child” as: a natural legitimate child, stepchild (under certain circumstances), legally adopted child, child of invalid ceremonial marriage, or dependent grandchild or step-grandchild.⁴⁵ A child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if the parent is not.⁴⁶ Additionally, any child born in the United States is automatically a U.S. citizen and therefore eligible for coverage.⁴⁷

Importantly, the use of the term “child” with respect to Medicaid coverage is based on a legally recognized connection between the adult and child. Therefore, a problem arises when defining the parent/child relationship in some legal immigrant families. For example, due to the HIV/AIDS epidemic or war turmoil in developing countries, some parents predecease their children, who are then raised by someone other than the biological parents. The child is often brought up in another family consisting of blood relatives such as aunts and uncles, or by an older sibling. There is frequently no official process of adoption when this occurs, as the child is absorbed

into the other family and raised as part of its own.

While this situation among immigrants is analogous to one that commonly occurs in U.S. culture – specifically, where a child is born to a teenage mother and raised by grandparents – the Medicaid “child” definition *does* include dependent grandchildren. The similarities between these two situations are obvious, as often there is no official adoption that occurs. Therefore, this creates a problem when an adult immigrant is attempting to apply for benefits for a child, as this person is the provider for the child, yet cannot satisfy the parent-child definition required for Medicaid.

Additionally, there is a clear distinction made between U.S. citizens and aliens under Medicaid and CHIP. To qualify for Medicaid coverage, an applicant must be a U.S. citizen or legal immigrant.⁴⁸ Legal immigrants who arrive in the United States can become eligible after they meet certain work, military service and residency requirements.⁴⁹

Despite an immigrant possessing a qualified status for eligibility, however, Medicaid coverage is only minimally provided under federal regulations, and extra assistance is often needed. While the same may be said for U.S. citizens, guidelines for additional levels of coverage are dictated at state levels and vary between legal immigrants and U.S. citizens. Specifically, any additional level of coverage is dictated at a state level, where some states have chosen to cover qualified legal immigrants (resident aliens) if these individuals meet the other Medicaid requirements (i.e. they fit into an eligibility category and meet the income and asset standards).⁵⁰

To qualify for Medicaid, one must belong to a qualified group. State’s eligibility groups will be considered as one of the following: categorically needy, medically needy, or special groups.⁵¹ Those categorically eligible are further broken down to include: “children; parents with dependent children;

continued on page 38

Immigrants and Healthcare: A Voice for Coverage

continued from page 37

pregnant women; people with severe disabilities; and the elderly.”⁵² There is no classification based on one’s citizenship or immigrant status. Importantly, undocumented aliens and non-immigrants in the United States who are in the country on a temporary basis (temporary work or student visa) are generally ineligible for Medicaid, regardless of their length of residence in the United States.⁵³

As outlined above, it is possible for legal immigrants to obtain Medicaid coverage, but the extent of this coverage varies based on many factors. Specifically, in order to qualify for even a minimum level of coverage, immigrants must be here legally and meet residency and work requirements. Therefore, the popular assumption that illegal aliens receive Medicaid coverage is erroneous.⁵⁴

Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”) of 1996

The Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”)⁵⁵ was signed into law by President Bill Clinton on August 26, 1996 and significantly changed the welfare system of the United States for all non-citizens. The introduction to Section 400 of PRWORA, which covers welfare and immigration, sets out that: “Self-sufficiency has been a basic principle of United States immigration law since this country’s earliest immigration statutes.”⁵⁶ The subsequent text in the Act then restricts the eligibility of non-citizens to receive aid under federal assistance programs and, with a few exceptions, generally bars new legal immigrants’ eligibility.⁵⁷ Importantly, PRWORA makes citizenship status and date of arrival into the United States determining factors in qualifying for federal benefits.

Under PRWORA, immigrants are generally barred from federally funded assistance for their first five years in the United States.⁵⁸ After five years has passed, immigrants may apply for healthcare services and receive them if they meet the programs’ other eligibility requirements. The only legal immigrants exempt from this bar are refugees, most other humanitarian immigrants, and active-duty members or veterans of the U.S. Armed Forces⁵⁹ and their families.⁶⁰ Restrictions previously in place prior to PRWORA remained. These include general ineligibility for undocumented aliens and non-immigrants in the United States (i.e., on a temporary basis), regardless of the length of actual residence in the United States.⁶¹

In 1997, through a series of public laws,⁶² Congress loosened restrictions and restored Medicare benefits to all elderly and disabled legal immigrants, or to those who may become disabled in the future, but who lived in the United States before PRWORA was enacted. PRWORA also redefined “qualified alien” to exclude those with the status previously considered to be “permanently residing under color of law (“PRUCOL”).”⁶³ Although PRUCOL is a category created by courts and not a legally recognized immigration status, the standard applies to legal immigrants who have resided in the United States for a long period of time and who are not yet citizens, but whom the U.S. Citizenship and Immigration Service (“USCIS”) or courts have decided not to deport.⁶⁴

Legal immigrants who arrived in the United States after the enactment of PRWORA, and who are now ineligible to receive federal benefits for five years, feel the main impact of the law. Additionally, many will still be ineligible when the five-year time limit expires, due to other restrictions. For example, immigrants seeking Medicaid coverage must meet other eligibility

requirements, such as low income. This presents a unique obstacle to immigrants, since many are in the United States to reunite with family and have sponsors⁶⁵ who pledge support in their transition. Federal law requires a portion of the income and resources of those who sponsor the immigrants to be viewed as available assets to the new immigrants, making it more difficult to qualify as “sufficiently poor.”⁶⁶ It is possible for sponsors to unintentionally push immigrants over the asset limit, regardless of their contribution, while the immigrants themselves have no resources.⁶⁷

States have broad authority in determining eligibility of their residents for coverage and use this in varying degrees. In response to the passage of PRWORA, some state legislatures created state-funded programs in an effort to ensure Medicaid assistance to legal immigrant residents.⁶⁸ State participation levels varied; for example, Connecticut set up a separate, state-funded program to provide legal immigrants with Medicaid equivalent coverage.⁶⁹ Conversely, Washington moved immigrants to a program with limited benefits and premium cost sharing requirements that led to significant coverage losses among immigrants.⁷⁰ About 50 percent of states have chosen to fill this gap in coverage. However, the impact of these replacement programs is limited, as there are still restrictions to coverage and they usually impose a six-month residency requirement.⁷¹

In 2004, 22 states and the District of Columbia used state funds to provide coverage to some immigrants ineligible for Medicaid and SCHIP (now CHIP).⁷² However, this expansion of coverage went to specific groups and their families, such as refugees, asylees, and active-duty members or veterans of the U.S. Armed Forces, not the general legal immigrant population.⁷³

The influence of PRWORA grows over time as the number of post-enactment legal immigrants accumulates.⁷⁴

Immediately after PRWORA was enacted, most legal immigrants were able to qualify and were not negatively impacted by this law. Now, fourteen years later, a much larger group of legal immigrants are affected and determined ineligible.

Deficit Reduction Act of 2005

In addition to the restrictions imposed by PRWORA, the Deficit Reduction Act (“DRA”),⁷⁵ effective February 8, 2006, requires all individuals potentially eligible for Medicaid to show “satisfactory evidence of citizenship or nationality of the individual,” such as a birth certificate or passport, to receive and retain Medicaid benefits.⁷⁶ Previously, most states allowed oral confirmation of citizenship status.⁷⁷

This additional step to receive benefits may appear to be minimal, but can cause confusion and prevent otherwise eligible individuals from receiving coverage. Specifically, it becomes more time-consuming and potentially difficult for individuals to locate the proper documents. Although one goal of requiring U.S. citizenship and residency documentation is to prevent undocumented aliens from receiving government-sponsored benefits, under PRWORA, legal immigrants already need to show their legal status to prove eligibility for coverage.⁷⁸ Accordingly, there is a growing concern that these requirements are preventing even United States citizens from receiving necessary benefits, simply because they cannot produce the required identification at the appropriate time.⁷⁹ Naturalized citizens previously covered under Medicaid, but now unable to produce required documentation, are also affected.⁸⁰

The Patient Protection and Affordable Care Act

In March 2010, Congress passed and President Obama signed into law the Patient Protection and Affordable Care Act (“PPACA”),⁸¹ amended

by the Health Care and Education Reform Act.⁸² PPACA contains a slew of comprehensive health insurance reforms that will attempt to lower costs and enhance quality healthcare for all Americans.⁸³ This law will provide coverage to 32 million Americans that are currently uninsured and increase the overall number of insured Americans to 94 percent.⁸⁴ These goals may be achieved by setting up state exchanges to create a new competitive private health insurance market and holding insurance companies accountable to keeping premiums down and avoiding denial of care.⁸⁵

Among the many changes that will unfold over the next ten years, Medicaid eligibility is expanded to include all non-elderly Americans with incomes at or below 133 percent of the Federal Poverty Level. However, illegal immigrants will continue to be ineligible for Medicaid.⁸⁶ Illegal immigrants will also be prohibited from purchasing health insurance from the exchanges – even if they pay the entire costs for coverage out-of-pocket.⁸⁷ However, since the implementation of this law is so recent, it is difficult to anticipate exactly how it will affect the legal immigrant population, let alone the entire country.

Why Do Immigrants Seem to be Targeted?

Based on the above summaries of the restrictions currently in place regarding immigrants and healthcare, it is easy to understand why many legal immigrants, an under-represented constituency due to their inability to vote, find themselves ineligible for health coverage. Despite this fact, many U.S. citizens blame immigrants (both illegal and legal) for deficiencies in the healthcare system due to a tendency among critics to blame the nation’s ills, specifically the health insurance crisis, on immigrant populations.

For example, a poll conducted on U.S. citizens during April and May 2010 revealed that a majority of U.S. citizens think that U.S. immigration

policies need to be overhauled.⁸⁸ The poll further stated:

Some attitudes about immigration have remained stable among the public. Most still say illegal immigrants weaken the nation’s economy rather than strengthen it, and public opinion remains divided over how the United States should handle illegal immigrants currently in the country.

Three quarters said that, over all, illegal immigrants were a drain on the economy because they did not all pay taxes but used public services like hospitals and schools. Nearly 2 in 10 said the immigrants strengthened the economy by providing low-cost labor and buying goods and services, a chief argument among many of their advocates.⁸⁹

Unfortunately, this negative opinion towards illegal immigrants is often equally applied to legal immigrants, which in turn spurs policymakers to enact increasingly restrictive immigration laws at the urging of their constituents. For example, in introducing PRWORA, Representative E. Clay Shaw Jr. (R-Fla.) stated his belief that welfare was partly responsible for bringing legal immigrants to the United States. “What about giving me your tired, your poor?” he questioned. “The inscription at the base of the Statue of Liberty was written before welfare... People came to this country to work. Now the question becomes, are these handouts a magnet that is bringing people into this country? To some degree, they are.”⁹⁰

While many perceive immigrants as unwelcome outsiders, most immigrants (74 percent) are here legally; illegal immigrants account for only 26 percent of the non-citizen population.⁹¹ In sum, what is frequently overlooked is that the majority of immigrants are here legally and employed. However, issues pertaining to healthcare coverage often arise because compared to native U.S. citizens, a large number of immigrants work in low-wage jobs, such as in small

continued on page 40

Immigrants and Healthcare: A Voice for Coverage

continued from page 39

firms, and in labor, service, or trade occupations.⁹² These industries are much less likely to offer health coverage to their employees. Specifically, statistics show that while two-thirds of native citizens get their health insurance through their employer, only 33 to 44 percent of non-citizens have employer-based coverage.⁹³ Legal immigrants demonstrate a need for healthcare assistance, but are unable to obtain it due to either their alien status or inadequate income.

Immigrants Do Not Come to the United States for Healthcare

Importantly, restricting access to healthcare for legal immigrants does not alone deter immigration to the U.S. Notably, even undocumented immigrants' motivation to come to the U.S. is to find work, not to obtain healthcare.⁹⁴ Therefore, those who have entered the United States legally should be afforded the same access to healthcare.

As previously discussed, gaining entry into the U.S. is not a simple or easy process that aliens could abuse every time they are ill. For example, aliens applying for entry will be denied if it is determined they are likely to become a public charge. The alien's age, health, family status, financial status, education and skills are some of the minimum factors to be considered in this determination.⁹⁵

Admissibility denials based on health-related grounds are determined in accordance with regulations promulgated by the Secretary of Health and Human Services, and create multiple exclusions for admissibility. Aliens with communicable diseases⁹⁶ or who fail to present documentation for vaccination against preventable diseases⁹⁷ are denied entry. Also banned under health-related grounds are aliens who currently have or have had "a physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the

property, safety, or welfare of the alien or others."⁹⁸ Finally, aliens determined to be drug abusers or addicts are inadmissible.⁹⁹ These health-related grounds for inadmissibility must be overcome by the high burden of proof on the alien and survive the subjective standards and discretion of the consular and immigration officers.

In a nutshell, if it is foreseeable that aliens will not be able to provide for themselves and therefore rely on public assistance, they will not be issued a visa by a consular officer or admission at point of entry by an immigration officer.

Legal Immigrants Do Not Over-Utilize Health Resources

Notably, U.S. healthcare expenditures are lower for legal immigrants than for native-born residents, and immigrants use less of these services overall than citizens.¹⁰⁰ In short, immigrants often do not even utilize the system, by choice or ineligibility, which they are supposedly abusing.

One reason for this is that the many provisions in the legislation addressed above create fear in legal immigrants' minds that using public assistance makes the immigrants ineligible for future citizenship and possible deportation.¹⁰¹ However, state Medicaid programs are prohibited from disclosing information on the immigration status of applicants or beneficiaries to USCIS without written consent from the family or individual.¹⁰² Many non-citizens are not aware of this and may be afraid to apply for available benefits. Uninsured aliens often avoid medical care, believing there is no way to pay for the services.¹⁰³

Since the implementation of the previously discussed programs, it is more time-consuming and complicated for immigrants to enroll in federal or state health assistance. As a result of these changes, immigrant enrollment in Medicaid has stabilized recently, but it is still below that of U.S. citizens.¹⁰⁴

The uninsured are continually growing in the recent economic downturn, regardless of nationality. While many legal immigrants are uninsured due to length of residency restrictions, they are not alone. Specifically, studies report that "[d]espite these high uninsured rates, research findings indicate that new immigrants are not primarily responsible for the growth in the overall uninsured population, mainly because their numbers are still small compared to the U.S. population as a whole."¹⁰⁵

However, regardless of documentation, all immigrants (including legal immigrants who are otherwise unqualified for federal benefits and illegal aliens) are eligible to receive emergency medical services as required by the federal Emergency Medical Treatment and Active Labor Act ("EMTALA").¹⁰⁶ EMTALA was enacted in 1986 to prevent "patient dumping" and ensure *all* individuals have access to emergency medical services regardless of their citizenship status, legal status, or ability to pay.¹⁰⁷ These obligations are imposed on Medicare-participating hospitals that offer emergency services.¹⁰⁸

In general, individuals with public insurance, chronic conditions, poor health and lower incomes have a higher reported usage of hospital emergency rooms.¹⁰⁹ However, surveys indicate that regardless of insurance status, low-income non-citizens were less likely than low-income citizens to visit the emergency room; from 2004-2005, for example, 24 percent of citizen non-elderly adults who required emergency services were uninsured, compared to 11 percent for non-citizens.¹¹⁰

Despite this, EMTALA imposes a greater burden on states with larger immigrant populations, as they are forced to pay for a larger amount of uninsured coverage and potentially overcrowded emergency departments. Hospital officials have noted that, "...care to illegal immigrants

contributes to their uncompensated care burden, so hospitals serving communities with an increased illegal immigrant population could be providing more uncompensated care.”¹¹¹

Therefore, it can be argued that by allowing *legal* immigrants to have equal access to regular and preventative healthcare coverage, this would reduce the legal immigrants’ use of emergency services and alleviate the additional burden placed on healthcare providers used by the illegal population.

Healthcare for Legal Immigrants Is Important to Promote Health and Well-Being

While restrictions on healthcare have not been found to impact immigration levels or settlement patterns,¹¹² such restrictions do place communities and public health at risk as contagious ailments are left untreated and vaccinations are not accessible to prevent the spread of curable diseases. The overall health of a given population depends on that population’s health insurance coverage, as it influences whether and when people get necessary medical care, and where they get their care.¹¹³

Finally, the positive and necessary impact immigrants have on our country’s healthcare labor force must be acknowledged. Ironically, immigrants are actually vital to ensuring health coverage to the country as a whole – specifically, immigrants now account for more than 25 percent of all physicians and surgeons, and roughly one-fifth of nursing, psychiatric and home health aides.¹¹⁴ As the population grows larger and older, and native-born healthcare professionals retire, the United States will experience a serious shortage of healthcare professionals, a critical gap that will be filled by immigrants.¹¹⁵ It is critical that American immigration policy be flexible to allow these immigrants into the country to help, and also provide them with health coverage once they have arrived.

Conclusion

Although individuals who legally immigrate to the United States are expected to abide by the same rules as U.S. citizens – and pay the same taxes as U.S. citizens – they are frequently denied equal healthcare coverage. While legislation can adjust the scope and impact of such discriminatory practices, it is important for U.S. citizens to understand that immigrants are not to blame for the country’s healthcare crisis.

Legal immigrants in the United States go through an extensive admission process that eliminates those attempting to enter without proper documentation, including proof of financial stability and medical admissibility. Many factors such as employment, resources, or health history are evaluated when determining admissibility and entry into the country. Because this exclusionary process eliminates any aliens attempting to come to the United States to “live off” federal assistance, those legal immigrants in the country are entitled to receive equal support.

Improving coverage to all families, regardless of citizenship status, who live, work, and pay taxes is essential to protecting public health. It is essential to remember the foundational goals of equality for which the United States purports to strive, while contemplating new legislation regarding healthcare to expand coverage to legal immigrants residing in the country.



Mercedes Varasteh Dordeski is an attorney with Frank, Haron, Weiner & Navarro in Troy, Michigan. Ms.

Dordeski focuses her practice on federal and state False Claims Act litigation, and representing medical professionals, group practices, home health agencies and ambulatory surgical facilities with matters pertaining to reimbursement, licensing, HIPAA compliance, Stark and Anti-Kickback law, hospital governance, and medical

staff credentialing/privileges. A former journalist, Ms. Dordeski contributes regularly to health law publications and also authors a health care blog, which may be accessed at www.healthcarelawyerblog.com. She may be reached at mdordeski@fhunlaw.com.



Kelly N. Steffens

is a third-year law student at Thomas M. Cooley Law School in Auburn Hills, Michigan.

Ms. Steffens will sit

for the Michigan Bar Exam in February 2011 and plans to practice in the area of immigration law. Portions of this article originated from a paper written by Ms. Steffens for a health law course at Cooley Law School taught by David L. Haron, a partner at Frank, Haron, Weiner and Navarro.

Endnotes

- ¹ Remarks before the Daughters of the American Revolution, April 21, 1938. Franklin D. Roosevelt & J.B.S. Hardman, *Rendezvous with Destiny: Addresses and Opinions of Franklin Delano Roosevelt* at 262 (Dryden Press, Inc., 1944).
- ² S.B. 1070, 49th Leg., 2nd Reg. Sess. (Ariz. 2010)(enacted).
- ³ *Id.*; Ariz. Rev. Stat. Ann. 11-1051 (effective July 29, 2010).
- ⁴ Tim Gaynor, *Critics, Backers of Arizona Immigration Law Rally*, Reuters.com, May 29, 2010, available at <http://www.reuters.com/article/idUSTRE64S1NV20100530> (last accessed June 21, 2010).
- ⁵ According to the National Conference of State Legislatures, in the first six months of 2010 every state in regular session considered laws related to immigrants or immigration. Legislators introduced 1,374 bills relating to immigrants and refugees, compared to only 300 bills in 2005. Many such bills relate to driver’s licenses, health and education. See Immigrant Policy Project, “2010 Immigration-Related Laws and Resolutions in the States (January – June 2010)”, available at <http://www.ncsl.org/default.aspx?TabId=20881> (last accessed July 29, 2010); see also Dana Bash, Ed Hornick & Kristi Keck, *What Does Arizona’s Immigration Law Do?*, CNN.com, April 23, 2010, available at <http://www.cnn.com/2010/POLITICS/04/23/immigration.faq/index.html> (last accessed June 21, 2010).
- ⁶ *Rep. Wilson shouts, ‘You lie’ to Obama During Speech*, CNN.com, September 10, 2009, available at <http://www.cnn.com/2009/POLITICS/09/09/joe.wilson/index.html?ref=allsearch> (last accessed June 25, 2010).

continued on page 42

Immigrants and Healthcare: A Voice for Coverage

continued from page 41

- 7 Steven A. Camarota, *Back Where We Started: An Examination of Trends in Immigrant Welfare Use Since Welfare Reform*, Center for Immigration Studies, March 2003, available at <http://www.cis.org/articles/2003/back503.html> (last accessed June 25, 2010).
- 8 See e.g., The Kaiser Commission on Medicaid and the Uninsured, *Immigrants and Health Coverage: A Primer*, June 2004, available at <http://www.kff.org/uninsured/upload/Immigrants-and-Health-Coverage-A-Primer.pdf> (last accessed June 25, 2010) [hereinafter *Immigrants and Health Coverage*].
- 9 8 U.S.C. §§1101 et seq.
- 10 “National” is defined as “a person owing permanent allegiance to a state.” 8 U.S.C. §1101(a)(21).
- 11 8 U.S.C. §1101(a)(3).
- 12 8 U.S.C. §1101(a)(15).
- 13 8 U.S.C. §1101(a)(13).
- 14 8 U.S.C. §1101 (a)(42).
- 15 8 U.S.C. §1101 (a)(15).
- 16 8 U.S.C. §1101 (a)(13).
- 17 *Immigrants’ Health Care Coverage and Access*, *supra* note 7.
- 18 National Center for Children in Poverty, *Children of Immigrants: A Statistical Profile*, September 2002, available at http://www.nccp.org/publications/pdf/text_475.pdf (last accessed June 25, 2010).
- 19 U.S. Census Bureau, *The Foreign-Born Population in the United States: March 2002, February 2003*, available at <http://www.census.gov/prod/2003pubs/p20-539.pdf> (last accessed June 25, 2010) [hereinafter *Foreign-Born Population*].
- 20 As of the date of publication, data from the 2010 U.S. census is not yet available.
- 21 *Foreign-Born Population*, *supra* note 18.
- 22 Aaron Terrazas & Jeanne Batalova, *Frequently Requested Statistics on Immigrants and Immigration in the United States*, Migration Information Source, October 2009, available at <http://www.migrationinformation.org/USfocus/display.cfm?ID=747#1> (last accessed June 25, 2010).
- 23 Steven Camarota & Karen Jensenius, *A Shifting Tide: Recent Trends in the Illegal Immigrant Population*, Center for Immigration Studies, July 2009, available at <http://www.cis.org/IllegalImmigration-ShiftingTide> (last accessed June 25, 2010).
- 24 Pub. L. No. 107-156 (2001). For example, in addition to other immigration requirements, would-be immigrants can be denied entry if there is any reason to believe that the immigrant is affiliated with terrorist organizations or poses a threat to the safety or security of the United States.
- 25 H.R. 4437 (109th Cong. 2005).
- 26 The Diversity Immigrant Visa is a lottery program for receiving a United States Permanent Resident or “Green” card, and makes available 55,000 permanent resident visas annually to persons from countries with low rates of immigration to the United States. See 8 U.S.C. §1153(c) and §1151(e).
- 27 8 U.S.C. §1101(a)(15).
- 28 *Id.*
- 29 8 U.S.C. §1182(a).
- 30 8 U.S.C. §1182(h).
- 31 8 U.S.C. §1361.
- 32 Karen Brulliard, *Study: Immigrants Pay Tax Share*, Washington Post, June 5, 2006, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/06/04/AR2006060400965.html> (last accessed June 24, 2010).
- 33 42 U.S.C. §§1396–1396v, subchapter XIX, chapter 7, Title 42.
- 34 Centers for Medicare and Medicaid Services, *About CMS: History Overview*, updated March 30, 2010, available at <https://www.cms.gov/History/> (last accessed June 25, 2010).
- 35 Kaiser Commission on Medicaid and the Uninsured, *Medicaid and SCHIP Eligibility for Immigrants*, April 2006, available at <http://www.kff.org/medicaid/upload/7492.pdf> (last accessed June 25, 2010) [hereinafter *Medicaid and SCHIP Eligibility for Immigrants*].
- 36 Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, November 2008, available at http://www.kff.org/medicaid/upload/7235_03-2.pdf (last accessed June 25, 2010) [hereinafter *The Medicaid Program at a Glance*].
- 37 *Id.*
- 38 Kaiser Family Foundation, *Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States*, May 2010, available at <http://www.kff.org/healthreform/upload/8072.pdf> (last accessed June 24, 2010).
- 39 Department of Health and Human Services, *Medicaid At-a-Glance: A Medicaid Information Source*, 2005, available at <https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/maag2005.pdf> (last accessed June 25, 2010).
- 40 *The Medicaid Program at a Glance*, *supra* note 32.
- 41 42 U.S.C. §§1397aa-1397jj, subchapter XXI, chapter 7, Title 42.
- 42 Centers for Medicare and Medicaid Services, *National CHIP Policy: Overview*, March 11, 2010, available at <https://www.cms.gov/NationalCHIPPolicy/> (last accessed June 25, 2010).
- 43 *Medicaid and SCHIP Eligibility for Immigrants*, *supra* note 31.
- 44 *Id.*
- 45 Social Security Administration, *Benefits For Children*, SSA Publication No. 05-10085, September 2004, available at <http://ssa.gov/pubs/10085.html#who> (last accessed June 28, 2010).
- 46 Centers for Medicare and Medicaid Services, *Medicaid Eligibility: Overview*, May 19, 2010, available at <https://www.cms.gov/MedicaidEligibility/> (last accessed June 25, 2010) [hereinafter *Medicaid Eligibility*].
- 47 U.S. Const. amend. XIV, §1 (providing in pertinent part that “[a]ll persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside.”)
- 48 *Id.*
- 49 Pennsylvania Medicaid Policy Center, *Medicaid Eligibility for Non-Citizens*, 2008, available at http://www.pamedicaid.pitt.edu/documents/non-citizen_format_no-pak%20_3_.pdf (last accessed June 25, 2010) [hereinafter *Medicaid Eligibility for Non-Citizens*].
- 50 *Medicaid Eligibility for Non-citizens*, *supra* note 44.
- 51 *Id.*
- 52 *The Medicaid Program at a Glance*, *supra* note 32.
- 53 *Medicaid Eligibility*, *supra* note 42.
- 54 Illegal aliens are also unable to receive Medicare coverage. See Barbara Klees, Christian Wolfe & Catherine Curtis, *Brief Summaries of Medicare & Medicaid*, Centers for Medicare & Medicaid Services, November 1, 2009, available at <https://www.cms.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2009.pdf> (last accessed July 22, 2010). Although coverage rules for private insurance vary significantly, under the Patient Protection and Affordable Care Act (see *infra* note 80) illegal immigrants are prohibited from purchasing health insurance from health exchanges. See Pub. L. No. 111-148, Sec. 1312(f)(3). Some illegal aliens may receive coverage through private insurance companies or through their employees, depending on how carefully an employer vets its employees. See e.g. <http://www.npr.org/templates/story/story.php?storyId=106376595> and http://www.washingtonexaminer.com/local/Report_-one-third-of-illegal-immigrants-have-employer-based-health-care-8354660-63687987.html.
- 55 Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub.L. 104-193, 110 Sta. 2105 (1996).
- 56 8 U.S.C. §1601(1).
- 57 Robin K. Cohen, *PRWORA’s Immigrant Provisions*, Connecticut General Assembly: Office of Legislative Research, December 2007, available at <http://www.cga.ct.gov/2007/rpt/2007-R-0705.htm> (last accessed June 25, 2010) [hereinafter referred to as Cohen].
- 58 *Medicaid and SCHIP Eligibility for Immigrants*, *supra* note 31.
- 59 Legal immigrants are allowed to serve in the armed forces.
- 60 *Medicaid and SCHIP Eligibility for Immigrants*, *supra* note 31.
- 61 *Id.*

- 62 Pub.L. 105-18 (1997), Pub. L. 105-33 (1997), Pub. L. 105-185 (1997).
- 63 Cohen, *supra* note 51.
- 64 *Id.* Examples of PRUCOL includes aliens who are presumed to have been lawfully admitted for permanent residence even though they lack documentation of their admission to the United States, or aliens who are granted a lawful immigration status that allows them to remain in the United States for an indefinite period of time.
- 65 An individual who executes an affidavit of support with respect to a sponsored alien. 8 U.S.C. §1183a(f).
- 66 Leighton Ku & Bethany Kessler, *The Number and Cost of Immigrants on Medicaid: National and State Estimates*, Urban Institute, December 16, 1997, available at <http://www.urban.org/url.cfm?ID=407384> (last accessed June 25, 2010) [hereinafter Ku, et al.]
- 67 *Medicaid and SCHIP Eligibility for Immigrants, supra* note 31.
- 68 Cohen, *supra* note 51.
- 69 Helga Niesz, *State Program Access for Non-Citizens*, Connecticut General Assembly: Office of Legislative Research, May 19, 2005, available at <http://www.cga.ct.gov/2005/rpt/2005-R-0462.htm> (last accessed June 25, 2010).
- 70 *Immigrants and Health Coverage, supra* note 7.
- 71 Cohen, *supra* note 51.
- 72 *Medicaid and SCHIP Eligibility for Immigrants, supra* note 31.
- 73 *Id.*
- 74 Ku, et al., *supra* note 59.
- 75 Deficit Reduction Act of 2005, Pub.L. No. 109-171, 120 Stat. 4 (2006).
- 76 *Id.*
- 77 *Medicaid Eligibility for Non-citizens, supra* note 44.
- 78 *Medicaid Eligibility for Non-citizens, supra* note 44.
- 79 Martha Raffaele, *Proof-of-Citizenship Bill for Benefits is Debated*, Philadelphia Inquirer, Oct. 18, 2007, available at http://www.philly.com/inquirer/local/20071018_Proof-of-citizenship_bill_for_benefits_is_debated.html (last accessed Oct. 23, 2009).
- 80 *Medicaid and SCHIP Eligibility for Immigrants, supra* note 31.
- 81 Pub. L. No. 111-148 (2010).
- 82 Pub. L. No. 111-152 (2010).
- 83 White House Press Release, *The Affordable Care Act – Implementation Timeline*, March 2010, available at www.whitehouse.gov/healthreform/timeline (last accessed June 15, 2010).
- 84 *Id.*
- 85 *Id.*
- 86 Pub. L. No. 111-148, Sec. 1312(f)(3).
- 87 *Id.*
- 88 Randal C. Archibold & Megan Thee-Brenan, *Poll Shows Most in U.S. Want Overhaul of Immigration Laws*, N.Y. Times, May 3, 2010, available at <http://www.nytimes.com/2010/05/04/us/04poll.html?ref=us> (last accessed June 25, 2010).
- 89 *Id.*
- 90 Richard Lacayo, et al., *Down on the Downtrodden*, Time Magazine, December 19, 1994, available at <http://www.time.com/time/magazine/article/0,9171,982006-4,00.html#ixzz0YQ6MIgQ8> (last accessed November 30, 2009).
- 91 *Immigrants and Health Coverage, supra* note 7.
- 92 Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, January 2006, available at <http://www.kff.org/uninsured/upload/7451.pdf> (last accessed July 18, 2010).
- 93 Marie Wang & John Holahan, *The Decline in Medicaid Used by Noncitizens Since Welfare Reform*, Urban Institute, April 2003, available at http://www.urban.org/uploadedpdf/900621_hponline_5.pdf (last accessed July 18, 2010).
- 94 James P. Smith and Barry Edmonston, *The New Americans: Economic, Demographic and Fiscal Effects of Immigration*, at 55 (National Academy Press 1997).
- 95 8 U.S.C. §1182(a)(4).
- 96 8 U.S.C. §1182 (a)(1)(A)(i).
- 97 8 U.S.C. §1182 (a)(1)(A)(ii).
- 98 8 U.S.C. §1182 (a)(1)(A)(iii).
- 99 8 U.S.C. §1182 (a)(1)(A)(iv).
- 100 *Immigrants and Health Coverage, supra* note 7.
- 101 *Id.*
- 102 See 42 C.F.R. §431.301 (providing that States may not use or disclose information concerning applicants or recipients for any purposes other than those directly connected with the administration of a plan); see also 42 C.F.R. 431.306(d).
- 103 Leighton Ku & Sheetal Matani, *Left Out: Immigrants' Access to Health Care and Insurance*, Health Affairs, 2001, available at <http://content.healthaffairs.org/cgi/content/full/20/1/247> (last accessed June 28, 2010).
- 104 *Medicaid and SCHIP Eligibility for Immigrants, supra* note 31.
- 105 Holahan, J. et al., *Is Immigration Responsible for the Growth in the Number of Uninsured?* Urban Institute, Feb. 2001, available at <http://www.urban.org/url.cfm?ID=1000359> (last accessed June 25, 2010).
- 106 42 U.S.C. §1396dd.
- 107 *Medicaid Eligibility for Non-citizens, supra* note 44.
- 108 Centers for Medicare and Medicaid Services, *EMTALA: Overview*, June 11, 2010, available at <http://www.cms.gov/EMTALA/> (last accessed July 18, 2010).
- 109 Kaiser Commission on Medicaid and the Uninsured, *Characteristics of Frequent Emergency Department Users*, October 2007, available at <http://www.kff.org/insurance/upload/7696.pdf> (last accessed July 18, 2010).
- 110 Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to care for Low-Income Non-Citizen Adults*, June 2007, available at: <http://www.kff.org/uninsured/upload/7651.pdf> (last accessed July 30, 2010).
- 111 U.S. General Accounting Office: Report to Congressional Committees, *Emergency Care-EMTALA Implementation and Enforcement Issues*, GAO-01-747, June 2001, p.12 available at <http://www.gao.gov/new.items/d01747.pdf> (last accessed July 18, 2010).
- 112 *Id.*
- 113 *Immigrants and Health Coverage, supra* note 7.
- 114 Walter Ewing, *Immigrants' Importance*, Modern Healthcare, Jan. 4, 2010, available at <http://www.modernhealthcare.com/article/20100104/SUB/301049966> (last accessed June 25, 2010).
- 115 *Id.*

REMINDER:

ABA Health Law Section members can access past issues of *The Health Lawyer* on the Section's website. To access back issues and *The Health Lawyer's* full index, go to www.abanet.org/health/03_publications/01_health_lawyer.html