

Holes in the Safety Net — Legal Immigrants' Access to Health Insurance

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While Congress debates whether publicly supported health care should be available to undocumented immigrants who may be placed on a path to citizenship under immigration reform, the health care needs of already legal immigrants continues to be overlooked. More than 12 million immigrants are lawfully present in the United States. They serve in the military, pay taxes, and contribute to the economy. Yet like undocumented immigrants, whose health care vulnerabilities are outlined in the Perspective article by Sommers, legal immigrants face substantial barriers to obtaining insurance coverage (see graph). As a result, some — such as Antonio Torres, an uninsured Arizona farmworker who was in a coma after a car accident — have been forcefully transferred to their native country when their treating hospitals were unable to find facilities willing to provide them with long-term care.¹

Legal immigrants form a highly heterogeneous group that includes legal permanent residents (“green card holders”), refugees, asylum seekers, and many others. Because of the heterogeneity of the class and the complexity of immigration categories, information on the proportion insured is scarce. Augmenting data from the 2008 Current Population Survey, the Pew Hispanic Center reports that 24% of legal immigrants were uninsured in 2008, as compared with 59% of unauthorized immigrants and 14% of native citizens.² In a 2005 article

that was based on data from the Los Angeles Family and Neighborhood Survey, Goldman et al. reported that 32% of permanent legal residents remained uninsured for an entire 2-year period, as compared with 65% of undocumented immigrants and 18% of citizens.³ Although legal immigrants, like other immigrants, spend less on health care and appear to be healthier than citizens, that appearance may be attributable in part to undiagnosed illnesses and lack of access to a regular source of care.⁴

There are many reasons why legal immigrants have low rates of health insurance. They are more likely to work in sectors of the economy, such as agriculture, that tend not to provide health insurance. Linguistic and cultural barriers also limit their access, as do laws barring them from public insurance programs.

There is no evidence that immigrants are excessive users of public benefits. Nevertheless, responding to the charge that immigration burdens taxpayers, Congress in 1996 enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which barred most legal immigrants from Medicaid and other federal health programs for the first 5 years after they attain their lawful status. PRWORA also permanently prohibited undocumented immigrants and several other classes of noncitizens, such as persons with temporary administrative status, from receiving federal benefits.

Since 1996, Congress has per-

mitted federal funds to be used to insure noncitizen children and pregnant women. PRWORA also allows states to use their own money to insure immigrants who are ineligible for federal programs. Sixteen states and the District of Columbia do so.⁵ However, state-funded programs for immigrants (who cannot vote) are often the first programs cut when state budgets are tight.

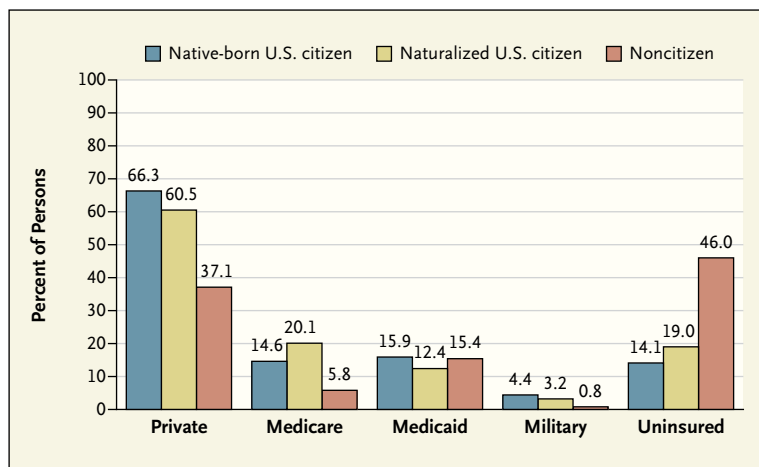
Although Congress has broad authority over immigration and can discriminate against legal immigrants, legal aliens are a protected class for purposes of the Equal Protection Clause of the U.S. Constitution. As a result, courts reviewing challenges to laws that are discriminatory against legal immigrants apply strict judicial scrutiny, the most stringent form of judicial review, and find the laws unconstitutional unless they are necessary to further a compelling state interest. Discriminatory state laws may also violate state constitutions.

Two recent cases demonstrate how courts look at state laws eliminating legal immigrants' access to state health programs — in different ways, depending on whether those programs insure only immigrants or citizens as well. *Finch v. Commonwealth Health Insurance Connector Authority* (Massachusetts Supreme Judicial Court, 2012, 2011) was a class action brought under the Massachusetts constitution by legal immigrants who challenged a 2009 state law excluding them from Commonwealth Care, a state-subsidized premium-support program established by the Massachu-

sets 2006 health care reform law. Initially, all legal residents with incomes under 300% of the federal poverty level who lacked access to other forms of health insurance were eligible for Commonwealth Care. After the 2008 financial crisis, the state excluded immigrants for whom it could not receive any federal support owing to PRWORA. The state simultaneously established a program with a more limited network of health care providers for immigrants who had been removed from Commonwealth Care, but that program was closed to noncitizens who first sought coverage after July 2009.

Since Commonwealth Care insured both immigrants and citizens, the Massachusetts Supreme Judicial Court saw the immigrants' exclusion as discriminating against them in favor of citizens. In 2011, Justice Francis X. Spina, writing for a five-to-three majority, ruled that the discrimination was subject to strict scrutiny under the state constitution. He added that PRWORA left the decision about whether to insure immigrants with state funds up to the state and did not justify less-searching judicial review. The next year, a unanimous Court, in an opinion by Justice Robert Cordy, ruled that the immigrants had been terminated from Commonwealth Care for fiscal reasons, which did not constitute a compelling state interest. As a result, the exclusion of the immigrants from Commonwealth Care was unconstitutional.

Bruns v. Mayhew (Federal District Court, Maine, March 14, 2013), in contrast, was a class action brought in federal district court by Hans Bruns, a legal permanent resident with adenoid cystic carcinoma, and Kadra



Health Insurance, According to Citizenship Status, 2009.

Data are from a Congressional Research Service analysis of the March 2010 Current Population Survey. Persons may be included in more than one category.

Hassan, an asylum seeker with end-stage renal disease. Both had been insured by a program that used state funds to provide immigrants with insurance comparable to Medicaid. When Maine eliminated the program, the plaintiffs sued, claiming a violation of the federal Constitution. In March, Federal Judge John A. Woodcock, Jr. denied the plaintiffs' request for a preliminary injunction. The judge found that unlike the program in *Finch*, the program at issue was a separate program, limited to immigrants. As a result, its termination did not put immigrants at a disadvantage as compared with citizens. An appeal is now pending.

Regardless of the appellate court's decision, once the relevant provisions of the Affordable Care Act (ACA) are implemented in 2014, legal immigrants will be eligible for tax subsidies and credits to purchase insurance through the newly established health insurance exchanges. Ironically, in states that choose not to expand their Medicaid programs — an option the Supreme Court gave states in its ACA decision last

summer — legal immigrants with incomes below 100% of the federal poverty level may have greater access to insurance than will low-income citizens: the drafters of the ACA assumed that citizens with such low incomes would receive Medicaid and therefore left them, but not legal immigrants, without support for purchasing insurance on the exchanges. It remains to be seen, however, whether the insurance on the exchanges will be affordable to such low-income immigrants. Moreover, medically frail and disabled low-income legal immigrants will continue to lack access to Medicaid's coverage for long-term care. As a result, many immigrants will remain dependent on state programs that continue to be susceptible to fiscal pressures. More litigation is likely.

Public policies that deny legal immigrants equal access to public insurance programs leave lawful residents and their health care providers unnecessarily vulnerable when injuries and illness strike. By encouraging immigrant-only programs, such policies also perpetuate needless complexity in the

health care system. Only by offering legal immigrants the same coverage as citizens can we ensure their health security and establish a more rational health care system.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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In the Shadows

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I open the door to find Carlitos galloping around the exam room. His parents, both of whom I've known for years, are seated in the corner. Carlitos's mom gives me a soft smile. I sit down on my stool, put the chart on my lap, and begin.

"What's wrong with Carlos today?" I ask in Spanish.

"Well, nothing, really," says his mom, her gaze falling to the floor.

"Um, OK," I respond. I'm perplexed, since I am a pediatrician and Carlos is the only child in the room. "Then why are you here today?"

"It's his father. He's sick. The doctors at the hospital say he's dying." I glance at the thin, frail man beside her, estimating that he's in his late 40s. "They say his liver is no good. My friends say that we should go back to Mexico for help, but we wanted to ask you."

"Is it hepatitis? Cancer?" I ask.

"Who knows?" shrugs the mom.

As a bilingual pediatrician, I have been afforded an unusual window into the lives of America's undocumented immigrant community. It is a difficult life, without any of the legal protec-

tions that most Americans take for granted. Their jobs are often under the table — with unsafe conditions and low wages, no possibility of workers' compensation or Social Security, and little tax revenue paid to the government.¹ They cannot legally drive — a huge barrier to everyday life here in suburban Atlanta. And of course they are shut out of our health care system, being ineligible for help even if they're disabled (like Carlos's father). Indeed, undocumented immigrants are specifically excluded from the benefits of the Affordable Care Act.

But their American-born children are eligible for Medicaid, so they come to the pediatrician and tell me their stories. A young mother needs her gallbladder removed — what to do? Another mother was taken to jail because she was caught driving. Should they drink the brownish water that comes out of the faucet at the trailer park? Two young children are feeling depressed because their father was recently deported. Could I look at this adult's rash or joints, listen to her wheeze, look in his ears, even though I am not an adult doctor?

I leave the room and call the gastroenterologist who took care of Carlos's dad during his recent admission to our local hospital. I'm informed that he has end-stage liver disease, brought about by a deadly combination of hepatitis C and years of heavy alcohol use. Palliative care, including treatment of his esophageal varices, will be difficult or impossible without health insurance. I go back into the room and explain the situation to the parents as best as I can. They decide that the father will return to Mexico, where he may receive further medical care. It is unclear whether his wife and children will accompany him or whether they will separate forever.

As I leave the room again, preparing my mind for the next patient, I stare at the superbill for Carlos's visit and tear it in half. There is no CPT code for this.

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From Conyers Pediatrics, Conyers, GA.

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