Laboratories of Exclusion: Medicaid, Federalism & Immigrants

Medha D. Makhlouf
Penn State Dickinson Law, mdm5849@psu.edu

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LABORATORIES OF EXCLUSION:
MEDICAID, FEDERALISM & IMMIGRANTS

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Medha D. Makhlouf*

ABSTRACT

Medicaid’s cooperative federalism structure gives states significant discretion to include or exclude various categories of immigrants. This has created extreme geographic variability in immigrants’ access to health coverage. This Article describes federalism’s role in influencing state policies on immigrant eligibility for Medicaid and its implications for national health policy. Although there are disagreements over the extent to which public funds should be used to subsidize immigrant health coverage, this Article reveals that decentralized policymaking on immigrant access to Medicaid has weakened national health policy. It has failed to incentivize the type of state policy experimentation and replication that justifies federalism arrangements in other contexts. Rather, federalism has (1) enabled states to enact exclusionary policies that are ineffective and inhumane and (2) created barriers for states to enact inclusionary policies that advance the normative goals of health policy. This Article concludes that immigrant access to health coverage is best addressed through centralized policymaking.

This Article contributes to scholarly conversations about federalism and health care by providing a case study to test the efficacy of federalism arrangements in achieving equity for those who were left behind by health reform. More broadly, it adds to the federalism literature by synthesizing insights from three fields that rarely comment on one another: health law, immigration law, and federalism theory.

* Assistant Professor and Director, Medical-Legal Partnership Clinic, Penn State University – Dickinson Law; Assistant Professor, Department of Public Health Sciences, Penn State College of Medicine. I received helpful feedback from participants in the University of Maryland Law Faculty Workshop, the NYU Clinical Law Review Writers’ Workshop, and the University of Richmond Junior Faculty Workshop. For their support and encouragement, I owe many thanks to members of the Katz Workshop, especially Matthew J.B. Lawrence and Tiffany Jeffers.
INTRODUCTION

I. EXCLUDING IMMIGRANTS FROM MEDICAID: HOW WE PAY
   A. Federal Framework
      1. Evolution of Exclusions
      2. Emergency Medicaid
      3. State Options
   B. State-Funded Programs

II. PROBLEMS WITH THE EXISTING PATCHWORK OF EXCLUSION
   A. Outcomes, Costs, Quality
   B. Equity
   C. Racial Dynamics

III. FEDERALISM’S INFLUENCE
   A. Enabling Exclusionary Policymaking
   B. Creating Barriers for Inclusionary Policymaking

IV. THE LIMITS OF DECENTRALIZED POLICY
   A. Stifled Innovation
   B. Incidental Health Policy

CONCLUSION
INTRODUCTION

In the first Democratic presidential primary debate of 2019, the moderators asked the candidates whether their health plan proposals would cover undocumented immigrants. An astonished audience watched as all ten candidates raised their hands. Following up on the question, Pete Buttigieg stated: “Our country is healthier when everybody is healthier…. This is not about a handout, this is an insurance program and we do ourselves no favors by having 11 million undocumented people in our country be unable to access health care.” Former Vice President Joe Biden agreed, responding, “[Y]ou cannot let people who are sick, no matter where they come from, no matter what their status, go uncovered, you can’t do that…. [I]t’s just got to be taken care of, period. You have to, it’s the humane thing to do.” As health care reform once again becomes a central focus of American politics—this time, with formerly fringe ideas like a universal, national health care system enjoying significant popularity—determining whether and how noncitizens residing in the United States should be included within that “universe” is increasingly vital.

This Article is the first sustained treatment of the vitally important legal and policy question of the interactions among federalism, access to health care, and immigration. It explores important themes in federalism

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3 Id.

4 I take inspiration from Laboratories of Destitution, David Super’s seminal case study of the relationship between federalism and anti-poverty policy. 157 U. PENN. L. REV 541, 547 (2008) (arguing that decentralized antipoverty policy has been ineffective at encouraging state policy experimentation and advocating for more centralized policymaking). However, the intersection of health care and immigration raises complex issues of economics, sovereignty, and justice that are unique and not presented as squarely in the anti-poverty context and in Super’s analysis. See discussion infra Parts I, III. Health law scholars have generally bracketed federalism issues as they relate to immigrants, if they are mentioned at all. See, e.g., Elizabeth Y. McCuskey, Big Waiver under Statutory Sabotage, 44 OH. N. UNIV. L. REV. 213, 230 (2019) (mentioning California’s withdrawal of a Section 1332 State Innovation Waiver application seeking to permit undocumented immigrants to purchase unsubsidized Marketplace coverage as an example of limited waiver activity caused by uncertainty about the future of the ACA); Abbe R. Gluck & Nicole Huberfeld, What is Federalism in Healthcare For?, 70 STANFORD L. REV. 1689, 1726 (2018) (noting that undocumented and some legal immigrants were left out of the
scholarship including policy fragmentation, inequity, and exclusion by examining how states react to federalism arrangements governing immigrant eligibility for Medicaid. It provides a valuable case study for understanding the efficacy of federalism arrangements in achieving equity. When Congress designates states to implement federal statutes, as in the ACA, who gets left behind? Finally, this Article adds to the growing literature analyzing federalism arrangements across a range of subjects in order to uncover trans-substantive insights about whether they are suited to achieving their stated policy goals.5

In this Article, I use the term “excluded noncitizens” to describe the population of focus: those who are ineligible for subsidized health coverage programs because of their immigration status and who have resided or intend to reside in the United States for the long term.6 The meaning of “excluded noncitizen” differs depending on the program being discussed and the state of residence. I focus on Medicaid because it is the means by

ACA’s federalism-oriented Medicaid expansion); Lindsay F. Wiley, Medicaid For All? State-Level Single-Payer Health Care, 79 OH. ST. L.J. 843, 865 (2018) (including undocumented immigrants among groups who may obtain access to health coverage through a state-level public option); id. at 864 (describing California and Oregon Section 1332 waiver applications that would improve access to health coverage for undocumented immigrants among state strategies to use waivers to “open up access to new populations”). In recent scholarship, Wendy E. Parmet has begun mapping the values at stake when state and federal action in the immigration and health care spheres intersect. The Plenary Power Meets the Police Power: Federalism at the Intersection of Health & Immigration, 45 AM. J. L. & MED. 224 (2019). In the extensive literature on immigration and federalism, scholars typically combine their analysis of Medicaid with other public benefit programs, and some of the most prominent articles were authored pre-ACA. See, e.g., Stella Burch Elias, The New Immigration Federalism, 74 Ohio St. L.J. 703, 733 (2013) (describing Congress’ delegation of authority to states to enact immigrant-exclusionary public benefit laws); id. at 743 (describing state and local immigrant-inclusionary laws providing a variety of services to undocumented immigrants); Cristina Rodriguez, The Significance of the Local in Immigration Regulation, 106 Mich. L. Rev. 567, 586 (2008) (using immigrant exclusion from Medicaid as an example of how “states and localities bear much of the cost of absorbing immigrants”); Michael J. Wishnie, Laboratories of Bigotry? Devolution of the Immigration Power, Equal Protection, and Federalism, 76 N.Y.U. L. Rev. 493, 506-509 (2001) (outlining the doctrine of state alienage restrictions in public benefit programs); Stephen H. Legomsky, Immigration, Federalism, and the Welfare State, 42 UCLA L. Rev. 1453, 1471 (1995) (including emergency Medicaid costs among those incurred by states with disproportionate numbers of undocumented immigrants).

5 See infra note 228.

6 Research suggests that significant numbers of noncitizens who are not legally barred from access to subsidized health coverage nevertheless avoid it because of immigration-related concerns. I focus on this population in a different paper. Medha D. Makhlof, Chilling Effects: Health Care Access in an Immigration Crackdown (unpublished manuscript) (on file with author).
which low-income households without access to affordable employer sponsored insurance obtain health coverage; it covers more than a quarter of the population; and it is an important building block and comparator for policymakers seeking to expand publicly funded health insurance.

Medicaid’s cooperative federalism structure gives states significant discretion to make decisions about immigrant eligibility. Federal law mandates Medicaid coverage of only a small category of noncitizens. Beyond this floor, states may expand coverage to additional groups of noncitizens using federal and state funds. I argue that this structure doesn’t just create extreme geographic variability in immigrants’ access to health coverage; it (1) enables states to enact exclusionary policies that are ineffective and inhumane and (2) creates barriers for states to enact inclusionary policies that would advance the normative goals of health policy. This is consistent with prior research demonstrating how federalism can exacerbate inequity and hinder social citizenship. On balance, decentralized policymaking on immigrant access to Medicaid has weakened national health policy.

This Article proceeds in four parts. Part I describes the existing patchwork of noncitizen exclusion from Medicaid and the ways in which the U.S. government subsidizes health care for excluded noncitizens in other, less efficient ways. This latter consideration is often missing from debates over whether immigrants should be eligible for publicly funded health insurance. Those who are opposed to expanding coverage for immigrants may be persuaded to reconsider their position when confronted with information about how public funds are already used to subsidize immigrant health care, and how we could do so more effectively.

Part II explains why the patchwork of noncitizen exclusion weakens national health policy. First, when states underprovide subsidized health coverage, individual and population health outcomes worsen, costs shift and can increase, and quality metrics suffer. Second, geographic variability in access raises concerns about health care equity, which scholars have

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7 Noncitizens with ESI are subsidized by their employers and wealthy noncitizens without access to ESI can purchase unsubsidized coverage from the private market and are therefore not the subject of this Article.


identified as the emerging normative foundation of health law scholarship and health care regulation. Horizontal inequity occurs when residents of different states with the same medical needs do not have the same access to health care. Vertical inequity occurs when noncitizen residents with great health care needs have less access than citizens with lesser needs. Third, state control of Medicaid is a legacy of racial politics, which scholars demonstrate is linked to immigration politics. Exclusion of immigrants from Medicaid disproportionately affects Latinx and non-white people. State policies shaped by antidemocratic values like racism undermine national health policy.

Part III analyzes federalism’s influence on the substance of state policies on immigrant eligibility for Medicaid. First, the structure enables states to enact exclusionary policies that are ineffective and inhumane. For example, the American Medical Association Journal of Ethics published a graphic narrative about the tragedy of undocumented immigrants with end-stage renal disease who live in states that do not authorize publicly funded coverage of routine outpatient dialysis, forcing patients into near-death situations before they can receive emergency treatment. Without a robust federal floor of Medicaid coverage for immigrants, states like Alabama, Mississippi, North Dakota, Virginia, Wyoming, and Texas have faced no obstacle to imposing harsher limits on immigrant eligibility for Medicaid.

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11 See, e.g., JAMILA MICHERE, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS 24 (2018) (“[A]mple research has confirmed that federalism bolsters one of the most antidemocratic forces in the American policy: racism.”); Hana E. Brown & Rachel Kahn Best, Logics of Redistribution: Determinants of Generosity in Three U.S. Social Welfare Programs, 60 SOCIOLOGICAL PERSPECTIVES 786, 793 (2017); Ellen Reese et al., The Politics of Welfare Inclusion: Explaining State Variation in Legal Immigrants’ Welfare Rights, 56 SOCIOLOGICAL PERSPECTIVES 97, 98-99 (2013) (“[M]any scholars suggest that the policies towards [legal immigrants] were shaped by wider attitudes toward the foreign-born population and its racial and ethnic make-up.”).


than are required under federal law. Federalism empowers states to enact exclusionary policies guided by ideologies like immigration restrictionism and other factors that are peripheral to health policy.

Second, federalism creates barriers for states to enact inclusionary policies that would advance the normative goals of health policy: improved outcomes and quality, reduced costs, and equitable access. States that want to expand Medicaid coverage for immigrants face a major obstacle in the form of fiscal capacity. Poor baseline economic conditions can prevent states from taking advantage of federal options to expand coverage, institutionalizing these decisions and inhibiting future reform. Because most states are required to balance their budgets each year, unlike the federal government, programs supported by state funds are more vulnerable to changes in economic conditions. States may be forced to cut their Medicaid budgets and deny necessary care to enrollees with few resources and options. Predictably, only a handful of states have created state-funded programs to expand immigrant eligibility for Medicaid-like coverage.

Part IV discusses the limits of federalism in the context of immigrant eligibility for Medicaid. In the conception of states as laboratories of democracy, states design and conduct policy experiments in order to identify policies that “work,” i.e. that accomplish their intended effects and that do not have counter-productive side effects. Successful experiments should serve as policy templates for other jurisdictions. Medicaid’s structure has largely failed to incentivize this type of experimentation and

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16 See Reese et al., supra note 11, at 97 (finding that states with higher poverty rates were less likely to restore benefits for noncitizens using state funds after welfare reform); id. at 117 (finding that states’ past spending patterns on welfare programs for noncitizens predict future spending patterns).

17 Super, supra note 15, at 547.


replication.20 Many states, including several of the “new destination” states for immigrants—Alabama, Tennessee, South Dakota, Nevada, Kentucky, Georgia, Idaho, Indiana, and Mississippi21—have not elected options to expand Medicaid for noncitizens after adopting the federal baseline of restrictions set out in the 1996 welfare and immigration reform laws.22 Policy reform has stagnated, despite shifting demographics and unmet health care needs among noncitizens residing in those states. The Article concludes by making a normative case for centralization of policy relating to immigrant eligibility for subsidized health coverage.

I. EXCLUDING IMMIGRANTS FROM MEDICAID: HOW WE PAY

Public support for expanding subsidized health coverage for undocumented immigrants—who make up the largest cohort of excluded noncitizens—is middling.23 Those who oppose expansion typically question why U.S. citizens should subsidize health care for noncitizens at all. However, they often overlook the ways in which we already pay for such care. We pay through safety net programs like Emergency Medicaid, public health services, and federally qualified health centers, and through grant programs intended to reimburse health care providers for uncompensated care provided to uninsured immigrants. These payments represent an institutional commitment to the “rescue principle” in health care, which holds that “anyone in immediate distress [should] not suffer and die in the street.”24 The important question for politicians is not whether we want to

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20 See, e.g., Abbe R. Gluck & Nicole Huberfeld, What is Federalism in Healthcare For?, 70 STANFORD L. REV. 1689, 1704 (2018) (“States have been limited in what they can accomplish alone in healthcare experimentation.”).
21 “New destination” states are those in “the foreign-born population grew at or above twice the national rate between 2000 and 2009.” Aaron Terrazas, Immigrants in New-Destination States, MIGRATION POL’Y INST., Feb. 8, 2011, https://www.migrationpolicy.org/article/immigrants-new-destination-states. They are listed in descending order of growth.
22 See discussion infra Section I.A.3.
24 Mark G. Kuczewski, Who is My Neighbor? A Communitarian Analysis of Access to Health Care for Immigrants, 32 THEORETICAL MED. & BIOETHICS 327, 329 (2011); see also PATRICIA ILLINGWORTH & WENDY E. PARMET, THE HEALTH OF NEWCOMERS: IMMIGRATION, HEALTH POLICY, AND THE CASE FOR GLOBAL SOLIDARITY 182 (2017) (noting that since immigrants are not fully excluded from the U.S. health care system means that there is at least some health-related solidarity between citizens and noncitizens); Patrick Glen, Health Care and the Illegal Immigrant, 23 HEALTH MATRIX 197, 229 (2013) (discussing EMTALA and its underlying ethical principle that every person should receive medical treatment when it is necessary).
pay for such care, but how we want to do so.

A review of the landscape of subsidized health coverage for noncitizens demonstrates an important point: Noncitizens are not—and have never been—completely excluded from subsidized health coverage programs. Going back to the earliest days of our social welfare system, there have been a variety of local, state, and federal health care programs that serve noncitizens. The rationales for including noncitizens in publicly funded health insurance are based on achieving health policy goals relating to outcomes, costs, and quality. Safety net programs and funding sources such as those described above are intended to fill the gaps in our public health insurance system. However, the existing patchwork of programs is woefully inadequate to meet the health care needs of many noncitizens.

A. Federal Framework

As Professor Wendy Parmet notes in her authoritative analysis of the roles of the federal and state governments as they relate to policies at the intersection of health and immigration, regulation of both health law and immigration law is “complex and dynamic.” While matters relating to health are traditionally the domain of state and local governments, matters relating to immigration are theoretically the exclusive domain of the federal government. The “messy” reality is that each level of government has a role in regulating matters at the intersection of health and immigration.


26 Parmet, supra note 25, at 232. In the earliest colonial governments, localities were deemed responsible for caring for indigent people in their territory under the “doctrine of local care.” Michener, supra note 11, at 34. However, even then, when the tradition of local primacy in health-related matters was strongest, certain health-related matters involving immigrants were shunted to a central authority when they were determined to be beyond the scope of the locality’s ability to address. For example, when “impoverished immigrants flooded seaport cities,” colonial localities could seek funds from the colonial treasury to provide for their basic needs. Id. Immigrants were among those characterized as the “unsettled” poor, which referred to people who had not settled in the locality but for whom it had nevertheless assumed responsibility. Id. The corollary to local responsibility for public assistance in the colonies (and later in the states prior to the establishment of the first comprehensive federal immigration law in 1882) was the authority to prohibit from settling or to expel persons who were dependent or likely to become dependent on public assistance. See Medha D. Makhlouf, The Public Charge Rule as Public Health Policy, 16 IND. HEALTH L. REV. 177, 179-81 (2019) (describing the rights and responsibilities of colonial localities and states prior to 1882 relating to the provision of public assistance and the expulsion of poor people). States’ police powers also encompassed the ability to
The doctrinal foundation of states’ authority to enact laws to preserve and protect the safety, health, welfare, and morals of the community is known as the “police power.” Over time, as this Section illustrates, the federal government has become increasingly influential in regulating and financing health care. Although the traditional presumption of state primacy in matters relating to health retains some influence in health care policy and constitutional jurisprudence, federal authority to regulate health insurance is undisputed. Debates over the preservation of states’ roles are not based on “separate spheres” federalism considerations about the primary function of each level of government with respect to health insurance regulation and finance; rather, they are mainly about policy disagreements.

Laws regulating immigrant eligibility for publicly funded health care sit at the nexus of two doctrinal traditions. They are not “immigration laws” per se as they do not regulate core immigration concerns such as admission and removal. They may be considered alienage laws, which regulate noncitizens’ rights and responsibilities once they are residing within the country. Alienage laws use citizenship or immigration status as the basis for treating residents differently, such as excluding them from eligibility for Medicaid.

In constitutional challenges to laws relating to health and immigrants, courts have cited various bases for their decisions—not only because such laws are at the nexus of two doctrinal traditions, but also because they are heavily regulated and complex fields. While it is true that the plenary power and police power doctrines have eroded over time, they remain influential in shaping the creation and interpretation of laws at the intersection of health and immigration. For example, the Supreme Court exclude immigrants from admission for public health reasons. Parmet, supra note 25, at 228.

27 See discussion in text accompanying notes 28-31 of Parmet, supra note 25.
28 Parmet, supra note 25, at 228.
29 Huberfeld, supra note 18, at 464 (“If Congress were to federalize Medicaid, the Spending Clause clearly provides the enumerated power to do so, just as it does for Medicare.”); Carleton B. Chapman & John M. Talmadge, Historical and Political Background of Federal Health Care Legislation, 35 L. & CONTEMP. PROBS. 334, 345 (1970).
30 Gluck & Huberfeld, supra note 20, at 1724.
31 Parmet, supra note 25, at 229-30.
33 See Parmet, supra note 25, at 232 (describing how legality of California’s Proposition 187 was decided on multiple bases).
34 Parmet, supra note 25, at 228-29 (describing how states have retained significant discretion in implementing federal health care laws as a result of the police power’s influence on federal healthcare legislation and federal lawmakers’ rhetoric); id. at 226
has relied on the federal exclusivity principle of the plenary power doctrine to strike down state alienage restrictions in Medicaid. Such analyses are particularly apt when these laws are actually shadow attempts by states to regulate immigration rather than to make good health policy. In general, however, the interjection of immigration policy motives into what is essentially a health policy matter has proven to be unnecessary and unhelpful for achieving national health policy goals.

1. Evolution of Exclusions

The U.S. social welfare system originated with the Social Security Act of 1935, which created a national system of retirement benefits and unemployment insurance and established the mechanism by which states receive federal funds to provide a variety of public assistance. This was the foundation for the creation of Medicare, a health insurance program for aged Social Security recipients, and Medicaid, a health insurance program for the poor, in 1965.

While Medicare has always enjoyed popular approval, Medicaid has long been “burdened by the stigma of public assistance.” At the time, Medicaid was widely regarded as an extension of existing, state-centric “welfare medicine” programs, such as Kerr-Mills. Medicaid has been criticized as both “under-theorized and underfunded.” Huberfeld, supra note 18, at 432. In establishing Medicaid, Congress did not explicitly grapple with the humanitarian, solidaristic, or other possible justifications for federal funding of health care for the poor; rather it “built on what came before; the program was remarkably path dependent.” Id. at 449.

See Parmet, supra note 25, at 226. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 was the end of this jurisprudence as it relates to public benefits because in it, Congress authorized states to impose restrictions on immigrant eligibility for public benefits that are harsher than those imposed by federal law. See discussion infra at text accompanying notes 51-73.


STARR, supra note 36, at 370.

Id. at 369 (describing Medicaid as “expanded assistance to the states for medical care for the poor”). Medicaid has been criticized as both “under-theorized and underfunded.” Huberfeld, supra note 18, at 432. In establishing Medicaid, Congress did not explicitly grapple with the humanitarian, solidaristic, or other possible justifications for federal funding of health care for the poor; rather it “built on what came before; the program was remarkably path dependent.” Id. at 449.

LAURA SYNDER & ROBIN RUDOWITZ, HENRY J. KAISER FAM. FOUND., MEDICAID FINANCING: HOW DOES IT WORK AND WHAT ARE THE IMPLICATIONS? 1 (2019),
state and federal governments, and state funding comes primarily from state general fund appropriations. The federal government provides matching funds to states at the Federal Medical Assistance Percentage (FMAP) rate to provide medical assistance to certain categories of poor people. While Medicare can be described as a type of national health insurance on account of its “uniform national standards for eligibility and benefits,” Medicaid cannot be characterized as such because of the considerable flexibility that states have to design and implement the program. Although states are required to provide Medicaid to applicants who fall within mandatory coverage groups, the number of which have increased over time, they can take advantage of federal matching funds to expand benefits to optional coverage groups in order to cover a much larger group of state residents.

Given the distinct character of Medicare and Medicaid, it is not surprising that each program’s restrictions on noncitizen eligibility evolved differently. Work history has always been a primary criterion for Medicare eligibility. Medicare Part A relates to coverage of inpatient hospital services and did not originally have any alienage-related eligibility criteria. Noncitizens who qualified for Medicare Part A based on their work history were also eligible for Part B, which covers physician visits and other outpatient services. Noncitizens who did not have sufficient work history to qualify for Part A, however, had to meet both an immigration status requirement and a durational residency requirement in order to be eligible for Part A or Part B. Eligibility was limited to “aliens[s] lawfully admitted for permanent residence who ha[ve] resided in the United States...continuously during the 5 years immediately preceding the month in which he applies for enrollment....”


Id.

STARR, supra note 36, at 370.

See MEDICAID & CHIP PAYMENT & ACCESS COMM’N (MACPAC), MANDATORY AND OPTIONAL ENROLLEES AND SERVICES IN MEDICAID 5 tbl. 1-1 (2017) (summarizing mandatory and optional Medicaid eligibility groups).

Social Security Amendments of 1965, § 1836 (codified as amended in 42 U.S.C. § 1395o(2)(B) (“Every individual who...has attained the age of 65, and...is entitled to hospital insurance benefits under part A, is eligible to enroll in the insurance program established by this part.”)).

Social Security Amendments of 1965, § 103(4) (codified as amended in 42 U.S.C. § 1395i-2(2)(A)(ii)) (relating to Part B eligibility). The Supreme Court affirmed the federal government’s authority to impose a five-year bar on Medicare eligibility for lawful permanent residents in Mathews v. Diaz, stating that “Congress may decide that as the
Medicaid, by contrast, did not initially have any federal restriction on noncitizen eligibility. Rather, it required states to cover “all individuals” who fell within the mandatory coverage groups, without reference to citizenship or immigration status. In 1971, only eight states had alienage-based eligibility restrictions for any federally funded welfare programs. Most states provided Medicaid to all otherwise eligible people, without regard to citizenship or immigration status.

It was not until 1973 that the federal government began to make centralized policy on immigrant eligibility for Medicaid. That year, the federal agency that administered Medicaid at the time—the Department of Health, Education, and Welfare (HEW)—promulgated a regulation imposing the first alienage-based restriction on Medicaid, mandating the exclusion of unauthorized immigrants.

The framework for the historically restrictive laws governing immigrant eligibility for Medicaid today is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Federal welfare and immigration reform collided that year to impose dramatic restrictions on immigrant eligibility for public benefits, including Medicaid. PRWORA limited eligibility for federal public benefits to citizens and “qualified aliens,” a term used for the first time in the Act itself. Noncitizens who do not fall under these categories are not eligible for Medicaid.

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46 See Tanya Broder et al., Overview of Immigrant Eligibility for Federal Programs, NAT’L IMMIGR. L. CTR. 1, https://www.nilc.org/wp-content/uploads/2015/12/overview-immeligfedprograms-2015-12-09.pdf (last revised Dec. 2015) (noting that during the early years of Medicaid, lawfully residing noncitizens with permission to remain in the United States indefinitely were eligible for federal public benefits on the same terms as U.S. citizens). The history of noncitizen eligibility for Medicaid is closely connected with—and often indistinguishable from—noncitizen eligibility for welfare programs generally. Any references to noncitizen eligibility for Medicaid in this Article should be read with the understanding that such provisions typically applied to the full range of welfare programs.

47 Social Security Amendments of 1965 § 1902(a)(10). In 1971, newly promulgated regulations clarified that there was no federal limit on noncitizen eligibility for Medicaid. 36 Fed. Reg. 3872 (Feb. 27, 1971), codified at 45 C.F.R. § 248.50 (1971). States were explicitly authorized, and in some cases required, to provide Medicaid to individuals “without regard to citizenship status,” a group that included unauthorized immigrants. Id.


51 Pub. L. No. 104-193, 110 Stat. 2105 (Aug. 22, 1996) (codified as amended in scattered sections of 42 U.S.C. and 8 U.S.C.). PRWORA modified the alienage-based criteria for nearly all federal public benefit programs, including Medicare. Immigrants who were previously eligible for Medicare based on their work history are no longer eligible unless they are “lawfully present.” Id. at § 401(b)(2) (codified as amended at 8 U.S.C. §
not have statuses that fall within the definition of “qualified alien” are generally ineligible for federally funded full-scope Medicaid. Unauthorized immigrants were already barred from Medicaid but PRWORA made it explicit by making them ineligible for all federal public benefits with very few exceptions.

Lawfully present noncitizens were hit the hardest by PRWORA’s restrictions. Not only were many previously eligible lawfully present noncitizens barred from eligibility, even qualified immigrants faced a new barrier to eligibility: the five-year bar. Qualified aliens are generally barred from eligibility for federal public benefits for a five-year period, although individuals holding certain statuses are exempt from this bar.

Table 1. Immigrant Eligibility for Federally Funded Medicaid Pre- and Post-PRWORA

<table>
<thead>
<tr>
<th>Categories of Immigrants</th>
<th>Pre-PRWORA</th>
<th>Post-PRWORA</th>
</tr>
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<tbody>
<tr>
<td>Lawful permanent residents (LPRs)</td>
<td>Eligible</td>
<td>State option to provide to: (1) LPRs with less than 40 qualifying work quarters who arrived before August 22, 1996; and (2) LPRs with less than 40 qualifying work quarters who arrived on or after August 22, 1996, and who have been an LPR for five years. LPRs with more than 40 qualifying work quarters eligible for first seven years;</td>
</tr>
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1611(b)(2)).


53 Emergency Medicaid, discussed *infra* Section I.A.2, was not affected by PRWORA’s new restrictions. However, the PRWORA House conferees emphasized that the types of services to be covered under Emergency Medicaid are very limited. H.R. Conf. Rep. No. 104-725, at 380 (1996), reprinted in 1996 U.S.C.C.A.N. 2649, 2768 (“The allowance for emergency medical services under Medicaid is very narrow. The conferees intended that it only apply to medical care that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit. The conferees do not intend that emergency medical services include prenatal or delivery care assistance that is not strictly of an emergency nature.”).

54 8 U.S.C. § 1641; *id.* § 1612 (listing categories of qualified aliens who are exempt from the five-year bar).
PRWORA did not create anything close to a uniform national policy on noncitizen eligibility for Medicaid.\textsuperscript{56} It devolved considerable authority to the states to restrict noncitizen eligibility for public benefits. States now had the authority to make critical decisions about whether to impose restrictions on various categories of noncitizens in Medicaid, including qualified noncitizens.\textsuperscript{57} They were not merely incorporated into a federal scheme; they were given broad discretion within the federal scheme to create wide-ranging policies on noncitizen eligibility for Medicaid.\textsuperscript{58}

\begin{center}
\begin{tabular}{|l|l|l|}
\hline
Refugees, asylees, parolees, persons granted conditional entry, persons granted withholding of deportation, veterans, and Cuban, Haitian, and Amerasian entrants & Eligible & Refugees, asylees, parolees, and veterans eligible for first seven years; state option after seven years. \\
\hline
Persons residing in the United States under color of law (PRUCOL)\textsuperscript{55} & Eligible & Certain PRUCOLs eligible for first seven years; state option after seven years. \\
& & For all other PRUCOLs, emergency Medicaid only. \\
\hline
Lawfully present noncitizens in a temporary status (e.g. tourists, students, temporary workers) & Emergency Medicaid only & Emergency Medicaid only. \\
\hline
Undocumented & Emergency Medicaid only & Emergency Medicaid only. \\
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\textsuperscript{55} PRUCOL is not defined in federal law. Most courts that have interpreted the term have favored a broad interpretation. Janet M. Calvo, \textit{Alien Status Restrictions on Eligibility for Federally Funded Assistance Programs}, 16. NYU REV. L. & SOC. CHANGE 395, 411-16 (1987-88). The term is generally understood to refer to noncitizens “actually living in the United States without any formal immigration status” and who have “the [federal immigration agency’s] tacit, if not explicit, permission to remain.” Richard Boswell, \textit{Restrictions on Non-Citizens Access to Public Benefits}, 42 UCLA L. REV. 1475, 1488 (1995).


\textsuperscript{57} 8 U.S.C. § 1622.

\textsuperscript{58} This devolution of authority over immigrant eligibility for Medicaid was done in a fairly neutral way, i.e. without financially penalizing states that chose or chose not to elect
Although PRWORA set a baseline of immigrant eligibility for Medicaid, it permitted states to restrict immigrant eligibility below the baseline to a very low “floor” of mandatory coverage for select categories of immigrants.\(^{59}\) In general, these include:

- Qualified aliens who were residing in the United States as of August 22, 1996;\(^ {60}\)
- Qualified aliens who “have a substantial work history or military connection”;\(^ {61}\)
- Lawful permanent residents (LPRs) who
- Certain humanitarian immigrants within seven years of receiving such status;\(^ {62}\)
- Noncitizen “cross-border” American Indians;\(^ {63}\)

PRWORA gave states a variety of options to tailor Medicaid eligibility. They were permitted to extend or bar Medicaid eligibility to qualified aliens who meet all of the following criteria: (1) entered the United States after August 22, 1996, (2) have held a qualified alien status for five years or more; and (3) did not otherwise fall into one of the mandatory noncitizen coverage groups.\(^ {64}\) They received the option to extend or bar Medicaid eligibility to LPRs who are pregnant or who are children.\(^ {65}\) PRWORA permitted states to extend or bar Medicaid eligibility to humanitarian immigrants beyond the initial seven-year mandatory coverage period.\(^ {66}\)

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\(^{59}\) States are required to cover the following groups of immigrants: lawful permanent residents with credit for 40 qualifying quarters of work, members of the military and veterans (and their spouses and children), those receiving SSI, noncitizen “cross-border” American Indians from Canada or Mexico, conditional entrants and parolees paroled for at least one year who have been residents since PRWORA was enacted, and humanitarian immigrants (asylees, refugees, Cuban/Haitian entrants, Iraqi and Afghan special immigrants, certain immigrants whose deportation/removal is being withheld for humanitarian reasons, Vietnamese-born Amerasians fathered by U.S. citizens, and victims of trafficking in persons) for a period of seven years. Alison Siskin, Cong. Res. Serv., NONCITIZEN ELIGIBILITY FOR FEDERAL PUBLIC ASSISTANCE: POLICY OVERVIEW (2016), https://fas.org/sgp/crs/misc/RL33809.pdf.

\(^{60}\) Id. at 8.

\(^{61}\) Id. at 16.

\(^{62}\) Id. at 2; id. at 2, note 8 (noting that this includes refugees, asylees, “Cuban/Haitian entrants, certain aliens whose deportation/removal is withheld for humanitarian purposes, Vietnam-born Amerasians fathered by U.S. citizens, and victims of human trafficking”).

\(^{63}\) Id. at 9.

\(^{64}\) Id. at 16-17.

\(^{65}\) Id. at 2.

\(^{66}\) Id. at 8-9
States had the option to extend or bar Medicaid eligibility to certain victims of abuse.  

As a result of this new discretion, shortly after PRWORA became effective, Louisiana and Wyoming barred most lawful permanent residents (LPRs) from Medicaid eligibility entirely. Currently, Wyoming and Texas have the most restrictive immigrant eligibility criteria for Medicaid. In Wyoming, LPRs are generally ineligible for Medicaid, even after completing the five-year bar, unless they have credit for forty quarters of work history in the United States. In Texas, most qualified noncitizens who entered the country on or after the date PRWORA was enacted, August 22, 1996, are ineligible for Medicaid, even after they complete the five-year bar. Alabama, Mississippi, North Dakota, and Virginia also have eligibility rules that are stricter than the general federal rules.

States were also authorized to impose restrictive criteria on noncitizens that were previously unknown in the Medicaid program, such as durational residency requirements and time limits. They also had virtually free reign to impose alienage-based restrictions on public benefits that are funded solely by the state government.

In 2010, after much debate and compromise, the Patient Protection and Affordable Care Act (ACA) transformed health law and policy by moving the U.S. health care system closer to universal coverage. One key provision of the ACA was the individual mandate, a requirement that most Americans maintain health insurance coverage or pay a penalty. A second key provision nearly eliminated categorical eligibility for Medicaid by requiring

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67 Id. at 10.
68 Wishnie, supra note 4, at 495, note 9.
69 NAT’L IMMIGR. LAW CTR., supra note 14, at 5. Wyoming has elected the option to expand Medicaid to lawfully residing pregnant women. Id.
70 Id. at 4. Texas has elected the option to expand Medicaid and CHIP to lawfully residing children and is one of the largest beneficiaries of reimbursement through the CHIP unborn child option, which provides maternity care to pregnant people regardless of citizenship or immigration status. Id.
72 Wishnie, supra note 4, at 495, note 9 (describing Washington’s six-month residency requirement and Indiana’s two-year eligibility limit for Medicaid that applied to noncitizens only).
75 26 U.S.C. §5000A.
states to cover adults with incomes up to 133% of the federal poverty level.\textsuperscript{76} Third, the ACA created new health insurance Marketplaces on which private health insurance plans could be bought and sold, and through which income-qualifying consumers could receive federal tax credit subsidies.\textsuperscript{77}

The ACA played a critical role in reducing the national uninsured rate from 17.8\% to a historic low of less than 10\% in 2016, with most of the gains attributed to expanded eligibility for Medicaid.\textsuperscript{78} It also represented a remarkable expansion of the federal government’s role in subsidizing health coverage for low-income people living in the United States by providing nearly 100\% federal funding to cover the newly eligible population.\textsuperscript{79} By expanding Medicaid eligibility to people with household incomes below 138\% of the Federal Poverty Level, Congress intended to move Medicaid policy away from its traditional categorization of the “deserving poor” and toward a uniform national standard for Medicaid eligibility.\textsuperscript{80} However, a successful legal challenge foreclosed this possibility, and preserved categorical restrictions on Medicaid eligibility in states that chose not to expand Medicaid.\textsuperscript{81}

Despite its success with increasing access to Medicaid, the ACA maintained PRWORA’s framework of alienage restrictions.\textsuperscript{82} The result is a

\textsuperscript{76} ACA § 2001(a)(2)(C); 42 U.S.C. § 1396a(a)(10)(i)(VIII).
\textsuperscript{77} ACA § 1321, 124 Stat. at 186-87 (codified at 42 U.S.C. § 18041); ACA §§ 1401(a), 10105(a)-(c), 10108(h)(1), 124 Stat. at 213-19, 906, 914 (codified as amended at I.R.C. § 36B (2016)).
\textsuperscript{78} HENRY J. KAISER FAM. FOUND., FACT SHEET: KEY FACTS ABOUT THE UNINSURED POPULATION 2 (2018), http://files.kff.org/attachment/fact-sheet-key-facts-about-the-uninsured-population. Id. at 3. The ACA also created Health Insurance Marketplaces for consumers to purchase health coverage and a new health insurance subsidy: A tax credit to offset the cost of premiums for health insurance purchased the Marketplaces.
\textsuperscript{79} Huberfeld, supra note 18, at 431-32, 450-51.
\textsuperscript{80} Huberfeld, supra note 18, at 450-51. Since the establishment of welfare medicine, Medicaid and its precursors were benefits restricted to the “deserving poor,” what some commentators describe as “poor plus.” Individuals in this category included pregnant women, parents of minor children, people with disabilities, and the elderly.
\textsuperscript{81} NFIB v. Sebelius, 567 U.S. 519 (2012).
\textsuperscript{82} Some lawfully present but non-qualified immigrants benefited from eligibility for the premium tax credits associated with health insurance purchases on the new ACA Marketplaces. Theoretically, lawfully present immigrants would also benefit from eligibility for Basic Health Programs (BHPs), established by section 1331 of the Affordable Care Act. BHPs are health plans for individuals who earn slightly too much to qualify for Medicaid or who are ineligible for Medicaid due to their immigration status. However, only two states—New York and Minnesota—have elected to establish Basic Health Programs. See, e.g., Michelle Andrews, Few States Use Health Law Option For Low-Cost Plans, NPR (Feb. 2, 2016), https://www.npr.org/sections/health-
nationally uniform policy of federal Medicaid exclusion for millions of unauthorized immigrants\textsuperscript{83} and hundreds of thousands of recipients of Deferred Action for Childhood Arrivals (DACA),\textsuperscript{84} and a patchwork of state policies governing Medicaid eligibility for lawfully present immigrants. Although millions of people, many of them poor, remain uninsured for reasons unrelated to legal eligibility for subsidized health coverage, poor immigrants are the only ones who are disqualified from federally funded Medicaid as a matter of law. The progressive reform of “decategorizing” Medicaid eligibility did not extend to the category of immigration status.

2. Emergency Medicaid

A federal statutory provision that contributes to the patchwork nature of immigrant access to health care is Emergency Medicaid, which is essentially a waiver of the alienage restrictions in Medicaid for limited-scope, emergency services. It authorizes federal reimbursement to states for “such care and services [that] are necessary for the treatment of an emergency medical condition” for people who would be eligible for federally funded Medicaid but for the alienage restriction, including unauthorized immigrants.\textsuperscript{85} In all fifty states, emergency Medicaid covers

\textsuperscript{83} Unauthorized immigrants include people who entered the country without authorization as well as people who entered with authorization but have violated the terms of their visa. See Medha D. Makhlouf, Health Justice for Immigrants, 4 U. PA. J. L. \\ & PUB. AFF. 235, 243 (2019) (describing the ways in which noncitizens become “undocumented”). For purposes of our discussion, it is important to understand that a person who is unauthorized at one point in time may have had an authorized immigration status in the past and may have such status in the future.

\textsuperscript{84} DACA is one category of deferred action, which is “a use of prosecutorial discretion to defer removal action against an individual for a certain period of time.” Consideration of Deferred Action for Childhood Arrivals (DACA), U.S. CITIZENSHIP \\ & IMMIGRATION SERV., https://www.uscis.gov/archive/consideration-deferred-action-childhood-arrivals-daca (last visited July 18, 2019). Although deferred action is not technically an immigration status, it permits individuals who qualify to reside in the United States for a limited time period and, in some cases, provides work authorization. Most individuals with deferred action are considered “lawfully present” in the United States and are therefore eligible for some federally funded health coverage programs. DACA recipients, however, were specifically excluded from eligibility for those programs as a result of political compromises that facilitated passage of the ACA. See Fatma Marouf, Alienage Classifications and the Denial of Health Care to Dreamers, 93 WASH. U. L. REV. 1271, 1279–83 (2016). DACA recipients are effectively treated as unauthorized immigrants for purposes of eligibility for federally funded health coverage programs.

\textsuperscript{85} OBRA § 9406(a).
care and services related to childbirth (labor and delivery), but not prenatal care. \textsuperscript{86} States then reimburse health care providers—typically hospitals—that provide such care and services. Emergency Medicaid is not intended to cover preventive health or care for patients discharged from the hospital after treatment of an emergency medical condition.

Since emergency Medicaid is available to noncitizens excluded from federally funded Medicaid, and states have options to expand or restrict federally funded Medicaid to noncitizens, the types of noncitizens served by this program in each state varies. For example, a Texas resident who became a lawful permanent resident six years ago does not qualify for full-scope Medicaid; therefore, he would qualify for emergency Medicaid coverage of treatment received in the emergency room for, say, a broken bone, but not follow-up care. By contrast, a Pennsylvania resident in the same situation would qualify for full-scope Medicaid, which would cover the emergency room visit, hospitalization (if necessary), and any follow-up care.

Depending on the state, emergency Medicaid can look like health insurance. In some states, residents can apply for emergency Medicaid coverage in advance of treatment; in others, residents can only apply after receiving treatment for an emergency medical condition or labor and delivery. States have significant discretion to define, within certain limits, the “emergency medical conditions” (EMC) that will be covered by EMA. There is enormous variation in the types of conditions that states have determined to fall within the federal statutory definition. For example, only twelve states characterize End Stage Kidney Disease (ESKD) as an EMC.\textsuperscript{87} An estimated 6,000 unauthorized immigrants have ESKD.\textsuperscript{88} The standard treatment option for ESKD is thrice-weekly dialysis or a kidney transplant.\textsuperscript{89} EMA does not cover organ transplants or anti-rejection medications, but the states that have recognized ESKD as an EMC enable Medicaid-ineligible noncitizens to receive routine hemodialysis rather than to wait until they are “in nearly critical condition” to obtain it on an emergency basis.\textsuperscript{90} Studies have found that “[u]ndocumented immigrants with ESKD that rely on emergency-only hemodialysis describe significant


\textsuperscript{87} David Ansell et al., Illinois Law Opens Door to Kidney Transplants for Undocumented Immigrants, 34 HEALTH AFF. 781, 783 (2015).

\textsuperscript{88} Id.

\textsuperscript{89} Id.

\textsuperscript{90} Id.
physical and psychosocial distress;” that they spend “tenfold more time in the hospital and less time in the outpatient setting compared with those receiving standard hemodialysis;” and their mortality is increased fourteen-fold compared with those receiving the standard treatment.91

It is fairly simple for a state to begin classifying ESKD as an EMC. CMS and HHS’s Office of the Inspector General (OIG) generally defer to state interpretations of the term EMC.92 They have not contested state requests for reimbursement of dialysis treatment through the EMA program.93 Colorado’s Department of Health Care Policy & Financing recently announced a change in policy that will enable its residents with ESKD to obtain EMA coverage for routine dialysis.94 However, states need not pass a law in order to cover a broader range of conditions under EMA.95 The state agency administering Medicaid could simply begin interpreting the term EMC more broadly, so long as the interpretation can be justified as reasonable under the federal definition.

3. State Options

In the years following PRWORA’s implementation, Congress gave states the option to restore eligibility for subsidized health coverage to a subset of noncitizens who had been barred by PRWORA’s alienage restrictions: excluded but lawfully residing immigrant children and/or pregnant women.96 States could provide this full-scope coverage through Medicaid or the Children’s Health Insurance Program, a program with a higher income threshold than Medicaid. These are known as the Immigrant Children’s Health Improvement Act (ICHIA) options because they were initially proposed in a Senate bill by that name in 2007.97 The ICHIA options were motivated by concerns about PRWORA’s impacts on health

91 Id.
92 Id. at 2.
93 Id.
94 Id. at 1.
care system efficiency and health outcomes. Many treatable conditions affecting children and pregnant women can be addressed in a cost-effective manner through primary and preventive care, which Medicaid enables.\textsuperscript{98} Although the ICHIA options were a positive development from a health policy perspective, they contribute to the geographic variability of immigrant access to health coverage because not all states have elected them.

In order for states to elect one or both ICHIA options, a state must submit a state plan amendment under the Medicaid program or under the Medicaid and CHIP programs to CMS.\textsuperscript{99} The state must specify whether it is electing the option for pregnant women, for children, or for both. Upon approval by CMS, states that have elected the option to expand Medicaid or CHIP to lawfully residing noncitizen children will receive funding at an enhanced federal matching rate.\textsuperscript{100} Currently, the enhanced Federal Medical Assistance Percentage (eFMAP) for CHIP ranges from 76.50% in Wyoming to 95.39% in Mississippi.\textsuperscript{101} States that have elected the option to expand CHIP to lawfully residing pregnant women receive funding at the Medicaid match rate.\textsuperscript{102}

As of January 2019, thirty-four states have adopted the ICHIA option to expand Medicaid coverage to lawfully residing children, and twenty-three of those states have also expanded CHIP to this population.\textsuperscript{103} Most of the states that have elected this option adopted it soon after CHIPRA was enacted: In twenty states, lawfully residing children became eligible for Medicaid and/or CHIP in 2009-2010. Fourteen more states have adopted the


\textsuperscript{100} Id. (noting that children eligible for Medicaid or CHIP under the CHIPRA § 214 option are considered “targeted low-income children,” who are eligible for the enhanced federal matching rate).

\textsuperscript{101} ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) FOR CHIP │ THE HENRY J. KAISER FAMILY FOUNDATION, https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/?currentTimeframe=0&selectedDistributions=enhanced-fmap&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22,%22%7D (last visited July 2, 2019).


\textsuperscript{103} HENRY J. KAISER FAM. FOUND., supra note 78, at 35 tbl. 3.
option over the last decade.

*Figure 1a. State Adoptions of ICHIA Child Option*

<table>
<thead>
<tr>
<th>CA CT DC HI</th>
<th>IL IA ME MD</th>
<th>MA MN NJ</th>
<th>NM NY OR PA</th>
<th>RI TX VA WA WI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2009-10</strong></td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>KY MT OH WV</th>
<th>AK NV SC</th>
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<tbody>
<tr>
<td><strong>2013-14</strong></td>
<td><strong>2017-19</strong></td>
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<table>
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<tr>
<th>2011-12</th>
<th>2015-16</th>
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<tbody>
<tr>
<td>DE NE NC VT</td>
<td>CO FL UT</td>
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</table>

Fewer states have adopted the ICHIA option to expand Medicaid or CHIP coverage to lawfully residing pregnant women: twenty-five states have expanded Medicaid, and three of those states (Colorado, New Jersey, and Washington) have also expanded CHIP coverage to this population.\(^{105}\) The trend in state adoptions of this option is similar to the pattern described for the ICHIA option for lawfully residing children: Most of the states that have elected the ICHIA option to expand Medicaid to lawfully residing pregnant people adopted it soon after CHIPRA was enacted. In thirteen states, lawfully residing pregnant women became eligible for Medicaid in 2009-2010. Over the next decade, twelve more states have adopted the option.

*Figure 1b. State Adoptions of ICHIA Pregnancy Option*

\(^{104}\) Figures 1a and 1b indicate effective dates of coverage under the new options, which may differ from the date that the state submitted its State Plan Amendment and the date that CMS approved the amendment.

\(^{105}\) *Id.* at 38 tbl. 4.
Of the states that elected one or both ICHIA options shortly after CHIPRA was enacted, many were already using state funds to provide coverage to LPR children or pregnant women who were excluded from Medicaid because of the five-year bar. 106 For these states, it should have been an easy decision to elect the ICHIA options in order to take advantage of the available federal matching funds to subsidize care for these population. A somewhat surprising finding, however, is that several “very different and diverse states” that had not subsidized coverage of these populations using state funds elected to expand Medicaid to lawfully residing immigrant children under the ICHIA option. 107 These include Illinois, Iowa, Montana, New Mexico, North Carolina, Oregon, Texas, Vermont, and Washington. This suggests that the infusion of federal funds via ICHIA made a difference in the state’s ability to expand coverage to these populations; one might infer that prior to ICHIA, they desired but could not afford to expand coverage to lawfully residing immigrant children. What made these decisions even more noteworthy was that they indicated the states’ willingness to commit funds to a Medicaid expansion for noncitizens during a recession. 108 Observers have noted that these expansions “demonstrate that incremental progress can be made on a bipartisan basis even during very tough fiscal times.” 109

107 Id.
108 Id. at 5-6.
109 Id. at 6.
Another surprising finding is that the enhanced FMAP for expanding coverage to lawfully residing children has not generally induced states to adopt this ICHIA option if they are ideologically or otherwise opposed to it. Figure 2 is a map of states that are color-coded based on their election of one, both, or neither of the ICHIA options. On the map, the navy blue-colored states have adopted both ICHIA options and the bright blue states have adopted the ICHIA child option only. Figure 3 displays the enhanced federal matching rate for each state, with the darker colors indicating higher eFMAP states. Notably, several states that would receive the “best deals” for adopting the ICHIA child option have not done so. These include Alabama, Arizona, Georgia, Idaho, Indiana, Oklahoma, Louisiana, Michigan, Missouri, and Tennessee.

**Figure 2. States That Have Elected One or Both ICHIA Options**

**Figure 3. Enhanced Federal Medical Assistance Percentage for CHIP, FY 2020**

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110 HENRY J. KAISER FAM. FOUND., supra note 78, at 10.
111 ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) FOR CHIP │ THE HENRY J. KAISER FAMILY FOUNDATION, supra note 101.
Another option available to states to receive federal reimbursement for providing pregnancy-related care to women regardless of their citizenship or immigration status is the “unborn child option.”112 In states that have elected this option, any person who is pregnant and who otherwise qualifies for CHIP can receive subsidized, limited-scope coverage of prenatal care, labor, and delivery.113 From the time the federal rulemaking for the unborn child option was announced, states understood it as a means to subsidize maternity care for unauthorized immigrants.114 At least some agency staff,

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112 State Children’s Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children; Final Rule, 67 Fed. Reg. 61,956, 61,974 (Oct. 2, 2002) (codified at 42 C.F.R. § 457.10) (revising the definition of “child” to mean a person from conception through age 19 for purposes of CHIP coverage). This revision was controversial, not only because it was considered by pro-choice advocates to be a step toward establishing legal personhood for fetuses, but also because it “put the unborn children of undocumented women in competition with already born children for diminishing SCHIP resources.” Patricia Gray, Unborn v. Undocumented: A Collision of Policy and Politics, HEALTH L. PERSPECTIVES 1 (2008), https://www.law.uh.edu/healthlaw/perspectives/2008/(PG)%20CHIP%20peri.pdf.

113 States have considerable flexibility to define pregnancy-related care and treatments to prevent complications in pregnancy if they elect the option, but postpartum services cannot be covered under the option because they are not provided to the child. Id. at 61,969.

114 Gray, supra note 112, at 1, 2.
on the other hand, did not seem to realize this use of the option until after states began submitting claims for reimbursement of services provided to pregnant unauthorized immigrants.\footnote{Id. at 2 (describing how CMS initially denied Louisiana’s claim for reimbursement on the ground that “the federal enabling legislation does not authorize service to undocumented residents”). HHS states that the unborn child option avoids PRWORA’s prohibition on providing federal public benefits to certain noncitizens because “[A]n unborn child is not an alien, and the status of the child is not necessarily tied to the status of the mother.” 67 Fed. Reg. at 61,966.} This oversight by the federal government betrays the “accidental”—as opposed to intentional—nature of many federal policies relating to immigrant access to Medicaid.

As of January 2019, sixteen states have elected the CHIP unborn child option to provide limited-scope coverage to pregnant women, regardless of their citizenship or immigration status.\footnote{HENRY J. KAISER FAM. FOUND., MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, AND COST SHARING POLICIES AS OF JANUARY 2019: FINDINGS FROM A 50-STATE SURVEY 38 tbl. 4 (2019) (Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Expansion Programs, January 2019), https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/.} Conservative political ideology does not appear to disfavor CHIP expansion under the unborn child option: Half of the states that have adopted it are red states.\footnote{This characterization is based on a state’s popular vote for the Democratic or Republican presidential candidate in the 2016 presidential election. See, e.g., 2016 Presidential Election Actual Results, 270TOWIN, https://www.270towin.com/maps/2016-actual-electoral-map (last visited July 8, 2019).} It is possible that the option’s association with fetal personhood has dissuaded more blue states from adopting it.\footnote{See, e.g., ELIZABETH RICH, NAT’L FAMILY PLANNING & REPRO. HEALTH ASS’N, POLICY SOLUTIONS TO IMPROVING ACCESS TO COVERAGE FOR IMMIGRANTS 3 (2016), https://www.nationalfamilyplanning.org/file/documents---policy-briefs/ImmigrationReport.pdf (“Health equity advocates oppose this policy because underlying the conferral of prenatal and maternity coverage is the notion that fetuses are functionally awarded personhood status and therefore rights to health care through the [unborn child option].”).}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{Figure4}
\caption{States That Have Elected the Unborn Child Option}
\end{figure}
As with the pattern of adoption of the ICHIA options, most states that have adopted the unborn child option did so in the first few years following the creation of the option. Of the five states with the largest share of unauthorized immigrants, only California and Texas have elected this option. Indeed, California and Texas are the largest beneficiaries of the unborn child option, with nearly 116,000 and 96,000 enrolled, respectively, in 2016.

Figure 5. State Adoptions of Unborn Child Option

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119 Jillian Hopewell, Access to Prenatal Care: The Case of Nebraska, 17 MCN STREAMLINE 1 (2011).

120 The states with the largest share of unauthorized immigrants in the population are Nevada (7.2%), California (6.8%), Texas (6.7%), New Jersey (6.2%), and Arizona (6.0%). Pew Research Ctr., Pew Hispanic Ctr., Unauthorized Immigrant Population: National and State Trends, 2010, at 15 tbl. 5 (2011), https://www.pewresearch.org/wp-content/uploads/sites/5/reports/133.pdf. California and Texas are also the only two of the top five states with the largest share of unauthorized immigrants in the workforce to have elected the unborn child option. The share is 9.7% in California and 9% in Texas. Id. at 21 tbl. A1. The other states in the top five are Nevada (10%), New Jersey (8.6%), and Arizona (7.4%). Id.

Of the sixteen states that adopted the unborn child option, seven have also elected the ICHIA option for expansion of full-scope Medicaid and/or CHIP coverage for lawfully residing pregnant women. These are Arkansas, California, Massachusetts, Minnesota, Nebraska, Washington, and Wisconsin. Four are blue states (California, Massachusetts, Minnesota, Washington) and three are red states (Arkansas, Nebraska, Wisconsin). All of the states except Wisconsin have adopted Medicaid expansion under the ACA. 122 Although a detailed analysis of the states’ motivations for making these choices is beyond the scope of this paper, the big picture seems to indicate that states haven’t chosen to adopt policies that maximize health policy outcomes, whether that is due to ideological, fiscal, or other reasons.

B. State-Funded Programs

This subsection describes state-funded programs that expand access to health care for noncitizens who are excluded from federal health coverage programs.

Six states and Washington, D.C., have created programs to provide health coverage for excluded noncitizens. 123 The six states are California, Massachusetts, Minnesota, Nebraska, Washington, and Wisconsin.

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Illinois, Massachusetts, New York, Oregon, and Washington.\textsuperscript{124} Politically, all seven jurisdictions are Democratic strongholds, and all have elected to expand Medicaid. Although five states—California, Florida, Texas, New York, and New Jersey—are home to more than half of undocumented immigrants living in the United States, 22 states have at least 100,000 undocumented immigrants residents.\textsuperscript{125} Of the five states with the highest percentage of unauthorized immigrant residents,\textsuperscript{126} only California has created a state-funded health coverage program for excluded noncitizens. Of the five states with the highest share of unauthorized immigrants in the workplace, again, only California is on this list.\textsuperscript{127} Using median household income as a measure of wealth, all seven jurisdictions are in the top twenty.\textsuperscript{128}

A review of state-funded health coverage programs for excluded noncitizens reveals significant diversity in program design. One commonality is that the programs in all seven jurisdictions treat children as special, offering comprehensive health coverage this population.\textsuperscript{129} California’s program also began covering young adults up to age twenty-six in 2020.\textsuperscript{130} One state, Massachusetts, treats pregnant women as a special population, using state funds to provide comprehensive coverage—not just prenatal care—to them.

One way in which it appears states have sought to reduce costs is to limit adult eligibility for programs by the type of medical service needed. Washington, D.C., excludes certain medical services from its coverage program for excluded noncitizens. These include vision, mental/behavioral health, and substance abuse services; non-emergency transportation services; long-term care longer than thirty days; cosmetic surgery; open heart surgery; organ transplantation; and dental services costing more than $1,000. New York, California, Illinois, and Oregon all use state funds to cover prenatal care for residents, regardless of citizenship or immigration status. Illinois’ program also covers kidney transplants for people with end-stage renal disease (ESRD), while California’s program also covers long-term care, dialysis, anti-rejection medication for organ transplant recipients,

\textsuperscript{124} CBPP REPORT, \textit{supra} note 123, at 15-16.
\textsuperscript{125} CBPP REPORT, \textit{supra} note 123, at 3.
\textsuperscript{126} \textit{See Pew Research Ctr., supra} note 120, at 15, tbl. 5.
\textsuperscript{127} \textit{Id.}
\textsuperscript{130} S. 104, 2019-20 Reg. Sess. § 3 (Cal. 2019).
and breast and cervical cancer treatment.  

II. PROBLEMS WITH THE EXISTING PATCHWORK OF EXCLUSION

This Part describes how states have exercised their options to provide coverage to noncitizens under the existing “intrastatutory federalism” arrangement in a way that weakens national health policy. Professor Abbe Gluck coined the term intrastatutory federalism to mean “federalism arrangements produced by federal statutes themselves.” One reason why Congress may elect such an arrangement is “to use[] state implementers to entrench new national programs.” In one sense, PRWORA entrenched a national program of immigration restrictionism in public benefits eligibility by limiting the availability of federal funds for noncitizen recipients of public benefits. In another sense, PRWORA may be interpreted as an abdication of federal responsibility for making uniform federal policy on immigrant eligibility for public benefits. In the current arrangement, which the ACA did not change, states can make policies on eligibility for publicly funded health coverage along a spectrum from universally inclusive to nearly exclusive of noncitizens.

All states have either already confronted or may soon confront the reality that a meaningful percentage of state residents lack access to affordable insurance because they are legally barred from eligibility for federal subsidies because of their immigration status. Unauthorized immigrants live in every state. Demographic trends indicate that certain states with historically low numbers of unauthorized immigrants have become top destination states over the past decade, and other states that were previously top destinations have become less attractive. Shifts in immigration policy and labor needs have an impact on where unauthorized

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132 Gluck & Huberfeld, supra note 20 at 1696.
134 PEW RESEARCH CTR., PEW HISPANIC CTR., UNAUTHORIZED IMMIGRANT POPULATION: NATIONAL AND STATE TRENDS, 2010, at 15 (2011), https://www.pewresearch.org/wp-content/uploads/sites/5/reports/133.pdf. It is also true that only a few states are home to the largest concentrations of unauthorized immigrants. Id.
135 Id. (describing Georgia and North Carolina as new destination states); id. at 2 (noting a decline in the population of unauthorized immigrants in Colorado, Florida, New York, and Virginia).
immigrants settle, and settlement patterns are likely to change over time.136

Very few states have engaged in serious efforts to address the health coverage needs of unauthorized immigrants. Predictably, the few states that have elected to use state funds to expand coverage to unauthorized immigrants tend to fall on the progressive end of the political spectrum.137 They also tend to have a more expansive view of the state’s responsibility for ensuring residents’ access to health coverage, as demonstrated by their decisions to expand Medicaid under the ACA.138

A larger number—and a more diverse collection—of states have chosen to take advantage of federal matching funds by electing options to expand Medicaid and/or CHIP to lawfully residing but excluded immigrants. A slight majority of states has elected one or both options to expand Medicaid and/or CHIP to non-qualified but lawfully residing children and pregnant women.139 All but two states have elected the federal option to expand Medicaid and/or CHIP to qualified noncitizens who have held that status for at least five years.140 All states except one have elected to permit LPRs who resided in the United States on the date PRWORA was enacted (August 22, 1996) to be eligible for Medicaid.141 These figures may not seem surprising; there is a logic to electing options to expand subsidized coverage to noncitizen populations with long-time residence and with reasonably secure pathways to citizenship.142

What is surprising, however, is that many states with large numbers of excluded noncitizen residents have not taken advantage of federal matching funds to expand coverage to excluded noncitizens, much less expended state funds to do so. And fewer states than might be expected have taken the

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136 Id. at 17 (“State patterns differ widely, but generally states with large numbers or shares of unauthorized immigrants also have relatively large numbers or shares in the workforce.”).

137 These states are California, the District of Columbia, Illinois, Massachusetts, New York, Oregon, and Washington.

138 Parmet, supra note 25, at 234-35.


141 Id. at 5.

142 The main rationales for excluding noncitizens from subsidized health coverage are cost, deterrence, and “deservingness.” I discuss—and address weaknesses of—these rationales in prior work. Makhlouf, supra note 52, at 264-74.
opportunity to make Medicaid more inclusive toward excluded noncitizens since the implementation of the ACA’s Medicaid expansion in 2014.\textsuperscript{143} Aside from state adoptions of the federal ICHIA and unborn child options, state policies relating to immigrant access to health coverage have stagnated rather than responded to demographic changes. The status quo of minimal coverage of noncitizens has become entrenched since the passage of PRWORA in 1996. Since then, most states have failed to acknowledge through health policy changes the robust evidence base indicating that immigrant-inclusive approaches can improve population health outcomes and community well-being, and benefit state and local communities in the long term.\textsuperscript{144}

Also surprising is the diversity—aside from political diversity—of the handful of states that have created state-funded health coverage programs for excluded noncitizens. These states differ significantly in GDP and in the share of unauthorized immigrants in their workforce.

The eligibility criteria of the state-funded programs themselves are surprisingly diverse, particularly in terms of limitations by demographic and by type of medical services covered. For example, although all of the state-funded programs provide coverage similar to full-scope Medicaid for


“children” who are excluded from federally funded Medicaid, some states define that category as people under age 19, and others as under age twenty-one. Some states use state funds to provide full-scope coverage to special categories of adults, such as pregnant women, DACA recipients, or young adults. One state provides full-scope coverage to all adults. Some states have expanded limited-scope Medicaid-type coverage to adults for basic primary and secondary services. Some will cover adults with particular medical needs, like breast and cervical cancer treatment, long-term care, or kidney transplants. Some states require some cost-sharing by enrollees in state-funded plans while others do not, and the upper range for income eligibility varies considerably. It is clear that there is no template for state-funded programs covering excluded noncitizens. States that want to expand coverage for health policy reasons are forced to ration limited resources, experimenting with ever-narrower categories of eligibility, which clashes with the ACA’s goal of decategorizing Medicaid eligibility.

A. Outcomes, Costs, Quality

There is considerable debate among academics and policymakers over what makes “good” health policy. In the decade since the passage of the ACA, however, some consensus has emerged around the following three pillars of national health policy, known as the “Triple Aim”: Improving population health outcomes, reducing health care costs, and improving quality.145

The goal of improving population health outcomes through policy involves measuring not only health status indicators but also the factors that affect them. The United States is an outlier compared with peer countries in terms of health care expenditures but does not rank near the top for important population health measures such as life expectancy.146 Troublingly, average life expectancy in the United States has stagnated over the last decade.147 These declines and this country’s lackluster health gains


146 Berwick et al., supra note 145, at 759.

147 See Sabrina Tavernise & Abby Goodnough, American Life Expectancy Rises for First Time in Four Years, N.Y. Times (Jan. 30, 2020),
relative to other rich nations, are partially attributed to increasing disparities in life expectancy among low-income and high-income Americans. One of the main ways in which the ACA aims to improve population health is “by improving access to the health care delivery system, which is a critical component of a community’s population health production system.” To improve health in low-income populations, the ACA decategorized Medicaid eligibility and thus expanded access to subsidized health insurance.

Reducing health disparities is an implicit goal of national health policy. Aside from justice- or fairness-based reasons to combat disparities, the goals of improving health outcomes and reducing health disparities are linked because “[c]onditions that lead to marked health disparities are detrimental to all members of society,” potentially impacting population health outcomes. When health outcomes for the most vulnerable or disadvantaged members of a community are significantly worse than for others, the community as a whole is worse off. It follows that improving conditions for the most vulnerable or disadvantaged members of a community can improve the well-being of all.

Under PRWORA, states have significant discretion to include or exclude noncitizens from Medicaid and state-funded health coverage programs. Decisions to restrict immigrant eligibility for subsidized coverage in nearly all states entrenched disparities between citizens and noncitizens. A notable exception is Massachusetts, which has provided some form of subsidized health coverage to all noncitizen residents since state health reform in 2006.

https://www.nytimes.com/2020/01/30/us/us-life-expectancy.html. Each year from 2015 to 2017, the country experienced “rare and troubling” declines in life expectancy, attributed to “deaths of despair” – younger people dying from overdoses, suicide, and alcoholism.” Id. at 2 (stating that reducing disparities is a goal of the population health perspective). See also Berwick, supra note 145, at 760 (“[T]he gain in health in one subpopulation ought not to be achieved at the expense of another subpopulation.”).
these disparities. By leaving states in charge of policymaking on immigrant access to health coverage, Congress lost an opportunity to align states’ health policies with the national policy goal of improving population health.153

A large body of research has examined states’ immigration restrictions on Medicaid eligibility and their impact on immigrant access to care and health outcomes. Some of these studies have found that exclusionary laws have negative impacts on individual and population health.154 Legal barriers to accessing subsidized health programs are theorized as the major cause of health disparities between immigrant and native-born children.155 A pair of researchers focused on young Latino immigrant children in Illinois who had lost public benefits post-PRWORA, finding that their general health status had declined significantly relative to their peers.156 A subsequent expanded study of preschoolers in immigrant families in Illinois found that loss of public benefits after welfare reform was associated with “substantial and significant declines in their health over time.”157 These findings spanned across multiple health dimensions, including parental ratings of children’s health, number of sick days, frequency of respiratory illness, and emergency room visits.158 Such studies support the proposition that exclusionary health policies are associated with poor health outcomes among immigrants and health disparities between immigrants and U.S. citizens.

Researchers have sought to explain why laws that limit access to health care based on citizenship or immigration status are associated with health disparities. There is a robust evidence base demonstrating that immigrants who do not have health insurance delay or never seek care for health

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153 Implementation of national health policy through the ACA was thwarted in other important ways due to political opposition. Of relevance is the Supreme Court’s ruling in *National Federation of Independent Business v. Sebelius*, which made Medicaid expansion optional for states. 567 U.S. 519 (2012). A 2015 study estimated that 3.1 million citizens and noncitizens who would have been eligible for Medicaid had the mandatory expansion provision survived are excluded because they live in states that have opted to not expand Medicaid. *See Joseph, supra* note 152, at 2092.


158 *Id.* at 209-10.
problems, causing unnecessary risks to their health. This behavior can also pose a risk to public health: When diagnosis and treatment of infectious disease is delayed, an entire community can be placed at risk. When members of the community lack access to treatment for mental health issues, particularly substance use disorders, all members of the community face potential negative spillover effects in the form of higher rates of property and violent crimes. When pregnant women are unable to access prenatal care, opportunities to prevent harm to women and fetuses are lost. Finally, immigration restrictions on health coverage can have spillover effects on U.S. citizen family members and low-income and minority communities, exacerbating health disparities in already vulnerable populations. When a person who is eligible for Medicaid is unable to provide documentation of citizenship or immigration status—a problem that disproportionately impacts children, the mentally ill, and people with dementia—they are likely to delay care, experience unnecessary pain and suffering, and create unnecessary risks to public health. This evidence demonstrates the pathways by which exclusionary laws create health disparities. It follows that inclusionary laws may reduce health disparities and their associated spillover effects on other members of the community.

Congress recognized these effects after the passage of PRWORA. Observers noted that many lawfully present noncitizens, including children and pregnant women, would be cut off from full-scope Medicaid benefits.

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159 See, e.g., Krista M. Perreira & Juan M. Pedroza, Policies of Exclusion: Implications for the Health of Immigrants and Their Children, 40 ANN. REV. PUBLIC HEALTH 147, 152 (2019).


162 See Perreira & Pedroza, supra note 159, at 156-57.


164 See Hacker, supra note 160, at 180.

165 Woodward & Kawachi, supra note 151, at 923; id. at 926 (“[I]f governments’ social and economic policies can widen health inequalities, then it is plausible that different policies could reduce them.”). See CTR. ON BUDGET & POL’Y PRIORITIES, supra note 144, at 2 (describing the growing body of evidence showing that immigrant-inclusive policies improve individual and population health outcomes).
and would therefore be only eligible for Emergency Medicaid. Concerns about PRWORA’s impact on health care system efficiency and health outcomes for children and pregnant women were the motivation behind Congress’s creation of the ICHIA options. Congress understood that by eliminating the arbitrary, five-year delay on children’s and pregnant women’s access to subsidized health coverage, the ICHIA options reduce the risk of negative health impacts and developmental delays for future U.S. citizens.

Reducing per capital healthcare costs is a second major goal of national health policy. Expanding access to subsidized health coverage inevitably costs money. Because of the high cost of health care in the United States, universal health coverage for U.S. citizens was, prior to the ACA, presumed to be out of reach. However, health reform was based on the understanding that expanding access to health coverage for low- and middle-income people can reduce inefficient health care spending. Equitable access to health care can improve health care system efficiency by meeting more health care needs per dollar spent. Addressing disparities in access to health coverage, therefore, has the potential to be cost-neutral or even cost-saving.

States’ health policies are undoubtedly influenced by cost concerns. For some politicians, limiting eligibility for health care subsidies by citizenship and immigration status in order to cut costs in the short term is more palatable than limiting benefits based on some other criteria that would affect citizens. However, it is less clear whether such exclusionary polices save costs over the long term.

Some scholars have pointed to the ways in which restricting noncitizens’ access to health coverage—and, by extension, affordable preventive health care—may even increase net costs. Researchers have found that excluded noncitizens are disproportionately likely to seek care in

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167 YOUDELMAN, supra note 98, at 4.
168 Berwick et al., supra note 145, at 760.
170 See Woodward & Kawachi, supra note 151, at 926 (“[R]educing inequalities will lead to larger gains in health status than might be achieved by similar expenditures elsewhere.”).
the most expensive health care venue: hospital emergency rooms. This is because uninsured immigrants often delay seeking care for health problems that could have been detected or treated effectively at an earlier time. This can lead to unnecessary complications from common chronic diseases such as diabetes and asthma. Treatment of these complications, especially if they are emergency situations, is much costlier than preventive care.

The federal government ultimately absorbs much of the costs of treatment for emergency conditions affecting excluded noncitizens through Emergency Medicaid funding, Medicaid Disproportionate Share Hospital payments, and other supplementary funding for states burdened by these costs. Most Emergency Medicaid expenditures are for services provided to undocumented immigrants, who make up the largest category of excluded immigrants nationwide. In 2004, several states reported that expenditures for Emergency Medicaid grew faster than their total Medicaid expenditures over the last few years.

Costs were one of the concerns motivating Congress’s passage of the ICHIA options, which restored Medicaid eligibility for lawfully present children and pregnant women who had been excluded by PRWORA. Congress recognized that many treatable conditions affecting children and pregnant women can be addressed in a cost-effective manner through primary and preventive care, which Medicaid enables. When pregnant women do not receive prenatal care, costs associated with postnatal and pediatric care can be twice as high.

Another often overlooked cost of restrictionist subsidized health coverage laws is the increased administrative burden for government agencies and publicly funded health care facilities that must determine whether a patient qualifies for benefits or services. Providing care or coverage to all patients becomes more expensive as a result.

Laws restricting noncitizen participation in the Health Insurance

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172 Nandi et al., supra note 171, at 435.
173 Gostin, supra note 23, at 1438; Nandi et al., supra note 171, at 435.
174 Nandi et al., supra note 171, at 435.
175 U.S. GENERAL ACCOUNTABILITY OFF., GAO-04-472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 10 (2004); id. (reporting that five of ten states polled reported that labor and delivery services for pregnant women made up at least half of their Emergency Medicaid expenditures).
176 Id. at 11 (noting that Georgia’s Emergency Medicaid expenditures grew by 349%, compared with an increase in total Medicaid expenditures of 44%).
177 YOUDELMAN, supra note 98, at 3.
Marketplaces create inefficiency in health insurance financing by preventing risks from being spread across a broader population. This causes instability and unpredictability in health insurance risk pools. It is likely that undocumented immigrants, who are excluded from participation in the Marketplaces, are relatively healthy compared with natural-born citizens. Permitting them to purchase subsidized insurance in the Marketplaces could result in insurers lowering premiums for all participants. Consumers who are eligible for little or no subsidy would benefit from lower premiums. The federal government could share in these savings through a reduction in the subsidies it pays to insurers.

Finally, physicians and hospitals may shift the costs of treating excluded immigrants to insurers and insured patients. Health care providers are ethically—and in some cases legally—obligated to treat patients in need. For example, hospitals participating in Medicare (which is nearly all hospitals) are obligated under federal law to provide emergency care to all patients who need it, regardless of ability to pay, immigration status, or any other factor unrelated to medical need. When states foreclose reimbursement for care provided to uninsured immigrants, they leave physicians and hospitals vulnerable to financial losses from the provision of uncompensated care. In turn, physicians and hospitals may seek to shift these costs on to insurers and insured patients by increasing charges.

As described here, expanding health coverage for immigrants would certainly shift health system costs and may save costs overall, in addition to

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179 Makhlouf, supra note 52, at 270. Although a federal law restricts participation in the ACA Marketplaces to lawfully present noncitizens, states can apply for waivers to permit residents to purchase coverage on state-run exchanges or create state-funded exchanges that do not discriminate based on immigration status. See, e.g., Ana B. Ibarra & Chad Terhune, California Withdraws Bid To Allow Undocumented To Buy Unsubsidized Plans, KAISER HEALTH NEWS (Jan. 20, 2017), https://khn.org/news/california-withdraws-bid-to-allow-undocumented-immigrants-to-buy-unsubsidized-obamacare-plans/ (describing California’s filing and withdrawal of a Section 1332 ACA state innovation waiver to permit excluded noncitizens to purchase unsubsidized coverage on its exchange).

180 See Patrick Glen, Health Care and the Illegal Immigrant, 23 HEALTH MATRIX 197, 222 (2013) (describing research indicating that recent immigrants and those who have resided in the United States for an extended period tend to be healthier than natural-born U.S. citizens).

181 See Glen, supra note 180, at 222 (explaining how adding undocumented immigrants to the insurance risk pool could lead to cost savings for all of the insured participants).


improving population health outcomes. Taking a wider lens, some researchers have examined how expanding health coverage could improve state and local economies over the long term. This is based on the observation that untreated health issues reduce individual productivity, increasing the economic costs of restricting noncitizens’ access to health care: “From an economic standpoint can any country afford to have the talent and performance of sizeable sections of the population stunted to such an extent?” Low-income families with health insurance have more economic security than those without because they are not subject to high out-of-pocket medical costs. Health insurance and the household economic security it promotes makes it more likely that children will succeed in school, earn higher incomes, and amass more wealth. For these reasons, expanding health coverage for immigrants has been called “a smart investment in a state’s long-term health and prosperity.” Therefore, state decisions to exclude noncitizens from eligibility for subsidized health coverage in order to cut costs may be undermining the national health policy goals of reducing health system costs overall.

The goal of improving healthcare quality focuses on “improving the individual experience of care.” One of the six dimensions of quality improvement in healthcare is “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” Essentially, the goal is to reduce disparities in patient experience that are based on personal characteristics, which could include actual or perceived immigration status.

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184 See Gostin, supra note 23, at 1438 (“Shifting toward prevention and early diagnosis and treatment would avoid or reduce costs over time.”); Nandi et al., supra note 171, at 435; see also Makhlof, supra note 52, at 269-70 (describing research on how expanding immigrants’ access to health coverage could decrease total health care expenditures).

185 See, e.g., CBPP REPORT, supra note 123, at 13-14.


187 CBPP REPORT, supra note 123, at 13-14.

188 Id.

189 Id.; see also Gostin, supra note 23, at 1439 (“[E]xpanding coverage for undocumented immigrants could save costs over all.”).

190 Berwick et al., supra note 145, at 760.


192 The Institute for Healthcare Improvement described thirteen measures of overall quality of a health system (“Whole System Measures) that are closely related to the Triple Aim. Berwick et al., supra note 145, at 762 (citing LINDSAY A. MARTIN ET AL., INSTITUTE
When states restrict immigrant access to subsidized health coverage, it affects low-income immigrants’ ability to access health care. Patients who fail to access health care in a timely manner are likely to negatively impact several of the widely recognized measures of health system quality. These include unadjusted raw mortality percentage, functional health outcomes score, hospital readmission percentage, patient experience score, and health care cost per capita.193

In addition, exclusionary policies impact the quality measure of “equity,” which examines stratification of quality measures among subpopulations and aims to “drive the difference in [health] outcomes between subpopulations to zero.”194 Because a majority of excluded noncitizens are members of already disadvantaged social groups, such as racial minorities, policies that exclude immigrants from access to subsidized health coverage exacerbate—rather than reduce—existing health disparities by reducing opportunities to be healthy.195 Laws that bar noncitizens from eligibility for Medicaid therefore disproportionately affect people of color.

B. Equity

Equity in health care may be defined as “equal access to available care for equal need, equal utilization for equal need, equal quality of care for all.”196 It calls for the elimination of barriers to health care access that cause or exacerbate health disparities that are unnecessary, avoidable, and

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193 See MARTIN ET AL., supra note 192, at 18-19 (briefly describing each of these quality measures).


196 Whitehead, supra note 186, at 434. This definition aligns with the health care profession’s ethical norm of the “principle of need,” which holds that a provider should respond to a patient’s need based on sound medical judgment and without regard to any other consideration. See Mahlouf, supra note 52, at 295-97 (discussing health care professionals’ ethical obligations to noncitizens guided by the principle of need).
unfair. A society’s willingness to tolerate health and health care inequities will depend to some extent on its time- and context-bound judgment of what is unfair. As a result, the strength of the health equity norm’s influence on health policy is also time- and context-bound.

A growing number of health law scholars have begun to identify equity as the emerging normative foundation of health law scholarship and health care regulation. Professor Lindsay F. Wiley’s Health Justice model is a conceptual framework for understanding these changes, and has generated a significant body of scholarship. Health Justice conceives of health law as a vehicle for social justice and identifies a shift in the way that health insurance is regulated post-ACA: from a system based on protecting individual interests toward one based on protecting collective interests. A growing number of Americans recognize the benefits of a collective approach, facilitated by the government, to meet health care needs. Equity in health care is not merely an ethical imperative; it also contributes to all three pillars of the Triple Aim: improved health outcomes, reduced health care costs, and improved quality. The Health Justice model identifies these beliefs as shared values upon which health care laws should be founded in order to protect members of the community.

Equity in health care is the principle behind efforts to achieve universal health coverage. This is evident from health reform’s overwhelming

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197 See Whitehead, supra note 186, at 431.
198 Whitehead, supra note 186, at 433.
199 See sources cited in footnote 10, supra.
201 Wiley, From Patient Rights to Health Justice, supra note 200, at 859.
202 Healthcare System, GALLUP HISTORICAL TRENDS (last visited Aug. 27, 2019), https://news.gallup.com/poll/4708/healthcare-system.aspx (indicating that 40% of respondents preferred a government-run health care system in November 2018, compared with 34% of respondents with the same preference in November 2010).
203 See Daniels, supra note 169, at 1067 (explaining how the goal of reducing costs is both an economic and an ethical concern); Woodward & Kawachi, supra note 151 (describing various rationales for addressing health disparities); Whitehead, supra note 186, at 432.
204 See Daniels, supra note 169, at 1058 (stating that the focus of the ACA was the question “Why should we care about who is missing coverage?”). While financial access to health care is necessary to ensure equity in health care, it is insufficient alone. Other
focus on regulation of health insurance, “the financial and pragmatic point of access to care for most people.”205 One of the ways in which Congress attempted to make access to health care more equitable through the ACA was by mandating that state Medicaid programs eliminate most nonfinancial categorical eligibility criteria.206 Previously, Medicaid was available to low-income children, pregnant women, caretakers of dependent children, and people with disabilities.207 The ACA expanded Medicaid to include all nonelderly individuals with income below 138% of the federal poverty level.

Although this reform is widely referred to as “Medicaid expansion,” for a discussion focused on equity, it is more apt to describe the provision as “Medicaid decategorization.” By eliminating categorical restrictions on Medicaid eligibility that were unrelated to medical need, millions of people living in the United State gained access to health insurance and health care became more equitable. This success, shared by multiple constituencies with differing interests, was built on the understanding that all humans are vulnerable to illness and the financial devastation that can result from efforts to combat illness. However, as discussed above, the Supreme Court’s decision in NFIB v. Sebelius hindered this goal by making Medicaid expansion/decategorization optional for states.208 Because some states have chosen to not expand/decategorize Medicaid, there is extreme geographic variability in Medicaid eligibility across the country even for citizens (and noncitizens whose immigration status does not bar them from eligibility).209

In a similar manner, because the ACA did not modify the federal barriers to access and overall quality of care must also be addressed. See, e.g., Whitehead, supra note 186, at 440 (stating that equity in health care “means actively promoting policies in the health sector to enhance access to and control quality of care, rather than assuming that a universal service provided by law is equitable in practice.”). Financial access to health care is also insufficient alone to eliminate health disparities. See id. at 436-37 (“Because most of the present inequities in health are determined by living and working conditions, attempts to reduce them need to focus on these root causes, with the aim of preventing problems developing. This is potentially a more efficient approach than relying solely on the health care sector to patch up the ill-health and disability such inequities create.”).

205 McCuskey, supra note 10, at 312.
206 ACA § 2001(a)(C); 42 U.S.C. § 1396a(a)(10)(i)(VIII). Notably, as discussed above, the ACA did not eliminate categorical eligibility relating to citizenship or immigration status.
207 42 U.S.C. § 1396d(a).
209 Historically, federal legislation and policymaking have been the driving force behind equity reforms in health care. Only a few states have dabbled in cutting-edge policymaking to promote health equity McCuskey, supra note 10, at 311-12 (citing DAWES, supra note 10, at 10-90). This pattern aligns with the historical trends in other equity-based reforms, such as the civil rights movement.
framework for immigrant eligibility for Medicaid;\(^{210}\) state discretion to craft alienage restrictions in public benefit programs has created geographic variability in Medicaid eligibility for noncitizens generally. The intrastatutory federalism arrangement governing immigrant eligibility for subsidized health care programs has resulted in each state having a unique set of alienage restrictions for the unique set of programs it offers. When residents of different states with the same medical needs do not have the same access to health care, horizontal inequity results.\(^{211}\)

Consider, for example, the difference between the types of noncitizens who fall within the category of “excluded noncitizen” in Texas versus in California, i.e. those who do not qualify for full-scope Medicaid or a comparable state-funded program.

**Table 2. Noncitizen eligibility for full-scope Medicaid or comparable state-funded coverage in California and Texas**

<table>
<thead>
<tr>
<th>Ineligible</th>
<th>California</th>
<th>Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undocumented immigrants over 26 years of age(^{212})</td>
<td>Nonimmigrant visa holders age 21 and over who are not considered to be permanently residing in the U.S. under color of law (PRUCOL).(^{213}) Examples include noncitizens with tourist visas and student visas.</td>
<td>Everyone not listed in the box below</td>
</tr>
</tbody>
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\(^{210}\) See Daniels, *supra* note 169, at 1065-66 (questioning whether it was fair for the ACA to “leave[] out many immigrants and undocumented individuals”).

\(^{211}\) Alienage restrictions also create vertical inequity, i.e. when noncitizen residents with great health care needs have less access to health care than citizens with lesser needs. This section focuses on the negative impact of geographic variability in immigrant eligibility for Medicaid on the national health policy goal of reducing horizontal inequity in access to health care.


\(^{213}\) PRUCOLs are eligible for Medi-Cal, California’s Medicaid program. 22 CCR § 50301. PRUCOL refers to noncitizens who “have a good faith belief that [USCIS] knows of their presence in the U.S. and does not intend to deport them. PRUCOL includes immigrants who have applied for legal status and are waiting for a response.” See MENTAL HEALTH ADVOCACY SERV., IMMIGRANT ACCESS TO MEDI-CAL, [http://users.neo.registeredsite.com/3/8/9/12669983/assets/Medi-Cal_immigrants_Dec2014.pdf](http://users.neo.registeredsite.com/3/8/9/12669983/assets/Medi-Cal_immigrants_Dec2014.pdf) (2014). Notably, it includes DACA applicants and recipients. *Id.* A variety of recognized PRUCOL statuses are listed at 22 CCR § 50301.3.
Differences in state alienage restrictions in Medicaid result in different financial obligations for the federal government. For example, in FY17, federal spending on “emergency services for undocumented aliens” (more accurately described as federal spending on emergency Medicaid for excluded noncitizens216) in California was $176,465,875.217 In Texas, the amount was $217,398,287.218 This differential is even more dramatic given that California is home to approximately 600,000 more undocumented immigrants than Texas.219 Better access to primary care in California may explain lower spending on emergency services for immigrants.

The patchwork of immigrant exclusion from health coverage across the country weakens national health policy by running counter to the larger trend of embracing health equity as the normative foundation of health policy. Some may question whether immigrants’ interests should be included in health law and policy efforts to improve health equity. In a prior Article, I argued that they should, based on both ethical norms in health care and the strong foundations for solidarity between immigrants and U.S. citizens as it relates to health care access.220 Immigrants are embedded in American society as neighbors, schoolmates, and colleagues at work. They live with and among U.S. citizens and contribute to the common good by

<table>
<thead>
<tr>
<th>Eligible</th>
<th>Everyone not listed in the box above</th>
<th>Qualified immigrants who arrived prior to Aug. 22, 1996214</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lawfully residing children ages 18 and under215</td>
</tr>
</tbody>
</table>

214 Qualified immigrants who arrived after August 22, 1996, and who fall within a coverage group mandated by federal law are eligible for Medicaid in Texas. These are described in Part I.A, supra.


216 See 42 C.F.R. § 440.255 (describing the availability of federal payments for emergency services provided to unauthorized immigrants as well as lawfully residing immigrants who are ineligible for Medicaid).


218 Id.


220 Makhlouf, supra note 52, 287-299
paying taxes and supporting local and state economies. They play important roles in the healthcare and caregiving workforces. Therefore, any examination of social equity should consider the relative status of immigrants.\footnote{Zhu & Xu, supra note 225, at 258.}

\section*{C. Racial Dynamics}

National health policy seeks to eliminate the influence of antidemocratic values, such as racism, in Medicaid policy.\footnote{Michener, supra note 11, at 24.} Historically, federalism arrangements regulating public accommodations, voting, housing, health care, and other topics were a proxy for the preservation of states’ rights to discriminate based on race. In particular, state control of means-tested social assistance programs is a legacy of racial politics.\footnote{See, e.g., Andrea Louise Campbell, Trapped in America’s Safety Net: One Family’s Struggle 72-75 (2014).} Scholars adopting a “nationalist” perspective blame federalism for weakening norms underlying the federal government’s goal of promoting racial equality.

Some scholars have linked “citizenship dynamics” in social policy with racial dynamics, suggesting that programs with a decentralized administrative structure that devolve power and discretion to local authorities are more prone to immigration politics.\footnote{Reese et al., supra note 11, at 79-99 (“[M]any scholars suggest that the policies towards [legal immigrants] were shaped by wider attitudes toward the foreign-born population and its racial and ethnic make-up. … Various studies thus highlight the role of anti-Latino and anti-Asian sentiment in contributing support for PRWORA’s anti-immigrant provisions or shaping politicians’ justifications of these policies.”).} Many scholars have explored the ways in which negative attitudes toward Latinos and Asians have shaped anti-immigrant provisions of welfare laws.\footnote{Ling Zhu & Ping Xu, The Politics of Welfare Exclusion: Immigration and Disparity in Medicaid Coverage, 43 POL’Y STUDIES J. 456, 459 (2015) (noting that PRWORA “was driven by a wave of strong anti-immigrant sentiment along with the resurgence of nativism”); Reese et al., supra note 11, at 98-99.} More generally, scholars have identified a link between growing racial and ethnic complexity attributed to immigration and a decrease in generosity in social policy.\footnote{Ling Zhu & Ping Xu, The Politics of Welfare Exclusion: Immigration and Disparity in Medicaid Coverage, 43 POL’Y STUDIES J. 456, 458 (2015).} Although the nuances of immigration politics are distinct from racial politics because of sovereignty-related concerns, the history of alienage restrictions in Medicaid has racial overtones that should not be ignored by policymakers concerned with eliminating the influence of racism.
Noncitizen eligibility for subsidized health care from state to state may be characterized as “predictably unpredictable.” But what explains the fact that even though every state hosts unauthorized immigrants, very few have engaged in serious efforts to address their health coverage needs? This Part describes how Medicaid’s structure can influence states’ policymaking on immigrant access to health coverage. I describe how federalism enables states to make or maintain exclusionary policy that undermines national health policy goals and frustrates states’ attempts to enact inclusionary policy that would advance those goals. This analysis is inspired by leading scholars from the progressive federalism school who urge others to bring “focused attention to historical realities and policy specificities” in order to understand the relationship between federalism and equality in a given context.

A. Enabling Exclusionary Policymaking

The laws governing noncitizen access to subsidized health coverage are situated at the intersection of health law and immigration law. History demonstrates the uneven but steady progress toward centralization of regulation of matters related to health. Immigration law, on the other


228 MICHENER, supra note 11, at 33. See also Gluck & Huberfeld, supra note 20, at 1703 (criticizing federalism scholarship for being “high on abstraction and low on concreteness”); Andrew Hammond, 92 WASH. L. REV. 1721, 1724-27 (2017); Jessica Bulman-Pozen & Heather K. Gerken, Uncooperative Federalism, 118 YALE L.J. 1256, 1308 (2009) (describing the usefulness of case studies for illuminating their account of uncooperative federalism); Heather K. Gerken, Our Federalism(s), 53 WM. & MARY L. REV. 1549, 1552 (2012) (encouraging context-specific examinations of institutional arrangements). But see Gluck & Huberfeld, supra note 20 (arguing that assessing the success of structural arrangements in health care is impossible until the field of health law establishes first principles).

229 For example, in 1944, the Supreme Court ruled that Congress could regulate health insurance under the Commerce Clause, because insurance is national commerce. Gluck & Huberfeld, supra note 20, at 1707 (citing United States v. Se. Underwriters Ass’n, 322 U.S. 533 (1944). In 1945, Congress legislated to return that power to the states so long as
hand, is the traditional domain of the federal government. Immigration laws
govern matters relating to the admission and expulsion of noncitizens,
which sometimes take into consideration a noncitizen’s use of public
benefits in the United States. Alienage laws govern matters relating to the
lives of noncitizen residents once they are within the United States.

The federal government’s authority to impose alienage restrictions on
eligibility for public benefits is well established under its broad
constitutional powers over immigration-related matters. So long as
alienage restrictions are supported by a rational basis, they will be
upheld. Because of this low bar, only rarely have courts invalidated
federal laws discriminating against noncitizens as unconstitutional.

On the other hand, the Supreme Court has interpreted state authority to
impose alienage restrictions on eligibility for public benefits differently. In
*Graham v. Richardson*, the Court considered an equal protection challenge
brought by lawfully residing immigrants against state welfare laws that
discriminated between citizens and noncitizens. The Court first looked to
whether the state laws were preempted by the exclusive federal immigration
power. A state alienage restriction on public benefits eligibility is
considered immigration policy because it imposes an auxiliary burden on
lawfully present immigrants that is stricter than the conditions that Congress
has not explicitly regulated in that space. *Id.* at 1707-1708 (citing McCarran-
1011-1015 (2016)).

Hiroshi Motomura, *Immigration and Alienage, Federalism and Proposition* 187, 35

Id.

See Mathews v. Diaz, 426 U.S. 67, 80 (1976) (“[T]he fact that Congress has
provided some welfare benefits for citizens does not require it to provide like benefits for
All aliens. Neither the overnight visitor, the unfriendly agent of a hostile foreign power, the
resident diplomat, nor the illegal entrant, can advance even a colorable constitutional claim
to a share in the bounty that a conscientious sovereign makes available to its own citizens
and Some of its guests.”); Wishnie, *supra* note 4, at 506-506 (describing how the plenary
power doctrine explains the Court’s deference to the federal government’s decisions to
discriminate between citizens and noncitizens in the administration of public benefits).

Courts recognized several rational bases for discriminating between citizens and
noncitizens in the administration of public benefits in the many unsuccessful legal
challenges to PRWORA’s alienage restrictions. *See City of Chicago v. Shalala*, 189 F.3d
598 (7th Cir. 1999); *Rodriguez v. United States*, 169 F.3d 1342 (11th Cir. 1999); *Kiev v.
799, 807-11 (S.D.N.Y. 1997); *Cid v. S.D. Dep’t of Soc. Servs.*, 598 N.W.2d 887, 891-93
(S.D. 1999).


*Id.* at 374-75 (quoting Shapiro v. Thompson, 394 U.S. 618, 633 (1969)).
has imposed on their residence.\textsuperscript{237} If it is not preempted, equal protection principles apply because states lack a like power to regulate regulation.\textsuperscript{238} The Court struck down the alienage restrictions because the states’ cost-based rationales did not satisfy strict scrutiny.\textsuperscript{239}

The legacy of Graham v. Richardson, prior to the passage of PRWORA, was that state public benefit laws that discriminated against lawfully present noncitizens were upheld only if they satisfied strict scrutiny. On account of the exclusive federal power over immigration, courts analyzed equal protection claims brought by noncitizens differently depending on whether they were challenging state or federal laws.\textsuperscript{240} With the passage of PRWORA, Congress largely eliminated the divergent treatment of state and federal alienage restrictions by explicitly authorizing states to enact discriminatory public benefit laws in a way that does not withstand strict scrutiny. As Professor Parmet notes, “PRWORA attempts to protect states that discriminate against non-citizens in a manner that would otherwise violate the Equal Protection Clause.”\textsuperscript{241}

Post-PRWORA, the courts’ analyses of discriminatory state laws have focused on whether the state is merely implementing federal law—in which case rational basis review applies—or whether it is governing a state-funded, state-administered program, in which case strict scrutiny would still apply.\textsuperscript{242} In essence, Congress devolved its authority to discriminate against noncitizens with limited judicial review in the area of public benefits law.\textsuperscript{243} As a result, states have faced very few barriers to excluding noncitizens from Medicaid, regardless of their reasons for doing so. Racism, nativism,
and xenophobia are just some of the motivations driving social welfare policy in the states.

B. Creating Barriers for Inclusionary Policymaking

For states desiring to enact health policies that are inclusive of low-income noncitizen residents, the decentralized structure of the laws governing immigrant eligibility for Medicaid represents a barrier. In this Section, I describe the fiscal, legal, and political barriers that frustrate state efforts to enact inclusionary policies that address the health care needs of noncitizens.

Any expansion of health coverage, whether it is at the state or federal level, requires the infusion of public funds. In terms of fiscal capacity, states begin at remarkably different baselines. In addition, states have varying ratios of noncitizen to citizen residents. These factors can limit their ability to self-fund health coverage programs or even to take advantage of federal options to expand Medicaid coverage, since states are responsible for a portion of the costs.\footnote{See Reese et al., supra note 11, at 97 (finding a positive relationship between states’ per capita revenue and decisions to enact inclusive policies with respect to immigrant eligibility for public benefits post-PRWORA).}

Indeed, Medicaid’s cooperative federal-state financing arrangement does not effectively address states’ fiscal difficulties because “the states most in need of help will be those least able to claim it.”\footnote{David A. Super, Rethinking Fiscal Federalism, 118 HARV. L. REV. 2544, 2587 (2005).} In the more general health reform context, we see that some states have cited fiscal concerns as one reason for declining to adopt the ACA Medicaid expansion even though federal support for expansion is exceptionally generous.\footnote{David K. Jones et al., The Changing Landscape of Medicaid: Practical and Political Considerations for Expansion, 311 JAMA 1965, 1966 (2014) (describing state officials’ concerns about the long-term cost burden of expanding Medicaid). The federal share of the cost of Medicaid expansion was 100% from 2014 to 2016, phasing down to 90% in 2020. Id. at 1965. Evidence of cost-effectiveness may motivate some states to adopt Medicaid expansion. See, e.g., Jonathan Gruber & Benjamin D. Sommers, The Affordable Care Act’s Effects on Patients, Providers, and the Economy: What We’ve Learned So Far, 38 J. POL’Y ANALYSIS & MANAGEMENT 1028, 1043 (2019) (citing studies finding no significant increase in state spending resulting from expansion).} Because federal funding for Medicaid expansion to noncitizens is less generous or nonexistent, we can expect fiscal concerns to be an even greater consideration in state policymaking.

Fiscal concerns arise in wealthier states’ decisions to expand health coverage to immigrants as well. For states, Medicaid is both a major
expenditure and the largest source of federal funding. Most states, unlike the federal government, are constitutionally required to balance their budgets every year. This means that during economic recessions, states must find ways to cut spending. Often, these cuts disproportionately affect countercyclical spending programs such as Medicaid, which are designed to increase spending when revenues are down. As more residents become eligible for Medicaid due to income loss, there is pressure for the state to restrict eligibility criteria and services in order to limit spending. Since eliminating programs due to budget constraints is always unpopular, politicians may be wary of committing funding to covering groups that are not required to be covered by Medicaid—which includes many immigrants.

Even if a state had elected federal options to expand Medicaid to some immigrants and then cut coverage of these groups during a recession, it is unlikely that the former level of coverage would be restored. During economic recoveries, states rarely restore eligibility and services back to their prior level due to competition for resources from other programs and spending generally declines as the economy improves and fewer residents qualify. Therefore, state balanced budget requirements, among other structural influences, have the effect of systematically ratcheting down state spending on countercyclical programs such as Medicaid over time. With fewer resources to devote to subsidizing health coverage overall, programs covering the least politically appealing groups such as low-income noncitizens are deprioritized. Programs that cover populations that are ineligible for Medicaid matching funds, such as undocumented immigrants, may be considered the most expendable from both fiscal and political perspectives.

Recent state efforts to expand coverage for noncitizens have faced cost-related barriers but are making incremental progress toward coverage for all residents. California has taken the lead in this effort by expanding Medi-Cal to undocumented children in 2016 and to young adults up to the age of

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248 Super, Rethinking Fiscal Federalism, supra note 245, at 2609.
249 Super, Rethinking Fiscal Federalism, supra note 245, at 2632.
250 Super, Rethinking Fiscal Federalism, supra note 245, at 2635-36 (“[T]hese programs’ budgets are vulnerable to budget-driven cuts in bad economic times and demand-driven reductions in good ones.”).
251 Super, Rethinking Fiscal Federalism, supra note 245, at 2615.
252 Id. at 2565-66 (noting that the federal government, in healthcare financing “commonly takes the most politically appealing functions for itself, leaving the less desirable ones to uncertain fates at the hands of the states”).
twenty-six in 2020. Still, in 2019, a proposal to expand Medi-Cal to all undocumented adults was vigorously debated and ultimately defeated over cost-related concerns. A modified proposal to cover undocumented senior citizens was defeated on the same grounds. California’s governor, Gavin Newsom, continues to support an expansion of Medi-Cal to undocumented senior citizens, maintaining that universal health coverage will ultimately save money. In January 2020, he proposed to allocate $80.5 million from the state general fund for that purpose in the 2020-21 budget.

From the legal perspective, PRWORA, in theory, maintained state authority and discretion to expand noncitizen eligibility for state-funded public benefits. However, two interlocking provisions of PRWORA limit states’ ability to enact immigrant-inclusive policy to improve health outcomes: (1) the express prohibition on most state and locally funded benefits for unauthorized noncitizens; and (2) the requirement that states enact a new law to provide unauthorized noncitizens with otherwise prohibited state or local benefits. In addition, in order to maintain the status quo of coverage for lawfully present immigrants post-PRWORA, states had to affirmatively enact new policies. By 1998, only thirteen states had restored Medicaid eligibility for newly excluded groups to pre-PRWORA levels. This indicates that PRWORA created a new baseline of immigrant eligibility for Medicaid. Even states that had provided relatively generous benefits to lawfully present immigrants in the past “reset” their baseline during this period of public benefits retrenchment in order to maintain high benefit levels for the eligible population.

Medicaid waivers are, in theory, a mechanism for states to expand coverage for immigrants. However, their ability to do so is limited when their goals conflict with the goals of the administration in power. With each new administration, CMS sets different priorities for Medicaid policy and

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255 Id.


257 Reese et al., supra note 11, at 98.

258 Reese et al., supra note 11, at 105-106.
waiver approvals tend to reflect those priorities. For example, the Trump administration issued revised CMS waiver approval criteria in November 2017. Notably, it eliminated the goal of expanding coverage for low-income people, which had been listed as a priority in past administrations. Although states can challenge denials of waiver applications through litigation, expanding coverage of excluded noncitizens through a Section 1115 waiver is likely to be feasible only with a relatively friendly administration. In 2016, California filed a Section 1332 ACA state innovation waiver that would enable excluded noncitizens to purchase unsubsidized coverage on its state-run exchange, Covered California. However, the state withdrew its waiver request in early 2017, anticipating that it would be denied by the Trump administration, which has made repealing the ACA and cracking down on immigration enforcement centerpieces of its policy agenda. Although waivers offer an option for inclusionary policymaking by states, it is highly dependent on the political orientation of the current administration.

Another way in which the federalism arrangement governing immigrant eligibility for Medicaid creates a barrier for inclusionary policymaking is by siloing state-level advocacy such that it becomes harder for organizations to harness synergies and pool knowledge and resources to advance equitable policy. Since states have wide discretion to make policy in this area, every state is a unique piece of the patchwork of immigration exclusion from Medicaid. When each state has a different baseline of coverage for immigrants, advocates for inclusionary policy must focus their energy and

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260 Id. at 9, app. B.

261 Id. at 1.

262 See id.


264 Id.

265 See Michener, supra note 9, at 119 (describing the ‘‘many-headed’’ [Medicaid] policy that takes very different forms in different places and has direct implications for politics.”).

266 See supra Sections I.A.3 and I.B (describing the patchwork of exclusion).
resources on different goals. For example, as described above, California is currently contemplating expanding access to state-funded Medi-Cal to undocumented senior citizens. All lawfully present immigrants and undocumented children and young adults up to the age of 26 are already eligible for Medi-Cal. The Governor views this effort as a step in the direction of achieving universal health coverage in the state. Meanwhile, in Georgia, only immigrants who have held qualified status for five years are eligible for Medicaid. The state has not elected any of the federal options to expand Medicaid and/or CHIP to additional noncitizens. Unsurprisingly, neither has it created state-funded programs to expand immigrant access to health coverage. In 2015, the executive director of Georgians for a Healthy Future, an advocacy group dedicated to closing the coverage gap for low-income Georgians, was quoted on this issue: “We are having a very different conversation…. I think we are really far away as a state from where California is.” Health advocacy efforts are currently focused on supporting Medicaid expansion for low-income citizens and otherwise eligible immigrants.

The fragmentation of Medicaid politics around immigrant eligibility is a sign of a larger flaw in the intrastatutory federalism structure of Medicaid. Jamila Michener writes that “[f]ederalism can fragment the politics of Medicaid, splinter policy coalitions and interest groups, raise barriers to political coordination across locales, impede democratic accountability, and differentially demobilize policy beneficiaries as well as those who live in communities alongside them. These effects are particularly acute in the post-ACA, polarized health policy space in which state-level advocates must funnel resources toward defending against attacks and maintaining the status quo rather than imagining a more inclusive future. For example, in states like Georgia that are proposing to adopt the ACA Medicaid expansion only if a waiver imposing work requirements on recipients is approved, health policy advocates are divided on whether to support the effort. One can imagine how immigrant-inclusionary policy would meet a similar fate,

267 Hart, supra note 254.
270 Michener, supra note 9, at 119.
271 Id. at 120.
272 Id. at 120-21.
dividing healthcare consumers who would otherwise stand to benefit from joint advocacy.  

IV. THE LIMITS OF DECENTRALIZED POLICY

As described in Part I, federalism arrangements in health care are not constitutionally required. Therefore, Congress must have had other reasons for designing Medicaid as a cooperative federalism program. Scholars have explored many possible reasons why Congress devolves regulatory authority to states on matters in which it indisputably possesses the power to regulate. However, the overarching justification for federalism in Medicaid is the assumption that state-run programs will result in better policy outcomes: better quality, lower costs, and more competition and innovation.  

Policy experimentation is the federalism value that is most often used to justify cooperative federalism arrangements in the regulation of health care and is the focus of this discussion. In theory, federalism arrangements enable states to engage in policy experimentation. These experiments are considered valuable because they produce useful knowledge in a contained environment, provide templates for other states to replicate successful experiments, and result in the enactment of optimal policy, i.e. policies that accomplish their intended effects and that do not have counter-productive side effects. This is Justice Brandeis’s well-known depiction of states as “laboratories of democracy.”

273 Id. at 121, 125-26.
274 See discussion supra at text accompanying notes 25 to 35.
275 Scholars have explored many possible reasons why Congress devolves regulatory authority to states on matters in which it indisputably possesses the power to regulate. For example, Abbe Gluck has described four ways in which state implementation of federal law can benefit federal lawmakers: (1) Encouraging and influencing experimentation at the state level; (2) entrenching federal statutory norms; (3) encroaching on a field of lawmaking that is traditionally governed by the states; and (4) effectuating traditional federalism values such as autonomy, policy variation, and political participation. Gluck, supra note 133, at 565. Although this discussion focuses on the policy experimentation rationale, it should not be read to exclude these and other factors that may have influenced Congress’ decision to devolve authority over immigrant eligibility for Medicaid to the states.
276 Gluck & Huberfeld, supra note 20, at 1799.
277 Huberfeld, supra note 18, at 457.
278 New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting), abrogated by W. Coast Hotel Co. v. Parrish, 300 U.S. 379 (1937) (“[A] state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).
However, federalism arrangements do not always produce optimal experimentation. This Part explores the limits of decentralization for producing optimal policy. I identify the mechanisms that stifle state policy innovation and that impede replication by other states. Although this Part focuses on the devolution of policy governing immigrant eligibility for Medicaid, the insights described extend beyond this context. Federalism scholars may use this analysis to inform broader investigations of the relationship between decentralization of policy and its effects on quality. Research about the effects of the growth of state and local regulation of matters affecting immigrants and its role in integrating immigrants are one example.

A. Stifled Innovation

In the ideal conception of states as laboratories of democracy, states would compete to test hypotheses about the effects of expanding or restricting immigrant eligibility for Medicaid; however, states have not done this in practice. For example, in popular and scholarly discourse, one of the main arguments against offering generous health care or other benefits to noncitizens is the fear of creating a “welfare magnet” for poor, unauthorized immigrants. The welfare magnet hypothesis predicts that low-income noncitizens will cluster in nations or states with the most generous benefits. Given the dominance of this justification for restrictionism, theoretical and empirical social science literature on the relationship between welfare states and immigration is surprisingly sparse. Empirical support for the welfare magnet hypothesis from existing studies is mixed. However, one recent study examining interstate


281 Nannestad, supra note 280, at 516 (citing George G. Borjas, Immigration and Welfare Magnets, J. OF LABOR ECON. 17 (1999)).

282 See id. at 513.

283 See Nannestad, supra note 280, at 516-17 (reviewing the mixed findings in the literature on the welfare magnet hypothesis); GIULIETTI, supra note 280, at 4 (same, but concluding that any welfare magnet effect that may exist is “limited compared with other determinants of migration”); Neeraj Kaushal, New Immigrants’ Location Choices: Magnets without Welfare, 23 J. OF LABOR ECON. 59 (2005) (finding that the availability and
migration of immigrants between 2000 and 2016 found that state expansions of Medicaid and/or CHIP to lawfully present children and/or pregnant women under the ICHIA options were not associated with migration in pursuit of health insurance. The authors suggest that this conclusion has important implications for states considering expanding health coverage for immigrants, particularly as they estimate the short- and long-term costs of expansion.

Even if state-level executive officials like governors and health care agency heads were persuaded that expanding access for noncitizens is good health policy, some states are discouraged from investing in inclusive Medicaid policy when they feel that the federal government is to blame for the disparity in immigrant access to health coverage. Communities with large populations of excluded noncitizens have sued the federal government in order to obtain reimbursement for the cost of providing health care benefits to them. Their argument is that since the federal government is responsible for both making immigration policy and barring certain noncitizens from eligibility for federal public benefits, it should be responsible for the results of its policies. When states fail to enact the policies that they deem optimal for their populations, federalism isn’t producing useful knowledge from the state laboratories.

PRWORA crippled meaningful state experimentation on immigrant-inclusive Medicaid policy by making restrictionism, rather than inclusion, the norm at the federal level. It is an example of how federal legislation can “influence the direction of state experiments in ways that state experimentation in the absence of federal law does not.” By imposing new restrictions on the use of federal funds to cover many previously eligible, lawfully present noncitizens, PRWORA made it much harder for

generosity of welfare programs have little effect on the location choices of newly arrived immigrants); Madeline Zavodny, Determinants of Recent Immigrants’ Locational Choices, 33 INT’L MIGRATION REV. 1014, 1028 (1999) (finding “little evidence that recent recipients of LPR status base their locational choices within the United States on the generosity of welfare benefits,” but noting that new refugees and asylees are more likely to settle in states with more generous welfare programs providing cash and nutrition benefits).

285 Id. at 27.
286 See Legomsky, supra note 4, at 1471 (describing state lawsuits against the federal government to recover social service costs associated with undocumented immigration).
287 See Bulman-Pozen & Gerken, supra note 5, at 1267; Calvo, supra note 55, at 411 (describing how Florida senators successfully advocated for making PRUCOLs eligible for SSI in 1972 based on the disproportional economic burden they would face if eligibility for the benefit were more restrictive).
288 Gluck, supra note 133, at 568.
states to experiment with inclusive Medicaid policy. States are unable to function as autonomous laboratories because, in the current intrastatutory federalism arrangement, they are heavily beholden to federal funds and, therefore, federal laws dictating those funds must be spent.

The reality is that most states are not in a good position to self-fund Medicaid expansions to noncitizens because of variability in resources (complicated by the requirement to balance the budget each year in most states) and variability in where excluded noncitizen populations reside. One study found “a significant and negative relationship between benefit replacements [after welfare reform] and states’ poverty rates,” meaning that states with higher poverty rates were less likely to restore benefits for noncitizens after welfare reform. It was only after Congress authorized additional federal funding to expand Medicaid to lawfully present pregnant women and children in CHIPRA that inclusionary experimentation became a realistic option for many states.

If the federal government does not provide adequate support, there is danger of creating a “race to the bottom” in which states that are concerned about the welfare magnet effect and the associated fiscal burden of expanding health care benefits will enact policies that are less generous those of their neighbors. Specifically, in this context, states will select more restrictive alienage criteria for their Medicaid programs. From a national perspective, the race to the bottom produces suboptimal policy for residents who would benefit from health coverage.

On the other hand, when the federal government steps in to cushion the costs of bad policy, it creates another disincentive to state innovation: economic spillovers. “Spillovers” are economic inefficiencies that arise from excessive variations in state policies and that are ultimately borne by the federal government. Spillovers indicate that there has been a misallocation of responsibility for a particular policy issue because the states clearly lack the capacity to address the issue on their own. Federalism scholars have told numerous “traditional spillover stories” that justify a

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289 See discussion supra Section III.B.
290 Reese et al., supra note 11, at 97.
291 See Gluck, supra note 133, at 567-68 (“Consider the idea that the federal government might use its own, national legislative power to encourage the very state-based experimentation and decentralization that animates the ‘states as laboratories’ theory.”).
293 Legomsky, supra note 4, at 1471 (explaining how state-level cuts to public benefits could create a race to the bottom if the welfare magnet hypothesis is accepted).
centralized approach to various areas of law.295 Since the federal government ultimately bears the costs of coverage for excluded noncitizens, it is in the best position to correct the spillover.

When states undersupply the optimal level of subsidized health coverage for noncitizens, they increase the likelihood that noncitizens will delay care until there is an emergency. Rather than seek treatment for health conditions from a primary care provider, where it is likely they can be treated relatively effectively and inexpensively, uninsured people tend to seek treatment when the condition has progressed to the point that it is too painful or debilitating to bear; and they seek it in the most expensive health care venue: the emergency room. The federal government absorbs a significant portion of these costs through programs to partially reimburse states such as EMA, Disproportionate Share Hospital payments, and supplemental funding for health care provided to unauthorized immigrants.296 When states are shielded from bearing the full cost of inefficient policies—and instead externalize a significant portion of the costs on to the federal government—they do not have the incentive to improve those policies. Centralizing funding and decisions about immigrant eligibility for Medicaid would avoid this scenario.

B. Incidental Health Policy

Another theoretical benefit of the laboratories of democracy concept is that states should replicate successful health care policy experiments.297 As described in the previous Section, few states have been able to engage in meaningful policy experimentation to expand health coverage to noncitizens. The successful experiments that have been conducted have, with few exceptions, not been replicated. Take coverage of kidney transplants as a case study: Illinois is the first and only state to fund kidney

295 Id. at 848; Robert P. Inman & Daniel L. Rubinfeld, Rethinking Federalism, 11 J. ECON. PERSPECTIVES 43, 46 (1997) (describing how the United States has corrected spillovers in national defense, old-age social security, and environmental protection by centralizing the provision of goods or mandating outcomes).

296 Perkins, supra note 166, at 392 (describing Balanced Budget Act of 1997 funding to subsidize emergency Medicaid for twelve states with the greatest number of undocumented immigrants and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 funding for providers in all states for emergency health services to undocumented); Legomsky, supra note 4, at 1470 (describing Congress’s authorization of “state legalization impact assistance grants” in 1986 to partially reimburse states for costs associated with providing services to previously undocumented immigrants who obtained status under the Immigration Reform and Control Act).

297 Wiseman, supra note Error! Bookmark not defined..
transplants for people with ESKD regardless of citizenship or immigration status.\textsuperscript{298} In order to pass the authorizing legislation, physician advocates joined forces with community activists to explain to state legislators that, “[f]or patients with renal failure, a kidney transplant represents the only path to full recovery.”\textsuperscript{299} They assembled evidence that unauthorized immigrants donate a disproportionate share of transplanted organs.\textsuperscript{300} Although humanitarian and fairness concerns did play a role in persuading legislators to support the bill, the most persuasive rationale was related to costs: the cost of providing standard dialysis treatment begins to exceed the cost of a kidney transplant at two years and nine months.\textsuperscript{301} Despite this compelling pragmatic and moral case for why states should fund kidney transplants for excluded noncitizens, no other states have followed Illinois’ example. In fact, states do not even cover regular dialysis treatment for excluded noncitizens with kidney failure.\textsuperscript{302}

This example demonstrates that even if state policy experimentation produces useful information from a social welfare perspective, states may not use that information to make choices that would further policy goals.\textsuperscript{303} Rather, state policies on subsidizing health care for noncitizens—like state policies on subsidizing health care generally—track other factors (demographic, fiscal, political, etc.) more closely than any useful indicator of “good” health policy.\textsuperscript{304} Scholars have also observed a remarkable degree of path dependence in health care policy: Poorer, southern states tend to decline options to expand cooperative federalism social welfare programs while wealthier states cash in on such options to the maximum extent.\textsuperscript{305}

A tradition of welfare generosity to residents generally may also influence a state’s decision to provide public benefits to noncitizens. Some scholars theorize that “states with more generous welfare spending in the

\textsuperscript{298} See Ansell et al., supra note 88, at 782.
\textsuperscript{299} Id. at 783.
\textsuperscript{300} Id. at 783-84.
\textsuperscript{301} Id. at 784.
\textsuperscript{302} See text accompanying notes 87 to 91.
\textsuperscript{303} See Jessica Bulman-Pozen, \textit{Executive Federalism Comes to America}, 102 V.A. L. REV. 953, 955 (2016) (describing how, on some policy issues, state action seems to be motivated more by ideological preference than by the desire to achieve federal policy outcomes in cooperative federalism arrangements); Hannah J. Wiseman, \textit{Regulatory Islands}, 89 NYU L. REV. 1661 (2014).
\textsuperscript{304} See Reese et al., supra note 11 (describing the relationship between states’ decisions to restore public benefits eligibility to authorized noncitizens after welfare reform and various other factors).
\textsuperscript{305} Gluck & Huberfeld, supra note 20, at 1717.
past would be more likely to spend more subsequently and to be more inclusive.”

In line with this hypothesis, one study found that states with the most generous welfare benefits for the general population were more likely to restore benefits for noncitizens after welfare reform.

Studies that have examined the effect of immigration on state social welfare policies do not reach consistent conclusions about the direction and extent of the relationship. For example, they do not establish a relationship between the size of a state’s foreign-born population and the inclusivity of social welfare policies for noncitizens. Reese et al. has proposed various theories to explain the causal mechanisms behind the relationships identified in these studies. However, additional research is needed to determine the precise mechanisms by which these relationships operate.

CONCLUSION

In recent months, prominent Democratic lawmakers have co-sponsored “Medicare for All” bills in the House and Senate that would transform the U.S. health care system into a single-payer system for “[e]very individual who is a resident of the United States,” including, potentially, currently excluded noncitizens. However, the idea of including more immigrants in

306 Reese et al., supra note 11, at 105 (describing the “institutionalist perspective”).
307 ZIMMERMAN & TUMLIN, supra note 56, at 46. Some studies have found that states with more immigrant-inclusive welfare policies tend to provide less generous TANF benefits. However, this could be explained in at least two different ways: that immigrant-inclusive policies erode support for TANF or that they signal support for equitable eligibility criteria over maximization of TANF grants for a more exclusive group of recipients. Reese et al., supra note 11, at 106.
310 Reese et al., supra note 11, at 104-05.
311 See Reese et al., supra note 11, at 119 (describing the types of data and future research that are needed to establish the causal mechanisms behind these relationships).
312 Medicare for All Act of 2019, S. 1129, 116th Cong. § 102(a) (2019); Medicare for All Act of 2019, H.R. 1384, 116th Cong. § 102(a) (2019). The bills do not define the term “U.S. resident” with enough specificity to guarantee that currently excluded noncitizens would be eligible to enroll; rather, it delegates this responsibility to the HHS Secretary. S. 1129, § 102(a); H.R. 1384, § 102(a). However, the primary sponsors of the bills publicly support the inclusion of noncitizens—including unauthorized immigrants. See, e.g., Paige Winfield Cunningham, Jayapal’s Medicare-for-all Bill Reflects Influence of Hard-Line
national health insurance programs is deeply contested. Why should the United States subsidize the health care of immigrants, especially if they are undocumented? What isn’t widely known is that we already do, and not in the most efficient manner. Through various safety net programs, federal subsidies to health care providers that treat a disproportionate share of uninsured people, hospital charity care programs, higher insurance premiums, and the patchwork of state and local policies on immigrant eligibility for subsidized health coverage, the United States spends approximately $18.5 billion to subsidize the health care of immigrants who are currently excluded from Medicaid.313

When Congress passed immigration and welfare reform in 1996, it devolved authority to the states to make policy about immigrant eligibility for Medicaid, thus relieving the federal government of pressure to address a national problem and contributing to political stasis. The existing patchwork of noncitizen exclusion from Medicaid is counterproductive to our national health policy goals of improving population health outcomes, controlling costs, and improving quality; it cuts against the emerging norm of health care equity within health law scholarship and health care regulation; and it undermines efforts to eliminate the influence of antidemocratic values like racism in health policy. Making access to federal health insurance programs more equitable for immigrants is a fiscally responsible option that also helps to safeguard the public’s health and align policy with ethical norms in health care.

This Article describes the role of federalism in shaping states’ policy decisions about immigrant eligibility for Medicaid. Although federalism theory has coalesced around the idea that federalism has no political

valence, scholars have called for research to understand the effects of federalism on fragmentation, inequity, and exclusion in practice. Scholarship analyzing federalism arrangements across a range of subjects opens the door to understanding deeper insights about how federalism shapes policy. This Article makes a unique contribution to this effort by synthesizing insights from three fields that rarely comment on one another: health law, immigration law, and federalism theory.

Consistent with prior research demonstrating how federalism can exacerbate inequity, this Article argues that the intrastatutory federalism structure of immigrant eligibility for Medicaid doesn’t just create extreme geographic variability in access to health coverage; it enables states to make or maintain exclusionary laws that undermine national health policy goals. PRWORA, the welfare reform law that created the framework governing immigrant eligibility for public benefits, set an extremely low floor of federal Medicaid coverage for immigrants. It also devolved federal authority to discriminate against noncitizens in the administration of public benefits with limited judicial review. Without a robust federal floor of Medicaid coverage and with authority to discriminate in a way that was previously held to violate the Equal Protection Clause, states face few obstacles to imposing harsh limits on immigrant eligibility for Medicaid—even when health policy choices are guided by antidemocratic values like racism, nativism, and xenophobia. The result is ineffective and inhumane policy that is responsible for significant human suffering.

For states that wish to expand immigrant eligibility for Medicaid, the current federalism arrangement poses fiscal, legal, and political obstacles. Of these, fiscal concerns likely represent the greatest barrier: PRWORA restricts the use of federal funds to enact inclusionary Medicaid policy. The ceiling of federal Medicaid coverage excludes a substantial population of noncitizens residing in the United States, including all but a few categories of lawful permanent residents (LPRs) during their first five years of residence, DACA recipients, and undocumented immigrants—including many categories of noncitizens with pending immigration applications. Although there are federal options to expand Medicaid coverage to select groups of immigrants, state fiscal concerns can pose an insurmountable barrier to electing those options, as well as to creating state-funded programs to expand coverage for immigrants.

By examining the role of federalism in shaping state policies that exclude immigrants from Medicaid, this Article helps to explain why some social policies are linked to fragmentation and inequity. Although, in theory, fragmentation should equally enable states that support inclusionary health policy to expand coverage for immigrants, this Article depicts the
uphill battle they face. In an era when progressive health policy embodied by the ACA is under attack, advocates for inclusionary health care reform are looking to state-based solutions.

This Article provides a case study for understanding the efficacy of federalism arrangements in achieving equity for those who were left behind by health reform. It offers insights to federalism scholars generally and to advocates seeking to advance health care equity. It links evidence about the uneven patchwork of subsidized health coverage for immigrants to the federalism literature on laboratories of experimentation. In this context, Medicaid’s structure has failed to incentivize the type of state policy experimentation and replication that justifies federalism arrangements. Rather, it has skewed state “experimentation” toward exclusionary policy and limited states’ ability to experiment with inclusive policy.

The implications of this analysis are clear: Centralization of immigrant eligibility for Medicaid would create uniformity, transparency, and equity in immigrant access to health care among the states.314 Centralization does not necessarily require federalizing the entire health care system or even Medicaid. Thoughtful federal reforms to Medicaid that create a more unified national policy on immigrant eligibility could be just as effective. Such reforms run the gamut from radical to incremental and could correct or reverse the existing imbalance.

For example, Congress could raise the federal floor of Medicaid eligibility by mandating coverage of all otherwise qualifying U.S. residents. This would eliminate states’ ability to enact immigrant-exclusionary Medicaid policies, which may be justified by evidence indicating that inclusive policy is cost-effective in the long term. A more modest—yet still impactful—reform could be to raise the federal floor of immigrant eligibility for Medicaid by eliminating the five-year bar for LPR children. Alternatively, Congress could remove the federal ceiling on immigrant eligibility for Medicaid by eliminating the citizenship and immigration status criterion.315 This would have the effect of enabling states to make inclusionary policy while not requiring states to expand coverage. By raising both the floor and the ceiling, Congress could reverse the existing imbalance.

314 See Huberfeld, Huberfeld, supra note 18, at 473.
315 For Congress to do this without affecting noncitizens’ eligibility for other public benefits under the PRWORA bar, it could list Medicaid as an exception to the general rule barring non-qualified noncitizens from eligibility for federal public benefits. See 8 U.S.C. § 1611(a) (2012) (general rule); id. at §1611(b) (exceptions). The reason why unauthorized and other excluded noncitizens are currently able to access EMA, public health services such as immunizations, and some emergency disaster relief programs providing medical services is that they were carved out as statutory exceptions to the general rule. PRWORA § 401(b) (codified at 8 U.S.C. § 1611(b)).
imbalance by making it easier for states to expand coverage for immigrants than to restrict coverage.

In order to ward off uncooperative behavior by states, Congress might consider giving states some flexibility—“microspheres of autonomy”—to make policy choices that best serve their populations within a federal scheme that promotes national goals. There are ways to structure a mostly federalized regime in order to preserve, in theory, values typically associated with decentralization, such as competition and experimentation. Giving states some flexibility within a federal scheme that promotes national goals enables policy experimentation just as well as (and possibly better than) totally decentralized approaches because it provides states with the federal funds they typically need to engage in true experimentation. One way to do this could be to provide states with a limited menu of options for expanding immigrant eligibility for subsidized health coverage.

A potential objection to centralizing policy on immigrant access to Medicaid is that an anti-immigrant Congress could just as easily roll back noncitizen eligibility for subsidized health coverage, defunding existing programs or restricting coverage to a smaller group of noncitizens. This would be unfortunate and would make terrible health policy, but Congress can do that today with the current intrastatutory federalism scheme. The political entrenchment of Medicaid eligibility for at least some noncitizens would hopefully protect against dramatic new alienage restrictions under a politically conservative administration. If not, this would certainly be an issue around which a broad-based, national coalition of groups could organize in opposition.

During the next round of health care reform, whether policymakers start from scratch or use Medicaid as a building block for universal coverage, it is imperative to consider the ways in which the patchwork of noncitizen exclusion is economically inefficient, medically ineffective, and morally damaging. This patchwork arises from the current intrastatutory federalism structure of immigrant eligibility for Medicaid, which enables states to

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316 Bulman-Pozen & Gerken, supra note 287, at 1268.
317 For example, states could choose among the following three options: (1) Expand Medicaid to all residents who would otherwise qualify; and/or (2) Permit all state residents to purchase coverage on the federal Exchange with the help of premium assistance tax credits and cost-sharing reduction payments; or (3) Receive a block grant to provide coverage to excluded noncitizens.
318 See Howard F. Chang, Public Benefits and Federal Authorization for Alienage Discrimination by the States, 58 NYU ANN. SURV. AM. L. 357, 369 (2002) (explaining how, in a slightly different context, if Congress is “required to impose a uniform rule nationwide, [i]t could respond to these concerns with a nationwide rule of exclusion, imposed even on those states that would prefer to be more generous.”).
become “laboratories of exclusion” rather than experimentation. In this historical and policy context, federal leadership is needed in order to enact inclusive policy on immigrant eligibility for health coverage.