

LABORATORIES OF EXCLUSION: MEDICAID, FEDERALISM & IMMIGRANTS

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Medicaid's cooperative federalism structure gives states significant discretion to include or exclude various categories of noncitizens. This has created extreme geographic variability in noncitizens' access to health coverage. This Article describes federalism's role in influencing state policies on noncitizen 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 noncitizen health coverage, this Article reveals that decentralized policymaking on noncitizen access to Medicaid has weakened national health policy by increasing wasteful spending and exacerbating inequities in access to healthcare. 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 noncitizen access to health coverage is best addressed through centralized policymaking.

This Article contributes to scholarly conversations about federalism and healthcare 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.

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INTRODUCTION

In the run-up to the 2020 presidential election, discussions of whether and how to expand healthcare access for noncitizens were already mainstream.¹ Then came the coronavirus pandemic. The tragic consequences and enormous risks of inequitable access to health coverage are undeniable. Noncitizen essential workers who are ineligible for publicly funded health insurance have faced particularly dire circumstances.² For the vast majority of U.S. voters who disapprove of the Trump Administration’s response to the pandemic,³ health reform can no longer wait. For the first time since 1996, when harsh restrictions were imposed on noncitizen eligibility for public

¹ See, e.g., Jan Hoffman, *What Would Giving Health Care to Undocumented Immigrants Mean?*, N.Y. TIMES (July 3, 2019), <https://www.nytimes.com/2019/07/03/health/undocumented-immigrants-health-care.html>.

² See, e.g., Suzanne Gamboa, *Undocumented Immigrants Without Health Care Were Among the ‘Essential Workers’ Felled by COVID-19*, NBCNEWS.COM (Aug. 28, 2020, 10:40 PM), <https://www.nbcnews.com/politics/2020-election/blog/2020-08-27-rnc-updates-n1238267/ncrd1238617#blogHeader>; Ariel Gelrud Shiro & Richard V. Reeves, *Latinos Often Lack Access to Healthcare and Have Poor Health Outcomes. Here’s How We Can Change That*, BROOKINGS: HOW WE RISE (Sept. 25, 2020), <https://www.brookings.edu/blog/how-we-rise/2020/09/25/latinos-often-lack-access-to-healthcare-and-have-poor-health-outcomes-heres-how-we-can-change-that>.

³ See Ashley Kirzinger, Audrey Kearney & Liz Hamel, *Voters Are Souring on President Trump’s Handling of Coronavirus, with Implications for November*, KAISER FAM. FOUND. (Aug. 17, 2020), <https://www.kff.org/policy-watch/voters-are-souring-on-president-trumps-handling-of-coronavirus-with-implications-for-november>.

benefits, there is a real possibility that laws excluding noncitizens from publicly funded health insurance will be reversed.⁴

As health reform once again becomes a central focus of American politics—this time with formerly fringe ideas like a nationally-uniform, single-payer healthcare system enjoying significant popularity⁵—determining *how* noncitizens residing in the United States should be included within that universe is increasingly urgent. However, this subject has eluded coherent policymaking due to the complexity of the laws governing noncitizen eligibility for publicly funded healthcare and the sheer number and diversity of noncitizen statuses.

This Article is the first sustained treatment of the vitally important legal and policy question of the interactions among federalism, access to healthcare, and immigration.⁶ It explores salient themes in

⁴ Larry Levitt, *Trump vs Biden on Health Care*, JAMA HEALTH F. (Sept. 3, 2020), <https://jamanetwork.com/channels/health-forum/fullarticle/2770427> (describing President-elect Joe Biden's proposal to eliminate the five-year bar on lawful permanent residents' eligibility for Medicaid and the Children's Health Insurance Program (CHIP) and to allow undocumented noncitizens to purchase unsubsidized coverage on the Patient Protection and Affordable Care Act (ACA) Marketplaces).

⁵ Jonathan Oberlander, *Lessons From the Long and Winding Road to Medicare for All*, 109 AM. J. PUB. HEALTH 1497, 1497 (2019) (noting that single payer has moved to the "mainstream of American politics").

⁶ I take inspiration from *Laboratories of Destitution*, David Super's seminal case study of the relationship between federalism and anti-poverty policy. David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541, 547 (2008) (arguing that decentralized antipoverty policy has failed to encourage effective state policy experimentation and advocating for more centralized policymaking). However, the intersection of healthcare 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. Health law scholars have generally bracketed federalism issues as they relate to noncitizens, if they are mentioned at all. See, e.g., Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1726 (2018) (noting that undocumented and some lawfully present noncitizens were left out of the ACA's federalism-oriented Medicaid expansion); Elizabeth Y. McCuskey, *Big Waiver Under Statutory Sabotage*, 45 OHIO N.U. L. REV. 213, 228–29 (2019) (mentioning California's withdrawal of a section 1332 State Innovation Waiver application seeking to permit undocumented noncitizens to purchase unsubsidized Marketplace coverage as an example of limited waiver activity caused by uncertainty about the future of the ACA); Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 865 (2018) (including undocumented noncitizens among groups who may obtain access to health coverage through a state-level public option); *id.* at 863–64 (describing California and Oregon section 1332 waiver applications that would improve access to health coverage for undocumented noncitizens among state strategies to use waivers to "open up access to new populations"). Recently, Wendy E. Parmet began the project of mapping the values at stake when state and federal action in the immigration and healthcare spheres intersect. Wendy E. Parmet, *The Plenary Power Meets the Police Power: Federalism at the Intersection of Health & Immigration*, 45 AM. J.L. & MED. 224, 225 (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

federalism scholarship—including policy fragmentation, political inequity, and social exclusion—by examining how states react to federalism arrangements governing noncitizen eligibility for Medicaid. It provides a valuable case study on the efficacy of federalism arrangements for achieving social justice. In particular, it examines who gets left behind when Congress designates states to implement federal statutes, as in the Patient Protection and Affordable Care Act (ACA).⁷ 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 these arrangements are suited to achieving their stated policy goals.

I use the term “excluded noncitizens” to describe the population of focus: low-income noncitizens who are ineligible for the major federally funded health coverage programs because of their immigration status and who have resided or intend to reside in the United States for the long term.⁸ The federal government subsidizes health coverage for people with limited means in two major ways: by providing insurance through Medicaid and by subsidizing insurance purchased on the ACA Marketplaces.⁹ The meaning of “excluded noncitizen” differs depending on the program being discussed and, in the case of Medicaid, the state of residence. In all states, however, undocumented noncitizens and recipients of Deferred Action for Childhood Arrivals

most prominent articles were authored before the passage of the ACA. *See, e.g.*, Stella Burch Elias, *The New Immigration Federalism*, 74 OHIO ST. L.J. 703, 733 (2013) (describing Congress’s delegation of authority to states to enact noncitizen-exclusionary public benefit laws); *id.* at 743 (describing state and local noncitizen-inclusionary laws providing a variety of services to undocumented noncitizens); Stephen H. Legomsky, *Immigration, Federalism, and the Welfare State*, 42 UCLA L. REV. 1453, 1470 (1995) (including emergency medical costs among those incurred by states with disproportionate numbers of undocumented noncitizens); Cristina M. Rodríguez, *The Significance of the Local in Immigration Regulation*, 106 MICH. L. REV. 567, 586 n.72 (2008) (using noncitizen 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, 506–09 (2001) (outlining the doctrine of state alienage restrictions in public benefit programs).

⁷ Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).

⁸ 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 other publications. *See* Medha D. Makhoulf & Jasmine Sandhu, *Immigrants and Interdependence: How the COVID-19 Pandemic Exposes the Folly of the New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146 (2020); Medha D. Makhoulf, *The Public Charge Rule as Public Health Policy*, 16 IND. HEALTH L. REV. 177, 194–96 (2019).

⁹ *See infra* notes 207–13 and accompanying text.

(DACA) are excluded from Medicaid and Marketplace subsidies.¹⁰ In this Article, I focus on Medicaid because it is the primary means by which low-income households without access to affordable employer-sponsored insurance (ESI) obtain health coverage;¹¹ it covers more than a quarter of the population;¹² it is more economically efficient than subsidizing Marketplace insurance purchases;¹³ and it is an important building block and comparator for policymakers seeking to expand publicly funded health insurance.¹⁴

Medicaid's cooperative federalism structure gives states significant discretion to make decisions about noncitizen eligibility. Federal

¹⁰ *Health Coverage of Immigrants*, KAISER FAMILY FOUND. (Mar. 18, 2020), <http://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants> (noting that “[u]ndocumented immigrants are not eligible to enroll in Medicaid or CHIP or to purchase coverage through the ACA Marketplaces” and “individuals with Deferred Action for Childhood Arrivals (DACA) status are not considered lawfully present and remain ineligible for coverage options”).

¹¹ See *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited Aug. 3, 2020) (“Medicaid is the single largest source of health coverage in the United States.”). The cost of ESI to beneficiaries is subsidized by employers. Like some citizens, noncitizens may find even subsidized coverage to be unaffordable. See KAISER FAMILY FOUND., *supra* note 10 (stating that lower average incomes among noncitizens make affording ESI challenging). Although some noncitizens who are excluded from Medicaid are eligible to purchase subsidized coverage on the Marketplaces, they are disproportionately likely, compared with citizens, to be uninsured even when they are eligible for Marketplace coverage. See *id.* (noting that nonelderly noncitizens are significantly more likely to be uninsured than nonelderly citizens and stating that many eligible noncitizens remain uninsured). It is likely that nonfinancial enrollment barriers that are unique to noncitizens play a role. See *id.* (noting that many eligible noncitizens remain uninsured because of barriers such as confusion about eligibility, difficulty navigating enrollment, and language and literacy challenges). Noncitizens with significant means but without access to ESI can purchase unsubsidized, non-Marketplace coverage on the individual market and are therefore not the subject of this Article. Cf. SAMANTHA ARTIGA & MARIA DIAZ, KAISER FAMILY FOUND., *HEALTH COVERAGE AND CARE OF UNDOCUMENTED IMMIGRANTS* 4 (2019), <https://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants> (“Undocumented immigrants can also purchase private coverage on the individual market outside of the ACA Marketplaces, although many may not be able to afford this coverage due to their limited incomes and lack of subsidies to offset the costs of this coverage.”).

¹² See MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 3 exhibit 1 (2019), <https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf> (showing that Medicaid and CHIP covered 29.3% of the U.S. population in 2018).

¹³ See Susannah Luthi, *ACA Subsidies Cost More per Person than Medicaid. Is That Sustainable?*, MODERN HEALTHCARE (Aug. 8, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180808/NEWS/180809915/aca-subsidies-cost-more-per-person-than-medicaid-is-that-sustainable> (citing research indicating that state-based public and private market structures are more efficient than exchanges).

¹⁴ See Jamila Michener, *Medicaid and the Policy Feedback Foundations for Universal Healthcare*, 685 ANNALS AM. ACAD. POL. & SOC. SCI. 116, 118 (2019) (“Given its size and scope, the future of any health care policy transformation likely pivots on the current-day status and effects of Medicaid policy.”).

law mandates Medicaid coverage of only a small category of non-citizens.¹⁵ Beyond this floor, states may expand eligibility to additional groups of noncitizens using federal and state funds.¹⁶ However, just as there is a federal floor of noncitizen eligibility, there is also a ceiling or limit on how much states can expand Medicaid to noncitizens using federal funds.¹⁷ This ceiling excludes a substantial population of low-income noncitizens from access to affordable health insurance in all but a few states that fund Medicaid-like coverage themselves (typically in a piecemeal and restricted manner).¹⁸ I argue that this structure does not only create extreme geographic variability in noncitizens' access to health coverage, but also (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.¹⁹ 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 other, less

¹⁵ See *infra* Section I.B; see also *infra* notes 134–55 and accompanying text.

¹⁶ See *infra* Sections I.B.3, I.C.

¹⁷ Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, § 402(b), 110 Stat. 2105, 2264–65 (codified at 8 U.S.C. § 1612(b) (1996)) (requiring states participating in Medicaid to cover certain noncitizens and permitting them to determine the eligibility of other noncitizens); *id.* § 401(a), 110 Stat. at 2261 (codified at 8 U.S.C. § 1612(a)) (stating that non-qualified noncitizens are generally ineligible for federal public benefits); *id.* § 403, 110 Stat. at 2265 (codified at 8 U.S.C. § 1613(a)) (describing five-year bar on benefits eligibility for qualified noncitizens generally and exceptions to it); Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 214, 123 Stat. 8, 56–57 (codified at 42 U.S.C. §§ 1396b(v)(4)(A), 1397gg(e)(1)(N) (2018)).

¹⁸ See *infra* Sections I.B.3, I.C; see also *infra* notes 130–33 and accompanying text.

¹⁹ See, e.g., Nicole Huberfeld, *Federalism in Health Care Reform*, in *HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY* 197, 207 (Ezra Rosser ed., 2019) (demonstrating how federalism has permitted states to deviate from the standards and priorities of Medicaid in ways that are contrary to health policy goals); JAMILA MICHENER, *FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS* 33–59 (2018) (describing how federalism in Medicaid generates geographical inequities and perpetuates systemic health disparities); Andrew Hammond, *Welfare and Federalism's Peril*, 92 WASH. L. REV. 1721, 1736–41 (2017) (discussing state-level inequities in the administration of Temporary Assistance for Needy Families); Rebecca J. Kreitzer, Candis Watts Smith, Kellen A. Kane & Tracee M. Saunders, *Affordable but Inaccessible? Contraception Deserts in the US States*, J. HEALTH POL., POL'Y & L. (forthcoming 2020) (assessing how differences in state administration of Title X programs leads to health inequity); Robert A. Schapiro, *States of Inequality: Fiscal Federalism, Unequal States, and Unequal People*, 108 CALIF. L. REV. 1531 (2020) (examining the role of fiscal federalism in creating inequities in education and health).

efficient ways in which the U.S. government subsidizes healthcare for excluded noncitizens. 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 noncitizens on efficiency grounds may reconsider their position when confronted with information about how public funds are already used to subsidize healthcare for noncitizens and how we could do so more effectively.²⁰

Part II explains why the patchwork of noncitizen exclusion weakens national health policy. First, variability in healthcare access based on characteristics that are unrelated to medical need—like state of residence and immigration status—raises ethical concerns about healthcare equity, which scholars have identified as the emerging normative foundation of health law scholarship and healthcare regulation.²¹ Healthcare equity is about the fair distribution of healthcare resources, including publicly funded health coverage.²² The classical conception of equity contains two dimensions: horizontal and vertical.²³ In the healthcare context, horizontal inequity occurs when residents of different states with the same medical needs do not have the same access to healthcare resources, while vertical inequity occurs when noncitizen residents with greater healthcare needs have less access than citizens with lesser needs.²⁴ Second, when states underpro-

²⁰ This information will not, of course, persuade those whose opposition to expanding health coverage for noncitizens is motivated by racism. See *infra* Section II.D.

²¹ See Elizabeth Y. McCuskey, *The Body Politic: Federalism as Feminism in Health Reform*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 303, 311 (2018) (noting that healthcare equity has become a guiding principle of healthcare regulation and scholarship); Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 50–51 (2014) (proposing a new “health justice” paradigm that reflects the socially conscious aims of the health law field). See generally DANIEL E. DAWES, 150 YEARS OF OBAMACARE (2016) (detailing the health equity movement and the passage of the ACA); JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE 2 (2009) (arguing that health systems’ primary goal is to reduce disparities while using resources efficiently); Michael Marmot, Sharon Friel, Ruth Bell, Tanja AJ Houweling & Sebastian Taylor, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, 372 LANCET 1661, 1661–62 (2008) (arguing that reducing health inequities is an ethical imperative and providing recommendations to that end).

²² See Anthony J. Culyer, *Equity - Some Theory and Its Policy Implications*, 27 J. MED. ETHICS 275, 275 (2001) (analyzing the equitable distribution of healthcare resources in affluent societies).

²³ *Id.* at 276 (“Horizontal equity requires the like treatment of like individuals and vertical equity requires the unlike treatment of unlike individuals, in proportion to the differences between them.”).

²⁴ See, e.g., Barbara Starfield, *The Hidden Inequity in Health Care*, 10 INT’L J. FOR EQUITY HEALTH 1, 1 (2011) (summarizing the concept of equity in access to healthcare resources, including its horizontal and vertical dimensions); Culyer, *supra* note 22, at 276–77 (defining horizontal and vertical equity in general terms and in relation to health, healthcare needs, and financial contributions to healthcare).

vide subsidized health coverage, individual and population health outcomes worsen, quality metrics suffer, and costs shift to the federal government and can increase. State decisions to exclude noncitizens from Medicaid in order to cut costs may be undermining the national health policy goal of improving the health system's overall efficiency.²⁵ Third, state control of Medicaid is a legacy of racial politics, which are linked to immigration politics.²⁶ Exclusion of noncitizens from Medicaid disproportionately affects Latinx people and people of color.²⁷ State policies that are shaped by antidemocratic values like racism or that exacerbate existing inequities in access to healthcare undermine the national health policy goal of achieving health equity.

Part III analyzes federalism's influence on the substance of state policies concerning noncitizen eligibility for Medicaid, showing why federalism fails to meet the national health policy goals discussed in the previous Part. First, federalism enables states to enact exclusionary policies that are ineffective and inhumane. For example, the *American Medical Association Journal of Ethics* published an illustrated narrative about the tragedy of undocumented noncitizens 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.²⁸ Without a robust federal floor of Medicaid coverage for noncitizens, states like Alabama, Mississippi, North Dakota, Virginia, Wyoming, and Texas have faced no obstacle to imposing harsher limits on noncitizen eligibility for Medicaid than are required under federal law.²⁹ Federalism empowers states to enact exclusionary policies

²⁵ See *infra* Sections II.B–C.

²⁶ See, e.g., MICHENER, *supra* note 19 (“[A]mple research has confirmed that federalism bolsters one of the most antidemocratic forces in the American polity: racism.”); Hana E. Brown & Rachel Kahn Best, *Logics of Redistribution: Determinants of Generosity in Three U.S. Social Welfare Programs*, 60 SOC. PERSP. 786, 793 (2017) (noting that racial dynamics play a stronger role in programs where authority has been delegated to states); Ellen Reese, Elvia Ramirez & Vanesa Estrada-Correa, *The Politics of Welfare Inclusion: Explaining State Variation in Legal Immigrants’ Welfare Rights*, 56 SOC. PERSP. 97, 98 (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.”).

²⁷ See Kevin R. Johnson, “Aliens” and the U.S. Immigration Laws: *The Social and Legal Construction of Nonpersons*, 28 U. MIAMI INTER-AM. L. REV. 263, 269 (1996–1997) (“Because a majority of immigrants are people of color, alienage classifications all-too-frequently are employed as a proxy for race. Alienage discrimination . . . allows one to disproportionately disadvantage people of color.”).

²⁸ Nathan A. Gray, *Cruel Carousel: The Grim Grind of “Compassionate” Dialysis*, 20 AMA J. ETHICS 778 (2018).

²⁹ See NAT’L IMMIGRATION LAW CTR., TABLE: MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES (2020) [hereinafter MEDICAL ASSISTANCE PROGRAMS

guided by ideologies that are peripheral to health policy, including immigration restrictionism among other factors.

Second, federalism creates barriers that inhibit states from enacting inclusionary policies that would advance the normative goals of health policy: equitable access to healthcare, and cost-effectiveness, defined as the benefits of better health and better care divided by cost.³⁰ Fiscal capacity presents a major obstacle to states that want to expand Medicaid coverage for noncitizens.³¹ Poor baseline economic conditions can prevent states from taking advantage of federal options to expand coverage, which institutionalizes these decisions and inhibits future reform.³² 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.³³ States may be forced to cut their Medicaid budgets and deny necessary care to enrollees who have few resources or alternative options.³⁴ Predictably, only a handful of states have created state-funded programs to expand noncitizen eligibility for Medicaid-like coverage.³⁵

Part IV discusses the limits of federalism in the context of non-citizen eligibility for Medicaid, explaining why the current federalism

FOR IMMIGRANTS IN VARIOUS STATES], <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf> (outlining Medical Assistance Programs for immigrants in various states).

³⁰ See *infra* notes 281, 295–99 and accompanying text. See generally Sections II.B–C, III.B.

³¹ See Super, *supra* note 6, at 547 (noting that state and local governments cannot respond effectively to increased responsibility for antipoverty programs, because they may be affected by shrinking revenues, free-riding localities, and lack of increased federal funding).

³² See Reese et al., *supra* note 26, at 117 (finding that states with higher poverty rates were less likely to restore benefits for noncitizens using state funds after PRWORA); *id.* (finding that states' past spending patterns on welfare programs for noncitizens predict future spending patterns).

³³ See Jared Walczak, *State Strategies for Closing FY 2020 with a Balanced Budget*, TAX FOUND. (Apr. 2, 2020), <https://taxfoundation.org/fy-2020-state-budgets-fy-2021-state-budgets> (noting that “states are constrained in a way the federal government is not: revenues and expenditures must be aligned, and the longer they are out of balance, the more intractable the problem becomes”); *cf.* Super, *supra* note 6, at 547 (stating that economic conditions that increase poverty also affect state and local governments' revenues).

³⁴ See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 480 (2011) (citing, as an example, Arizona's fiscally motivated decision to cut transplant services from its Medicaid program).

³⁵ See Rebecca Adams, *Undocumented Kids Get Health Care in Six States, D.C.*, CTR. FOR HEALTH JOURNALISM (Jan. 22, 2018), <https://www.centerforhealthjournalism.org/fellowships/projects/undocumented-kids-get-health-care-six-states-dc> (describing how undocumented noncitizen children are eligible for publicly funded health coverage in California, Illinois, Massachusetts, New York, Oregon, and Washington).

structure fails to meet the goals of federalism itself. The conception of states as “laboratories” of democracy assumes that states design and conduct policy experiments in order to identify policies that accomplish their intended effects and that do not have counter-productive side effects.³⁶ Successful experiments should serve as policy templates for other jurisdictions.³⁷ Medicaid’s structure has largely failed to incentivize this type of experimentation and replication.³⁸ Many states, including several of the “new destination” states for non-citizens—Alabama, Tennessee, South Dakota, Nevada, Georgia, Kentucky, Idaho, Indiana, and Mississippi³⁹—have not elected federal options to expand Medicaid for noncitizens after adopting the federal baseline of restrictions set out in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), nor have they used state funds exclusively to expand coverage for excluded noncitizens.⁴⁰ Policy reform has stagnated in these states despite shifting demographics and unmet healthcare needs among noncitizens residing there.⁴¹ The Article concludes by making a normative case for centralization of policy relating to noncitizen eligibility for subsidized health coverage.

I

EXCLUDING NONCITIZENS FROM MEDICAID: HOW TAXPAYERS PAY

Public support for expanding subsidized health coverage for undocumented noncitizens—who make up the largest cohort of excluded noncitizens⁴²—is middling.⁴³ Those who oppose expansion

³⁶ See, e.g., Michael A. Livermore, *The Perils of Experimentation*, 126 YALE L.J. 636, 638–39 (2017) (citing *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

³⁷ *Id.* at 649–50 (describing the mechanisms by which policies spread across jurisdictions, including “policy learning,” a model wherein jurisdictions develop policy based on successes or failures in other jurisdictions).

³⁸ See, e.g., Gluck & Huberfeld, *supra* note 6, at 1704 (“States have been limited in what they can accomplish alone in healthcare experimentation.”).

³⁹ “New destination” states are those in which “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. *Id.*

⁴⁰ See discussion *infra* Sections I.B.3, I.C.

⁴¹ See Terrazas, *supra* note 39 (“The foreign born in new-destination states were less likely than immigrants elsewhere to have health insurance.”).

⁴² See KAISER FAMILY FOUND., *supra* note 10.

⁴³ See Lawrence O. Gostin, *Is Affording Undocumented Immigrants Health Coverage a Radical Proposal?*, 322 JAMA 1438, 1438 (2019); Grace Sparks, *CNN Poll: Democrats See Sanders as the Best to Handle Health Care*, CNN (July 1, 2019, 7:01 PM), <https://>

typically question why U.S. citizens should subsidize healthcare for noncitizens at all.⁴⁴ However, they often overlook the little-known ways in which all taxpayers—noncitizens included—already pay for such care: through existing safety net programs, public health services, and federally qualified health centers (FQHCs); through supplemental Medicaid payments to hospitals that serve a high proportion of uninsured low-income patients; and through grants intended to reimburse healthcare providers for uncompensated care provided to uninsured noncitizens.⁴⁵ One might view these payments as a partial, institutional commitment to the “rescue principle” in healthcare,⁴⁶ or

www.cnn.com/2019/07/01/politics/cnn-poll-june-health-care/index.html (indicating that thirty-eight percent of survey respondents agreed that health insurance coverage provided by the government should be available to undocumented immigrants).

⁴⁴ See, e.g., Donald J. Trump (@realDonaldTrump), TWITTER (June 27, 2019, 9:37 PM), <https://twitter.com/realdonaldtrump/status/1144419410729242625?lang=EN> (“All Democrats just raised their hands for giving millions of illegal aliens unlimited healthcare. How about taking care of American Citizens first!?”).

⁴⁵ See, e.g., Chris Conover, *How American Citizens Finance \$18.5 Billion in Health Care for Unauthorized Immigrants*, FORBES (Feb. 26, 2018, 5:06 PM), <https://www.forbes.com/sites/theapothecary/2018/02/26/how-american-citizens-finance-health-care-for-undocumented-immigrants>.

⁴⁶ See Mark G. Kuczewski, *Who is My Neighbor? A Communitarian Analysis of Access to Health Care for Immigrants*, 32 THEORETICAL MED. & BIOETHICS 327, 329 (2011) (defining the “rescue principle” as “anyone in immediate distress [should] not suffer and die in the street”); 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 noncitizens are not fully excluded from the U.S. healthcare system, 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). Some might argue that this is an eroding principle, particularly with respect to noncitizens and people of color. High-profile members of the Trump Administration and the current President himself have openly questioned the humanity of noncitizens, reacted with indifference to glaring racial inequities in mortality from COVID-19, and encouraged violent policing that disproportionately kills people of color. See, e.g., Abigail Simon, *People Are Angry President Trump Used This Word to Describe Undocumented Immigrants*, TIME (June 19, 2018, 11:56 AM), <https://time.com/5316087/donald-trump-immigration-infest> (reporting on reactions to Trump’s use of the word “infest” to describe the act of migration and a prior use of the word “animals” to refer to immigrants); Laura Barrón-López, *Trump Coronavirus Response Feeds Distrust in Black and Latino Communities*, POLITICO (Apr. 21, 2020, 4:30 AM), <https://www.politico.com/news/2020/04/21/race-coronavirus-outreach-197470> (noting statements by administration officials, including Surgeon General Jerome Adams); Sean Collins, *Trump’s Policies Have Enabled Police Violence Against Black Americans*, VOX (May 30, 2020, 3:50 PM), <https://www.vox.com/identities/2020/5/30/21275588/trump-policing-policies-doj-george-floyd-protests> (“[S]ince his inauguration, Trump and his administration have worked to solidify a place for police violence in American life through both rhetoric and policy.”). In this environment, it may not be prudent to take for granted reimbursement mechanisms that cover excluded noncitizens, like Emergency Medicaid. However, I introduce the rescue principle as a value underlying existing programs at the time of their establishment.

as a pragmatic means of ensuring the financial viability of public and teaching hospitals and safeguarding public health.⁴⁷ Either way, the important question for politicians and the public is not *whether* we want to 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. Social welfare programs designed to increase access to healthcare have long served noncitizens.⁴⁸ The rationales for including noncitizens in publicly funded health insurance are based on achieving health policy goals relating to health-system efficiency and equity.⁴⁹ Safety net programs and funding sources are intended to fill the gaps in our public health insurance system.⁵⁰ However, the

⁴⁷ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-19-603, MEDICAID: STATES' USE AND DISTRIBUTION OF SUPPLEMENTAL PAYMENTS TO HOSPITALS 21 (2019) (finding that, nationally, Medicaid Disproportionate Share Hospital (DSH) payments covered about half of the uncompensated care costs of the hospitals that received the payments); *Health Headlines – March 30, 2020*, KING & SPALDING (Mar. 30, 2020), <https://www.kslaw.com/news-and-insights/health-headlines-march-30-2020> (describing new federal funding and program changes to protect public health during the COVID-19 pandemic, including approval of Emergency Medicaid waivers, new grants through the Public Health and Social Services Emergency Fund, approval of reimbursement for telehealth services provided by FQHCs, and a delay of planned Medicaid DSH cuts).

⁴⁸ See Cybelle Fox, *Unauthorized Welfare: The Origins of Immigrant Status Restrictions in American Social Policy*, 102 J. AM. HIST. 1051, 1058–59 (2016) (describing the lack of federal alienage restrictions in social assistance programs between 1935 and 1971, a pattern that the introduction of Medicaid did not change); *infra* note 102; see also Fox, *supra*, at 1051 (describing the U.S. Department of Health, Education, and Welfare's reliance, in 1971, on the fact that most states' public assistance programs did not restrict eligibility on the basis of citizenship or immigration status); Leighton Ku & Sheetal Matani, *Left Out: Immigrants' Access to Health Care and Insurance*, 20 HEALTH AFF. 247, 247 (2001) (noting that before the passage of PRWORA in 1996, “[h]istorically, legally admitted immigrants were eligible for Medicaid and other benefits on the same terms as citizens were”).

⁴⁹ See Medha D. Makhoul, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235, 265 (2019) (noting that “exclusionary laws and policies based on immigration concerns make bad health policy” and asserting that “[f]rom a population health perspective, to ignore policies that reduce the public accessibility of health services is to ignore a major determinant of inequity”).

⁵⁰ This pattern of using inefficient and unreliable “patches” to fill intentional gaps in primary public benefit programs is not exclusive to healthcare. For example, PRWORA slashed funding for Food Stamps, now called the Supplemental Nutrition Assistance Program (SNAP), even as it modestly increased funding for the Emergency Food Assistance Program (TEFAP), a less efficient program that funds the purchase of food commodities by emergency food pantries, food banks, soup kitchens, and shelters. See David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 701 (2004) (“The agriculture committees cut the food stamp program \$600 million more deeply in PRWORA than the Republican leadership required so that they could buy commodities for the Emergency Food Assistance Program (TEFAP), which aids food banks and soup kitchens.”).

existing patchwork of programs is woefully inadequate to meet the healthcare needs of many noncitizens.

This Part describes the legal framework for noncitizen access to publicly funded health coverage. It begins with a discussion of terminology used throughout this Article. The next Section opens with a synopsis of the doctrines governing issues at the intersection of health law and immigration law. It then describes the history of noncitizen eligibility for Medicaid and the Children's Health Insurance Program (CHIP), focusing on the impact of PRWORA's sweeping restrictions and its devolution of authority to states to make decisions about how to treat noncitizens. The final Section describes state-funded efforts to provide health coverage to noncitizens who are excluded from Medicaid and Marketplace subsidies. This collection of programs, each with its distinct logic for including or excluding various categories of people, creates the unique and threadbare patchwork of health coverage for noncitizens living in the United States.

A. Terminology

Terminology about noncitizen status is complex, and choices about terminology are often imbued with ideology. This Section provides an overview of the relevant categories of noncitizens that are used throughout this Article. For the most part, I use the language found in statutes or regulations. However, in some cases, relevant laws use different terms to refer to the same or overlapping categories of noncitizens. For example, PRWORA refers to a group of noncitizens of various statuses who are qualified to enroll in federally funded public benefits using a term that is not found in immigration law. In other cases, common usages conflict with or do not have a legal definition but are so ubiquitous that they are unavoidable in a discussion of noncitizen access to publicly funded healthcare. Finally, where there are meaningful choices to be made about terminology, I opt for inclusive, humanizing language.

I use the term "noncitizen" to refer to any person who is not a U.S. citizen. I opt for this term rather than the more common, colloquial term "immigrant," because "immigrant" (1) has a legal meaning that is narrower than a person who is not a U.S. citizen⁵¹ and (2) is

⁵¹ See 8 U.S.C. § 1101(a)(15) (2012) (the Immigration and Nationality Act (INA) broadly defines the term "immigrant" to mean "every alien except an alien who is within one of the [delineated] classes of nonimmigrant aliens"); *Immigrants and Refugees: What is an Immigrant or Refugee?*, U.C. IRVINE LIBR., <https://guides.lib.uci.edu/immigrants/whatis> (last updated July 23, 2020, 6:39 PM) ("An illegal alien who entered the United States without inspection, for example, would be strictly defined as an immigrant under the INA . . .").

used conversationally and in some scholarship to refer to naturalized U.S. citizens, i.e., people who are not “natural-born citizens” but who have become citizens through the naturalization process established in the Immigration and Nationality Act.

I prefer “noncitizen” to “alien” because, although the latter has a long history of usage and is found in federal immigration laws and state laws on a variety of matters, the term is increasingly recognized by local and state policymakers as disparaging of noncitizens.⁵² Scholars have analyzed how use of the term “alien” has reinforced hostility toward noncitizens and, as immigration has changed the racial and ethnic composition of the country, become synonymous for noncitizen people of color.⁵³ This effect is magnified by the current President’s vitriolic rhetoric about noncitizens—and about noncitizens of color in particular⁵⁴—coupled with his frequent and deliberate use of the term “illegal alien.”⁵⁵ Given the normative bent of this Article, I eschew the ideologically loaded term, “alien,” in favor of the relatively neutral term, “noncitizen.” For example, even in discussions of the category “qualified alien,” which originated in PRWORA, I use the term “qualified noncitizen” unless I am quoting the statute directly.

For similar reasons, I use the term “undocumented” instead of “illegal.”⁵⁶ To use the term “illegal” to refer to a person, as opposed to their actions, is literally dehumanizing. The foregoing also explains why I opt for “undocumented noncitizen” as opposed to “illegal alien,” “undocumented immigrant,” or any combination of those terms.

⁵² See Mihir Zaveri, *This Lawmaker Wants to Remove the Words ‘Illegal Alien’ from the Law*, N.Y. TIMES (Feb. 13, 2020), <https://www.nytimes.com/2020/02/13/us/politics/colorado-illegal-immigrants.html>. Recently, the New York City Council voted to prohibit the use of “alien” in local laws, replacing it with “noncitizen.” Maya Rajamani, *NYC Council Votes to Ban Phrases ‘Alien,’ ‘Illegal Immigrant’ from All Local Laws*, 1010 WINS (May 28, 2020, 3:30 PM), <https://1010wins.radio.com/articles/nyc-council-bans-alien-illegal-immigrant-from-local-law>. On the other hand, the Trump Administration’s Justice Department has urged federal prosecutors to use the term “illegal aliens” instead of “undocumented” in news releases. Zaveri, *supra*. Advocates for inclusive policies have long recognized the dehumanizing nature of the term “alien.” *Id.*

⁵³ See Johnson, *supra* note 27, at 267 (summarizing concerns of scholars about the use of “alien” in immigration law).

⁵⁴ See Jayashri Srikantiah & Shirin Sinnar, *White Nationalism as Immigration Policy*, 71 STAN. L. REV. ONLINE 197, 198–200 (2019) (discussing President Trump’s remarks on immigrants and immigration and noting that “[t]he President’s comments on immigration . . . strongly suggest that he views immigration as a cultural threat to the U.S.”).

⁵⁵ Zaveri, *supra* note 52 (noting that President Trump used the term “illegal alien” at least five times during the February 2020 State of the Union address).

⁵⁶ Use of the term “illegal immigrant” in local laws was also prohibited by the New York City Council’s action. Rajamani, *supra* note 52.

Regarding the concept of “undocumented,” there is no precise definition.⁵⁷ The term is not found in immigration law. Rather, it is used to refer to people who entered the country either (1) without inspection or (2) with authorization and inspection, but then violated the terms of their authorization.⁵⁸ For example, one way to become undocumented is to remain in the United States beyond the authorized period of stay for a tourist visa.⁵⁹ For many undocumented non-citizens, their status is temporary: they have held legal status in the past and may obtain legal status in the future, depending on the outcome of pending immigration applications.⁶⁰

In prior work, I described the complexity and number of non-citizen statuses as a “spectrum from ‘permanent’ to temporary to quasi-status to undocumented.”⁶¹ In the following paragraphs, I will describe some of these statuses or categories of statuses that matter for determining eligibility for publicly funded health coverage. Lawful permanent residents (LPRs) have the most secure status among noncitizens and are on the path to U.S. citizenship.⁶² The government recognizes that LPRs plan to live indefinitely and permanently in the

⁵⁷ In general usage, the term “unauthorized” is often used interchangeably with undocumented. *See, e.g.*, Geoffrey Heeren, *The Status of Nonstatus*, 64 AM. U. L. REV. 1115, 1126 (2015) (“[T]he approximately 11.5 million noncitizens in the United States without status . . . are often described as ‘illegal,’ ‘undocumented,’ or ‘unauthorized’ noncitizens.”).

⁵⁸ *See, e.g., id.* (describing undocumented immigrants as those who have overstayed legal visas or entered the country without inspection); Stephen H. Legomsky, *Portraits of the Undocumented Immigrant: A Dialogue*, 44 GA. L. REV. 65, 68–69 (2009) (same); Peter L. Markowitz, *Undocumented No More: The Power of State Citizenship*, 67 STAN. L. REV. 869, 873 n.14 (2015) (same).

⁵⁹ One report estimates that forty percent of undocumented noncitizens living in the United States entered the country with authorization. MICHAEL A. RODRÍGUEZ, MARIA-ELENA YOUNG & STEVEN P. WALLACE, CREATING CONDITIONS TO SUPPORT HEALTHY PEOPLE: STATE POLICIES THAT AFFECT THE HEALTH OF UNDOCUMENTED IMMIGRANTS AND THEIR FAMILIES 3 (2015).

⁶⁰ *Id.*

⁶¹ Makhlof, *supra* note 49, at 292. Sociologist Tiffany Joseph has helpfully conceptualized documentation status categories as a continuum from citizens to undocumented noncitizens with “gray area” documentation statuses in between. The documentation status continuum helps to explain how the allocation of public benefits along the spectrum reinforces civic stratification. Tiffany D. Joseph, *The Documentation Status Continuum: Citizenship and Increasing Stratification in American Life*, CTR. FOR OPEN SCI. (2020).

⁶² *See, e.g.*, *Lawful Permanent Residents (LPR)*, U.S. DEP’T HOMELAND SEC., <https://www.dhs.gov/immigration-statistics/lawful-permanent-residents> (last updated Oct. 22, 2020).

United States, as the name implies, and therefore accords more rights to this group than to other noncitizen groups.⁶³

A similar term, “lawfully present,” refers to a much broader group than LPRs, and was used in the ACA to describe noncitizens who are eligible to enroll in health coverage through the Health Insurance Marketplace and receive subsidies in the form of premium tax credits.⁶⁴ As defined in regulations, “lawfully present” noncitizens include LPRs, a variety of persons with humanitarian statuses,⁶⁵ applicants for certain humanitarian statuses, and some noncitizens without status whose removal from the country has been deferred—what I refer to as a “quasi-status.”⁶⁶

Yet another similar term, “lawfully residing in the United States,” is used in the context of Medicaid and CHIP. Since 2009, states have had the option to provide Medicaid or CHIP to lawfully residing noncitizen children and/or pregnant women who are otherwise ineligible for those programs.⁶⁷ The term is functionally equivalent to “lawfully present.”⁶⁸

The term “qualified alien” originates in PRWORA and encompasses a narrower group of noncitizens than “lawfully present” and “lawfully residing.” It refers to noncitizens who qualify for eligibility for Medicaid and CHIP.⁶⁹ These include LPRs and certain humanitarian statuses: refugees, people granted asylum, people granted parole by the U.S. Department of Homeland Security (DHS) for a period of at least one year, people granted withholding of deportation/removal, people granted conditional entry, Cuban and Haitian

⁶³ See, e.g., *id.* (“LPRs may accept an offer of employment without special restrictions, own property, receive financial assistance at public colleges and universities, and join the Armed Forces.”).

⁶⁴ Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. § 1411(a)(1) (2010).

⁶⁵ *Humanitarian*, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/humanitarian> (last visited Aug. 11, 2020) (summarizing humanitarian statuses, which include refugee; asylum; battered spouse, children, and parents; victims of human trafficking and other crimes; Temporary Protected Status (TPS); Deferred Enforced Departure (DED); and other special situations).

⁶⁶ See 45 C.F.R. § 152.2 (2018). The healthcare.gov website provides a clearer list of twenty-eight immigration statuses that qualify for Marketplace coverage. *Immigrants: Immigration Status and the Marketplace*, HEALTHCARE.GOV, <https://www.healthcare.gov/immigrants/immigration-status> (last visited Aug. 11, 2020).

⁶⁷ See *infra* Section I.B.4.

⁶⁸ See Letter from Cindy Mann, Director, Ctrs. for Medicare & Medicaid Servs., to State Health Officials (July 1, 2010), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf> [hereinafter 2010 Letter from Cindy Mann].

⁶⁹ The term applies to a variety of federally funded public benefit programs, but Medicaid and CHIP are the only relevant programs for this Article’s purposes.

entrants, certain survivors of trafficking, and certain abused immigrants, their children, and their parents.⁷⁰

“Permanently residing in the United States under color of law” (PRUCOL) is another term that is used in the Medicaid context.⁷¹ It is not clearly defined in federal statutes or regulations but 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.”⁷² There is evidence that Congress intended for the term to be interpreted broadly,⁷³ and courts in various jurisdictions have interpreted PRUCOL differently, creating an informal zone of state policymaking.⁷⁴ Prior to PRWORA, PRUCOL signified a category of noncitizens who were eligible for Medicaid.⁷⁵ By creating the new category of qualified noncitizens, PRWORA essentially eliminated usage of PRUCOL in Medicaid.⁷⁶ However, some states continue to use the

⁷⁰ Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, § 431(b), Pub. L. No. 104-193, 110 Stat. 2105, 2274 (1996) (codified as amended at 8 U.S.C. § 1641(b)); *see also* William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. No. 110-457, § 211, 122 Stat. 5044, 5063 (2008) (adding certain survivors of trafficking to the definition of “qualified alien”). A detailed discussion of qualified noncitizen statuses is provided in Section I.B.

⁷¹ *See, e.g., Medicaid for Immigrants Who Are Not Permanent Residents (Do Not Have “Green Cards”)-- PRUCOL and Temporary Non-Immigrant Eligibility*, N.Y. HEALTH ACCESS, <http://www.wnyc.com/health/entry/33/#PRUCOL> (last updated Sept. 29, 2020).

⁷² *See* Richard A. Boswell, *Restrictions on Non-Citizens’ Access to Public Benefits: Flawed Premise, Unnecessary Response*, 42 UCLA L. REV. 1475, 1488 (1995).

⁷³ Janet M. Calvo, *Alien Status Restrictions on Eligibility for Federally Funded Assistance Programs*, 16 N.Y.U. REV. L. & SOC. CHANGE 395, 412 (1987–88) (“According to the House report on the bill, Congress intended that the Secretary of Health and Human Services interpret this phrase broadly so as to include aliens residing in the United States pursuant to immigration law, policy or practice.”).

⁷⁴ *See, e.g., Berger v. Heckler*, 771 F.2d 1556, 1576–77 n.33 (2d Cir. 1985) (defining PRUCOL to include fifteen categories of noncitizens, including those “residing in the United States with the knowledge and permission of the [INS] and whose departure from the United States the INS does not contemplate enforcing” (alteration in original)); *Sudomir v. McMahon*, 767 F.2d 1456, 1459–60 (9th Cir. 1985) (“[P]ermanently residing . . . under color of law’ rests on two factors: first, an official determination by the INS that an alien is legitimately present in the country and, second, a determination that the alien is legitimately present for an indefinite period of time.”). *See generally* Calvo, *supra* note 73, at 411–16 (discussing judicial interpretations of PRUCOL).

⁷⁵ The Second Circuit, in *Holley v. Lavine*, 553 F.2d 845 (2d Cir. 1977), derived from 45 C.F.R. § 233.50 a doctrine that required states to provide public benefits to certain categories of noncitizens. *See Holley*, 553 F.2d at 848–51. The doctrine outlined in *Holley* would come to be referred to as PRUCOL. *See* Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the “Contract with America” Congress*, 90 KY. L.J. 1043, 1046 & n.14 (2001–02) (citing *Holley* in explaining the origins of the PRUCOL doctrine).

⁷⁶ *See* Costich, *supra* note 75, at 1053 (“The PRWORA defines ‘qualified aliens’ . . . in a manner that abolishes the PRUCOL doctrine.”).

term to describe noncitizens who may qualify for state-funded benefits.⁷⁷

B. Federal Framework

This Section illustrates how, over time, the federal government has become increasingly influential in regulating and financing health-care, yet has devolved considerable power and discretion to states to govern noncitizen eligibility for publicly funded health insurance. 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.”⁷⁸ While matters relating to health are traditionally within the domain of state and local governments,⁷⁹ matters relating to immigration are theoretically within the exclusive domain of the federal government.⁸⁰ The “messy” reality is that each level of government has a role in regulating matters at the intersection of health and immigration policy.⁸¹

The doctrinal foundation of states’ authority to enact laws to preserve and protect the safety, health, welfare, and morals of the com-

⁷⁷ See, e.g., *infra* note 320 (describing health coverage for PRUCOL noncitizens in California).

⁷⁸ Parmet, *supra* note 6, at 225–26.

⁷⁹ See *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 203 (1824) (holding that the power to enact health laws belongs to the states).

⁸⁰ See, e.g., *De Canas v. Bica*, 424 U.S. 351, 354 (1976) (“Power to regulate immigration is unquestionably exclusively a federal power.”); *Chy Lung v. Freeman*, 92 U.S. 275, 280 (1875) (“The passage of laws which concern the admission of citizens and subjects of foreign nations to our shores belongs to Congress, and not to the States.”).

⁸¹ Parmet, *supra* note 6, 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 19, 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 local authorities determined that they were beyond the scope of the locality’s ability to address them. For example, when “impoverished immigrants flooded seaport cities,” colonial localities could seek funds from the colonial treasury to provide for their basic needs. *Id.* at 34–35. 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. See *id.* at 35. 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 Makhlof, *supra* note 8, at 179–81 (describing the rights and responsibilities of colonial localities and states prior to 1882 relating to the provision of public assistance and the expulsion of people with few financial resources). States’ police powers also encompassed the ability to exclude immigrants from admission for public health reasons. See Parmet, *supra* note 6, at 228.

munity is known as the “police power.”⁸² Although the traditional presumption of state primacy in matters relating to health retains some influence in healthcare policy and constitutional jurisprudence,⁸³ federal authority to regulate health insurance is undisputed.⁸⁴ Debates over the preservation of states’ roles are not based on considerations about the primary function of each level of government with respect to health insurance regulation and finance, typical of “separate spheres” federalism; rather, they are mainly about policy disagreements.⁸⁵

Laws regulating noncitizen eligibility for publicly funded healthcare 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.⁸⁶ Rather, 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.⁸⁷

In constitutional challenges to laws relating to noncitizens’ access to publicly funded healthcare programs, courts have cited various bases for their decisions—not only because such laws sit at this nexus, but also because they are heavily regulated and complex fields.⁸⁸ While it is true that the plenary power and police power doctrines

⁸² See *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905); see also *Gibbons*, 22 U.S. (9 Wheat.) at 203 (noting various exercises of the police power, including quarantine, inspection, and health laws); *Parmet*, *supra* note 6, at 227–28 nn.28–31.

⁸³ See *Parmet*, *supra* note 6, at 228.

⁸⁴ See Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334, 345 (1970) (discussing the federal government’s cemented role in health matters after the passage of Medicare and Medicaid); Huberfeld, *supra* note 34, 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.”).

⁸⁵ See Gluck & Huberfeld, *supra* note 6, at 1724 (“[W]e should be wary of arguments for federalism or states’ rights that are couched in constitutional arguments when they are really arguments about policy disagreements and statutory design.”).

⁸⁶ See *Parmet*, *supra* note 6, at 229–30 (distinguishing “‘alienage laws,’ which regulate the rights and responsibilities of non-citizens who live within the U.S. from ‘immigration laws,’ which regulate admissibility, deportability, registration, and immigration enforcement”).

⁸⁷ See Kerry Abrams, *Plenary Power Preemption*, 99 VA. L. REV. 601, 618 (2013).

⁸⁸ See, e.g., *Mathews v. Diaz*, 426 U.S. 67, 82 (1976) (“Congress has no constitutional duty to provide *all aliens* with the welfare benefits provided to citizens . . .”); *Graham v. Richardson*, 403 U.S. 365, 378 (1971) (“State laws that restrict the eligibility of aliens for welfare benefits merely because of their alienage conflict with . . . overriding national policies in an area constitutionally entrusted to the Federal Government.”); *League of United Latin Am. Citizens v. Wilson*, 908 F. Supp. 755, 783–84 (C.D. Cal. 1995) (finding that the provision excluding undocumented noncitizens from receiving services from community health centers is preempted by the Public Health Service Act).

have eroded over time, they remain influential in shaping the creation and interpretation of laws at the intersection of health and immigration.⁸⁹ For example, courts have relied on the federal exclusivity principle of the plenary power doctrine to strike down alienage restrictions in state-funded healthcare programs.⁹⁰ Such analyses are particularly apt when these state laws actually regulate immigration by imposing unequal burdens on noncitizens as compared with citizens.⁹¹ In general, however, the interjection of immigration-policy motives into what is essentially a health-policy matter has proven unnecessary and unhelpful for achieving national health policy goals.

1. *Origin of Exclusions*

The Social Security Act of 1935 is the cornerstone of the modern, federal social welfare system in the United States. It created a national system of retirement benefits and unemployment insurance and established the mechanism by which states receive federal funds to provide a range of public assistance.⁹² This Act was the foundation for the creation of Medicare, a health insurance program for aged Social Security recipients, and Medicaid, a health insurance program for low-income people, in 1965.⁹³

⁸⁹ See Parmet, *supra* note 6, at 228–29 (describing how states have retained significant discretion in implementing federal healthcare laws as a result of the police power’s influence on federal healthcare legislation and federal lawmakers’ rhetoric); *id.* at 226–27 (describing how the plenary power doctrine is the basis for a bifurcated equal protection jurisprudence of equal protection claims brought by noncitizens); *see also infra* note 441.

⁹⁰ See *Kurti v. Maricopa Cty.*, 33 P.3d 499, 502 (Ariz. Ct. App. 2001) (striking down eligibility requirements for healthcare benefits that excluded certain noncitizens in Arizona because the state-law requirements could not withstand strict scrutiny); *Ehrlich v. Perez*, 908 A.2d 1220, 1243 (Md. 2006) (applying strict scrutiny and awarding healthcare benefits to noncitizens in Maryland because the eligibility requirements “discriminated in the provision of State-funded medical assistance benefits based on an alienage classification or sub-classification”); *Aliessa ex rel. Fayad v. Novello*, 754 N.E.2d 1085, 1094 (N.Y. 2001) (“Plaintiffs urge this Court to adopt strict scrutiny because section 122 [New York state Medicaid eligibility requirements] creates classifications based on alienage. The State argues that section 122 implements Federal immigration policy and therefore must merely withstand rational basis scrutiny. We agree with plaintiffs.”); *see also Graham*, 403 U.S. at 378–81 (discussing the federal exclusivity principle in the context of cash assistance welfare programs); Commonwealth of Pa., Office of the Att’y Gen., Opinion Letter (Dec. 9, 1996) (binding opinion applying strict scrutiny and preserving lawfully present noncitizen eligibility for a state-funded healthcare program).

⁹¹ *Graham* considered state statutes imposing alienage restrictions on cash assistance benefits. 403 U.S. at 366. The Court noted that the states stipulated that the residency requirements “discourage[d] entry into or continued residency in the State [by noncitizens].” *Id.* at 379.

⁹² See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 269–70 (1982).

⁹³ Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. The beneficiaries and services covered by Medicare have expanded significantly since its

While Medicare has always enjoyed popular approval, Medicaid has long been “burdened by the stigma of public assistance.”⁹⁴ Upon its establishment, Medicaid was widely regarded as an extension of existing, state-centric “welfare medicine” programs, such as Kerr-Mills.⁹⁵ Although both programs are funded primarily through federal income taxes, public misperceptions of the funding sources have contributed to the idea of distinct programs for distinct populations: there is a belief that Medicare is funded solely through employer payroll taxes and premiums paid by beneficiaries.⁹⁶ Medicaid, on the other hand, is jointly funded by the state and federal governments, and state funding comes primarily from state general fund appropriations.⁹⁷ The federal government provides matching funds to states at the Federal Medical Assistance Percentage (FMAP) rate to provide medical assistance to certain categories of low-income people.⁹⁸

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 uniform because of the considerable flexibility that states have to design and implement the program.⁹⁹ Although states are required to provide Medicaid to applicants who fall within mandatory coverage groups, the number of which has increased over time, states make their own decisions about whether to take advantage of federal matching funds to expand coverage to additional groups.¹⁰⁰

founding. *See, e.g.*, Social Security Amendments of 1972, Pub. L. No. 92-603, sec. 201(b)(1), 299I, 86 Stat. 1329, 1370–74, 1463–64 (expanding eligibility to people under the age of sixty-five with long-term disabilities and people with end-stage renal disease).

⁹⁴ STARR, *supra* note 92, at 370.

⁹⁵ *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 34, at 432. In establishing Medicaid, Congress did not explicitly grapple with the humanitarian, solidaristic, or other possible justifications for federal funding of healthcare for low-income people; rather, it “built on what came before; the program was remarkably path dependent.” *Id.* at 449.

⁹⁶ *See* David A. Super, *The Modernization of American Public Law: Health Care Reform and Popular Constitutionalism*, 66 STAN. L. REV. 873, 923 (2014) (describing public beliefs about the self-sufficiency of social insurance programs like Medicare and the reality of how their redistributive nature has been concealed); *id.* at 928 (“The myth of self-sufficiency of first-tier programs [like Medicare], along with the appeal of the populations they serve, has resulted in considerable political strength, low stigma for beneficiaries, and generally respectful, deferential program administration.”).

⁹⁷ ALISON MITCHELL, CONG. RESEARCH SERV., R42640, MEDICAID FINANCING AND EXPENDITURES 1–4 (2015).

⁹⁸ *Id.*

⁹⁹ STARR, *supra* note 92, at 370.

¹⁰⁰ *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).

Given the distinct characters of Medicare and Medicaid, it is not surprising that each program's restrictions on noncitizen eligibility evolved differently. The law governing Medicare eligibility has always contained alienage restrictions.¹⁰¹ Medicaid, by contrast, did not initially have any federal restriction on noncitizen eligibility.¹⁰² Rather, it required states to cover "all individuals" who fell within the mandatory coverage groups, without reference to citizenship or immigration status.¹⁰³ In 1971, only eight states had alienage-based eligibility restrictions for any federally funded welfare programs.¹⁰⁴ Most states provided Medicaid to all otherwise eligible people, without regard to citizenship or immigration status.¹⁰⁵

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

¹⁰¹ Social Security Amendments of 1965, Pub. L. No. 89-97, § 103(4), 79 Stat. 286, 333 (codified as amended in 42 U.S.C. § 1395i-2(a)(3)(B)) (relating to alienage restrictions in Part A eligibility); *id.* at § 1836 (codified as amended in 42 U.S.C. § 1395o) (relating to alienage restrictions in 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 alien's tie grows stronger, so does the strength of his claim to an equal share of that munificence." 426 U.S. 67, 80 (1976).

¹⁰² See Sharon F. Carton, *The PRUCOL Proviso in Public Benefits Law: Alien Eligibility for Public Benefits*, 14 NOVA L. REV. 1033, 1036 (1990) ("It was only in the 1970s that states began to restrict eligibility for state-administered federal programs such as [Aid to Families with Dependent Children] or welfare."); Steven Sacco & Sarika Saxena, *Permanently Residing Under Color of Law: A Practitioner's Guide to an Ambiguous Doctrine*, 23 CUNY L. REV. 364, 369 (2020) (citing *Lewis v. Grinker*, 965 F.2d 1206, 1211 (2d Cir. 1992)) ("Between the original enactment of Medicaid in 1965 and 1973, there were actually no [federal] citizenship-based restrictions on Medicaid . . ."); Charles Wheeler, *Alien Eligibility for Public Benefits: Part I*, 88-11 IMMIGR. BRIEFINGS 1 (1988) ("Twenty years ago there were no restrictions on alien access to public benefits.").

¹⁰³ Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(10), 79 Stat. 286, 345. Regulations promulgated in 1971 clarified that there was no federal limit on noncitizen eligibility for Medicaid. 45 C.F.R. § 248.50 (1972). States were explicitly authorized, and in some cases *required*, to provide Medicaid to individuals "without regard to citizenship status," a group that included undocumented immigrants. *Id.*

¹⁰⁴ See Citizenship and Alienage, 38 Fed. Reg. 16911 (June 27, 1973).

¹⁰⁵ See, e.g., *Lewis v. Gross*, 663 F. Supp. 1164, 1181-82 (E.D.N.Y. 1986) (noting that "[f]rom Medicaid's inception in 1965 until the promulgation of the Secretary's alienage requirement in 1973, New York State provided federally participating Medicaid benefits to all otherwise eligible aliens"); see also Fox, *supra* note 48, at 1053 (noting that "[s]tates were free to enact their own alienage-based restrictions on jointly funded programs, but in 1970 only Texas required Aid to Families with Dependent Children . . . and Medicaid recipients to be U.S. citizens" and stating that "Arizona and eight other states barred noncitizens from some of their other welfare programs, but the vast majority of states did not ask applicants about their legal status").

dating the exclusion of undocumented immigrants.¹⁰⁶ In 1986, a federal district court invalidated the regulation, holding that it had no statutory basis.¹⁰⁷ In part to respond to this decision, Congress passed a law codifying the exclusion of certain noncitizens from Medicaid, namely those who were not LPRs or PRUCOL.¹⁰⁸ The law also created a waiver of the alienage restriction in Medicaid for coverage of emergency services, known as Emergency Medicaid.¹⁰⁹

2. *The Emergency Medicaid Exception*

Emergency Medicaid 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 Medicaid but for the alienage restriction, including undocumented noncitizens.¹¹⁰ In all fifty states, Emergency Medicaid authorizes payments for care and services related to childbirth (labor and delivery), but not prenatal care.¹¹¹ States then reimburse healthcare providers—typically hospitals—that provide such care and services.¹¹² Emergency Medicaid is not intended to cover preventive healthcare or follow-up care for patients discharged from the hospital after treatment of an emergency medical condition.¹¹³

Since Emergency Medicaid is available to noncitizens excluded from Medicaid eligibility, and states have options to expand or restrict Medicaid to noncitizens, the types of noncitizens who qualify for it in each state vary. For example, a Texas resident who became an LPR through marriage six years ago would not qualify for Medicaid

¹⁰⁶ 45 C.F.R. § 248.50 (1974).

¹⁰⁷ *Lewis*, 663 F. Supp. 1164.

¹⁰⁸ Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)) (providing that, with the exception of Emergency Medicaid, “no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law”).

¹⁰⁹ *Id.*

¹¹⁰ Omnibus Budget Reconciliation Act of 1986 § 9406(a), 42 U.S.C. § 1396b(v)(1)–(3) (2018).

¹¹¹ C. Annette DuBard & Mark W. Massing, *Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants*, 297 JAMA 1085, 1085–86 (2007) (“Federal funds cannot be applied toward Medicaid coverage of any services that fall outside of this definition, such as routine prenatal care.”).

¹¹² MEDICAID & CHIP PAYMENT & ACCESS COMM’N (MACPAC), *THE MEDICAID FEE-FOR-SERVICE PROVIDER PAYMENT PROCESS 3* (2018), <http://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-Fee-For-Service-Provider-Payment-Process.pdf>.

¹¹³ See H.R. REP. NO. 104-725, at 380 (1996) (Conf. Rep.) (noting congressional intent that Emergency Medicaid only cover “medical care that is strictly of an emergency nature”).

because of their immigration status.¹¹⁴ However, if they suffered a traumatic injury, they would likely qualify for Emergency Medicaid to reimburse their providers for treatment received in the emergency room, but not for follow-up care.¹¹⁵ By contrast, a Pennsylvania resident in the same situation would qualify for Medicaid, which would cover the emergency room visit, hospitalization (if necessary), and any follow-up care.¹¹⁶

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;¹¹⁷ in others, residents can only apply after receiving treatment for an emergency medical condition or labor and delivery.¹¹⁸ States have significant discretion to define, within certain limits, the “emergency medical conditions” (EMCs) that will be covered by Emergency Medicaid. There is enormous variation in the types of conditions that states have deemed to

¹¹⁴ See *Texas Medicaid*, BENEFITS.GOV, <https://www.benefits.gov/benefit/1640> (last visited Aug. 11, 2020) (listing Texas’s eligibility requirements). Because Texas did not expand Medicaid under the ACA, eligibility is very restrictive for non-disabled, non-elderly U.S. citizen adults as well. However, such a person could qualify under the Medicaid for Parents and Caretaker Relatives Program, 1 Tex. Admin. Code § 366.707, .713 (2020), if their income is low enough. See *Texas Works Handbook: C-100, Income Limits and Proration Charts: C-131.2 Medically Needy and Parents and Caretaker Relatives Medicaid*, TEX. HEALTH & HUM. SERVS. (Apr. 1, 2020), <https://hhs.texas.gov/laws-regulations/handbooks/twh/part-c-appendix/c-100-income-limits-proration-charts#C131.2> (indicating an income limit of \$285 per month for a two-parent family of four, for example, which is equivalent to thirteen percent of the Federal Poverty Level). The LPR described here would not qualify for the program under § 366.713(3). See *Texas Works Handbook: A-300, Citizenship: A-342 TANF and Medical Programs Alien Status Eligibility Charts: Chart C*, TEX. HEALTH & HUM. SERVS. (Apr. 1, 2020), <https://hhs.texas.gov/laws-regulations/handbooks/twh/part-a-determining-eligibility/section-300-citizenship#A342>.

¹¹⁵ *Texas Medicaid Provider Procedures Manual* § 4.3.1, TEX. MEDICAID & HEALTHCARE PARTNERSHIP (Aug. 2020), http://www.tmhp.com/Manuals_HTML1/TMPMP/Current/index.html (click “Section 4: Client Eligibility” dropdown, then click “4.3 Restricted Medicaid Coverage” dropdown, then click “4.3.1 Emergency Only” hyperlink) (specifying services covered).

¹¹⁶ *Medical Assistance Eligibility Handbook* § 322.31–.311, PA. DEP’T HUM. SERVS., http://services.dpw.state.pa.us/oimpolicymanuals/ma/Medical_Assistance_Handbook.htm (last updated Oct. 5, 2018) (in left-hand sidebar, under “Contents,” click “322 Citizen Noncitizen” dropdown, then click “322.3 Non-Citizen Status” dropdown, then click “322.31_Qualified_Non-Citizens” hyperlink) (describing LPR eligibility for Medicaid after completing the five-year bar). Because Pennsylvania has expanded Medicaid, the LPR in this situation would qualify with a higher income, up to 138% of the FPL.

¹¹⁷ See, e.g., *Medicaid for the Treatment of an Emergency Medical Condition (“Emergency Medicaid”)*, N.Y.C. HUM. RESOURCES ADMIN., DEP’T SOC. SERVS. (2016), <https://www1.nyc.gov/assets/ochia/downloads/pdf/fly-957-emergency-medicaid-english.pdf> (noting New Yorkers’ ability to pre-apply for Emergency Medicaid and obtain coverage for twelve-month periods).

¹¹⁸ See, e.g. *Texas Medicaid Provider Procedures Manual*, *supra* note 115, § 4.3.1 (noting that in Texas, “[c]ertification for emergency Medicaid occurs after the services have been provided”).

fall within the federal statutory definition. For example, only twelve states and the District of Columbia characterize End Stage Kidney Disease (ESKD) as an EMC.¹¹⁹ An estimated 6000 undocumented noncitizens have ESKD.¹²⁰ The standard treatment option for ESKD is thrice-weekly dialysis or a kidney transplant.¹²¹ Emergency Medicaid does not cover organ transplants or antirejection medications,¹²² but the states that have recognized ESKD as an EMC enable Medicaid-ineligible noncitizens to receive routine dialysis rather than wait until they are “in nearly critical condition” to obtain it on an emergency basis.¹²³ Studies have found that “[u]ndocumented immigrants with ESKD that rely on emergency-only hemodialysis describe significant physical and psychosocial distress”; that they spend “ten-fold more time in the hospital and less time in the outpatient setting compared with those receiving standard hemodialysis”; and that their mortality is fourteen times higher than those receiving the standard treatment.¹²⁴

It is fairly simple for a state to begin classifying ESKD as an EMC. The Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General of the Department of Health and Human Services (HHS) generally defer to state interpretations of the term “EMC.”¹²⁵ They have not contested state requests for reimbursement of dialysis treatment through Emergency Medicaid.¹²⁶ Colorado’s Department of Health Care Policy and Financing recently announced a policy change that will enable its residents with ESKD to

¹¹⁹ See Lilia Cervantes, William Mundo & Neil R. Powe, *The Status of Provision of Standard Outpatient Dialysis for US Undocumented Immigrants with ESKD*, 14 CLINICAL J. AM. SOC’Y NEPHROLOGY 1258, 1259 (2019); see also Carolyn Crist, *Scheduled Dialysis for Undocumented Immigrants Saves Money and Lives*, REUTERS (Dec. 28, 2018, 11:19 AM), <https://www.reuters.com/article/us-health-immigrants-dialysis/sched...is-for-undocumented-immigrants-saves-money-and-lives-idUSKCN1OR17Z>.

¹²⁰ David Ansell, Kristen Pallok, Marieli D. Guzman, Marycarmen Flores & Jose Oberholzer, *Illinois Law Opens Door to Kidney Transplants for Undocumented Immigrants*, 34 HEALTH AFF. 781, 783 (2015).

¹²¹ *Id.* (transplant); Crist, *supra* note 119 (thrice-weekly dialysis).

¹²² Vanessa Grubbs, *Undocumented Immigrants and Kidney Transplant: Costs and Controversy*, 33 HEALTH AFF. 332, 334 (2014) (noting that Emergency Medicaid does not pay for transplants); *Emergency Medical Coverage for Noncitizens*, ILL. DEP’T OF HUM. SERVS. (Mar. 21, 2003), <https://www.dhs.state.il.us/page.aspx?item=19608> (“Organ transplants and related services, such as anti-rejection drugs are not covered under this program.”); *Medicaid for the Treatment of an Emergency Medical Condition Fact Sheet*, N.Y. STATE DEP’T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/emergency_medical_condition_faq.htm (last updated Dec. 2013).

¹²³ See Cervantes et al., *supra* note 119, at 1258.

¹²⁴ *Id.*

¹²⁵ *Id.* at 1259.

¹²⁶ *Id.*

obtain Emergency Medicaid coverage for routine dialysis.¹²⁷ However, states need not pass a law or even submit a State Plan Amendment in order to cover a broader range of conditions under Emergency Medicaid.¹²⁸ 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. *Increasing Exclusion Under PRWORA*

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) heralded a new era of restrictions on non-citizen eligibility for public benefits, and PRWORA is the framework for the laws governing noncitizen eligibility for Medicaid today.¹²⁹ Anti-poor and anti-immigrant animus collided in 1996 to impose dramatic restrictions on noncitizen eligibility for public benefits, including Medicaid.¹³⁰ PRWORA limited eligibility for federal public benefits to citizens and “qualified aliens,” a term first used in the Act.¹³¹ Noncitizens who do not have statuses that fall within the definition of “qualified alien” are generally ineligible for Medicaid.¹³² Undocumented noncitizens were already barred from Medicaid, but PRWORA provided an opportunity for lawmakers to clarify the lim-

¹²⁷ See COLO. DEP’T OF HEALTH CARE POLICY & FIN., FREQUENTLY ASKED QUESTIONS: EMERGENCY MEDICAID & END-STAGE RENAL DISEASE POLICY 1–3 (2019), https://www.health.ny.gov/health_care/medicaid/emergency_medical_condition_faq.htm.

¹²⁸ See Eilis O’Neill, *Transplants a Cheaper, Better Option for Undocumented Immigrants with Kidney Failure*, NPR (May 12, 2019, 5:09 PM), <https://www.npr.org/2019/05/12/721800514/transplants-a-cheaper-better-option-for-undocumented-immigrants-with-kidney-fail> (describing how some states, like Washington, are “quietly expanding” Emergency Medicaid coverage to include scheduled, rather than emergency-only, dialysis).

¹²⁹ Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C. and 8 U.S.C.).

¹³⁰ See Amanda Levinson, *Immigrants and Welfare Use*, MIGRATION POL’Y INST. (Aug. 1, 2002), <https://www.migrationpolicy.org/article/immigrants-and-welfare-use> (noting that “[a]pproximately 935,000 noncitizens lost benefits due to the passage of the [PRWORA]” and “[a]t the time of PRWORA’s passage in 1996, immigrants represented 15 percent of all welfare recipients in the U.S.,” but “[b]y 1999, that number dropped to 12 percent”).

¹³¹ Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2261–62 (codified as amended at 42 U.S.C. and 8 U.S.C. § 1611) (stating that only qualified noncitizens are eligible for federal public benefits); *id.* § 431, 110 Stat. at 2274 (codified as amended at 8 U.S.C. § 1641) (defining “qualified alien”).

¹³² 8 U.S.C. § 1611(a) (2018). See Makhlof, *supra* note 49, at 249–54, for an overview of noncitizen eligibility for Medicaid.

ited scope of services eligible for reimbursement under Emergency Medicaid.¹³³

PRWORA created a new, lower federal “ceiling” of Medicaid eligibility for lawfully present noncitizens, who were hit the hardest by its restrictions. Many previously eligible, lawfully present noncitizens were barred from eligibility, and even qualified noncitizens faced a new barrier to eligibility: the five-year bar. Qualified noncitizens are generally barred from eligibility for federal public benefits for five years,¹³⁴ although individuals holding certain statuses are exempt from this bar.¹³⁵

TABLE 1. PRE- AND POST-PRWORA ELIGIBILITY OF SELECTED CATEGORIES OF NONCITIZENS FOR MEDICAID¹³⁶

Broad Categories of Noncitizens	Pre-PRWORA	Post-PRWORA
Lawful permanent residents (LPRs), generally	Eligible. ¹³⁷	LPRs with 40 or more qualifying work quarters are eligible. ¹³⁸ States have the option to provide to: (1) LPRs with fewer than 40 qualifying work quarters who arrived before August 22, 1996; ¹³⁹ and (2) LPRs with fewer than 40 qualifying work quarters who arrived on or after August 22, 1996, and who have held LPR status for at least 5 years. ¹⁴⁰

¹³³ Emergency Medicaid, discussed *infra* in Section I.B.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. REP. NO. 104-725, at 380 (1996) (Conf. Rep.), *as reprinted in* 1996 U.S.C.C.A.N. 2649, 2768 (noting that “[t]he allowance for emergency medical services under Medicaid is very narrow” and that “[t]he conferees intend[ed] 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” and did not intend it to include or cover “prenatal or delivery care assistance that is not strictly of an emergency nature”).

¹³⁴ 8 U.S.C. § 1613 (2018).

¹³⁵ *Id.* § 1613(b) (listing categories of qualified noncitizens who are exempt from the five-year bar).

¹³⁶ *Id.* § 1612(b) (governing eligibility of qualified noncitizens for Medicaid).

¹³⁷ Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)) (limiting participation in Medicaid to U.S. citizens, LPRs, and PRUCOL noncitizens).

¹³⁸ 8 U.S.C. § 1612(b)(2)(B) (noting, however, that a quarter of work is not counted if it occurred after 1996 and the noncitizen received a federal means-tested public benefit during that period).

¹³⁹ *See id.* § 1612(b)(1); *see also id.* § 1612(b)(2)(B) (requiring coverage of LPRs with forty or more qualifying work quarters).

¹⁴⁰ *See id.* § 1612(b)(1); *see also id.* § 1612(b)(2)(B); *id.* § 1613 (2010) (imposing five-year bar on qualified aliens who enter after enactment).

Refugees and asylees (including former refugees and asylees with LPR status)	Eligible. ¹⁴¹	Eligible for first 7 years; state option after 7 years. ¹⁴²
Veterans and noncitizens on active duty (a subgroup of LPRs)	Eligible. ¹⁴³	Eligible. ¹⁴⁴
Persons residing in the United States under color of law (PRUCOL)	Eligible. ¹⁴⁵	Emergency Medicaid only. ¹⁴⁶
Lawfully present noncitizens in a temporary status (e.g., tourists, students, temporary workers)	Emergency Medicaid only. ¹⁴⁷	Emergency Medicaid only. ¹⁴⁸
Undocumented	Emergency Medicaid only. ¹⁴⁹	Emergency Medicaid only. ¹⁵⁰

¹⁴¹ Refugees and asylees without LPR status were considered PRUCOL. *See* Boswell, *supra* note 72, at 1488. Therefore, they were eligible under the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)).

¹⁴² 8 U.S.C. § 1612(b)(2)(A)(i).

¹⁴³ As LPRs, these individuals qualify under the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)).

¹⁴⁴ 8 U.S.C. § 1612(b)(2)(C).

¹⁴⁵ Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)) (limiting participation in Medicaid to U.S. citizens, LPRs, and PRUCOL noncitizens).

¹⁴⁶ *See* 8 U.S.C.A. § 1641(b) (1996) (defining qualified alien and not including a category of PRUCOL noncitizens); 8 U.S.C.A. § 1611(b)(1)(A) (1996) (describing the Emergency Medicaid exception from the restriction on eligibility for federal public benefits for non-qualified aliens); 42 U.S.C.A. § 1396b(v)(2)(A) (1996) (mechanism of reimbursement).

¹⁴⁷ Although the definition of “PRUCOL” is imprecise, people with temporary status do not fit the definition of a “person . . . in the United States with the INS’s tacit, if not explicit, permission to remain [permanently].” Boswell, *supra* note 72, at 1488. Rather, they have explicit permission to remain *temporarily*. New York’s interpretation of PRUCOL aligns with this understanding. *See, e.g., Medicaid for Immigrants Who Are Not Permanent Residents (Do Not Have “Green Cards”)— PRUCOL and Temporary Non-Immigrant Eligibility*, *supra* note 71 (stating that persons who entered with a temporary visa and have not filed for permanent immigration status or relief are not considered PRUCOL); *see also* 42 U.S.C.A. § 1396b(v)(2)(A) (providing the mechanism of reimbursement for emergency medical care).

¹⁴⁸ *See* 8 U.S.C.A. § 1641(b) (1996) (defining qualified alien to include LPRs, along with other limited categories, but not including a general category of lawfully present noncitizens who are not LPRs); *id.* § 1611(b)(1)(A) (describing the Emergency Medicaid exception from the restriction on eligibility for federal public benefits for non-qualified aliens); 42 U.S.C.A. § 1396b(v)(2)(A). In 2009, however, Congress passed a law giving states the option to cover lawfully residing children and/or pregnant women through Medicaid. *See infra* Section I.B.4.

¹⁴⁹ Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9406(a), 100 Stat. 1874, 2057 (amending 42 U.S.C. § 1396b (1982)) (limiting participation in Medicaid to U.S. citizens, LPRs, and PRUCOL noncitizens).

¹⁵⁰ *See* 8 U.S.C.A. § 1641(b) (defining qualified alien to include, among others, LPRs but not undocumented noncitizens); *id.* § 1611(b)(1)(A) (describing the Emergency Medicaid exception from the restriction on eligibility for federal public benefits for non-qualified aliens); 42 U.S.C.A. § 1396b(v)(2)(A).

Section 402(b) of PRWORA created a federal “floor” of Medicaid coverage by requiring states that participate in Medicaid to include select categories of noncitizens. In general, these include:

- LPRs with 40 or more qualifying work quarters;¹⁵¹
- Qualified noncitizens with a military connection;¹⁵²
- Certain humanitarian immigrants within seven years of receiving such status;¹⁵³
- Certain noncitizen American Indians;¹⁵⁴ and
- Noncitizens receiving Medicaid based on Supplemental Security Income.¹⁵⁵

PRWORA did not create anything close to a uniform national policy on noncitizen eligibility for Medicaid.¹⁵⁶ It devolved considerable authority to the states to restrict noncitizen eligibility for Medicaid between the statutory floor and ceiling. States now had the authority to make critical decisions about whether to impose restrictions on various categories of noncitizens in Medicaid, including qualified noncitizens.¹⁵⁷ 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. For example, states can expand or restrict eligibility for Medicaid to LPRs who do not otherwise fall into one of the mandatory noncitizen coverage groups.¹⁵⁸ Another example is that states can extend or bar Medicaid eligibility to humanitarian immigrants after their first seven years in such status.¹⁵⁹

As a result of this new discretion, shortly after PRWORA became effective, Louisiana and Wyoming barred most LPRs from

¹⁵¹ 8 U.S.C. § 1612(b)(2)(B) (2018).

¹⁵² *Id.* § 1612(b)(2)(C).

¹⁵³ *Id.* § 1612(b)(2)(A)(i) (describing this group as “refugees and asylees”).

¹⁵⁴ *Id.* § 1612(b)(2)(E).

¹⁵⁵ *Id.* § 1612(b)(2)(F). Noncitizen eligibility for SSI is described in § 1612(a).

¹⁵⁶ See generally WENDY ZIMMERMANN & KAREN C. TUMLIN, URBAN INST., PATCHWORK POLICIES: STATE ASSISTANCE FOR IMMIGRANTS UNDER WELFARE REFORM (1999), <http://www.urban.org/sites/default/files/publication/69586/309007-Patchwork-Policies-State-Assistance-for-Immigrants-under-Welfare-Reform.PDF>.

¹⁵⁷ 8 U.S.C. § 1612(b) (2018).

¹⁵⁸ *Id.* § 1612(b)(1) (authorizing states to determine eligibility for qualified noncitizens); *id.* § 1612(b)(2) (describing mandatory coverage categories); *id.* § 1641(b)(1) (defining “qualified alien” to include LPRs). PRWORA does not permit states to extend Medicaid eligibility to LPRs who arrived after PRWORA was enacted, who have not held qualified status for at least five years, and who do not otherwise fall into one of the mandatory noncitizen coverage groups. *id.* § 1613 (imposing five-year bar on public benefits eligibility for qualified noncitizens who entered the United States after PRWORA was enacted).

¹⁵⁹ See *id.* § 1612(b)(2)(A)(i) (listing time-limited exceptions to a state’s authority to determine eligibility for Medicaid).

Medicaid eligibility entirely.¹⁶⁰ Currently, Wyoming and Texas have the most restrictive noncitizen eligibility criteria for Medicaid, setting eligibility at or near the federal floor of Medicaid coverage: LPRs who entered the country on or after August 22, 1996—the date PRWORA was enacted—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.¹⁶¹ Wyoming went a step further than Texas by excluding even those LPRs who entered the country before August 22, 1996—that is, it went no higher than the federal floor of Medicaid coverage.¹⁶²

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.¹⁶³ They also had virtually free rein to impose alienage-based restrictions on public benefits that are funded and administered solely by state governments, subject only to a federally imposed floor that is even lower than the floor for Medicaid described above and, in the case of discrimination against LPRs, to equal protection principles.¹⁶⁴

¹⁶⁰ Wishnie, *supra* note 6, at 495 n.9.

¹⁶¹ MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, *supra* note 29, at 5. Both states have elected options to slightly expand Medicaid eligibility: Wyoming has elected the option to expand Medicaid to lawfully residing pregnant women. *Id.* at 5. Texas has elected 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.*; Julia Belluz & Nina Martin, *The Extraordinary Danger of Being Pregnant and Uninsured in Texas*, VOX (Dec. 19, 2019), <https://www.vox.com/science-and-health/2019/12/6/20995227/women-health-care-maternal-mortality-insurance-texas> (“CHIP Perinate [in Texas] provides benefits to about 33,000 women a month, regardless of their immigration status, up to 202 percent of the federal poverty level.”). Nevertheless, the limitations of the program and barriers to access mean that “Texas [still] has the highest rate of uninsured women of reproductive age in the country In some counties, mainly along the Mexico border, that estimate approaches 40 percent.” *Id.*

¹⁶² See Table 6 *Qualified Immigration Status – Wyoming Eligibility Online Manual*, WYO. DEP’T OF HEALTH (Mar. 1, 2016), <https://sites.google.com/a/wyo.gov/ecom/tables/table6> (last visited Aug. 25, 2020).

¹⁶³ See Wishnie, *supra* note 6, at 495 n.9 (describing Connecticut’s six-month residency requirement, Washington’s twelve-month residency requirement, and Indiana’s two-year eligibility limit for Medicaid that applied to noncitizens only).

¹⁶⁴ See 8 U.S.C. § 1622(a) (2018) (allowing states “to determine the eligibility for any State public benefits” except as provided in § 1622(b)); *id.* § 1622(b) (providing exceptions for, among others, certain noncitizens who are subject to withholding of deportation for the first five years they hold such status, certain refugees and asylees for the first five years they hold such status, LPRs with forty or more qualifying work quarters, and certain veterans); *infra* Section III.A.

4. *State Options to Expand Coverage for Children and Pregnant Women*

In the years following PRWORA's implementation, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states the option to cover lawfully residing children and/or pregnant women through Medicaid or CHIP, a program with a higher overall income threshold than Medicaid.¹⁶⁵ 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 2007.¹⁶⁶ The ICHIA options restored eligibility for federally funded health coverage to a subset of noncitizens who had been eligible for Medicaid pre-PRWORA: children and/or pregnant women who are LPRs and subject to the five-year bar or who have a non-qualified lawful status.¹⁶⁷ The ICHIA options enjoyed broad, bipartisan support from both houses of Congress, the National Governors Association, and the National Conference of State Legislatures.¹⁶⁸ Advocates for the ICHIA options were motivated to address the disparity in health coverage between citizen and noncitizen children caused by PRWORA's alienage restrictions, which was impacting noncitizen children's health as well as healthcare-system efficiency.¹⁶⁹ Many treatable conditions affecting children and pregnant women can be addressed in a cost-effective manner through primary and preventive care, which Medicaid and CHIP cover.¹⁷⁰ Although the ICHIA options were a positive development from a health policy perspective, they contribute to the geographic variability of noncitizen access to health coverage because not all states have elected them.

¹⁶⁵ Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 214, 123 Stat. 8, 56-57 (codified at 42 U.S.C. §§ 1396b(v)(4)(A), 1397gg(e)(1)(N) (2018)); see 2010 Letter from Cindy Mann, *supra* note 68, at 1; *Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level*, KAISER FAMILY FOUND. (Jan. 1, 2020), <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level> (showing that CHIP has a higher overall income threshold than Medicaid).

¹⁶⁶ Legal Immigrant Children's Health Improvement Act of 2007, S. 764, 110th Cong. § 2 (2007).

¹⁶⁷ See *supra* Table 1.

¹⁶⁸ See e.g., LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, REDUCING DISPARITIES IN HEALTH COVERAGE FOR LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN 3-4 (2007), <http://www.cbpp.org/sites/default/files/atoms/files/4-20-07health2.pdf>.

¹⁶⁹ See *id.* at 2-3 (describing disparities in access to care faced by immigrant children and suggesting that health insurance coverage can ameliorate these disparities).

¹⁷⁰ See Mara Youdelman, *Q&A on ICHIA: The Legal Immigrant Children's Health Improvement Act*, NAT'L HEALTH L. PROGRAM 3 (June 2013), <https://healthlaw.org/resource/q-a-the-legal-immigrant-childrens-health-improvement-act>.

In order 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.¹⁷¹ The state must specify whether it is electing the option for pregnant women, for children, or for both.¹⁷² States receive funding at an enhanced federal matching rate for individuals served by CHIP or for CHIP-funded Medicaid expansions, including noncitizens.¹⁷³ Currently, the enhanced Federal Medical Assistance Percentage (eFMAP) for CHIP ranges from 76.50% in Wyoming to 95.93% in Mississippi.¹⁷⁴ States that have elected the option to expand CHIP to lawfully residing pregnant women receive funding at the Medicaid match rate.¹⁷⁵ Federal matching rates for Medicaid and CHIP are designed to induce and enable states to expand their publicly funded health programs or maintain them during recessions.¹⁷⁶

As of January 2020, thirty-five states have adopted the ICHIA option to expand Medicaid coverage to lawfully residing children, and twenty-four of those states have also expanded CHIP to this population.¹⁷⁷ In twenty states, lawfully residing children became eligible for Medicaid and/or CHIP shortly after CHIPRA was enacted, between

¹⁷¹ 2010 Letter from Cindy Mann, *supra* note 68, at 5.

¹⁷² *Id.*

¹⁷³ See *id.* (noting that children eligible for Medicaid or CHIP under the CHIPRA section 214 option are considered “targeted low-income children,” who are eligible for the enhanced federal matching rate). However, because CHIP is a fixed block grant, a state would not receive more funding at the eFMAP after electing the ICHIA option unless it is not already using all its available federal CHIP funds or it is eligible for a shortfall funding source. See *id.* at 8–9; see also Tricia Brooks, *CHIP Funding Has Been Extended, What's Next for Children's Health Coverage?*, HEALTH AFF.: BLOG (Jan. 30, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180130.116879/full>.

¹⁷⁴ *Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP*, KAISER FAMILY FOUND., <https://www.kff.org/state-category/medicaid-chip/chip> (follow “Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP” and navigate to “Map,” ensuring that “FY 2021” is selected in the “Timeframe” dropdown menu) (last visited Oct. 15, 2020).

¹⁷⁵ NAT'L IMMIGRATION LAW CTR., *FACTS ABOUT FEDERAL FUNDING FOR STATES TO PROVIDE HEALTH COVERAGE TO IMMIGRANT CHILDREN AND PREGNANT WOMEN* 5 (2010), <https://www.medicaid.gov/sites/default/files/2020-01/facts-about-federal-funding-for-states-to-provide-health-coverage-to-immigrant-children-and-pregnant-women.pdf>.

¹⁷⁶ See Genevieve Kenney & Victoria Lynch, *Monitoring Children's Health Insurance Coverage Under CHIPRA Using Federal Surveys, in DATABASES FOR ESTIMATING HEALTH INSURANCE COVERAGE FOR CHILDREN* 66–67 (2010) (describing the role of eFMAP in the American Recovery and Reinvestment Act and the ACA).

¹⁷⁷ TRICIA BROOKS, LAUREN ROYGARDNER, SAMANTHA ARTIGA, OLIVIA PHAM & RACHEL DOLAN, KAISER FAMILY FOUND., *MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, AND COST SHARING POLICIES AS OF JANUARY 2020: FINDINGS FROM A 50-STATE SURVEY* 37 tbl.2 (2020), <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.

2009 and 2010.¹⁷⁸ Political scientists have studied how temporal sequences of events and processes can explain policy trajectories.¹⁷⁹ For example, Jacobs and Callaghan have found that states' past policy decisions to expand access to Medicaid may have predisposed them to adopt the ACA Medicaid expansion.¹⁸⁰ The mechanism explaining these policy outcomes is that established policies "generate both identities and groups that equate their interests with programmatic continuation and expansion and generate resources to mobilize beneficiaries."¹⁸¹ The term for this temporal process is "path dependence," which, in the simplest terms, holds that "[i]nitial moves in a particular direction encourage further movement along the same path."¹⁸² Early events or processes are more significant in influencing the development of future policies than later events or processes.¹⁸³ Although a full analysis of whether path dependence is at work in states' decisions to expand noncitizen eligibility would be beyond the scope of this Article, I highlight some data points in this Section suggesting that this may be the case.

Fewer states have adopted the ICHIA option to expand Medicaid or CHIP coverage to lawfully residing pregnant women than have expanded coverage to lawfully residing children. Twenty-five states have expanded Medicaid to lawfully residing pregnant women, and three of those states (Colorado, New Jersey, and Virginia) have done the same for CHIP coverage.¹⁸⁴ 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 women adopted it soon after CHIPRA was enacted.¹⁸⁵

¹⁷⁸ JENNIFER SULLIVAN, *FAMILIES USA, EXPANDING COVERAGE FOR RECENT IMMIGRANTS: CHIPRA GIVES STATES NEW OPTIONS 6-8* (2010), <http://research.policyarchive.org/96110.pdf>.

¹⁷⁹ See Paul Pierson, *Not Just What, but When: Timing and Sequence in Political Processes*, 14 *STUD. AM. POL. DEV.* 72, 72-73 (2000).

¹⁸⁰ Lawrence R. Jacobs & Timothy Callaghan, *Why States Expand Medicaid: Party, Resources, and History*, 38 *J. HEALTH POL., POL'Y & L.* 1023, 1038 (2013).

¹⁸¹ *Id.* at 1037; see also *id.* at 1038 ("[T]he policy trajectory of widening access may have generated identities, interests, and resources that predispose states—in conjunction with other factors—to support adoption of the [ACA's] Medicaid expansion.").

¹⁸² Pierson, *supra* note 179, at 74.

¹⁸³ *Id.* at 75 ("[O]utcomes of early events or processes in the sequence are amplified, while later events or processes are dampened. . . . [E]arly stages in a sequence can place particular aspects of political systems onto distinct tracks, which are then reinforced through time.").

¹⁸⁴ BROOKS ET AL., *supra* note 177, at 38 tbl.4.

¹⁸⁵ See SULLIVAN, *supra* note 178, at 6-8 (noting that seventeen states adopted the ICHIA option for lawfully residing pregnant women between 2009 and 2010).

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.¹⁸⁶ For these states, it should have been an easy decision to elect the ICHIA options from the perspective of maximizing net resources, taking advantage of the available federal matching funds to subsidize care for these populations. 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 noncitizen children under the ICHIA option.¹⁸⁷ These include Illinois, Iowa, Montana, New Mexico, North Carolina, Oregon, Texas, Vermont, and Washington.¹⁸⁸ This suggests that the infusion of federal funds via ICHIA made a difference in states’ ability to expand coverage to this population. One might infer that prior to ICHIA, they desired, but could not afford, to expand coverage to lawfully residing noncitizen children. These decisions were particularly noteworthy because they indicated the states’ willingness to commit funds to a Medicaid expansion for noncitizens during a recession.¹⁸⁹ These expansions may demonstrate that even during an economic downturn, it is possible to obtain bipartisan support for efforts to fill healthcare coverage gaps.¹⁹⁰

Another finding is that the eFMAP for CHIP that applies to the ICHIA option for lawfully residing children has not generally induced states to adopt it if they are ideologically or otherwise opposed to it, much as political ideology has influenced some states to decline significant funding for expanding Medicaid under the ACA.¹⁹¹ Figure 1 is a map of states depicting whether they have elected one, both, or neither of the ICHIA options. Figure 2 displays the eFMAP for each state. Notably, several states that would receive the “best deals” for adopting the ICHIA child option have not done so. These include

¹⁸⁶ LEIGHTON KU & MARIELLEN JEWERS, MIGRATION POLICY INST., HEALTH CARE FOR IMMIGRANT FAMILIES: CURRENT POLICIES AND ISSUES 5 (2013), <http://www.migrationpolicy.org/sites/default/files/publications/COI-HealthCare.pdf> (describing states’ reactions to the ICHIA option to cover legal permanent resident pregnant women following passage of CHIPRA).

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ *See id.* at 5–6.

¹⁹⁰ *Id.* at 6.

¹⁹¹ *See* Charles Barrilleaux & Carlisle Rainey, *The Politics of Need: Examining Governors’ Decisions to Oppose the “Obamacare” Medicaid Expansion*, 14 ST. POL. & POL’Y Q. 437, 447–49 (2014) (analyzing empirical data to show that political considerations had greater influence on state decisions to not adopt Medicaid expansion than considerations of need and economics).

Alabama, Arizona, Georgia, Idaho, Indiana, Oklahoma, Louisiana, Michigan, Missouri, and Tennessee.

FIGURE 1. STATES THAT HAVE ELECTED ONE OR BOTH ICHIA OPTIONS¹⁹²

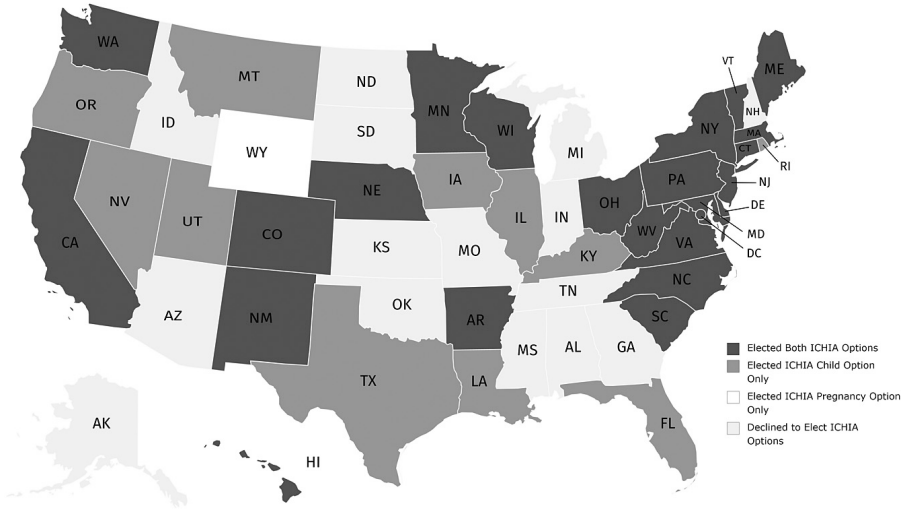
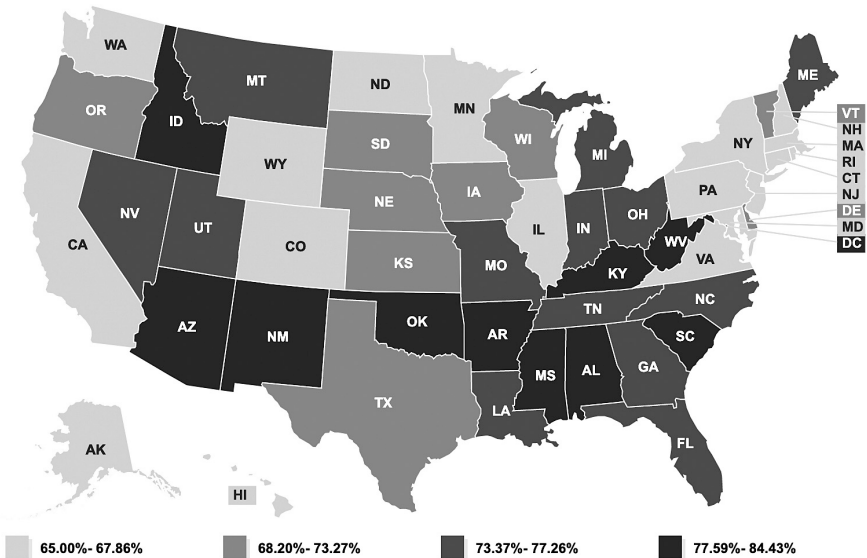


FIGURE 2. ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE (eFMAP) FOR CHIP, FY2021¹⁹³



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¹⁹² BROOKS ET AL., *supra* note 177, at 13 fig.9.

¹⁹³ *Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP*, *supra* note 174.

Perhaps indicating the role of path dependence, all seven of the jurisdictions that have created robust self-funded programs to provide health coverage for low-income undocumented noncitizens and DACA recipients (which are discussed in the next Section) were among the earliest adopters of the ICHIA options.¹⁹⁴ This may indicate a link between state decisions to expand Medicaid generally and state decisions to elect noncitizen-specific expansion options.

Another option states can use to receive federal reimbursement for providing pregnancy-related care regardless of citizenship or immigration status is the “unborn child option.”¹⁹⁵ In states that have elected this option, any person who is pregnant and otherwise qualifies for CHIP can receive subsidized, limited-scope coverage of prenatal care, labor, and delivery.¹⁹⁶ From the time the federal rulemaking for the unborn child option was announced, states understood it as a means to subsidize maternity care for undocumented noncitizens.¹⁹⁷ At least some agency staff, on the other hand, did not seem to appreciate or did not want to acknowledge this use of the option until after states began submitting claims for reimbursement of services provided to pregnant undocumented noncitizens.¹⁹⁸ This oversight by the federal government betrays the “incidental”—as opposed to intentional—nature of many federal policies relating to noncitizen access to Medicaid.

¹⁹⁴ California, Washington, D.C., Massachusetts, New York, and Washington elected both ICHIA options in 2009. SULLIVAN, *supra* note 178, at 6–7. Illinois and Oregon elected the ICHIA child option only in 2009, but already covered prenatal care for excluded noncitizens through the unborn child option. *Id.*

¹⁹⁵ See State Children’s Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children, 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 pro-choice advocates considered it 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. PERSP., Jan. 2008, at 1, [http://www.law.uh.edu/healthlaw/perspectives/2008/\(PG\)%20CHIP%20peri.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(PG)%20CHIP%20peri.pdf).

¹⁹⁶ 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. 67 Fed. Reg. at 61,969.

¹⁹⁷ See Gray, *supra* note 195, at 1–2.

¹⁹⁸ See *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 “an 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.

As of January 2020, seventeen states have elected the CHIP unborn child option to provide limited-scope coverage to pregnant women, regardless of their citizenship or immigration status.¹⁹⁹ In a curious twist, conservative political ideology favors CHIP expansion under the unborn child option: half of the states that have adopted it are red states.²⁰⁰ It is possible that the option's association with fetal personhood has dissuaded more blue states from adopting it.²⁰¹

Of the five states with the largest share of undocumented non-citizens, only California and Texas have elected this option.²⁰² Indeed, California and Texas are the largest beneficiaries of the unborn child option, with nearly 116,000 and 96,000 enrolled, respectively, in 2016.²⁰³

Of the seventeen states that have adopted the unborn child option, seven have also elected the ICHIA option for expansion of full-scope Medicaid or CHIP coverage for lawfully residing pregnant women: Arkansas, California, Massachusetts, Minnesota, Nebraska, Washington, and Wisconsin.²⁰⁴ Four are blue states (California,

¹⁹⁹ BROOKS ET AL., *supra* note 177, at 40 tbl.3. Some states may restrict benefits under this option for certain income categories. *See id.* at 41–42.

²⁰⁰ 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 Results*, 270TOWIN, <https://www.270towin.com/maps/2016-actual-electoral-map> (last updated July 20, 2017) (showing the winner of the popular vote in each state for the 2016 presidential election). Support for this option is part of a conservative strategy to consistently recognize unborn children as full human beings, with the goal of overturning *Roe v. Wade*, 410 U.S. 113, 153 (1973) (holding that the decision whether or not to seek an abortion falls within the constitutional right of privacy).

²⁰¹ *See, e.g., ELIZABETH RICH, NAT'L FAMILY PLANNING & REPROD. 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].”).

²⁰² The states with the largest share of undocumented noncitizens in the population are Nevada (7.2%), California (6.8%), Texas (6.7%), New Jersey (6.2%), and Arizona (6.0%). PEW HISPANIC CTR., PEW RESEARCH CTR., UNAUTHORIZED IMMIGRANT POPULATION: NATIONAL AND STATE TRENDS, 2010, at 15 tbl.5 (2011) [hereinafter 2010 UNAUTHORIZED IMMIGRANT POPULATION: NATIONAL AND STATE TRENDS], <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 undocumented noncitizens 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.*

²⁰³ MEDICAID & CHIP PAYMENT & ACCESS COMM'N, FACT SHEET: STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 16–17 tbl.5 (2018), <http://www.macpac.gov/wp-content/uploads/2015/03/State-Childrens-Health-Insurance-Program-Fact-Sheet.pdf>.

²⁰⁴ BROOKS ET AL., *supra* note 177, at 40 tbl.3.

Massachusetts, Minnesota, Washington), and three are red states (Arkansas, Nebraska, Wisconsin).²⁰⁵

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 do not always choose to adopt policies that maximize health-system efficiency and equity, whether that is due to ideological, fiscal, or other reasons.²⁰⁶

5. Maintenance of Exclusions Under the ACA

In 2010, after lengthy debate and compromise, the Patient Protection and Affordable Care Act (ACA)²⁰⁷ transformed health law and policy by moving the U.S. healthcare system closer to universal coverage. A key provision of the ACA created a new, mandatory category of Medicaid eligibility for adults with incomes up to 138% of the Federal Poverty Level (FPL).²⁰⁸ Until the passage of the ACA, states were required to cover only those adults who met both financial and categorical eligibility criteria. The latter criterion consisted of various categories of "deserving poor," which have historically included families with dependent children, people with disabilities, people who are blind, and the elderly.²⁰⁹ The ACA's attempt to create a new baseline of Medicaid coverage for low-income adults was a major shift in the law of publicly funded healthcare.²¹⁰ However, a successful legal chal-

²⁰⁵ See 2016 Presidential Election Results, *supra* note 200.

²⁰⁶ See Jacobs & Callaghan, *supra* note 180, at 1040 (finding that political party orientation, economic circumstances, previous policy trajectories, and administrative capacity influence states' decisions to expand Medicaid under the ACA); Joshua Meyer-Gutbrod, *Between National Polarization and Local Ideology: The Impact of Partisan Competition on State Medicaid Expansion Decisions*, 50 *PUBLIUS* 237, 238–39 (2019) (describing the role of strong inter-party competition in mitigating partisan decisionmaking among Republican-controlled states regarding Medicaid expansion under the ACA); Jamila Michener, *Race, Politics, and the Affordable Care Act*, 45 *J. HEALTH POL., POL'Y & L.* 547, 551 (2020) (describing studies that found racialized politics played a role in states' decisions to expand Medicaid under the ACA).

²⁰⁷ Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C. and I.R.C.).

²⁰⁸ ACA § 2001(a)(1)(C); 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018). This is the effective minimum income limit for Medicaid eligibility under the ACA expansion, taking into account a standard income disregard of five percentage points of the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (establishing the 133% FPL income limit); 42 C.F.R. § 435.603(d)(4) (2019) (describing the 5% income disregard).

²⁰⁹ 42 U.S.C. § 1396-1. Since the establishment of welfare medicine, Medicaid and its precursors were benefits restricted to the "deserving poor," what some commentators describe as "poor plus." See Nicole Huberfeld, *NFIB v. Sebelius at 5*, 12 *U. ST. THOMAS J.L. & PUB. POL'Y* 48, 51 (2017).

²¹⁰ See Huberfeld, *supra* note 34, at 450 ("Considering that the welfare/deserving poor/medical assistance connection dates to colonial America, this is a sea change."); Super, *supra* note 96, at 930 (suggesting that the ACA's Medicaid expansion was the most decisive move against the concept of the deserving poor in decades because it, "[a]part from

lence rendered the Medicaid expansion optional for states, foreclosing a guarantee of near-universal coverage of low-income people through Medicaid.²¹¹

Nevertheless, the ACA played a critical role in reducing the national uninsured rate from 15.5% to a historic low of 8.6% in 2016.²¹² It also represented a remarkable expansion of the federal government's role in subsidizing health coverage for low- and middle-income people living in the United States. This occurred through two main mechanisms: the aforementioned Medicaid expansion, the costs of which are borne almost entirely by the federal government; and new subsidies for income-qualifying consumers who purchase private health insurance on the ACA Marketplaces.²¹³

Despite its success with increasing access to health coverage, the ACA maintained PRWORA's framework of alienage restrictions for Medicaid eligibility.²¹⁴ The result is a nationally uniform policy of fed-

undocumented immigrants, . . . recognizes all people's need for health care—and on surprisingly equal terms”).

²¹¹ Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012) (holding that states could not be penalized for failing to expand Medicaid). At the time of publication, the number of states that have not expanded Medicaid is small and declining. See Alex Smith, *Missouri Voters Approve Medicaid Expansion Despite Resistance from Republican Leaders*, NPR: SHOTS (Aug. 5, 2020, 11:01 AM), <https://www.npr.org/sections/health-shots/2020/08/05/898899246/missouri-voters-approve-medicaid-expansion-despite-resistance-from-republican-le> (noting that thirty-eight states plus the District of Columbia had expanded Medicaid as of August 2020). The states that have held out on expanding Medicaid tend to be states with very high levels of uninsurance and large noncitizen populations, e.g., Texas and Florida. JENNIFER TOLBERT, KENDAL ORGERA, NATALIE SINGER & ANTHONY DAMICO, KAISER FAMILY FOUND., KEY FACTS ABOUT THE UNINSURED POPULATION 6, 14 tbl.A (2019), <http://files.kff.org/attachment/Issue-Brief-Key-Facts-about-the-Uninsured-Population>; see *infra* notes 231–32 and accompanying text.

²¹² MATT BROADDUS & AVIVA ARON-DINE, CTR. ON BUDGET & POLICY PRIORITIES, UNINSURED RATE ROSE AGAIN IN 2019, FURTHER ERODING EARLIER PROGRESS 4 (2020), <https://www.cbpp.org/sites/default/files/atoms/files/9-15-20health.pdf>.

²¹³ ACA § 1321, 124 Stat. at 186–87 (codified at 42 U.S.C. § 18041); *id.* §§ 1401(a), 10105(a)–(c), 10108(h)(1), 124 Stat. at 213–19, 906, 914 (codified as amended at I.R.C. § 36B); Huberfeld, *supra* note 34, at 432, 450–51; see also *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUND. (Jan. 16, 2020), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health> (“The ACA offers subsidies to reduce monthly premiums and out-of-pocket costs in an effort to expand access to affordable health insurance for moderate and low-income people . . .”).

²¹⁴ Some lawfully present but non-qualified noncitizens 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 ACA § 1331, 42 U.S.C. § 18051. BHPs are health plans for individuals who earn slightly too much to qualify for Medicaid or who are lawfully present yet ineligible for Medicaid due to their immigration status. STAN DORN, MATTHEW BUETTGENS & CAITLIN CARROLL, HEALTH POLICY CTR., URBAN INST., USING THE BASIC HEALTH PROGRAM TO MAKE COVERAGE MORE AFFORDABLE TO LOW-INCOME HOUSEHOLDS: A PROMISING APPROACH FOR MANY

eral Medicaid exclusion for millions of noncitizens living in the United States, including undocumented noncitizens, recipients of Deferred Action for Childhood Arrivals (DACA),²¹⁵ and a handful of others; and a patchwork of state policies governing Medicaid eligibility for lawfully present noncitizens. Although millions of people, many of them low-income, remain uninsured for reasons unrelated to legal eligibility for subsidized health coverage,²¹⁶ low-income noncitizens are the only ones who are disqualified from Medicaid as a matter of law. In short, the progressive reform to universalize Medicaid eligibility for low-income people did not extend to noncitizens.

The ACA did expand access to subsidized health coverage for a subset of noncitizens who are excluded from Medicaid through the subsidies offered for health insurance purchased on the Marketplace.

STATES 1 (2011), <http://www.urban.org/sites/default/files/publication/27596/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households-A-Promising-Approach-for-Many-States.PDF>. However, only two states—New York and Minnesota—have elected to establish Basic Health Programs. See, e.g., *Basic Health Program*, MEDICAID.GOV, <https://www.medicaid.gov/basic-health-program/index.html> (last visited Aug. 10, 2020); see also Michelle Andrews, *Few States Use Health Law Option for Low-Cost Plans*, NPR: SHOTS (Feb. 2, 2016, 10:33 AM), <https://www.npr.org/sections/health-shots/2016/02/02/465184081/few-states-use-health-law-option-for-low-cost-plans> (describing Basic Health Programs).

²¹⁵ 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 & IMMIGR. SERV., <https://www.uscis.gov/archive/consideration-deferred-action-childhood-arrivals-daca> (last visited Aug. 10, 2020). 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. *Id.* Most individuals with deferred action are considered “lawfully present” in the United States and are therefore eligible for Marketplace coverage. *Immigrants: Coverage for Lawfully Present Immigrants*, HEALTHCARE.GOV, <https://www.healthcare.gov/immigrants/lawfully-present-immigrants> (last visited Aug. 10, 2020) (stating that lawfully present noncitizens can purchase insurance on the Health Insurance Marketplace); *Immigrants: Immigration Status and the Marketplace*, *supra* note 66 (listing Deferred Action Status among noncitizens who qualify to use the Marketplaces, and noting the exception for DACA recipients). DACA recipients, however, were specifically excluded from eligibility for those programs as ACA coverage was not deemed to fall within the intended scope of DACA status. 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 undocumented immigrants for purposes of eligibility for federally funded health coverage programs. See *Immigrants: Coverage for Lawfully Present Immigrants*, *supra* (noting that only lawfully present immigrants are eligible); *Immigrants: Immigration Status and the Marketplace*, *supra* note 66 (excluding DACA as an immigration status eligible for coverage).

²¹⁶ Munira Z. Gunja & Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, COMMONWEALTH FUND (Aug. 28, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage> (noting that despite the passage of the ACA, many people remain uninsured, and uninsured working-age adults are disproportionately low-income).

Although the alienage criterion for Marketplace participation is complex, it is nationally uniform: only “lawfully present immigrants” are eligible.²¹⁷ Noncitizens who are considered lawfully present and who earn income up to 400% of the FPL may benefit from the Marketplace’s subsidies.²¹⁸ However, consumers generally consider Marketplace coverage to be inferior to Medicaid because of cost-sharing obligations, even if they are subsidized.²¹⁹ Some participants would qualify for premium-free “bronze” plans,²²⁰ but they would then be responsible for paying a higher deductible for costs associated with non-preventive care.²²¹

Although some excluded noncitizens may be eligible for subsidized employer-sponsored insurance (ESI), it is unavailable or unaf-

²¹⁷ See *Immigrants: Coverage for Lawfully Present Immigrants*, *supra* note 215.

²¹⁸ I.R.C. 36B(c)(1)(A)–(B) (2018); *Health Coverage of Immigrants*, *supra* note 10. The ACA provides that individuals with income between 100% and 400% of the FPL are eligible for Marketplace subsidies. RACHEL GARFIELD, KENDAL ORGERA & ANTHONY DAMICO, KAISER FAMILY FOUND., *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 2* (2020), <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid>. It was presumed that individuals with income below 100% of the FPL would be eligible for Medicaid instead because of the mandatory expansion. See *id.* at 1. Congress realized, however, that some lawfully present noncitizens with income below 100% of the FPL would be barred from Medicaid because of their immigration status, and specially provided that such noncitizens could purchase subsidized Marketplace coverage. Sonya Schwartz, *A Step Forward for Lawfully Present Immigrants Living in Poverty*, GEO. U. HEALTH POL’Y INST.: CTR. FOR CHILD. & FAM. (Dec. 11, 2014), <https://ccf.georgetown.edu/2014/12/11/step-forward-covering-lawfully-present-immigrant-families-living-poverty>. When *NFIB v. Sebelius* decentralized the Medicaid expansion decision and some states chose not to expand Medicaid, it created a coverage gap for citizens and noncitizens who qualify for Medicaid and whose income is below 100% of the FPL but above the income limit for Medicaid in their state. GARFIELD ET AL., *supra*, at 1 (noting that the median income limit for Medicaid eligibility in non-expansion states is 40%). Oddly, this means that lawfully present noncitizens who live in non-expansion states, who are ineligible for Medicaid, and whose income falls in this range are in a better position than their citizen and Medicaid-eligible noncitizen counterparts: the former can purchase subsidized Marketplace coverage and the latter cannot. See Schwartz, *supra*.

²¹⁹ See Aaron E. Carroll & Austin Frakt, *Don’t Assume that Private Insurance Is Better than Medicaid*, N.Y. TIMES (July 12, 2017), <https://www.nytimes.com/2017/07/12/upshot/dont-assume-that-private-insurance-is-better-than-medicaid.html> (describing a study that found that “poorer and sicker people — exactly the kind more likely to be on Medicaid — were slightly more likely to die” if they were enrolled in insurance that required cost sharing than if they were enrolled in insurance without cost sharing).

²²⁰ Rachel Fehr, Cynthia Cox & Matthew Rae, *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?*, KAISER FAM. FOUND. (Dec. 10, 2019), <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020>.

²²¹ See *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAMILY FOUND. (Jan. 16, 2020), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health>; Fehr et al., *supra* note 220.

fordable to many.²²² The federal government subsidizes the provision of ESI through a tax exclusion for employer and employee contributions to health insurance premiums.²²³ Noncitizens who work for employers that offer ESI are eligible to enroll on the same terms as citizens.²²⁴ The federal government is effectively subsidizing health insurance for these noncitizens through the federal tax exclusions on payroll and income tax. Notably, this group includes DACA recipients, who are ineligible for both Medicaid and Marketplace insurance because of their status.²²⁵ Other categories of lawfully present noncitizens whose ESI is subsidized through the tax exclusion may be ineligible for Medicaid but eligible for subsidized Marketplace coverage.²²⁶

²²² See KAISER FAMILY FOUND., *supra* note 10 (discussing low-income noncitizens' limited access to ESI and, when it is offered, the challenge of affording it).

²²³ See *Employee Benefits*, U.S. INTERNAL REVENUE SERV., <https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits> (last updated Jan. 16, 2020) (discussing tax exclusions for employer contributions); *Topic No. 502 Medical and Dental Expenses*, U.S. INTERNAL REVENUE SERV., <https://www.irs.gov/taxtopics/tc502> (last updated June 26, 2020) (discussing tax exclusions for employee contributions). Employer contributions are not treated as wages, which are subject to payroll taxes. *Tax Policy Center Briefing Book: Key Elements of the U.S. Tax System: Taxes and Health Care*, TAX POL'Y CTR. (May 2020), http://www.taxpolicycenter.org/sites/default/files/briefing-book/taxes_and_health_care_1.pdf (describing income tax exclusion for employee contributions to health insurance premiums and estimating that the exclusion from income and payroll taxes reduced government revenue by \$273 billion in 2019).

²²⁴ However, noncitizens generally are more “often employed in low-wage jobs and industries that are less likely to offer employer-sponsored coverage.” See, e.g., KAISER FAMILY FOUND., *supra* note 10. Undocumented noncitizens—who may make up approximately one quarter of the foreign-born population in the United States—are much less likely than citizens to be offered ESI. ARTIGA & DIAZ, *supra* note 11, at 3 (noting that undocumented noncitizens often work in low-wage positions that do not offer ESI); Abby Budiman, *Key Findings About U.S. Immigrants*, PEW RES. CTR.: FACT TANK (Aug. 20, 2020), <https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants> (finding twenty-three percent of immigrants in 2017 to be “unauthorized”). This may be because undocumented noncitizens lack work authorization and therefore work “off the books.”

²²⁵ KAISER FAMILY FOUND., KEY FACTS ON INDIVIDUALS ELIGIBLE FOR THE DEFERRED ACTION FOR CHILDHOOD ARRIVALS (DACA) PROGRAM 2 (2018), <http://files.kff.org/attachment/Fact-Sheet-Key-Facts-on-Individuals-Eligible-for-the-DACA-Program> (noting Medicaid and Marketplace ineligibility); *Immigrants: Immigration Status and the Marketplace*, *supra* note 66 (noting Marketplace ineligibility).

²²⁶ These include, among others, temporary agricultural and non-agricultural workers, temporary specialty occupation workers, Temporary Protected Status (TPS) recipients and applicants with employment authorization, asylum applicants with employment authorization, Deferred Enforced Departure (DED) recipients, applicants for Special Immigrant Juvenile Status, Deferred Action Status recipients (except DACA recipients), applicants for adjustment to LPR status, and LPRs, depending on their state of residence. *Immigrants: Coverage for Lawfully Present Immigrants*, *supra* note 215 (listing Medicaid-qualifying immigration statutes); *Immigrants: Immigration Status and the Marketplace*, *supra* note 66. Given that noncitizens are more likely to be low-income, they are less likely

In addition to tax exclusions for employer health benefits, the federal government may subsidize health coverage for certain noncitizens on the same terms it does for citizens, through other deductions or exclusions.²²⁷ These subsidies, while important, are unlikely to benefit the population of focus in this Article, low-income noncitizens who are excluded from Medicaid because of their immigration status, because they are designed for people for whom purchasing health insurance is an option.

C. State-Funded Programs

This Section describes state-funded programs that are intended to subsidize health coverage for noncitizens who are excluded from Medicaid and/or premium tax credits associated with health insurance purchases on the ACA Marketplaces. This group may include undocumented noncitizens, DACA recipients, and, in some cases, lawfully present noncitizens who are otherwise excluded from Medicaid. As a general rule, PRWORA maintained state discretion to expand noncitizen eligibility for state-funded public benefits. However, it created an obstacle to enacting immigrant-inclusive policy in the form of two interlocking provisions: (1) an express prohibition on most state- and locally-funded benefits for certain non-qualified noncitizens, including all undocumented noncitizens; and (2) a new requirement that states desiring to provide undocumented noncitizens with otherwise prohibited state or local benefits must authorize such provision through state law.²²⁸

Six states—California, Illinois, Massachusetts, New York, Oregon, and Washington—and Washington, D.C., have created programs to provide health coverage for all children who reside in the jurisdiction regardless of immigration status, which includes otherwise

to take up ESI even when it is offered. KAISER FAMILY FOUND., *supra* note 10 (visually depicting in Figure 5 how noncitizens are more likely to be low-income).

²²⁷ See ALISON SISKIN & ERIKA K. LUNDER, CONG. RESEARCH SERV., R43561, TREATMENT OF NONCITIZENS UNDER THE AFFORDABLE CARE ACT 5 (2016); *Tax Policy Center Briefing Book: Key Elements of the U.S. Tax System: Taxes and Health Care*, *supra* note 223, at 5–6 (discussing various subsidies besides the exclusion for employer contributions to health insurance).

²²⁸ 8 U.S.C. § 1621(a), (d) (2018). These provisions should not be read to require that a state legislature enact a statute to opt out of the prohibition on providing state and local benefits to undocumented noncitizens. Rather, “any state enactment with the force of law is [likely] sufficient to opt out of the federal prohibition.” David A. Super, Options for State and Local Governments to Aid Low-Income Immigrants 5 (May 20, 2020) (unpublished manuscript) (on file with author). For a detailed analysis of the requirements of section 1621(d), see *id.* at 3–8.

excluded noncitizen children.²²⁹ Politically, all seven jurisdictions are Democratic strongholds, and all have elected to expand Medicaid.²³⁰ Although five states—California, Florida, Texas, New York, and New Jersey—are home to more than half of undocumented noncitizens living in the United States, twenty-two states have at least one hundred thousand undocumented noncitizen residents.²³¹ Of the five states with the highest percentage of undocumented noncitizen residents,²³² only California has created a state-funded health coverage program for excluded noncitizens.²³³ Of the four states with the highest share of undocumented noncitizens in the workplace,²³⁴ again, only California is on this list.²³⁵ Using median household income as a measure of wealth, all seven jurisdictions are in the top half.²³⁶

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 income-qualifying children as special, offering comprehensive health coverage to this population.²³⁷ However, some states define that category as people under age nineteen,²³⁸ and others as under age twenty-one. Going one step further, California began covering income-qualifying

²²⁹ ERICA WILLIAMS, ERIC FIGUEROA & WESLEY THARPE, CTR. ON BUDGET & POLICY PRIORITIES, *INCLUSIVE APPROACH TO IMMIGRANTS WHO ARE UNDOCUMENTED CAN HELP FAMILIES AND STATES PROSPER* 15–16 (2019) [hereinafter CBPP REPORT], <https://www.cbpp.org/sites/default/files/atoms/files/8-21-19sfp.pdf>.

²³⁰ See Jeffrey M. Jones, *Democratic States Exceed Republican States by Four in 2018*, GALLUP (Feb. 22, 2019), <https://news.gallup.com/poll/247025/democratic-states-exceed-republican-states-four-2018.aspx> (classifying each state's political party leaning and strength of lean); *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUND. (July 27, 2020), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map>.

²³¹ CBPP REPORT, *supra* note 229, at 3.

²³² See 2010 UNAUTHORIZED IMMIGRANT POPULATION: NATIONAL AND STATE TRENDS, *supra* note 202, at 15 tbl.5 (identifying Nevada, California, Texas, New Jersey, and Arizona as the five states with the largest share of unauthorized immigrants in their population).

²³³ Bobby Allyn, *California Is 1st State to Offer Health Benefits to Adult Undocumented Immigrants*, NPR (July 10, 2019), <https://www.npr.org/2019/07/10/740147546/california-first-state-to-offer-health-benefits-to-adult-undocumented-immigrants>.

²³⁴ *U.S. Unauthorized Immigrant Population Estimates by State, 2016*, PEW RES. CTR. (Feb. 5, 2019), <https://www.pewresearch.org/hispanic/interactives/u-s-unauthorized-immigrants-by-state> (identifying Nevada, California, Texas, and New Jersey as the four states with the largest share of unauthorized immigrants in their workforce).

²³⁵ *Id.*

²³⁶ See *Historical Income Tables: Households*, U.S. CENSUS BUREAU, tbl.H-8 (Sept. 8, 2020), <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-income-households.html> (setting out data in current dollars).

²³⁷ See MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, *supra* note 29, at 1–5.

²³⁸ See, e.g., *About All Kids*, ILL. DEP'T HEALTHCARE & FAM. SERVS., <https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/about.aspx> (last visited July 18, 2020).

young adults ages nineteen to twenty-six in 2020.²³⁹ Health and immigration advocates, along with California Governor Gavin Newsom, see this expansion as an incremental step towards universal coverage of California residents.²⁴⁰

The upper range of income eligibility for state programs varies considerably, as do policies relating to cost sharing by enrollees. For example, New York's Child Health Plus program is available to all children regardless of immigration status or income.²⁴¹ There is no cost sharing for households with income up to 160% FPL, and households with income up to 400% FPL have to pay a subsidized monthly premium on an income-based sliding scale ranging from \$9 to \$60 per child.²⁴² Households with income at 400% FPL and above can still receive coverage through the program at full cost.²⁴³ By contrast, Washington's Apple Health for Kids has an income limit of 317% FPL.²⁴⁴ There is no cost sharing for households with income up to 215% FPL.²⁴⁵ For households with an income between 215% FPL and 265% FPL, the monthly premium is \$20 per child with a \$40 family

²³⁹ See S.B. 104, 2019-20 Reg. Sess., ch. 67 § 3 (Cal. 2019); see also Press Release, California Dept't of Healthcare Servs., DHCS Expands Medi-Cal Young-Adult Eligibility, Restores Benefits, Adds Childhood-Trauma Screening in 2020 (Dec. 30, 2019), <http://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2019/19-03-DHCS-EXPANDS-YOUNG-ADULT-ELIGIBILITY.pdf> (explaining that the coverage extension was designed to mimic the ACA provision that permits young adults up to age twenty-six to be covered by their parents' private health insurance).

²⁴⁰ Sammy Caiola, *Regardless of Immigration Status, All Low-Income Californians Up to Age 26 Can Now Sign Up for Medi-Cal*, CAPRADIO (Jan. 6, 2020), <https://www.capradio.org/articles/2020/01/06/regardless-of-immigration-status-all-low-income-californians-up-to-age-26-can-now-sign-up-for-medi-cal>; Sammy Caiola, *Young Undocumented Californians Cheer Promise of Health Benefits*, NPR: SHOTS (July 11, 2019, 2:48 PM) [hereinafter Caiola, *Promise of Health Benefits*] <https://www.npr.org/sections/health-shots/2019/07/11/739536305/young-undocumented-californians-cheer-promise-of-health-benefits>.

²⁴¹ *Child Health Plus*, N.Y.C. OFF. OF CITYWIDE HEALTH INS. ACCESS, <https://www1.nyc.gov/site/ochia/coverage-care/child-health-plus.page> (last visited Aug. 3, 2020).

²⁴² N.Y.C. OFFICE OF CITYWIDE HEALTH INS. ACCESS, *CHILD HEALTH PLUS YEARLY INCOME ELIGIBILITY AND MONTHLY PREMIUMS* (2020), https://www1.nyc.gov/assets/ochia/downloads/pdf/child_health_plus.pdf. At each income level, there is a maximum monthly premium for a household regardless of the number of children. For example, for households with income from 160–222% FPL, the maximum monthly premium is \$27 per month, while it is \$180 per month for a family with household income between 350–400% FPL. *Id.*

²⁴³ *Id.*

²⁴⁴ *Health Care Services and Supports – Children*, WASH. ST. HEALTH AUTHORITY, <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/children> (last visited Aug. 19, 2020); see also Federal Poverty Level (FPL), HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/federal-poverty-level-fpl> (last visited Aug. 19, 2020).

²⁴⁵ *Health Care Services and Supports – Children*, *supra* note 244.

maximum.²⁴⁶ For other households, the monthly premium is \$30 per child with a \$60 family maximum.²⁴⁷

Another way in which it appears states and the District of Columbia have sought to reduce costs is to limit adult eligibility for programs based on the type of medical service needed. The DC Healthcare Alliance, a locally funded program in Washington, D.C., covers basic primary and secondary services.²⁴⁸ The program does not cover 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 \$1000.²⁴⁹ New York, California, Illinois, and Oregon all use state funds to cover prenatal care for residents, regardless of citizenship or immigration status.²⁵⁰ Massachusetts provides comprehensive coverage for pregnant residents with an income up to 200% FPL.²⁵¹ Illinois's program also covers kidney transplants for people with end-stage renal disease,²⁵² while California's program also covers long-term care,²⁵³ dialysis,²⁵⁴ anti-rejection medication for organ transplant recipients,²⁵⁵ and breast and cervical cancer treatment.²⁵⁶ It appears that these coverage limitations are a mechanism for states to conserve costs—in some cases, by excluding coverage of elective or expensive services; in others, by choosing to cover cost-effective services.

It is clear that there is no template for state-funded programs covering excluded noncitizens. Given the unique fiscal environment and demographic composition of each state, along with the common fiscal

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ See *Health Care Alliance*, DC.GOV, <https://dhcf.dc.gov/service/health-care-alliance> (last visited Aug. 31, 2020).

²⁴⁹ *Id.*

²⁵⁰ MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, *supra* note 29, at 1–2, 4.

²⁵¹ *Id.* at 3.

²⁵² See Ansell et al., *supra* note 120, at 782, 785.

²⁵³ CAL. WELF. & INST. CODE §§ 14007.2, 14007.65 (West 2018).

²⁵⁴ See Eilis O'Neill, 'It's a Terrible Existence': The Crisis of Emergency Dialysis Care for Undocumented Immigrants, NATION (July 8, 2019), <https://www.thenation.com/article/archive/dialysis-health-immigration> (noting that California "decided to define kidney failure as a 'permanent emergency' covered by Medicaid, allowing all patients to qualify for regular dialysis, paid for by state taxpayers").

²⁵⁵ See WELF. & INST. § 14132.70; Letter No. 11-02 from Toby Douglas, Director, Cal. Dep't of Health Care Servs., to All County Welfare Directors, All County Administrative Officers, All County Medi-Cal Program Specialists/Liaisons, All County Health Executives, All County Mental Health Directors, at 2 (Feb. 1, 2011), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c11-02.pdf>.

²⁵⁶ See CAL. HEALTH & SAFETY CODE §§ 104161-104163 (discussing California's state-funded Breast and Cervical Cancer Treatment Program).

constraint of a lack of federal funding, true experimentation in programs covering excluded noncitizens at the state level has been thwarted. Likewise, no clear lessons have emerged from the last two-and-a-half decades of state policymaking on publicly funded health coverage for noncitizens in general. States that want to expand coverage for health policy reasons are forced to ration limited resources, experimenting with ever-narrower categories of eligibility. This patchwork of state policies on coverage and exclusion of noncitizens means that for low-income noncitizens, the only certainty is that access to healthcare is uncertain. What is inevitable, however, is the patchwork's link with undesirable policy outcomes.

II

PROBLEMS WITH THE EXISTING PATCHWORK OF EXCLUSION

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. Undocumented noncitizens live in every state.²⁵⁷ Demographic trends indicate that certain states with historically low numbers of undocumented noncitizens have become top destinations over the past decade, and other states that were previously top destinations have become less attractive.²⁵⁸ Shifts in immigration policy and labor needs have an impact on where undocumented noncitizens settle, and settlement patterns are likely to change over time.²⁵⁹

This Part provides a lens through which to understand how states have exercised their options to restrict noncitizen eligibility for pub-

²⁵⁷ 2010 UNAUTHORIZED IMMIGRANT POPULATION: NATIONAL AND STATE TRENDS, *supra* note 202, at 15. It is also true that only a few states are home to the largest concentrations of undocumented noncitizens. *Id.*

²⁵⁸ *Id.* (describing Georgia and North Carolina as new destination states); *id.* at 2 (noting a decline in the population of undocumented immigrants in Colorado, Florida, New York, and Virginia).

²⁵⁹ *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.”); *cf.* Rob Paral et al., *Growing the Heartland: How Immigrants Offset Population Decline and an Aging Workforce in Midwest Metropolitan Areas*, CHI. COUNCIL ON GLOBAL AFF. (June 2014), http://www.thechicagocouncil.org/sites/default/files/GrowingHeartland_June2014.pdf (noting that “[i]mmigrants play a key role in the Midwest economy because the Midwest’s Baby Boomers are moving into retirement and the native-born population as a whole is aging,” whereas “[i]mmigrants are predominantly young adults, and they help to fill precisely [these declining] age groups,” and asserting that “thousands of immigrants from around the globe choose the Midwest as the place they want to live”).

lily funded coverage in a way that weakens national health policy. It closes by examining the particularly salient, distortive role that racism plays in skewing health policy away from its normative goals.

A. Goals Versus Drivers of Health Policy

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 noncitizen eligibility for public benefits. In the current arrangement, states can make policies on eligibility for Medicaid along a spectrum from universally inclusive to nearly exclusive of noncitizens.²⁶⁰

Aside from state adoptions of the federal ICHIA and unborn child options, state policies relating to noncitizen access to health coverage have stagnated instead of responding to demographic changes since 1996. Most states have failed to use health policy changes to acknowledge the robust evidence indicating that inclusive approaches can improve population health outcomes and community well-being, reduce healthcare inequity, and benefit state and local economies in the long term.²⁶¹ Very few states have engaged in serious efforts to address the health coverage needs of undocumented noncitizens.²⁶² Predictably, the few states that have elected to use state funds to expand coverage to undocumented noncitizens tend to fall on the progressive end of the political spectrum.²⁶³ 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.²⁶⁴ A larger number—and a more politically diverse collection—of states have chosen to take advantage of federal matching funds by electing options to expand Medicaid or CHIP to lawfully residing but excluded noncitizens.²⁶⁵ As

²⁶⁰ See *supra* notes 134–70 and accompanying text.

²⁶¹ See CBPP REPORT, *supra* note 229, at 2 (describing the benefits of expanding health coverage to all children regardless of immigration status); Glen, *supra* note 46, at 221–24 (discussing the system-wide cost savings that could be achieved by extending health coverage to unauthorized immigrants). Regarding state health policy's effect on increasing healthcare inequity between citizens and noncitizens, one study found that restrictive alienage criteria in Medicaid had the biggest effect in states with the lowest levels of immigrant population density. Ling Zhu & Ping Xu, *The Politics of Welfare Exclusion: Immigration and Disparity in Medicaid Coverage*, 43 POL'Y STUD. J. 456, 457–58 (2015).

²⁶² See *supra* Section I.C.

²⁶³ These states are California, Illinois, Massachusetts, New York, Oregon, and Washington, as well as the District of Columbia. CBPP REPORT, *supra* note 229, at 15–16.

²⁶⁴ Parmet, *supra* note 6, at 234–35.

²⁶⁵ See discussion *supra* Sections I.B.3, I.B.4.

described in Section I.B, even some states that would stand to benefit in terms of population health and net resource maximization by expanding coverage for noncitizens have chosen not to do so.

State decisions to restrict or expand eligibility for Medicaid are influenced by several possible factors.²⁶⁶ Ideological polarization undoubtedly plays an important role.²⁶⁷ Researchers have also found that states' economic circumstances, previous policy trajectories, and institutional capacity to implement health policy can affect their decisions to expand Medicaid.²⁶⁸ In some states, political actors and the electorate may favor restrictions on noncitizen eligibility that are based on racism,²⁶⁹ nativism,²⁷⁰ and xenophobia.²⁷¹ In others, economic or sovereignty-related concerns may be the dominant motivation for restrictive policy relating to noncitizens. Nevertheless, health policies that exclude noncitizens based on the latter concerns are just as effective in impeding the advancement of health policy as those based on the former.²⁷²

Even if one were to assume that states are well-motivated to advance health policy, there is considerable debate among academics and policymakers over what makes "good" health policy.²⁷³ In the decade since the passage of the ACA, however, certain frameworks have influenced academic and high-level political discussions of the goals of the U.S. health system. The Triple Aim framework, created by the Institute for Healthcare Improvement (IHI), was designed to guide improvement efforts at the level of the healthcare organization, but it has been adapted for and integrated into national health-system

²⁶⁶ Jacobs & Callaghan, *supra* note 180.

²⁶⁷ See Meyer-Gutbrod, *supra* note 206 (describing how national partisanship interacts with state politics to influence states' decisions to expand Medicaid); Jacobs & Callaghan, *supra* note 180, at 1031 (describing how the "bubbling cauldron of party vitriol" in which the ACA was born spilled over into state implementation decisions).

²⁶⁸ Jacobs & Callaghan, *supra* note 180, at 1031, 1033–40.

²⁶⁹ See Michener, *supra* note 206, at 551 (describing the racialized motivations of some states' decisions to not expand Medicaid under the ACA and the disproportionate impact on people of color).

²⁷⁰ Nativism is defined as "the preference for native-born people of a given society." Lilia Fernandez, *Nativism and Xenophobia*, in *THE ENCYCLOPEDIA OF GLOBAL HUMAN MIGRATION* 1, 1 (Immanuel Ness ed., 2013).

²⁷¹ Xenophobia is defined as "the fear of foreigners or 'others' considered to be outsiders based on racial, ethnic, or national origin or religion." *Id.*

²⁷² See *id.* (describing how "purportedly economic concerns" can mask nativist and xenophobic policy); *id.* at 5 (describing how objections to illegal immigration are racially charged because of the overrepresentation of certain ethnic or national origin groups among the undocumented).

²⁷³ See Norman Daniels, *The Ethics of Health Reform: Why We Should Care About Who Is Missing Coverage*, 44 *CONN. L. REV.* 1057, 1064 (2012) (counseling that any discussion of how to allocate healthcare resources will involve reasonable disagreement based on differing values).

policy in the United States and other countries.²⁷⁴ The Triple Aim is the simultaneous pursuit of “improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.”²⁷⁵ More pithily, the Triple Aim is “better care, better health, lower cost.”²⁷⁶

Two common adaptations of the Triple Aim for national health-system policy are to replace the aim of “lower cost” with “better value” and include an additional aim of health equity.²⁷⁷ The first adaptation reflects the understanding that while reducing overall costs may be a worthwhile aim at the level of the healthcare provider, at the national-health-system level, a plateau or even an increase in expenditures may be justified by improved health outcomes.²⁷⁸ To achieve

²⁷⁴ Gustavo Mery, Shilpi Majumder, Adalsteinn Brown & Mark J. Dobrow, *What Do We Mean When We Talk About the Triple Aim? A Systematic Review of Evolving Definitions and Adaptations of the Framework at the Health System Level*, 121 HEALTH POL’Y 629, 629–30 (2017) (“Despite numerous references by [IHI] about the implications of pursuing the Triple Aim for the healthcare system, the framework was proposed as the strategic organizing principle to guide improvement initiatives at the organization or local community level.”); John W. Whittington, Kevin Nolan, Ninon Lewis & Trissa Torres, *Pursuing the Triple Aim: The First 7 Years*, 93 MILBANK Q. 263, 297 (2015) (“The concept of the Triple Aim is now widely used, both in the United States, where it has become a national model for implementing health care, and around the world.”). The Triple Aim was incorporated into the U.S. National Quality Strategy. See *About the National Quality Strategy*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://www.ahrq.gov/workingforquality/about/index.html> (last updated Mar. 2017) (describing the Strategy as building on the IHI’s Triple Aim); Maria Castellucci, *Quality Experts Call for HHS to Revive the National Quality Strategy 10 Years After ACA*, MOD. HEALTHCARE (Mar. 9, 2020, 1:00 AM), <https://www.modernhealthcare.com/safety-quality/quality-experts-call-hhs-revive-national-quality-strategy-10-years-after-aca> (stating that the “Strategy’s main objective was to achieve the Triple Aim: better care, healthier communities and lower costs”). The National Strategy has three similar aims: better care, healthy people/healthy communities, and affordable care. *About the National Quality Strategy*, *supra*; see also Mery et al., *supra*, at 634 (noting the similarity between the National Strategy and the Triple Aim and summarizing its goal as “to provide better, more affordable care for individuals and the community”). However, the Triple Aim’s creators made clear that it does not necessarily address all of the goals of a national healthcare system. *Id.* at 630.

²⁷⁵ Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 760 (2008).

²⁷⁶ Donald M. Berwick, *And We Said, “No.” in PROMISING CARE: HOW WE CAN RESCUE HEALTH CARE BY IMPROVING IT* 249, 262 (2013).

²⁷⁷ Mery et al., *supra* note 274, at 633. *But see id.* (noting that “replacing [‘lower cost’] with ‘better value’ presents a problematic redundancy in the framework” because “[t]he Triple Aim is inherently a ‘value’ framework”).

²⁷⁸ See, e.g., Elizabeth H. Bradley & Amanda Brewster, *Untangling the Relationship Between Social Service and Health Care Spending and Health Outcomes*, HEALTH AFF.: BLOG (Nov. 18, 2019), https://www.healthaffairs.org/doi/10.1377/hblog20191112.848045/full/?utm_source=newsletter&utm_medium=email&utm_content=COVID-19%3A+Prenatal+Care+And=Delivery%2C+Pricing+Vaccines+And+Therapeutics%3B+Improving+Birth+Outcomes+And+Lowering+Costs+For+Women+On+Medicaid&utm_campaign=HAT+6-23-20 (suggesting that increased investment in social services may improve health outcomes but will not necessarily lead to a reduction in overall healthcare costs).

better value in a national health system is to become more cost-effective from a societal perspective.²⁷⁹ This means “achieving the best outcome at the lowest cost.”²⁸⁰ When all three aims are pursued simultaneously, the Triple Aim can itself be understood as a proxy for cost-effectiveness: the value of a particular reform is measured by its benefits of better health and better care divided by its cost.²⁸¹

Regarding the second adaptation, health equity may be defined as a state in which “everyone . . . [has] a *fair opportunity* to attain their full health potential.”²⁸² It requires eliminating health inequities, which are “differences in health that are not only unnecessary and avoidable, but in addition, are considered unfair and unjust.”²⁸³ A related concept, healthcare equity, calls for the elimination of barriers to healthcare access that cause or exacerbate health inequities.²⁸⁴ Healthcare equity may be defined as “equal access to available care for equal need, equal utilization for equal need, equal quality of care for all.”²⁸⁵ Equity in access to high-quality healthcare is essential to achieving health equity.²⁸⁶

These definitions make it clear that equity is a matter of ethics and values.²⁸⁷ Although the concept of equity is related to equality, it is not identical.²⁸⁸ Healthcare equity does not necessarily require that every person has equally unfettered access to healthcare for every health-related need.²⁸⁹ Rather, it “requires that patients who are alike in relevant respects be treated in like fashion and that patients who

²⁷⁹ See, e.g., Joel Tsevat & Christopher Moriates, *Value-Based Health Care Meets Cost-Effectiveness Analysis*, 169 ANNALS INTERNAL MED. 329, 329 (2018) (explaining that cost-effective analysis “considers costs and benefits from the societal or healthcare sector perspective” in order to assess value).

²⁸⁰ Kevin Fiscella, *Confronting the Post-ACA American Health Crisis: Designing Health Care for Value and Equity*, 42 J. AMBULATORY CARE MGMT. 202, 204 (2019).

²⁸¹ Mery et al., *supra* note 274, at 633.

²⁸² Margaret Whitehead, *The Concepts and Principles of Equity and Health*, 22 INT’L J. HEALTH SERVS. 429, 433 (1992).

²⁸³ *Id.*

²⁸⁴ *Id.* at 434–36.

²⁸⁵ *Id.* at 434. This definition aligns with the healthcare 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 Makhlof, *supra* note 49, at 295–97 (discussing healthcare professionals’ ethical obligations to noncitizens guided by the principle of need).

²⁸⁶ Geoffrey W. Wilkinson et al., *No Equity, No Triple Aim: Strategic Proposals to Advance Health Equity in a Volatile Policy Environment*, 107 AM. J. PUB. HEALTH S223, S223–24 (2017) (“To achieve health equity and improve the overall health of the population, it is necessary to . . . ensure medical security to all US residents through universal access to affordable, high-quality health care.”).

²⁸⁷ Culyer, *supra* note 22, at 275.

²⁸⁸ *Id.* at 276.

²⁸⁹ *Id.* at 280.

are unlike in relevant respects be treated *in appropriately* unlike fashion.”²⁹⁰ These are the concepts, described earlier, of horizontal and vertical equity. If there is a relevant characteristic that makes unlike treatment of two people appropriate, such treatment may be considered equitable.²⁹¹ Since healthcare equity is considered pluralist—or informed by many, sometimes overlapping values—a determination of what is equitable must balance these elements and minimize or reject those that contradict strongly held principles.²⁹²

Several scholars have identified equity as an implicit element of the Triple Aim,²⁹³ and in 2016, the IHI described equity as “not a fourth aim, but rather an element of all three components of the Triple Aim.”²⁹⁴ In other words, pursuing health equity reinforces the aims of improving health, cost-effectiveness, and quality. Because access to healthcare is an important determinant of health, and health coverage is the means of ensuring financial access to healthcare, it follows that pursuing healthcare equity also reinforces the Triple Aim.

Based on the principles that guided the last health reform and that are still used by federal healthcare agencies,²⁹⁵ I identify two overarching goals of national health reform in the post-ACA era: equity and cost-effectiveness.²⁹⁶ These goals should influence decisions about noncitizen eligibility for publicly funded health coverage in a universal system, regardless of the financing structure that is adopted. Cost-effectiveness as a principle of national health policy asks if the benefits of a particular reform are worth the cost. The question reveals that cost-effectiveness, like other principles that purport to be objective (such as “efficiency” or “utility maximization”), in fact

²⁹⁰ *Id.* at 276.

²⁹¹ *Id.*

²⁹² *Id.*

²⁹³ See, e.g., Fiscella, *supra* note 280, at 204 (“Equity is presumed but not explicitly called out.”); Mery et al., *supra* note 274, at 634 (“[I]t can be argued that the aim of ‘equity’ may be implicit in the Triple Aim’s ‘better population health’”); Wilkinson et al., *supra* note 286, at S224 (“Ultimately, population health goals cannot be achieved without a focus on equity.”); *id.* at S227 (describing health equity as “the guiding framework for achieving the Triple Aim”).

²⁹⁴ RONALD WYATT, MARA LADERMAN, LAURA BOTWINICK, KEDAR MATE & JOHN WHITTINGTON, INST. FOR HEALTHCARE IMPROVEMENT, *ACHIEVING HEALTH EQUITY: A GUIDE FOR HEALTH CARE ORGANIZATIONS* 5 (2016).

²⁹⁵ See Castellucci, *supra* note 274 (indicating that the priorities of the National Quality Strategy still guide the work of both AHRQ and CMS, as well as the healthcare industry as a whole).

²⁹⁶ Fiscella proposes a similar Dual Aim of “value (outcomes and processes desired by patients relative to costs) and equity (optimal outcomes and process regardless of disadvantaged status).” Fiscella, *supra* note 280, at 204.

rests on value judgments.²⁹⁷ What counts as cost-effective depends on what one values.²⁹⁸ This is where equity comes in, and where the next Section begins: equity supplies the baseline for determining what counts as cost-effective.²⁹⁹

B. Equity

A growing number of health law scholars now identify equity as the normative foundation of health law scholarship and healthcare regulation.³⁰⁰ Professor Lindsay F. Wiley's Health Justice model is a conceptual framework for understanding these changes and has generated a significant body of scholarship.³⁰¹ 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.³⁰²

²⁹⁷ See Neil H. Buchanan & Michael C. Dorf, *A Tale of Two Formalisms: How Law and Economics Mirrors Originalism and Textualism*, 106 CORNELL L. REV. (forthcoming 2020) (manuscript at 5) (“[T]he very idea of efficiency is empty without a highly contestable set of value judgments.”); Guido Calabresi, *An Exchange About Law and Economics: A Letter to Ronald Dworkin*, 8 HOFSTRA L. REV. 553, 558–59 (1980) (discussing wealth maximization in light of other values such as wealth distribution and justice); Jules L. Coleman, *Efficiency, Utility, and Wealth Maximization*, 8 HOFSTRA L. REV. 509, 510–12 (questioning the value of the wealth maximization principle both in general and in legal theory).

²⁹⁸ See Buchanan & Dorf, *supra* note 297 (manuscript at 14) (“[W]here one starts as a baseline determines what counts as efficient and inefficient.”).

²⁹⁹ With this framing, I am attempting to avoid engaging in what Buchanan and Dorf term “the equity/efficiency debate,” in which scholars on both sides tacitly accept the coherence and objectivity of the term “efficiency.” *Id.* (manuscript at 9). In the health systems literature, efficiency and cost-effectiveness are closely related concepts. See Ranjeeta Thomas & Kalipso Chalkidou, *Cost-Effectiveness Analysis*, in HEALTH SYSTEM EFFICIENCY: HOW TO MAKE MEASUREMENT MATTER FOR POLICY AND MANAGEMENT 115 (Jonathan Cylus et al. eds., 2016) (discussing the use of cost-effectiveness analysis to achieve health-system efficiency). I do not argue that concern for equity should outweigh concern for efficiency, but that concern for equity should inform our understanding of efficiency.

³⁰⁰ See *supra* note 21 and accompanying text.

³⁰¹ Wiley, *supra* note 21; see, e.g., ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, *ESSENTIALS OF HEALTH JUSTICE: A PRIMER*, at x (2019) (contextualizing the concept of health justice in the United States); Makhlof, *supra* note 49, at 285 (explaining how the Health Justice model is grounded in a communitarian conception of social justice); Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 277–78 (2015); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 838 (2016) [hereinafter Wiley, *Patient Rights*] (describing how a new health justice model could transform healthcare); Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191 (2016) [hereinafter Wiley, *Applying the Health Justice Framework to Diabetes*].

³⁰² Wiley, *Patient Rights*, *supra* note 301, at 859.

A society's willingness to tolerate health and healthcare inequities will depend to some extent on its time- and context-bound judgment of what is unfair.³⁰³ As a result, the strength of the health equity norm's influence on health policy is also time- and context-bound. Post-ACA, a growing number of Americans recognize the benefits of a collective approach, facilitated by the government, to meet healthcare needs.³⁰⁴

Equity in healthcare is the principle behind efforts to achieve universal health coverage.³⁰⁵ This is evident from health reform's overwhelming focus on regulation of health insurance, "the financial and pragmatic point of access to care for most people."³⁰⁶ The goal of the ACA was to make access to healthcare more equitable by expanding eligibility for Medicaid and by creating new programs to reach a larger portion of the nation's uninsured.³⁰⁷ With respect to the Medicaid expansion, Congress attempted to mandate that state Medicaid programs add a category of eligibility for people who were not traditionally considered "deserving poor."³⁰⁸ Previously, Medicaid was available to low-income children, pregnant women, caretakers of dependent children, and people with disabilities.³⁰⁹ The ACA expanded Medicaid to include non-elderly, non-pregnant adults with income up to 138% of the FPL.³¹⁰

³⁰³ Whitehead, *supra* note 282, at 433; Culyer, *supra* note 22, at 275 ("[A]ny idea of 'equity' must embody value judgments about what it is that makes for a good society.").

³⁰⁴ *Healthcare System*, GALLUP HISTORICAL TRENDS, <https://news.gallup.com/poll/4708/healthcare-system.aspx> (last visited July 26, 2020) (indicating that 42% of respondents preferred a government-run healthcare system in November 2019, compared with 34% of respondents with the same preference in November 2010).

³⁰⁵ See Daniels, *supra* note 273, at 1058 (stating that the focus of the ACA was the question "[w]hy should we care about who is missing coverage?").

³⁰⁶ McCuskey, *supra* note 21, at 312. While financial access to healthcare is necessary to ensure equity in healthcare, it is insufficient alone. See, e.g., Whitehead, *supra* note 282, at 440 (stating that equity in healthcare "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"). Other barriers to access and overall quality of care must also be addressed. See *id.* at 436–37 (noting that "[b]ecause 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" and suggesting that "[t]his is potentially a more efficient approach than relying solely on the healthcare sector to patch up the ill-health and disability such inequities create").

³⁰⁷ Jacobs & Callaghan, *supra* note 180, at 1024.

³⁰⁸ Patient Protection and Affordable Care Act (ACA) § 2001(a)(1)(C) (2010); 42 U.S.C. § 1396a(a)(10)(i)(VIII).

³⁰⁹ 42 U.S.C. § 1396d(a).

³¹⁰ The pre-ACA eligibility categories remain as the statutorily mandated categories that determine the financial criteria for eligibility—i.e., individuals with income up to 138% of the FPL floor. For example, the minimum income threshold for the category of "pregnant women" ranges, depending on the state, from 133% to 185% of the FPL.

Millions of people living in the United States gained access to health insurance by qualifying for the Medicaid expansion category, which does not depend on notions of “deservingness” that are unrelated to financial need. 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.³¹¹ However, as discussed *supra*, the Supreme Court’s decision in *NFIB v. Sebelius* hindered this goal by making Medicaid expansion optional for states.³¹² Because some states have chosen not to expand 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).³¹³ 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 not to expand Medicaid.³¹⁴ Therefore, the ACA’s aim of ensuring equitable access to health coverage for low-income citizens and eligible noncitizens is still incomplete.

Similarly, because the ACA did not modify the federal framework governing noncitizen eligibility for Medicaid,³¹⁵ states continue to wield broad authority to craft alienage restrictions, producing horizontal inequity in access to health coverage for low-income non-

MEDICAID & CHIP PAYMENT & ACCESS COMM’N, FEDERAL REQUIREMENTS AND STATE OPTIONS: ELIGIBILITY 5 tbl.1, 14 n.2 (2017), <http://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf>.

³¹¹ See, e.g., Allison K. Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 1481, 1483 (2014) (“[The ACA] attempted to ensure that Americans would have adequate health insurance, in part to reduce these threats to financial security.”); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL’Y, & L. 287, 290 (1993) (“The politics of health insurance can only be understood as a struggle over the meaning of sickness and whether it should be a condition that automatically generates mutual assistance.”).

³¹² Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

³¹³ Historically, federal legislation and policymaking have served as the driving force behind equity reforms in healthcare. See McCuskey, *supra* note 21, at 311–12 (citing DAWES, *supra* note 21, at 10–90). Only a few states have dabbled in cutting-edge policymaking to promote health equity. See *id.* at 312 (noting few states use health insurance regulation to promote health equity). This pattern aligns with the historical trends in other equity-based reforms, such as the civil rights movement. See Heather K. Gerken, *Federalism 3.0*, 105 CALIF. L. REV. 1695, 1708–09 (2017) (describing how the Civil Rights Era shaped federalism theory’s assumptions about the roles of states and localities versus the federal government); *id.* at 1709 (“It is precisely to combat the evils of decentralization that equality scholars emphasize the need for nationally enforced constitutional rights in the first place.”).

³¹⁴ See Tiffany D. Joseph, *Still Left Out: Healthcare Stratification Under the Affordable Care Act*, 43 J. ETHNIC & MIGRATION STUD. 2089, 2096 (2017).

³¹⁵ See Daniels, *supra* note 273, at 1065–66 (questioning whether it was fair for the ACA to “leave[] out many immigrants and undocumented individuals”).

citizens and vertical inequity between noncitizens and citizens.³¹⁶ Horizontal inequity occurs among noncitizens when noncitizen residents of different states with the same medical needs do not have the same access to health coverage. Vertical inequity occurs when noncitizen residents with great healthcare needs have less access than citizens with lesser needs.³¹⁷ On account of this arrangement, each state has a unique set of alienage restrictions for the unique set of programs it offers.

As an illustration of horizontal inequity among noncitizens, consider the difference between the types of noncitizens who fall within the category of excluded noncitizens in Texas versus in California—i.e., those who do not qualify for Medicaid or a comparable state-funded program.

TABLE 2. NONCITIZEN ELIGIBILITY FOR MEDICAID OR COMPARABLE STATE-FUNDED COVERAGE IN CALIFORNIA AND TEXAS

	California	Texas ³¹⁸
Ineligible	Undocumented immigrants over 26 years of age. ³¹⁹ Nonimmigrant visa holders age 21 and over who are not pregnant and not considered to be permanently residing in the U.S. under color of law (PRUCOL). ³²⁰ Examples may include noncitizens with tourist visas and student visas.	Everyone not listed in the box below.

³¹⁶ States’ decisions to restrict noncitizen eligibility for Medicaid under PRWORA entrenched healthcare inequities between citizens and noncitizens. A notable exception is Massachusetts, which has provided some form of subsidized health coverage to all noncitizen residents since it reformed its state healthcare in 2006. *See* Joseph, *supra* note 314, at 2097–98. By leaving states in charge of policymaking on noncitizen access to publicly funded health coverage, the ACA further entrenched the existing healthcare inequities.

³¹⁷ *See, e.g.,* Culyer, *supra* note 22, at 276–77 (defining horizontal and vertical equity in general terms and in relation to health, healthcare needs, and financial contributions to healthcare); Starfield, *supra* note 24, at 1 (summarizing the concept of equity in access to healthcare resources, including its horizontal and vertical dimensions).

³¹⁸ *Texas Works Handbook: A-300, Citizenship: A-342 TANF and Medical Programs Alien Status Eligibility Charts: Chart C, supra* note 114.

³¹⁹ S. 104, 2019-20 Reg. Sess. § 3 (Cal. 2019).

³²⁰ PRUCOL noncitizens are eligible for Medi-Cal, California’s Medicaid program. CAL. CODE REGS. tit. 22, § 50301 (2020). For an explanation of the term “PRUCOL,” see discussion *supra* Section I.A.

Eligible	Everyone not listed in the box above.	Noncitizens who received SSI, Medicaid, or both on August 22, 1996, and lawfully resided in the United States on or before that date; LPRs with 40 or more qualifying work quarters or a military connection; Certain humanitarian immigrants; Non-citizen cross-border American Indians; and Lawfully residing children ages 18 and under.
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As an illustration of vertical inequity between low-income citizens and noncitizens—and an example of the distinctive health harms that uninsured noncitizens face—consider the following scenario: Jasmine is a 36-year-old DACA recipient whose parents brought her to live in the United States when she was one year old. She works as a caregiver for a family with four children. Approximately one year ago, Jasmine began feeling pain in her side and rapidly losing weight.³²¹ She delayed seeking care due to the expense. She does not have health insurance and is ineligible for Medicaid because DACA recipients are beyond the ceiling of federally-funded Medicaid coverage and she does not live in a state that funds coverage for noncitizens who are excluded from Medicaid.³²² When the pain became debilitating, Jasmine sought care at an FQHC, but the next available appointment was several months later. After her examination, Jasmine learned that she has Stage 4 renal cell carcinoma—a rare and terminal diagnosis because this condition is typically detected at an earlier stage.³²³ This scenario is certainly tragic, but it would be considered inequitable only if it is deemed unfair to treat Jasmine—a long-residing noncitizen—differently from a citizen with regard to Medicaid eligibility.

Alienage restrictions in public benefits laws use citizenship as a proxy for community membership. The goal of healthcare equity is the equitable distribution of health in the community (however that community is defined).³²⁴ Health enables members of the community

³²¹ This scenario draws on the clinical profile of a patient described in a narrative by physician Cheryl Bettigole. Cheryl Bettigole, *An Uninsured Immigrant Delays Needed Care*, 34 HEALTH AFF. 2192, 2192 (2015) (detailing a physician's first-hand experience with an uninsured immigrant who avoided care).

³²² See KAISER FAMILY FOUND., *supra* note 225 (noting that DACA recipients are ineligible for Medicaid); *supra* Section I.C.

³²³ Bettigole, *supra* note 321, at 2193 (“Stage 4 renal cell carcinoma is a diagnosis I’ve never seen before or since.”).

³²⁴ See Culyer, *supra* note 22, at 276 (noting equity in healthcare necessitates similar patients be treated in a similar fashion).

to flourish; therefore, the subjects of healthcare equity are those who the community believes have an equal right to flourish.³²⁵

In a prior Article, I argued that noncitizens' interests should be considered in health law and policy efforts to improve health and healthcare equity. Drawing on the Health Justice model's foundation in the social philosophy of responsive communitarianism, I identified broadly shared norms about the embeddedness of noncitizens in the healthcare sphere and in the broader community.³²⁶ For example, they 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 paying taxes and supporting local and state economies.³²⁷ They play important roles in the healthcare and caregiving workforces.³²⁸ I also demonstrated how ethical norms within healthcare—namely, the principle of need and the concept of mutual aid—support inclusion of noncitizens in publicly funded healthcare programs.³²⁹

The patchwork of noncitizen exclusion from Medicaid, which is enabled by PRWORA's alienage restrictions, weakens national health policy by running counter to the larger trend of embracing health equity as the normative foundation of health policy. Alienage is a crude and imperfect proxy for community membership, which is what matters when it comes to health and healthcare equity. Therefore, any examination of social equity should consider the relative position of

³²⁵ *Id.* at 276.

³²⁶ Makhoulouf, *supra* note 49, at 287–95.

³²⁷ See, e.g., Gretchen Frazee, *4 Myths About How Immigrants Affect the U.S. Economy*, PBS (Nov. 2, 2018, 6:48 PM), <https://www.pbs.org/newshour/economy/making-sense/4-myths-about-how-immigrants-affect-the-u-s-economy>.

³²⁸ See, e.g., Jeanne Batalova, *Immigrant Health-Care Workers in the United States in 2018*, MIGRATION POL'Y INST. (May 14, 2020), <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states>. The COVID-19 pandemic has drawn attention to the importance of the immigrant healthcare workforce in the United States as well as how immigration policy can create barriers to deploying this workforce effectively. See, e.g., Silva Mathema, *Removing Barriers for Immigrant Medical Professionals Is Critical to Help Fight Coronavirus*, CTR. FOR AM. PROGRESS (Apr. 2, 2020, 10:38 AM), <https://www.americanprogress.org/issues/immigration/news/2020/04/02/482574/removing-barriers-immigrant-medical-professionals-critical-help-fight-coronavirus> (highlighting federal immigration barriers and state medical licensing barriers for noncitizen healthcare providers); Miriam Jordan & Annie Correal, *Foreign Doctors Could Help Fight Coronavirus. But U.S. Blocks Many.*, N.Y. TIMES (Apr. 13, 2020), <https://www.nytimes.com/2020/04/13/us/coronavirus-foreign-doctors-nurses-visas.html> (same); Adam Liptak, *'Dreamers' Tell Supreme Court Ending DACA During Pandemic Would Be 'Catastrophic.'* N.Y. TIMES (Mar. 27, 2020), <https://www.nytimes.com/2020/03/27/us/dreamers-supreme-court-daca.html> (warning of the public health threat of ending DACA during the pandemic).

³²⁹ Makhoulouf, *supra* note 49, at 295–99.

noncitizens.³³⁰ But, as the next Section illustrates, achieving healthcare equity is not merely an ethical imperative. It also contributes to healthcare-system efficiency.

C. Cost-Effectiveness

As discussed in Section II.A, the cost-effectiveness of a health policy is measured by the benefits of better health and better care produced by the policy divided by the cost of the policy.³³¹ The meaning of cost-effectiveness, however, rests on assumptions about what we value in terms of “better health” and “better care.” It also depends on the baseline against which “costs” are assessed.³³² The previous Section described why the principle of equity should inform each of these terms. This Section describes how.

The relationship between equitable access to health coverage and each of the three aims can be summarized as follows: (1) Improving health in populations that are disparately unhealthy is a strategy for improving population health overall. Access to health coverage is an important determinant of health. (2) Equitable access to health coverage improves health-system quality because it helps to ensure that patients receive care when they need it. Equity is a widely recognized measure of quality healthcare across the various frameworks that influence U.S. national health policy.³³³ (3) Addressing inequities in access to health coverage can be cost-effective when it shifts spending from expensive healthcare venues like the emergency room to less expensive primary and preventive care. A detailed analysis of these relationships follows.

The United States has long spent far more on healthcare than its peer countries but, perhaps paradoxically, has experienced a pervasive health disadvantage relative to other wealthy countries for nearly four

³³⁰ See Zhu & Xu, *supra* note 261, at 458 (suggesting that “social inequality in the U.S. states cannot be fully understood without considering the politics of [immigrant] exclusion in policymaking . . . at the subnational level”).

³³¹ Mery et al., *supra* note 274, at 633.

³³² Cf. Buchanan & Dorf, *supra* note 297 (manuscript at 14) (“[W]here one starts as a baseline determines what counts as efficient and inefficient.”).

³³³ See, e.g., U.S. DEP’T OF HEALTH & HUMAN SERVS., NO. 19-0070-EF, NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT 2 (2019) [hereinafter NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT] (incorporating reporting on “disparities in care experienced by different racial and socioeconomic groups” as a component of healthcare quality); LINDSAY A. MARTIN, EUGENE C. NELSON, ROBERT C. LLOYD & THOMAS W. NOLAN, INST. FOR HEALTHCARE IMPROVEMENT, WHOLE SYSTEM MEASURES 4 (2007) (describing thirteen measures of overall quality of a health system (“Whole System Measures”) that are closely related to the Triple Aim, one of which is “equity”).

decades.³³⁴ For example, during that time, the United States has fallen behind in annual gains in life expectancy, a common indicator of a population's health.³³⁵ Troublingly, life expectancy at birth has stagnated over the last decade, even declining each year from 2014 to 2017.³³⁶

However, increases in mortality rates have not burdened everyone living in the United States equally. Young and middle-aged adults in a lower socioeconomic class, with fewer years of education, and living "in rural areas or other settings with evidence of economic distress or diminished social capital" have suffered disproportionately.³³⁷ It is posited that "systemic deficiencies" in the healthcare system—including the lack of universal access to healthcare—may partially explain increased mortality from certain conditions, and that state policies affecting the social determinants of health could explain geographic inequities.³³⁸ The U.S. healthcare system is marked by significant inequity in access to healthcare in comparison to other wealthy countries.³³⁹

Aside from ethical reasons to combat healthcare inequity, discussed in the previous Section, there are instrumental reasons to do so. If the United States seeks to keep pace with peer countries with respect to annual gains in population health indicators like average life expectancy, it must decide where to allocate its resources. This includes but is not limited to healthcare resources.³⁴⁰ Improving health outcomes for the *most* affluent groups is likely to require technological or scientific advances. By contrast, one strategy for improving health outcomes in the least affluent groups is low-tech and

³³⁴ Steven H. Woolf & Heidi Schoomaker, *Life Expectancy and Mortality Rates in the United States, 1959-2017*, 322 JAMA 1996, 1996 (2019).

³³⁵ *Id.*

³³⁶ See Sabrina Tavernise & Abby Goodnough, *American Life Expectancy Rises for First Time in Four Years*, N.Y. TIMES (Jan. 30, 2020), <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.*

³³⁷ Woolf & Schoomaker, *supra* note 334, at 2009; see also Julia Belluz, *What the Dip in U.S. Life Expectancy Is Really About: Inequality*, VOX (Nov. 30, 2018, 9:13 AM), <https://www.vox.com/science-and-health/2018/11/9/16860994/life-expectancy-us-income-inequality> (describing America's worsening life expectancy wealth gap).

³³⁸ Woolf & Schoomaker, *supra* note 334, at 2010.

³³⁹ Fiscella, *supra* note 280, at 204.

³⁴⁰ See, e.g., NAT'L RESEARCH COUNCIL, EXPLAINING DIVERGENT LEVELS OF LONGEVITY IN HIGH-INCOME COUNTRIES 118 (Eileen M. Crimmins et al. eds., 2011) ("[A] country with greater income inequality . . . may have worse average health and greater average mortality because the health benefits to the wealthy from their extra income are outweighed by the health deficits experienced by the poor.").

straightforward: expanding access to health coverage.³⁴¹ Addressing health inequities is thus an implicit goal of national health policy.³⁴²

From a societal perspective, the policies underlying the conditions that create marked health inequities can cause harm to all members of the community.³⁴³ Lack of access to affordable healthcare is a condition that contributes to health inequities. An obvious way in which the effects of this condition spill over to the general population is during an outbreak of an infectious disease. Uninsured members of the community with symptoms of illness may hesitate to seek care and therefore risk exposing the rest of the community to the infectious agent—a topic with increased salience during the COVID-19 pandemic.³⁴⁴ Less obvious are the health-related spillover effects of untreated substance abuse and mental illness, which may include higher rates of property and violent crimes.³⁴⁵ When pregnant women are unable to access prenatal care, opportunities to prevent harm to women and fetuses are lost.³⁴⁶ Finally, immigration restrictions on

³⁴¹ 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.” Michael A. Stoto, *Population Health in the Affordable Care Act Era*, ACAD. HEALTH 1, 4 (2013), <https://www.academyhealth.org/files/publications/files/AH2013pophealth.pdf>. To target low-income populations specifically, the ACA created a new category of eligibility for low-income adults who were otherwise excluded from the historic “deserving poor” categorical eligibility in Medicaid. Huberfeld, *supra* note 209, at 51 (“Medicaid has covered only the deserving poor The ACA changed that standard by creating a new baseline, allowing non-elderly adults earning up to 133% of the FPL to enroll in Medicaid, regardless of the status of being ‘deserving.’”).

³⁴² Stoto, *supra* note 341, at 2 (stating that reducing disparities is a goal of the population health perspective); *see also* Berwick et al., *supra* note 275, at 760 (“[T]he gain in health in one subpopulation ought not to be achieved at the expense of another subpopulation.”). Although the terms “health disparity” and “health inequity” are sometimes used interchangeably, I have elected to use the latter term to mean “differences in health outcomes that are systematic, avoidable, and unjust,” unless I am quoting directly from a source. WYATT ET AL., *supra* note 294, at 8. “Health disparity” is “the difference in health outcomes between groups within a population,” without the implicit judgment of such difference as unjust. *Id.*

³⁴³ Alistair Woodward & Ichiro Kawachi, *Why Reduce Health Inequalities?*, 54 J. EPIDEMIOLOGY & COMMUNITY HEALTH 923, 923 (2000).

³⁴⁴ *See* Karen Hacker, Maria Anies, Barbara L. Folb & Leah Zallman, *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 RISK MGMT. & HEALTHCARE POL’Y 175, 178 (2015); Makhlof & Sandhu, *supra* note 8, at 4–5.

³⁴⁵ *See* Hefei Wen, Jason M. Hockenberry & Janet R. Cummings, *The Effect of Medicaid Expansion on Crime Reduction: Evidence from HIFA-Waiver Expansions*, 154 J. PUB. ECON. 67, 68 (2017) (finding the increase in substance abuse disorder treatment and decrease in substance use that result from state HIFA-waiver expansions may lead to reductions in crime).

³⁴⁶ *See* Krista M. Perreira & Juan M. Pedroza, *Policies of Exclusion: Implications for the Health of Immigrants and Their Children*, 40 ANN. REV. PUB. HEALTH 147, 155–56 (2019) (noting that some studies show undocumented noncitizen “pregnant women are less likely

health coverage can have spillover effects on U.S. citizen family members and low-income and minority communities, exacerbating health inequities in already vulnerable populations.³⁴⁷ For example, undocumented noncitizen parents may decline to enroll their U.S. citizen children in Medicaid if they are required to provide information or documentation about themselves.³⁴⁸ And U.S. citizens who do not have ready access to birth certificates or passports—a problem that disproportionately affects children, the mentally ill, and people with dementia—are likely to experience documentation requirements linked to immigration restrictions as a barrier to healthcare.³⁴⁹ 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.

A large body of research has examined states' immigration restrictions on Medicaid eligibility and their impact on noncitizen access to care and health outcomes. Some of these studies have found that exclusionary laws have negative impacts on individual and population health.³⁵⁰ Scholars theorize that legal barriers to accessing subsidized health programs are the major cause of health inequities

to have adequate prenatal care visits and are more likely to experience complications during delivery, to have preterm births, and to have low-birthweight babies”).

³⁴⁷ Hacker et al., *supra* note 344, at 178 (describing spillover effects of documentation requirements on U.S. citizen family members); *see also* DONNA COHEN ROSS, *CTR. ON BUDGET & POLICY PRIORITIES, MEDICAID DOCUMENTATION REQUIREMENT DISPROPORTIONATELY HARMS NON-HISPANICS, NEW STATE DATA SHOW 3–4* (2007), <https://www.cbpp.org/sites/default/files/atoms/files/7-10-07health.pdf> (noting that documentation requirement has led to decline in Medicaid enrollment among citizen children in several states).

³⁴⁸ *See* Hacker et al., *supra* note 344, at 178.

³⁴⁹ *See* Meredith A. Devlin, *When Policies Collide: Citizenship Documentation Requirements and Barriers to Obtaining Photo Identification—The New Medicaid Citizenship Requirements as a Case Illustration*, 41 *IND. L. REV.* 451, 462–63 (2008) (discussing how a Medicaid requirement to provide documentation of citizenship will negatively impact disabled citizens' access to healthcare). Documentation requirements linked to immigration restrictions are found to pose a “special risk” to Black children, who are both more likely to lose Medicaid because of a documentation requirement and more likely to be diagnosed with conditions that are difficult and expensive to treat without health coverage, such as asthma. COHEN ROSS, *supra* note 347, at 4 (finding the largest declines in Medicaid enrollment after implementation of the documentation requirement in Black children).

³⁵⁰ *See* TIM O'SHEA & CRISTOBAL RAMÓN, *IMMIGRANTS AND PUBLIC BENEFITS: WHAT DOES THE RESEARCH SAY?* 1, 9 (Bipartisan Pol'y Ctr. 2018), <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Immigrants-and-Public-Benefits-What-Does-the-Research-Say.pdf>.

between noncitizen and native-born children.³⁵¹ A pair of researchers focused on young Latinx noncitizen children in Illinois who had lost public benefits post-PRWORA, finding that their general health status had declined significantly relative to their peers.³⁵² A subsequent expanded study of preschoolers in noncitizen families in Illinois found that loss of public benefits after PRWORA was associated with “substantial and significant declines in their health over time.”³⁵³ These findings spanned multiple health dimensions, including parental ratings of children’s health, number of sick days, frequency of respiratory illness, and emergency room visits.³⁵⁴ Such studies support the proposition that exclusionary health policies are associated with poor health outcomes among noncitizens and health inequities between noncitizens and U.S. citizens. This evidence demonstrates the ways in which exclusionary laws create health inequities. Conversely, inclusionary laws may reduce health inequities and their associated spillover effects on other members of the community.³⁵⁵

Moreover, laws that limit noncitizen eligibility for Medicaid can negatively affect national-health-system efficiency. Congress has recognized this, and has passed legislation to partially ameliorate those impacts. After the passage of PRWORA, observers noted that many lawfully present noncitizens, including children and pregnant women, would be cut off from Medicaid coverage, reducing their access to preventive care and increasing their reliance on Emergency Medicaid for treatment of emergency medical conditions.³⁵⁶ Such concerns about PRWORA’s impact on healthcare-system efficiency and health outcomes for children and pregnant women were the motivation behind Congress’s creation of the ICHIA options.³⁵⁷ Congress understood

³⁵¹ Fernando S. Mendoza, *Health Disparities and Children in Immigrant Families: A Research Agenda*, 124 *PEDIATRICS* S187, S192 (2009).

³⁵² Ariel Kalil & Danielle A. Crosby, *Welfare-Leaving and Child Health and Behavior in Immigrant and Native Families*, in *IMMIGRANTS AND WELFARE: THE IMPACT OF WELFARE REFORM ON AMERICA’S NEWCOMERS* 193 (Michael E. Fix ed., 2009).

³⁵³ Ariel Kalil & Danielle Crosby, *Welfare Leaving and the Health of Young Children in Immigrant and Native Families*, 39 *SOC. SCI. RES.* 202, 212 (2010).

³⁵⁴ *Id.* at 209–10.

³⁵⁵ See Woodward & Kawachi, *supra* note 343, 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.”); CBPP REPORT, *supra* note 229, at 13–14 (describing the growing body of evidence showing that immigrant-inclusive policies improve individual and population health outcomes).

³⁵⁶ See Jane Perkins, *Medicaid Coverage of Emergency Medical Conditions*, 38 *CLEARINGHOUSE REV. J. POVERTY L. & POL’Y* 384, 385–86 (2004) (noting that PRWORA’s restrictions would cut the number of noncitizens who qualify for full Medicaid while expanding the number of people who can rely on Emergency Medicaid).

³⁵⁷ See, e.g., 155 *CONG. REC.* S1028 (daily ed. Jan. 29, 2009) (statement of Sen. Durbin) (“The policy [of restricting noncitizen eligibility for public benefits under PRWORA] was

that by eliminating the arbitrary five-year delay on children's and pregnant women's access to subsidized health coverage, the ICHIA options would reduce the risk of negative health impacts and developmental delays for future U.S. citizens.³⁵⁸ This reasoning may be extended to all noncitizens who are considered members of the community: health policies that ameliorate vertical health inequity between U.S. citizens and a subset of noncitizens will be more effective at reducing inequity when applied to all noncitizen residents.

"Better care," the second component of the numerator of the cost-effectiveness equation, involves the quality of care provided in a national health system.³⁵⁹ Equity is a goal of both the Triple Aim and the National Quality Strategy, the leading frameworks guiding U.S. national health policy on quality improvement. These frameworks draw on an influential 2001 report by the Institute of Medicine (IOM) which proposed a strategy for improving the quality of healthcare in America in the twenty-first century.³⁶⁰ The committee that authored the report recommended that "all health care constituencies . . . commit to . . . a shared agenda of six aims for improvement that can raise the quality of care to unprecedented levels."³⁶¹ In summary, healthcare should be safe, effective, patient-centered, timely, efficient, and equitable.³⁶² By "equitable" care, the committee meant "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."³⁶³ The goal is to reduce differences in patient

instated over 10 years ago, and almost immediately we started changing it, realizing it really did not work as planned. . . . [E]xtending health insurance to this population actually saves the health care system of America a lot of money."); *id.* at S1050 (stating that the five-year bar under PRWORA has "severely undermined the health status of immigrant families across the Nation"); 155 CONG. REC. H230 (daily ed. Jan. 14, 2009) (describing the purpose of the ICHIA options as "promot[ing] the health of needy children and pregnant women residing lawfully in the United States").

³⁵⁸ See Youdelman, *supra* note 170, at 4.

³⁵⁹ See Berwick et al., *supra* note 275, at 760 (arguing that the United States will not "achieve high-value health care unless improvement initiatives pursue a broader system of linked goals").

³⁶⁰ INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001) [hereinafter IOM REPORT]; see also NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT, *supra* note 333, at 67 (discussing the IOM report's identification of healthcare disparities as a quality issue); WYATT ET AL., *supra* note 294, at 4–5 (discussing progress on the IOM report's equity aim and its relationship to the Triple Aim); Castellucci, *supra* note 274 (noting that the National Quality Strategy goals were strongly influenced by the IOM report).

³⁶¹ IOM REPORT, *supra* note 360, at 5.

³⁶² *Id.* at 5–6.

³⁶³ *Id.* at 6.

experience that are based on personal characteristics, which could include actual or perceived immigration status.³⁶⁴

In addition, as discussed earlier, the IHI has recognized that equity is an element of each component of the Triple Aim, including better care.³⁶⁵ The IHI has developed a system of metrics that is linked with the Triple Aim and designed to measure health-system quality.³⁶⁶ One of the Whole System Measures is equity, which examines stratification of quality measures among subpopulations and aims to “drive the difference in [health] outcomes between subpopulations to zero.”³⁶⁷

Likewise, the National Quality Strategy, established in 2011 as a requirement of the ACA, builds on the Triple Aim.³⁶⁸ Its purpose is to coordinate quality improvement strategies in the public and private healthcare sectors in order to improve health and healthcare nationwide.³⁶⁹ Each year, the Agency for Healthcare Research and Quality, an agency within HHS, reports on “the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups.”³⁷⁰ This focus on disparities reveals the importance of equitable access to healthcare as an element of the National Quality Strategy.

State policies that exclude noncitizens from subsidized health coverage negatively affect several of the widely recognized measures of health-system quality, including equity.³⁷¹ Without access to afford-

³⁶⁴ See, e.g., NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT, *supra* note 333, at 113, 119–20 (noting that immigration status is a barrier to health coverage).

³⁶⁵ WYATT ET AL., *supra* note 294, at 5.

³⁶⁶ MARTIN ET AL., *supra* note 333, at 1 (noting that the purpose of the paper is to promote a system of metrics that measure the overall quality of health systems).

³⁶⁷ *Id.* at 38.

³⁶⁸ 42 U.S.C. § 280j(a)(1) (2018) (“The [HHS] Secretary . . . shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.”); *The National Quality Strategy: Fact Sheet*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://www.ahrq.gov/workingforquality/about/nqs-fact-sheets/fact-sheet.html> (last updated Nov. 2016).

³⁶⁹ *Id.*

³⁷⁰ NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT, *supra* note 333, at 2.

³⁷¹ See MARTIN ET AL., *supra* note 333, at 18–19 (briefly describing each of these quality measures). The rate of adverse events measures “injury or harm to [a] patient related to (or from) the delivery of care.” *Id.* at 20. A landmark publication on the effects of uninsurance on health found that uninsured hospitalized patients are more likely to be injured due to substandard care than insured patients. INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 72–73 (2002) [hereinafter CARE WITHOUT COVERAGE], https://www.ncbi.nlm.nih.gov/books/NBK220639/pdf/Bookshelf_NBK220639.pdf. Unadjusted raw mortality percentage is “a measure of acute care inpatient mortality” and is computed by dividing the number of in-hospital deaths in the acute care inpatient population by the number of acute care inpatient discharges. MARTIN ET AL., *supra* note 333, at 24. Uninsured patients who are hospitalized are more likely to

able health coverage, low-income noncitizens are less likely to seek healthcare in a timely manner. When uninsured low-income noncitizens do seek care, they are often limited to a small number of providers who are willing to provide uncompensated care or to charge affordable rates. Such providers are often overextended and have long wait times for appointments.³⁷² In order to stay financially viable, they may have to see a large volume of patients, which means patients receive less individualized attention and providers are more likely to miss signs and symptoms. Insured patients, on the other hand, can typically choose among various providers and withdraw from a provider's care if they are not receiving high-quality care. This serves as an indirect regulation of quality control that is absent in the pool of providers that serve uninsured, low-income patients.

In addition, because a majority of excluded noncitizens are members of already disadvantaged social groups, policies that exclude noncitizens from access to subsidized health coverage exacerbate—rather than ameliorate—existing health inequities by reducing opportunities to be healthy.³⁷³ For example, laws that bar noncitizens from eligibility for Medicaid disproportionately affect people of color.³⁷⁴

States' health policies are undoubtedly influenced by cost, which is the denominator in the cost-effectiveness equation. For some politicians, limiting eligibility for healthcare subsidies by citizenship and

die in the hospital than insured patients. CARE WITHOUT COVERAGE, *supra*, at 72. The functional health outcomes score is measured using the Functional Health Survey and is a measure of a system's patient population's physical and mental health status. MARTIN ET AL., *supra* note 333, at 25. Uninsured adults are more likely to have "worse overall functional and health status" than similar insured adults. CARE WITHOUT COVERAGE, *supra*, at 81.

³⁷² See Bettigole, *supra* note 321, at 2192 (noting that even had one of her patients discovered her clinic earlier, they likely would have experienced a wait time of several months because the clinic was struggling to keep up with existing demand).

³⁷³ See Zhu & Xu, *supra* note 261, at 460 ("[B]ecause of immigrants' particularly vulnerable legal and social status, the immigrant-specific provisions of welfare reform may have increased immigrants' confusion about their eligibility for welfare benefits . . .") (quoting Jennifer Van Hook, *Welfare Reform's Chilling Effects on Noncitizens: Changes in Noncitizen Welfare Reciprocity or Shifts in Citizenship Status?*, 84 SOC. SCI. Q. 613, 613–14 (2003)); Paula Braveman, *Health Disparities and Health Equity: Concepts and Measurement*, 27 ANN. REV. PUB. HEALTH 167, 187 (2006) ("[H]ealth disparities reflect unequal opportunities to be healthy, making disadvantaged groups even more disadvantaged with respect to their health; correspondingly, reducing health disparities means giving disadvantaged social groups equal opportunities to be healthy.").

³⁷⁴ See Samantha Artiga, Kendal Orgera & Anthony Damico, *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018*, KAISER FAM. FOUND. (Mar. 5, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018> ("[U]ninsured Hispanics and Asians are less likely than Whites to be eligible for financial assistance with coverage, in part, reflecting higher shares of noncitizens who face immigrant eligibility restrictions among these groups compared to Whites.").

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. There is no doubt that expanding access to subsidized health coverage costs money. However, even if expanding access results in healthcare spending that is higher than current spending, it does not necessarily mean that such a reform is not cost-effective.³⁷⁵ Exclusionary policies may save costs in the short term but not over the long term.

Any attempt to calculate the costs of restrictive versus inclusive health policy is informed by value-laden assumptions. The ACA provides an example of health policy that recognizes the cost-effectiveness of equitable access to health coverage even if absolute healthcare spending increases as a result. The high cost of healthcare in the United States is an oft-cited barrier to achieving universal health coverage.³⁷⁶ However, efforts to achieve universal health coverage are based, in part, on the understanding that expanding access can reduce inefficient healthcare spending and otherwise improve national prosperity by improving health—a goal deemed worthwhile even if overall public spending increases.³⁷⁷

Opponents of expanding Medicaid for excluded noncitizens may argue that subsidizing primary and secondary healthcare for noncitizens is not cost-effective because it would increase overall public healthcare expenditures on noncitizens. This argument rests on an assumption that high-priority medical needs of noncitizens are “covered” by Emergency Medicaid (severe, acute conditions) and public health agencies (vaccinations, screening and treatment for communicable diseases), and that treatment of chronic disease among noncitizens should not be a priority. It also relies on the “right now” baseline rather than a baseline of equitable access to health coverage. What it overlooks, however, is that it can be more cost-effective to cover non-emergent than emergent care, e.g., covering routine versus

³⁷⁵ See Buchanan & Dorf, *supra* note 297 (manuscript at 14). Buchanan and Dorf describe how arguments based on finding “efficient” solutions are incoherent if one does not acknowledge the normative priors on which the term “efficiency” rests. *Id.* The same could be said about arguments for the “cost-effective” solution.

³⁷⁶ See, e.g., David E. Bloom, Alexander Khoury & Ramnath Subbaraman, *The Promise and Peril of Universal Health Care*, 361 *SCIENCE* 766, 766 (2018) (noting that the high costs of new healthcare technologies and meeting the healthcare needs of older populations are a barrier for achieving universal health coverage in wealthy industrial countries).

³⁷⁷ See David E. Bloom, Alexander Khoury & Ramnath Subbaraman, *The Promise and Peril of Universal Health Care*, 361 *SCIENCE* eaat9644, Aug. 24, 2018, at 1 (“These economic arguments [in support of universal health coverage] are bolstered by evidence that committing resources to health care is associated with a high return on investment, rivaling, or even surpassing, other high-return investments like those in primary and secondary education.”).

emergency dialysis, and that people are less likely to seek screening and treatment for communicable diseases if they do not have a primary care provider, even if those services are covered financially.³⁷⁸ Insurance enables people to establish care with a provider. Another consequence that this argument does not consider is the absurd and cruel result of prioritizing the subsidization of life-saving versus life-enhancing healthcare for uninsured noncitizens: those with chronic diseases must delay seeking care until their lives are in jeopardy before they can qualify for subsidized care in a hospital emergency room.³⁷⁹

What is cost-effective for U.S. citizens and Medicaid-eligible noncitizens is likely cost-effective for excluded noncitizens. Therefore, if a future health reform is guided by the principle of equity, as the last health reform was, inclusion of a broader range of noncitizens in publicly funded healthcare should be considered cost-effective if it meets more healthcare needs per dollar spent, particularly when it reduces inequitable suffering and morbidity.³⁸⁰ Addressing vertical inequity between citizens and noncitizens in access to publicly funded health coverage, therefore, has the potential to be cost-effective.³⁸¹

Some scholars have pointed to the ways in which restricting noncitizens' access to health coverage—and, by extension, affordable preventive healthcare—may even increase net costs.³⁸² Researchers have found that excluded noncitizens are disproportionately likely to seek care in the most expensive healthcare venue: hospital emergency rooms.³⁸³ This is because uninsured immigrants often delay seeking

³⁷⁸ See, e.g., K. Tom Xu, *Usual Source of Care in Preventive Service Use: A Regular Doctor versus a Regular Site*, 37 HSR 1509, 1509–10 (2002) (discussing studies finding that having a regular doctor is a stronger predictor of timely care-seeking than having health insurance and that “individuals with a usual source of care were more likely to receive timely immunizations”); cf. *Access to Primary Care*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary> (last visited Oct. 13, 2020) (noting that people residing in rural areas may face geographical barriers to having a primary care provider, and in turn, “may be less likely to seek preventive care”).

³⁷⁹ See Culyer, *supra* note 22, at 279 (discussing and criticizing the argument that “[w]e should first allocate resources to those areas where they are immediately needed to save life and only when this is done should the remainder be allocated to alleviating non-fatal conditions”).

³⁸⁰ See Daniels, *supra* note 273, at 1067 (explaining why efficiency and cost are ethical—and not simply economic—concerns).

³⁸¹ See Woodward & Kawachi, *supra* note 343, at 926 (“[R]educing inequalities will lead to larger gains in health status than might be achieved by similar expenditures elsewhere.”).

³⁸² See, e.g., Arijit Nandi, Sana Loue & Sandro Galea, *Expanding the Universe of Universal Coverage: The Population Health Argument for Increasing Coverage for Immigrants*, 11 J. IMMIGRANT & MINORITY HEALTH 433, 435 (2009).

³⁸³ *Id.*

care for health problems that could have been detected or treated effectively at an earlier time.³⁸⁴ Such delay can lead to unnecessary complications from common chronic diseases such as diabetes and asthma,³⁸⁵ and remedial treatment of these complications, especially in 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.³⁸⁶ Most Emergency Medicaid expenditures are for services provided to undocumented noncitizens, who make up the largest category of excluded noncitizens nationwide.³⁸⁷ A 2011 article states that the program “has long paid about \$2 billion a year for emergency treatment” for noncitizens.³⁸⁸

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.³⁸⁹ 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

³⁸⁴ See Gostin, *supra* note 43, at 1438; Nandi et al., *supra* note 382, at 435 (noting that undocumented immigrants are relatively more likely to have preexisting disease and wait longer before seeking medical care).

³⁸⁵ Nandi et al., *supra* note 382, at 435.

³⁸⁶ See, e.g., Nathanael J. Scheer, Comment, *Keeping the Promise: Financing EMTALA’s Guarantee of Emergency Medical Care for Undocumented Immigrants in Arizona*, 35 ARIZ. ST. L.J. 1413, 1421–23 (2003) (discussing the various sources of federal funding that Arizona hospitals use to defray the cost of providing emergency medical care to undocumented noncitizens).

³⁸⁷ See U.S. GEN. ACCOUNTING OFFICE, GAO-04-472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 10 (2004) (noting that several states have indicated that “most of their emergency Medicaid expenditures were for services provided to undocumented aliens”); *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).

³⁸⁸ Phil Galewitz, *Medicaid Helps Hospitals Pay for Illegal Immigrants’ Care*, KAISER HEALTH NEWS (Feb. 12, 2013), <https://khn.org/news/medicaid-illegal-immigrant-emergency-care>. In addition, DSH payments totaled about \$16.5 trillion in FY2018, with Texas, New York, and Louisiana receiving the largest amounts. *Distribution of Medicaid Spending by Service*, KAISER FAMILY FOUND., <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service> (last visited Aug. 9, 2020).

³⁸⁹ See 155 CONG. REC. S1028 (daily ed. Jan. 29, 2019) (statement of Sen. Durbin) (“[E]xtending health insurance to this population actually saves the health care system of America a lot of money. . . . Avoiding . . . pregnancy complications is not only the humane thing to do, it is the economic thing to do. . . . ER care is expensive, sometimes unnecessary.”).

Medicaid enables.³⁹⁰ When pregnant women do not receive prenatal care, costs associated with postnatal and pediatric care can be twice as high.³⁹¹ This example illustrates that “the goal of increased equity need not be incompatible with the goal of maximising efficiency.”³⁹²

Another often overlooked cost of restrictionist subsidized health coverage laws is the increased administrative burden for government agencies and healthcare providers that must determine whether a patient qualifies for benefits or services. These determinations, which are often complicated, divert resources to government agencies and can increase the cost of providing publicly funded coverage.³⁹³ Lack of certainty about whether care will be covered can also lead healthcare providers to delay treatment, which can increase costs and reduce effectiveness. For example, a dentist diagnoses a noncitizen patient with a tooth infection and recommends surgery. The patient does not have health insurance and is unable to pay for the surgery out of pocket. The patient tells the dentist that they “overstayed” a tourist visa and are afraid of applying for public benefits. Based on their experience treating other noncitizen patients, the dentist assumes that the patient is ineligible for publicly funded coverage. Several months later, the dentist learns that the patient, as an applicant for asylum whose application has been pending for more than six months, is eligible for state-funded health coverage comparable to Medicaid.³⁹⁴ By the time the patient has coverage, it has been eight months since the infection was diagnosed, and the surgery is much more complicated

³⁹⁰ See Youdelman, *supra* note 170, at 3 (explaining how ICHIA’s expansion of Medicaid eligibility can reduce emergency room visits and prevent expensive exacerbation of preventable conditions).

³⁹¹ See Gostin, *supra* note 43, at 1438.

³⁹² Woodward & Kawachi, *supra* note 343, at 927 (describing how a policy to schedule Pap screening for cervical cancer every three years instead of annually saved resources that could be devoted to reaching women who were screened only every ten years, resulting in fewer cases of cervical cancer at the population level).

³⁹³ See Hacker et al., *supra* note 344, at 178 (reviewing studies identifying bureaucratic barriers for healthcare providers created by policies excluding undocumented noncitizens from healthcare); Jeffrey T. Kullgren, *Restrictions on Undocumented Immigrants’ Access to Health Services: The Public Health Implications of Welfare Reform*, 93 AM. J. PUB. HEALTH 1630, 1632 (2003) (“Sorting through immigration documents for each patient, and turning away those who lack sufficient documentation but are unable to pay for the full cost of services, would increase administrative costs and waiting times, reducing the efficiency of already overburdened safety-net institutions.”); Michael E. Fix & Karen Tumlin, *Welfare Reform and the Devolution of Immigrant Policy*, in NEW FEDERALISM: ISSUES AND OPINIONS FOR STATES 1997, at 1, 5–6 (Urban Inst., Ser. A., No. A-15, 1997) (describing how PRWORA forces states “to bear new administrative costs from expanded verification and reporting requirements” such as new systems to enforce the affidavit of support signed by an immigrant’s sponsor).

³⁹⁴ See *supra* Section I.C.

and expensive than it would have been had the patient received timely care.³⁹⁵

Laws excluding noncitizens from the ACA Marketplaces also create inefficiency in health insurance financing by preventing risks from being spread across a broader population.³⁹⁶ This causes instability and unpredictability in health insurance risk pools. It is likely that noncitizens are relatively healthy compared with citizens.³⁹⁷ Permitting undocumented noncitizens to purchase subsidized insurance on the Marketplaces could result in insurers lowering premiums for all participants.³⁹⁸ 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, in the absence of subsidized insurance for excluded noncitizens, physicians and hospitals may shift the costs of treating uninsured excluded noncitizens to insurers and insured patients.³⁹⁹

³⁹⁵ Cf. Robin E. Canada, *Best Practices for Teaching Care Management of Undocumented Patients*, 21 *AMA J. ETHICS* E44, E45 (2019) (describing the different standard of care provided to undocumented patients treated at a low-cost clinic versus at an academic medical practice); Peter Ellis & Lydia S. Dugdale, *How Should Clinicians Respond when Different Standards of Care Are Applied to Undocumented Patients?*, 21 *AMA J. ETHICS* E26 (2019) (describing the ethical conflict faced by providers who lack the resources to provide optimal care); Meredith Van Natta, *First Do No Harm: Medical Legal Violence and Immigrant Health in Coral County, USA*, 235 *SOC. SCI. & MED.*, Aug. 2019, at 1, 3 (2019) (finding that since the 2016 election providers have started to weigh the risk of untreated illness or injury against the risk of immigration surveillance and enforcement when treating undocumented noncitizens or noncitizens who are subject to public charge determinations).

³⁹⁶ Makhlof, *supra* note 49, at 270. Although 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). However, states may have legitimate concerns about the federal government's use of information gathered from the exchanges for immigration enforcement purposes, which was one of the concerns cited by Sen. Ricardo Lara, the California state senator who spearheaded that state's authorizing legislation for the waiver. *Id.*

³⁹⁷ *See* Glen, *supra* note 46, at 222 (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).

³⁹⁸ *See id.* (explaining how adding undocumented noncitizens to the insurance risk pool could lead to cost savings for all of the insured participants).

³⁹⁹ *See* Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 *MILBANK Q.* 90 (2011) (reviewing the literature on cost shifting in response to public payment policy).

Healthcare providers are ethically⁴⁰⁰—and in some cases legally⁴⁰¹—obligated to treat patients in need. For example, federal law obligates hospitals participating in Medicare (nearly all hospitals)⁴⁰² to provide emergency care to all patients who need it, regardless of their ability to pay, immigration status, or any other factor unrelated to medical need.⁴⁰³ When states foreclose reimbursement for care that hospitals provide to uninsured noncitizens, they leave those hospitals and their physicians vulnerable to financial losses from the provision of uncompensated care. In turn, physicians and hospitals may seek to shift these costs to insurers and insured patients by increasing charges. This is a perennial topic of interest in health policy, and there is no good reason to distinguish cost shifting generated by uninsured excluded noncitizens from that generated by any other population. Subsidizing insurance for excluded noncitizens can prevent this wasteful cost shifting.

As described here, expanding health coverage for noncitizens would certainly shift health-system costs and may save costs overall, in addition to improving population health outcomes and healthcare quality.⁴⁰⁴ Taking a wider lens, some researchers have examined how expanding health coverage could improve state and local economies over the long term.⁴⁰⁵ This is based on the observation that untreated health issues reduce worker productivity,⁴⁰⁶ increasing the economic

⁴⁰⁰ See *The Refusal of Care*, HEALTHCARE RISK MGMT. REV. (Jan. 26, 2015), <https://www.hrmronline.com/article/the-refusal-of-care> (“Healthcare providers have legal, ethical and professional duties to address a patient’s needs that fall within the provider’s scope of practice.”).

⁴⁰¹ See *infra* note 403 (obligating hospitals to treat patients in emergencies, regardless of their eligibility for health insurance).

⁴⁰² See AM. HOSP. ASS’N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET 1 (Dec. 2017), <https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf> (explaining that while hospitals can elect not to participate in Medicaid or Medicare, conditions on federal tax exemptions prompt most hospitals to participate).

⁴⁰³ Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd(a)–(b) (2010).

⁴⁰⁴ See Gostin, *supra* note 43, at 1438 (“Shifting toward prevention and early diagnosis and treatment would avoid or reduce costs over time.”); Nandi et al., *supra* note 382, at 435 (noting that offering noncitizens the same standard of care as citizens may save costs); see also Makhlof, *supra* note 49, at 269–70 (describing research on how expanding immigrants’ access to health coverage could decrease total healthcare expenditures).

⁴⁰⁵ See, e.g., Woodward & Kawachi, *supra* note 343, at 925 (“[H]ealth is an exquisitely sensitive mirror of social circumstances. . . . [R]educing the social and economic inequalities that lie behind the uneven distribution of disease will bring a wide range of benefits.”); CBPP REPORT, *supra* note 229, at 13–14 (noting that extending health coverage, regardless of citizenship status, can lead to better long-term economic outcomes).

⁴⁰⁶ WYATT ET AL., *supra* note 294, at 9 (noting how “higher rates of absenteeism and presenteeism (i.e., working while sick)” can reduce worker productivity).

costs of restricting noncitizens' access to healthcare: "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?"⁴⁰⁷ Additionally, low-income families with health insurance experience greater economic security than those without because they are not subject to high out-of-pocket medical costs.⁴⁰⁸ Health insurance and the household economic security it promotes make it more likely that children will succeed in school, earn higher incomes, and amass more wealth.⁴⁰⁹ For these reasons, the Center on Budget and Policy Priorities has called extending health coverage regardless of citizenship status "a smart investment in a state's long-term health and prosperity."⁴¹⁰

This Section has demonstrated how state decisions to exclude noncitizens from eligibility for subsidized health coverage in order to cut costs undermine the national health policy goal of improving cost-effectiveness. Whether the goal is to have a fairer or more efficient national health system—or, ideally, both—the answer is inclusion.

D. Racial Dynamics

National health policy seeks to eliminate the influence of antidemocratic values, such as racism, in Medicaid.⁴¹¹ Historically, federalism arrangements regulating public accommodations, voting, housing, healthcare, and other areas were proxies 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.⁴¹² Scholars adopting a nationalist perspective blame federalism for weakening norms underlying the federal government's goal of promoting racial equality.⁴¹³

⁴⁰⁷ Whitehead, *supra* note 282, at 431.

⁴⁰⁸ CBPP REPORT, *supra* note 229, at 13.

⁴⁰⁹ *Id.* at 13–14.

⁴¹⁰ *Id.* at 13; *see also* Gostin, *supra* note 43, at 1439 ("[E]xpanding coverage for undocumented immigrants could save costs over all.").

⁴¹¹ *See, e.g.*, Michener, *supra* note 206, at 557–61 (summarizing ACA provisions supporting the goal of reducing racial and ethnic inequities and discrimination); *id.* at 549 (describing Medicaid expansion as "one of the ACA's boldest and most promising mechanisms for reducing racial inequities").

⁴¹² *See, e.g.*, ANDREA LOUISE CAMPBELL, TRAPPED IN AMERICA'S SAFETY NET: ONE FAMILY'S STRUGGLE 72–75 (2014) (explaining the links between the tradition of state control of social assistance programs and efforts to maintain the racial and class structure of the South).

⁴¹³ *See* Gerken, *supra* note 313, at 1710 ("Academics often unthinkingly blame decentralization for shortfalls in our equality norms.").

Racism plays a particularly ugly role in the development of federal health policy⁴¹⁴ and, in particular, Medicaid's cooperative federalism arrangement. Congress agreed to devolve authority to states to make critical decisions regarding their Medicaid programs in order to appease Southern Democrats, who wished to avoid federal scrutiny of racist policies.⁴¹⁵ The racist belief that Black people are undeserving of public benefits has long influenced social welfare policy.⁴¹⁶ In health policy, this belief, along with the racist trope of the "welfare queen" taking advantage of taxpayer contributions, has motivated the development of stringent eligibility criteria and unforgiving, punitive policies.⁴¹⁷ Racial inequities in healthcare access are attributed in part to state control of Medicaid eligibility policies.⁴¹⁸ As Professor Evelynn Hammonds stated, "There has never been any period in American history where the health of blacks was equal to that of whites Disparity is built into the system."⁴¹⁹

The ACA was designed to implement a uniform national standard for Medicaid eligibility that would stealthily reduce healthcare inequities affecting low-income Black and Latinx people.⁴²⁰ Because the *NFIB v. Sebelius* decision devolved the issue of the new Medicaid

⁴¹⁴ See Jeneen Interlandi, *Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do with Race.*, N.Y. TIMES (Aug. 14, 2019), <https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html> ("In the United States, racial health disparities have proved as foundational as democracy itself.").

⁴¹⁵ See Gluck & Huberfeld, *supra* note 6, at 1710 n.82 (describing the racist origins of Medicaid's devolution to states); see also Interlandi, *supra* note 414 (describing how Southern Democrats obtained key concessions during negotiations over the Hill-Burton Act, enabling states to control the disbursement of funds for hospital construction and ensuring that they remained segregated).

⁴¹⁶ See MARTIN GILENS, *WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTI-POVERTY POLICY* (1999) (positing that white Americans oppose welfare because recipients have often been portrayed through the lens of racial stereotypes, casting recipients as lazy and undeserving people of color); Madison Allen, *Racism in Public Benefit Programs: Where Do We Go from Here?*, CTR. FOR L. & SOC. POL'Y (July 23, 2020), <https://www.clasp.org/blog/racism-public-benefit-programs-where-do-we-go-here> (discussing the connection between racism and the history of public benefit programs and welfare reform in America).

⁴¹⁷ See, e.g., Michener, *supra* note 206, at 557.

⁴¹⁸ *Id.* at 550–51; Interlandi, *supra* note 414 ("Federal health care policy was designed, both implicitly and explicitly, to exclude black Americans. As a result, they faced an array of inequities").

⁴¹⁹ Interlandi, *supra* note 414.

⁴²⁰ See Michener, *supra* note 206, at 548 ("[T]he ACA was viewed as a stealthy civil-rights achievement of the Obama presidency." (internal quotation marks omitted)); *id.* at 550 ("Though the planned expansionary tack was not explicitly race based, the outsized presence of blacks and Latinos among the population of Americans living in or near poverty . . . meant that uniform national expansion of Medicaid would have had inequality-reducing racial effects.").

expansion to the states, however, the ACA did not reach its potential to achieve this goal.⁴²¹ Most of the thirteen states that have not adopted the Medicaid expansion are in the South.⁴²² Given the existing racial demographics of these non-expansion states, low-income Black people are disproportionately impacted by state decisions to not expand Medicaid; as a result, they disproportionately lack access to health coverage.⁴²³

Some scholars have linked citizenship dynamics in social policy with racial dynamics, suggesting that programs with decentralized administrative structures devolving power and discretion to local authorities are more prone to immigration politics.⁴²⁴ Because most noncitizens are people of color, the structural discrimination of alienage restrictions in Medicaid eligibility layers on to existing race-based institutional discrimination in the public benefits system.⁴²⁵ Many scholars have explored the ways in which negative attitudes toward Latinx and Asian people have shaped anti-immigrant provisions of welfare laws.⁴²⁶ More generally, scholars have identified a link between growing racial and ethnic complexity attributed to immigration and a decrease in generosity in social policy at the state level.⁴²⁷ As Professor Kevin Johnson has written, “[a]ntipathies for benefit recipients and immigrants are not completely unrelated. Indeed, one

⁴²¹ See *id.* at 551 (discussing *Sebelius*’s “negative implications for the racial equitability of health resources”).

⁴²² See Interlandi, *supra* note 414 (“Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion. And several are still trying to make access to the program contingent on onerous new work requirements.”).

⁴²³ Michener, *supra* note 206, at 551.

⁴²⁴ See Brown & Kahn Best, *supra* note 26, at 793 (discussing research suggesting that decentralized programs may see stronger immigration effects); see also Reese et al., *supra* note 26, at 98–99 (“[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.”).

⁴²⁵ Daniel E. Dawes provides a simple, clear definition of these types of discrimination: “[S]tructural discrimination advantages one group to the disadvantage of another, whereas institutional discrimination employs seemingly facially neutral policies that have a disparate impact on racial and ethnic groups, women, LGBTQ+ individuals, and people with disabilities, among others.” DANIEL E. DAWES, *THE POLITICAL DETERMINANTS OF HEALTH* 65–66 (2020).

⁴²⁶ See Kevin R. Johnson, *Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class*, 17 IMMIGR. & NAT’LITY L. REV. 457, 465 (1995) (“[T]he ethnicity of ‘illegal aliens’ is often a subtext to the debate about the availability of public benefits and services to noncitizens, as well as to the entire immigration debate.”); Reese et al., *supra* note 26, at 98–99; Zhu & Xu, *supra* note 261, at 459 (noting that PRWORA “was driven by a wave of strong anti-immigrant sentiment along with the resurgence of nativism”).

⁴²⁷ See Zhu & Xu, *supra* note 261, at 458–59 (reviewing the literature on this relationship).

could view the ability to immigrate . . . as one of the scarcest, and most highly sought after, public benefits.”⁴²⁸ Noncitizens, like low-income Medicaid recipients, are politically marginalized.⁴²⁹ Therefore, their ability to oppose state policies that restrict their access to publicly funded health coverage and other public benefits is attenuated.⁴³⁰

Scholars have noted that some state-driven policies are designed to include noncitizens.⁴³¹ However, it is unlikely that the decentralization trend in immigration law will lead to inclusive health policy because of health policy’s increasingly national character and because expanding noncitizen access to subsidized health coverage is more about health policy than it is about immigration policy. While it may be said that one principle of immigration policy is integration of noncitizens into society at large and especially the political community,⁴³² the normative goal of integration in this context is narrower: integration into the U.S. healthcare system. In addition, eligibility changes in subsidized health coverage programs are only tangentially related to the core aspects of immigration law, admission and removal of noncitizens.⁴³³

Though 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 in the healthcare system.

III

FEDERALISM’S INFLUENCE

Noncitizen eligibility for subsidized health coverage from state to state may be characterized as “predictable variability.”⁴³⁴ But what

⁴²⁸ Johnson, *supra* note 426, at 458–59.

⁴²⁹ *Id.* at 486 (discussing how noncitizens may be in fact more marginalized than low-income citizens); see also MICHENER, *supra* note 19, at 57.

⁴³⁰ Johnson, *supra* note 426, at 486 (“The idea that undocumented persons are not part of the community carries great weight in the political process.”).

⁴³¹ See, e.g., Burch Elias, *supra* note 6, at 706 (discussing inclusive state-level policies such as expanding noncitizens’ access to driver’s licenses, in-state tuition rates, and financial aid); see also Rodríguez, *supra* note 6, at 581–82, 591 (detailing local governments’ role in integrating noncitizens into public life).

⁴³² See Adam B. Cox, *Immigration Law’s Organizing Principles*, 157 U. PA. L. REV. 341, 378–79 (2008).

⁴³³ See *supra* note 86 and accompanying text.

⁴³⁴ Abbe R. Gluck & Nicole Huberfeld, *Federalism Under the ACA: Implementation, Opposition, Entrenchment*, in *THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA* 176, 190 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020); see also Zhu & Xu, *supra* note 261, at 457 (describing state-level policy on immigrant access to Medicaid as “show[ing] mixed promises”).

explains the fact that, even though all states host undocumented noncitizens, very few have engaged in serious efforts to address these individuals' health coverage needs?

This Part describes how Medicaid's structure can influence states' policymaking on noncitizen access to health coverage. It explains how federalism enables states to make or maintain policy that entrenches the "othering" of noncitizens in healthcare and undermines national health policy goals;⁴³⁵ and how it frustrates other 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.⁴³⁶

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 centralizing the regulation of matters related to health.⁴³⁷ Immigration law, on the other hand, is the traditional domain of the federal government.⁴³⁸ Immigration laws govern matters relating to the admission and expulsion of noncitizens, which sometimes take into

⁴³⁵ See generally Edna A. Viruell-Fuentes, Patricia Y. Miranda & Sawsan Abdulrahim, *More Than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health*, 75 SOC. SCI. & MED. 2099, 2101 (2012) (describing the concept of "othering" as "processes [that] produce and reproduce marginalization, disempowerment and social exclusion") (internal quotation marks omitted).

⁴³⁶ MICHENER, *supra* note 19, at 33; see also 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); Gluck & Huberfeld, *supra* note 6, at 1703 (criticizing federalism scholarship for being "high on abstraction and low on concreteness"); Hammond, *supra* note 19, at 1724–27 (2017) (describing the need for a case-specific approach as opposed to a trans-substantive and theoretical approach to federalism). *But see* Gluck & Huberfeld, *supra* note 6, at 1694 (arguing that assessing the success of structural arrangements in healthcare is impossible until the field of health law establishes first principles).

⁴³⁷ 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 6, at 1707 (citing *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 552–53 (1944)). In 1945, Congress legislated to return that power to the states, so long as Congress has not explicitly regulated in that space. *Id.* at 1707–08 (citing McCarran-Ferguson Act of 1945, Pub. L. No. 79-15, 59 Stat. 33 (codified as amended at 15 U.S.C. §§ 1011–15 (2018))).

⁴³⁸ See *supra* notes 86–91 and accompanying text (discussing the plenary power doctrine).

consideration a noncitizen's use of public benefits in the United States.⁴³⁹ Alienage laws govern matters relating to the lives of non-citizen residents once they are within the United States.⁴⁴⁰

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.⁴⁴¹ So long as alienage restrictions are supported by a rational basis, they will generally be upheld.⁴⁴² Because of this low bar, only rarely have courts invalidated federal laws discriminating against noncitizens as unconstitutional.⁴⁴³

On the other hand, the Supreme Court has interpreted state authority to impose alienage restrictions on eligibility for public benefits differently.⁴⁴⁴ 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.⁴⁴⁵ After considering whether the state laws violated the Equal Protection Clause, the Court looked to whether the state laws

⁴³⁹ Hiroshi Motomura, *Immigration and Alienage, Federalism and Proposition 187*, 35 VA. J. INT'L L. 201, 202 (1994).

⁴⁴⁰ *Id.*

⁴⁴¹ See *Mathews v. Diaz*, 426 U.S. 67, 80 (1976) (noting that “the fact that Congress has provided some welfare benefits for citizens does not require it to provide like benefits for *all aliens*” and suggesting that “[n]either 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 6, at 506–07 (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).

⁴⁴² See Andrew Hammond, *The Immigration-Welfare Nexus in a New Era?*, 22 LEWIS & CLARK L. REV. 501, 511–14 (2018) (summarizing case law on challenges to disparate treatment of noncitizens in welfare programs). Courts have 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, e.g., *City of Chicago v. Shalala*, 189 F.3d 598, 606–07 (7th Cir. 1999) (“[T]he citizenship requirement is still rationally related to the goal of encouraging aliens to rely on private, not public, resources to meet their needs.”); *Rodriguez ex rel. Rodriguez v. United States*, 169 F.3d 1342, 1350–51 (11th Cir. 1999) (recognizing “the legitimate purpose of reducing the cost of . . . welfare programs [food stamps and Supplemental Security Income]”); *Kiev v. Glickman*, 991 F. Supp. 1090, 1100 (D. Minn. 1998) (“promoting naturalization and placing the highest priority for limited welfare funds to provide for citizens”); *Cid v. S.D. Dep't of Soc. Servs.*, 598 N.W.2d 887, 892 (S.D. 1999) (recognizing the “legitimate interest in implementing the nation's immigration policy and its uniform rules with respect to alien eligibility for public benefits”).

⁴⁴³ *Wishnie*, *supra* note 6, at 501.

⁴⁴⁴ See generally Ava Ayers, *Discriminatory Cooperative Federalism*, 65 VILL. L. REV. 1 (2020) (analyzing doctrines governing Congress's authority to devolve its power to discriminate against noncitizens).

⁴⁴⁵ 403 U.S. 365 (1971).

were preempted by the exclusive federal immigration power.⁴⁴⁶ A state alienage restriction on public benefits eligibility is considered immigration policy because it imposes an auxiliary burden on lawfully present noncitizens that is stricter than the conditions that Congress has imposed on their residence.⁴⁴⁷ If it is not preempted, equal protection principles apply because states lack a like power to regulate.⁴⁴⁸ The Court struck down the alienage restrictions because the states' cost-based rationales did not satisfy strict scrutiny.⁴⁴⁹

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.⁴⁵⁰ 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.⁴⁵¹ With the passage of PRWORA, Congress largely eliminated the divergent treatment of state and federal alienage restrictions on federal public benefits 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."⁴⁵²

Post-PRWORA, 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 gov-

⁴⁴⁶ *Id.* at 376–78.

⁴⁴⁷ *See id.* at 378–79 (“[W]here the federal government, in the exercise of its superior authority in this field, has enacted a complete scheme of regulation . . . states cannot, inconsistently with the purpose of Congress, conflict or interfere with, curtail or complement, the federal law, or enforce additional or auxiliary regulations.” (alteration in original) (quoting *Hines v. Davidowitz*, 312 U.S. 52, 66–67) (1941)).

⁴⁴⁸ *See id.* at 377–78. LPRs have long been considered “persons” protected by the Equal Protection Clause of the Fourteenth Amendment. *See Takahashi v. Fish & Game Comm’n*, 334 U.S. 410, 419 n.7 (1948) (citing several Supreme Court cases dating back to 1886 recognizing this principle). State discrimination against undocumented immigrants, on the other hand, has not been subject to heightened scrutiny except for in one case, *Plyler v. Doe*, in which the Supreme Court applied intermediate scrutiny to a Texas law restricting public education access to undocumented immigrants. *Cf.* 457 U.S. 202, 230 (“If the State is to deny a discrete group of innocent children the free public education that it offers to other children residing within its borders, that denial must be justified by a showing that it furthers some substantial state interest. No such showing was made here.”).

⁴⁴⁹ *Graham*, 403 U.S. at 376.

⁴⁵⁰ Jenny-Brooke Condon, *The Preempting of Equal Protection for Immigrants?*, 73 WASH. & LEE L. REV. 77, 93, 102–03 (2016).

⁴⁵¹ *See* Parmet, *supra* note 6, at 226.

⁴⁵² *Id.* at 233 n.81.

erning a state-funded, state-administered program—in which case strict scrutiny would still apply.⁴⁵³ In essence, in the area of public benefits, Congress has devolved its authority to discriminate against noncitizens with limited judicial review to states.⁴⁵⁴ 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 among 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 noncitizen eligibility for Medicaid represents a barrier. In this Section, I describe the fiscal and political barriers that frustrate state efforts to enact inclusionary policies that address the healthcare needs of noncitizens.

Any expansion of health coverage, whether it is at the state or federal level, requires the infusion of public funds. For states, Medicaid is both a major expenditure and the largest source of federal funding.⁴⁵⁵ In terms of fiscal capacity, states begin at remarkably different baselines. In addition, states have varying ratios of noncitizen residents 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.⁴⁵⁶ 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."⁴⁵⁷ In the broader health reform context, we see that some states have cited fiscal concerns as one reason for declining to

⁴⁵³ See Conn. Att'y Gen., Opinion No. 2004-002, Opinion Letter on Constitutionality of 2002 Conn. Pub. Acts No. 02-07 (Feb. 24, 2004). As described in note 448, *supra*, this bifurcated standard does not apply to state discrimination against undocumented noncitizens.

⁴⁵⁴ In Massachusetts and New York, courts have determined that alienage restrictions for subsidized health coverage that apply to lawfully present immigrants violate their state constitutions. See Parment, *supra* note 6, at 234 (citing *Finch v. Commonwealth Health Ins. Connector Auth.*, 959 N.E.2d 970, 984 (Mass. 2012) and *Fayad ex rel. Aliessa v. Novello*, 754 N.E.2d 1085, 1098–99 (N.Y. 2001)).

⁴⁵⁵ Robin Rudowitz, Kendal Orgera & Elizabeth Hinton, *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (Mar. 21, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/view/print>.

⁴⁵⁶ Cf. ZIMMERMANN & TUMLIN, *supra* note 156, at 4 ("States with higher per capita incomes are also generally more likely to provide assistance than states with lower per capita incomes.").

⁴⁵⁷ David A. Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2587 (2005).

adopt the ACA Medicaid expansion, even though federal support for expansion is exceptionally generous.⁴⁵⁸ 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. For example, PRWORA imposed a five-year bar on LPR eligibility for Medicaid, with limited exceptions.⁴⁵⁹ Immediately post-PRWORA, states had to consider the fiscal implications of devoting state funds to restoring Medicaid eligibility to certain LPRs for whom expansion was optional. More dauntingly, states were faced with the decision of whether to use state funds only to restore publicly funded health coverage for LPRs during their first five years in the United States. It is likely that some states concluded that it was infeasible to do so.⁴⁶⁰ After the ICHIA options became available, providing states with the opportunity to expand Medicaid to a subset of noncitizens who had lost coverage under PRWORA, states once again weighed the decision of devoting significant state funds to expanding access to health coverage for low-income noncitizens against other fiscal needs.

Most states, unlike the federal government, are constitutionally required to balance their budgets every year.⁴⁶¹ 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 *increase* spending when revenues are down.⁴⁶² 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 noncitizens.

⁴⁵⁸ See David K. Jones, Phillip M. Singer & John Z. Ayanian, *The Changing Landscape of Medicaid: Practical and Political Considerations for Expansion*, 311 JAMA 1965, 1966 (2014) (describing state officials' concerns that the federal government will not sustain its increased share of Medicaid funding, further burdening states in the long term). The federal share of the cost of Medicaid expansion was 100% from 2014 to 2016, phasing down to 90% in 2020. *Id.* at 1965.

⁴⁵⁹ See *supra* notes 151–55, 158 and accompanying text.

⁴⁶⁰ See ZIMMERMANN & TUMLIN, *supra* note 156, at 46 (“States with higher per capita incomes are generally more likely to provide assistance than states with lower per capita incomes. States with the lowest per capita incomes almost uniformly provide fewer benefits”); Reese et al., *supra* note 26, at 117 (“[L]egal immigrants’ welfare rights partly depend on economic conditions. . . . [S]tates adopted more exclusive policies when they had a higher poverty rate (and hence a larger demand for welfare).”).

⁴⁶¹ Super, *supra* note 457, at 2608–09.

⁴⁶² See *id.* at 2632–33.

Even if a state had elected federal options to expand Medicaid to some noncitizens and then cut coverage of these groups during a recession, it is unlikely that the former level of coverage would be restored after the recession. During economic recoveries, states rarely restore eligibility and services back to their prior level due to competition for resources from other programs. Spending generally declines as the economy improves and fewer residents qualify.⁴⁶³ Therefore, state balanced budget requirements, among other structural influences, have the effect of systematically ratcheting down state spending on countercyclical programs over time.⁴⁶⁴ With fewer resources to devote to subsidizing health coverage overall, programs covering the least politically appealing groups, such as low-income noncitizens, are deprioritized.⁴⁶⁵ For example, post-PRWORA, most states were not persuaded to maintain the status quo of coverage for lawfully present but non-qualified noncitizens.⁴⁶⁶ Programs that cover populations that are ineligible for Medicaid matching funds, such as undocumented noncitizens, may be considered the most expendable from both fiscal and political perspectives.

By 1998, only fourteen states had used state funds to restore publicly funded health insurance comparable to Medicaid for noncitizen groups affected by PRWORA's five-year bar.⁴⁶⁷ Some states initially restored eligibility for state-funded health coverage to only a subset of noncitizens affected by the five-year bar. For example, within two years of PRWORA's passage, Illinois and Rhode Island provided coverage to noncitizen children and pregnant women; Maryland provided coverage to noncitizen children, full-time students expected to complete high school before the end of the calendar year, and pregnant noncitizens; Virginia provided coverage to noncitizen children and noncitizens receiving Medicaid and living in long-term care facilities on June 30, 1997; and Washington and Connecticut imposed new residency requirements of twelve months and six months, respectively, for noncitizens who were no longer eligible for Medicaid because of the five-year bar.⁴⁶⁸ Since then, at least fifteen more states have used

⁴⁶³ *Id.* at 2635–36 (“[T]hese programs’ budgets are vulnerable to budget-driven cuts in bad economic times and demand-driven reductions in good ones.”).

⁴⁶⁴ *Id.* at 2615.

⁴⁶⁵ *See 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”).

⁴⁶⁶ Wishnie, *supra* note 6, at 514–16.

⁴⁶⁷ *See* ZIMMERMANN & TUMLIN, *supra* note 156, at 59 tbl.4.

⁴⁶⁸ *See id.* at 64 tbl.8.

exclusively state funds to provide publicly funded health coverage to categories of noncitizens excluded by PRWORA.⁴⁶⁹

These state-funded programs differ significantly in terms of the eligible noncitizen categories,⁴⁷⁰ reflecting different priorities about how best to fill the gaps that federal law leaves behind. This variability is a function of PRWORA's new federal floor of noncitizen eligibility for Medicaid and its devolution of authority to states to determine noncitizen eligibility for groups above that floor. Even some states that had provided relatively generous benefits to lawfully present noncitizens in the past "reset" their floor during this period of public benefits retrenchment in order to maintain high benefit levels for the mandatory coverage groups.⁴⁷¹

Since fiscal and political concerns are typically two sides of the same coin, a related way in which the federalism arrangement governing noncitizen eligibility for Medicaid creates a barrier for inclusionary policymaking is by siloing state-level advocacy. In consequence, it becomes harder for organizations to harness synergies and pool knowledge and resources to advance equitable policy.⁴⁷² 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.⁴⁷³ When each state has a different baseline of coverage for immigrants, advocates for inclusionary policy must focus their energy and resources on different goals.

Despite these political and cost-related barriers, recent state efforts to expand coverage for noncitizens are making incremental progress toward coverage for all residents.⁴⁷⁴ California has taken the

⁴⁶⁹ See MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, *supra* note 29, at 1–5. In addition to the six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia, whose programs are discussed in Section I.B, they are Alaska, Colorado, Florida, Hawaii, Minnesota, New Jersey, New Mexico, Ohio, and Pennsylvania. Section I.B.4 reviewed how states have taken advantage of the ICHIA and Unborn Child options to jointly fund coverage for some categories of noncitizens who lost eligibility post-PRWORA.

⁴⁷⁰ See *id.* For example, Minnesota uses state funds only to provide coverage to DACA recipients and individuals who receive services from the Center for Victims of Torture, while New Mexico provides coverage to qualified battered noncitizens and PRUCOL noncitizens who resided in the United States before PRWORA was enacted.

⁴⁷¹ Cf. Reese et al., *supra* note 26, at 105–06.

⁴⁷² See Michener, *supra* note 14, at 119 (describing the “‘many-headed’ [Medicaid] policy that takes very different forms in different places” and thus makes it harder for advocates to coordinate efforts across state lines).

⁴⁷³ See *supra* Section I.B (describing the patchwork of exclusion).

⁴⁷⁴ See, e.g., Odette Yousef, *Undocumented, Low-Income Illinois Seniors Can Soon Get Publicly Funded Health Coverage*, NPR (June 11, 2020), <https://www.npr.org/local/309/2020/06/11/874985727/undocumented-low-income-illinois-seniors-can-soon-get-publicly-funded-health-coverage> (describing how Illinois became “the first state in the country to

lead in this effort by expanding Medi-Cal to undocumented children in 2016 and to young adults up to the age of twenty-six in 2020.⁴⁷⁵ Still, in 2019, a proposal to expand Medi-Cal to all undocumented adults was vigorously debated and ultimately defeated over cost-related concerns.⁴⁷⁶ A modified proposal to cover undocumented senior citizens was defeated on the same grounds.⁴⁷⁷ California governor Gavin Newsom continues to support an expansion of Medi-Cal to undocumented senior citizens, maintaining that universal health coverage will ultimately save money.⁴⁷⁸ In January 2020, he proposed to allocate \$80.5 million from the state general fund for that purpose in the 2020-21 budget.⁴⁷⁹

Meanwhile, in Georgia, undocumented and lawfully present but non-qualified noncitizens are excluded from Medicaid, as are most qualified noncitizens for the first five years after obtaining that status.⁴⁸⁰ The state has not elected any of the federal options to expand Medicaid or CHIP to additional noncitizens.⁴⁸¹ Nor, unsurprisingly, has it created state-funded programs to expand noncitizen access to health coverage.⁴⁸² In 2015, the executive director of

expand publicly funded health care coverage to undocumented seniors and seniors who have held green cards for less than five years,” although fiscal concerns limited the initial proposal to expand state-funded health coverage to all Illinois residents who qualified financially); Rosanna Carvacho, Charlie Iovino, Sage Schafel & Gianna Setoudeh, *Expansion of Medicaid Eligibility for Undocumented Young Adults*, JD SUPRA (Mar. 1, 2019), <https://www.jdsupra.com/legalnews/expansion-of-medicaid-eligibility-for-55794> (describing proposals by California and Washington to expand Medicaid eligibility for undocumented young adults and related fiscal considerations).

⁴⁷⁵ *SB 75 - Full Scope Medi-Cal for All Children*, DHCS, <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB-75.aspx> (last updated July 19, 2019); *Young Adult Expansion*, DHCS, <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/YoungAdultExp.aspx> (last updated July 21, 2020).

⁴⁷⁶ See, e.g., Caiola, *Promise of Health Benefits*, *supra* note 240.

⁴⁷⁷ *Id.*

⁴⁷⁸ See, e.g., Angela Hart, *Newsom Proposes Medicaid Benefits for Undocumented Senior Citizens*, POLITICO (Jan. 10, 2020, 3:11 PM), <https://www.politico.com/states/california/story/2020/01/10/newsom-proposes-medicaid-benefits-for-undocumented-senior-citizens-1248937> (noting that “Gov. Gavin Newsom is proposing that California provide Medicaid benefits to undocumented senior citizens” and citing the Governor’s remarks that doing so “is the right thing morally” and also “financially responsible”).

⁴⁷⁹ *Id.*

⁴⁸⁰ See Laura Harker, *Five-Year Waiting Period Is a Barrier to Immigrant Health Care Access*, GA. BUDGET & POL’Y INST. (Oct. 21, 2019), <https://gbpi.org/2019/five-year-waiting-period-barrier-immigrant-health> (“Georgia children and pregnant women who are lawful permanent residents (LPRs or ‘green card’ holders) typically must wait five years after they gain this status to be eligible for Medicaid or PeachCare.”).

⁴⁸¹ See *id.* (“When the CHIP Reauthorization Act of 2009 was signed into law on February 4, 2009, it included several policies to get more children enrolled in health care coverage. . . . Georgia’s Medicaid agency can take [these options] . . .”).

⁴⁸² See MEDICAL ASSISTANCE PROGRAMS FOR IMMIGRANTS IN VARIOUS STATES, *supra* note 29 (listing states that provide access to health coverage to noncitizens beyond the

Georgians for a Healthy Future, an advocacy group dedicated to closing the coverage gap for low-income Georgians, observed: “We are having a very different conversation . . . I think we are really far away as a state from where California is.”⁴⁸³ Health advocacy efforts are currently focused on supporting Medicaid expansion for low-income citizens and otherwise eligible immigrants.

This is a sign of a larger flaw in Medicaid’s structure. 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.”⁴⁸⁴ 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.⁴⁸⁵ 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, advocacy organizations are divided on whether to support the effort.⁴⁸⁶ One can imagine how immigrant-inclusionary policy would meet a similar fate, dividing healthcare consumers who would otherwise stand to benefit from joint advocacy.⁴⁸⁷

federal floor of Medicaid and CHIP coverage and enumerating the programs offered, but excluding other states, such as Georgia, that offer no such access).

⁴⁸³ Anna Gorman, *California Has Novel View of Health Care for Undocumented Immigrants*, USA TODAY (Jan. 17, 2015), <https://www.usatoday.com/story/news/nation-now/2015/01/17/california-dramatically-different-approach-to-health-care-for-undocumented-immigrants/21871167>.

⁴⁸⁴ Michener, *supra* note 14, at 119.

⁴⁸⁵ See *id.* at 120 (“Although [health policy advocates] continue to push back as each new hurdle is erected, doing so absorbs energy that might otherwise be useful for mobilizing more broadly and deeply, thinking beyond the most immediate political challenges and organizing affirmatively—not just against regressive change but for positive change.”).

⁴⁸⁶ See Michener, *supra* note 14, at 120–21; *Georgia Proposal to Partially Expand Medicaid Would Disproportionately Jeopardize Patients with Cancer*, ASCO (Jan. 21, 2020), <https://www.asco.org/practice-policy/policy-issues-statements/asco-in-action/georgia-proposal-partially-expand-medicaid>; Jill Nolin, *Commenters Question State Medicaid Waiver Plan for Work Requirements*, GA. RECORDER (Dec. 13, 2019), <https://georgiarecorder.com/2019/12/13/commenters-question-state-medicaid-waiver-plan-for-work-requirements>.

⁴⁸⁷ *Id.* at 125–26 (“[T]hese negative feedback processes can dampen coalitional possibilities by straining the organizations that might work to forge coalitions and dividing those with the most at stake.”).

IV THE LIMITS OF DECENTRALIZED POLICY

As described in Part I, federalism arrangements in healthcare are not constitutionally required.⁴⁸⁸ 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 which it indisputably possesses the power to regulate.⁴⁸⁹ 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.⁴⁹⁰

Policy experimentation is the federalism value that is most often used to justify cooperative federalism arrangements in the regulation of healthcare and is the focus of this discussion.⁴⁹¹ In theory, federalism arrangements enable states to engage in policy experimentation.⁴⁹² 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 counterproductive side effects. This is Justice Brandeis's well-known depiction of states as "laboratories of democracy."⁴⁹³

However, federalism arrangements do not always produce optimal experimentation. This Part explores the limits of decentralization for producing optimal policy, showing why the current structure of Medicaid fails to meet the goals of federalism itself. I identify the mechanisms that stifle state policy experimentation and that impede

⁴⁸⁸ See discussion *supra* notes 81–84.

⁴⁸⁹ For example, Abbe Gluck has described four ways in which state implementation of federal law can benefit federal lawmaking: it can do so by (1) encouraging and influencing experimentation at the state level; (2) entrenching federal statutory norms; (3) easing entry into 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. Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 *YALE L.J.* 534, 565 (2011). 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's decision to devolve authority over immigrant eligibility for Medicaid to the states.

⁴⁹⁰ See Gluck & Huberfeld, *supra* note 6, at 1799.

⁴⁹¹ Huberfeld, *supra* note 34, at 457.

⁴⁹² *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) ("It is one of the happy incidents of the federal system that a single courageous 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.")

⁴⁹³ See *id.*

replication by other states. Although this Part focuses on the devolution of policy governing noncitizen 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 equality.

A. Sluggish Experimentation

In the ideal conception of states as laboratories of democracy, states would compete to test hypotheses about the effects of expanding or restricting noncitizen eligibility for publicly funded health coverage. But states have not done this in practice. Rather, experimentation has been sluggish, and immigrant-inclusive policy diffusion is nearly nonexistent.

One of the challenges of policy learning across states in this context is undoubtedly ideological polarization on issues relating to noncitizens' rights. Restrictionist ideology can cloud state officials' judgment even in the face of empirical evidence contradicting their views. For example, in popular and scholarly discourse, a principal argument against offering generous healthcare or other benefits to noncitizens is the fear of creating a "welfare magnet" for low-income noncitizens.⁴⁹⁴ The welfare magnet hypothesis predicts that low-income noncitizens will cluster in nations or states with the most generous benefits.⁴⁹⁵ Despite the dominance of this justification for immigration restrictionism, theoretical and empirical social science literature on the relationship between welfare states and immigration is surprisingly sparse.⁴⁹⁶ Existing empirical support for the welfare magnet hypothesis is mixed, and there is some evidence against it in the Medicaid context.⁴⁹⁷ One recent study examining interstate migra-

⁴⁹⁴ See, e.g., Corrado Giulietti, *The Welfare Magnet Hypothesis and the Welfare Take-up of Migrants*, 37 IZA WORLD LAB. 1, 3 (2014) ("There is a widespread perception in developed countries that immigrants from less-developed areas . . . potentially decide to migrate to countries offering more generous welfare programs."); Peter Nannestad, *Immigration and Welfare States: A Survey of 15 Years of Research*, 23 EUR. J. POL. ECON. 512, 516–17 (2007) (reviewing scholarly literature on the welfare magnet hypothesis).

⁴⁹⁵ Nannestad, *supra* note 494, at 516–17 (citing George J. Borjas, *Immigration and Welfare Magnets*, 17 J. LAB. ECON. 607 (1999)).

⁴⁹⁶ See *id.* at 513 (noting that most research on the welfare state and immigration has only been done within economics).

⁴⁹⁷ See *id.* at 516–17 (reviewing the mixed findings in the literature on the welfare magnet hypothesis); Giulietti, *supra* note 494, at 4 (reviewing the same body of literature, 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. LAB. ECON. 59, 79 (2005) (finding that the availability and 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

tion of noncitizens between 2000 and 2016 found that state expansions of Medicaid or CHIP to lawfully present children or pregnant women under the ICHIA options were not associated with migration in pursuit of health insurance.⁴⁹⁸ The authors suggest that this conclusion has important implications for states considering expanding health coverage for noncitizens, particularly as they estimate the short- and long-term costs of expansion.⁴⁹⁹ Despite the lack of evidence supporting the welfare magnet hypothesis, it is among the most common objections to expanding public benefits for noncitizens.

Conversely, state-level executive officials like governors and healthcare agency heads may already be persuaded that expanding access for noncitizens is good health policy, but they may be unwilling to enact such policy if they feel it is the federal government's responsibility to remedy the disparity in noncitizen 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 healthcare benefits to them.⁵⁰⁰ 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.⁵⁰¹ Although these lawsuits were ultimately unsuccessful,⁵⁰² they reflect the normative argument that the federal government should indemnify or compensate state governments when federal policies—particularly those that are exclusively within federal authority—create costs for states.⁵⁰³ At times, the federal government has recognized a responsibility to compensate states for such costs, as when it created State Legalization Impact Assistance Grants to assist states

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).

⁴⁹⁸ Vasil I. Yassenov, Duncan Lawrence, Fernando S. Mendoza & Jens Hainmueller, *Public Health Insurance Expansion for Immigrant Children and Interstate Migration of Low-Income Immigrants*, 174 JAMA PEDIATRICS 22, 27 (2020).

⁴⁹⁹ *Id.*

⁵⁰⁰ See *Chiles v. United States*, 874 F. Supp. 1334 (S.D. Fla. 1994), *aff'd*, 69 F.3d 1094 (11th Cir. 1995), *cert. denied*, 517 U.S. 1188 (1996); Legomsky, *supra* note 6, at 1471 (describing state lawsuits against the federal government to recover social service costs associated with undocumented immigration).

⁵⁰¹ See Bulman-Pozen & Gerken, *supra* note 436, at 1267 (explaining that one of the main arguments against commandeering is the belief that the federal government should cover the costs of its policies); Calvo, *supra* note 73, at 411 (describing how Florida senators successfully advocated for making PRUCOL noncitizens eligible for SSI in 1972 based on the disproportionate economic burden they would face if eligibility for the benefit were more restrictive).

⁵⁰² All were dismissed as presenting a nonjusticiable political question.

⁵⁰³ See Super, *supra* note 457, at 2572 (describing the compensatory model).

with the costs of providing social services to formerly undocumented noncitizens who obtained status through the Immigration Reform and Control Act of 1986.⁵⁰⁴ In the absence of such recognition and assistance, states may be driven to make suboptimal policy.⁵⁰⁵ When states fail to enact the policies that they deem optimal for their populations, federalism is not producing useful knowledge from the state laboratories.

More broadly, PRWORA crippled meaningful state experimentation on immigrant-inclusive Medicaid policy by making exclusion, 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.”⁵⁰⁶ By imposing new restrictions on the use of federal funds to cover many previously eligible, lawfully present noncitizens, PRWORA made it much harder for states to experiment with inclusive Medicaid policy. States are unable to function as autonomous laboratories because, in the current federalism arrangement, they are heavily beholden to federal funds and, therefore, federal laws dictating how those funds must be spent. Moreover, the reality is that most states are not in a good position to self-fund expansions of publicly funded health coverage to noncitizens because of variability in resources (complicated by the requirement in most states to balance the budget each year) and in where excluded noncitizen populations reside.⁵⁰⁷

Finally, the existing structure of federal exclusion of noncitizens from Medicaid, the state patchwork of coverage, and federal mechanisms to reimburse healthcare providers for treating excluded noncitizens depress state experimentation and produce suboptimal policy. 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

⁵⁰⁴ See *id.* (naming the State Legalization Impact Assistance Grants as one of the few times the federal government has compensated states for costs resulting from federal policies).

⁵⁰⁵ See, e.g., Angela M. Elspenger, *Florida's Battle with the Federal Government over Immigration Policy Holds Children Hostage: They Are Not Our Children!*, 13 *LAW & INEQ.* 141, 147 (1995) (telling the story behind *Chiles v. United States*, in which Florida claimed that it must deny foster care to undocumented noncitizen children in response to the federal government's lack of enforcement of immigration laws and reimbursement for program costs).

⁵⁰⁶ Gluck, *supra* note 489, at 568.

⁵⁰⁷ See discussion *supra* Section III.B.

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 emergency room, the most expensive place to receive care.⁵⁰⁸

The federal government has committed to bearing a significant portion of these costs through programs to partially reimburse states such as Emergency Medicaid,⁵⁰⁹ Disproportionate Share Hospital payments,⁵¹⁰ and supplemental funding for healthcare provided to undocumented noncitizens.⁵¹¹ By stepping in to cushion the costs of bad policy, the federal government creates another disincentive for state innovation. 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 noncitizen eligibility for Medicaid would avoid this scenario.

On the other hand, if the federal government did not absorb some of the costs of healthcare for excluded noncitizens, there would be a risk 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 healthcare benefits would enact policies that are less generous than those of their neighbors.⁵¹² Specifically, in this context, states would select more restrictive alienage criteria for Medicaid.⁵¹³ From both the state and national perspectives, the race to the bottom would produce suboptimal policy for residents who would benefit from health coverage.

⁵⁰⁸ See *supra* notes 383–84 and accompanying text.

⁵⁰⁹ See *supra* notes 386–88 and accompanying text.

⁵¹⁰ See Teresa A. Coughlin, Leighton Ku & Johnny Kim, *Reforming the Medicaid Disproportionate Share Hospital Program*, 22 HEALTH CARE FINANCING REV. 137, 137, 139 (2000); Super, *supra* note 228, at 8–9; see also discussion *supra* Section I.B.2.

⁵¹¹ See Legomsky, *supra* note 6, 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); Perkins, *supra* note 356, 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 immigrants).

⁵¹² See Jan K. Brueckner, *Welfare Reform and the Race to the Bottom: Theory and Evidence*, 66 SOUTHERN ECON. J. 505, 507 (2000) (explaining the race-to-the-bottom argument in favor of federal welfare contributions in the form of matching grants). Even though the evidence does not support the existence of a welfare magnet effect, states may rely on it out of fear or xenophobia.

⁵¹³ See Legomsky, *supra* note 6, at 1471 (explaining how state-level cuts to public benefits could create a race to the bottom if the welfare magnet hypothesis is accepted).

B. *Incidental Health Policy*

Another theoretical benefit of the laboratories of democracy concept is that states should replicate successful healthcare policy experiments.⁵¹⁴ 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 transplants for people with ESKD regardless of citizenship or immigration status.⁵¹⁵ 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.”⁵¹⁶ They assembled evidence that undocumented noncitizens donate a disproportionate share of transplanted organs.⁵¹⁷ Although humanitarian and fairness concerns did play a role in persuading legislators to support the bill, the most persuasive rationale was related to costs, because the cost of providing standard dialysis treatment begins to exceed the cost of a kidney transplant at two years and nine months.⁵¹⁸ Despite this compelling pragmatic and moral case for why states should fund kidney transplants for excluded noncitizens, no other states have followed Illinois’s example. In fact, some states do not even cover regular dialysis treatment for excluded noncitizens with kidney failure.⁵¹⁹

This example demonstrates that even if a state’s policy experimentation produces useful information from a social welfare perspective, other states may not use that information to inform their own policy content.⁵²⁰ Rather, state policies on subsidizing healthcare for noncitizens—like state policies on subsidizing healthcare generally—track other factors (demographic, fiscal, political, etc.) more closely

⁵¹⁴ See Hannah J. Wiseman, *Regulatory Islands*, 89 N.Y.U. L. REV. 1661, 1689 (2014) (explaining that many theories about state policy experimentation expect states to copy the policies of other states when there is accessible information about the policy).

⁵¹⁵ See Ansell et al., *supra* note 120, at 782.

⁵¹⁶ *Id.* at 782–83.

⁵¹⁷ *Id.* at 783–84.

⁵¹⁸ *Id.* at 784.

⁵¹⁹ See *supra* text accompanying notes 119–23.

⁵²⁰ See Jessica Bulman-Pozen, *Executive Federalism Comes to America*, 102 VA. 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); Wiseman, *supra* note 514, at 1718 (2014) (noting that states may produce inadequate information regarding their policy experimentation in part as a result of their “political views”).

than any useful indicator of “good” health policy.⁵²¹ Scholars have also observed a remarkable degree of path dependence in healthcare 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.⁵²²

A tradition of welfare generosity to residents may also influence a state’s decision to provide public benefits to noncitizens. Some scholars have theorized that “states with more generous welfare spending in the past would be more likely to spend more subsequently and to be more inclusive.”⁵²³ 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 PRWORA.⁵²⁴

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.⁵²⁵ 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.⁵²⁶ Reese et al. have proposed various theories to explain the causal mechanisms behind the relationships identified in these studies;⁵²⁷ however, additional research is needed to determine the precise mechanisms by which these relationships operate.⁵²⁸

⁵²¹ See Reese et al., *supra* note 26 (describing the relationship between states’ decisions to restore public benefits eligibility to authorized noncitizens after PRWORA and various other factors).

⁵²² See Gluck & Huberfeld, *supra* note 6, at 1717 (discussing poorer, southern states’ reluctance to expand Medicaid and wealthier states’ embrace of the ACA’s Medicaid expansion).

⁵²³ Reese et al., *supra* note 26, at 105 (describing the “institutionalist perspective”).

⁵²⁴ ZIMMERMANN & TUMLIN, *supra* note 156, at 46. Some studies have found that states with more immigrant-inclusive welfare policies tend to provide less generous TANF benefits. Rodney E. Hero & Robert R. Preuhs, *Immigration and the Evolving Welfare State: Examining Policies in the U.S. States*, 51 AM. J. POL. SCI. 498, 510 (2007) [hereinafter Hero & Preuhs, *Immigration and the Evolving Welfare State*]. 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 26, at 106 (citing Rodney E. Hero & Robert R. Preuhs, *Black-Latino Political Relationships: Policy Voting in the U.S. House of Representatives*, 38 AM. POL. RES. 531 (2010) for the first explanation and Ybonne Zylan and Sarah A. Soule, *Ending Welfare As We Know It (Again): Welfare State Retrenchment, 1989–1995*, 79 SOC. FORCES 623 (2000) for the second explanation).

⁵²⁵ Brown & Kahn Best, *supra* note 26, at 789.

⁵²⁶ Hero & Preuhs, *Immigration and the Evolving Welfare State*, *supra* note 524 (finding no relationship); Reese et al., *supra* note 26 (finding a positive relationship).

⁵²⁷ Reese et al., *supra* note 26, at 104–05.

⁵²⁸ See *id.* at 119 (describing the types of data and future research that are needed to establish the causal mechanisms behind these relationships).

State policies on the subject of noncitizen eligibility for publicly funded health coverage are motivated more by factors unrelated to good health policy. Rather, they are what I term “incidental health policy,” untethered to the normative goals of efficiency and equity. Since states in this context are not functioning as effective laboratories of experimentation for health policy, this justification for federalism does not apply.

CONCLUSION

A decade after the passage of the ACA, prominent Democratic lawmakers have co-sponsored “Medicare for All” bills in the House and Senate that would transform the U.S. healthcare system into a single-payer system for “[e]very individual who is a resident of the United States,” including, potentially, currently excluded non-citizens.⁵²⁹ Others, including President-elect Joseph R. Biden Jr., support more modest plans that would build on the ACA and herald a new standard of inclusion of noncitizens in publicly funded health insurance programs.⁵³⁰ Although there is substantial popular support for preserving the ACA’s coverage expansions and protections, the idea of including more noncitizens in national health insurance programs is deeply contested.⁵³¹

⁵²⁹ 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, they delegate 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 undocumented immigrants. *See, e.g.*, Paulina Firozi, *Jayapal’s Medicare-for-All Bill Reflects Influence of Hard-Line Progressive Groups*, WASH. POST: THE HEALTH 202 (Mar. 11, 2019), <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/03/11/the-health-202-jayapal-s-medicare-for-all-bill-reflects-influence-of-hard-line-progressive-groups/5c82a8d61b326b2d177d6037/>; Bernie Sanders (@BernieSanders), TWITTER (June 21, 2019, 12:31 PM), <https://twitter.com/BernieSanders/status/1142107691671859200> (“If you are a human being, regardless of your immigration status, you have a right to health care. #MedicareForAll.”).

⁵³⁰ *See* Medicare for America Act of 2019, H.R. 2452, 116th Cong. § 111 (2019) (stating that all residents who would be eligible for Emergency Medicaid, which has no alienage restriction, would qualify for coverage); Larry Levitt, *Trump vs. Biden on Health Care*, JAMA HEALTH FORUM (Sept. 3, 2020) (describing Biden’s proposal to expand Medicaid and CHIP to a broader group of noncitizens and to allow undocumented noncitizens to purchase unsubsidized coverage on the ACA Marketplaces).

⁵³¹ *Compare* Proclamation No. 9945, 84 Fed. Reg. 53,991 (Oct. 9, 2019) (restricting the entry of immigrants “who will financially burden the United States healthcare system”), with N.Y. Times Editorial Board, Opinion, *With Coronavirus, ‘Health Care for Some’ Is a Recipe for Disaster*, N.Y. TIMES (Mar. 6, 2020), <https://www.nytimes.com/2020/03/06/opinion/coronavirus-immigrants-health.html> (noting doctors’ and immigration advocates’ concerns that the Trump Administration’s public charge rule “could deter millions of noncitizens . . . from using programs like Medicaid, WIC and SNAP or from seeking medical care of any kind”).

Why should the United States subsidize the healthcare of non-citizens, especially if they are undocumented? Not only is it morally imperative to provide coverage to all who need it, but it is also directly beneficial to the community as a whole. The entire community benefits along a number of measures when all receive access to health coverage. Moreover, because taxpayers already subsidize healthcare for some excluded noncitizens, the question, more accurately, is how to realize these benefits in the most efficient way, where greater efficiency has a substantial connection to greater equity. Through various safety net programs, federal subsidies to healthcare 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 noncitizen eligibility for subsidized health coverage, the United States spends approximately \$18.5 billion to subsidize the healthcare of noncitizens who are currently excluded from Medicaid.⁵³²

When Congress passed PRWORA in 1996, it devolved authority to the states to make policy about noncitizen 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, cost-effectiveness, and quality; it cuts against the emerging norm of healthcare equity within health law scholarship and healthcare 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 noncitizens is a fiscally responsible option that also helps to safeguard public health and align policy with ethical norms in healthcare.

This Article analyzes the role of federalism in shaping states' policy decisions about noncitizen eligibility for Medicaid. Although federalism theory has coalesced around the idea that federalism has no political valence,⁵³³ 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 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.

⁵³² Conover, *supra* note 45.

⁵³³ See, e.g., Heather K. Gerken, *Distinguished Scholar in Residence Lecture: A User's Guide to Progressive Federalism*, 45 HOFSTRA L. REV. 1087, 1087 (2017) (“[F]ederalism doesn't have a political valence.”).

For states that wish to expand noncitizen eligibility for Medicaid, the current federalism arrangement poses legal, fiscal, 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 federal ceiling of Medicaid coverage excludes a substantial population of noncitizens residing in the United States, such as all but a few categories of LPRs during their first five years of residence, DACA recipients, and undocumented noncitizens—including those noncitizens with pending immigration applications. Although there are federal options to expand Medicaid coverage to select groups of noncitizens, state fiscal concerns can pose an insurmountable barrier to electing those options, as well as to creating state-funded programs to expand coverage for noncitizens.

By examining the role of federalism in shaping state policies that exclude noncitizens 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 noncitizens, this Article demonstrates the uphill battle they face. Under an administration that is hostile to progressive health policy embodied by the ACA, advocates for inclusionary health reform are looking to state-based solutions. It is therefore important to acknowledge that, for some issues, the potential for large-scale reform at the state level is weak.

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 healthcare equity. It links evidence about the uneven patchwork of subsidized health coverage for noncitizens 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 non-citizen eligibility for Medicaid could correct or reverse the existing imbalance. It would also promote uniformity, transparency, and equity in noncitizen access to healthcare among the states.⁵³⁴ Centralization does not necessarily require federalizing the entire healthcare system or even Medicaid. Thoughtful federal reforms to Medicaid that

⁵³⁴ See Huberfeld, *supra* note 34, at 473.

create a more unified and inclusive national policy on noncitizen eligibility could be just as effective.

Potential approaches to immigrant-inclusive reform run the gamut from radical to incremental. 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 noncitizen eligibility for Medicaid by eliminating the five-year bar for LPRs. Alternatively, Congress could remove the federal ceiling on noncitizen eligibility for Medicaid by eliminating the citizenship and immigration status criterion entirely.⁵³⁵ This would have the effect of enabling states to make inclusionary policy while not requiring states to expand coverage. By both raising the floor and removing the ceiling, Congress could reverse the existing imbalance by making it easier for states to expand coverage for non-citizens 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.⁵³⁶ There are ways to structure a mostly federalized regime in order to preserve values typically associated with decentralization, such as competition and experimentation. Giving states some flexibility with federal guardrails may enable 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 noncitizen eligibility for subsidized health coverage with different funding mechanisms attached to each option. For example, each of the following would be an improvement on the status quo of noncitizen exclusion from publicly funded

⁵³⁵ 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) (2018) (general rule); *id.* at § 1611(b) (exceptions). The reason why undocumented and other excluded noncitizens are currently able to access Emergency Medicaid, 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. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, § 401(b), 110 Stat. 2105 (codified at 8 U.S.C. § 1611(b)).

⁵³⁶ Bulman-Pozen & Gerken, *supra* note 436, at 1268.

health coverage: (1) Medicaid expansion to all income-qualifying state residents, regardless of citizenship or immigration status, based on the existing per capita funding structure with, perhaps, an eFMAP in the initial years as in the ACA Medicaid expansion; (2) elimination of the citizenship and immigration status criterion for purchasing insurance from the Marketplaces; and (3) a categorical grant to finance health coverage for excluded noncitizens that meets federally established standards of creditable coverage. This strategy would allow states to retain some autonomy, preserve some of the experimentation benefits of decentralized policymaking, and still potentially achieve universal health coverage.⁵³⁷ These are just some of the potential approaches and issues that are worthy of further investigation as the United States reexamines its commitment to sharing healthcare costs and risks, achieving universal coverage, and financing health reform.

A possible objection to centralizing policy on noncitizen 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 non-citizens.⁵³⁸ This would be unfortunate and would make terrible health policy, but Congress can do that today with the current 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 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 governing structure of noncitizen eligibility for Medicaid, which enables states to become “laboratories of exclusion” rather than experimentation. In

⁵³⁷ Some might argue that, on this issue, there are no real differences among the states that justify offering these options. After all, there are excluded noncitizens living in every state and they all have bodies that can contract diseases, malfunction, age, or be injured (regardless of whether they live in California or Wyoming). On a topic as polarized and racialized as immigration, the only reason states might choose one option over the other is ideology. I do not necessarily disagree; I offer this as a proposal that may placate various constituencies while still moving our national health system toward greater efficiency and equity.

⁵³⁸ See Howard F. Chang, *Public Benefits and Federal Authorization for Alienage Discrimination by the States*, 58 N.Y.U. ANN. SURV. AM. L. 357, 369 (2002) (explaining how, in a slightly different context, if Congress is “required to impose a uniform rule nationwide, [it] could respond to these concerns with a nationwide rule of exclusion, imposed even on those states that would prefer to be more generous”).

this historical and policy context, federal leadership is needed in order to enact inclusive policy on noncitizen eligibility for health coverage.