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Health Care and the Illegal Immigrant

Patrick Glen

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Health Care and the Illegal Immigrant

Patrick Glen†

Abstract

The question of whether illegal immigrants should be entitled to some form of health coverage in the United States sits at the intersection of two contentious debates: health reform and immigration reform. Proponents of extending coverage argue that the United States has a moral obligation to provide health care to all those within its borders. Conversely, those against doing so argue that immigrants illegally present in the country should not be entitled to public benefits. This Article seeks to chart a middle course between these extremes while answering two questions. First, does constitutional law mandate extending health coverage to illegal immigrants? Second, even if not legally mandated, are there compelling policy reasons for extending such coverage? This Article concludes that while health coverage for illegal immigrants is not required under prevailing constitutional norms, extending coverage as a matter of policy would serve the broader interests of the United States. Extending coverage would be beneficial as a matter of economics and public health, generating spillover benefits for all US citizens and those in the US healthcare and health insurance systems.

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INTRODUCTION

For those who caricature Canada as an endlessly welcoming environ for immigrants and unceasingly generous in its provision of health and other public benefits, these expectations were dealt a dual blow by the Federal Court of Appeal’s 2011 decision in Toussaint v. Attorney General.1 In that decision, the court determined that an illegal immigrant was properly excluded from a federal health insurance program and held that benefits under that program were only available to a narrow class of resident aliens and a limited number of illegal aliens within the control and jurisdiction of the Canadian immigration authorities. The decision was applauded by those who believed it would deter medical tourism—the legal or illegal entry of an alien for the purposes of obtaining medical treatment or services unavailable in the alien’s home country.2 In the words of one Canadian lawyer, “[t]his case is extremely important because it limits the potential claims that other classes of people in Canada may make for medical coverage, such as visitors or those without any status and under the radar, of which the number is currently unknown but estimated in the hundreds of thousands.”3 But others contested that Toussaint would not affect incidences of medical tourism. One Toronto-area doctor wrote that “[w]hile the government may have legal grounds to justify denying illegal immigrants health coverage, it is naïve to think this will protect [Canada] from the form of medical tourism described [by the court].”4 Still others objected to the legal reasoning of the decision, arguing that the provision of health care to illegal immigrants would be “in accordance with international and humanitarian principles.”5

1. Toussaint v. Canada (Attorney General), 2011 FCA 213 (Can.).
2. See Adrian Humphreys, No Charter Rights to Health Care for Illegal Immigrants; Appeals Court Rules; Decision May Help Prevent Medical Tourism, Expert Says, NAT’L POST (Toronto), July 9, 2011, at A13.
3. Id.
5. Humphreys, supra note 2.
Toussaint points to an increasingly significant issue: how should countries deal with the health concerns of their illegal populations? The reasoning of the Toussaint court, along with the reactions thereto, reflect the controversy this issue has engendered in both Canada and the United States. At one extreme, it is argued that illegal immigrants should not have access to public benefits, as this would impede lawful citizens’ ability to enjoy those benefits. At the other extreme, it is argued that there is a moral or ethical obligation to provide health services to anybody within a country, regardless of his legal status or right to be present. Although US courts have not had occasion to pass on this issue as decisively as the Canadian Federal Court of Appeal, Touissant’s partisan discourse was paralleled in the United States during the debate over the Patient Protection and Affordable Care Act (ACA). Illegal immigrants are not covered under the ACA’s individual mandate provision, nor are they entitled to any government subsidies or other benefits associated with the reform. Nonetheless, the mere hint that illegal immigrants might be able to take advantage of some of the reforms generated rhetorical shock waves.

This Article begins by exploring whether some form of health care must be extended to illegal immigrants under either the Canadian Charter of Rights and Freedoms or the US Constitution. Next, this Article considers whether some form should be extended regardless of whether the law requires that extension. The first question is a legal one: whether illegal immigrants have a claim to public benefits in a country where they otherwise have no status. The second question is policy-oriented: whether, regardless of if health care legally must be extended,

6. See, e.g., Leighton Ku, Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States, 99 AM. J. PUB. HEALTH 1322, 1322 (2009) (“Some . . . believe that ‘high rates of immigration are straining the health care system to the breaking point’ or that ‘illegal aliens in [the United States] are taking a large part of [its] health care dollars.’") (internal citations omitted).

7. See id. (“[O]thers believe that steps should be taken to bolster immigrants’ health care, such as restoring their eligibility for Medicaid or having insurers pay for interpreter services for patients who are not proficient in English.”).


10. See, e.g., Charles Krauthammer, Does He Lie?, NAT’L REV. ONLINE (Sep. 18, 2009, 12:00 AM), http://www.nationalreview.com/articles/228267/does-he-lie/charles-krauthammer# (chronicling Representative Joe Wilson’s outburst during President Obama’s 2009 joint address to Congress on his health form plan).
there are compelling economic or pragmatic reasons for extending certain health services or insurance to illegal immigrants. In answering these questions, this Article seeks to steer a middle course between the rhetorical extremes of the healthcare and immigration debates. By narrowly focusing on aspects of the problem that appeal to their constituencies, the extremes have become myopic and minimized many of the nuances that could contribute to a broad-based and equitable solution. By focusing on the purely legal and policy questions raised by the issue, this Article seeks to chart a moderate course that could culminate in a solution that, even if not perfectly acceptable to the extremes, would best serve the needs of the affected populations.

Part I of this Article reviews the Canadian and US constitutional provisions relevant to the legal consideration of the issue. While both countries do offer protections to everyone within their borders regardless of legal status, these protections are neither limitless nor coextensive with those offered to citizens. Part II charts the course of the *Toussaint* decision through the Federal Court of Canada and the Federal Court of Appeal. This section highlights the general legal reasoning that should be applied to the question of whether some form of health care must be extended to illegal immigrants as a matter of law. Parts III and IV move beyond the specifics of *Toussaint* and attempt to answer the two questions posed in this Introduction: whether healthcare must be extended to illegal immigrants and whether healthcare should be extended. This Article concludes that although current US and Canadian law, and any foreseeable future evolutions, do not mandate that a state provide its benefits to noncitizens, there are nevertheless compelling policy reasons for extending health services and coverage. These range from economic considerations to public health concerns and strongly indicate that the health and well-being of the population as a whole may be influenced by the level and timing of care offered to illegal immigrants. This Article concludes by outlining some ideas about how best to extend healthcare coverage to illegal immigrants.

I. THE PLACE OF ILLEGAL IMMIGRANTS UNDER CANADIAN AND US CONSTITUTIONAL LAW

Although illegal immigrants possess no status or right to residence in either the United States or Canada, they nevertheless have limited legal and constitutional protections in both countries.

The relevant rights under Canadian law are embodied in the Canadian Charter of Rights and Freedoms. Enacted in 1982, the Charter

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contains such guarantees as due process and equal protection.12 These rights apply to everyone physically present in Canada, not just citizens or those lawfully residing in the country.13 Under Section 7 of the Charter, “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”14 Section 15 states that “[e]very individual is equal before and under the law and has the right to equal protection and equal benefit of the law,” regardless of “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”15 Nevertheless, Section 1 clarifies that these rights and freedoms are subject to “reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”16

The constitutional principles at issue in the United States are analogous to those in the Canadian Charter. As the Supreme Court has noted, “the Due Process Clause applies to all ‘persons’ within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent.”17 While aliens outside the United States are not entitled to constitutional protections, aliens physically present in the country—lawfully or otherwise—enjoy limited protections.18 What process is due depends on specific facts and circumstances and varies from case to case,19 and illegal immigrants do not have rights coextensive


15. Id. § 15.

16. Id. § 1.


19. See Mathews v. Eldridge, 424 U.S. 319, 334-35 (1976) (“[O]ur prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.”); see also Landon v. Plasencia, 459 U.S. 21, 34 (1982); Lassiter v. Dep’t of Soc. Servs, 452 U.S. 18, 24-25
with those of citizens: “[A] host of constitutional and statutory provisions rest on the premise that a legitimate distinction between citizens and aliens may justify attributes and benefits for one class not accorded to the other.”20 The entire structure of immigration law represents line-drawing of a sort that would be impermissible in other circumstances.21 Thus, as the Supreme Court has made clear, distinctions between citizens and immigrants, or between different classes of immigrants, do not give rise to any presumption of a violation of due process or equal protection.

II. NELL TOUSSAINT AND CANADA’S INTERIM FEDERAL HEALTH PROGRAM

In the Toussaint litigation, Canada had an opportunity to confront the main issue presented by this Article: whether, or to what extent, an illegal immigrant is entitled to public health insurance. The judiciary’s resolution of this issue provides the legal frame of reference for much of the analysis that follows.

Nell Toussaint, a native and citizen of Grenada, entered Canada as a visitor on December 11, 1999.22 She overstayed her visa and continued to reside in Canada without legal status.23 Nevertheless, Toussaint was employed between 1999 and 2006 and was able to pay her medical expenses during this time, even without health insurance.24 After 2006, however, her failing health led to an increasing need for medical services.25

In June 2008, Toussaint had surgery to remove uterine fibroids, although she was unable to pay the costs of the procedure.26 Shortly after, Toussaint was hospitalized for ten days for uncontrolled hypertension and further diagnosed with nephrotic syndrome, a kidney disorder that may have resulted from her preexisting diabetes.27 Because Toussaint could not afford tests to find the causes of her nephrotic syndrome, she was discharged from the hospital with a prescription for high-blood-pressure medication.28


21. Id. at 80.
22. Toussaint v. Canada (Attorney General), 2010 FC 810, at para. 5 (Can.).
23. Id.
24. Id. at para. 6.
25. Id.
26. Id. at para. 7.
27. Id. at para. 8.
28. Id.
In February 2009, Toussaint experienced pain in her right leg that was diagnosed as potential deep venous thrombosis.\(^{29}\) A diagnostic ultrasound was denied by the hospital—again, because Toussaint could not afford the procedure.\(^{30}\) After developing chest pains, Toussaint returned to the hospital with legal counsel.\(^{31}\) An examination revealed a pulmonary embolism.\(^{32}\) Toussaint was discharged after an eight-day hospitalization with a month’s supply of medication.\(^{33}\)

At the time of her proceedings before the Federal Court of Canada, Toussaint was described as “forty years old, divorced, and living in poverty.”\(^{34}\) Two medical experts provided grim prognoses of her health. One expert testified that Toussaint’s medical problems were “severe” and could be “life-threatening over the short term,” adding that Toussaint required “intensive medical management by highly skilled professionals, including medical subspecialists.”\(^{35}\) He concluded that Toussaint’s reliance on pro bono care was “extremely unsatisfactory and potentially dangerous because of delays caused by lack of coverage and her inability to pay.”\(^{36}\) The second expert testified that Toussaint’s inability to afford medication in the past contributed to the poor control of her diabetes and hypertension, and continued non-treatment would expose her to a high risk of long-term or severe complications and even immediate death.\(^{37}\)

As her health declined, Toussaint belatedly attempted to legalize her immigration status in Canada. In 2008, she applied for permanent residence based on humanitarian and compassionate grounds.\(^{38}\) If granted, Toussaint would have been eligible for public health coverage in her province of residence, Ontario. This application was denied for failure to pay the required fees, and a subsequent application for a Temporary Resident Permit was denied on the same grounds in March 2009, after the immigration authorities denied fee waiver requests submitted with each application.\(^{39}\) Toussaint also inquired about

\(^{29}\) Id. at para. 9.

\(^{30}\) Id.

\(^{31}\) Id.

\(^{32}\) Id.

\(^{33}\) Id.

\(^{34}\) Id. at para. 5.

\(^{35}\) Id. at para. 11.

\(^{36}\) Id.

\(^{37}\) Id. at para. 12.

\(^{38}\) See Andrea Bradley, Beyond Borders: Cosmopolitanism and Family Reunification for Refugees in Canada, 22 Int’l J. Refugee L. 379, 394 n. 75 (2010).


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inclusion in the Ontario Health Insurance Program, but was told she was not eligible.40 Undeterred, in May 2009, Toussaint applied for coverage under the Interim Federal Health Program (IFHP).41 The IFHP provides limited medical benefits to qualifying non-citizens.42 This request was rejected by a Canadian immigration official because Toussaint did not fit within any class of alien that the IFHP was intended to cover, and Toussaint sought judicial review of this determination.43 It is important to note that during the course of events before the federal courts, Toussaint never challenged the determination that she was ineligible for health benefits under the Ontario program.44

On August 6, 2010, the Federal Court upheld Toussaint’s exclusion from the IFHP. The court turned to the precursors of IFHP, pointing out that analogous provisions throughout history had paid only the medical expenses of immigrants who were lawfully admitted to Canada.45 The current structure of the IFHP was established by an Order-in-Council in 1957 (the Order) that authorized the payment of medical expenses for two classes of noncitizen, “in cases where the immigrant or such person lacks the financial resources to pay these expenses”46:

(a) an immigrant, after being admitted at a port of entry and prior to his arrival at his destination, or while receiving care and maintenance pending placement in employment, and
(b) a person who at any time is subject to Immigration jurisdiction or for whom the Immigration authorities feel responsible and who has been referred for examination and/or treatment by an authorized Immigration officer.47

40. Id. at para. 17.
41. Id. at para. 18.
42. See id. at para. 36.
43. Id. at paras. 18-19.
44. In separate proceedings, Toussaint challenged the immigration authorities’ failure to consider her request for a waiver of the required fees in conjunction with her applications for residency. See generally Toussaint v. Canada (Minister of Citizenship and Immigration), 2011 FCA 146 (Can.). The Federal Court of Appeal did hold that her request for a waiver must be considered by the authorities, but this distinct holding was, in the instant proceedings, deemed ultimately irrelevant as the mere fact of a pending application would not alter the courts’ conclusion that Toussaint was ineligible for benefits under the IFHP. Moreover, to the extent that a pending application may have relevance to her eligibility for benefits under the Ontario health program, that issue was not presented to the court during the course of litigation on the IFHP issue, as Toussaint never challenged her exclusion from that program.
45. Toussaint, 2010 FC 810, at paras. 30-36.
46. Id. at para. 36.
47. Id. (quoting Order-in-Council P.C. 157-11/848 (June 20, 1957)).
Toussaint was not—and never had been—an “immigrant” because she came to Canada as a temporary visitor and remained illegally. Thus, she could not establish eligibility for the IFHP under subsection (a) of the Order.

Toussaint argued, however, that she fell within the purview of subsection (b) because, as a non-citizen, non-permanent resident, she was subject to the Immigration Act and thus necessarily subject to the jurisdiction of the Canadian immigration authorities. The court rejected this interpretation because it would render subsection (a) superfluous—those aliens defined in subsection (a) would, as a class, also be subsumed by subsection (b). Focusing on the “jurisdiction” language of the Order, the court held that subsection (b) referred to “only those persons . . . under the custody and care of the Immigration authorities, or who are the subject of an immigration proceeding provided for in the Act.” While this definition includes some nonresidents and illegal aliens, it refers to a narrow and well-defined class of aliens comprised of refugee claimants, resettled refugees, persons being detained under the immigration laws, and trafficking victims. Because Toussaint was neither an immigrant nor fell into any of these specific categories of alien, the court upheld her denial of benefits under the IFHP.

Whether Toussaint was properly excluded from coverage under the language of the IFHP was only the threshold inquiry. Beyond the strict interpretation question was the issue of whether Toussaint was properly excluded from federal health benefits consistent with her rights under the Charter. In this regard, Toussaint contended that: (1) the denial of coverage under the IFHP violated her Section 15 rights as a prohibited distinction based on her disability and citizenship, and (2) the delay in receiving medical treatment violated her Section 7 rights to life, liberty, and security of person. The court had little trouble rejecting these contentions.

As to her Section 15 argument, the court noted that “the eligibility requirements for [the IFHP] result in unequal access and therefore, the question is whether the unequal access is discriminatory.” In finding no

48. Id. at para. 39.
49. Id.
50. Id. at para. 40.
51. Id. at para. 41.
52. Id. at paras. 43-50.
53. See id. at paras. 19, 49-50.
54. Id. at para. 51.
55. Id. at paras. 73, 84.
56. Id. at para. 78.
discrimination, the court held that Toussaint was not denied coverage because of her health problems—her purported “disability” under Section 15.\textsuperscript{57} Nor was her lack of citizenship a basis for the denial of coverage, as the IFHP extends some coverage to noncitizens.\textsuperscript{58} Instead, Toussaint was denied coverage because she could not otherwise establish her eligibility to receive benefits under the language of the IFHP.\textsuperscript{59} Because there was no discriminatory basis for the denial of coverage, there was no violation of Section 15 of the Charter.

The court also rejected Toussaint’s Section 7 argument, although it found more substance to her contentions. Toussaint argued “that her exclusion from the IFHP [was] arbitrary and not consistent with the requirements of fundamental justice,\textsuperscript{60} adding that delays in treatment—purportedly caused by coverage denials—resulted in long-term health risks, pain, and psychological harm.”\textsuperscript{61} The court acknowledged that Toussaint’s deteriorating health was attributable to the extreme delays in treatment caused by her exclusion from the IFHP.\textsuperscript{62} Thus, as a threshold matter, the court held that there was a deprivation of those rights protected by Section 7 of the Charter, specifically, the rights to life, liberty, and security.\textsuperscript{63} On the other hand, the court found nothing fundamentally unjust about denying the extension of a public benefit to an illegal immigrant.\textsuperscript{64} Accordingly, there was no violation of Section 7, because the deprivation of rights was not inconsistent with the principles of fundamental justice.\textsuperscript{65} The court noted that there was “nothing arbitrary in denying financial coverage for health care to persons who have chosen to enter and remain in Canada illegally,”\textsuperscript{66} and pointed out the dangers in “mak[ing] Canada a healthcare safe-haven for all who require health care and healthcare services.”\textsuperscript{67}

In sum, the Federal Court rejected all of Toussaint’s claims. It determined that the proper interpretation of the text of the IFHP narrowly circumscribed the class of aliens who were eligible for coverage, and that Toussaint was outside that class. It also held that this exclusion from a federal benefit was not contrary to any right enjoyed under the Charter.

\begin{footnotes}
57. \textit{Id.} at para. 80.
58. \textit{Id.} at para. 81.
59. \textit{See id.}
60. \textit{Id.} at para. 84.
61. \textit{Id.}
62. \textit{Id.} at para. 91.
63. \textit{Id.}
64. \textit{Id.} at para. 93.
65. \textit{Id.} at para. 92.
66. \textit{Id.} at para. 94.
67. \textit{Id.}
\end{footnotes}
Although Toussaint sought reconsideration of this decision, arguing that her claim under Section 15 was broader than the court had recognized, reconsideration was denied.68

A. Events before the Federal Court of Appeal

Approximately one year later, the Federal Court of Appeal upheld the lower court’s determination, but it did not concur wholly with its rationale or reasoning.69 The Court of Appeal noted its cognizance of the fact that Toussaint was attempting to “take one of Canada’s immigration laws (the Order-in-Council), get a court to include her by extending the scope of that law, and then benefit from the extension while remaining in Canada contrary to Canada’s immigration laws.”70

The appellate court did not disturb the lower court’s decision regarding the reach of subsection (a) of the Order. The court also agreed that Toussaint did not fall within the scope of subsection (b). As to the Charter issues, the Court of Appeal provided a refined analysis of why Toussaint’s Section 7 and 15 rights were not violated by her exclusion from the IFHP. Regarding the factual basis of her claim, the appellate court seemed to doubt that Toussaint suffered any significant delays in treatment or that any delay contributed to her health’s deterioration, noting that Toussaint received treatment for several distinct maladies.71 Under a highly deferential standard of review, the Court of Appeal declined to find error in that aspect of the lower court’s holding.72 Rather than reverse this aspect of the Federal Court’s holding, or rest its decision entirely on the basis of whether any deprivation was consistent with principles of fundamental justice, the Court of Appeal focused on the causal connection between Toussaint’s health issues and the denial of coverage under the IFHP.

Toussaint had to establish that the government’s failure to provide her with coverage under the IFHP was the “operative cause of the injury to her rights to life and security of person.”73 This connection was lacking. The court stated that, “[i]f there is an operative cause of the appellant’s difficulties, it is the fact that although she is getting some treatment under provincial law, that law does not go far enough to cover all of her medical needs.”74 Because Toussaint failed to challenge her

68. See Toussaint v. Canada (Attorney General), 2010 FC 926, at para. 7 (Can.).
69. Toussaint v. Canada (Attorney General), 2011 FCA 213 at para. 11 (Can.).
70. Id. at para. 8.
71. See id. at paras. 59-66.
72. See id. at para. 66.
73. Id. at para. 68 (citing TrueHope Nutritional Support Ltd. v. Canada (Attorney General), 2011 FCA 114, para. 11 (Can.)).
74. Id. at para. 70.
exclusion from the provincial Ontario health benefits program, her main source of health coverage, the court declined to find that exclusion from the narrowly constructed IFHP was the operative cause of her problems.75 Behind this determination, however, was the Court of Appeal’s deep skepticism regarding Toussaint’s attempt to place blame on the government for failing to implement a benefits program that would be broad enough to include her.76

The Court of Appeal further held that even if such a causal connection existed, Toussaint’s exclusion from the IFHP would not be contrary to the principles of fundamental justice. In response, Toussaint argued that “[g]overnments ought never to deny access to healthcare necessary to life as a means of discouraging unwanted or illegal activity,” including to illegal and undocumented immigrants.77 However, the court noted flatly that these assertions were “no part of our law or practice, and they never have been.”78 Indeed, Canada does not recognize any free-standing right to health care, health insurance, or health services, and no fundamental principle mandated that Toussaint must be included within a program for which she was ineligible.79 The Court of Appeal largely concurred in the lower court’s conclusion that Toussaint’s exclusion was not arbitrary, stating that the IFHP provides “temporary, emergency assistance to those who lawfully enter Canada and find themselves under the jurisdiction of the immigration authorities” and is not broadly available to “all persons who have entered and who remain in Canada, lawfully or unlawfully.”80

As to Toussaint’s Section 15 claim, the Court of Appeal focused on the distinction between prohibited discrimination and permissible differential treatment.81 The court adopted the Supreme Court of Canada’s description of discrimination: discrimination exists where a distinction is made between individuals or groups based on personal characteristics, and this distinction leads to disparate treatment.82 The eligibility grounds for the IFHP do not discriminate based on any of the classifications in Section 15 of the Charter. In rejecting Toussaint’s argument that “immigration status” was an impermissible basis for distinction, the court noted that immigration status is something that a

75. See id. at paras. 71, 73.
76. See id. at para. 72.
77. Id. at para. 75.
78. Id. at para. 76.
79. See id. at paras. 77-80.
80. Id. at para. 82.
81. See id. at para. 91.
country can expect to be changed, and that the government “has a real, valid and justified interest in expecting those present in Canada to have a legal right to be in Canada.”83

The court also rejected Toussaint’s argument that a limited interpretation of the Order promoted prejudice and stereotyping of certain aliens. Although the Order establishes eligibility criteria relating to entry and legal status, it does “not suggest that the appellant and others like her are less capable or less worthy of recognition or value as human beings.”84 Nor does it “single out, stigmatize or expose the appellant and others like her to prejudice and stereotyping” or “perpetuate any pre-existing prejudice and stereotyping.”85 Rather, the Order treated Toussaint, “a non-citizen who has remained in Canada contrary to Canadian immigration law—in the same way as all Canadian citizens, rich or poor, healthy or sick.”86 As the Court of Appeal noted, the Supreme Court of Canada “has repeatedly held that the legislature is under no obligation to create a particular benefit” and may “target the social programs it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory manner.”87 In other words, the question is whether it “excludes a particular group in a way that undercuts the overall purpose of the program.”88 If, however, “the exclusion is consistent with the overarching purpose and scheme of the legislation, it is unlikely to be discriminatory.”89 Toussaint’s exclusion from the IFHP was not inconsistent with the intent of the IFHP; rather, it was perfectly consistent with the rationale underlying the program—to provide health benefits to a very narrowly defined class of aliens.90

Neither the Federal Court nor the Court of Appeal addressed the Section 1 Savings Clause for limitations on Charter rights. Because neither court found any infringement of Toussaint’s rights under the Charter, neither had to determine whether the infringement was reasonable or demonstrably justified in the context of Canada’s democratic society.91 Nevertheless, the Court of Appeal concluded its decision by

83. Id. at paras. 96-101.
84. Id. at para. 104.
85. Id.
86. Id.
88. Id. at para. 42.
89. Id.
assessing the factors that would be relevant to any Section 1 assessment of the issue. The court looked to the state’s interest in “defending its immigration laws” and determined that allowing Toussaint to receive medical coverage under the Order “without complying with Canada’s immigration laws” would make Canada “a health care safe haven, its immigration laws undermined.” The Court cautioned that “[m]any, desperate to reach that safe haven, might fall into the grasp of human smugglers, embarking upon a voyage of destitution and danger, with some never making it to our shores.” Although dicta, this passage leaves little doubt that even had the court found an infringement of Toussaint’s Charter rights, that infringement would have been deemed justified for the operation of a democratic society.

B. The Aftermath and Implications of Touissant

When considering the bare-bones legal issues raised in Toussaint, its outcome does not seem to be particularly far-reaching or consequential for two reasons.

First, the issue raised and resolved in the case was extremely narrow: whether an existing federal scheme for providing health coverage to a limited class of eligible aliens can be expanded to include an illegal immigrant who (1) has never had any legal immigrant status in Canada and (2) is not being detained by Canadian immigration authorities. The courts did not have to address a broader claim that there exists a free-standing right to health care under Canadian law, even though Toussaint did, occasionally, verge on this absolutist tenor. Even in considering the Charter arguments, the courts did not wander too far afield from the touchstone of the IFHP. Both courts determined that Toussaint’s exclusion from the program was not arbitrary and thus did not violate Section 7; the Court of Appeal would have held that there was not even a causal link between the deprivation of her Section 7 rights and her exclusion from the IFHP. The Section 15 analyses were likewise straightforward, with both courts concluding that no protected ground motivated denial of coverage. Thus, the courts’ reasoning narrowly addressed whether the IFHP, a scheme of limited scope, could or should be expanded to a class of individuals that were previously excluded.

93. Id. at para. 113.
94. Id.
95. Id. at paras. 70-72.
96. Toussaint v. Canada (Attorney General), 2010 FC 810, paras. 73-83 (Can.); Toussaint v. Canada (Attorney General), 2011 FCA 213, at paras. 91-108 (Can.).
Second, this case does not present any issue regarding whether the provinces—the traditional focal point of health coverage in the Canadian system—should be required to extend health coverage under public benefits plans to illegal immigrants. Toussaint did apply for coverage under the Ontario program, but her application was denied. She declined to challenge this denial in court, a point noted by both the Federal Court and the Court of Appeal. The issue of whether she could obtain coverage under a general benefits plan, such as the Ontario health program, is more important in the health coverage debate, as it would presumably dictate the bounds of inclusion for illegal immigrants across the whole of Canada within the discrete state health insurance schemes. While Toussaint did not raise that issue before the federal courts, it may yet have life. If her applications for status are accepted, the mere fact of pending applications may have an effect on her ability to obtain coverage in Ontario, even if it will not affect her eligibility for the IFHP. Nonetheless, it is these important issues that are more relevant to the question of whether health coverage, as a general matter, should be extended to illegal immigrants, and it is exactly these issues that the federal courts did not have any occasion to resolve in *Toussaint*.

These points aside, the rhetoric of the courts seems to encompass more than the narrow issue decided. The Court of Appeal’s logic would seemingly be as applicable to upholding a denial of coverage under a provincial or local health benefits plan based on the illegal status of the applicant. If that reasoning were to be applied in a similar manner, it seems likely that the same panel of appellate judges would have found no infringements of the applicant’s Section 7 and 15 rights under the Charter. The Section 15 analysis would be straightforward, as immigration status is not an analogous ground and thus excluding illegal immigrants from provincial coverage is not discriminatory. Likewise, under the prevailing holdings regarding Section 7, there would be nothing arbitrary about excluding illegal immigrants from a public benefits scheme meant to benefit citizens and lawful immigrants. Moving beyond these points to a matter of pure dicta in the Court of Appeal’s decision, even if an infringement were found, it seems likely that it could be justified under the savings clause of Section 1 as an infringement that is necessary to Canada’s democratic society. The justifications, as the Court of Appeal noted, would stem from the interest Canada has in seeing that its immigration law is respected and that it does not become a healthcare provider of last resort, regardless of legal status or right to enter the country. Economic considerations would also come into play in justifying any limitation under a provincial plan, as would the traditional legislative prerogative to allocate governmental benefits in a reasonable manner.

98. *Id.* at paras. 17-18; *Toussaint*, 2011 FCA 213, at para. 116.
Thus, although the actual decisions in *Toussaint* were relatively narrow, the underlying rationale and logic has broader import.

### III. Are Illegal Immigrants Legally Entitled to Public Health Benefits Under Prevailing Constitutional Norms?

Although some of the courts’ reasoning in the *Toussaint* litigation sought to address the broad parameters of the debate on health care and illegal immigrants, the decisions were ultimately wedded to the narrow issue of eligibility for the IFHP. This section moves from the narrow confines of those decisions to the broader questions those cases raised but did not decide. The main question becomes: is it constitutionally permissible to limit the extension of public benefits to certain well-defined classes of individuals, such as citizens and lawful permanent residents? Put another way, do illegal immigrants have any cognizable legal right to benefits from a government that does not recognize their right to reside within its jurisdiction? The answer under both prevailing Canadian and US law would seem to be no.

#### A. Under Canadian Law

In Canada, the term “resident,” for purposes of provincial health insurance programs, is defined under state law. In Ontario, for instance, under the regulations implementing the Ontario Health Insurance Act, “resident” is defined in such a manner as to exclude illegal immigrants who do not enjoy status under the federal Immigration Act. Any Section 7 challenge would have to surmount the issue of causality and the question of whether the deprivation of rights was nonetheless consistent with fundamental justice. Regarding causality, any failure to obtain coverage under a public program that limits eligibility to citizens or lawful residents could be attributed to the illegal immigrant’s failure to legalize his status within Canada. As the Court of Appeal held in *Toussaint*, it was not the government’s failure to extend benefits to all within Canada that exacerbated Toussaint’s health problems, but her own failure to legally enter the country or seek to legalize her status after her lawful status lapsed. It is within an illegal immigrant’s power to attempt to change her status. Absent that attempt, there is no colorable argument that the failure to provide coverage is the operative cause of a deprivation of rights under Section 7.

Beyond this point, it would seem that without a free-standing right to health care, excluding certain classes of individuals from a government benefit cannot be deemed contrary to fundamental justice. The government may deny access to public benefits to those whose presence

100. *Id.* at para. 68.

101. *Id.* at paras. 70-73.
it has not consented to, and there is no claim that the denial of coverage to such persons is arbitrary.\textsuperscript{102} Granting greater access to public benefits as the individual’s connection with the granting country grows—from nonimmigrant, to immigrant, to citizen—is a rational way by which to apportion limited resources. As the Federal Court noted in \textit{Toussaint}, even if the delays in medical treatment caused by Toussaint’s exclusion from the IFHP were the operative cause of a deprivation of rights under Section 7, that deprivation was not inconsistent with fundamental justice.\textsuperscript{103} So too, it would seem, the exclusion of illegal immigrants from a public health program designed to benefit citizens and permanent residents is not inconsistent with fundamental justice.

A Section 15 challenge to a benefits program that extends to only citizens and those with legal status under the Immigration Act would likely face an even stiffer battle than a Section 7 challenge. In this context, there is no protected ground on which to base a Section 15 argument, as the relevant limitation would not be based on race, national or ethnic origin, colour, religion, sex, age, or disability. Alienage and citizenship are inapplicable, as the program would extend to at least some aliens (lawful residents and others having status under the Act). The Court of Appeal rejected “immigration status” as an analogous ground to those explicitly listed bases, but even if accepted as the basis for a Section 15 challenge, success would be questionable. The program would not discriminate against any similarly situated persons because all citizens and all those with status to reside in Canada would be treated identically. Conferral of the benefit would also be consistent with the program’s goals. A public health insurance or benefits program represents the legislative allocation of finite resources in a manner that favors those individuals who have established the requisite connection to the state—citizens, permanent residents, and others with authorization to reside in Canada. The purpose of the program—to confer benefits on those who share this connection—is served, as with the case of the IFHP, by the exclusion of illegal immigrants and all those who lack the required connection. Such a limitation would constitute a permissible distinction, not prohibited discrimination.\textsuperscript{104}

Finally, even if a violation occurred, it is possible that the exclusionary scheme would be permissible under Section 1, which justifies limiting rights “to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”\textsuperscript{105} Under the \textit{Oakes} test, the government may restrict Charter rights if it can “demonstrate that

\begin{itemize}
  \item \textsuperscript{102} See \textit{id.} at paras. 76-80.
  \item \textsuperscript{103} \textit{Toussaint}, 2010 FC 810 at paras. 92-94.
  \item \textsuperscript{104} See \textit{Auton v. British Columbia (Attorney General)}, [2004] 3 SCR 657, at paras. 41-42 (Can.).
  \item \textsuperscript{105} Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, \textit{being} Schedule B to the Canada Act, 1982, c. 11, § 1 (U.K.).
\end{itemize}
the objective of the legislation is ‘pressing and substantial’ to warrant
the restriction.”106 If the government can pass this threshold step, the
court will then assess proportionality—whether there is a rational
connection between the limitation and the objectives of the legislation,
whether the right is only minimally impaired, and whether the effects of
the limitation are proportional to the objectives of the legislation.107

Providing public health benefits while limiting coverage to citizens
and other residents with legal status would seem to present a “pressing
and substantial” legislative objective. The extension of benefits itself
represents an attempt to advance the health of the population while
providing an avenue to reduce costs and expenditures. This sort of
legislation represents the allocation of finite resources to classes of
individuals who have demonstrated a substantial connection to Cana-
da—its citizens and those granted status under its immigration laws.
Limiting benefits to only citizens and lawful residents encourages respect
for immigration laws by rewarding those who “play by the rules.” These
considerations justify the restriction on an illegal immigrant’s Charter
rights at the first step of the Oakes assessment.

As to proportionality, the legislative objective is undoubtedly ration-
ally connected to the legislation: to provide health care to a class or
classes of individuals who have established permanence in Canada, either
by being native-born citizens, naturalized citizens, or having been
granted lawful status. Excluding illegal immigrants from coverage under
such a scheme obviously shares a rational connection to the aim of
allocating scarce public benefits to those residing lawfully in Canada. It
is also as minimal an impairment of the Charter rights as possible while
still limiting access to public benefits. Additionally, the denial of cover-
age under a public benefits scheme would not result in a total lack of
health care for illegal immigrants but rather a limitation on what
services they may take advantage of. Illegal immigrants could still obtain
emergency medical treatment and, like Toussaint, obtain treatment
through clinics or other institutions that assist the indigent and
uninsured. The fact that these avenues would still be available for
medical treatment make it all the more likely that the denial of
additional public benefits would be upheld as proportionate to any
infringement of Charter rights. Finally, there would be proportionality
between any limit on an illegal immigrant’s Charter rights and the
objectives of the legislation. The act would discourage violations of
Canada’s immigration laws by declining to extend benefits to those who
enter or remain illegally. Accordingly, it would discourage medical
tourism by illegal immigrants, a fact noted by the Court of Appeal in

106. Elvina C. Chow, Direct-to-Consumer Advertising of Pharmaceuticals on
107. Id.
hinting at how it would have addressed the proportionality analysis. It would also protect the allocation of finite governmental resources by declining to open Canada’s coffers to expenses incurred by all within the country, regardless of their status or right to remain.

Considering these objectives, limiting the extension of benefits to citizens and legal residents, and thereby excluding illegal immigrants and infringing their Charter rights to that degree, cannot be said to be disproportionate. On consideration of the entirety of the Oakes assessment, the exclusion of illegal immigrants from a public health scheme should survive any challenge as proportionate under Section 1 of the Charter even if an infringement of rights is otherwise found.

Under the logic of the courts’ decisions in Toussaint, it seems unlikely that a court would hold that the exclusion of illegal immigrants from a public health benefits program violates the rights guaranteed by the Charter. Even assuming a deprivation of rights under the Charter—an unlikely holding given the courts’ disposition of Toussaint’s Section 7 and 15 claims—any limitation on eligibility for health benefits could be saved by the Section 1 provision for limitations necessary in a democratic society.

B. Under US Law

As with the residency requirement under the Ontario health benefits program, illegal immigrants in the United States are generally excluded from government benefits programs. Public insurance programs such as Medicaid generally require proof of citizenship or legal residency. Illegal immigrants are also excluded from the individual mandate requirement of the ACA, which restrictively defines “applicable individual” to exclude “an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.” Illegal immigrants are further ineligible for any other benefits or subsidies under the ACA.

Despite these general exclusions, illegal immigrants have access to some health care in the United States. Children and women, regardless of their legal status in the United States, may have certain emergency procedures covered by Medicaid, and many state and local governments provide limited healthcare services to illegal residents, especially preg-

nant women. In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals that receive Medicaid funds to screen and stabilize, if possible, any patient who comes in with an emergency condition. The term “emergency medical condition” is defined expansively as a condition that could “reasonably be expected” to place the health of the individual in serious jeopardy or cause serious impairment to bodily functions, a bodily organ, or any part thereof. EMTALA mandates that treatment must be provided regardless of ability to pay, insurance status, and legal status in the United States. In a sense, emergency treatment has proven an insurance of last resort for those lacking necessary coverage or funds to pay out-of-pocket: one study of Medicaid spending from 2001 to 2004 in North Carolina estimated that 99 percent of emergency Medicaid recipients were illegal immigrants.

Under the rationale of the Supreme Court’s decision in Mathews v. Diaz, limiting the ability of illegal immigrants to obtain medical benefits and services passes constitutional muster. At issue in Diaz was the requirement that, in order to qualify for Medicaid benefits, a noncitizen had to be lawfully admitted to the United States and continuously reside therein for the five years preceding application for benefits. Although the District Court for the Southern District of Florida found the continuous residency requirement unconstitutional and non-severable from the requirement that an individual be lawfully admitted to the United States, the Supreme Court upheld both conditions as constitutional. The Constitution does not require identical treatment for every individual in the United States, citizen or alien, or identical treatment across different classes of aliens. As the Court clarified in Diaz, Congress is

114. See id. § 1395dd(e)(1)(A).
115. See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006); California v. United States, 104 F.3d 1086 (9th Cir. 1997) (upholding requirement that states provide emergency medical services to illegal aliens as condition on receipt of Medicaid funding); see also Jeremy J. Schirra, A Veil of Tax Exemption?: A Proposal for the Continuation of Federal Tax Exempt Status for “Nonprofit” Hospitals, 21 Health Matrix 231, 259 (2011).
119. Mathews, 426 U.S. at 69.
120. Id. at 78-79 ("[A] legitimate distinction between citizens and aliens may justify attributes and benefits for one class not accorded to the other; and
not required to provide every benefit it provides to citizens to all aliens, nor must it extend identical benefits to every distinct class of alien.\textsuperscript{121} The decision as to whether or to what extent a benefit will be extended can permissibly turn on the character of the relationship between the alien and the United States.\textsuperscript{122} “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.”\textsuperscript{123} This decision, delegated to the plenary authority of Congress, must inevitably involve some sort of line-drawing “[s]ince it is obvious that Congress has no constitutional duty to provide \textit{all} aliens with the welfare benefits provided to citizens.”\textsuperscript{124} Courts may not second-guess Congress’ decision unless the line it draws is irrational.\textsuperscript{125}

The Court found nothing irrational in Congress dictating that an alien’s access to public benefits in the United States should depend upon the nature and duration of his presence in the country.\textsuperscript{126} In the Court’s opinion, the aliens’ claim was simply that Congress could have drawn a line that would have included them within the eligibility criteria.\textsuperscript{127} In rejecting this argument, the Court noted that it was “especially reluctant to question the exercise of congressional judgment” in matters of policy.\textsuperscript{128} Ultimately, there was no principled basis for drawing a different line than the one chosen by Congress and thus nothing for the Court to do but uphold the line that was chosen.

\textit{Diaz} remains good law, and its rationale would be equally applicable to any challenge to a governmental benefits program, including provisions of the ACA, that require legal residency or citizenship as an eligibility criteria. On the assumption that the government does not have to extend benefits to \textit{any} class of noncitizen, it can certainly limit access to public subsidies and programs to only certain classes of aliens.\textsuperscript{129} Drawing a line between those who are residing in the United States lawfully and those who are not is an eminently rational and principled way in which to allocate resources and limit eligibility for governmental benefits. So long as the legislature is free to make such distinctions,

the class of aliens is itself a heterogeneous multitude of persons with a wide-ranging variety of ties to this country.”\textsuperscript{129}

\begin{itemize}
\item \textsuperscript{121} \textit{Id.} at 80.
\item \textsuperscript{122} \textit{Id.}
\item \textsuperscript{123} \textit{Id.}
\item \textsuperscript{124} \textit{Id.} at 82.
\item \textsuperscript{125} \textit{See id.} at 84.
\item \textsuperscript{126} \textit{Id.} at 83.
\item \textsuperscript{127} \textit{Id.}
\item \textsuperscript{128} \textit{Id.} at 84.
\item \textsuperscript{129} \textit{See id.} at 84.
\end{itemize}
differentiation based on alienage and status is a permissible way for the government to condition access to its programs.

IV. POLICY CONSIDERATIONS THAT WEIGH IN FAVOR OF EXTENDING HEALTH COVERAGE TO ILLEGAL IMMIGRANTS

No law requires the United States or Canada to extend public health benefits to illegal immigrants. Excluding illegal immigrants from coverage available to citizens and lawful residents is rational and recognizes the necessity of line-drawing in developing public programs. Nevertheless, these legal limits do not necessarily represent the best public policy. Under the US Constitution and Canadian Charter, no provision mandates that public coverage be extended to illegal immigrants—yet nothing forbids that choice as a matter of policy. Are there compelling policy considerations that would dictate the extension of some form of public health coverage to illegal immigrants? Although what follows is based on empirical research done in the United States, the similarity of context between the United States and Canada should mean that the policy prescriptions advocated by this Article are likely equally valid to the Canadian situation.130

The answer to this question by necessity tracks closely the bounds of traditional health reform arguments. In determining whether illegal immigrants should be covered, the goals of health reform should be examined: “to increase access to quality affordable care, while reining in costs.”131 As with health reform generally, the specific determination of whether to extend some kind of coverage to illegal immigrants must also be cognizant of the dual dimensions of any health system—the twin pillars of “health care” and “public health.” Broadly stated, “health care is concerned with the individual’s care and treatment, while public health is concerned with the health and well-being of populations.”132 Extending coverage to illegal immigrants will obviously increase access to quality care, but it would also have the likely effects of decreasing costs of that care for everyone within the system by lowering emergency expenditures. Coverage would also have carryover benefits in the realm of public health, as it would begin to act as a preventative regime rather than allowing the progression of illness to more advanced points. Subsections A and B thus address these arguments for extending some form of public coverage or subsidy to illegal immigrants.

130. The focus will thus be on the propriety of reform in the United States rather than in both the United States and Canada. Again, however, there is nothing about Canada that would make the arguments offered in this section inapplicable or inapposite.


132. Gostin et al., supra note 9, at 1783.
Subsection C asks whether there are any countervailing ethical or other considerations that would override the policy arguments for extending coverage to illegal immigrants. It also considers whether there are insurmountable obstacles to implementing coverage for illegal immigrants. It is likely that such hurdles do exist, but they are largely the product of misguided rhetoric that refuses to parlay with the facts.

Subsection D considers what form coverage for illegal immigrants might take. This question takes on significance because of the nature of the illegal population, the diverse areas in which it works, and its general lack of knowledge concerning potential benefits under US law. Any extension of coverage must be finely crafted so as to actually include this population within the US healthcare system; otherwise, if a plan is simply put into place that does not ensure such inclusion, it might fail to achieve the objectives that drove its implementation in the first place.

A. The Provision of Health Coverage to Illegal Immigrants Could Help Alleviate Existing Costs in the US Healthcare System

The staggering costs of health insurance, care, and services in the United States were a primary motivating factor behind the push for general healthcare reform in 2010. As Peter Orszag, former director of the Office of Management and Budget, wrote in the wake of the ACA’s passage, “[t]he Congressional Budget Office projects that between now and 2050, Medicare, Medicaid, and other federal spending on health care will rise from 5.5 percent of GDP to more than 12 percent.”133 If public financing is combined with private financing, total spending in 2010 reached almost 17 percent of GDP, “or over $7,000 on each American annually.”134 An increasingly large share of this price is the result of uncompensated healthcare costs—costs that are not paid out-of-pocket by the individual treated, by the government via a public benefits program, or by a private insurance company. Between 1994 and 2000, uncompensated care costs were approximately $26 billion.135 In 2001, the University of Arizona’s Udall Center estimated that uncompensated healthcare costs ranged from $34 to $38 billion.136 These costs are the result of an uninsured population in the United States that exceeds 46 million individuals.137

134. Gostin et al., supra note 9, at 1779.
Measuring the number of illegal immigrants in this population is difficult given an understandable reluctance to state that one lacks legal status to be in a country. Nevertheless, most studies note clear trends in insurance coverage related to whether an individual is a citizen, lawful resident, or illegal immigrant. A study published in *Health Affairs* in 2006 reported that 68 percent of illegal immigrants lacked coverage versus 23 percent of naturalized US citizens.138 Moreover, while 23 percent of illegal immigrants possessed insurance coverage through their employer, nearly 60 percent of naturalized citizens had such coverage.139 The next year, *Health Affairs* estimated that 65 percent of illegal immigrants lacked insurance coverage versus 32 percent of lawful residents.140 A 2007 *JAMA* article reported the uninsured percentage of illegal immigrants at 77 percent,141 while a 2008 *USA Today* report indicated that 59 percent of illegal immigrants are uninsured, versus 25 percent of lawful residents and 14 percent of US citizens.142 Whatever the exact number of uninsured illegal immigrants in the United States, these studies show that the number is substantial, especially when contrasted against the number of uninsured US citizens and lawful residents.

Along with the difficulty in estimating the exact number of the illegal immigrant population, pinpointing the costs of health care attributable to this segment has proven equally troublesome. There are “no reliable national figures on hospital costs for undocumented immigrants” and no reliable figure regarding what amount of uncompensated healthcare costs are attributable to illegal immigrants.144 Nevertheless, there have been attempts to estimate the cost of providing health care to illegal immigrants within discrete regional areas. For instance, one study of Medicaid spending from 2001 to 2004 in North Carolina estimated that 99 percent of emergency Medicaid recipients were illegal immigrants.145 This number casts some light on the issue but focuses only on one type of medical spending in a single state. Studies in

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139. Id.


145. Id. at 1087 & tbl.1.
Colorado and Minnesota estimated that those states spent $31 million and $17 million respectively on health care for illegal immigrants in 2005, while a 2004 California study found the state’s expenditures at $1.4 billion, and the Texas state comptroller estimated that state spent $1.3 billion in 2006.146 As with the number of illegal immigrants, whatever the true cost of providing health care and services to these individuals, it is not de minimis.

Bringing illegal immigrants within the fold of the official US healthcare system—by allowing them to come within the bounds of Medicaid or providing subsidies through which to purchase private insurance—could help to significantly lower many of these costs. The idea that extending government benefits could reduce costs is perhaps counterintuitive, but a similar projection holds for the course of the ACA itself. As Orszag noted, “[p]rojections from the CBO suggest that the added cost of covering millions more Americans will initially exceed the cost reductions included in the legislation but that eventually the pattern will be reversed.”147 Likewise, adding illegal immigrants, although adding costs at some points in the system, should save money on a system-wide basis. This is a function of two trends. First, including illegal immigrants in the pool of those insured should spread costs more broadly across the system, especially as immigrants tend to seek and use fewer health services. Second, by encouraging insurance coverage, public or private, the government can save costs elsewhere, such as in emergency Medicaid spending and by paying for cheaper, preventative treatments before chronic issues arise.

Including illegal immigrants would increase the risk pool of either private or public insurance programs, while evidence indicates that contributions to insurance would outpace payments to medical providers. The mechanism of medical insurance is meant to spread “the risk of individuals across a population to ensure that everyone can afford medical care when he or she needs it.”148 “In effect, the healthy subsidize the sick as part of a social contract, which recognizes that everyone may become ill one day.”149 Pooling risk in this fashion only works if the pool “include[s] enough healthy individuals to keep overall health care expenditures lower than premium costs so that high-cost individuals will be covered.”150 Larger populations generate “more predictable and stable premiums because the high cost of a few is spread out across many.”151

146. See Wolf, supra note 142.
147. Orszag, supra note 133, at 55.
149. Id.
150. Id.
151. Id.
There is a growing body of literature that indicates a health continuum from recent immigrants through natural-born citizens that declines as the individual remains in the United States. As a threshold matter, “most immigrants, at least those who are young and come to the United States primarily for work, are relatively healthy and often experience better health outcomes, including lower mortality, than their US-born counterparts.” Along this continuum, the recent immigrant (including the illegal immigrant) enjoys better health than aliens who have been living in the United States for an extended period of time (including lawful residents), and those aliens who have lived in the United States for an extended period of time in turn enjoy better health, on average, than native born citizens. For instance, there are lower reports of chronic disease in recent immigrants, with only 19 percent of illegal immigrants reporting some form of chronic disease versus 27 percent of lawful immigrants and 38 percent of native-born citizens. Whatever the reason behind this discrepancy, whether it is the result of “strong positive migration selection” or a deleterious shift in lifestyle after arriving in the United States, it could have beneficial effects on the US healthcare system as a whole. A public or private health insurance program that includes illegal immigrants adds a class of insured that is generally healthier than the legal immigrants and citizens who already comprise the program’s risk pool. Multiplying the healthy within the program contributes to overall cost savings to all participants in the scheme in the form of lower premiums, which has a spillover effect in encouraging lower general healthcare costs.

This inevitable effect of including more healthy individuals to share the risk of medical costs may be further multiplied when the class to be included is illegal immigrants. Studies indicate that medical expenditures for recent immigrants are less than half that for citizens, and recent immigrants have significantly lower medical service utilization. This is likely due to a combination of factors, including the better overall health of recent immigrants and a fear of detection if they seek medical care. The cost of medical services consumed by male illegal immigrants constituted only 39 percent of the cost of male native-born citizens, whereas the cost for female illegal immigrants was only 54 percent of the cost of female native-born citizens. Reviewing the habits of illegal

152. Derose et al., supra note 140, at 1263.
153. See Ku, supra note 6, at 1323.
154. See Goldman et al., supra note 138, at 1705.
155. See id. (“A growing body of evidence indicates that on average, immigrants are healthier than the native-born and that strong positive migration selection on health is the primary reason.”).
156. See Ku, supra note 6, at 1324.
immigrants, this same study found that only 2 percent of male illegal immigrants were hospitalized and less than 50 percent saw a doctor, whereas 20 percent of female illegal immigrants did not have a medical checkup (versus 5 percent of native-born women) and 7 percent did not visit a doctor.\footnote{Id. at 1705-06.} Overall, the study found that 32 percent of the illegal immigrant population never received a medical checkup and 17 percent had never seen a doctor.\footnote{Id.} Thus, not only does the illegal immigrant population fill the risk pool with a disproportionately healthy group, as a necessary extension of that fact, it takes a disproportionately small chunk from the resources that the risk pool makes available. Illegal immigrants are thus a healthy segment of the population that would consume a comparatively small amount of expenditures. This reality is to every insured’s benefit.

Beyond benefiting the risk pool in this manner, by finding a way to include illegal immigrants within public or private insurance programs, costs could be saved in current emergency expenditures at both the state and federal levels. As noted earlier, although federal law generally precludes the extension of health benefits to illegal immigrants, it does mandate that any individual exhibiting an emergency medical condition must be treated in an emergency room receiving Medicaid compensation.\footnote{See 42 U.S.C. § 1395dd (2006); Thomas More Law Ctr. v. Obama, 651 F.3d 529, 548 (6th Cir. 2011), abrogated by Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).} This has the perverse effect of multiplying emergency medical costs at the same time that costs for preventative or ambulatory services remain low. As Dr. Susan Okie has noted, “annual per capita expenses for health care were 86% lower for uninsured immigrant children than for uninsured US-born children—but emergency department expenditures were more than three times as high.”\footnote{Okie, supra note 143.} Bringing illegal immigrants within the fold of an insurance program would eliminate the need to rely on emergency room treatments and all the costs that such reliance entails. This would not simply represent a shift in expenditures from emergency medical costs to other forms of reimbursement. In shifting the focus from emergency medical treatment to the types of preventative and ambulatory care that are available under prevailing standard insurance programs, costs will be saved in the form and intensity of any resulting medical treatment or service. The emergency medical costs of illegal immigrants are high “because immigrant children’s costs per visit [are] much higher,” a fact largely

158. Id. at 1705-06.

159. Id.


161. Okie, supra note 143.
attributable to “poor access to primary care.” Thus, in providing access to insurance, costs can be saved not only by decreasing emergency medical expenditures but also by focusing on less costly care and services. Less costly care and services could negate the need for the more expensive emergency procedures that may result from the deterioration of a condition or the development of chronic issues.

The foregoing summarizes the benefits of including illegal immigrants in the US health system. The inclusion of this healthy class of individuals has the potential to lower premiums and other medical costs while utilizing a disproportionately small amount of healthcare services. It also has the potential to greatly diminish existing emergency medical expenditures by both state and federal authorities while saving money in the long term by focusing resources on typical medical procedures rather than emergency room utilization. To be sure, there are unknown variables. Perhaps the provision of insurance, for whatever reason, will not lead to a significant diminution in the use of emergency facilities by illegal immigrants. Perhaps usage trends will change significantly if illegal immigrants are provided with insurance, thereby undercutting one of the ways in which costs are projected to be saved by their inclusion. Alternatively, a large number of illegal immigrants may decide to remain on the outside of the system in order to avoid detection by state or federal authorities. This would have the effect of minimizing positive additions to the risk pool, undercutting the projected savings from healthy additions with low per-person expenditure trends.

It is impossible to say with certainty that the inclusion of illegal immigrants within the bounds of an insurance program will inevitably decrease costs. By focusing on the underlying logic of these arguments, however, policymakers can formulate an approach to the issue that understands the high potential for a beneficial outcome for all those within the insurance industry, whether private insurers, the insured, or the federal government. This rationale simply contends that illegal immigrants need not be seen as a drag on state and federal healthcare systems; they can provide real and tangible benefits to all those concerned with a fully and fairly functioning healthcare system.

B. Ensuring Timely and Appropriate Medical Treatment Advances

Important Public Health Principles

Providing some form of health insurance to illegal immigrants should not only lower the economic burden on the US healthcare system, it may also contribute to public health generally. By directing medical care and services at the initial stages of an illness or disease, not only can money be saved by warding off the potentially more complicated and costly

procedures required when diseases and illnesses are left untreated, but the population in general would be protected from the spread of disease, thus ensuring its overall health and well-being.

Lawrence Gostin argues that “[t]he intentional decision not to cover certain disadvantaged populations, such as illegal immigrants, has significant public health implications, particularly in the area of communicable diseases,” including “[u]ndiagnosed and untreated infectious and sexually transmitted diseases, such as HIV, syphilis, and tuberculosis (especially multidrug-resistant strains), [that] pose a major risk to the population.” The preceding section noted that illegal immigrants have lower frequencies of doctor’s visits, a lower frequency of utilizing healthcare services, and a disproportionate reliance on emergency medical services. These patterns can be partly, if not entirely, explained by the lack of insurance, public or private. This lack of coverage raises concerns about both the long-term health of illegal immigrants who are not receiving necessary treatment at the outset of illness as well as the health of the public at large, who could be exposed to infectious and contagious diseases that might have been addressed by a simple visit to the doctor.

Thomas Rundall argues that “an effective public health system reduces the need for medical services to treat conditions that can be prevented, thereby helping to control costs and make personal health care affordable.” However, at present, because preventative and ambulatory care are too expensive or inaccessible for broad swaths of the population, including illegal immigrants, the healthcare system must spend even higher amounts at the back-end of illnesses by treating more virulent and troublesome manifestations using procedures far more expensive than primary care. This is an obvious extension of the

163. Gostin et al., supra note 9, at 1780 n.10.

164. See Marc L. Berk et al., Health Care Use Among Undocumented Latino Immigrants, 19 HEALTH AFF. 44, 50 (2000) (noting lower rates of physician visits amongst illegal immigrants, and a lower use of care even if available); Leighton Ku & Sheetal Matani, Left Out: Immigrants’ Access to Health Care and Insurance, 20 HEALTH AFF. 247, 251 (2001) (“[B]eing a noncitizen adult or child was associated with a substantial and significant reduction in access to regular ambulatory health care . . . and to the emergency room, compared with native citizens or their children.”); DuBard & Massing, supra note 112, at 1089 (“[R]egional studies suggest that [illegal immigrants] are more likely than legal immigrants to use emergency department and less likely to use ambulatory care and preventative services.”).

165. See, e.g., Goldman et al., supra note 138, at 1701 (“The relative unavailability of health insurance raises concerns about long-term health effects if immigrants do not obtain needed medical care.”).


167. Gostin et al., supra note 9, at 1785 (“Instead of upfront investments in prevention and wellness, the nation spends billions of dollars on high-
economic argument made in the preceding section: by providing insurance to illegal immigrants, the system can save money by offering cheaper preventative care that makes the need for subsequent emergency care or more sophisticated procedures less likely.

The extension of insurance thus trades higher-priced health services for lower-priced alternatives. It also frees up resources for other public health programs that could prove beneficial to the population as a whole. Yet this argument contains more than just an assertion that preventative care can lessen the general economic strains on the healthcare system. The true public health benefits lies in preventing diseases, including possible epidemic and other contagious conditions, and thereby safeguarding the health of the public as a whole. For instance, contagious diseases such as tuberculosis may cause widespread infection if not properly diagnosed and treated at the outset. The unavailability of a service that would permit treatment at the earliest stages makes such diagnosis and treatment less likely, which in turn increases the possibilities of broader infections amongst the entire population. This scenario is applicable to all types of infectious disease. By making primary care more difficult or costly to obtain, the entire population is opened up to greater exposure to infection and contagious disease. When preventative or educational care is unavailable, the dangers of illnesses like heart disease and diabetes risk being magnified, and care is ultimately shifted from prevention to more costly treatments. Preventative care can ensure better health over longer periods of time, benefiting both the economic and public health aspects of the healthcare system. Denying coverage for preventative care, but permitting technology interventions to treat conditions that might otherwise have been prevented or reduced in severity.

168. See, e.g., Rundall, supra note 166, at 15 (“[A]n effective medical care system with universal coverage virtually frees public health from playing the role of medical care provider to the poor and uninsured, thereby freeing resources to pursue population-based disease prevention and health promotion activities.”).

169. See Okie, supra note 143 (“Although U.S. hospitals must provide emergency care without first asking about income, insurance, or citizenship, early diagnosis and treatment in a primary care setting are both medically preferable and a better use of resources.”).

170. See, e.g., Gostin et al., supra note 9, at 1780 n.10 (noting the dangers inherent to the population as a whole from undiagnosed diseases or a delay in the proper diagnosis of infectious diseases).


172. See Derose et al., supra note 140, at 1263.
emergency treatment, also has a pernicious effect in the context of family planning. “By not providing prenatal care and routine or preventative services,” the system is unlikely to see fewer babies born, but it will see fewer healthy babies born as inadequate numbers of expecting mothers will receive quality medical care during their pregnancies. Thus, the pernicious effects of denying coverage may begin at the very birth of these children (who would be US citizens), bringing about a possible lifetime of expensive care that could have been avoided by providing certain benefits and coverage to the illegal immigrant mother.

A more pressing concern may be that non-diagnosis, a delay in diagnosis, inadequate treatment, or misguided self-treatment can create even more virulent and drug-resistant strains of diseases. This concern is a function of two factors. First, inadequate access to health care and treatments has been linked to the development of drug-resistant strains of certain illnesses. This development has broad public health implications because hardier disease strains, being less susceptible to available or prevailing treatments, would have deleterious effects even within the population that does have access to medical care. In refusing access to important medical services at this threshold step, the current exclusion of illegal immigrants from the system encourages the development of strains of disease that could prove disastrous for the population as a whole. Second, by relegating illegal immigrants to gray and black markets of medical care, the same end result may occur (development of more virulent or treatment-resistant strains of diseases) through inadequate self-medication. Studies in poverty-stricken areas of the world note the prevalence of medications that contain inadequate quantities of necessary ingredients. Such treatments not only fail to eradicate the illness, they also help create more resistant strains of the disease that may have an adverse impact across the entire population.

There also may be unforeseen consequences of excluding illegal immigrants from public health benefits. After Congress mandated that providers submit their patients’ proof of citizenship or residency to obtain Medicaid reimbursements, the number of claims dropped dramatically. This drop was not, as had been anticipated, on account of illegal immigrants being disqualified from the reimbursement scheme, but rather occurred because US citizens and residents could not provide the requisite

173. Berk et al., supra note 164, at 54.
175. See Paula Park, Lethal Counterfeits, 27 World Pol’y J. 35, 39 (Summer 2010).
The problem in the instant context is that the citizen children of illegal immigrant parents may be effectively barred from public benefits programs because of parental lack of immigration status. At least one study supports this proposition, finding that the citizen children of noncitizen parents “face health care barriers . . . similar to those faced by foreign-born children.” Thus, the citizenship of the parent may be a more important factor in obtaining health care for a child than the child’s own citizenship. Citizen children of noncitizen parents do enjoy better access to medical care than the noncitizen children of noncitizen parents, but both classes enjoy less access to quality medical care than the citizen children of citizen parents. Because of the high number of citizen children in families with illegal immigrant parents, a large swath of individuals who are eligible to receive government medical benefits are not receiving those benefits to the degree to which they are entitled. The illegal status of the parents undoubtedly contributes to the barriers to access their citizen children face, perhaps making parents fearful of exposing themselves in the course of gaining medical treatment for their eligible children. Removing the barriers for parents should thus contribute to greater access to medical services for those citizen children living in such families.

Behind the simple economic calculations that weigh in favor of bringing illegal immigrants within the purview of governmental health benefits, there are pressing issues related to public health. The failure to promptly diagnose, treat, or medicate diseases can bring about public health consequences touching every segment of the population. Drug-resistant or more virulent strains of disease are a risk for everyone within the United States and would, beyond the obvious impact of making people sick, likely cause cost spikes across the system. These risks can be mitigated in part by simply bringing illegal immigrants within the fold of the public health system. Preventative and ambulatory care can properly and promptly diagnose illnesses. Keeping individuals within the formal market negates the need to track down possibly counterfeit medications that would fail to adequately address the disease. Such results are

177. See id. at 23-24.
179. Id.
180. See Ku & Matani, supra note 164, at 253.
beneficial not only to the individual seeking care, but to the population as a whole.

C. Is There Any Countervailing Consideration That Would Prove Fatal to Implementation of a Health Care Program for Illegal Immigrants?

As the preceding sections establish, extending health coverage to illegal immigrants may have important benefits. Nonetheless, there are certainly countervailing considerations. Three main arguments seem apparent. First, the mere illegality of immigrants should bar them from receiving any public benefits. Second, the formal extension of public benefits to illegal immigrants could legitimize their status in the United States, thereby undermining respect for this country’s immigration laws. Third, illegal immigrants are already a drain on the US healthcare resources, and including them within public insurance programs would only multiply an already unjustifiable cost. Ultimately, these arguments do not trump the policy rationales for extending coverage to illegal immigrants.

Illegality does not inherently constitute a compelling argument against extending health coverage to illegal immigrants. As noted above, EMTALA mandates that emergency conditions must be treated regardless of legal status, and Medicaid provides for certain treatments for children and women. These provisions were driven by policy rationales, including the ethical belief that services should be extended when gravely needed. And the policy rationales for further extending coverage offered by this Article are compelling enough to trump the “illegality should bar health care” argument. Further, despite the intuitive appeal of the contention that individuals who are here illegally should not reap public benefits, not even the Immigration and Nationality Act (INA) treats illegality in this definitive manner. Beyond the traditional paths to permanent residency by visa petition and application for adjustment of status, the INA offers several means of relief to individuals present in the United States who can demonstrate a connection with the country and/or hardship if returned to their native country. Cancellation of removal permits illegal immigrants with qualifying relatives in the United States to seek relief if their removal would result in “exceptional and extremely unusual hardship” to their qualifying relative. The provisions providing for inadmissibility and removability, which enumerate the grounds upon which an individual may be denied admission to or be removed from the United States, likewise provide waivers of those grounds for certain qualifying individuals.


183. See, e.g., 8 U.S.C. §§ 1182(d)(11), (h)(1)(B), (i)(1), (k) (providing for waivers of certain grounds of inadmissibility under 8 U.S.C. § 1182); 8
The logic behind these provisions, as with the extension of certain health services to classes of illegal immigrants, is that there may be compelling policy reasons to extend benefits even to those here illegally. The focus in the healthcare debate should thus remain on whether there are benefits to extending coverage to illegal immigrants. By bashing the rhetoric of the debate continually upon the shores of “illegality,” opponents of such coverage miss the bigger picture and unduly minimize the potential for broad benefits to the US healthcare system if coverage is extended. Because of the compelling economic and public health reasons for extending coverage to illegal immigrants, the mere fact of their illegality, just as in the debates surrounding limited extension of healthcare services and the provision for relief from removal under the INA, does not offer a strong counterpoint.

The argument may also be made that permitting illegal immigrants to take full part in the US healthcare system would constitute a de facto legitimation of their status, thereby undermining immigration enforcement efforts. This argument fails to acknowledge that granting illegal immigrants some combination of private and public health coverage would not amount to de jure recognition of legal status under immigration laws. In other words, there can never be an argument that status will obtain simply because illegal immigrants are eligible for certain public benefits.

Illegal immigrants are already covered under certain provisions of Medicaid and state and local health programs, meaning that extension of coverage would be just that—an extension of existing coverage. Although this extension could be a more significant step towards legitimation than the existing state of coverage, as it would constitute a full absorption of the illegal population into the healthcare system, nothing about this reform would give aliens any right to remain in the United States solely because they are enjoying a public benefit. Moreover, considering the vast number of employed illegal immigrants, it is hard to fathom how the extension of certain public benefits could create a more pernicious legitimation than that which is prevailing under this country’s current policy towards the illegal population.

There is also no demonstrated correlation between levels of illegal immigration and the extension of public benefits or illegal immigrants’ potential eligibility for public benefits.184 Employment continues to be the biggest driving force behind illegal immigration, and less than 1 percent of illegal immigrants cited obtaining social services or public benefits as a driving force behind their decision to immigrate.185 The social and economic factors of having family in the United States and

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184. Berk et al., supra note 164, at 53.
185. Id. at 49, 53.
better employment opportunities here will continue to drive illegal immigration.

Finally, the argument that providing health services to illegal immigrants would inflate the already high costs of doing so falters badly on available data. While it is impossible to argue that illegal immigrants do not cost the system money, the focus should be on the net costs or benefits illegal immigrants may bring, rather than a one-sided assessment as to whether the provision of services constitutes a cost to the system. It obviously does, but limiting arguments in this way ignores the possible benefit of the influx of immigrants, legal and illegal, that the United States has absorbed in the preceding decades. Workers without valid social security numbers pay an estimated $8.5 billion into Social Security and Medicare each year without receiving eligibility credits for their contributions.\textsuperscript{186} Although not all of these workers are illegal immigrants, a large proportion are,\textsuperscript{187} meaning that the funding provided to these programs will be utilized solely by the lawful resident and citizen population. Additionally, the “National Resource Council concluded that immigrants add as much as $10 billion to the economy each year and that immigrants will pay on average $80,000 per capita more in taxes than they use in government services over their lifetimes.”\textsuperscript{188} These findings undercut the assertion that the cost of illegal immigrant health care constitutes a drag on the system. Although the expenditures are not small in many states, including California and Texas,\textsuperscript{189} the overall contributions to the economic well-being of the United States as a whole is benefited to a greater degree than it is burdened.\textsuperscript{190}

In addition, illegal immigrants underutilize the healthcare system, meaning that the costs for this segment of the population are less than its representation in the population. In 1998, it was estimated that total immigrant expenditures constituted only 7.9 percent of total US healthcare spending.\textsuperscript{191} Focusing solely on the public costs (i.e., the costs to federal, state, and local governments), illegal immigrants account for between 1 percent and 1.5 percent of healthcare expenditures while constituting between 3.2 percent and 5 percent of the adult population.\textsuperscript{192} The public sector cost of providing health care to immigrants is

\textsuperscript{186} See Mohanty et al., \textit{supra} note 162, at 1431.


\textsuperscript{188} Id.

\textsuperscript{189} See Wolf, \textit{supra} note 142.

\textsuperscript{190} See Mohanty et al., \textit{supra} note 162, at 1431.

\textsuperscript{191} Id. at 1433.

\textsuperscript{192} See Ku, \textit{supra} note 6, at 1325 (estimating total costs of 1 percent and a population representation of 5 percent); Goldman et al., \textit{supra} note 138, at 1709 (estimating total costs of 1.5 percent and a population representation of 3.2 percent).
thus less than their population representation, and “[t]his gap is largest for the undocumented.”193 This disproportionately small consumption of resources can be traced to illegal immigrants’ usage trends: they require fewer hospitalizations, visit the doctor less, and generally seek less health care than residents and citizens. In any event, the small share of resources consumed and the low rates of healthcare usage indicate that illegal immigrants are not a burden on the system and do not overuse or abuse the benefits the United States offers.194

The other often-ignored issue in the public-sector cost debate is that the elimination of certain services may lead to even higher expenses at other points in the system. For instance, California declined to eliminate coverage of prenatal care for illegal immigrants, as it was far less costly to offer such care than it would be to care later for an unhealthy baby.195 As long as emergency medical care is mandated by federal law, care must be extended and thus must entail costs. It is far more rational to allocate these costs in a manner that minimizes them by providing for preventative and other care. In the end, the arguments based on costs fail to account for the fiscal benefits that illegal immigrants bring to the health care system.

D. The Form of Coverage for Illegal Immigrants

The main arguments against extending health coverage to illegal immigrants are largely misplaced. This leaves only one question—what form should coverage of the illegal immigrant population take? Any solution should be twin-faceted, extending coverage under governmental programs and easing access to coverage through private insurers. This Article proposes three possible solutions: (1) extending Medicaid benefits to anybody who can establish eligibility through the means-tested approach, regardless of legal status in the United States; (2) eliminating the citizenship and residency requirements for the individual mandate and opening up the ACA’s subsidy provisions to illegal immigrants; and (3) addressing the shortcomings in employee-offered programs in those sectors where illegal immigrants are most likely to work.

First, Medicaid benefits should be made available to all who fall within the parameters of the program irrespective of their immigration status.

193. Goldman et al., supra note 138, at 1701.

194. See Alexander N. Ortega et al., Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, 167 ARCHIVES INTERNAL MED. 2354, 2359 (2007) (“Low rates of use of health care services by Mexican immigrants and similar trends among other Latinos do not support public concern about immigrants’ overuse of the health care system.”); Ku, supra note 6, at 1326 (“[T]he low per-person medical expenditures for immigrants indicate that immigrants consume a disproportionately small share of the nation’s health care costs and do not create a major financial burden for the nation’s health care system.”).

status in the United States. It is not clear what percentage of the illegal immigrant population would be reached by such an extension, but it seems likely that the extension of normal Medicaid coverage would undercut the overreliance on the emergency aspect of Medicaid, which is already available to illegal immigrants. By covering noncitizen parents, this extension of benefits could also have the effect of increasing the frequency and quality of treatment for both noncitizen and citizen children of illegal-immigrant parents. Extending Medicaid benefits would not grant any lawful status to individuals otherwise in the country illegally, but the mere fact of coverage may make it more likely that the children of illegal immigrants will receive timely and appropriate medical care while the citizen children of illegal immigrants will begin to receive the care that they are already entitled to under the law.\textsuperscript{196} Coverage would also encourage early diagnoses and even preventative treatments and checkups, thereby relieving the stress that illegal immigrants place on the back-end of the system in seeking treatment and care only after a disease has progressed or when an emergency or chronic condition has arisen.

Second, reforms should be instituted to encourage obtaining private insurance for those who do not meet the means-tested eligibility criteria for Medicaid. Everyone residing in the United States who meets the requisite criteria for being required to purchase insurance under the individual mandate provision of the ACA should be required to participate, regardless of their citizenship or residency status. Accordingly, the provision excluding illegal immigrants from the purchase requirement of the mandate should be repealed.\textsuperscript{197} Mandating the purchase of insurance or assessing a penalty for failure to purchase a policy may prove ineffectual and unfair absent subsidies for low-income families and individuals. As Lawrence Gostin and Elenora Connors have written, “Premium and cost-sharing subsidies for low-income individuals and expanded Medicaid eligibility would facilitate affordable coverage and are critically important for expanding access to medical care.”\textsuperscript{198} Medicaid will provide coverage to those with sufficiently low incomes to warrant such government assistance, but that might still leave a large percentage of illegal immigrants who are subject to the individual mandate but unable to afford coverage on their own. Thus, extending government subsidies to illegal immigrants is a vitally important aspect of ensuring broad coverage of this population.

Third, although the extension of Medicaid and the individual mandate to illegal immigrants would conceivably cover the entirety of the

\textsuperscript{196} Cf. Ku & Matani, \textit{supra} note 164, at 253 (noting that the children of illegal immigrants, whether citizens or not, enjoy less access to medical services than the children of US citizens).


\textsuperscript{198} Gostin & Connors, \textit{supra} note 131, at 1189.
illegal population, another reform might be worth considering: mandating employer-sponsored coverage. As one commentator has noted, the lack of coverage under governmental programs would be less harmful if more illegal immigrants worked in professions that extended health insurance coverage: “Not only are they [undocumented immigrants] ineligible for most government insurance programs, but they are also often forced to work in ‘off-the-books’ occupations that offer no health benefits.” Thus, for most illegal immigrants, it is the lack of employer-based health insurance plans that constitute their biggest obstacle to participating in the US healthcare system. An employer mandate would have the effect of reaching this large segment of the illegal immigrant population, relieve reliance on privately obtained health insurance, and lessen government expenditures on insurance subsidies and Medicaid coverage.

However, employer-mandates would be a difficult sell politically, even if it does make sense ethically and fiscally. The current state of immigration law makes it a crime to hire an illegal immigrant for employment, and it penalizes illegal immigrants who seek employment with false documents. Although prior to 1986 there were no provisions barring or criminalizing the employment of illegal immigrants, the trend in immigration legislation in the preceding two decades has been to greatly restrict the employment of illegal immigrants and use those restrictions as a brake on immigration. These penalties have not stopped the employment of illegal immigrants, but they have placed those employed outside the general protections offered by employment and labor law. For an employer-mandate to be effective, immigration law must revert to its pre-1986 state of tacitly permitting the employment of illegal immigrants. This repeal would recognize that the employment of illegals has continued, even if it has moved more to the shadows, and that US employers are gaining real benefits from their employment of these workers. Employment of illegal immigrants by private businesses does not give rise to any obligation on the part of the government to provide coverage, but there is a very strong argument that it should, as a matter of fairness, give rise to an obligation on the


200. Id. at 1615.

201. See Derose et al., supra note 140, at 1266.


203. Id. § 1324c.


205. See id.
part of the businesses who take advantage of illegal immigrant labor. This would place the costs of illegal immigrant health care on those reaping the benefits from their presence within the United States.

These reforms should be undertaken together to extend healthcare coverage to as many people as possible. Nonetheless, they could be undertaken separately and thereby relieve at least part of the problem of cost-overruns in the current system. An employer mandate would reach many illegal immigrants and their families, as would subsidizing private health insurance coverage. Medicaid would provide an additional safety net, allowing funds currently used for emergency expenditures to be put to more efficient uses. If there is a political will, then the above suggestions provide the proverbial “way.” If the will is lacking, even in the face of compelling evidence that an extension of health coverage would be in the interests of all, the viability of the way becomes irrelevant. In that case, we will simply be stuck “at the intersection of two broken systems.”

CONCLUSION

The question of whether health coverage should be extended to illegal immigrants will continue to rankle in the political arena for the foreseeable future. With the divisive political climate now prevailing, “there is little chance that legislators will offer funding to provide health care services to the undocumented immigrant population.” Nonetheless, this Article has argued that extending such coverage is sound policy, even if there is no colorable claim that illegal immigrants are legally entitled to these public benefits. The inclusion of the illegal-immigrant population may lower costs in numerous ways, including lower insurance premiums, lower emergency medical expenditures, and a switch from expensive late-stage treatments to cost-effective preventative and ambulatory care. Coverage will obviously benefit illegal immigrants, but the entire US population will also reap the rewards of a broader risk pool comprising individuals with comparatively low medical expenditures and usage trends. Extending coverage could also have important public health benefits. Ensuring treatment, especially of infectious disease, protects the health of the population as a whole, and this is especially important considering the ease of travel and access to different parts of the globe. The public health is also served by prompt diagnosis and treatment of chronic diseases, such as heart disease and diabetes.

Practicality and pragmatism thus argue in favor of the reforms presented by this article. In writing about the Toussaint decision and arguing that some form of coverage should likely be extended to illegal immigrants in Canada, one commentator noted that “[a]llowing [illegal

206. Okie, supra note 143, at 525.
207. Berk et al., supra note 164, at 54.
immigrants to stay and pretending they’re not here doesn’t work for anyone.”308 Prohibiting inclusion in the formal healthcare system while extending piecemeal benefits through Medicaid, emergency rooms, and a patchwork of state and local governments is a poor way to address a problem that is, practically speaking, intractable. The federal government should meet this challenge head-on in the form of health coverage, recognizing the benefits that could accrue to it by instituting such reforms. Even if immigration reform does materialize, nothing will have been lost by providing coverage in the interim. As the illegal immigrant population declines, for instance, because of fewer economic opportunities in the United States or absorption into the lawful immigrant category, the system has enough fluidity to respond. Further tweaks may be necessary, but incremental improvement is a characteristic of any public benefits scheme. What is not acceptable is to tacitly ignore the problem while setting up additional barriers to coverage.

208. Pugash, supra note 4.