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RSC Policy Brief:
Health Care and Illegal Aliens

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In order to assist Congressional staff developing health reform proposals, the RSC has prepared the following policy brief analyzing the impact of illegal aliens on the American health care system.

Background: Data from this year's Census Bureau report on the uninsured indicate that more than one-fifth—over 9.7 million—of the uninsured are foreign-born residents of the United States lacking American citizenship. This category—which includes both legal residents not yet citizens as well as undocumented aliens—contains the highest percentage of uninsured Americans (43.8%) of any age, race, income, or other cohort included in the Census survey.[1]

While the Census Bureau reports do not contain specific data on the uninsurance rate among illegal immigrants, a 2005 study using data from the Los Angeles area provides some insight regarding this population.[2] Extrapolating the 68% uninsured rate for aliens found in the Los Angeles study to a nationwide undocumented population of 12 million would yield approximately eight million uninsured—about one-sixth of the total number of uninsured Americans—who are illegally present.

Impact on Federal Programs: In general, provisions in Title IV of the 1996 welfare reform law (P.L. 104-193) prohibit the provision of health care or other services to aliens illegally present in the United States.[3] However, federal health care programs address the issue of

[1] "Income, Poverty, and Health Insurance Coverage in the United States: 2007" (Washington, Census Bureau, August 2008), available online at http://www.census.gov/prod/2008pubs/p60-235.pdf (accessed August 26, 2008), Table 6, p. 30.
[2] Dana Goldman, James Smith, and Neeraj Sood, "Legal Status and Health Insurance among Immigrants," *Health Affairs* 24:6 (November/December 2005), 1640-1653.
[3] Illegal aliens are eligible for emergency care (as defined by the EMTALA statute discussed below) provided under Medicaid, and for public health assistance with respect to immunization for, and treatment of, communicable diseases. Some groups of qualified aliens—excluding those illegally present—are eligible for other federal benefits, as discussed below.

verifying identity and nationality as a condition of providing care in various ways, while other programs attempt indirectly to offset the impact of uncompensated care for illegal aliens on health care providers. The most important of these include:

Medicare: Under Title XVIII of the Social Security Act, Medicare benefits are available to eligible citizens, as well as to legal aliens continually resident in the United States for at least five years prior to application for benefits.[4] The five-year residency requirement was challenged on due process grounds, and eventually upheld by the Supreme Court in June 1976; Justice John Paul Stevens, writing for a unanimous Court, stated "it is obvious that Congress has no constitutional duty to provide all aliens with the welfare benefits provided to citizens."[5]

The Social Security Administration (SSA) determines eligibility for Medicare benefits, including the process of verifying an applicant's identity and citizenship (or legal resident status). The standards used by SSA are found in federal regulations, and include evidence of age (e.g. birth certificate or hospital record), identity (e.g. driver's license, school record, or other documents identifying an individual), and citizenship (e.g. birth certificate, passport, or certificate of naturalization).[6]

Medicaid: Under the provisions of the welfare reform law, states may only receive federal Medicaid matching funds for legal U.S. citizens or qualified aliens (subject to a five-year waiting period in most cases.[7] However, while the Medicaid statute has required since 1986 that applicants declare their nationality under penalty of perjury, until recently most states relied on self-attestation to verify citizenship status.[8] A 2005 report by the Department of Health and Human Services Inspector General found that 40 states (including the District of Columbia) allowed self-declaration, with an additional seven states sometimes permitting self-declaration of citizenship status; of these 47 states, 27 did not verify the accuracy of the citizenship attestation.[9]

As a result of this report, Congress in the Deficit Reduction Act (DRA, P.L. 109-171) eliminated the ability of state Medicaid programs to rely on self-declarations by beneficiaries as the sole means of citizenship verification. Specifically, Section 6036 of the Act requires states receiving federal Medicaid funds to verify participants' identity and citizenship on the basis of appropriate documentation (e.g. passport, birth certificate, etc.). The verification provisions do not apply to dual eligible (i.e. enrolled in both Medicare and Medicaid) beneficiaries, or to Medicaid

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[4] Available at 42 U.S.C. 1395o.
[5] *Mathews v. Diaz*, 426 U.S. 82 (1976).
[6] Some examples of documentation can be found at 20 CFR 422.107. In addition, SSA's Program Operations Manual System (POMS) includes guidelines for workers in SSA field offices; the section of the manual relating to citizenship, alien status, and residency can be found online at https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0200303000 (accessed August 25, 2008).
[7] According to the Kaiser Family Foundation, 17 states provide benefits funded solely by state dollars to illegal aliens and/or aliens subject to the waiting period. See "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Adults," (Washington, Kaiser Policy Brief #7651, June 2007), available online at http://www.kff.org/uninsured/upload/7651.pdf (accessed August 26, 2008), p. 3.
[8] The requirement is in Section 1137 of the Social Security Act, available at 42 U.S.C. 1320b-7(d)(1)(A).
[9] Daniel Levinson, "Self-Declaration of U.S. Citizenship for Medicaid," (Washington, DC, HHS Office of the Inspector General, Report OEI-02-03-00190, July 2005), available online at http://oig.hhs.gov/oei/reports/oei-02-03-00190.pdf (accessed August 20, 2008), pp. 16-18.

beneficiaries receiving SSI benefits, as the Social Security Administration verifies the identities of these beneficiaries, as outlined above.

Shortly after the DRA provisions took effect, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule on July 12, 2006, using discretionary authority included in the DRA to expand the list of eligible documents that could be used to verify citizenship and/or identity, in order to ease the transition to the new verification regime.[10] In addition, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) exempted children in foster care from the DRA documentation provisions. While the verification requirements were sharply criticized by some organizations at the time of their enactment, many conservatives may note the relative lack of controversy surrounding Medicaid verification two years after the provisions took effect as proof that citizenship verification can be implemented in an effective manner that ensures aliens do not have access to federal benefits while preserving existing programs for eligible individuals.

SCHIP: Because of the hybrid nature of the State Children's Health Insurance Program (SCHIP), only some children undergo citizenship verification as part of the application process. The Balanced Budget Act of 1997 (P.L. 105-33), which created SCHIP, gave states the option to use SCHIP funds to expand their Medicaid programs, create a new program for SCHIP beneficiaries, or some combination of the two approaches. The eight states (and the District of Columbia) which chose Medicaid expansion programs—as well as Medicaid participants in the 24 states with combination programs—are subject to the citizenship verification requirements enacted as part of DRA.[11] However, the 18 states with separate SCHIP programs currently have no requirement to verify the identity and nationality of individuals before enrolling beneficiaries.

EMTALA: Enacted in 1986 as part of the Combined Omnibus Budget Reconciliation Act (P.L. 99-272), the Emergency Medical Treatment and Active Labor Act (EMTALA) imposes requirements on hospitals accepting Medicare payments to treat patients in emergency conditions. The Act's requirements apply to all patients, regardless of their Medicare eligibility status, ability to pay, or immigration status.[12] The Act also includes significant penalties: violations of EMTALA can result in fines of up to $50,000 and exclusion from the Medicare program in repeated or egregious cases, as well as lawsuits by patients adversely harmed by an EMTALA violation.

In recognition of the rising costs to providers associated with the EMTALA unfunded mandate, particularly as it relates to care for illegal aliens, Section 1011 of the Medicare Modernization Act (P.L. 108-173) provided a total of $1 billion in grants directly to providers (though on the basis of state-based formulae) for uncompensated emergency care given to illegal aliens—$250 million for each of Fiscal Years 2005 through 2008.

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[10] A final rule incorporating comments to the July 12, 2006 interim final rule was published in the *Federal Register* on July 13, 2007 and can be found online at http://edocket.access.gpo.gov/2007/pdf/07-3291.pdf (accessed August 20, 2008).

[11] A state-by-state breakdown of SCHIP program status can be found in Congressional Research Service, *The State Children's Health Insurance Program (SCHIP): An Overview*, Report RL 30473, available online at http://www.congress.gov/erp/rl/pdf/RL30473.pdf (accessed August 21, 2008), Table 1, Column 1, pp. 18-21.

[12] The full EMTALA statute can be found at 42 U.S.C. 1395dd.

Community Health Centers: Under the Public Health Service Act, the federal government provides competitive grants to federally qualified health centers, including migrant health centers. In 2007, health centers treated 16.3 million patients, while the health centers grant program received $2.065 billion in the Fiscal Year 2008 omnibus appropriations bill (P.L. 110-161).[13] Subsequent legislation passed in the House (H.R. 1343) and Senate (S. 901) would increase health center authorization levels to $15 billion over the FY09-FY13 period.

The statute authorizing the health centers grant program requires that care not be denied to patients based on an inability to pay for services.[14] In addition, the Congressional Research Service reports that grant recipients are not required to verify the citizenship status of their patients. Given that the authorizing statute is silent with respect to enforcing the prohibition against federal benefits being provided to illegal immigrants, some conservatives therefore may be concerned that federal tax dollars are being used to provide aliens with health care services.

Disproportionate Share Hospital (DSH) Payments: While not providing care to illegal aliens, the section of the Medicaid statute related to DSH payments implicitly recognizes the impact this population can have on providers. In particular, the statute deems hospitals with a low-income utilization rate of 25% as qualifying for DSH payments, without limiting the low-income population to citizens normally eligible for federally-funded care.[15] As a result, states may allocate portions of their Medicaid DSH payments—estimated to total $8.8 billion in Fiscal Year 2008—to offset care provided by hospitals to illegal aliens.[16]

Legislative Proposals: Much of the debate surrounding health care for aliens during the 110th Congress has focused on SCHIP reauthorization. While many Democrats have attempted to use reauthorization as a vehicle to limit or repeal the Medicaid citizenship verification provisions enacted in DRA, many conservatives believe that a reauthorized SCHIP program should incorporate the Medicaid documentation requirements to improve the integrity of the program.

More specifically, H.R. 3162, passed by the House in July 2007, would make Medicaid citizenship verification a state option for children under 21, retroactive to the July 2006 effective date of the DRA provisions. In addition, Section 112 of the bill would also establish "Express Lane" agencies to enroll beneficiaries in Medicaid and SCHIP, without including citizenship verification or documentation requirements; Section 136 would require states to conduct audits on a sample caseload to ensure that federal Medicaid and SCHIP funds "are not unlawfully spent" on illegal aliens. Some conservatives may be concerned that the removal of the mandatory Medicaid verification language for children, along with the "Express Lane" provisions, would effectively undermine the important reforms enacted as part of DRA, and that sample audits would not be sufficient to ensure compliance with provisions of the 1996 welfare law cited above stating that no illegal alien may receive federal health or welfare benefits.

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[13] Fiscal Year 2009 HHS Budget in Brief, available online at http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf (accessed August 20, 2008), pp. 21-25.
[14] The statutory language is available at 42 U.S.C. 254b(k)(3)(G)(iii)(I).
[15] The definitions of Medicaid DSH institutions can be found at 42 U.S.C. 1396r-4(b).
[16] March 2008 CBO Medicaid baseline, available online at http://www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf (accessed August 20, 2008).

H.R. 3963, vetoed by the President in October 2007, would extend citizenship verification requirements to both the SCHIP program has a whole and the "Express Lane" mechanism outlined in H.R. 3162 above. However, the bill would provide an alternative verification process to the DRA provisions that would instead rely upon name and Social Security number validation—a process which, according to a September 2007 letter from Social Security Administration Commissioner Michael Astrue, would *not* keep an applicant from fraudulently receiving coverage under Medicaid or SCHIP (if they claimed they were someone they were not). Some conservatives may therefore be concerned that this provision—coupled with the incentive to states provided by a greatly enhanced federal match to establish this more lenient verification system—would weaken the process put in place by the Deficit Reduction Act.

Conversely, several proposed Republican SCHIP alternatives (H.R. 3176, H.R. 3888, and S. 2193) would apply the Medicaid citizenship verification requirements, as created by the DRA, to the SCHIP program, with an enhanced federal match for administrative costs. Some conservatives would support the extension of the reasonable Medicaid DRA provisions to the SCHIP program, along with an enhanced administrative match to reimburse states for any increase in overhead costs associated with citizenship verification.

More recently, press reports indicate that the Democratic "Tri-Caucus" of Hispanic, Black, and Asian Members have written to Speaker Pelosi asking her to include provisions repealing the five-year waiting period for qualified aliens to become eligible for Medicaid or SCHIP coverage as part of any SCHIP bill considered by the House this fall.[17] This change would alter provisions in the 1996 welfare reform law—which also prohibited illegal aliens from receiving federal benefits—that limited access to benefits for most "qualified aliens" for five years.[18] Some conservatives may be concerned that this provision would increase costs while encouraging would-be immigrants to file claims for asylum in order to obtain federal health care coverage.

Implications for Comprehensive Health Reform: In light of reports suggesting that illegal immigrants represent a significant—and fast-growing—component of the uninsured in America, some conservatives may focus on two elements necessary to address this issue in any comprehensive health care bill that may be considered. First, consistent with the debate surrounding SCHIP legislation during this Congress, many conservatives may believe that any reform package must include provisions similar to those in the DRA that impose verification requirements for all applicants to preserve the integrity of federal programs and avoid providing incentives for illegal immigration. For instance, while the Healthy Americans Act (S. 334) by Sen. Ron Wyden (D-OR) excludes access to new state-based health plans for illegal immigrants, it contains no enforcement or verification provisions to implement this restriction.

[17] Mike Soraghan, "Minority Caucuses to Press for Two SCHIP Provisions," *The Hill* August 13, 2008, available online at http://thehill.com/leading-the-news/minority-caucuses-to-press-for-two-schip-provisions-2008-08-12.html (accessed August 21, 2008).

[18] Title IV of P.L. 104-193 did contain some exceptions to the "qualified alien" waiting period—most notably for legal permanent residents with a substantial work history (i.e. 40 qualifying quarters of Social Security coverage) and for those with a military connection (i.e. veterans, active-duty servicemen, and their spouses and dependents).

Secondly, some conservatives may be concerned about the impact which uncompensated care given to illegal immigrants may impose on providers, particularly hospitals. The unfunded mandate created by EMTALA has a significant impact on providers treating illegal immigrants, who are less likely to have the health insurance necessary to pay catastrophic expenses. The combination of DSH payments and the $1 billion uncompensated care fund created by MMA, scheduled to sunset at the end of the fiscal year, only partially defer the uncompensated care cost paid by providers who treat illegal aliens.

Consistent with the conservative concerns about uncompensated care is the relatively new phenomenon of lawsuits against hospitals initiated by illegal immigrants. *The New York Times* recently reported on a case from Florida where a hospital, having provided $1.5 million in uncompensated care to a Guatemalan alien, asked for and obtained a court order to return the immigrant to Guatemala; no nursing home in the United States would accept an alien patient without insurance and ineligible for Medicaid, while the hospital could not release a patient with brain injuries into the general population without arranging post-discharge care.[19] In a case with potentially far-reaching implications, relatives for the alien had the Florida court order reversed after deportation—and subsequently filed suit against the hospital for false imprisonment.

Though tragic on multiple levels, the Florida case highlights a reality a growing number of providers may face—offer virtually unlimited care to illegal aliens, even when an inability to pay is glaringly apparent, or face legal action initiated by the aliens or their caretakers. Therefore, some conservatives may support actions designed to ensure that providers offering reasonable emergency care to illegal aliens need not be subjected to additional and costly lawsuits.

Conclusion: The Census data breaking down the uninsured by citizenship and national origin, while not widely publicized, illustrate one reason why the concept of universal health insurance coverage may prove ineffective. Democrat proposals for an individual mandate to purchase coverage would prove ineffective for this population, who by their very presence have already violated United States law. Although the uninsured population is not limited to undocumented aliens, many conservatives may believe that a truly comprehensive solution to this health care issue must address the significant demands on the health care system placed by illegal immigrants in a way that preserves the fiscal integrity of existing entitlement programs while protecting providers from liability imposed upon them by aliens illegally present.

For further information on this issue see:

- *RSC Policy Brief on the Uninsured*
- *Census Report: Income, Poverty, and Health Insurance Coverage*
- *Centers for Medicare and Medicaid Services: Information on Medicaid Citizenship Requirements*

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[19] Deborah Sontag, "Immigrants Facing Deportation by U.S. Hospitals," *New York Times* August 3, 2008, available online at http://www.nytimes.com/2008/08/03/us/03deport.html?_r=1&sq=jimenez&st=cse&adxnnl=1&oref=slogin&scp=10&adxnnlx=1219331895-evIAEOYXEq2SKfB7dLGcEg&pagewanted=print (accessed August 21, 2008).

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