Patchwork Solution to A Complicated Problem: How the Current Healthcare Legislation is Failing to Address the Difficulties Created by Undocumented Immigrants.

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A Patchwork Solution to A Complicated Problem: How the Current Healthcare Legislation is Failing to Address the Difficulties Created by Undocumented Immigrants.

As a nation that values immigration, and depends on immigration, we should have immigration laws that make us proud. Yet today we do not.
--President George W. Bush

I. INTRODUCTION

Many Americans believe that the administrative burdens and rising state costs presented by undocumented immigration are too great for the county to bear and that immediate, corrective action is necessary. Among the myriad of problems presented by this issue, the burden undocumented immigration places on the healthcare system continues to produce especially strong feelings, as legal citizens debate about whether undocumented immigrants should be provided with healthcare, and if so, who should bear the associated costs.

Proponents of denying undocumented immigrants federal and state funded healthcare argue that providing healthcare to illegal aliens will further encourage immigration, and thus it should not be provided. In effort to appease their constituents, lawmakers have enacted several statutes that prohibit undocumented immigrants from receiving publicly funded healthcare. As I will demonstrate in this paper, these restrictions on undocumented immigrants’ access to publicly funded healthcare are misplaced, provide a patchwork solution, and therefore warrant re-evaluation.

Congress’ repeated attempts to quell the American public by enacting legislation which purports to limit undocumented immigrants’ access to healthcare is not founded on verifiable data, nor is it in line with sound public policy. Although the cost of undocumented immigrants on the healthcare system is cited as motivation for restricting
access to publicly funded healthcare, the true cost of undocumented immigrants on the healthcare system is unknown; the methodology applicable to calculating the cost of undocumented workers has proved to be especially suspect.⁷

Moreover, the current federal legislation provides contradictory standards that complicate the duties of healthcare providers and results in harsh penalties for those who misinterpret the confusing federal and state standards.⁸ Also, the legislation currently in place poses an ever increasing burden on the country’s emergency rooms as they are becoming the federal healthcare safety net; yet these same facilities are not adequately compensated for the costs that they incur.⁹ The present legislative scheme is also economically inefficient. The cost of providing emergency care is far greater than the cost of providing preventative medicine and routine check-ups.¹⁰

Despite the inadequacies of the present federal legislative scheme dealing with the effects of undocumented immigrants on the healthcare system, the federal legislature continues to stall. By refusing to directly acknowledge the problem and provide adequate solutions, the costs continue to grow exponentially as the nation’s hospitals are incurring substantial debt and in some cases are being forced to shut down. Although most of the pressing issues could be addressed by federal funding of preventative treatment programs, costs continue to grow and hospitals continue to close.¹¹

The purpose of this article is to examine how the current legislation regarding undocumented immigration has failed to address the real issues and actual impact of undocumented immigrants on the healthcare system. First, article will examine The Welfare Reform Act of 1996 and the practical effects of its enactment. In particular, it
will examine how limiting undocumented immigrants’ access to publicly funded healthcare has further worsened the situation for all of the appropriate stakeholders. For hospitals and taxpayers, the enactment of the Welfare Reform Act has increased the cost of treating undocumented immigrants in emergency situations as compared to providing preventative care.\textsuperscript{12} Moreover, the enactment of the Welfare Reform Act has forced emergency rooms to become the primary care provider for undocumented immigrants, but has not correspondingly compensated them for their costs of treatment.\textsuperscript{13}

Second, the article will focus on the Emergency Medical Treatment and Active Labor Act and its application to undocumented immigrants. Specifically, it will illustrate the differing standards articulated in EMTALA and Welfare Reform Act and the difficulty that healthcare providers have in determining the appropriate standard of care.\textsuperscript{14}

The third piece of legislation that this article will examine is the Immigration Reform Act of 1996. The article will address how the Act has furthered the ethical and moral dilemmas for hospitals in making a determination of whether or not to notify INS of the Immigration status of its patients.\textsuperscript{15} After discussing the relevant federal immigration laws applicable to undocumented immigrants and their access to healthcare, this article will articulate the myriad of problems that the federal legislation has created and the continuing problems that it has failed to address. Specifically, it will examine the faulty procedures used to determine the actual cost that healthcare organizations incur in treating undocumented immigrants and how these inaccurate figures have provided legislatures with a distorted account of the problem presented and should not relied upon as the basis for their legislative acts.\textsuperscript{16}
Next, this article will illustrate the conflicting standards of the Welfare Reform Act and the Emergency Medical Treatment and Labor Act (hereafter “EMTALA”), and the difficulties these contradictory federal mandates have placed on healthcare providers.

In addition to creating conflicting standards, this article will note how the current legislation has created a disproportionate burden on the nation’s emergency departments. By refusing to aid undocumented immigrants seeking preventative care, emergency departments are the only available source of healthcare for the undocumented. As a corollary to the burden that the current legislation places on emergency departments, this article will demonstrate the economic inefficiencies of the current, federal healthcare laws. Most notably, the article will illustrate that the cost of providing preventative care is far lower than providing treatment for emergency care.

After identifying the problems of the current federal laws, this article will attempt to provide possible solutions. First, in order to provide sensible and effective federal healthcare legislation, an accurate assessment of the problem is needed. The most effective method for determining the true cost of undocumented immigrants on the healthcare system is to allow them temporary legal status under a guest worker program. Under such a program, undocumented immigrants could register with the federal government and healthcare providers could obtain accurate information without fear of Constitutional violations. Additionally, a cohesive standard for the Welfare Reform Act and EMTALA is essential to alleviate healthcare provider’s confusion and uncertainty regarding the standard of care required and the amount of reimbursement anticipated. A third possible solution to this increasing problem is to allocate the Social
Security taxes paid by undocumented immigrants to cover the expenses that healthcare providers incur in treating them. Also, if undocumented immigrants were granted temporary legal status, the revenue that they would produce for the federal government in taxes would also substantially reduce the costs that are incurred in providing for their healthcare.

II. HYSTERICAL POLICY-MAKING REGARDING HEALTHCARE FOR UNDOCUMENTED IMMIGRANTS

A. Welfare Reform Act

During the mid-1990’s, the growing number of undocumented immigrants and their increased impact on the country’s healthcare system became an issue of national importance for Congress and President Clinton. At the crux of this issue was the tension between the individual states and the federal government, as states were bearing the majority of the costs and were not being sufficiently aided by the federal government. In reaction to this disparity, states like California created legislation aimed at reducing their burden of providing healthcare to undocumented immigrants. In California voters passed Proposition 187, which restricted undocumented immigrants from receiving public benefits, including healthcare. Although, it was ultimately declared to be beyond state power to regulate immigration, Proposition 187 reflected the general public’s desire to limit undocumented immigrants’ access to healthcare. Due to this increased pressure, Congress and President Clinton passed the Welfare Reform Act of 1996. Congress passed the Welfare Reform Act under the “plenary authority of the federal government over immigration matters”. The Act’s goal was to eliminate the majority of public benefits for undocumented immigrants, including
The authors of the acts stated that the purpose of denying undocumented immigrants public healthcare was so that aliens would not “depend on public resources, but rather rely on their own capabilities and the resources of the families, their sponsors, and private organizations.” The act also stressed the purpose of this act was put into effect so “the availability of public benefits would not constitute an incentive for immigration into the United States.”

Although the Welfare Reform Act effectively denied undocumented immigrants access to publicly funded healthcare, there were a few exceptions. Undocumented immigrants could receive publicly funded healthcare for treatment of “emergency medical conditions” and “assistance with respect to immunizable diseases and testing for treatment of symptoms of communicable diseases.” The Act also provided some severe restrictions on a state’s ability to treat undocumented immigrants. It restricts the ability of a state to use federal, state, or county funds to pay for any “public benefit” for undocumented immigrants without an affirmative state law and a waiver from the Department of Health and Human Services. In effect, while the Act allows government funds to be used to pay for emergency care for undocumented immigrants, the federal government provides only a fraction of the actual costs incurred by state hospitals and prevents states and local counties from providing reimbursement by requiring an “affirmative state law” and an HHS waiver. As a result of these restrictions, the Welfare Reform Act has removed preventative health care benefits for undocumented immigrants and has made it more difficult and confusing for states to provide undocumented immigrants with state and local funded health care services.
B. Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress on April 7, 1986 as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 as Congress’ second attempt to provide emergency medical services for anyone who needed such services. Congress first attempted to address this problem in 1946 with the Hill-Burton Act, which provided grants for hospital construction. The grants were subject to the condition that the hospital would provide medical services to all individuals living within a geographically defined area. However, the Hill-Burton Act failed to provide general care as it was applicable for not-for-profit and public hospitals and did not include private hospitals. Over time, the number of private hospitals continued to grow and correspondingly the benefit of the Hill-Burton Act diminished. As a result, private institution increasingly refused to treat patients based on their ability to pay for services. This phenomenon becomes known as “patient dumping.” In effort to end this practice, Congress mandated that any hospital receiving federal funds must accept any patient seeking treatment in its emergency room.

EMTALA requires that hospitals with emergency departments and that participate in the medicare program provide a medical examination within the capability of the hospital’s emergency department to any person requesting one. The purpose of the examination is to determine whether the person is suffering from a medical condition or in active labor. A person found to be to have an emergency medical condition or in active labor must be treated or transferred. Although the intention of the Act was to eliminate “patient dumping,” the practical effects of this act have greatly
strained the emergency departments of hospitals throughout the country. Undocumented Immigrants are forced to use the emergency room as their sole source of healthcare. Moreover, because there is no federal funding for preventative care for undocumented immigrants, the cost of treating advanced diseases and health problems is greater than the cost of providing preventative treatment. In effect, EMTALA has become the federal healthcare safety net.

C. Immigration Reform Act

Section 642 of the Immigration Reform Act was enacted on September 30, 1996. The act enlarged Section 434 of the Welfare Reform Act by prohibiting any government entity from restricting another government entity or official from exchanging information with INS about the immigration status of individuals. The practical effect of this law is that state hospitals would be permitted to disclose the immigration status of its patients with INS. However, this law poses distinct problems for both the hospitals and the undocumented immigrants seeking emergency care. Hospitals are put in a position of effectively acting as INS agents, a position they often do not want nor are well equipped to handle. This ambiguity of the hospitals’ status creates further discomfort and unease for the undocumented immigrants as they become afraid of deportation. The conflict in the federal law is apparent, as the federal government allows undocumented immigrants emergency care, however they face the chance of being deported for exercising this right.
III. PROBLEMS PRESENTED BY CURRENT LEGISLATION

A. No Verifiable Method for Determining Actual Cost of Undocumented Immigrants on Health Care System.

Although the motivation behind the current legislation was to limit the cost of undocumented immigrants, the true cost on the healthcare system remains unknown. Since 1985 studies have cited great difficulty in obtaining accurate information on the cost of undocumented immigration on the healthcare system. The source of this difficulty is that hospitals do not ask the immigration status of their patients. Instead, hospitals (and many studies) use the absence of a social security number as the sole determinative factor. Therefore, if a person does not present a social security number, they are considered undocumented immigrants. This method is clearly susceptible to criticism as patients may withhold their social security number for privacy reasons or simply may not know it. The United States General Accounting Office (hereafter “GAO”) used this criterion in a study conducted in 2004 in an attempt to ascertain the cost of undocumented immigrants on the healthcare system and noted its obvious limitations. The study concluded,

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\text{[d]espite hospitals’ long standing concern about the cost of treating undocumented aliens, the extent to which these patients affect hospitals’ uncompensated cares costs remains unknown. The lack or reliable data on this patient population and lack of proven methods to estimate their numbers make it difficult to determine the extent to which hospitals treat undocumented aliens and the costs of their care.}\]

Arizona Senator John Kyl initiated a similar study that attempted to determine the effect of undocumented immigrants on counties bordering Mexico. This study encountered the same difficulties as the GAO. In particular, this study noted, “Our literature review
revealed that the absence of a standard method for tracking the amount of uncompensated care for undocumented immigrants is a perennial problem.”

Obtaining accurate information on the cost and affect of undocumented immigrants is necessary to creating effective legislation. However, the current legislation has been based on figures that could be grossly inaccurate and may overstate the cost of providing healthcare to undocumented immigrants. The disparity in the results from multiple studies indicates the possibility of inaccuracy. The study initiated by Senator Kyl of the counties bordering Mexico estimated that the cost due to emergency medical treatment of undocumented immigrants was $190 million, however the 95 percent confidence interval around this estimate ranged from about $7 million to $373 million. The disparity between these results demonstrates the ambiguity surrounding the actual costs.

B. Conflicting standards of EMTALA and the Welfare Reform Act

Under the Welfare Reform Act, undocumented immigrants may receive federal Medicaid assistance for treatment of “emergency medical conditions”. However the definition of “emergency medical conditions” has been narrowly construed to apply only to those medical conditions that in the absence of immediate medical attention would result in immediate harm to the patient. This definition does not include EMTALA’s requirement to screen a patient to determine whether an emergency medical condition exists. Under the intersection of these standards, a hospital is required to screen a patient to determine whether a medical condition exists, however, if a medical condition does not exist, then Medicaid will not pay for the screening and
thus the hospital is left uncompensated for the screening.\textsuperscript{56} Aside from failing to provide for the screening required by EMTALA, federal Medicaid oftentimes will not provide reimbursement for continuing care that the hospital deems necessary.\textsuperscript{57} In essence, hospitals are left in very difficult position, as they are required to provide treatment, but the moment that treatment is not considered a medical emergency they will not be compensated. A California hospital administrator noted this difficulty: “We’re never sure where we can stop, or what’s required from legislative and ethical perspective. EMTALA really seems to be odds with Medicaid and other Federal requirements.”\textsuperscript{58} As a result of this ambiguity, hospitals are left to determine for themselves what is the appropriate procedure regarding these legislatives mandates.

Moreover, the ambiguity over the requirements of EMTALA and the restrictions of the Welfare Reform Act have produced a great deal of litigation. In particular the standard for the appropriate level of screening was decided in a landmark case from the Sixth Circuit of Appeals, in \textit{Cleland v. Bronson}.\textsuperscript{59} In this case, the court held, “If a hospital acts in the same manner as it would have for the usual paying patient, then the screening provided is adequate within the meaning of the statute”.\textsuperscript{60} The court reasoned that the Act should be read broadly and nothing in the legislative history indicated a narrower reading of the federal statute.\textsuperscript{61} Despite this holding, the standard of care is still ambiguous. In an attempt to further clarify the subtleties of EMTALA, Congress amended the Act in 2003.\textsuperscript{62} The Amendment stated, “The hospital is only required to perform such screening as would be appropriate for any individual presenting in that manner [requesting an examination or treatment for a medical condition], to determine that the individual does not have an emergency medical condition”.\textsuperscript{63} Although this
amendment has helped to clarify the appropriate level of care, it still does not align itself with the conditions and requirements of the Welfare Reform Act and until it does, confusion and ambiguity will continue to exist for healthcare providers.

In attempting to define the appropriate level of care, healthcare organizations have expressed a great deal of concern, for if the hospital misjudges its obligation to treat, the penalties can be severe. Hospital’s compliance with EMTALA is overseen by two distinct agencies. The first is the Office of the Inspector General, and the second is Centers for Medicare and Medicaid Services. The Office of the Inspector General has the authority to enforce civil penalties upon the hospital, whereas Centers for Medicare and Medicaid Services has the power to terminate the hospital’s participation in Medicare and Medicaid. The power to terminate a hospital’s participation in Medicare and Medicaid is especially damaging as a large proportion of hospital patients are covered by one or the other. The combination of the vague and conflicting standards and the harsh penalties for noncompliance have left hospitals little choice, but to error strongly on the side of treating and simply bear the cost that they incur.

C. EMTALA Has a Created a Disproportionate Burden on Hospital’s Emergency Departments.

The original intention of EMTALA was to ensure that everyone could receive emergency medical care regardless of their ability to pay or immigration status. However, Congress’s original expectation of EMTALA was that it would provide a short term fix for the uninsured and undocumented, as Congress had made two previous attempts to enact some form of national health care coverage, and many expected that
national healthcare coverage would be provided shortly after EMTALA was enacted. However, twenty years later, this short term solution remains and continues to be an inefficient solution for providing healthcare coverage for the uninsured and the undocumented.

Currently EMTALA is the only available avenue for healthcare for undocumented immigrants to pursue, and as such provides an ever increasing strain on the healthcare system, especially emergency rooms. Moreover, due to the fact that EMTALA only ensures that the patients will receive care for emergency situations and does not provide for any preventative treatment, the strain and cost continue to grow. Since EMTALA was enacted, emergency department use has surged from 85 million visits per year to near 110 million visits per year, while more than 550 hospitals and 1,100 Emergency Departments closed. In 1992, the General Accounting Office was asked by Congress to study the national problem of overcrowding in emergency departments. According to the report, 37% of emergency department patients who did not have a primary care provider in 1990 were either uninsured or on Medicaid. Ultimately, the GAO concluded that the overcrowding in the emergency department was largely due to an increase, in nonurgent, uninsured patients. Due to the increasing percentage of undocumented immigrants coming to the country, these numbers have surely risen since 1992 further exacerbating the situation.

Additionally, EMTALA has had the greatest negative effect on inner-city, rural, and public hospitals. Despite the fact that the federal government does provide some aid to these hospitals in the form of grants, the amount is not sufficient to cover the extraordinary cost that these hospitals bear. Moreover, poor hospitals do not have the
ability to secure subsidiaries to help finance the cost incurred, whereas suburban hospitals often receive subsidies that they do not need. This occurrence is illustrated by the John Kyl study that noted the increased cost and burden of undocumented immigrants on the rural and often less-funded counties in Arizona, New Mexico, California, and Texas.

D. The Combination of the Welfare Reform Act and EMTALA creates economic inefficiencies.

By mandating that hospitals cannot provide preventative care to undocumented immigrants with federal funds, the current legislation creates an inefficient economic policy. The economic inefficiency is created as emergency medical care is consistently more expensive than providing preventative treatment to patients, as it can be four to ten times more expensive. The increase in cost is due to the fact that it costs less for health facilities to treat symptoms and conditions before they degenerate into emergencies that necessitate more elaborate procedures and care.” However, undocumented immigrants have no other viable alternatives and thus will continue to go the emergency departments as the initial source of medical treatment.

The economic inefficiency is well illustrated by threat of infectious diseases among undocumented immigrants. The majority of undocumented immigrants that enter the country are poor, are living in unsanitary conditions, and therefore are more likely to contract infectious diseases. In this case, it is far less costly to provide immunizations, preventative information, and treatment than it is to treat an increasing population with infectious diseases.
III. POSSIBLE SOLUTIONS TO PROBLEMS PRESENTED

A. Obtain Reliable Statistics Regarding the Cost of Undocumented Immigrants by Granting Undocumented Immigrants Temporary Legal Status.

Before effective legislation can be created to help alleviate the problem of healthcare for undocumented immigrants, it is essential to define the parameters of the problem and determine what the true cost is. Currently, healthcare organizations are placed in a difficult position as they cannot directly ask if a patient is an undocumented immigrant, because Title VI of the Civil Rights Act of 1994 prohibits discrimination on the basis of race, color, or national origin in any program or activity, whether operated by a public or private entity, that receives federal funds or other federal financial assistance. However, oftentimes the amount of federal funding that healthcare organizations receive or will receive under proposed legislation is in part based on the number of undocumented immigrants that they treat. This apparent contradiction in practice clearly needs to be resolved that healthcare organizations and the federal government will be operating under the same standard.

To help alleviate this problem, a number of solutions have been proposed. The Centers for Medicare and Medicaid Services (CMS) has suggested several methods for obtaining information about undocumented immigrants. One suggestion is a sample questionnaire which would be presented to the patient after the emergency treatment has begun. The patient would be told that his or her answers would in no way lead to deportation. For each question asked, the patient is given the option to decline to answer and can simply move onto the next question. However, this method was denounced by hospital administrators, because they believed that undocumented immigrants would not answer the questions truthfully for fear of deportation, regardless
of assurances that they would not be deported. Due to the widespread criticism of this plan, it was ultimately dropped as a method for determining the cost of undocumented immigrants on the healthcare system.

The study initiated by Senator Kyl proposed that the current method of using the absence of a social security number should be the appropriate method of identifying undocumented immigrants. The study noted the limitations and the potential for error, however, it concluded that this would be the best solution to the problem because of its simplicity and easy implementation, as “using the absence of social security numbers who received uncompensated emergency treatment combined with the level of emergency aid that a facility receives should provide a good approximation of undocumented immigrants seen at a given location”.

Both of these solutions fail to truly estimate the cost of the undocumented immigrants on the healthcare system due to the lack of administrability or because of the potential for error. However, until legislation passes granting undocumented immigrants temporary citizenship, such as the guest worker program, these problems will continue to exist. The problems will continue to exist because as long as there is a fear of deportation and the enforcement of the Title VI of the Civil Rights Act, hospitals cannot inquire about the immigration status of their patients and questionnaires would be futile. Moreover, using the absence of the social security number will continue to wrongly estimate the cost of undocumented immigrants on the healthcare system. However, if under a guest worker program undocumented immigrants could register with the government and obtain an identification number this problem would be decreased dramatically. Although this would seem to provide the most accurate
information about undocumented immigrants it would still be subject to some criticism, as there would be no guarantee that every undocumented immigrant would register for temporary citizenship. However, even with this criticism it would be more accurate than the competing methods.

B. Align the Standards of EMTALA and The Welfare Reform Act and Provide States with Appropriate Funds to Support the Federal Government’s Regulations.

By aligning the differing definitions of “medical condition” contained in the Welfare Reform Act and EMTALA, the appropriate standard of care would be clearer and medical providers would not be placed in a position of having to choose between treating a patient and not receiving reimbursement because of the different definition or not treating the patient and be subject to having Medicare and Medicaid privileges removed and civil fines.

Aside from aiding the states by presenting a unified federal standard, the federal government needs to give the states sufficient funds to support their federal legislation. In the past three years, there have been a number of pieces of legislation that attempting to accomplish this goal. However, each bill differs in the amounts given and the recipients of the given funds. For example, a bill entitled “Border Hospital Survivor and Illegal Immigrant Care Act” sponsored by Representative Kolbe (R-AZ) sought to establish a 5 year, $50 million pilot program to reimburse emergency care providers directly for care to persons in the United States illegally. Representative Reyes (D-TX) sponsored a bill that amends the Balanced Budget Act of 1997 by providing restrictions on special allotments for emergency health services provided to
undocumented immigrants to Metropolitan statistical areas with populations exceeding 1 million or counties along the U.S. and Mexico border.\textsuperscript{93}

Also, Senator Kyl and Senator Condit proposed a bill that provides $200 million each year for 5 years to reimburse local governments, hospitals, and related providers of emergency healthcare in the 17 states with the highest number of undocumented immigrants.\textsuperscript{94} The bill also directs the Department of Health and Human Services to compute the allotments based on each state’s relative share of undocumented immigrant population in 17 states.\textsuperscript{95} It further requires the states to take into account payments received by eligible local government, hospital, or related providers under Emergency Medicaid or an appropriate proxy that measures the volume of emergency health services provided to undocumented immigrants by qualified entities.\textsuperscript{96} Aside from the amount of funding and the recipients of the funding, some bills, such as the Federal Responsibility for Immigrant Health Act have proposed to allow states to provide preventative care to undocumented immigrants without having to pass affirmative state legislation.\textsuperscript{97}

Despite the many attempts to help better alleviate the financial drains being placed on hospitals, very few have been successful. In 2004, under the Medicare Modernization Act the federal government provided $250 million over the period of three years to treat undocumented immigrants.\textsuperscript{98} Two thirds of the $250 million was to be split among the fifty states, and one third was allotted for the six states with the greatest number of undocumented apprehensions.\textsuperscript{99} The Act also empowers the Secretary of Health and Human Services with the authority to pay the expenses of providers who treat undocumented immigrants under EMTALA, and in doing so gives
the federal government direct oversight. However, numerous amendments to this bill are currently being proposed that will continue to place restrictions on payment for the healthcare of undocumented immigrants. Essentially, very little has been achieved in providing the states with sufficient funds to handle the demand of treating undocumented immigrants. By failing to provide adequate funding for the enactment of federal legislation and denying the states the ability to provide preventative treatment, the federal government continues to drain state’s abilities to survive.

C. Utilize taxes paid by Undocumented Immigrants to Help Fund Healthcare Costs.

Under the current federal tax system, undocumented workers and their employers must pay Social Security taxes. The amount of Social Security paid by undocumented workers and their employers has been consistently rising. In 2003, the federal government collected an estimated $7 billion in Social Security taxes from 7.5 million workers who are presumed to be undocumented due to inconsistencies with their tax reports. Despite the fact that undocumented immigrants contribute to Social Security, due to their immigration status, they are prevented from accessing any of the benefits that their taxes provide. Undocumented immigrants contribute to Social Security because they understand that it is an important step to naturalization.

Based on these statistics the argument that undocumented immigrants should not have access to healthcare because they are not paying for it seems to be misplaced, as they are in fact paying for Medicare and Medicaid for legal citizens and yet are still prevented from access to healthcare for themselves. Moreover, if undocumented
immigrants were given the opportunity to work lawfully in the United States, more revenue would be generated as there would be less incentive to work “under the table” and not pay taxes. It is noted that this occurrence comes at a significant loss to the federal government, as a change in the tax compliance of even 1 percentage point equates to an annual loss of more than $250 billion of revenue for the federal government. Conversely, if there was higher percentage paying taxes the revenue would increase correspondingly.

**IV. CONCLUSION**

Undocumented immigration is not fad; it is not going away. Recent statistics show that the rate of people entering the United States illegally continues to grow. The current federal legislation, however, does not reflect the severity of this phenomenon, as the present laws were not meant to be enduring pieces of legislation, but rather temporary solutions. Although the motivation for failing to provide a more comprehensive healthcare policy for undocumented immigrants is to discourage further immigration, the statistics indicate the current laws have done little to dissuade undocumented immigrants from entering the country. In particular, the current federal legislation does not provide an adequate method for determining the actual cost of undocumented immigrants on the national healthcare system and therefore they are unable to provide correspondingly effective legislation. Additionally, the federal legislative scheme contains contradictory standards for healthcare providers attempting to provide emergency care to undocumented immigrants. The differing standards have created a great deal confusion for healthcare providers in providing an adequate
standard of care. A third problem with the current legislation is that it places a disproportionate burden on the nation’s emergency departments. By refusing to provide preventative care, emergency departments have become the sole source of medical treatment for undocumented immigrants, but are not compensated correspondingly. As a practical result of compensating healthcare providers for emergency care only, the current legislation creates a great deal of inefficiencies.

In order to create effective legislation, the actual impact of undocumented immigration on the nation’s healthcare system needs to be determined. To obtain accurate information regarding the scope of this problem, undocumented immigrants need to be granted temporary legal status. By granting temporary legal status, undocumented immigrants would be able to register with the federal government and obtain an identifying number. In addition to obtaining an accurate representation of the scope of the problem, the differing standards of EMTALA and the Welfare Reform Act need to be aligned to alleviate the confusion for healthcare providers. Finally, the burden that the federal legislation places on the state and local hospitals could be greatly alleviated by the taxes that the undocumented contribute to Social Security. Although these solutions would not eliminate the myriad of problems created by the intersection of undocumented immigration and healthcare, they would provide a foundation to creating solutions that directly address the problems presented.


5 See Infra sections II A, B, C.

6 See infra section III A.


11 See infra section III C.

12 See infra section III D.

13 Id.

14 See infra section III B.

15 See infra section I C, footnote 41-42.

16 See infra section III A.

17 See infra sections III B.

18 Park, supra at 571 quoting Allison Fee, Forbidding States From Providing Essential Services to Illegal Immigrants: The Constitutionality of Recent Federal Action, 7 B.U. Pub. Int. L.J. 93, 110 (1998); see also Padavan v. United States, 82 F.3d. 23 (2d Cir. 1996) (involving a group of New York senators who brought suit against the United States seeking reimbursement for providing costs associated with the welfare of undocumented immigrants, which included providing their healthcare).

19 Id.

20 Id.

21 Park, supra at 573.

22 Id.


24 Id. at § 1601(2)(B).


26 8 U.S.C.A. §§ 1611(a), 1621(a) (1997)(2000). [states] may provide that illegal aliens are eligible for a state of local public benefits only through the enactment, after August
22, 1996, of a state law which affirmatively provides for such eligibility and state authority to limit the eligibility of qualified aliens for state public benefits.

27 Id.


30 Id.

31 Id.


33 Id.

34 Id.

35 § 1395(DD).

36 Id. In the case of a hospital has a hospital emergency department, if any individual (whether eligible or not eligible for Medicare or Medicaid) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.
42 U.S.C. § 1395dd(b)(1)(A)(B). If any individual (whether eligible for Medicare or Medicaid) comes to the hospital and the hospital determines that the individual has an emergency room condition, the hospital must provide either…such treatment as may be required to stabilize the medical condition, or for transfer of the individual to another medical facility in accordance with subsection (c).


39 Id.

40 Id.


42 Id. Notwithstanding any other provision of Federal, State or local, a Federal, State, or local government entity or official may not prohibit, or in any restrict, any government entity from sending to, or receiving from, the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual: Sending such information to, or requesting or receiving such information from the Immigration and Naturalization Service; Maintaining such information: (3) Exchanging such information with any Federal, State, or local government entity.

Obligation to Respond to Inquiries: Immigration and Naturalization service shall respond to an inquiry by a Federal, State, or local agency seeking to verify or ascertain the citizenship or immigration status of any individual within the jurisdiction of the agency for any purpose authorized by law, by providing the required verification or status information.

43 Park, supra at 576
44 Id.

45 See generally: G.A.O Report


47 Id. Determining the number of undocumented aliens treated at a hospital is challenging because hospitals generally do not collect information on patients’ immigration status.

48 Id.

49 G.A.O., supra at 21

50 See Generally MGT Report.

51 MGT Report at 70.

52 Id.

53 U.S.C.A. § 1621(b)(1)


55 MGT Report, supra at 52.

56 Id. “Depending on the patient’s complaint, the screening necessary to eliminate a diagnosis of an emergency medical condition can be quite costly. The potential liability a hospital may incur under EMTALA is substantial and encourages the use of thorough and sometimes costly medical screening. However, if after running the appropriate
tests, the hospital finds no emergency the patient will not be covered by Emergency Medicaid even if the patient would have categorically eligible for Medicaid.”

57 Id.

58 Id.

59 917 F.2d 266, 271 (6th Cir. 1990)

60 Id.

61 Id.


63 Id.

64 104 ALR Fed. 166 § 7(a) (1991)

65 Id.

66 Lebedinski, supra at 153

67 Id.


69 Id. at 724.

70 Fields, et al. supra at 1064.

71 Hermer, supra at 716.

72 Id.

73 Id.

74 300,000 to 500,000 undocumented immigrants enter the United States each year.

Kullgren, Jeffrey. Restrictions on Undocumented Immigrant’s Access to Health

75 Fields, Wesley, The Emergency Medical Treatment and Labor Act as a Federal Health Care Safety Net Program. Academic Emergency Medicine, 2001, citing Institute of Medicine study that found that nearly half the hospitals in the top decile of uncompensated care were rural facilities, with fewer than 50 beds.

76 Id.

77 Id.

78 MGT, supra at 68.

79 Park, supra at 581.

80 Id.


82 Id at 582.

83 Id.

84 Lebedinski supra at 165.

85 Id.

86 Id.

87 Id.

88 Questions: (1) Are you a United States Citizen? (2) Are you a lawful permanent resident, an alien with a valid and current I-688B, or other qualified alien? (3) Are you in the United States on a non-immigrant VISA? (4) Are you a foreign citizen that has been admitted to the U.S. with 72 hour border crossing card? (5) Have you been paroled
into the United States for the purposes of receiving eligible services and have a Form I-94? (6) Do you have a Social Security Number or health insurance policy number? (7) For the purposes of medical reimbursement, please provide the following information. [Social Security Number and Medicaid or health insurance policy number] (8) In the course of interviewing a patient, you [hospital staff] are encouraged to obtain the information necessary to complete the following questions: (a) the patient has informed me that he/she is an undocumented alien (b) the combination of an alleged foreign place of birth and two pieces of missing or faulty demographic information can be used as an affirmative demonstration of immigration status.

89 Id.

90 MGT, supra 49.

91 Id.

92 MGT at 17, citing the Border Hospital Survival and Illegal Immigrant Care Act, H.R. 2256, 107th Cong.

93 Id. citing H.R. 823, 107th Cong.

94 Id. citing S.B. 169

95 Id.

96 Id.

97 MGT, supra at 17.

98 Blum, et al. supra at 335.

99 Id.

100 Id.

101 Id.
102 Lipman, supra at 19.

103 Id.

104 Id.

105 Fields, supra at 1065.