

HEALTHCARE FOR ALL: ENSURING STATES COMPLY WITH THE EQUAL PROTECTION RIGHTS OF LEGAL IMMIGRANTS

Abstract: Noncitizens lawfully residing in the United States are considered a “discrete and insular minority” in equal protection jurisprudence. Foreclosed from meaningful political participation because of an inability to vote, this population is frequently the target of budget cuts in an economic downturn when legislators struggle to preserve benefits for their voting constituents. Recently, Massachusetts and New Jersey dealt with looming deficits by eliminating many legal permanent residents’ eligibility for state-funded health insurance programs. Each state relied on provisions in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, federal legislation that purports to allow individual states to discriminate against legal immigrants in state-funded social welfare programs. This Note concludes that states like Massachusetts and New Jersey cannot adopt a federal classification scheme excluding newly arrived legal immigrants from their respective state-funded healthcare programs without running afoul of the Equal Protection Clause. First, Massachusetts and New Jersey’s state-funded healthcare programs are unrelated to, and thus not justified by, federal immigration policy. Second, federal legislation cannot authorize individual states to circumvent strict scrutiny review by the courts. Moreover, it is economically unwise for a state to exclude its “citizens in waiting” from cost-effective, accessible healthcare, despite the federal government’s decision to do so.

INTRODUCTION

In 2006, Massachusetts passed An Act Providing Access to Affordable, Quality and Accountable Healthcare, becoming the first state to insure nearly all its residents.¹ Despite this landmark legislation, the recession has recently forced the state to retreat from its ambitious goal of universal coverage.² On September 1, 2009, the Massachusetts legislature, facing an insurmountable budget shortfall, eliminated legal

¹ See An Act Providing Access to Affordable, Quality and Accountable Healthcare, 2006 Mass. Acts 111–202 (codified as amended at MASS. GEN. LAWS ch. 111M, §§ 1–5 (2006)).

² See Abby Goodnough, *Massachusetts Takes a Step Back from Health Care for All*, N.Y. TIMES, July 15, 2009, at A10.

permanent residents³ from its comprehensive Commonwealth Care program.⁴ Instead, Massachusetts now offers this population a basic plan for a third of the cost.⁵ Eugenio Hernandez, a tax paying, low-income worker, is among the thirty thousand Massachusetts residents who lost Commonwealth Care coverage.⁶ Through Commonwealth Care, Hernandez received frequent radiation treatments for his prostate cancer, and was in recovery as of 2009.⁷ His new health plan, CeltiCare, charges substantially higher co-pays and premiums, yet offers limited services.⁸ If his cancer returns, Hernandez's new insurance plan may not cover all of his necessary treatments, and he will have to find new doctors and pay substantially higher co-pays for covered services.⁹ Although CeltiCare now covers legal immigrants like Hernandez who previously received Commonwealth Care, individuals who were not enrolled in the program as of September 2009 are entirely ineligible for subsidized health insurance in Massachusetts.¹⁰ Despite losing access to comprehensive state coverage, legal immigrants remain subject to the

³ See Immigration and Nationality Act, ch. 477, § 101, 8 U.S.C. § 1101(a)(20) (2006). The term "legal permanent resident" refers to noncitizens permitted to remain permanently in the United States, as distinguished from "nonimmigrants," defined as noncitizens permitted to reside temporarily in the United States for a specific purpose. See *id.* § 1101(a)(15). Additionally, "unlawful" or "undocumented" immigrants are defined as individuals who entered the United States without inspection or remained in the United States after the expiration of a visa, and have neither temporary nor permanent residence authorization. See *id.* Throughout this Note, "legal immigrant" and "lawful immigrant" both refer to noncitizens that are authorized to remain permanently in the United States. See *id.* § 1101(a)(20).

⁴ See Act of Aug. 7, 2009, 2009 Mass. Acts 695. The Act declares that "notwithstanding any general or special law to the contrary, an eligible individual pursuant to section 3 of chapter 118H of the General Laws shall not include persons who cannot receive federally-funded benefits." *Id.* Individuals who have held legal permanent resident status for five years or more are eligible for the Commonwealth Care program. *Id.* For a discussion of federal immigrant eligibility guidelines, see *infra* notes 70–80 and accompanying text. For an overview of the Commonwealth Care program, see *infra* notes 201–211 and accompanying text.

⁵ See Memorandum from Melissa Boudreault, Dir., Commonwealth Connector, to Dirs. of Commonwealth Care Bd., Update on Legal Immigrant Program 1 (Sept. 5, 2009) (on file with author).

⁶ Kay Lazar & Maria Sacchetti, *Immigrant Fighting Cancer and the Fear of Losing Care*, BOS. GLOBE, July 15, 2009, at B1.

⁷ See *id.*

⁸ See Abby Goodnough, *Massachusetts Cuts Back Immigrants' Health Care*, N.Y. TIMES, Sept. 1, 2009, at A17.

⁹ See *id.*

¹⁰ See Act of Aug. 7, 2009, 2009 Mass. Acts 695; see also Complaint at 1, *Finch v. Commonwealth Health Ins. Connector Auth.*, No. SJ-2010–0103 (Mass. filed Feb. 25, 2010) [hereinafter *Massachusetts Complaint*] (estimating that at least eight thousand legal immigrants are left without any form of healthcare).

individual healthcare mandate.¹¹ If an individual is uninsured, the individual must affirmatively apply for a hardship waiver to avoid substantial tax penalties.¹² Thirty thousand legal immigrants, who pay taxes that fund the Commonwealth Care program, and who remain subject to the individual healthcare mandate, are now foreclosed from participation in the program.¹³

When asked by a reporter why legal immigrants were the targets of healthcare cuts in Massachusetts, State Representative Robert DeLeo replied that “there is only so much money that we have.”¹⁴ Massachusetts is not the only state to balance its budget at the expense of non-citizen residents: on March 31, 2010, New Jersey similarly de-enrolled twelve thousand newly arrived legal permanent residents from its state-funded medical assistance program.¹⁵ Legal immigrants pay taxes, serve in the military, and participate in important civic functions, yet their inability to vote limits meaningful political participation.¹⁶ Therefore, this population is uniquely vulnerable to budget cuts in government programs at both the state and federal levels.¹⁷ Although the recently enacted Patient Protection and Affordable Health Care Act significantly expanded Medicaid coverage for lower income U.S. citizens, legal permanent residents remain ineligible for Medicaid for their first five years in status.¹⁸ Individual states like Massachusetts and New

¹¹ See MASS. GEN. LAWS ch. 111M, § 1(1) (2006) (including legal immigrants in the definition of residents subjected to the mandate); *id.* § 2(a), (b) (imposing tax penalties on Massachusetts residents who do not obtain individual health insurance coverage).

¹² See *id.* §§ 1(1), 2(a).

¹³ See *id.* § 2(a) (subjecting legal immigrants to the individual mandate); 2009 Mass. Acts 695 (excluding legal immigrants from the Commonwealth Care program).

¹⁴ See Goodnough, *supra* note 2.

¹⁵ See N.J. ADMIN. CODE § 10:78-3.2(e)(1) (2010) (terminating FamilyCare eligibility for legal permanent residents who are in status for less than five years); Medicaid Communication No. 10-01 from John R. Guhl, Dir., N.J. Dep’t of Health & Human Servs., Div. of Med. Assistance & Health Servs., to Cnty. Welfare Agency Dirs. 1 (Mar. 2, 2010), *available at* http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2010/10-01_Program_Changes_For_NJ_FamilyCare_Parents_Caretakers.pdf (citing the “unprecedented financial crisis” as the reason for terminating legal permanent residents from the program).

¹⁶ See *Graham v. Richardson*, 403 U.S. 365, 376 (1971) (citing *Leger v. Sailer*, 321 F. Supp. 250, 253 (E.D. Pa. 1970)) (noting that legal immigrants participate in meaningful civic duties and pay taxes, but cannot vote).

¹⁷ See *id.*

¹⁸ See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001(a), 124 Stat. 119, 271 (expanding Medicaid coverage for adults and families whose income is at or below 133% of the poverty level, and declining to repeal restrictions on legal immigrant participation); see also NAT’L IMMIGRATION LAW CTR., HOW ARE IMMIGRANTS INCLUDED IN HEALTH CARE REFORM? I (2010), *available at* <http://www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf> (commenting that legal

Jersey, facing looming budget deficits, often target legal immigrants for cuts in programs and services to safeguard government benefits for their voting constituents.¹⁹ For this reason, the courts play a vital role in determining whether legislation that targets legal immigrants violates the Fourteenth Amendment's Equal Protection Clause.²⁰

On February 25, 2010, Health Law Advocates filed a class action lawsuit on behalf of legal immigrants in Massachusetts, asserting that the legislature's restriction on their participation in Commonwealth Care violated both the Massachusetts and U.S. Constitutions.²¹ Specifically, the complaint alleges that the Commonwealth's actions violate the Equal Protection Clause of the Fourteenth Amendment by "invidiously treating [legal immigrants] differently than citizens similarly situated solely on account of their status as legal aliens."²² On September 1, 2010, the Center for Social Justice at Seton Hall Law School filed a class action lawsuit in New Jersey and similarly asserted that de-enrolling legal permanent residents from the state's FamilyCare program "improperly, and without justification, single[s] out Class Members for disparate treatment on the basis of their alienage and immigration status in violation of the Equal Protection Clause."²³

This Note asserts that individual states like Massachusetts and New Jersey cannot and should not exclude legal immigrants from state-subsidized healthcare programs.²⁴ Discrimination against lawfully present immigrants in state programs contravenes the spirit of the Four-

immigrants may purchase insurance through exchanges, but remain ineligible for Medicaid under previous restrictions). For a more detailed discussion of recent federal legislation, see *infra* notes 219–234 and accompanying text.

¹⁹ See Goodnough, *supra* note 2.

²⁰ See *infra* notes 250–331 and accompanying text.

²¹ See Massachusetts Complaint, *supra* note 10, at 1. The complaint was filed in the Supreme Judicial Court for Suffolk County, the single justice session of the Massachusetts Supreme Judicial Court. See *id.* Defendants sought to have the case removed to federal court, and plaintiffs amended their complaint to excise the federal question and to remand the case back to the Supreme Judicial Court. See Plaintiff's Updated Motion to Reserve Ruling and Report this Matter to the Full Court at 1, *Finch v. Commonwealth Health Ins. Connector Auth.*, No. SJ-2010-0103 (Mass. filed June 8, 2010). Oral arguments were heard in the case before the full Supreme Judicial Court on November 1, 2010, and the case is currently pending a determination as to whether the challenged legislation deprives plaintiffs of equal protection under Massachusetts law. See *id.*

²² See Massachusetts Complaint, *supra* note 10, at 13.

²³ See Verified Amended Class Action Complaint for Injunctive and Declaratory Relief at 25, *Guaman v. Velez*, No. L-1608-10 (N.J. Super. Ct. Law Div. filed Sept. 1, 2010) [hereinafter *New Jersey Complaint*].

²⁴ See *infra* notes 250–346 and accompanying text.

teenth Amendment and violates the Equal Protection Clause.²⁵ From a policy perspective, foreclosing participation in subsidized healthcare to a population that is, by definition, permanently residing in the United States only shifts expenditures from cost-effective, cost-controlled preventive care to expensive emergency room treatment.²⁶ Federal law mandates that all hospitals treat patients with an emergency medical condition, regardless of their ability to pay.²⁷ As a result, immigrant restrictions in state healthcare programs—enacted to reduce costs—in fact increase the costs absorbed by states and hospitals in treating legal immigrants.²⁸

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (the “PRA”) curtailed immigrant eligibility for most federal benefits, including the jointly funded federal-state Medicaid program.²⁹ Equal protection challenges to the PRA’s immigrant restrictions in federally funded programs have been largely unsuccessful, as the judiciary accords broad deference to federal immigration-related legislation.³⁰ Conversely, individual states cannot prohibit participation in state-funded health programs by noncitizens lawfully residing within state borders because individual states are not empowered to regulate immigration.³¹ Legal immigrants constitute a suspect class, and state legislation that discriminates against this population is closely scrutinized by the courts.³²

Through the PRA, Congress attempted to delegate its authority to enact immigrant restrictions to the states so that states could exclude legal immigrants from their respective benefit programs.³³ Despite statutory authorization, Congress cannot delegate its broad power to regulate immigration to individual states, and immigration restrictions in state-funded benefit programs violate the Equal Protection Clause.³⁴ A

²⁵ See *infra* notes 250–331 and accompanying text.

²⁶ See NAT’L IMMIGRATION LAW CTR., COMPREHENSIVE HEALTH CARE REFORM FOR IMMIGRANTS: A SOUND STRATEGY FOR FISCAL AND PUBLIC HEALTH 1 (2004), available at http://www.nilc.org/immspbs/health/Issue_Briefs/comphealthcare_0404.pdf.

²⁷ See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006).

²⁸ See *id.*

²⁹ See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 8 and 42 U.S.C.).

³⁰ See *infra* notes 172–178 and accompanying text.

³¹ See *infra* notes 179–193 and accompanying text.

³² See *infra* notes 155–167 and accompanying text.

³³ See 8 U.S.C. § 1601(7) (2006).

³⁴ See *infra* notes 262–331 and accompanying text.

unanimous U.S. Supreme Court decision in 1971, *Graham v. Richardson*, held that “Congress does not have the power to authorize the individual states to violate the Equal Protection Clause.”³⁵ *Graham* survives congressional attempts to insulate state-funded programs from equal protection challenges brought by legal immigrants seeking access to government benefits.³⁶ Although courts diverge as to whether jointly funded federal-state programs, like Medicaid, can adopt the PRA’s immigrant restrictions, independent, state-funded programs remain subject to *Graham*.³⁷ Therefore, Massachusetts and New Jersey violated the equal protection rights of legal immigrant residents by denying them access to their respective state-funded Commonwealth Care and FamilyCare programs.³⁸ As states fill remaining healthcare coverage gaps in the wake of national reform, they must provide coverage to citizens and lawful immigrants on equal terms.³⁹

Part I of this Note provides an overview of government healthcare programs and legislation restricting immigrants’ access to these programs.⁴⁰ It then outlines the development of equal protection jurisprudence regarding federal and state programs that condition eligibility upon immigration status, and reviews recent state and federal developments in healthcare legislation.⁴¹ Part II asserts that state legislation that forecloses legal immigrants from state-funded healthcare programs violates the Equal Protection Clause, and creates bad public policy.⁴²

I. THE ROAD TO EXCLUSION: SUBSIDIZED HEALTHCARE, WELFARE REFORM, AND THE STATE-FEDERAL DISTINCTION

This Part begins with an overview of government healthcare programs at the state and federal levels,⁴³ including the Emergency Medical Treatment and Active Labor Act (“EMTALA”) treatment mandate.⁴⁴ Next, Section B summarizes relevant provisions of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which significantly curtailed immigrant benefits eligibility and delegated to the states

³⁵ See 403 U.S. at 382.

³⁶ See *id.*

³⁷ See *id.*; *infra* notes 262–294 and accompanying text.

³⁸ See Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25.

³⁹ See *infra* notes 235–346 and accompanying text.

⁴⁰ See *infra* notes 48–110 and accompanying text.

⁴¹ See *infra* notes 111–234 and accompanying text.

⁴² See *infra* notes 235–346 and accompanying text.

⁴³ See *infra* notes 48–74 and accompanying text.

⁴⁴ See *infra* notes 63–74 and accompanying text.

the authority to impose parallel restrictions in state-funded programs.⁴⁵ Third, Section C outlines the development of equal protection jurisprudence in state and federal courts, focusing on the appropriate standard of review for both federal and state programs that exclude legal residents based on their immigration status.⁴⁶ Finally, Section D provides a brief overview of the Massachusetts model, which until recently included all income-eligible legal immigrants in its supplemental coverage.⁴⁷

A. *Covering the Needy: The Medicaid Program and the Emergency Medical Treatment and Active Labor Act*

I. Medicaid and Medicare

Congress created the Medicaid and Medicare programs in the Social Security Amendments of 1965.⁴⁸ The Medicaid program replaced prior patchwork federal grants to states that provided medical care for welfare recipients and the aged; it was also intended to fill the gap more comprehensively in care for low-income individuals who were not covered through employer-based insurance.⁴⁹ The Medicare program provides health coverage based upon old age or permanent disability.⁵⁰ Generally, to be eligible for Medicare, an individual must pay Social Security and Medicare taxes for a minimum of ten years.⁵¹ This provision effectively excludes many immigrants from coverage, as it imposes a de facto durational residency requirement.⁵² Medicare is adminis-

⁴⁵ See *infra* notes 75–110 and accompanying text.

⁴⁶ See *infra* notes 111–200 and accompanying text.

⁴⁷ See *infra* notes 201–218 and accompanying text. Although both Massachusetts and New Jersey's healthcare programs are being challenged by legal immigrants facing termination of coverage, New Jersey's program has always been more limited in scope. See N.J. STAT. ANN. § 30:4J-12 (West 2008) (setting forth limited circumstances in which supplemental health coverage is available). Therefore, this Note focuses on the "Massachusetts Model" of health reform, which offers a more comprehensive blueprint for other states to follow. See *infra* notes 201–218.

⁴⁸ See Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 343–52 (codified as amended in scattered sections of 42 U.S.C.) (establishing a Medicaid program and enumerating eligibility, requirements, and responsibilities of states and federal government); see also 42 U.S.C. §§ 1395c, 1395j (2006).

⁴⁹ See 42 U.S.C. § 1396a.

⁵⁰ See *id.* §§ 1395–1395b-1.

⁵¹ See *id.* §§ 413–414 (2006). Although there are some exceptions, most Medicare recipients must meet this requirement, thereby earning sufficient credits for coverage. See *id.*

⁵² See *id.*

tered and funded by the federal government and primarily serves U.S. citizens and long-term permanent residents.⁵³

The Medicaid program is a partnership between the federal government and individual states.⁵⁴ The federal government provides a significant subsidy to participating states, thus enabling the states to provide healthcare coverage to income-eligible residents.⁵⁵ The federal government determines which healthcare services states must provide to their participants⁵⁶ and mandates a baseline set of eligibility guidelines for participating individuals.⁵⁷ The participant state then promulgates its own regulations which may supplement the federally-proscribed minimum guidelines.⁵⁸ States may provide supplemental coverage for certain populations or include additional types of medical treatment and care.⁵⁹ As long as the state provides the minimum federally mandated services, the state is permitted to receive matching funding for these variations in services and eligibility criteria.⁶⁰ As a result, the Medicaid program is not a uniform program with consistent services and eligibility requirements across the nation: instead, it resembles a series of state medical coverage programs that loosely conform to

⁵³ *See id.* Medicare will not be discussed at length in this Note. Because it is administered, regulated, and funded by the federal government, reviewing courts will invoke a rational basis standard of review when immigration restrictions in the program are challenged. *See Mathews v. Diaz*, 426 U.S. 67, 81 (1976). Medicare eligibility focuses on “qualifying quarters” of Social Security coverage: an individual earns a quarter when the individual earns a certain amount within three months and pays Social Security and Medicare taxes on that income. *See* 42 U.S.C. § 413. Because Medicare requires that an individual earn a minimum of forty “qualifying quarters,” immigration status is only a secondary consideration. *See id.* § 414. By definition, newly-arrived immigrants are ineligible for the program because they have not earned sufficient qualifying quarters. *See id.*

⁵⁴ *See* 42 U.S.C. § 1396a (1)–(17).

⁵⁵ *See id.*

⁵⁶ *Id.* § 1396d(a) (enumerating mandatory benefits that states must provide to their residents).

⁵⁷ *Id.* § 1396d(a)(10) (defining broad categories of individuals who are either eligible or ineligible for benefits according to federal guidelines, such as individuals receiving Supplemental Security Income).

⁵⁸ *See id.* § 1396c.

⁵⁹ *Id.* § 1396d(a). States are permitted to provide optional *services*, like targeted case management and additional maternity care services, beyond the minimum federal requirements. *Id.* § 1396d(a)(1)–(17). States are also permitted to expand the pool of eligible residents (non-immigration-related) beyond the federal minimum. *Id.* § 1396d(a)(i)–(xiii). For example, a state can offer Medicaid to the “medically needy”—persons whose income may be higher than the limit for Medicaid eligibility, but who have extraordinarily high monthly medical expenses that, if deducted from their gross income, render them income-eligible. *Id.*

⁶⁰ *See* 42 U.S.C. § 1396c.

broad federal guidelines.⁶¹ Therefore, the scope and quality of services that an individual receives, and whether the individual may receive those services at all, largely depends on the state of residence.⁶²

2. Emergency Care: The Emergency Medical Treatment and Active Labor Act

Congress enacted EMTALA in 1986.⁶³ EMTALA ensures that any individual, regardless of insurance coverage, ability to pay, or immigration status, can receive emergency medical treatment, including medical attention while in labor.⁶⁴ Hospitals that operate emergency rooms are required to comply with EMTALA to receive federal funding and therefore must treat anyone with a health emergency.⁶⁵ Medicaid reimburses hospitals for emergency treatment in accordance with EMTALA, but the statutory definition of “emergency” is vague, and emergency room staff must make immediate decisions on patient admission.⁶⁶ Medicaid does not reimburse hospitals for “non-emergency” treatment, leaving hospitals, municipalities and states to absorb the costs.⁶⁷ Hospitals face fines of up to fifty thousand dollars per patient, however, if an individual with a medical emergency is refused treatment.⁶⁸ Therefore,

⁶¹ See Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1504–05 (2008).

⁶² David M. Herszenhorn, *Medicaid Expansion Poses Test for Some Democrats*, N.Y. TIMES, Sept. 14, 2009, at A23. Eligibility criteria for Medicaid services vary significantly from state to state. *Id.* In Alabama, for example, the maximum qualifying household income is 12% of the federal poverty level, whereas in Minnesota, it is 275% of the federal poverty level. *Id.* In addition to variations in eligibility criteria, there are significant differences in individual states’ reimbursement schemes for Medicaid services. See Rosemary B. Gultinan, Note, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipients’ Access to Healthcare*, 51 B.C. L. REV. 1583, 1591–92 (2010) (describing disparities in reimbursement levels between states).

⁶³ Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, tit. IX, § 9121 (b) (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)).

⁶⁴ See 42 U.S.C. § 1395dd.

⁶⁵ See *id.* § 1395dd(b).

⁶⁶ See *id.* § 1395dd(e)(1), (h) (defining an emergency medical condition as a “medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in” risk to the health of the individual, serious impairment to bodily functions, and organ malfunction).

⁶⁷ See 42 C.F.R. § 430.25(g)(2) (2009) (exempting states from reimbursing hospitals for Medicaid-eligible recipients who receive nonemergency services in emergency rooms). For a discussion of the interplay between immigration and EMTALA, see *infra* notes 97–104 and accompanying text.

⁶⁸ See 42 C.F.R. § 489.53(b) (2006) (setting penalties for failure to treat a patient in an emergency condition). Hospitals may also be civilly liable in tort for any injuries resulting from refusal to treat an individual with an emergency condition. See 42 U.S.C. § 1395dd(d).

states, municipalities, and hospitals must accept patients with urgent medical needs and frequently absorb the costs of treating individuals who are either financially ineligible for Medicaid or whose immigration status places them outside the eligibility guidelines.⁶⁹ Most low-income immigrants do not qualify for federally subsidized health insurance programs and often rely on the EMTALA mandate to receive medical treatment in an emergency.⁷⁰ As a result, individual states must fund treatment for immigrants who are ineligible for Medicaid.⁷¹ The costs absorbed by states have exploded since 1996 when the PRA eliminated Medicaid eligibility for most legal immigrants, and the costs continue to rise: between 2000 and 2005, uncompensated emergency room care costs rose from \$4 billion per year nationwide, to \$25 billion per year.⁷² Beginning in 2005, Congress appropriated \$250 million per year to reimburse states for the increase in costs resulting from the PRA.⁷³ According to estimates by the American Hospital Association, this figure represents only one percent of the total costs shouldered by hospitals and states under EMTALA.⁷⁴

B. Immigrants Need Not Apply: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

1. Background and Major Provisions of the PRA

Prior to 1996, legal immigrants were eligible for Medicaid coverage in every state, as broad federal eligibility guidelines included all

When a hospital incorrectly determines that an individual arriving in the emergency room is not experiencing an “emergency” under the EMTALA definition, it faces fines of up to fifty thousand dollars per patient. *See id.* § 1395dd(d) (2) (A).

⁶⁹ *See* Adrienne Ortega, Note, . . . *And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Care*, 35 AM. J.L. & MED. 185, 193–94 (2009).

⁷⁰ *See* KARYN SCHWARTZ & SAMANTHA ARTIGA, KAISER COMM’N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE COVERAGE AND ACCESS TO CARE FOR LOW-INCOME NON-CITIZEN ADULTS 2 (2007), available at <http://www.kff.org/uninsured/upload/7651.pdf> (indicating that legal immigrants are far less likely to be eligible for employer-sponsored or state-sponsored health coverage, and therefore often receive treatment for emergency care only).

⁷¹ *See* Ortega, *supra* note 69, at 193–94.

⁷² AM. HOSP. ASS’N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET 2 (2006), available at <http://www.aha.org/aha/content/2006/pdf/underpaymentfs2006.pdf>.

⁷³ *See Impacts of Border Security and Immigration on Ways and Means Programs: Hearing Before the H. Comm. on Ways & Means*, 109th Cong. 29–30 (2006) [hereinafter *House Ways & Means Hearing*] (statement of Thomas Gustafson, Deputy Director, U.S. Department of Health & Human Services).

⁷⁴ *See* AMERICAN HOSPITAL ASSOCIATION, *supra* note 72, at 2.

legally present aliens.⁷⁵ Additionally, the Social Security Amendments of 1972 provided an expansive definition of legally present immigrants by creating a legislative category of persons “permanently residing under color of law” (“PRUCOL”), which included individuals who were not affirmatively granted legal status but whose departure the then-Immigration and Naturalization Service did not contemplate enforcing.⁷⁶ Under this definition, a majority of indigent immigrants qualified for subsidized coverage in some capacity.⁷⁷

The PRA signaled a significant departure from permissive federal Medicaid guidelines.⁷⁸ Title IV of the PRA severely curtailed noncitizens’ eligibility for needs-based benefits, including Medicaid.⁷⁹ To justify this paradigm shift, Congress invoked the sweeping powers of the federal government to regulate immigration, emphasizing that immigrants are motivated by the availability of public benefits.⁸⁰ The part of the bill codified at 42 U.S.C. § 1601 links public benefits to border control and replaces the pre-1996 statutes with more restrictive eligibility guidelines.⁸¹ Congress laments in § 1601 that “[d]espite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State and local governments at increasing rates,” and that “current eligibility rules . . . have proved wholly incapable of assuring that individual aliens not burden the public benefits system.”⁸² The PRA eliminated permissive immigration categories; the PRUCOL

⁷⁵ See Act of Oct. 30, 1972, Pub. L. No. 92-603, § 1614, 86 Stat. 1329, 1471, *repealed by* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (allowing all legally present immigrants access to Medicaid benefits).

⁷⁶ See Sharon F. Carton, *The PRUCOL Proviso in Public Benefits Law: Alien Eligibility for Public Benefits*, 14 NOVA L. REV. 1033, 1039 (1990) (citing 86 Stat. at 1471). PRUCOL is a legislatively created category, not an immigrant status, created for the purpose of providing benefits to immigrants who are not being deported any time soon. See *id.* at 1043. This category was eliminated in the 1996 PRA, but still exists in some state benefits programs. See, e.g., 18 N.Y. COMP. CODES R. & REGS. tit 18, § 349.3(2)(b)(iv) (2008) (qualifying persons residing under color of law for New York’s state-funded benefits programs).

⁷⁷ See Carton, *supra* note 76, at 1034, 1043 (reasoning that the PRUCOL category was construed broadly by the states and therefore included all legal immigrants and many undocumented immigrants).

⁷⁸ See 110 Stat. at 2105 (codified as amended in scattered sections of 7, 8, 21, and 42 U.S.C.).

⁷⁹ See 8 U.S.C. §§ 1601, 1611–1613, 1621–1622, 1641 (2006).

⁸⁰ See *id.* § 1601(2)(A) (stating that the PRA’s immigrant restrictions are important for fostering self-sufficiency, and that immigrants “within the nation’s borders [cannot] depend on public resources to meet their needs”); *id.* § 1601(2)(B) (stating that a priority of the Act is to ensure that “the availability of public benefits not constitute an incentive for immigration to the United States”).

⁸¹ See *id.* § 1601(2)(B).

⁸² See *id.* § 1601(3), (4).

category vanished from the eligibility guidelines altogether.⁸³ Furthermore, the PRA restricted the receipt of most federal means-tested benefits for almost all noncitizens.⁸⁴ As a result, legal permanent residents were barred from receiving Supplemental Security Income and were ineligible for any other means-tested benefit for their first five years in legal resident status (the “five-year bar”).⁸⁵

The PRA took the unprecedented step of extending these immigration restrictions to individual states, reasoning that states receive federal funding for programs like Medicaid.⁸⁶ Moreover, in a controversial provision, the PRA authorized states to restrict the participation of noncitizens in independent, state-funded benefits programs wholly unrelated to federal entitlements.⁸⁷ In doing so, the PRA attempted to undo the previous jurisprudential distinction between federal immigration-related legislation and parallel state legislation.⁸⁸ The statute reads, “a State is authorized to determine the eligibility for any State public benefits of an alien who is a qualified alien,” thereby granting a state discretion to bar all noncitizens from receiving benefits under its programs.⁸⁹

This delegation of authority from Congress to the states attempts to insulate the states from the strict scrutiny review traditionally employed by the courts.⁹⁰ The statute declares that a state that adopts the federal restrictions in its own state-funded program presumptively satisfies strict scrutiny because the state “shall be considered to have chosen the *least restrictive means for achieving the compelling government interest* of assuring that aliens be self-reliant in accordance with *national immigration policy*.”⁹¹ This language adopts the terminology of the U.S. Su-

⁸³ See *id.* § 1641(a)–(c).

⁸⁴ See *id.* §§ 1611–1613. The PRA separates noncitizens into two categories: qualified and unqualified aliens. See *id.* § 1641. Qualified aliens include legal permanent residents, refugees, asylees, and Cuban or Haitian entrants. *Id.* § 1641(b). Unqualified aliens are all nonimmigrants, persons residing under color of law, and individuals with pending applications for legal status; essentially, all immigration categories omitted from the “qualified alien” definitions. See *id.* § 1611(a) (prohibiting any alien not “qualified” under the Act from receiving benefits).

⁸⁵ See 8 U.S.C. § 1613(a).

⁸⁶ See *id.* § 1621(a).

⁸⁷ See *id.* § 1622(a).

⁸⁸ See *id.*; *infra* notes 168–200 and accompanying text.

⁸⁹ See 8 U.S.C. § 1622(a).

⁹⁰ See *id.* § 1601(7); see also Michael J. Wishnie, *Laboratories of Bigotry? Devolution of the Immigration Power, Equal Protection, and Federalism*, 76 N.Y.U. L. REV. 493, 512–13 (2001) (noting that the PRA attempted to shield individual state benefits legislation from traditional strict scrutiny review by the courts).

⁹¹ 8 U.S.C. § 1601(7) (emphasis added).

preme Court's equal protection jurisprudence and places the state's immigration legislation under the umbrella of the federal plenary power to regulate immigration.⁹² Therefore, the PRA takes the unprecedented step of attempting to delegate congressional plenary power over immigration to the states.⁹³ Through this delegation, the PRA attempts to shield state restrictions on noncitizens from traditional strict scrutiny review.⁹⁴ Additionally, the PRA does not allow a state to provide noncitizens greater access to solely state-funded benefits programs unless that state affirmatively enacted legislation to that effect after the passage of the PRA.⁹⁵ Therefore, the PRA declares most noncitizens ineligible for federal, state, and local benefits, and places the burden of preserving immigrant eligibility for state-funded benefits on state legislatures.⁹⁶

2. Intersection of the PRA with Existing Federal and State Programs

The PRA drastically reduced the number of individuals eligible for Medicaid and attempted to authorize similar restrictions in state-funded healthcare programs.⁹⁷ Meanwhile, EMTALA, enacted in 1986, continued to require hospitals to treat individuals facing medical emergencies regardless of their ability to pay, their immigration status, or whether the hospital could receive reimbursement for services that went beyond simply stabilizing the patient's medical emergency.⁹⁸ Although the federal mandate remained intact, the percentage of patients for whom a hospital could receive reimbursement diminished appreciably.⁹⁹ Reimbursement for emergency treatment was premised upon whether a patient was Medicaid eligible in the particular state.¹⁰⁰ Under the PRA, however, states were prohibited from providing ser-

⁹² See *Mathews*, 426 U.S. at 86–87; *Graham v. Richardson*, 403 U.S. 365, 371–72 (1971).

⁹³ See 8 U.S.C. § 1601(7).

⁹⁴ See *id.*; Wishnie, *supra* note 90, at 512–13.

⁹⁵ 8 U.S.C. § 1621(3)(d) (“A State may provide that [a legal immigrant] is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section *only through the enactment of a state law after August 22, 1996, which affirmatively provides for such eligibility.*”) (emphasis added).

⁹⁶ See *id.*

⁹⁷ See *id.* §§ 1611–1613, 1622.

⁹⁸ See 42 U.S.C. § 1395dd(a), (b)(1) (2006).

⁹⁹ See Ryan Knutson, Note, *Deprivation of Care: Are the Federal Laws Restricting the Provision of Medical Care to Immigrants Working as Planned?*, 28 B.C. THIRD WORLD L.J. 401, 404–05 (2008) (stating that the passage of the PRA imposed significant economic hardships on hospitals and emergency rooms).

¹⁰⁰ See 42 U.S.C. § 1396(a), (b) (2006) (setting mandatory guidelines for states participating in Medicaid, but permitting wide variation in services and eligibility criteria).

vices to “unqualified” aliens and were permitted to further restrict alien eligibility for Medicaid beyond the federal guidelines.¹⁰¹ Therefore, the pool of patients for whom hospitals could be reimbursed grew even smaller as states enacted additional immigrant restrictions.¹⁰² Beginning in 2005, the U.S. Department of Health and Human Services authorized modest annual reimbursements both to individual states and to hospitals for the cost of treating patients under the EMTALA mandate who were not eligible for Medicaid.¹⁰³ These appropriations, however, cover a small fraction of the actual costs incurred by hospitals and states under the EMTALA mandate.¹⁰⁴

In the years immediately following the PRA’s enactment, states were flush with budget surpluses.¹⁰⁵ Most states adopted the federal guidelines and allowed limited access to benefits for qualified aliens who met enumerated residency requirements, though few states eliminated non-citizens’ eligibility for benefits altogether.¹⁰⁶ States promulgated regulations for their Medicaid programs that followed the guidelines of the PRA.¹⁰⁷ Some states enacted affirmative legislation that created supplemental health insurance programs for certain categories of immigrants, although in some cases the breadth of services available to eligible immigrants, as well as the categories of eligible immigrants, were less comprehensive than the pre-PRA federal Medicaid provisions.¹⁰⁸ Still, in the

¹⁰¹ See *id.* §§ 1621(a), 1622(a) (2006); Wishnie, *supra* note 90, at 567 (listing states that decided to enact additional restrictions on noncitizens in state welfare programs).

¹⁰² See 42 U.S.C. §§ 1395dd(a), 1622(a); Wishnie, *supra* note 90, at 567.

¹⁰³ See *House Ways & Means Hearing*, *supra* note 73, at 29–30 (statement of Thomas Gustafson, Deputy Director, U.S. Department of Health & Human Services).

¹⁰⁴ See AMERICAN HOSPITAL ASSOCIATION, *supra* note 72, at 2.

¹⁰⁵ See Wishnie, *supra* note 90, at 498 n.25.

¹⁰⁶ See *id.* at 495 n.9, 497 n.24. Only five states, immediately following passage of the PRA, tried to terminate eligibility of all noncitizens for Medicaid: Alabama, Louisiana, Pennsylvania, Wyoming, and initially, New York. See *id.* at 497 n.24. Other states enacted more onerous eligibility requirements for noncitizens, including waiting periods of up to one year. *Id.* at 495 n.9. In 2005, Colorado terminated Medicaid eligibility for all noncitizens. See *Soskin v. Reinertson*, 353 F.3d 1242, 1246 (10th Cir. 2004). Interestingly, the PRA requires states to cover otherwise-eligible asylees and refugees for seven years but also requires states to terminate asylee and refugee eligibility after seven years. See 8 U.S.C. §§ 1621(b), 1622(b) (2006).

¹⁰⁷ See SHAWN FREMSTAD & LAURA COX, KAISER COMM’N ON MEDICAID & THE UNINSURED, COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS’ ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 18 (2004), available at <http://www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-of-Federal-and-State-Policies-Related-to-Immigrants-Eligibility-and-Access-to-Publicly-Funded-Health-Insurance-Report.pdf>.

¹⁰⁸ See *id.* at ii, 18. Massachusetts, Rhode Island, Florida, and Washington, D.C. cover all income-eligible children regardless of immigration status; thirteen states provide prena-

midst of any economic instability, as evidenced by the recent recession, state-subsidized programs for legal immigrants are the first to be cut from state budgets.¹⁰⁹ Therefore, the recession prompts a reexamination of the PRA's true impact: states that were previously generous to immigrants in their state-funded programs are now eliminating coverage for this demographic.¹¹⁰

C. Equal Protection Challenges to Immigration Restrictions: Federal Plenary Power, State Strict Scrutiny, and Post-PRA Decisions

I. Overview of Divergent Standards of Review

Prior to the PRA, the U.S. Supreme Court examined federal legislation that restricts immigrant access to benefits differently from parallel state provisions.¹¹¹ The Court accorded broad discretion to federal legislation, using a rational basis standard of review for evaluating the equal protection claims of immigrants.¹¹² The rational basis standard of review requires only that the challenged statute or regulation relate to a legitimate governmental interest to survive an equal protection challenge.¹¹³ The Court recognizes that provisions of federal benefits law that classify eligibility by immigration status are discriminatory.¹¹⁴ Notwithstanding the discriminatory nature of such classifications, the Court understands the federal government's interest in controlling immigration to override the equal protection rights of immigrants.¹¹⁵

Generally, when a statute or regulation targets a "suspect class" or discrete and insular minority, the reviewing court examines the challenged statute or regulation more closely.¹¹⁶ To pass constitutional mus-

tal care regardless of immigration status. *Id.* at 17. Additionally, a handful of states provide a limited form of care to PRUCOLs. *See id.*

¹⁰⁹ *See id.* at 18; *see also* Goodnough, *supra* note 8. In both Massachusetts and New Jersey, noncitizens were the first to lose healthcare coverage in the recession. *See* Act of Aug. 7, 2009, 2009 Mass. Acts 695; N.J. ADMIN. CODE § 10:78-3.2(e)(1) (2010).

¹¹⁰ *See* FREMSTAD & COX, *supra* note 107, at 18.

¹¹¹ *See Mathews*, 426 U.S. at 82; Wishnie, *supra* note 90, at 496. For a discussion of the post-PRA regime, *see infra* notes 168–200 and accompanying text.

¹¹² *See Mathews*, 426 U.S. at 82.

¹¹³ *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152–53 n.4 (1938) (reasoning that different levels of judicial scrutiny shall apply in different contexts).

¹¹⁴ *See Mathews*, 426 U.S. at 81; *see also* Wishnie, *supra* note 90, at 496.

¹¹⁵ *See Mathews*, 426 U.S. at 81.

¹¹⁶ *See Graham*, 403 U.S. at 371–72 (reasoning that aliens are a discrete and insular minority or "suspect class" that warrant special protections under the laws because noncitizens possess an immutable trait, share a history of discrimination, and are politically vulnerable because they are unable to vote); *see also* *Foley v. Connelie*, 435 U.S. 291, 294

ter, the government must prove that the statute or regulation is the least restrictive means of advancing a compelling governmental interest.¹¹⁷ This more stringent standard applies to lawful immigrants challenging state legislation.¹¹⁸ The Court has consistently held that lawful immigrants are a suspect class because of their inability to vote and participate in the political process.¹¹⁹ In theory, the Court applies a strict scrutiny standard of review when examining discriminatory legislation affecting legal immigrants.¹²⁰ In contrast, when unlawfully present or undocumented immigrants challenge legislation, the Court employs either a rational basis or intermediate standard of review depending upon the interests at stake.¹²¹ These divergent standards of review reflect the Court's recognition that lawfully present immigrants warrant greater protection than other noncitizen groups,¹²² largely because lawfully present immigrants may remain permanently in the United States and thus shoulder important civic duties.¹²³ Therefore, when there is an equal protection challenge to an immigration-related law, lawfully present immigrants, but not undocumented immigrants or temporarily present "nonimmigrants," deserve review under the heightened strict scrutiny standard.¹²⁴ Indeed, the outcome of these cases is often dictated by the standard of review employed:¹²⁵ the Court generally upholds a statute subject to a rational basis standard but strikes a statute

(1978) (echoing *Graham* in reasoning that noncitizens' inability to vote deprives them of "a direct voice in the political process" and contributes to their classification as a suspect class); *Carolene Prods.*, 304 U.S. at 152–53 n.4.

¹¹⁷ See *Yick Wo v. Hopkins*, 118 U.S. 356, 369 (1886) (striking down a local ordinance that, in effect, discriminated against businesses owned by noncitizens).

¹¹⁸ See *id.*

¹¹⁹ See *Foley*, 435 U.S. at 294; *Graham*, 403 U.S. at 373.

¹²⁰ See *Graham*, 403 U.S. at 372.

¹²¹ *Plyler v. Doe*, 457 U.S. 202, 226 (1982) (adopting an intermediate standard of scrutiny to invalidate a Texas statute denying public education to undocumented immigrant children).

¹²² See *Graham*, 403 U.S. at 371.

¹²³ See *id.* at 376; *supra* notes 16–17 and accompanying text.

¹²⁴ See *Plyler*, 457 U.S. at 219 n.19, 224–25. The role of undocumented immigrants in the debate over healthcare reform is significant. See *Ortega*, *supra* note 69, at 187 (addressing the role of undocumented immigrants in healthcare reform). Notwithstanding the importance of this issue, the jurisprudence concerning the equal protection rights of undocumented immigrants is dissimilar to those of legal permanent residents, and the issue is therefore outside the scope of this Note. See *Plyler*, 457 U.S. at 223–25. For a thoughtful analysis of the role of undocumented immigrants in the healthcare debate, see *Ortega*, *supra* note 69, at 193–94.

¹²⁵ See *Wishnic*, *supra* note 90, at 507 (positing that the judiciary has uniformly invalidated statutes reviewed with the strict scrutiny standard and validated statutes reviewed with the rational basis standard).

subject to a strict scrutiny standard absent a compelling showing by the government that such a statute is justified.¹²⁶

2. The Federal Immigration Power and Rational Basis Review

Despite the fact that lawful immigrants constitute a suspect class in equal protection challenges, federal legislation that discriminates against noncitizens in accessing government programs and economic entitlements has traditionally been upheld under a rational basis standard of review.¹²⁷ In upholding discriminatory federal laws, the Court does not contend that these laws are any less invidious than their state counterparts; rather, the Court holds that the equal protection claims of immigrants are subverted by the federal government's plenary power to regulate immigration.¹²⁸

For over a century, the Court has championed the federal government's exclusive authority to regulate immigration.¹²⁹ Although the power to regulate immigration is not specifically enumerated in the U.S. Constitution, the Court has recognized numerous textual sources that implicitly grant this power and has found additional, inherent sources from which this plenary power derives.¹³⁰ Textual sources include the Naturalization Clause, the Foreign Commerce Clause, and the treaty power.¹³¹ An important extra-textual source of the power is the unenumerated, sweeping doctrine of inherent national sovereignty.¹³² The Naturalization Clause grants Congress the authority "to establish a[n] uniform rule of naturalization."¹³³ The Court interprets this clause to apply to general immigration laws that regulate the admission and removal of noncitizens within the United States, as well as laws that set criteria for granting permanent resident status.¹³⁴ The Foreign Commerce Clause, also enumerated in Article I, has been interpreted by the Court

¹²⁶ See *id.*

¹²⁷ See, e.g., *Mathews*, 426 U.S. at 81.

¹²⁸ See *id.* at 80–81.

¹²⁹ See *Fong Yue Ting v. United States*, 149 U.S. 698, 707 (1893); *Chae Chan Ping v. United States*, 130 U.S. 581, 603–04 (1889) (initiating over a century of Supreme Court jurisprudence that supported expansive federal immigration powers).

¹³⁰ See *Chae Chan Ping*, 130 U.S. at 603–04 (holding that the doctrine of inherent sovereignty grants the federal government vast authority to regulate immigration, and simultaneously insulates its decisions from substantive constitutional challenge).

¹³¹ See *infra* notes 132–136 and accompanying text.

¹³² See *Wishnie*, *supra* note 90, at 530.

¹³³ U.S. CONST. art. I, § 8, cl. 4.

¹³⁴ *Plyler*, 457 U.S. at 219 n.19 (reasoning that a single comprehensive policy toward the treatment of aliens is a fundamental objective of the federal government).

to include congressional authority over persons who enter the United States.¹³⁵ Furthermore, the treaty power, vested in the federal government alone, underscores Congress's exclusive domain over relations with foreign nations.¹³⁶

For a brief period in the nation's history, the states were permitted to apply their own naturalization requirements under the Articles of Confederation, which led to disastrous results.¹³⁷ There is a consensus among scholars that the Framers granted exclusive immigration and foreign affairs powers to the federal government to encourage a national, uniform immigration law.¹³⁸ Therefore, the textual delegation represented a direct and purposeful choice to remove any immigration policy powers from the states.¹³⁹ In addition to the textual sources for federal immigration power, the Court has advanced the doctrine of inherent sovereign authority as a source of that power for over a century.¹⁴⁰

The combination of textual authority and the judicial doctrine of inherent sovereign authority creates a potent federal immigration power that is largely insulated from judicial oversight.¹⁴¹ This doctrine of inherent sovereign authority originated in the late nineteenth century, when Chinese-Americans, who were denied the right to naturalize, challenged their arbitrary exclusion and removal from the United States.¹⁴² The plaintiffs lost their claims: the Supreme Court essentially declared federal immigration laws to be nonjusticiable.¹⁴³ Many scholars criticize this doctrine as a *Plessy*-era aberration that legitimized racist and xenophobic immigration laws that conflict with basic constitutional princi-

¹³⁵ U.S. CONST. art. I, § 8, cl. 3; see also *Fong Yue Ting*, 149 U.S. at 712 (recognizing Congress's power over the "bringing of persons into the ports of the United States").

¹³⁶ U.S. CONST. art. I, § 10, cls. 1, 3 (prohibiting states from entering into treaties or entering into any agreements with a foreign power).

¹³⁷ See Wishnie, *supra* note 90 at 534–35 (commenting on the Framers' awareness of the failures of state-regulated immigration).

¹³⁸ See *id.*

¹³⁹ See *id.*

¹⁴⁰ See *Fong Yue Ting*, 149 U.S. at 707; *Chae Chan Ping*, 130 U.S. at 603–04 (creating the doctrine of inherent sovereign authority pertaining to federal laws regulating immigration). First introduced as an unfortunate emblem of bigotry, the U.S. Supreme Court in *Chae Chan Ping v. United States* declared that "[t]he power of the legislative department of the government to exclude aliens from the United States is an incident of sovereignty" 130 U.S. at 581.

¹⁴¹ See *Chae Chan Ping*, 130 U.S. at 581; see also Gabriel J. Chin, *Segregation's Last Stronghold: Race Discrimination and the Constitutional Law of Immigration*, 46 UCLA L. REV. 1, 18 (1998).

¹⁴² See *Fong Yue Ting*, 149 U.S. at 699; *Chae Chan Ping*, 130 U.S. at 582.

¹⁴³ See *Fong Yue Ting*, 149 U.S. at 707; *Chae Chan Ping*, 130 U.S. at 603.

ples.¹⁴⁴ Although the Court qualified the scope of these cases—the so-called *Chinese Exclusion Cases*—in the twentieth century, the vestiges of plenary power remain.¹⁴⁵ The Court has declared noncitizens “persons” protected by the Equal Protection Clause of the Fourteenth Amendment, enabling legal immigrants to challenge federal laws that discriminate based upon alienage.¹⁴⁶ Notwithstanding this constitutional protection, the plenary power doctrine allows even the most discriminatory federal immigrant-related statutes to survive legal challenges.¹⁴⁷

In 1976, the U.S. Supreme Court decided *Mathews v. Diaz*, which involved a federal law that withheld government benefits based upon alienage.¹⁴⁸ The equal protection challenge concerned a provision of the Social Security Act that restricted noncitizen participation in Medicare Part B (outpatient care) to legal permanent residents who had maintained their lawful resident status in the United States for a minimum of five years.¹⁴⁹ The Court acknowledged that noncitizens constitute a discrete and insular minority but invoked a rational basis standard of review to find that the exclusion was not “wholly irrational” because it was reasonably related to governmental budgetary constraints.¹⁵⁰ *Mathews* expanded the federal government’s sweeping plenary power over immigration into the realm of economic benefits.¹⁵¹ The Court held that the federal government may restrict lawful immigrants from subsidized health programs without providing a compelling justification.¹⁵² Although subsequent cases have restrained this sweeping deference to the federal legislature,¹⁵³ *Mathews* signaled the Court’s willingness to subvert the due process claims of noncitizens to the federal government’s interest in regulating immigration.¹⁵⁴

¹⁴⁴ See Chin, *supra* note 141, at 18 (arguing that racism underscores the plenary power doctrine).

¹⁴⁵ See *Fiallo v. Bell*, 430 U.S. 787, 793 n.5 (1977) (cautioning that federal action concerning immigration is not completely insulated from judicial review and that the courts have some authority to review due process challenges by immigrants).

¹⁴⁶ See *Yick Wo*, 118 U.S. at 369.

¹⁴⁷ See Wishnie, *supra* note 90, at 503–04 (arguing that, despite the inequities of the plenary power doctrine, finding alternative ways to protect the constitutional rights of immigrants may be more effective than attacking the doctrine itself).

¹⁴⁸ 426 U.S. at 69.

¹⁴⁹ See *id.*

¹⁵⁰ See *id.* at 83.

¹⁵¹ See *id.* at 79–80.

¹⁵² See *id.*

¹⁵³ See *Fiallo*, 430 U.S. at 793 n.5; *Hampton v. Mow Sung Wong*, 426 U.S. 88, 103 (1976) (qualifying the scope of the federal plenary power by requiring the government to demonstrate that an immigration restriction was motivated by an overriding national interest).

¹⁵⁴ See 426 U.S. at 81.

3. Strict Scrutiny for State-Funded Benefits Programs

In 1971, five years before *Mathews*, the U.S. Supreme Court unanimously struck down state legislation in *Graham v. Richardson* that—similar to the federal legislation in *Mathews*—restricted benefits eligibility based on citizenship status.¹⁵⁵ The Court consolidated appeals from Arizona and Pennsylvania that challenged restrictions on noncitizens in state public benefits programs.¹⁵⁶ The Arizona law at issue provided welfare benefits to U.S. citizens and to legal permanent residents who had resided in the United States for fifteen years or more.¹⁵⁷ Otherwise eligible legal immigrants who did not meet this state-imposed durational residency requirement were therefore excluded from the welfare program.¹⁵⁸ The Pennsylvania law was more restrictive: it precluded any noncitizen from receiving state-funded welfare benefits.¹⁵⁹ Examining Arizona and Pennsylvania's imposition of welfare restrictions on lawful immigrants, the Court employed a strict scrutiny standard of review to invalidate the statutes.¹⁶⁰ Reasoning that legal permanent residents shoulder important civic duties like paying taxes and registering for the selective service, Justice Blackmun rejected the state defendants' claims that the allocation of scarce government resources necessitated limiting welfare benefits to citizens.¹⁶¹ Therefore, in *Mathews* and *Graham*, the Court articulated vastly disparate standards of review depending on whether a state or the federal government enacted the statute.¹⁶² The Court defended this disparity on the grounds that "the Fourteenth Amendment's limits on state powers are substantially different from the constitutional provisions applicable to the federal power over immigration and naturalization."¹⁶³

The Court consistently adheres to a strict federal-state dichotomy in examining legislation that discriminates against noncitizens, not-

¹⁵⁵ *Graham*, 403 U.S. at 383.

¹⁵⁶ *Id.* at 366.

¹⁵⁷ *Id.* at 367.

¹⁵⁸ *Id.*

¹⁵⁹ *See id.* at 368. The Pennsylvania statute provided, however, that immigrants who were eligible for the jointly funded state-federal program could receive state-federal welfare benefits. *See id.* Therefore, the restriction was limited to wholly state-funded welfare benefits. *See id.*

¹⁶⁰ *See id.* at 376.

¹⁶¹ *See Graham*, 403 U.S. at 375 (reasoning that "[s]ince an alien as well as a citizen is a 'person' for equal protection purposes, a concern for fiscal integrity is no more compelling a justification for the questioned classification in these cases than" an imposition of a one-year residency requirement in a particular state to receive federal welfare benefits).

¹⁶² *See Mathews*, 426 U.S. at 85; *Graham*, 403 U.S. at 375.

¹⁶³ *Mathews*, 426 U.S. at 86–87.

withstanding the intermediate standard of review reserved for unlawfully present immigrants.¹⁶⁴ Therefore, the Court upholds most federal legislation that restricts the rights of noncitizens to government benefits and privileges and invalidates most parallel state legislation.¹⁶⁵ Moreover, individual state courts generally invalidate state statutes and regulations that, if promulgated by Congress, would be upheld as constitutional.¹⁶⁶ Whereas federal laws concerning economic benefits that classify and target legal immigrants are categorized as *immigration* laws, their state counterparts are categorized as *alienage* laws, even when the laws are identical but for this national-local distinction.¹⁶⁷

4. Post-PRA Equal Protection Challenges: Federal v. State Restrictions

The PRA disrupted decades of federal and state precedent.¹⁶⁸ Previously, courts applied a rational basis standard of review to federal legislation that discriminates against noncitizens in government programs, and a strict scrutiny standard of review to parallel state legislation.¹⁶⁹ Because the PRA contained a delegation of the federal government's plenary immigration power, the legislation attempted to replace the *Graham* test for state legislation with a *Mathews* rational basis standard.¹⁷⁰ Noncitizens that were newly precluded from subsidy programs brought equal protection challenges, both in federal and state courts.¹⁷¹

¹⁶⁴ See *Plyler*, 457 U.S. at 223–24 (establishing an “intermediate” scrutiny for state discrimination against undocumented immigrants); *Mathews*, 426 U.S. at 67 (reasoning that markedly different standards of review apply to states and the federal government); *Graham*, 403 U.S. at 372 (holding that state legislation must be subjected to strict scrutiny review).

¹⁶⁵ See *Mathews*, 426 U.S. at 84–85; *Graham*, 403 U.S. at 365; see also *Takahashi v. Fish & Game Comm’n*, 334 U.S. 410, 418–19 (1948) (holding that state statute discriminating against legal residents in issuance of commercial licenses violated equal protection).

¹⁶⁶ See *Barannikova v. Town of Greenwich*, 643 A.2d 251, 264–65 (Conn. 1994) (invalidating town ordinance utilizing different methods of computing welfare benefits for legal residents and citizens); *El Souri v. Dep’t of Soc. Servs.*, 414 N.W.2d 679, 686–87 (Mich. 1987) (utilizing a strict scrutiny standard of review to invalidate a state ordinance subjecting only noncitizens to “sponsor deeming” in state-run welfare program).

¹⁶⁷ See *Wishnie*, *supra* note 90, at 505; see also *Graham*, 403 U.S. at 380 (construing state laws affecting immigrants as alien residency requirements that encroach upon the federal power to regulate immigrants’ entrance and abode).

¹⁶⁸ See *infra* notes 169–200 and accompanying text.

¹⁶⁹ See *Mathews*, 426 U.S. at 86–87; *Graham*, 403 U.S. at 372.

¹⁷⁰ See 8 U.S.C. § 1601(7) (2006) (importing rational basis language into PRA-supported state legislation); *Mathews*, 426 U.S. at 86–87; *Graham*, 403 U.S. at 372.

¹⁷¹ See *infra* notes 172–198 and accompanying text.

The first line of cases challenged the restrictions on legal permanent residents in *federally* administered programs.¹⁷² The underlying premise of plaintiffs' arguments was that the courts may defer to the federal political branches on immigration but not on economic policy.¹⁷³ Plaintiffs reasoned that Congress and the President have the sole discretion to regulate foreign affairs, whereas economic benefits may be administered by any federal or state agency.¹⁷⁴ Although deference is certainly warranted in certain circumstances, advocates questioned whether the internal regulation of economic benefits fits into this category.¹⁷⁵ These lawsuits alleged that the PRA's restrictions on public benefit programs for legal immigrants had a negligible impact upon the political branches' relationships with foreign nations.¹⁷⁶ Therefore, Congress was not authorized to invoke the plenary power and was not entitled to judicial deference.¹⁷⁷ Generally, these claims were unsuccessful: courts held that the plenary immigration power insulates federal benefits restrictions from searching judicial review.¹⁷⁸

Immigrants who were newly ineligible for state, as opposed to federal, programs had more success in the courts.¹⁷⁹ In 2001 in *Aliessa ex*

¹⁷² See *Lewis v. Thompson*, 252 F.3d 567, 582 (2d. Cir. 2001) (upholding rational basis standard of review for PRA Medicaid restrictions in accordance with federal guidelines); *City of Chicago v. Shalala*, 189 F.3d 598, 600 (7th Cir. 1999) (affirming immigration restrictions on federal programs in the 1996 PRA as constitutionally valid); *Abreu v. Callahan*, 971 F. Supp. 799, 820–21 (S.D.N.Y. 1997) (affirming noncitizen restrictions on food stamps and supplemental security income); *Cid v. S.D. Dep't of Soc. Servs.*, 598 N.W.2d 887, 891–92 (S.D. 1999) (affirming PRA restrictions on Temporary Assistance for Needy Families (TANF) welfare grants to noncitizens).

¹⁷³ See *Lewis*, 252 F.3d at 583; *Shalala*, 189 F.3d at 603–04; *Abreu*, 971 F. Supp. at 806–11; *Cid*, 598 N.W.2d at 891–92.

¹⁷⁴ See *Lewis*, 252 F.3d at 582–84; *Shalala*, 189 F.3d at 601–02; *Abreu*, 971 F. Supp. at 806–07; *Cid*, 598 N.W.2d at 891–92.

¹⁷⁵ See *Shalala*, 189 F.3d at 604–05; see also *Plyler*, 457 U.S. at 224–25 (rejecting state defendant's contention that public education is related to immigration regulation and policy).

¹⁷⁶ See *Lewis*, 252 F.3d at 582–84; *Shalala*, 189 F.3d at 604; *Abreu*, 971 F. Supp. at 806–07; *Cid*, 598 N.W.2d at 891–92.

¹⁷⁷ See *Lewis*, 252 F.3d at 582–83; *Shalala*, 189 F.3d at 604; *Abreu*, 971 F. Supp. at 806; *Cid*, 598 N.W.2d at 891–93.

¹⁷⁸ See *Lewis*, 252 F.3d at 583; *Shalala*, 189 F.3d at 604–05, 607; *Abreu*, 971 F. Supp. at 807–11; *Cid*, 598 N.W.2d at 892–93. *But see Saenz v. Roe*, 526 U.S. 492, 501–02 (1999). The Court invalidated a statute that imposed a twelve-month waiting period for welfare benefits, despite authorization by the PRA for the legislation. *Saenz*, 526 U.S. at 501–02. By applying strict scrutiny review, the Court determined that the statute violated the right to travel in the Fourteenth Amendment's Privileges and Immunities Clause by unconstitutionally classifying individuals based upon durational residency. See *id.*

¹⁷⁹ See *Kurti v. Maricopa Cnty.*, 33 P.3d 499, 501 (Ariz. Ct. App. 2001) (holding PRA-sanctioned restrictions on state-funded Medicaid violated the Equal Protection Clause); *Ehrlich v. Perez*, 908 A.2d 1220, 1233 (Md. 2006) (holding PRA-authorized denial of

rel. Fayad v. Novello, the New York Court of Appeals struck down a state statute enacted in response to the PRA.¹⁸⁰ The statute eliminated state-funded Medicaid eligibility for many categories of immigrants that were previously eligible, including PRUCOLs, newly adjusted legal permanent residents, and additional categories of immigrants deemed “unqualified” under the new PRA provisions.¹⁸¹ After considering a state constitutional claim, the court considered the equal protection rights of the plaintiffs.¹⁸² The court subjected the state statute to strict scrutiny review and held that the government could not withhold economic benefits from lawfully present immigrants without demonstrating that such withholding was the least restrictive means of satisfying a compelling governmental interest.¹⁸³ Notably, the court held that the conservation of scarce fiscal resources was not a compelling governmental interest.¹⁸⁴ The court echoed *Graham* when it held that the PRA was an unlawful delegation of plenary power to the states, reasoning that the federal government cannot authorize the states to violate the Equal Protection Clause.¹⁸⁵ New York had not limited eligibility for Medicaid beyond the federal scheme, so the court essentially declared that the PRA alienage restrictions, when literally translated into state statutes, violated the Equal Protection Clause.¹⁸⁶

In 2006, in *Ehrlich v. Perez*, the Maryland Court of Appeals adopted the *Aliessa* court’s reasoning and affirmed the trial court’s grant of an injunction to prevent implementation of a 2005 state budget provision that adopted the federal five-year bar to legal permanent residents’ receipt of Medicaid.¹⁸⁷ The court reasoned that the state’s budgetary cuts could not survive a strict scrutiny standard of review, even though the budget provisions accorded with parallel PRA-sanctioned federal eligibility guidelines.¹⁸⁸ As a result, both New York and Maryland now pro-

Medicaid benefits to lawful permanent residents subject to strict scrutiny and likely to succeed on the merits); *Aliessa ex rel. Fayad v. Novello*, 754 N.E.2d 1085, 1096 (N.Y. 2001) (striking a PRA-sanctioned regulation eliminating state-funded Medicaid benefits for PRUCOL and qualified aliens who had not fulfilled a five-year residency requirement).

¹⁸⁰ See 754 N.E.2d at 1096.

¹⁸¹ See Karin H. Berg, Note, *May Congress Grant the States the Power to Violate the Equal Protection Clause? Aliessa v. Novello and Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, 17 BYU J. PUB. L. 297, 302 (2003).

¹⁸² See *Aliessa*, 754 N.E.2d at 1094.

¹⁸³ See *id.* at 1098.

¹⁸⁴ See *id.* at 1096.

¹⁸⁵ *Id.* at 1098.

¹⁸⁶ See *id.*

¹⁸⁷ See *Erllich*, 908 A.2d at 1228.

¹⁸⁸ See *id.* at 1233.

vide supplemental state Medicaid coverage to legal permanent residents who are subject to the five-year bar for federal-state Medicaid coverage.¹⁸⁹

Additional post-PRA challenges have examined the constitutionality of state statutes that restrict immigrant eligibility requirements beyond even the federal scheme.¹⁹⁰ In 2001 in *Kurti v. Maricopa County*, the Arizona Court of Appeals invalidated a county ordinance restricting subsidized healthcare to citizens and legal permanent residents who entered prior to August 22, 1996.¹⁹¹ The court reasoned that the eligibility restrictions violated the Equal Protection Clause because they exceeded the parameters of the federal equivalent.¹⁹² Had the county restricted eligibility in exact accordance with the federal guidelines, however, the court would likely have upheld the restrictions (unlike the *Aliessa* and *Ehrlich* courts).¹⁹³

In 2003, in *Soskin v. Reinertson*, the U.S. Court of Appeals for the Tenth Circuit reviewed the constitutionality of Colorado's decision to remove all noncitizens from the federal-state Medicaid rolls.¹⁹⁴ The court upheld the Colorado measure, diverging from the New York and Maryland high courts in its equal protection analysis.¹⁹⁵ The court distinguished the case from *Graham*, holding that strict scrutiny was not applicable because the PRA only granted states a small window of variation in their state-federal programs, and the state was not independently creating alienage classifications if it legislated within that window.¹⁹⁶ The court invoked the plenary powers of the federal government to regulate immigration and concluded that, under a rational basis standard of review, the PRA was valid and Colorado's budget plan thus did not violate the Equal Protection Clause.¹⁹⁷ Notably, the *Soskin* court considered a federal-state Medicaid program, whereas the *Aliessa* court considered a state-funded Medicaid program.¹⁹⁸

¹⁸⁹ See MD. CODE ANN., HEALTH-GEN. § 15-103(a)(1)(2) (West 2010); 18 N.Y. COMP. CODES R. & REGS. tit. 18, § 349.3(2)(b)(iv) (2008); FREMSTAD & COX, *supra* note 107, at 29.

¹⁹⁰ See *Kurti*, 33 P.3d at 501.

¹⁹¹ See *id.*

¹⁹² See *id.*

¹⁹³ See *id.*

¹⁹⁴ See 353 F.3d at 1244. The legislature, however, preserved Medicaid eligibility for a small number of refugees, asylees, and special status immigrants for whom the PRA mandated eligibility. 8 U.S.C. § 1622(b) (2006); *Soskin*, 353 F.3d at 1246.

¹⁹⁵ See *Soskin*, 353 F.3d at 1255.

¹⁹⁶ See *id.* at 1256, 1257.

¹⁹⁷ See *id.* at 1255.

¹⁹⁸ See *id.* at 1244; *Aliessa*, 754 N.E.2d at 1096.

The U.S. Supreme Court has not decided the constitutionality of the PRA's statutory delegation to the states, and there remains a conflict between the high courts of New York and Maryland, on the one hand, and the Tenth Circuit, on the other.¹⁹⁹ It is unclear how the Court would rule, given that state discrimination against noncitizens may be subjected either to the *Mathews* rational basis test or the *Graham* strict scrutiny test, depending on how the law in question is classified.²⁰⁰

D. *The Massachusetts Model and Federal Healthcare Reform*

1. The Massachusetts Model: Retreating from Universal Coverage

On April 12, 2006, Massachusetts passed An Act Providing Access to Affordable, Quality, and Accountable Health Care (the "Massachusetts Act").²⁰¹ The legislation was prompted by a looming budget crisis largely caused by the discrepancy between the mandates of EMTALA, which required hospitals to treat all patients with a medical emergency, and stringent Medicaid restrictions, which rendered many patients ineligible for coverage.²⁰² Massachusetts had borrowed federal Medicaid dollars, at an unsustainable pace, to reimburse its public hospitals for the growing expense of treating the uninsured.²⁰³ Because Massachusetts adopted the PRA's federal immigration restrictions, a large percentage of individuals receiving uncompensated care at public hospitals were noncitizens ineligible for Medicaid.²⁰⁴ As Massachusetts has a relatively large percentage of noncitizen residents, its reforms are a model for expanding noncitizen access to health insurance.²⁰⁵ Additionally, although Massachusetts residents were more likely than the average

¹⁹⁹ See *Soskin*, 353 F.3d at 1255; *Ehrlich*, 908 A.2d at 1233; *Aliessa*, 754 N.E.2d at 1096.

²⁰⁰ See *Mathews*, 426 U.S. at 86–87; *Graham*, 403 U.S. at 371.

²⁰¹ An Act Providing Access to Affordable, Quality and Accountable Healthcare, 2006 Mass. Acts. 111–202 (codified as amended at MASS. GEN. LAWS ch. 111M, §§ 1–5 (2006)).

²⁰² See Knutson, *supra* note 99, at 404–05 (indicating that the PRA created a shrinking pool of Medicaid-eligible emergency room patients, resulting in budget shortfalls for public hospitals).

²⁰³ See John Holahan et al., *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays, and What Would Full Coverage Add to Medical Spending?*, 2004 URB. INST. 31, available at <http://bluecrossfoundation.org/~media/Files/Policy/Roadmap%20to%20Coverage/041116RTCCostsCaringForUninsuredHolahan.pdf> (indicating an increase in state reimbursements to hospitals providing emergency room care to the uninsured).

²⁰⁴ See 130 MASS. CODE REGS. § 504.002(B), (F) (2006) (defining qualified aliens by the PRA guidelines and precluding unqualified aliens from participation in MassHealth).

²⁰⁵ *Massachusetts Quick Facts from the US Census Bureau*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/25000.html> (last visited Nov. 13, 2010) (stating that twelve percent of the Massachusetts population is foreign-born).

U.S. resident to have employer-sponsored health insurance, immigrants tend to be concentrated in industries with historically low percentages of employer-sponsored health coverage.²⁰⁶

Prior to the Massachusetts Act's passage, all lawful immigrants who did not fall under narrow PRA eligibility requirements were ineligible for Medicaid (MassHealth) and were therefore ineligible for non-emergency medical care.²⁰⁷ Yet the Act allows "special status immigrants," defined as legally present immigrants ineligible for the federal-state program, to participate in the newly created Commonwealth Care program.²⁰⁸ Alternatively, if their income was too high, special status immigrants could purchase a low-cost plan from a private insurer through the newly created Commonwealth Connector referral service.²⁰⁹ One year later, between two and three hundred thousand Massachusetts residents who were previously uninsured were covered, with two out of three receiving subsidized state care.²¹⁰ By 2009, only 2.6% of residents were uninsured, compared to the national average of 15%.²¹¹

Due to the economic crisis beginning in 2008, the Massachusetts legislature faced an insurmountable budget shortfall.²¹² The legislature voted to trim the Commonwealth Care program and directed nearly all of the budget cuts at noncitizens who were participating in the program by voting to terminate the coverage of legal permanent residents

²⁰⁶ See Tamara Forsys, Introduction, *Left Out in the Cold: How the United States' Healthcare System Excludes Immigrants*, 17 ANNALS HEALTH L. 351, 352 (2008).

²⁰⁷ See 130 MASS. CODE REGS. § 504.002(F)(2) (2009) (defining "special status immigrants" as unqualified aliens in the federal PRA and declaring that special status immigrants are ineligible for MassHealth).

²⁰⁸ See Mary Ann Chirba-Martin & Andres Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L.J. 409, 415–16 (2008). Commonwealth Care provides coverage for individuals and families earning between 100% and 300% of the federal poverty level ("FPL"). *Id.* The program sets a low premium scale according to income, where households earning less than 133% of the FPL pay no premiums at all, and households earning the maximum pay \$130 per month in premiums. *Id.* Until September 1, 2009, all legally present, income-eligible immigrants who were ineligible for MassHealth due to their immigration status received coverage under Commonwealth Care. See *id.* In 2009, this coverage option was eliminated for this category of immigrants. See Act of Aug. 7, 2009, 2009 Mass. Acts 695.

²⁰⁹ See Matthew Kanter, *Healthy Start: A Policy and Legal Analysis of Health Care Reform in Massachusetts*, 2 MCGILL J.L. & HEALTH 65, 66–67 (2008). The Connector is a "state chartered clearinghouse" from which households earnings above three hundred percent of the FPL and small businesses can purchase, with pre-tax dollars, private insurance plans whose rates are bargained for by the state. *Id.*

²¹⁰ See Chirba-Martin & Torres, *supra* note 208, at 416–17.

²¹¹ Goodnough, *supra* note 8.

²¹² Goodnough, *supra* note 2.

who had adjusted status less than five years ago.²¹³ The legislature chose to cut back services for legal permanent residents to avoid reducing any services available to citizens.²¹⁴ At the urging of Governor Deval Patrick, the legislature compromised and created a stripped-down program, administered by CeliCare, to provide limited healthcare coverage to any immigrant who was enrolled in Commonwealth Care as of August 1, 2009.²¹⁵ Legal immigrants not already enrolled in Commonwealth Care on that date, however, were ineligible for any subsidized health insurance program.²¹⁶ Although the legislature determined that CeliCare was an adequate plan for legal immigrants, it was deemed insufficient as a general provider for Massachusetts residents.²¹⁷ The recent class action lawsuit, filed by Health Law Advocates, alleges that legal immigrants in Massachusetts have been unconstitutionally singled out for disparate treatment.²¹⁸

2. Federal Healthcare Reform: Retaining the Five-Year Bar

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act into law.²¹⁹ The long-awaited federal healthcare reform legislation is expected to cover an additional thirty-two million Americans by 2019.²²⁰ In addition to creating state-run healthcare exchanges, the healthcare reform legislation expands Medicaid eligibility, requiring states to provide Medicaid to any individual or family whose annual income is at or below 133% of the federal poverty level.²²¹ Congress declined to repeal many of the immigrant restrictions enacted in the PRA.²²² Notably, the new legislation retains the five-year

²¹³ See 2009 Mass. Acts 695.

²¹⁴ See Julia Preston, *Health Care Debate Revives Immigration Battle*, N.Y. TIMES, Sept. 6, 2009, at A22.

²¹⁵ See Goodnough, *supra* note 2; Boudreault, *supra* note 5, at 1.

²¹⁶ See 2009 Mass. Acts 695; Massachusetts Complaint, *supra* note 10, at 1.

²¹⁷ See Kay Lazar, *Insurer Told to Hold Off in Mass.: Network Needs to Expand, State Says*, BOS. GLOBE, Oct. 31, 2009, at B5. Massachusetts rejected CeliCare's bid to offer its plan on the state's general healthcare exchange. See *id.* The state cited CeliCare's deficient network coverage and inadequate range of provider choices in its decision. See *id.*

²¹⁸ See Massachusetts Complaint, *supra* note 10, at 1.

²¹⁹ See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119.

²²⁰ See KAISER COMM'N ON HEALTHCARE & THE UNINSURED, FOCUS ON HEALTH REFORM: SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2010), available at <http://www.kff.org/healthreform/upload/8023-R.pdf>.

²²¹ *Id.*

²²² See NATIONAL IMMIGRATION LAW CENTER, *supra* note 18, at 1.

bar to Medicaid for legal permanent residents.²²³ Furthermore, low-income legal immigrants who would qualify for Medicaid but for their immigration status cannot receive the premium tax credits and cost-sharing reductions available to citizens in state-run healthcare exchanges, and must pay market rates for these plans.²²⁴ Therefore, the five-year bar carries over into the healthcare exchanges.²²⁵ Legal immigrants may purchase health insurance through the exchange but will not receive any healthcare subsidies.²²⁶ It appears that these measures, which adopt the PRA's immigration restrictions, will adversely impact lower-income immigrants who may be unable to afford the full premium rates through the exchange.²²⁷ Furthermore, all legal immigrants are subject to the individual healthcare mandate, even though this population cannot receive any government subsidies or tax credits.²²⁸ The debates in both houses were reminiscent of the PRA era, with Republicans warning that covering legal permanent residents as soon as they adjust status would serve as a "magnet" for immigration to the United States.²²⁹ Ultimately, political pressure and concern for voting constituents resulted in legislation that largely overlooks the healthcare needs of noncitizens.²³⁰

Despite the enactment of an ambitious healthcare reform bill, it appears that federal guidelines will not revert back to their pre-PRA form, when legal immigrants enjoyed access to affordable healthcare.²³¹ Therefore, state-funded healthcare programs continue to provide the only source of subsidized health insurance for legal immigrants.²³² States may replicate the Massachusetts model, and the

²²³ *Id.*

²²⁴ *Id.* Therefore, the same immigration restrictions that the PRA implemented for receipt of Medicaid apply to receipt of premium tax and cost-sharing reductions in the exchange. *See id.*

²²⁵ *See id.*

²²⁶ *Id.*

²²⁷ *See id.*

²²⁸ NATIONAL IMMIGRATION LAW CENTER, *supra* note 18, at 1.

²²⁹ *See* Julia Preston, *Congress Quarrels on Covering Immigrants*, N.Y. TIMES, Nov. 4, 2009, at A14 (citing PRA, 8 U.S.C. § 1601 (2)(B) (2006)) The Republicans in these debates echoed the language in the PRA itself that "the availability of public benefits constitute[s] an incentive for immigration to the United States." *See id.*

²³⁰ *See id.*

²³¹ *See* Act of Oct. 30, 1972, Pub. L. No. 92-603, § 1614, 86 Stat. 1329, 1471, *repealed by* PRA, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (liberally construing immigration categories prior to the PRA).

²³² *Cf.* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2001–2007, 124 Stat. 119, 271–86 (2010) (declining to extend Medicaid eligibility to legal immigrants and thereby foreclosing potential for federal coverage for legal immigrants).

outcome of the pending equal protection challenge will likely determine whether legal immigrants nationwide enjoy equal access to state-funded healthcare programs.²³³ Notwithstanding equal protection considerations, states must consider the economic impact of excluding legal immigrants from their subsidized healthcare programs while remaining subject to the EMTALA mandate.²³⁴

II. EQUAL PROTECTION AND ECONOMIC SUSTAINABILITY CONVERGE: WHY INVALIDATING ALIENAGE RESTRICTIONS IN STATE-FUNDED HEALTH INSURANCE PROGRAMS MAKES LEGAL AND ECONOMIC SENSE

Given that federal Medicaid expansion excludes newly adjusted legal immigrants, state-funded Medicaid programs continue to provide the only source of subsidized medical coverage to this population.²³⁵ Unfortunately, noncitizens are the first to lose state-funded Medicaid eligibility as state legislatures grapple with record deficits.²³⁶ Foreclosed from direct political participation, legal immigrants must turn to the courts to assert their equal protection rights to state-funded Medicaid.²³⁷ Because the “Massachusetts model” is likely to be replicated by other states considering healthcare expansion, the recent actions taken by the Massachusetts legislature highlight the need for close judicial scrutiny.²³⁸ The Massachusetts Supreme Judicial Court should use the strict scrutiny standard established in the U.S. Supreme Court’s 1971 decision in *Graham v. Richardson* to hold that classification of benefits based on alienage violates the Equal Protection Clause.²³⁹

²³³ See Massachusetts Complaint, *supra* note 10, at 1.

²³⁴ See IMMIGRATION POLICY CTR., INCLUDING LEGAL IMMIGRANTS IN HEALTHCARE REFORM, JUST WHAT THE DOCTOR ORDERED 1 (2009), available at http://www.immigrationpolicy.org/sites/default/files/docs/Including_Legal_Immigrants_in_Health_Care_Reform.pdf. Studies show that legal immigrants are overwhelmingly likely to remain in the United States permanently and become citizens, at which point they become eligible for Medicaid. See *id.* Therefore, the Medicaid program must spend more to treat individuals whose preventable illnesses have advanced to a critical stage. See NATIONAL IMMIGRATION LAW CENTER, *supra* note 26, at 2.

²³⁵ See Patient Protection and Affordable Care Act §§ 2001–2007; SAMANTHA ARTIGA & JENNIFER TOLBERT, KAISER COMM’N ON MEDICAID & THE UNINSURED, IMMIGRANTS’ HEALTH COVERAGE AND HEALTH REFORM: KEY QUESTIONS AND ANSWERS I (2009), available at <http://www.kff.org/healthreform/upload/7982.pdf>.

²³⁶ See Act of Aug. 7, 2009, 2009 Mass. Acts 695; N.J. ADMIN. CODE § 10:78-3.2(e)(1) (2010); FREMSTAD & COX, *supra* note 107, at 18.

²³⁷ See *Graham v. Richardson*, 403 U.S. 365, 371–72 (1971).

²³⁸ See FREMSTAD & COX, *supra* note 107, at 18. Noncitizens shouldered the majority of budget cuts so that the legislature could preserve citizen healthcare benefits. See *id.*

²³⁹ See *Graham*, 403 U.S. at 372 (applying a strict scrutiny standard of review); see also 130 C.M.R. § 504.002(B), (D) (Mass. 2009) (defining “special status immigrants,” as de-

Section A of this Part analyzes the arguments for and against a strict scrutiny standard of review in the Massachusetts context.²⁴⁰ It concludes that a state cannot terminate legal immigrants from its state-funded Medicaid program even if the restrictions adhere to the PRA guidelines.²⁴¹ Congress's plenary power over immigration does not extend to the allocation of economic benefits within individual states for several reasons: First, the issue of state healthcare benefits is neither related to the federal immigration power, nor a "political question" of the type that is typically nonjusticiable.²⁴² Second, Congress cannot proclaim that the PRA guidelines satisfy a strict scrutiny standard of review when adopted by the states, because such a proclamation usurps the role of the judiciary and violates the separation of powers.²⁴³ Third, delegation to the states contravenes uniformity in setting immigration policy and is therefore inconsistent with both textual and jurisprudential justifications for the federal plenary power.²⁴⁴

Section B of this Part argues that from a policy standpoint, state-funded Medicaid restrictions adversely impact both legal immigrants and the general public.²⁴⁵ Allowing the states to discriminate against legal immigrants contravenes the spirit of the Fourteenth Amendment and perpetuates inequality.²⁴⁶ Practically, foreclosing health insurance coverage for lawfully present immigrants simply shifts the costs of treatment from cost-efficient, preventive care, to emergency rooms.²⁴⁷ Because legal permanent residents tend to remain permanently in the United States, providing timely access to preventive care controls the

financed by the federal PRA, and declaring that special status immigrants are ineligible for MassHealth); Massachusetts Complaint, *supra* note 10, at 1 (alleging that the Massachusetts legislation violates the equal protection rights of legal immigrants); New Jersey Complaint, *supra* note 23, at 25.

²⁴⁰ See *infra* notes 242–331 and accompanying text.

²⁴¹ See *infra* notes 242–331 and accompanying text.

²⁴² See Raquel Aldana, *On Rights, Federal Citizenship, and the "Alien,"* 46 WASHBURN L.J. 263, 268 (2007) (delineating between federal legislation relating to border control, where the courts defer to the political branches, and "alienage" regulation that bears no clear relationship to border control).

²⁴³ See 8 U.S.C. § 1601(7) (2006) (declaring that states who adopt PRA immigration guidelines in their own state-funded benefits programs "shall be considered to have chosen the least restrictive means for achieving the compelling government interest of assuring that aliens be self-reliant in accordance with national immigration policy").

²⁴⁴ See *supra* notes 127–140 and accompanying text.

²⁴⁵ See *infra* notes 332–346 and accompanying text.

²⁴⁶ See Wishnie, *supra* note 90, at 553–54 (arguing that shielding state benefits programs from equal protection challenges violates American "anticaste" principles).

²⁴⁷ See *infra* notes 332–341 and accompanying text.

future costs of untreated illnesses.²⁴⁸ Finally, restrictions on some immigrants cause ripple effects within the entire immigrant community by discouraging participation in government-funded programs.²⁴⁹

A. *State-Funded Medicaid Programs That Place Eligibility Restrictions on Lawful Immigrants Violate the Equal Protection Clause*

When state-funded Medicaid programs restrict the eligibility of legal immigrants, they violate the Equal Protection Clause of the U.S. Constitution.²⁵⁰ The U.S. Supreme Court, balancing equality concerns against a significant national security and foreign affairs interest, has held that the Constitution grants the federal government plenary power over immigration.²⁵¹ Because national security and foreign policy lie solely within the powers of the federal government, the states cannot invoke the plenary power.²⁵² But state laws that restrict lawful immigrants from subsidized healthcare programs are not immigration laws,²⁵³ even when a state's regulation impacts immigration.²⁵⁴ Therefore, a challenge to a state-enacted alienage classification must be based in the Equal Protection Clause rather than the federal plenary immigration power.²⁵⁵ When states discriminate against lawful immigrants, a "suspect class," the Court will apply a strict scrutiny standard of review.²⁵⁶ Under this standard, the discriminatory regulation must be necessary to further a compelling governmental interest. The *Graham* Court determined that a state's restricting benefits for lawful immigrants to conserve scarce fiscal resources does not constitute a compelling governmental interest.²⁵⁷ Therefore, the Massachusetts and New Jersey legislatures' decision to terminate lawful immigrants from state-funded

²⁴⁸ See *infra* notes 332–341 and accompanying text.

²⁴⁹ See *infra* notes 342–346 and accompanying text.

²⁵⁰ See U.S. CONST. amend XIV; *infra* notes 251–331 and accompanying text.

²⁵¹ See *Mathews v. Diaz*, 426 U.S. 67, 80 (1976).

²⁵² See *Wishnie*, *supra* note 90, at 548–49.

²⁵³ See *Graham*, 403 U.S. at 372.

²⁵⁴ *De Canas v. Bica*, 424 U.S. 351, 355–56 (1976) (“Standing alone, the fact that aliens are the subject of a state statute does not render it a regulation of immigration . . . even if such local regulation has some purely speculative and indirect impact on immigration, it does not thereby become a constitutionally proscribed regulation of immigration.”).

²⁵⁵ See *Mathews*, 426 U.S. at 85.

²⁵⁶ *Graham*, 403 U.S. at 372.

²⁵⁷ See *id.* at 375 (“The saving of welfare costs cannot justify an otherwise invidious classification.”). The Court reasoned that lawful immigrants residing in the state contribute to state revenues on an equal basis with citizens. See *id.*

healthcare programs to reconcile a looming budget deficit violates the Equal Protection Clause.²⁵⁸

Furthermore, Congress cannot invoke its plenary power to authorize individual states to adopt federal alienage classifications in their respective state-funded benefits programs.²⁵⁹ The PRA's proclamation that states implementing the federal restrictions shall satisfy a strict scrutiny standard of review is an unconstitutional usurpation of the judiciary's role.²⁶⁰ Congress cannot authorize the states to violate the Equal Protection Clause.²⁶¹

1. State Healthcare Legislation Does Not Invoke the Federal Plenary Immigration Power and Is Subject To Strict Scrutiny

The PRA asserts that *federal* public benefits policy affects immigration patterns and declares restrictions necessary to ensure that “[t]he availability of public benefits not constitute an incentive for immigration to the United States.”²⁶² This alleged nexus between immigration and the availability of federal benefits is itself widely contested.²⁶³ For many scholars, the PRA ignores the distinction between border control laws, which legitimately invoke the federal plenary power, and economic benefits laws and regulations that concern immigrants living within our borders, which do not invoke the same national priorities.²⁶⁴ Distinguishing between immigration and alienage laws in the federal context, however, is difficult because federal legislation often contains elements of both.²⁶⁵ The PRA's claim that the availability of benefits in the United States affects immigration patterns is refuted by statistical surveys, which conclude that most immigrants come to the United States for work.²⁶⁶ Indeed, the decision to immigrate to the United

²⁵⁸ See *id.*; Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25.

²⁵⁹ See *Graham*, 403 U.S. at 382.

²⁶⁰ Compare 8 U.S.C. § 1601(7) (2006), with *City of Boerne v. Flores*, 521 U.S. 507, 515–16 (1997) (invalidating statute where Congress proscribed the standard of review as a violation of the separation of powers).

²⁶¹ *Graham*, 403 U.S. at 382.

²⁶² 8 U.S.C. § 1601(2)(B) (2006).

²⁶³ See Aldana, *supra* note 242, at 268 (criticizing the application of the plenary power doctrine in the context of economic benefits legislation).

²⁶⁴ See, e.g., *id.* at 269.

²⁶⁵ See Wishnie, *supra* note 90, at 525 (noting that it is difficult to distinguish “alienage” laws from “immigration” law in federal legislation).

²⁶⁶ See MEREDITH L. KING, CTR. FOR AM. PROGRESS, IMMIGRANTS AND THE U.S. HEALTHCARE SYSTEM: FIVE MYTHS THAT MISINFORM THE AMERICAN PUBLIC 6 (2007), available at http://www.americanprogress.org/issues/2007/06/pdf/immigrant_health_report.pdf (con-

States is seldom motivated by the availability of public benefits.²⁶⁷ Although a nexus between federal benefits and immigration is possible, state benefits legislation clearly falls outside the purview of national immigration law.²⁶⁸ Echoing this widely accepted dichotomy between state and federal legislation, the Supreme Court in 1976 in *Mathews v. Diaz* reasoned that:

Insofar as state welfare policy is concerned, there is little, if any, basis for treating persons from another State differently from persons who are citizens of another country. Both groups are noncitizens as far as the State's interests in administering its welfare programs are concerned. Thus, a division by a State of the category of persons who are not citizens of that State into subcategories of United States citizens and aliens has no apparent justification, whereas, a comparable classification by the Federal Government is a routine and normally legitimate part of its business.²⁶⁹

For two decades, *Mathews* controlled challenges to federal legislation, and *Graham* controlled challenges to state legislation.²⁷⁰ The PRA contains two controversial provisions that import a *Mathews* rational basis standard into state alienage laws, and thereby muddle the bright-line test.²⁷¹ First, 8 U.S.C. § 1622 permits a state to restrict eligibility for jointly funded state-federal programs beyond the mandatory immigrant restrictions imposed by the PRA.²⁷² Second, § 1621 permits a state to impose alienage restrictions in state and locally funded programs, and § 1607 declares that states that import the federal restrictions into their own programs will satisfy a strict scrutiny standard of review.²⁷³ These latter provisions purport to authorize Massachusetts, New Jersey, and any state providing state-funded healthcare benefits to prohibit or subsequently terminate the participation of legal immigrants without demonstrating a compelling governmental interest.²⁷⁴

cluding that immigrants are seldom motivated to come to the United States for healthcare and instead come most frequently for jobs).

²⁶⁷ *See id.*

²⁶⁸ *See Mathews*, 426 U.S. at 85.

²⁶⁹ *Id.*

²⁷⁰ *See Mathews*, 426 U.S. at 86–87; *Graham*, 403 U.S. at 374.

²⁷¹ *See* 8 U.S.C. §§ 1601(7), 1621(a), 1622(a) (2006).

²⁷² *See id.* § 1622(a).

²⁷³ *See id.* §§ 1601(7), 1621(a).

²⁷⁴ *See id.* § 1607.

May Congress insulate state-funded health insurance programs from judicial scrutiny by delegating the federal plenary power? Several cases suggest that it cannot: the PRA does not alter the existing strict scrutiny standard of review in this context.²⁷⁵ Therefore, the claims by Massachusetts and New Jersey that their alienage discrimination is federally authorized should be rejected by those states' high courts.²⁷⁶

First, the PRA does not disturb the Court's holding and analysis in *Graham*.²⁷⁷ Although it predates the PRA, *Graham* suggests that challenges to state alienage classifications that are authorized by Congress remain subject to strict scrutiny review.²⁷⁸ In *Graham*, Arizona defended its durational residency requirement—resembling the five-year bar imposed on legal permanent residents in the PRA—by claiming the restriction was actually authorized by federal law.²⁷⁹ Although the Court rejected this argument and treated the statute as Arizona's, it stated in dicta that if the federal statute were “to be read so as to authorize discriminatory treatment of aliens at the option of the States, *Takahashi* [*v. Fish & Game Commission*] demonstrates that *serious constitutional questions are presented*.”²⁸⁰ The Court forcefully concluded that “Congress does not have the power to authorize the individual States to violate the Equal Protection Clause.”²⁸¹ This unanimous opinion suggests that the PRA's authorization of alienage classification by the states does not alter the level of scrutiny applied to a state-funded program.²⁸² Therefore, the legal immigrants residing in Massachusetts and New Jersey who challenged their termination from state-funded health insurance programs may rely on *Graham*.²⁸³ Relying on *Graham*, the state high courts should apply strict scrutiny review to each state's actions, and should therefore invalidate the legislation.²⁸⁴

²⁷⁵ See *infra* notes 277–316 and accompanying text.

²⁷⁶ See Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25.

²⁷⁷ See 403 U.S. at 382.

²⁷⁸ See *id.*

²⁷⁹ See *id.* at 380.

²⁸⁰ *Id.* at 382 (emphasis added) (citing *Takahashi v. Fish & Game Comm'n*, 334 U.S. 410, 418–19 (1948)). The case referenced in the dicta invalidated a federally authorized state statute that discriminated against noncitizens in the issuance of fishing licenses. See *Takahashi*, 334 U.S. at 418–19.

²⁸¹ See *Graham*, 403 U.S. at 382.

²⁸² See *id.*; Massachusetts Complaint, *supra* note 10, at 13; New Jersey Complaint, *supra* note 23, at 25.

²⁸³ See *Graham*, 403 U.S. at 382; Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25.

²⁸⁴ See *Graham*, 403 U.S. at 382; Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25.

Following *Graham*, the Supreme Court created exceptions to the general rule that state alienage classifications are unconstitutional. In *Sugarman v. Dougall*, decided in 1973, the Court recognized that an individual state's ability to establish and maintain its own representative government constituted a compelling governmental interest, but that this compelling interest must be narrowly construed.²⁸⁵ Articulating the exception, the Court drew a sharp distinction between state restrictions that serve a political function and those that serve an economic function, holding that the latter does not serve a compelling governmental interest.²⁸⁶ Clearly, a state-funded health insurance program is an economic benefit and therefore remains at the core of *Graham*'s strict scrutiny standard of review.²⁸⁷

Moreover, the PRA's delegation of federal plenary power over immigration violates the separation of powers doctrine.²⁸⁸ In the PRA, Congress declares that states adopting the federal immigration restrictions in state-funded benefits programs will satisfy the strict scrutiny standard of review.²⁸⁹ The Court, however, not the legislature, is entrusted both with defining the scope of the rights guaranteed under the Fourteenth Amendment and with determining whether a particular law violates those rights.²⁹⁰

In 1997, in *City of Boerne v. Flores*, the Court held that Congress exceeded its legislative authority when it statutorily proscribed a strict scrutiny standard of review for challenges brought by plaintiffs asserting that a state law burdened their religious practice.²⁹¹ Although in *City of Boerne* Congress expanded individuals' protection vis-à-vis the states, whereas the PRA attempts to insulate state legislation from judicial review, the same separation of powers principles articulated by the

²⁸⁵ 413 U.S. 634, 639, 647–48 (1973) (rejecting New York civil service statute that excluded noncitizens as overly broad and not directly related to political function); *cf.* *Cabell v. Chavez-Salido*, 454 U.S. 432, 439 (1982) (carving out a “public service exception” to general strict scrutiny review for police officers).

²⁸⁶ *See Sugarman*, 413 U.S. at 647–48; *cf.* *Cabell*, 454 U.S. at 439.

²⁸⁷ *See Graham*, 413 U.S. at 647–48; *Graham*, 403 U.S. at 382.

²⁸⁸ *See* Roger C. Hartley, *Congressional Devolution of Immigration Policymaking: A Separation of Powers Critique*, 2 DUKE J. CONST. L. & PUB. POL'Y 93, 94–95 (2007) (detailing the constitutional problems with the PRA from a separation of powers perspective); *see also* New Jersey Complaint, *supra* note 23, at 26 (alleging that the state's action violates the separation of powers doctrine).

²⁸⁹ *See* 8 U.S.C. § 1601(7) (2006).

²⁹⁰ *See* *Marbury v. Madison*, 5 U.S. 137, 177 (1803) (“It is emphatically the province and duty of the judicial department to say what the law is.”).

²⁹¹ 521 U.S. at 515–16 (requiring the government to demonstrate that a substantial religious burden is the least restrictive means of furthering a compelling governmental interest).

Court apply to both laws.²⁹² In *City of Boerne*, the Court rejected the notion that Congress has the power to decree the substance of the Fourteenth Amendment's restrictions on the states.²⁹³ The decision thus suggests that Massachusetts and New Jersey cannot invoke the rational basis standard of review pursuant to section 1607 of the PRA: the Court has already held that Congress violates separation of powers principles when it prescribes the standard of review for equal protection challenges to state action.²⁹⁴

2. Post-PRA Cases Suggest that the Massachusetts and New Jersey Courts Cannot Survive an Equal Protection Challenge

Although post-PRA case law is not extensive, the precedent set by various state and federal courts suggests that the Massachusetts and New Jersey courts should invalidate the state's recent alienage restrictions.²⁹⁵ Following enactment of the PRA, states promulgated new regulations that incorporate mandatory immigration restrictions into their jointly funded federal-state programs.²⁹⁶ The outcome of an equal protection challenge in this area generally hinges on how the court classifies the challenged law: if the law is construed as an administrative rule that simply codifies the federal requirements, the court will generally apply a rational basis standard of review and affirm the regulations as an extension of the federal plenary immigration power.²⁹⁷ When a regulation complies with federal guidelines, it is in furtherance of the plenary power rationale for preserving uniformity in the administration of federal government benefits.²⁹⁸ In 1999, in *Cid v. South Dakota Department of Social Services*, the South Dakota Supreme Court considered a challenge to the state's administrative rules implementing the five-year bar in Medicaid, Temporary Assistance to Needy Families, and

²⁹² See *id.* at 519. The fact that the PRA insulates state alienage discrimination from judicial review creates a more compelling need for strict scrutiny. See *Graham*, 403 U.S. at 382. The legislation at issue in *City of Boerne* expanded the rights of a discrete and insular minority, whereas the PRA constricts those rights. Compare 8 U.S.C. § 1601(7), with *City of Boerne*, 521 U.S. at 515–16.

²⁹³ See *City of Boerne*, 521 U.S. at 519.

²⁹⁴ See *id.*

²⁹⁵ See Massachusetts Complaint, *supra* note 10, at 1; New Jersey Complaint, *supra* note 23, at 25; *infra* notes 305–316 and accompanying text.

²⁹⁶ See 8 U.S.C. §§ 1621(d), 1622(a) (creating state-administered block grants, and thus requiring states to promulgate new regulations to administer the jointly funded programs).

²⁹⁷ See *infra* notes 317–324 and accompanying text.

²⁹⁸ See *Mathews*, 426 U.S. at 80–81.

food stamp programs.²⁹⁹ In affirming the regulation, the court distinguished South Dakota's administrative rule from the state statute at issue in *Graham*.³⁰⁰ The court upheld the rule because it merely implemented the PRA's mandatory restrictions on jointly administered state-federal programs.³⁰¹ Additional challenges to state-enacted administrative rules have similarly been upheld in other states under a rational basis standard of review.³⁰² But state-funded healthcare restrictions, like those in Massachusetts and New Jersey, do not implement mandatory, uniform federal guidelines and do not comply with a mandatory provision for receiving federal funding.³⁰³ Instead, these restrictions were wholly created by the state legislatures.³⁰⁴

This distinction is important because although a state's compliance with mandatory federal guidelines invokes rational basis review, the courts regard independent state legislation differently.³⁰⁵ State regulations applying section 1621 of the PRA (permitting adoption of the federal guidelines in state-funded benefits programs) are generally invalidated by the courts.³⁰⁶ The *Graham* Court's proclamation that "Congress does not have the power to authorize the individual states to violate the Equal Protection Clause" has survived the PRA.³⁰⁷ In 2001 in *Aliessa ex rel. Fayad v. Novello*, for example, the New York Court of Appeals invalidated the state's restrictions on legal immigrants' access to benefits programs.³⁰⁸ Following the PRA, New York amended eligibility requirements for its state-funded Medicaid program, mirroring the restrictions in the jointly funded Medicaid program.³⁰⁹ Like Commonwealth Care and FamilyCare, the state-funded Medicaid program was designed to supplement federal-state Medicaid coverage, and, also like

²⁹⁹ See 598 N.W.2d 887, 891 (S.D. 1999).

³⁰⁰ See *id.* at 892.

³⁰¹ See *id.*

³⁰² See *Lewis v. Thompson*, 252 F.3d 567, 583 (2d Cir. 2001); *City of Chicago v. Shalala*, 189 F.3d 598, 604–05 (7th Cir. 1999); *Abreu v. Callahan*, 971 F. Supp. 799, 807–08 (S.D.N.Y. 1997); *Cid*, 598 N.W.2d at 891–92.

³⁰³ See Press Release, Health Law Advocates, HealthCare Advocacy Group Health Law Advocates Challenges Law Excluding Legal Immigrants from HealthCare 2 (Feb. 25, 2010) (on file with author) ("The federal government never said Massachusetts had to create this program and never said immigrants must be excluded from it.").

³⁰⁴ See Act of Aug. 7, 2009, 2009 Mass. Acts 695; N.J. ADMIN. CODE § 10:78-3.2(e)(1) (2010).

³⁰⁵ See *Ehrlich v. Perez*, 908 A.2d 1220, 1233 (Md. 2006); *Aliessa ex rel. Fayad v. Novello*, 754 N.E.2d 1085, 1096 (N.Y. 2001).

³⁰⁶ See *infra* notes 308–316 and accompanying text.

³⁰⁷ See 403 U.S. at 382.

³⁰⁸ See 754 N.E.2d at 1098.

³⁰⁹ See *id.*

Commonwealth Care and FamilyCare, New York provided benefits for both immigrants and citizens under its supplemental program.³¹⁰ The state defendants had argued that the supplemental program mirrored the PRA eligibility restrictions and served as an extension of federal legislation, and was therefore within the purview of the federal plenary immigration power.³¹¹ The New York Court of Appeals relied on *Graham* to reject this argument.³¹² It reasoned that the federal government, in granting the states sole discretion to determine eligibility guidelines for state-funded benefits programs, is not implementing uniform immigration laws.³¹³ Although the PRA encourages states to mirror the federal eligibility requirements in their respective state programs, it cannot delegate its plenary power to independent state legislation.³¹⁴ Subsequently, the Maryland Court of Appeals invalidated legislation that imposed a five-year bar in its state-funded Medicaid program.³¹⁵ The court rejected the state defendant's claims that the restrictions mirrored and were authorized by the PRA and instead adopted the *Aliessa* court's reasoning.³¹⁶

Colorado, like Massachusetts and New Jersey, dealt with its budget crisis by targeting noncitizens for healthcare cuts.³¹⁷ The legislature, in accordance with PRA, enacted restrictions that exceeded the suggested federal guidelines.³¹⁸ In 2004, in *Soskin v. Reinertson*, the U.S. Court of Appeals for the Tenth Circuit upheld the cuts, holding that *Graham* did not apply in the specific situation.³¹⁹ The court reasoned that, because the PRA permits only a small window of variation for states to determine immigrant eligibility for jointly funded state-federal Medicaid, the PRA does not delegate any immigration power to the states.³²⁰ Still, the *Soskin* holding does not implicate the Massachusetts legislature's alienage classification because the holding applies only to the jointly

³¹⁰ *See id.*

³¹¹ *See id.*

³¹² *See id.* at 1097.

³¹³ *See id.* (quoting *Graham*, 403 U.S. at 382 (“[A] congressional enactment construed so as to permit state legislatures to adopt divergent laws on the subject of citizenship requirements for federally supported welfare programs would appear to contravene [the] explicit constitutional requirement of uniformity.”)).

³¹⁴ *See Aliessa*, 754 N.E.2d at 1098.

³¹⁵ *See Ehrlich*, 908 A.2d at 1233.

³¹⁶ *See id.*

³¹⁷ *See Soskin v. Reinertson*, 353 F.3d 1242, 1244 (10th Cir. 2004).

³¹⁸ *See id.*

³¹⁹ *See id.* at 1255.

³²⁰ *See id.*

funded state-federal Medicaid program.³²¹ Notwithstanding the criticism surrounding the *Soskin* court's analysis,³²² the holding does not apply to the Massachusetts and New Jersey restrictions. The PRA sets no mandatory guidelines that states must follow in running state-funded healthcare programs.³²³ Massachusetts and New Jersey, unlike Colorado, are not operating within a limited window of discretion but are legislating independently of a federal classification scheme.³²⁴

Finally, denying legal immigrants, who constitute a discrete and insular minority, a strict scrutiny standard of review contravenes the equality principles underlying the Fourteenth Amendment.³²⁵ For over a century, the U.S. Supreme Court has maintained that the Equal Protection Clause ensures that "all persons residing lawfully in this country shall abide in any state on an equality of legal privileges with all citizens under nondiscriminatory laws."³²⁶ Discrimination against lawful immigrants is no less invidious than other forms of discrimination prohibited by the Fourteenth Amendment.³²⁷ The federal government is vested with a plenary immigration power, arguably, because the need to protect national security, enact sensible foreign affairs policy, and ensure uniformity in the admission, exclusion and naturalization of immigrants outweighs the effects of the resulting discrimination.³²⁸ Extending this power to the individual states, which possess no national security, foreign affairs, or immigration lawmaking power, would ignore over a century of equal protection jurisprudence that prohibits dis-

³²¹ See *id.*

³²² See Michael Shapland, Comment, *Soskin v. Reinertson: An Analysis of the Tenth Circuit's Decision to Permit the State of Colorado to Withhold Medicaid Benefits from Aliens Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act*, 2 SETON HALL CIRCUIT REV. 339, 340 (2005) (arguing that the court's analysis is inconsistent with the nature of the federal immigration power and diverges from established jurisprudence on the subject).

³²³ See 8 U.S.C. § 1622(a) (2006).

³²⁴ Compare *Soskin*, 353 F.3d at 1255 (finding that states legislating in accordance with PRA guidelines in a jointly funded state-federal program do not contravene the plenary power rationale of uniformity), with *Aliessa*, 754 N.E.2d at 1098 (holding that state-funded programs that adopt the PRA guidelines are not furthering the goal of national uniformity inherent in the plenary power doctrine).

³²⁵ See Wishnie, *supra* note 90, at 504 ("Anti-immigrant discrimination has long been at the heart of equal protection jurisprudence.")

³²⁶ See *Yick Wo v. Hopkins*, 118 U.S. 356, 369 (1886) (holding that a facially neutral laundry licensing scheme that disparately impacted immigrants violated equal protection).

³²⁷ See *id.* at 369–70.

³²⁸ See Wishnie, *supra* note 90, at 499 n.31 (observing that the plenary power is granted to the federal government out of necessity); *supra* notes 127–154 (outlining the justifications for the plenary power doctrine).

criminating against lawful immigrants.³²⁹ In Massachusetts, lawful immigrants are foreclosed from a program supported by their tax dollars and yet are legally mandated to purchase market-rate private health insurance or face significant tax penalties.³³⁰ Insulating discrimination that targets a politically vulnerable minority from judicial review offends the principles of equality enshrined in the Constitution.³³¹

B. *Restricting Legal Immigrants' Access to State-Funded Health Insurance Is Detrimental to Immigrants and Citizens Alike*

When state-funded healthcare programs restrict access to noncitizens, both immigrants and citizens suffer adverse consequences.³³² From an economic perspective, the shifting of costs from subsidized, preventive care to emergency-room treatment increases medical costs and exacerbates state budget deficits.³³³ From a social policy perspective, restricting noncitizens' healthcare access decreases participation in government programs that are vital to the public interest.³³⁴

Irrespective of the restrictions enacted in the PRA and by individual states, EMTALA requires that all hospitals treat medical emergencies regardless of a patient's immigration status.³³⁵ Therefore, legal immigrants without access to preventive care will still be treated at emergency rooms, but at a significantly higher cost.³³⁶ Statistically, treating illnesses with preventive care results in significant cost savings and vastly improves chances of recovery and reduction of severe symptoms.³³⁷ According to the Director of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, restricting healthcare subsidies means that "we are already paying a substantial amount to care for a large uninsured population without any guarantee of coverage," and "we pay for care in the least efficient way possible—after peo-

³²⁹ See *Graham*, 403 U.S. at 372.

³³⁰ See Act of Aug. 7, 2009, 2009 Mass. Acts 695 (excluding most legal immigrants from state health coverage); An Act Providing Access to Affordable, Quality and Accountable Healthcare, 2006 Mass. Acts 129–30 (subjecting all residents of the commonwealth to the individual mandate, and assessing tax penalties for noncompliance).

³³¹ See Wishnie, *supra* note 90, at 504.

³³² See *infra* notes 333–346 and accompanying text.

³³³ See *infra* notes 334–341 and accompanying text.

³³⁴ See *infra* notes 342–346 and accompanying text.

³³⁵ See 42 U.S.C. § 1395dd(a) (2006).

³³⁶ See NATIONAL IMMIGRATION LAW CENTER, *supra* note 234, at 2 (finding that denying immigrants preventive care and relying on emergency room treatment is the least cost-effective strategy).

³³⁷ *Id.* For example, diabetes, which disproportionately affects immigrant communities, has devastating consequences if left untreated. *Id.*

ple get sick and need emergency or hospital care.”³³⁸ Imposing a five-year bar on legal permanent residents is the most fiscally damaging for at least two reasons: first, legal permanent residents are “citizens in waiting”, and the vast majority will naturalize.³³⁹ Second, even if legal permanent residents do not naturalize, they become eligible for federal health programs after five years.³⁴⁰ The five-year bar “hits immigrants at their worst, and most inappropriate time” in the United States, as they are statistically least likely when they first arrive to have employer-sponsored coverage, and tend to earn less than more established immigrants.³⁴¹

Furthermore, restricting lawful immigrants from state-funded healthcare discourages participation in government programs that are vital to the public interest.³⁴² Immigrants who cannot qualify for certain government benefits are less likely to participate in programs for which they are eligible under the PRA: immunizations, crisis intervention, emergency shelter, and disaster relief.³⁴³ Also, many immigrants live in “mixed households,” containing both citizens and noncitizens.³⁴⁴ Particularly common are households containing noncitizen adults and citizen children, and these children are adversely affected by their parents’ lack of access to medical care.³⁴⁵ Noncitizen parents are also less likely to enroll their citizen children, who are fully eligible for all government healthcare programs, out of fear and confusion over potential immigration consequences for utilization of public benefits.³⁴⁶

CONCLUSION

The decisions of Massachusetts and New Jersey to terminate legal immigrants from their state-funded healthcare programs violate the Equal Protection Clause and represent bad public policy. Courts con-

³³⁸ See *id.* (internal quotation marks omitted).

³³⁹ See IMMIGRATION POLICY CTR., *supra* note 234, at 1 (citing statistic that between 2006 and 2008, over two million legal permanent residents became U.S. citizens).

³⁴⁰ See 8 U.S.C. § 1613(a) (2006) (stating that legal permanent residents are eligible for benefits five years after becoming qualified aliens).

³⁴¹ See NAT’L IMMIGRATION LAW CTR., IMPROVING IMMIGRANT ACCESS TO AFFORDABLE HEALTH COVERAGE: ANALYSIS OF THE MASSACHUSETTS HEALTH CARE SYSTEM AS A MODEL 2 (2009), available at <http://www.nilc.org/immspbs/health/MA-health-reform-2009-05-26.pdf>.

³⁴² See *infra* notes 343–346 and accompanying text.

³⁴³ See 8 U.S.C. § 1621(b) (2006); NATIONAL IMMIGRATION LAW CENTER, *supra* note 234, at 1.

³⁴⁴ See IMMIGRATION POLICY CENTER, *supra* note 234, at 1.

³⁴⁵ See *id.*

³⁴⁶ See *id.*

tinue to be bound by *Graham v. Richardson* following the enactment of the PRA, and must subject a state's alienage classification to strict scrutiny review. Furthermore, a state cannot justify its decision to discriminate against legal immigrants by citing the scarcity of fiscal resources. For these reasons, the Massachusetts and New Jersey high courts should strike these restrictions on legal immigrants. Federal healthcare reform, though ambitious in scope, adopts the PRA's restrictive immigration criteria and excludes most legal immigrants from Medicaid, subsidies, and tax credits. As a result, state-funded healthcare programs persist as the only option for legal immigrants who cannot afford the high cost of private health insurance. By providing cost-effective preventive care to legal immigrants, states both respect the constitutional rights of these "citizens in waiting," and reduce the large deficits created by the EM-TALA mandate. As more states compensate for the discrepancies in national reform by expanding their state-funded healthcare programs, they must be mindful of the legal and policy ramifications resulting from any potential exclusion of legal immigrants.

ANNA C. TAVIS