“Healthcare for All”? The Gap Between Rhetoric and Reality in the Affordable Care Act

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ABSTRACT

The rhetoric of universal healthcare and healthcare for all that pervaded the healthcare debate culminated in the Affordable Care Act’s (ACA’s) passage. The ACA, however offers reduced to no healthcare services for certain noncitizen groups, specifically: (1) recently arrived legal permanent residents, (2) nonimmigrants, and (3) undocumented immigrants. This Article explores how the ACA fails to ensure healthcare for all. Specifically, the Essay demonstrates the gap between rhetoric and reality by parsing the ACA’s legislative history, and posits reasons for the gap. The ACA’s legislative history suggests that legislators’ biases towards these noncitizen groups, particularly with respect to the idea that they are not “American,” may explain why the ACA fell short of its goal of healthcare for all. The Essay also offers suggestions on how healthcare advocates for these noncitizen groups may use this understanding of the gap to prevail on their agenda.

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INTRODUCTION

According to its proponents, the passage of the Affordable Care Act (ACA)\(^1\) “enshrined . . . the core principle that everybody should have some basic security when it comes to their health care.”\(^2\) However, the ACA does not ensure healthcare coverage for many groups. Indeed, projections indicate that 27 million uninsured Americans will remain even after enactment of all of the ACA’s provisions.\(^3\) Most sizeable among these groups are certain classes of noncitizens, including but not limited to undocumented immigrants.

Why does the statutory reality differ from the lofty, expansive language used by the ACA’s proponents in Congress and the White House, especially with respect to noncitizens? A parsing of the ACA’s legislative history, particularly the congressional floor debates over the bill, reveals two possible answers. Both answers are instructive to advocates hoping to extend access to health insurance coverage to all noncitizen groups. First, at least some legislators implicitly qualify the notion of healthcare for all with the requirement that beneficiaries of the law must pay taxes. Second, at least some legislators seem to exclude certain noncitizen groups from their definition of “Americans,” which is used interchangeably with the terms “everybody” or “all” throughout the legislative history of the ACA.

Part I of this Essay examines the ACA’s statutory and accompanying regulatory language, identifying three noncitizen groups that receive reduced or no protections under the law: (1) recently arrived legal immigrants; (2) noncitizens present under temporary nonimmigrant visas, known as nonimmigrants; and (3) undocumented immigrants. Part II explores the legislative

\(^1\) For the purposes of this Essay, the ACA also refers to the Health Care and Education Reconciliation Act of 2010, which was passed a week later to amend portions of the Patient Protection and Affordable Care Act. See Pub. L. No. 111-152, 124 Stat. 1029 (2010).


history of the ACA and the idealistic statements repeatedly made by legislators about the idea of healthcare for all. It identifies similar statements made by proponents of previous versions of healthcare reform during prior presidential administrations, suggesting a historical pattern of disconnect.

Part III concludes that implicit normative and economic arguments legislators made against the expansion of healthcare coverage to these excluded groups, particularly the undocumented, offer a partial explanation for the gap between the rhetoric and reality of the ACA. It also critiques these arguments and offers suggestions to advocates for expanded healthcare coverage in overcoming these implicit arguments against true healthcare for all.

I. THE AFFORDABLE CARE ACT AND EXCLUSION OF CERTAIN NONCITIZEN GROUPS

This Part distills a general outline of the ACA’s contours before analyzing how recent legal immigrants, legal nonimmigrants, and undocumented immigrants are not protected under the new legislation. The ACA is both voluminous and complex, clocking in at nearly 1000 pages and containing various provisions that will not go into effect until later this decade. Multiple constitutional and political challenges to the ACA, the most significant of which the U.S. Supreme Court resolved only in June of 2012, slowed down the states’ implementation of the bill. Further, the U.S. Department of Health and Human Services is still promulgating regulations in accordance with the statute’s decrees more than two years after the bill’s passage. All of this uncertainty over the ACA makes it difficult to analyze the ACA with a high degree of specificity. However, even a general summary of the law demonstrates the notable absence of the three groups identified above from all of the ACA benefits.

7. See, e.g., Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 33,233 (June 4, 2013) (to be codified at 45 C.F.R. pts. 155–156).
A. General Outline of the ACA

A brief political history of the ACA provides context for the mechanics of the ACA. President Obama campaigned on the promise of healthcare reform and made the issue a legislative priority when he assumed office in 2009.8 The ACA was first introduced in the U.S. House of Representatives in October of 20099 and signed into law in March of 2010.10 The ACA passed both chambers of Congress with largely Democratic support; at the time, Democrats controlled both the House and the Senate.11

The ACA contains multiple components aimed at expanding healthcare coverage for Americans. The primary components are: (1) the insurance mandate, also known as the individual mandate; (2) state-run individual health exchanges; (3) federally run high risk pools; (4) premium credits and cost-sharing subsidies; and (5) expanded Medicaid coverage for families earning up to 133 percent of the federal poverty line (FPL).12

A broad overview of these components will suffice for the purposes of this Essay. The individual mandate requires all citizens to purchase health insurance or pay a penalty.13 Individual health exchanges are intended to be state-run marketplaces in which individuals may select private, federally subsidized health insurance plans.14 High-risk pools are temporary federal health exchanges that will cease in 2014 when states begin running their own health exchanges.15 Premium credits and cost-sharing subsidies allow individuals making up to 400 percent of the FPL to receive either (1) tax credits for their insurance premiums if they purchase healthcare plans outside of the health exchanges or (2) federal subsidies if they purchase plans within the exchanges.16 These credits and subsidies

11. See id.
13. See Liptak, supra note 5.
15. Originally, state-run exchanges were slated to begin running on January 1, 2014; however, delays have ensued due to constitutional uncertainty surrounding the Act and recalcitrance on the part of some states. The federal government will run exchanges in any states that are unwilling or unable to run their own exchanges. Id.
are calculated according to a sliding scale. Finally, the ACA expanded Medicaid from a program that only served certain groups such as poor children, parents, and pregnant women to one that serves all eligible individuals who earn up to 133 percent of the FPL. It did so by threatening to withhold federal Medicaid payments to states that refused to expand their Medicaid coverage according to the ACA.

Critics of the ACA challenged its constitutionality, and the U.S. Supreme Court ruled in June 2012 that the ACA’s individual mandate was lawful under Congress’s taxing and spending power. The Court, however, viewed Congress’s threat to withhold Medicaid funding from states that failed to expand the program to eligible individuals making up to 133 percent of the FPL as coercive. The Court struck down the ACA’s Medicaid expansion enforcement mechanism, holding that such coercive action exceeded the scope of Congress’s spending powers.

B. Reduced Protections for Recently Arrived Legal Immigrants

One aspect of our healthcare system the ACA does not change was the noncitizen eligibility requirements for the Medicaid program. Under President Clinton’s 1996 welfare reform law, most legal permanent residents (LPRs) must wait for five years after they establish residence until they are eligible to receive Medicaid benefits. Refugees and asylees must generally wait seven years to become eligible. Some states provide limited exceptions for pregnant women

17. Id. at 1916.
18. Id. at 1920.
20. Liptak, supra note 5.
21. John Elwood, What Did the Court “Hold” About the Commerce Clause and Medicaid?, VOLOKH CONSPIRACY (July 2, 2012, 11:28 AM), http://www.volokh.com/2012/07/02/what-did-the-court-hold-about-the-commerce-clause-and-medicaid. States may now choose whether to expand Medicaid coverage without incurring a loss of federal Medicaid funding if they choose not to expand. Pear, supra note 19. If they do choose to expand, they may seek the ACA’s additional funding for the expansion. Id.
22. Id.
24. Id. at 112–13.
and children.26 While recently arrived LPRs, nonimmigrants, and undocumented immigrants may avail themselves of the federal emergency Medicaid program for immediate and severe medical emergencies, they are unable to access preventative and nonemergency care under this program.27

Because the ACA left the five- and seven-year bars to Medicaid unchanged and because all lawfully residing U.S. residents are subject to the individual mandate,28 low-income and recently arrived LPRs must search for health insurance on the private market or through health exchanges, regardless of whether their states expand Medicaid coverage under the ACA. While these immigrants may be eligible for premium tax credits and cost-sharing subsidies, those making less than 133 percent of the FPL bear significantly higher financial burdens in complying with the individual mandate than U.S. citizens and LPRs who are eligible to receive Medicaid. This is especially unfortunate given that newly arrived LPRs “are statistically the least likely to have employer provided coverage and tend to earn less than citizens or immigrants [who] have been in the country for longer periods of time.”29

Moreover, the ACA reduces federal funding for immigration status–blind emergency medical treatment, which negatively impacts the ability of non-Medicaid eligible legal permanent residents to access emergency healthcare particularly in geographic areas with high concentrations of recently arrived LPRs, nonimmigrants, and undocumented immigrants.30 The cuts also burden emergency rooms (ERs), which are required to treat all patients regardless of immigration status and ability to pay, because poor individuals without access to Medicaid must use ERs for healthcare as a last resort.31

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26. Guerrero, supra note 23, at 115 (“Emergency Medicaid covers the costs of emergency medical treatment through the Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, which requires 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.”).

27. See Mee Moua et al., Immigrant Health: Legal Tools/Legal Barriers, 30 J.L. MED. & ETHICS 189, 192 (2002).


29. Guerrero, supra note 23, at 115–16 (footnote omitted).


C. Reduced Protections for Legal Nonimmigrants

The ACA also fails to offer full protections to the nearly two million nonimmigrant residents in the United States. Nonimmigrants, who are present in the country on temporary visas and include university students, skilled and unskilled laborers recruited by U.S. employers, and family members of U.S. citizens or lawful permanent residents, are often a forgotten group. Yet many of these individuals lawfully reside in this country for up to several years. Many of them undoubtedly require access to healthcare at some point during their time here.

The ACA is perhaps at its murkiest when attempting to determine the extent to which nonimmigrants benefit from the legislation. Moreover, very few policy analysts have elucidated the ACA’s impact on nonimmigrants, further exhibiting how this group is often ignored. It is still unclear, for example, which portions of this group are subject to the insurance mandate. On the other hand, nonimmigrants who have not overstayed their visas are considered “lawfully present,” which is a requirement for participation in high-risk pools and health exchanges.

What is clear, however, is that the ACA does not change federal Medicaid access requirements for nonimmigrants. Under the 1996 welfare reform law, nearly all nonimmigrants are ineligible for Medicaid coverage, among other federal benefits. The ACA’s cuts to federal funding for emergency medical treatment irrespective of immigration status will presumably negatively affect nonimmigrants, and emergency rooms, particularly if this group is not eligible for premium tax credits, participation in health exchanges, and cost-sharing subsidies available to recently arrived LPRs.

34. Id. at 2287.
37. SISKIN, supra note 28, at 7–8.
39. See Diamond, supra note 30, at 275–78.
D. Reduced Protections for Undocumented Immigrants

Finally, the estimated eleven million undocumented immigrants in this
country are specifically excluded from virtually all of the ACA’s protections
As one commentator summarizes:

Congress took pains to clarify that health reform will not help those
who are not lawfully present. . . . [T]he Affordable Care Act explicitly
prohibits those who are not “lawfully present” from (1) accessing
temporary high-risk pools for those with preexisting conditions; (2)
enrolling in special state-created plans for low-income individuals not
eligible for Medicaid; (3) enrolling in new health care cooperatives; (4)
receiving cost-sharing subsidies or premium tax credits to purchase
health insurance; and (5) purchasing policies in the newly created
exchanges, even without the benefit of government subsidies or
credits.

No other group’s exclusion from the ACA’s protections is so complete. The
law does not even spare those granted deferred action under President Obama’s
high-profile directive this spring to protect many immigrants who arrived in the
United States without papers as minors from being denied access to healthcare.

Undocumented immigrants will make up approximately one-third of the
estimated 27 million Americans who will remain uninsured after the ACA takes
full effect.

While the ACA did not make lawful immigration status a requirement to
access Emergency Medicaid, the ACA’s cuts in funding for that program impact
undocumented immigrants more than the other groups. Unlike recently
arrived LPRs and nonimmigrants, undocumented immigrants are not eligible for
any of the ACA’s alternative means of obtaining health insurance and are thus
more dependent on emergency healthcare. Further, a majority of the approxi-
mately $5 billion per year in uncompensated emergency healthcare costs are

40. Id. at 277.
41. Cortez, supra note 35, at 870 (footnotes omitted).
42. See Sarah Kliff & Ezra Klein, Individual Mandate 101: What It Is, and Why It Matters, WASH.
43. The U.S. Department of Health and Human Services recently issued a rule clarifying that
individuals granted deferred action were not considered “lawfully present” under the law. Robert
Pear, Limits Placed on Immigrants in Health Care Law, N.Y. TIMES, Sept. 17, 2012,
law.html.
44. Maggie Mertens, Health Care for All Leaves 23 Million Uninsured, NPR (Mar. 24, 2010, 10:37
45. See supra notes 30, 38, and accompanying text.
mostly generated by undocumented immigrants. This number and proportion is likely to rise as Emergency Medicaid funding decreases, as the undocumented immigrant population ages, and as the majority of the undocumented remain without access to health insurance.46

II. LEGISLATIVE HISTORY OF AND RHETORIC SURROUNDING THE AFFORDABLE CARE ACT

The ACA deliberately refrained from extending full access to healthcare for recently arrived LPRs and nonimmigrants. The ACA also excluded undocumented immigrants from all, or virtually all, of its protections. Yet, as this Part demonstrates, the ACA’s statutory realities appear to belie the expansive language used by the ACA’s advocates, who repeatedly defended the idea of healthcare access to “everyone” or “all Americans” in the sponsor statements, floor debates, and signing statements associated with the bill.47 This trend is a continuation of history, as policymakers who pushed previous iterations of healthcare reform during previous presidential administrations also employed universal language in publicizing their efforts. Yet policymakers did not include groups like the undocumented in their policy proposals. The result is an apparent, longstanding tension between the ideas of healthcare for all and healthcare for noncitizens.

A. The Legislative History of the ACA

The House of Representatives took up a version of what would ultimately become the ACA in October of 2009.48 House Speaker Nancy Pelosi presented the bill to the public along with eight other Congressmen, including House Majority Leader Steny Hoyer and the bill’s principal sponsor, John Dingell.49 All

49. Id.
of the Congressmen who spoke at the presentation interchangeably stated that the bill embodied the idea that “all Americans,” “all,” or “everyone” deserved access to healthcare. Moreover, Representative Dingell made mention of the 47 million uninsured Americans at the time, a number that includes the undocumented.

In floor debates over the bill, the conflict between healthcare for all and healthcare for noncitizens becomes apparent. Proponents of the bill were adamant: The legislation would extend healthcare coverage to nearly all “Americans” or “everyone,” filling an important hole in the nation’s social safety net. One of the chief arguments made by the bill’s opponents, however, was that undocumented immigrants might benefit from the bill. The bill’s supporters emphatically responded, and the statutory language of the ACA cor-

50. See, e.g., id. ("[W]e're here at a historic time, when for over half a century a family elected by their citizens to come to this Congress have raised the banner of health care for all that they could afford.") (statement of Rep. Steny Hoyer); id. ("[I]t is clear that Congress needs to make reforms to expand health care coverage so that everyone in this great Nation has health insurance.") (statement of Rep. Diaz-Balart); id. at H12,614 ("Six principles have guided my work and determined my vote on this legislation: health insurance reform must create stability, contain costs, guarantee choice, improve quality, cover everyone, and include a strong public option. The Affordable Health Care for America Act delivers on each of these principles.") (statement of Rep. Heinrich).


52. E.g., 155 CONG. REC. H12,623, H12,844 (daily ed. Nov. 7, 2009) ("[T]his will do for America what we should have done 100 years ago: provide health care for all Americans as a matter of right, not as a matter of privilege.") (statement of Rep. Frank); 155 CONG. REC. H12,598, H12,611 (daily ed. Nov. 7, 2009) ("[H]ealth insurance reform must create stability, contain costs, guarantee choice, improve quality, cover everyone, and include a strong public option. The Affordable Health Care for America Act delivers on each of these principles.") (statement of Rep. Heinrich).

53. E.g., 155 CONG. REC. H12,623, H12,844 (daily ed. Nov. 7, 2009) ("[W]e are creating a new health insurance marketplace and requiring everyone to have coverage, which I support.") (statement of Rep. Frank); 155 CONG. REC. H12,598, H12,611 (daily ed. Nov. 7, 2009) ("[I]t is clear that Congress needs to make reforms to expand health care coverage so that everyone in this great Nation has health insurance.") (statement of Rep. Diaz-Balart); id. at H12,614 ("Six principles have guided my work and determined my vote on this legislation: health insurance reform must create stability, contain costs, guarantee choice, improve quality, cover everyone, and include a strong public option. The Affordable Health Care for America Act delivers on each of these principles.") (statement of Rep. Heinrich).

54. 155 CONG. REC. H12,623, H12,851 (daily ed. Nov. 7, 2009) ("This bill cuts healthcare for our seniors by hundreds of billions of dollars while providing subsidized health care of illegal immigrants, which will draw more illegals into our country.") (statement of Rep. Rohrabacher); id. at H12,870 ("As if that wasn’t enough, the bill opens the floodgates of taxpayer money for illegal immigrants to abuse the system and obtain free government health insurance—all on the backs of law-abiding Americans.") (statement of Rep. Rogers).
robates, that no additional protections were extended to the undocumented under the bill.\footnote{Representative Holt stated,} Another myth is that health reform would provide federal benefits for undocumented aliens. Undocumented immigrants currently may not receive any federal benefits except in specific emergency medical situations. There are no provisions in the House health reform bill that would change this policy. In fact, the legislation explicitly states that federal funds for insurance would not be available to any individual who is not lawfully present in the United States.\footnote{Id. at H12,876 (statement of Rep. Holt).}

Representative Louise Slaughter’s seemingly contradictory statements are indicative of this paradox. Representative Slaughter called up the bill for a vote and in her remarks stated:

Mr. Speaker, this is a wonderful, exciting day for us and the culmination of nearly 100 years of work that we will join the community of nations that believe that the people who live within them are deserving of decent health care, all of them, regardless of their financial situation.\footnote{155 CONG. REC. H12,598, H12,620 (daily ed. Nov. 7, 2009) (emphasis added).}

Earlier that very day during the same floor debates, however, she answered Representative Poe’s claim that the bill would benefit illegal immigrants with the retort, “[T]hat’s not the way it is. There are no illegal aliens in this bill who get anything at all.”\footnote{Id. at H12,615.}

The legislative history of the bill is less clear, however, about the reasons for offering diminished protection to newly arrived LPRs and nonimmigrants. Only one congressman made a floor statement about the plight of newly arrived legal immigrants under the bill. Representative Honda lamented that the bill did not “lift the 5 year bar on legal immigrant participation in Medicaid. Legal immigrants are tax paying [sic] citizens in waiting who work hard and contribute. It is only fair that we afford them equal access to the benefits of Medicaid.”\footnote{155 CONG. REC. H12,623, H12,899 (daily ed. Nov. 7, 2009).}

Meanwhile, no floor statements, committee reports, or other statements made by lawmakers suggested that legislators were preoccupied by the fate of nonimmigrants under the bill.

Finally, after the bill passed both Congressional houses and landed on President Obama’s desk on March 23, 2010, the president also used expansive, even universal, language when referring to the beneficiaries of the ACA:

[P]erhaps the greatest—and most difficult—challenge is to cobble together out of those differences the sense of common interest and common purpose that’s required to advance the dreams of all people—
especially in a country as large and diverse as ours . . . . [W]e are blessed by leaders in each chamber who not only do their jobs very well but who never lost sight of that larger mission . . . And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care. 59

B. History of Healthcare Reform Advocacy in America

The ACA was an unprecedented overhaul of our nation’s healthcare system. It was the product of decades of advocacy for expanded access to healthcare for Americans that germinated in Theodore Roosevelt’s presidential administration nearly a century ago. 60 As healthcare costs and the number of uninsured in the United States continued to balloon, the political will to reform the system strengthened. And just like with the ACA, the idea that “all Americans” deserved access to healthcare animated the political discourse through Republican and Democratic presidencies alike in the last hundred years, though the concrete proposals failed to extend protection to all noncitizen groups. The ACA’s repetition of history may be instructive in understanding why legislators persist in leaving out certain noncitizens from their conception of universal healthcare.

Presidents Franklin Roosevelt, Harry Truman, Richard Nixon, and Jimmy Carter all attempted to pass legislation ensuring universal healthcare coverage but failed to do so. 61 Lyndon Johnson came the closest to this goal in creating the Medicare and Medicaid programs, which established a healthcare safety net for the elderly and the poor, respectively. 62 He too failed to pass universal healthcare. 63 And of course, the first years of Bill Clinton’s tenure were consumed with Hillarycare, the doomed healthcare reform bill of which first lady Hillary Clinton was a chief architect. 64

62. See id.
64. For example, see W. John Thomas, Play It Again, Hillary: A Dramaturgical Examination of a Repeat Health Care Plan Performance, 19 STAN. L. & POLY REV. 283, 290 (2008), for a brief overview of the 1993 Health Care Reform Plan.
The rhetoric past legislators and policy advocates used to push for such legislation also centered around the notion that “all Americans deserve healthcare.” For example, Mrs. Clinton and other advocates of her plan 1993 Health Care Reform Plan made such statements as “If we do not have universal coverage . . . we do not have health care reform.” And yet, past iterations of healthcare expansion legislation, such as the 1993 plan, did not cover undocumented immigrants beyond already existing emergency Medicaid protections in the event of immediate and severe health crises. In the past, as in the present, a gap existed between the ideals that animated the push for healthcare reform and the substance of the proposals ultimately put forth with respect to noncitizen groups like the undocumented.

III. IMPLICIT RATIONALE FOR THE GAP BETWEEN REALITY AND RHETORIC: THE DEFINITION OF “AMERICAN”

It is, of course, impossible to definitively explain how the entire 111th U.S. Congress rationalized the exclusion of the three noncitizen groups identified above. Parsing the legislative history—particularly the floor debates—reveals implicit economic and normative social assumptions legislators made about the role of undocumented immigrants in particular. Perhaps these assumptions explain, at least in part, the inconsistencies in the statutory language of and legislative history about the ACA explored in this Article. This Part explores these potential economic and social rationales, critiques them, and offers ways for healthcare reform advocates to overcome them.

A. Concerns About Economic Freeridership

Most of the comments made by legislators concerned the potential for undocumented immigrants to benefit from the ACA are economic in nature. Time and time again, legislators opposed to the bill mentioned the fear that undocumented immigrants would benefit from free healthcare at the (presumably legally present) taxpayers’ expense and “open[] the floodgates” to


67. E.g., 155 CONG. REG. H12,598, H12,607 (daily ed. Nov. 7, 2009) (“Millions of illegal immigrants will receive taxpayer subsidies for enrollment in subsidized health care plans [under the initial House version of the ACA].”) (statement of Rep. Posey); id. at H12,615 (“This massive
millions more of the undocumented who would further burden our welfare system. News reports suggest the floodgates argument also partially explains why legislators declined to lift the Medicaid residency and immigrant status requirements in the ACA for legal immigrants and nonimmigrants. A plausible way this fear qualifies the seemingly unconditional healthcare for all is the idea that legislators actually mean healthcare for all who pay into the system.

While this modified notion of healthcare for all may explain how some legislators subjectively reconcile the tension between the ACA’s statutory language and the descriptive language used by its proponents, it fails to justify the complete exclusion of undocumented individuals from the ACA’s benefits objectively. First, many undocumented immigrants do pay into the system. For example, undocumented immigrants paid an estimated $6 billion to $7 billion into our Social Security program and another $1.5 billion into our Medicare program between 2000 and 2005 through paycheck withholdings, even though they currently cannot ever access benefits from either program. Further, in 2005 alone, nearly 2 million taxpayers filed federal tax returns using individual taxpayer numbers instead of Social Security numbers, the vast majority of whom are believed to be undocumented immigrants. Finally, millions of U.S. citizens currently pay no federal income tax for various reasons, yet benefit the most from the ACA.

Second, the floodgates argument is also specious. The number of legal immigrants and nonimmigrants would not increase with expanded access to Medicaid because the United States has caps on the number of immigrants and nonimmigrants who may enter the country each year.

government takeover of our health care still allows the 20 million people in this country that are illegally here to get one of those fake Social Security cards without benefit of even a photo ID and get some of that free government health care that everybody else has to pay for.”) (statement of Rep. Poe); 155 CONG. REC. H12,623, H12,870 (daily ed. Nov. 7, 2009) (statement of Rep. Rogers); see also Dolgin & Dieterich, supra note 47, at 284.


74. CONG. BUDGET OFFICE, IMMIGRATION POLICY IN THE UNITED STATES 8 (2006).
gation analysts argue that undocumented are primarily motivated to enter this country due to the presence of brighter economic opportunities, especially in the unskilled and low-skilled sectors, where the supply of U.S. citizen workers is low.\textsuperscript{75} Whether healthcare benefits are available is ancillary when compared to whether upward social and economic mobility is possible through available jobs.\textsuperscript{76} The decrease in the number of undocumented immigrants during the past four years\textsuperscript{77} as the American economy underwent a recession and a slow recovery\textsuperscript{78} supports this view of immigration.

Finally, some studies have shown that giving all individuals access to preventative and nonemergency healthcare is ultimately more cost-effective for the nation as a whole.\textsuperscript{79} In support of this point, it is worthwhile to note that the undocumented population is generally younger and healthier than the American population as a whole,\textsuperscript{80} and adding them into insurance risk pools may lower premiums and costs of emergency healthcare for all.\textsuperscript{81} It is true that other studies claim that the federal government may not gain money from subsidizing so many Americans’ health insurance.\textsuperscript{82} It is impossible, however to deny the longterm gains in economic productivity and reduction in emergency room and emergency Medicaid costs that would result if all people—including recently arrived LPRs,
nonimmigrants and the undocumented—had health insurance.83 The possibility of realizing such gains would seem to merit seriously considering expanding undocumented immigrants’ rights to access healthcare.

Perhaps most who opposed the ACA covering undocumented immigrants generally oppose the concept of the ACA. It is true that those who mentioned the potential economic burdens that undocumented immigrants would create by receiving benefits under the ACA were opposed to the ACA as a whole on other grounds. This includes the idea that the ACA was too redistributivist.84 This counterargument, however, fails to explain why those who supported the ACA and the idea that wealthy taxpayers pay more taxes for all less wealthy Americans’ health insurance also supported excluding the noncitizen groups identified above from the bill.

If indeed some legislators were motivated to deny undocumented immigrants, recently arrived LPRs, and nonimmigrants access to full healthcare benefits under the ACA because of economic concerns, those who advocate for expanded healthcare coverage for these three noncitizen groups may do well to make two primary economic arguments supporting coverage. First, these groups, particularly the undocumented, contribute to federal tax revenue. Second, the national economy and federal government would benefit from an expansion of coverage for all three groups.

B. Healthcare as a Privilege of Citizenship

Another argument legislators made against extension of ACA benefits to undocumented immigrants emphasized the idea that the right to healthcare is reserved to “Americans,” as opposed to literally everyone living in the United States. Therefore, the three noncitizen groups examined in this Essay fall outside the legislators’ definition of “Americans.”85

84. See, e.g., 155 CONG. REC. H12,598, H12,616 (daily ed. Nov. 7, 2009) (“[T]oo many people in America are uninsured, 47 million. Well, subtract from that 47 million illegal aliens which will be funded under this bill, immigrants, those that qualify for Medicaid and other government programs, employer programs that make over $75,000 a year, now you’re down to really only 12.1 million Americans who are without affordable options. That is less than 4 percent of America. And for that you would throw out the liberty of América, throw out the baby with the bathwater of the best health insurance industry in the world, the best health care delivery system in the world, destroyed by a desire to create a dependency society to steal our freedom.”) (statement of Rep. King).
85. For support of this theory, see Dolgin & Dieterich, supra note 47, at 312–13.
Public officials use universal terms such as “everyone,” “all,” and “everybody” when referring to whom universal health coverage should apply, most notably President Obama in his signing statement. It is possible, however, that these seemingly expansive terms are imprecise references. Previously failed attempts at healthcare reform in the past century described healthcare for “Americans,” an arguably more limited term. For example, Representative Hal Rogers distinguished between illegal immigrants and “Americans” when he accused the ACA of “open[ing] the floodgates . . . for illegal immigrants to abuse the system and obtain free government health insurance—all on the backs of law-abiding Americans.” Moreover, Representative King dismissed the idea that there were 47 million uninsured Americans at the time of the debates over the ACA by subtracting the number of undocumented immigrants from that calculation. Escalating levels of antimmigrant rhetoric and social conflict between immigrants and native-born Americans may feed into the perception that recently arrived legal immigrants, nonimmigrants, and undocumented immigrants are not “American.”

This us versus them mentality towards certain immigrants has deep historical roots. Unfortunately, however, allowing the millions of newly arrived immigrants, nonimmigrants, and undocumented immigrants to live in this country without socially or politically including them in the term “American” already has harmful social consequences. This two-tiered system will continue to tear at our societal bonds. This exclusionary way of thinking can calcify

86. See supra note 52 and accompanying text.
87. See Biden & Obama, supra note 2.
88. See supra notes 63–65 and accompanying text.
89. See supra note 53 and accompanying text.
90. See John F. Manning, The New Purposivism, 2011 SUP. CT. REV. 113, 172 (cautioning against over-analyzing the breadth of a term used in the legislative history such as “substantially all”).
92. See supra note 84.
95. See Matthew, supra note 76, at 222 (discussing the “Us-Them dichotomy” espoused by many “in-group” Americans).
96. See id. at 201 (quoting Oris L. Graham, The Unfinished Reform: Regulating Immigration in the National Interest, in DEBATING AMERICAN IMMIGRATION, 1882–PRESENT 89, 91 (2001)).
97. Dolgin & Dieterich, supra note 47, at 285 (“[I]mmigrants—especially undocumented, Hispanic immigrants—have become scapegoats on which social discontent and economic anxiety are displaced.”). See generally MARK HUGO LOPEZ ET AL., PEW HISPANIC CTR., ILÍGAL IMMIGRATION BACKLASH WORRIES, DIVIDES LATINOS (2010) (explaining how animosity towards the undocumented has led to Latinos fearing prejudice and discrimination based on their ethnic characteristics, regardless of their immigration status).
socioeconomic stratifications, creating an underclass, and lead to “prejudice, stereotyping, discrimination, hatred, conflict and violence,” all common problems associated with labeling groups in a particular society as an “other.”

Of course, not all legislators may implicitly exclude the undocumented from their definitions of “American.” Further, the ACA’s legislative history does not clearly answer the question of whether any legislators also exclude other noncitizen groups such as recently arrived LPRs and nonimmigrants from their definitions.

To the extent that legislators do regard “Americans” and certain noncitizen groups as separate entities, those who advocate for expanded health coverage for these groups face a difficult task. One solution is to push for comprehensive immigration reform (CIR) with a path to citizenship for the undocumented in order to turn large swaths of the undocumented into lawfully present individuals. Presumably, turning previously undocumented individuals into legal immigrants would bring them within the definition of “American” discussed in this Part. Further, becoming lawfully present would mean that these individuals would be able to benefit from the ACA as currently written. Successfully pushing through CIR in the current political climate, however, may rival the effort involved in passing healthcare reform in terms of complexity, strategy, and uncertainty of outcome. Further, even if CIR passes, some legislators may still seek to withhold healthcare benefits for newly legalized immigrants, at least for a period.

Another solution to overcoming legislators’ exclusive definition of “American” is to expand the definition of “American” in the political discourse to

100. See Dolgin & Dietrich, supra note 47, at 312–14, for a discussion suggesting that the ACA’s proponents neglected to include the undocumented in the bill because it would be “politically explosive.”
101. See supra note 58 and accompanying text identifying the dearth of legislative history regarding reasons for giving reduced protections for these two groups under the ACA.
102. Most conceptions of comprehensive immigration reform include a path to citizenship for at least some portion of the undocumented community. See Understanding Immigration Reform, N.Y. TIMES, Dec. 9, 2012, http://www.nytimes.com/roomfordebate/2012/12/09/understanding-immigration-reform; see also Preston, supra note 69 (“We are not trying to expand health care coverage to illegal immigrants through this legislation,’ said Senator Jeff Bingaman, Democrat of New Mexico. ‘That will have to be dealt with through comprehensive immigration reform.”.).
103. See supra note 36.
105. See, e.g., supra note 43 and accompanying text.
include the noncitizen groups in question. This task would be no less Herculean, as it requires changing long-held views on the role of immigrants in the United States.\footnote{See Matthew, supra note 76, at 225.} This effort, however, would have the added benefits of staving off the desire of some legislators to oppose CIR efforts if and when that mantle is again taken up by public officials and of preventing legislators from potentially limiting the benefits to which newly legalized immigrants are entitled.

A close examination of the ACA’s legislative history suggests two possibly interrelated ways that legislators reconciled the competing concepts of universal healthcare and fewer healthcare protections for noncitizens in crafting the ACA. Perhaps understanding these rationales will allow healthcare advocates on behalf of noncitizens to redouble their efforts to obtain equal access to healthcare for recently arrived legal immigrants, nonimmigrants, and the undocumented.

**CONCLUSION**

Despite the rhetoric of universal healthcare and healthcare for all that pervaded the healthcare debate, the ACA does not fully protect certain legal immigrants or nonimmigrants and fails to protect the undocumented at all, leaving millions of Americans still without access to health insurance. The legislative history of the ACA suggests that legislators’ biases towards these noncitizen groups, particularly with respect to the economic impact of insuring them and the idea that they are not “American,” may explain this gap. Advocates for universal healthcare must combat these biases, push for comprehensive immigration reform, or, preferably, employ both strategies in order for rhetoric to meet reality in the concept of healthcare for all.