Undocumented and Unprotected: Solutions for Protecting the Health of America's Undocumented Mexican Migrant Workers

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Pedro awoke suddenly in the middle of the night, his eyes on fire. Out of nowhere—sharp, blazing pain....’Daddy! Juan! Daddy!....he hollered, waking his father, who...pried open one of Pedro’s eyes. It was yellow, the eyeball hidden beneath a thick curtain of pus. ‘I can’t see!’ Pedro screamed. ‘Daddy, I can’t see.’ There are systems in place, of course—family doctors, pharmacies, and twenty-four hour urgent care centers. But a lot of those amenities are not immediately within reach if you’re a migrant worker living out of your car, sleeping beside a field of [crops]. Pinkeye, stupid pinkeye, a bad case of conjunctivitis. A complete nonissue for a kid with access to simple antibiotics; terrifying blindness for a kid without.¹

Anywhere from an estimated eleven to twelve million immigrants are present in the United States illegally.² According to the Pew Hispanic

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Center, of the 11-12 million, there are specifically 6.5 million unauthorized Mexicans living in the U.S., "mak[ing] up the majority of the unauthorized immigrant population, [or] 58%..." Many of those from Mexico come into the United States to serve as seasonal agricultural workers, harvesting food in the face of harsh working conditions throughout the United States, while suffering from infectious diseases, chemical-related illnesses, and other health problems as a result of these conditions. Although many federal laws have been implemented to protect the health of American workers, these laws are often interpreted to preclude undocumented immigrants' coverage due to their immigration status. Additionally, undocumented immigrants are often reluctant to take steps to enforce their rights, or take advantage of services even when they are available, due to

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3. The terms "unauthorized immigrants" or "undocumented immigrants" are used in this Comment to refer to foreign-born non-citizens residing in the United States who do not have authorization from the Department of Homeland Security. "The vast majority of unauthorized immigrants entered the [United States] without valid documents or arrived with valid visas but stayed past their visa expiration date or otherwise violated the terms of their admission." PASSEL & COHN, supra note 2, at 5.

4. Id. at 11.


7. The specific scope of this Comment is on health care access for undocumented Mexican migrant workers. However, to offer perspective, there will be some discussion of undocumented immigrants, in general. Since undocumented Mexican migrant workers are a sub-set of "undocumented immigrants" and "migrant workers" in general, the terms "undocumented immigrants", "undocumented migrant workers", "migrant workers" and "unauthorized immigrants" may be used to refer specifically to undocumented Mexican migrant workers for the sake of this Comment.
fear of removal\textsuperscript{8} from the United States. To make matters worse, undocumented immigrants are intentionally denied federal health insurance coverage and employer mandated coverage in the 2010 Patient Protection and Affordable Care Act (PPACA),\textsuperscript{9} and will have no viable means of obtaining reasonable health care without incurring extraordinary cost.

This Comment addresses the current and future statutory and legal barriers in the United States that prevent undocumented immigrant workers from obtaining the health insurance and health care they need to survive. Part I of this comment outlines the current health care regime that has evolved for undocumented immigrants and studies the historical, statutory, and legal events that created the ‘chilling effect’ that prevents immigrants (both legal and undocumented) from attaining health care protection. Specifically, this Comment explores the implementation of the Immigration Reform and Control Act (IRCA) of 1986\textsuperscript{10} and case law that has had a profound effect on the interpretation of the interaction between federal immigration laws and benefits for undocumented immigrants. This Comment discusses the social, health, and economic impacts that affect the United States when undocumented immigrants are precluded from receiving health care.

Part II of this Comment calls for the United States to amend its health care coverage schemes and improve federal statutes to protect undocumented Mexican migrant workers. Specifically, this Comment outlines a proposal mandating that employers of Mexican migrant workers must provide bi-national health insurance plans, which will provide reasonable health insurance coverage in both the United States and Mexico. Secondly, this Comment calls on the United States government to reduce its enforcement of immigration laws through private insurance providers and private employers and outlines the issues with federally proposed verification tools designed to limit undocumented immigrants’ access to federal health benefits.

\textsuperscript{8} See 8 U.S.C. § 1237(a)(B) (2006) (stating that non-citizens who are present in the U.S. in violation of the INA or any other law of the United States are removable (previously known as deportable)).

\textsuperscript{9} The PPACA (along with the Health Care and Education Reconciliation Act of 2010) is the principal health care reform legislation of the 111th United States Congress. PPACA reforms certain aspects of the private health insurance industry and public health insurance programs, increases insurance coverage of pre-existing conditions, expands access to insurance to over 30 million Americans, and increases projected national medical spending. The Affordable Care Act was signed into law on March 23, 2010 and becomes effective in stages through 2018. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

I. CURRENT HEALTH CARE REGIME FOR UNDOCUMENTED MEXICANS

A. Background on Undocumented Mexican Migrant Workers

According to a Pew Research study, there are approximately 11.2 million undocumented immigrants in the United States,11 most of whom work in the construction, agriculture, manufacturing, and food preparation industries.12 Since 1980, immigrants from Mexico “have been the largest single immigrant group in the United States.”13 In fact, approximately one out of every two undocumented immigrants residing in the United States is Mexican.14 According to the Migration Policy Institute, “Mexican immigrants disproportionately have lower educational attainment, lack English proficiency, lack access to quality health care, and are more likely to work in low-wage, unskilled occupations that do not offer health insurance but may expose many to unsafe working conditions.”15

1. Migrant Worker Health Effects

Agriculture is one of the most dangerous occupations in the United States,16 with one of the highest fatality rates for foreign workers—15.2 workers for every 100,000.17 The farm labor industry is seasonal and

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11. PASEL & COHN, supra note 2.

12. See generally Hansen & Donohoe, supra note 5.


15. LAGLAGARON, supra note 13.


intense as migrant workers harvest in all seasons and weather conditions, including extreme heat, cold, rain, and sun.\textsuperscript{18} The work conducted requires constant bending, working with soil and heavy machinery, climbing, and carrying heavy items, all leading to "chronic musculoskeletal symptoms."\textsuperscript{19} Although the percentage of foreign-born employment in the U.S. workforce increased by only 22% from 1996-2000, there was a 43% increase in fatal occupational injuries amongst foreign-born employees in the agricultural industry.\textsuperscript{20} Furthermore, Mexican men have the greatest overall risk of fatal occupational injury,\textsuperscript{21} and see a tremendous number of fatalities in the farming, forestry, and fishing occupations.\textsuperscript{22}

Despite these staggering statistics, the number of employees suffering from injuries or illness may actually be much higher due to prevalent underreporting of injuries in the agriculture industry—stemming from limited access to health care, cultural differences regarding health and disease, and most importantly, fear of lost wages and jobs or immigration retaliation.\textsuperscript{23} Migrant workers suffer from the same health problems as the general population, but are at an increased risk of specific health issues due to "occupational hazards, poverty, substandard living conditions, . . . as well as language and cultural barriers . . . ."\textsuperscript{24} As a result, migrant farm workers

\textsuperscript{18} Id. at 10.

\textsuperscript{19} Hansen & Donohoe, supra note 5, at 155.


\textsuperscript{21} See AFL-CIO, supra note 17, at 3 (quoting NATIONAL RESEARCH COUNCIL, SAFETY IS SEGURIDAD (2003)).

\textsuperscript{22} See AFL-CIO, supra note 17, at 6 (stating that the farming, forestry and fishing occupations account for nearly a quarter of all fatal injuries sustained by Mexican-born workers).

\textsuperscript{23} Don Villarejo & Sherry L. Baron, The Occupational Health Status of Hired Farm Workers, OCCUP. MED. 613, 613-35 (1999); see also AFL-CIO, supra note 17, at 7-8 (stating that underreporting especially occurs among workers with insecure immigration status, limited permission to work, or lack of marketable job skills. Low-wage and immigrant workers are most likely to be fired or threatened for complaining).

\textsuperscript{24} Hansen & Donohoe, supra note 5, at 156.
have a life expectancy of only 49 years, a 26-year reduction from the national average of 75 years.25

a. General Health Issues

Migrant workers have a heightened risk for numerous viral, bacterial, fungal, and parasitic infections26 and are six times more likely to contract tuberculosis than the general population.27 They are many times more likely to have parasitic infections which, if left untreated, can lead to chronic anemia and malnutrition.28 Additionally, migrant workers are at a higher risk for urinary tract infections, mostly due to a lack of toilets in their workplaces and harsh working conditions that lead to chronic urine retention.29 Urine retention encourages bacterial growth, stretches and weakens the bladder, and promotes chronic infection.30 Migrant workers also experience 150-300% more decayed teeth than the national population, primarily due to their overall lack of access to dental care.31 Migrant children who do not receive dental care may develop severe periodontal issues when they get older.32

b. Chemical and Pesticide Related Illnesses

The Environmental Protection Agency estimates that 300,000 migrant farm workers suffer from acute pesticide poisoning each year, and suffer from the highest rates of toxic chemical injuries of any group of workers in


28. See Sandhaus, supra note 25, at 52.


30. See Hansen & Donohoe, supra note 5, at 157.


32. See Hansen & Donohoe, supra note 5, at 159.
the United States.\textsuperscript{33} This chemical and pesticide poisoning likely arises from direct spraying of pesticides on workers, indirect spray from winds carrying pesticides, direct contact with crop residue, or from drinking and bathing in contaminated water.\textsuperscript{34}

Acute exposure to organophosphate, a chemical in insecticide and herbicides,\textsuperscript{35} causes increased salivation, blurred vision, nausea, abdominal cramps, urinary and fecal incontinence, increased bronchial secretions, coughing, wheezing, and sweating.\textsuperscript{36} Exposure to more severe acute intoxication of organophosphate may result in dyspnea,\textsuperscript{37} bradycardia,\textsuperscript{38} heart block,\textsuperscript{39} hypotension,\textsuperscript{40} pulmonary edema,\textsuperscript{41} paralysis,\textsuperscript{42} convulsions,

\begin{itemize}
\item \textsuperscript{33} See generally U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-92-46, HIRED FARMWORKERS HEALTH AND WELL-BEING AT RISK: REPORT TO CONGRESSIONAL REQUESTERS 3 (1992); see also Hansen & Donohoe, supra note 5, at 157.
\item \textsuperscript{34} Hansen & Donohoe, supra note 5, at 157.
\item \textsuperscript{35} Kenneth D. Katz, MD, Organophosphate Toxicity, MEDSCAPE (Jan. 23, 2012), http://emedicine.medscape.com/article/167726-overview (defining herbicides as "tricresyl phosphate-containing industrial chemicals").
\item \textsuperscript{36} Hansen & Donohoe, supra note 5, at 157.
\item \textsuperscript{37} Dyspnea is defined as "[d]ifficult or labored breathing; shortness of breath. Dyspnea is a sign of serious disease of the airway, lungs, or heart." Definition of Dyspnea. MEDICINENET.COM (Mar. 19, 2012), http://www.medterms.com/script/main/art.asp?articlekey=3145.
\item \textsuperscript{38} "A slow heart rate, usually defined as less than 60 beats per minute." Definition of Bradycardia. MEDICINENET.COM (Mar. 19, 2012), http://www.medterms.com/script/main/art.asp?articlekey=2515.
\item \textsuperscript{40} Hypotension is also known as "low blood pressure." "Blood pressure is the force exerted by circulating blood on the walls of blood vessels. It constitutes one of the critically important signs of life or vital signs which include heart beat, breathing, and temperature. Blood pressure is generated by the heart pumping blood into the arteries modified by the response of the arteries to the flow of blood." John P. Cunha, DO, Low Blood Pressure (Hypotension), MEDICINENET.COM (Oct. 4, 2010), http://www.medicinenet.com/low_blood_pressure/article.htm.
\end{itemize}
and even death. In addition to organophosphate exposure, extensive, long-term pesticide exposure may cause permanent neurological deficits, such as peripheral neuropathy, or deficits in motor skills and memory, and cancer.

c. Dermatitis

Agricultural workers have a higher incidence of skin problems than employees in any other occupation. Dermatitis, a severe form of inflammation on the skin, is the most common occupational health problem amongst migrant farm workers. These skin disorders can arise from the use of pesticides, fertilizers, latex, chemicals, and from exposure to poison ivy, ragweed, sumac, or other allergenic crops. Additionally, sun

41. Pulmonary edema is the term used when swelling occurs in the lungs. “Swelling typically occurs when fluid from inside blood vessels seeps outside the blood vessel into the surrounding tissues, causing swelling. This can happen either because of too much pressure in the blood vessels or not enough proteins in the bloodstream to hold on to the fluid in the plasma (the part of the blood that does not contain any blood cells)” Siamak T. Nabili, MD, Pulmonary Edema, MEDICINENET.COM (May 20, 2009) http://www.medicinenet.com/pulmonaryedema/article.htm.


43. Hansen & Donohoe, supra note 5, at 157.

44. “Peripheral neuropathy is a disorder of the nerves apart from the brain and spinal cord. Patients with peripheral neuropathy may have tingling, numbness, unusual sensations, weakness, or burning pain.” William C. Shiel Jr., Peripheral neuropathy, MEDICINENET.COM (Apr. 4, 2012), http://www.medicinenet.com/peripheral-neuropathy/article.htm.


46. Id.


49. See Hansen & Donohoe, supra note 5, at 157.
exposure, sweat, chapped skin, lack of protective clothing, and insufficient hand washing facilities may increase the prevalence of skin conditions. Occupational dermatitis often occurs on the employee’s hands, a body part vital to the lifestyle and employment of a migrant worker. As a result of a painful dermatitis outbreak, migrant workers often suffer reduced working hours, capability, and income, which consequently lead to an overall loss in productivity.

\[ \text{d. Respiratory Conditions} \]

Migrant workers are exposed to hazardous agents, such as organic and inorganic dusts, gases, herbicides, fertilizers, solvents, fuels, and

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50. See id. at 157-158.

51. NAT’L RURAL HEALTH CARE ASS’N, supra note 29, at 7.

52. Organic dust comes from hay, grain, fuel chips, straw, and livestock. Organic dust includes molds, pollens, bacteria, pesticides, chemicals, feed and bedding particles, and animal particles including hair, feathers, and droppings. Heavy concentrations of organic dust are common in grain dryers, livestock pens, and swine buildings or other enclosed spaces. Long-term exposure to organic dust can lead to congestion, coughing or wheezing, sensitivity to dust, and frequent infections, such as colds, bronchitis, and pneumonia. Organic Dust, OCCUPATIONAL SAFETY & HEALTH ADMIN., U.S. DEP’T OF LABOR, http://www.osha.gov/SLTC/youth/agriculture/organicdust.html (last visited Dec. 16, 2012).


welding fuels in their daily work. 57 This continuous exposure places them at risk for mucous membrane irritation, allergies, asthma, hypersensitivity pneumonitis (farmer's lung), pulmonary fibrosis, chronic bronchitis, pulmonary edema, tracheobronchitis, emphysema, and asphyxiation. 64


59. Pulmonary fibrosis is defined as a scarring throughout the lungs. Pulmonary fibrosis can be caused by many conditions including environmental agents such as asbestos, silica, and exposure to certain gases. Pulmonary Fibrosis, MEDICINE.net (Dec. 2, 2010), http://www.medicinenet.com/pulmonary_fibrosis/article.htm.

60. “Bronchitis is a term that describes inflammation of the bronchial tubes that results in excessive secretions of mucus into the tubes, leading to tissue swelling that can narrow or close off bronchial tubes. Bronchial tubes extend from the trachea and terminate at the alveoli in the lungs . . . .” Charles Patrick Davis, MD, PhD, Chronic Bronchitis, MEDICINE.net (May 19, 2011), http://www.medicinenet.com/chronic_bronchitis/article.htm.

61. Nabili, supra note 41.


63. “[A] condition of the lung that is marked by distension and eventual rupture of the alveoli with progressive loss of pulmonary elasticity, that is accompanied by shortness of breath with or without cough, and that may lead to impairment of heart action.” Emphysema Definition, MERRIAM-WEBSTER, http://www.merriam-webster.com/medical/emphysema (last visited Dec. 16, 2012).

e. Cancer

Migrant workers have increased mortality rates from cancer including cancer of the lip, stomach, skin, prostate, testes, and hematopoietic\textsuperscript{65} and lymphatic systems.\textsuperscript{66} These health issues result from increased exposure to carcinogens like pesticides, solvents, oils, fumes, UV rays and human and animal viruses (biologic agents).\textsuperscript{67} Specifically, in a study of United Farm Workers of America\textsuperscript{68} members, migrant farm workers developed increased cases of leukemia, stomach cancer, and uterine corpus and cervix cancers than the general documented California Hispanic population.\textsuperscript{69} When diagnosed, these migrant workers were found to have late stage diseases at major cancer sites, in comparison with the general Hispanic populations, likely resulting from impaired access to preventive and screening health services.\textsuperscript{70}

\begin{itemize}
  \item \textsuperscript{65} "Hematopoietic cells are blood-forming cells in the living body." Hematopoietic Definition, Merriam-Webster, http://www.merriam-webster.com/dictionary/hematopoietic (last visited Dec. 16, 2012).
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  \item \textsuperscript{67} See Hansen & Donohoe, supra note 5, at 159.
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  \item \textsuperscript{68} In California, labor unions were organized to protect the rights of migrant farm workers. The United Farmworkers of America (UFW) was founded in 1966 by combining the National Farmworkers Association and Agricultural Workers Organizing Committee. The union has represented tens of thousands of California farmworkers, including both those in the U.S., and those who are migrants from Mexico. Paul K. Mills & Sandy Kwong, Cancer Incidence in the United Farmworkers of America (UFW), 1987-1997, 40 Am. J. Ind. Med. 596, 601 (2001), available at http://www.ufw.org/white_papers/cancerfw.pdf.
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  \item \textsuperscript{69} Id.
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  \item \textsuperscript{70} Id.
\end{itemize}
f. Reproductive Health

Female migrant workers are at an “increased risk of spontaneous abortion, premature delivery, fetal malformation and growth retardation, and abnormal postnatal development[,]” as a result of prolonged standing, bending, over exertion, dehydration, lack of nutrition, and pesticide or chemical exposure. Migrant farm workers experience infant mortality rates that are estimated to be twice the national average. Exacerbating the reproductive health risks, migrant workers are of low socioeconomic status, frequently of a young maternal age, and have little, late, or no prenatal care.

B. Statutory and Legal Impact on Status of Undocumented Migrant Workers

Despite agriculture’s ranking as one of the most dangerous occupations in the nation, the industry is not subject to the safety legislation that protects workers in other American industries. Furthermore, laws have been put into place allowing small farms to be exempt from the Fair Labor Standards Act, the legislation that regulates wages and hours for American workers. Moreover, only recently has the Occupational Safety and Health

71. See Hansen & Donohoe, supra note 5, at 158; see also K.G. Smith, The Hazards of Migrant Farm Work: An Overview for Rural Public Health Nurses, 3 PUBLIC HEALTH NURS. 48, 48-56. (1986); see also Marni E. Gwyther & Melinda Jenkins, Migrant Farmworker Children: Health Status, Barriers to Care, and Nursing Innovations in Health Care Delivery, 12 J. OF PEDIATRIC HEALTH CARE 60, 66 (1998); NAT’L RURAL HEALTH CARE ASS’N, supra note 29.

72. See Hansen & Donohoe, supra note 5, at 158.

73. See Gwyther & Jenkins, supra note 71.


75. KAY EMBREY, CORNELL MIGRANT PROGRAM, FARMWORKERS IN THE UNITED STATES 11 (2002).


77. EMBREY, supra note 75, at 11.
Administration (OSHA) required employers of eleven or more farm workers to provide toilet facilities or drinking water for workers in the fields.  

1. Immigration Reform and Control Act

Prior to Congress's implementation of the Immigration Reform and Control Act (IRCA) in 1986, there was little statutory law that specifically regulated the employment of undocumented immigrants. The Immigration and Nationality Act (INA) "generally concerned only the terms and conditions under which foreign nationals would be classified and admitted to [the United States] and, perhaps become its naturalized citizens." Under the INA, it was illegal for an immigrant to enter the United States without inspection, but not expressly unlawful for them to seek employment. That changed in 1986 when Congress passed IRCA.

IRCA was enacted as a means of reducing illegal immigration by limiting the ability of undocumented immigrants to gain employment in the

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80. The Immigration and Nationality Act, or INA, was passed in 1952. Before the INA, a variety of statutes governed immigration law but were not organized in one location. The McCarran-Walter bill of 1952, Public Law No. 82-414, collected and codified many existing provisions and reorganized the structure of immigration law. The Act has been amended many times since 1952, but is still the basic body of immigration law. See generally Immigration and Nationality Act, 8 U.S.C.A. §§ 1101-1105 (2005).


82. See Ho & Chang, supra note 81, at 479.


United States.\textsuperscript{85} To achieve this goal, Congress decided to impose sanctions on employers and to limit the number of employment opportunities available to undocumented workers.\textsuperscript{86} As the Court in \textit{EEOC v. Tortilleria “La Mejor”}\textsuperscript{87} stated, “Congress enacted the IRCA to reduce illegal immigration by eliminating employers’ economic incentive to hire undocumented aliens.”\textsuperscript{88}

To effect this goal, IRCA instituted two major changes from the INA: first, it made it illegal for employers to knowingly hire undocumented workers,\textsuperscript{89} and second, it required employers to verify the employment authorization of their employees.\textsuperscript{90} Thus, after IRCA, hiring undocumented workers became unlawful in itself and employers who did so were subject to sanctions.\textsuperscript{91}

As a result of IRCA, there has been a rise in the private enforcement of immigration laws, and thus a restriction on the benefits available to immigrants who do not meet the statutory requirements to work in the

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\textsuperscript{85} See Ho & Chang, \textit{supra} note 81, at 481 n.32 (arguing that, “the House Judiciary Committee’s report on the IRCA legislation stated” that “the primary reason for the illegal alien problem is the economic imbalance between the United States and the countries from which aliens come, coupled with the chance of employment in the United States . . . . The committee, therefore, is of the opinion that the most reasonable approach to this problem is to make unlawful the ‘knowing’ employment of illegal aliens, thereby removing the economic incentive which draws such aliens to the United States as well as the incentive for employers to exploit this source of labor.”); see also \textit{H.R. Rep. No. 682, supra} note 84, at 52.

\textsuperscript{86} \textit{H.R. Rep. No. 682, supra} note 84, at 46 (employer sanctions are codified at 8 U.S.C. §§ 1324(a)(1)(A), (e)(4)(A)-(B), and (f)(2) (2000)).


\textsuperscript{88} \textit{Id.}


\textsuperscript{90} See \textit{id.} § 1324a(b).

\textsuperscript{91} See Ho & Chang, \textit{supra} note 81, at 482.
United States.\textsuperscript{92} Private enforcement of immigration laws occurs when private parties, such as employers or health care providers, check for legal immigration status before granting access to a restricted benefit.\textsuperscript{93}

2. The Hoffman Decision

Aside from IRCA, the Supreme Court’s holding in \textit{Hoffman Plastic Compounds, Inc. v. National Labor Relations Board}\textsuperscript{94} has created one of the biggest impacts on the ability of undocumented immigrants to obtain health rights and benefits from their employers. In \textit{Hoffman}, the Supreme Court decided that after IRCA, the National Labor Relations Board (NLRB) was authorized to award monetary compensation to an undocumented worker fired in violation of fair employment and labor laws.\textsuperscript{95} However, the Court held that the NLRB’s awarding of back pay to undocumented workers was foreclosed by the federal immigration policies in the IRCA.\textsuperscript{96} The Court stated that awarding back pay to unauthorized immigrants would reward their illegal behavior, thus eradicating the intent of IRCA to limit the employment of undocumented immigrants.\textsuperscript{97} Although the Supreme Court stated that undocumented immigrants are considered “employees” under interpretations of the National Labor Relations Act,\textsuperscript{98} that classification only grants undocumented workers the right to form unions, engage in collective bargaining and take part in labor strikes.\textsuperscript{99} While these rights are important to protect suitable labor representation and working conditions, they are far from enough to provide adequate living conditions for undocumented workers.


\textsuperscript{93} “[B]eginning with federal employer sanctions in 1986, private enforcement has spread into housing and transportation areas, with proposals for expansion into the medical, educational, and charitable areas.” \textit{Id.} at 782.


\textsuperscript{95} \textit{Id.}

\textsuperscript{96} \textit{Id.} at 140.

\textsuperscript{97} See \textit{id.}

\textsuperscript{98} \textit{Id.} at 144-49.

\textsuperscript{99} \textit{Id.}
3. *Hoffman's Chilling Effect*

Immigration advocates have warned that an undue “chilling effect” was created due to IRCA’s federal prohibition against employment of unauthorized immigrants, and *Hoffman’s* limitation of labor protections based on immigrant status. This “chilling effect” indirectly creates reluctance amongst undocumented workers to report or complain of substandard labor conditions and health effects due to fears that these measures may draw attention to their undocumented status. The “chilling effect” inevitably “silences and immobilizes workers, degrade[s] working conditions and weaken[s] workplace standards . . .”

Some have argued that the *Hoffman* Court’s acknowledgement that undocumented workers are not entitled to all labor rights has “created a legal basis for employers to pry into, or threaten to pry into, a worker’s immigration status, thereby discouraging undocumented workers who are injured on the job from filing complaints or bringing suit.”

Despite the high risk of injury and fatality rates faced by undocumented migrant workers, these employees rarely seek remedies for workplace injuries, or report hazards on the job. According to the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), the reluctance largely stems from fear of employer retaliation – particularly firings – and having their immigration status reported to the federal government, which could lead to removal from the U.S.

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106. *Id.*
Under current U.S. law and OSHA regulations, there is “no penalty for employers who hire undocumented workers and fire them if they complain about safety conditions.” Thus, the lack of anti-retaliatory protections for undocumented workers widens the barrier between employers and their undocumented employees, and further burdens the ability of undocumented immigrants to obtain health care for injuries that stem from these safety issues.

C. Impaired Access to Health Care

It has been stated that, “[t]he health status of migrant farm workers is at the same standard of most Third World Nations, while the country in which they work, the United States, is one of the richest nations on earth.” Undocumented Mexican immigrant workers face “numerous barriers to medical care” including poor access to care based on a shortage of health services where they live and work, lack of employer provided insurance due to their immigration status, and the exorbitant costs of private insurance.

In 1996, Congress’ enactment of welfare reform limited documented and undocumented immigrants’ access to Medicaid and other federal health benefits, and harmed their ability to gain access to the U.S. health care system.

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107. Goal of the act was “[T]o assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health . . . .” OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, OHSA 3021-09R, WORKER’S RIGHTS (2011), http://www.osha.gov/Publications/osha3021.pdf.

108. AFL-CIO, supra note 17, at 10.


110. See Hansen & Donohoe, supra note 5, at 153.

system.\textsuperscript{112} When Congress passed the Patient Protection and Affordable Care Act of 2010,\textsuperscript{113} it made clear that health reform would not help migrant workers who are in the United States illegally. The Affordable Care Act explicitly prohibits those who are not “lawfully present”\textsuperscript{114} from

\begin{enumerate}
  \item accessing temporary high-risk pools for those with preexisting conditions;
  \item enrolling in special state-created plans for low-income individuals not eligible for Medicaid;
  \item enrolling in new health care cooperatives;
  \item receiving cost-sharing subsidies or premium tax credits to purchase health insurance; and
  \item purchasing policies in the newly created exchanges, even without the benefit of government subsidies or credits.
\end{enumerate}

Undocumented immigrants are thus barred from receipt of public insurance, and their low incomes likely price them out of most privately available plans.\textsuperscript{115} However, since undocumented immigrants are still in need of medical care, they must seek out alternative sources of care through what is known as the U.S. health care safety net\textsuperscript{117}—“providers that organize and deliver a significant level of health care . . . to uninsured, Medicaid, and

\begin{itemize}
  \item \textsuperscript{112} This Act prohibits unauthorized “aliens” from enrolling in Medicaid and other public benefit programs, and created a five-year waiting period for Lawful Permanent Residents (LPRs). The bill imposed a five-year waiting period for LPRs to become eligible for Medicaid and other federal programs. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, §§ 401-404, 110 Stat. 2105, 2261-67 (codified as amended at 8 U.S.C. §§ 1611-1614 (2006)).
  
  
  \item \textsuperscript{114} Id.
  
  \item \textsuperscript{115} Nathan Cortez, Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform, 84 S. CAL. L. REV. 859, 870-871 (2011).

  \item \textsuperscript{116} See RANDY CAPPS, MARC R. ROSENBLUM & MICHAEL FIX, NAT’L CENTER ON IMMIGRANT INTEGRATION POLICY, IMMIGRANTS AND HEALTH CARE REFORM: WHAT’S REALLY AT STAKE? 24 (Oct. 2009), http://www.migrationpolicy.org/pubs/healthcare-Oct09.pdf (“Very few unauthorized immigrants currently purchase their own insurance because 80 percent of them have incomes below 400 percent of [Federal Poverty Levels], pricing them out of most private plans”).

  \item \textsuperscript{117} Cortez, supra note 115, at 872.
other vulnerable patients." A major portion of the safety net consists of public and nonprofit providers, such as federally funded community health centers. Approximately one thousand federally funded community health centers provide care for medically indigent populations. Additionally, there are approximately 1,300 public hospitals that offer more specialized treatments and 3,000 community health departments that care for vulnerable patients, particularly those with special health needs.

While these safety net providers offer significant health benefits to migrant workers, the location of the providers is far and wide, leaving many immigrants who live in remote locations without care. Many of these immigrants live in locations where access to these ‘safety net providers’ is unavailable. Given this limited proximity to safety net facilities, and their lack of health insurance, most undocumented immigrants are forced to rely on hospital emergency rooms to receive care.

Federal law, through the Emergency Medical Treatment and Active Labor Act (EMTALA), requires hospital emergency rooms to screen all patients and “stabilize those


120. Id.

121. Raymond J. Baxter & Robert E. Mechanic, The Status of Local Health Care Safety Nets, 16 HEALTH AFF. 7, 9 (1997) (academic hospitals and affiliated medical schools may also provide specialized care for a large volume of indigent patients).

122. Id.

123. Cortez, supra note 115, at 874.

124. EMTALA distinguished between medical emergency patients and non-emergency patients, allowing hospitals to care for undocumented immigrants only if they are facing a medical emergency. The Department of Health and Human Services has defined “emergency services” as “those services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.” See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006).
with emergent conditions[,] regardless of their immigration status. Since emergency departments cannot turn away patients, they offer immediate care for emergency medical conditions to any individual, regardless of their ability to pay or their immigration status. As a result, emergency rooms have come to be known as "serve as a true provider of last resort." Although emergency medical treatment is available, this care is only available to undocumented immigrants with severe, emergent conditions. Therefore, undocumented immigrants do not have general availability to preventive health care, which leads to an increased risk of communicable diseases.

While this domestic safety net provides undocumented immigrants with some options in obtaining health care, there are significant issues with this system's sustainability. It "lacks any discernible organization" due to multiple sources of funding, and there is generally no legal obligation for these providers to offer uncompensated care to those who are not in an emergency scenario. Additionally, although EMTALA ensures that everyone in the United States will receive emergency medical assistance, the law imposes significant challenges for hospitals dealing with over-strained budgets, placing economic burdens on the hospitals and the American taxpayers at large.

125. EMTALA requires emergency departments to stabilize patients regardless of their immigration status. See id.

126. See Cortez, supra note 115, at 874.

127. See EMTALA, § 1395dd.


129. Cortez, supra note 115, at 874-75.

130. Id.


1. Immigration Status as a Barrier to Care

The undocumented immigrant's lack of legal status and fear of detection and apprehension by federal agents serves as one of the greatest barriers in their ability to seek medical services. Undocumented immigrants who are sick may not have the means to hire a legal advocate to defend against removal if their legal status is discovered while receiving health care, despite the fact that immigration courts have generally suspended removal based on an individual's health. Furthermore, undocumented immigrants may fear the consequences of protecting themselves through publicly funded medical benefits such as Medicaid, for if they choose to apply for legal residence at a later time, they may be inadmissible as they received public benefits and became a public charge on the United States during this time. Even if states decided to provide preventive care in an attempt to prevent the spread of infectious diseases, the removal laws within the INA “provide[e] an even greater incentive for undocumented immigrants to avoid revealing their presence to [authorities] that they perceive as agents of the government, meaning that they are unlikely to seek treatment even with active communicable diseases.”


134. Suspension of removal is potentially available to respondents in removal proceedings if they can demonstrate good moral character, seven years continuous physical presence in the United States, and extreme hardship to themselves or to a U.S. citizen or lawfully admitted permanent resident spouse, child, or parent as a result of their removal. Immigration and Nationality Act, 8 U.S.C. § 1254(a) (1988 & Supp.II 1990). An individual’s health may be relevant to a finding of extreme hardship. Mejia-Carrillo v. INS, 656 F.2d 520 (9th Cir.1981); In re Anderson, 16 I & N Dec. 596, 597 (BIA 1978).

135. Loue, supra note 133, at 303.

136. Immigration and Nationality Act, 8 U.S.C. § 1182(a)(4) (Supp. II 1990). An alien may be excluded from the U.S. for any of nine broadly enumerated grounds. Id. § 1182 (1988 & Supp.II 1990). The exclusion grounds apply whenever an alien is seeking to effect an entry. Id. § 1101(a)(13) (1988). Once an alien is physically in the United States, he or she may be removed under one or more of five broadly worded provisions. Id. § 1251 (1988 & Supp.II 1990). One of the grounds of removal is excludability at the time of the original entry, for any of the nine grounds of exclusion. Id. § 1251(a)(1).

137. Costich, supra note 128, at 1060.
Since undocumented immigrants live with the constant fear of removal, they are unlikely to access health care until their health worsens to a crisis situation. The cost of treating these emergency patients who lack insurance, as opposed to providing preventive care, will place significant financial burdens on the public hospitals and local economies forced to foot the bill.138

D. Economic Impact of Not Receiving Care

As noted above, undocumented, uninsured Mexican migrant workers are likely to suffer from debilitating yet preventable diseases. Since many diseases are communicable, sick migrant workers who are in constant contact with food consumed by the general public could place entire communities at risk if their illnesses are not treated.139 Therefore, the public impact of undocumented immigrants’ diseases is both physical and economic.140

Unpaid medical bills attributed to the care for undocumented immigrant workers are reported to be $2 billion per year.141 While some argue that terminating medical services for undocumented immigrants could save money,142 providing only emergency care to undocumented immigrants creates a situation where basic health needs evolve into expensive,


142. Gregory J. Ehardt, Why California’s Proposition 187 is a Decision for the U.S. Supreme Court, 3 TULSA J. COMP. & INT’L L. 293, 309 (1996) (arguing that some view illegal immigrants as detrimental to the welfare system and economy, and that preventive care drains local resources that are better used to serve the documented population).
uncontrollable emergent needs,\textsuperscript{143} thus forcing taxpayers to incur prohibitive emergency treatment costs.\textsuperscript{144} It would cost far less to prevent infectious diseases and provide early treatment for serious conditions than to wait for the disease to reach the acute stage.\textsuperscript{145} Furthermore, such costs will increase even more if the general population is exposed to these diseases.\textsuperscript{146}

When the cost of emergency treatment is four to ten times greater than that of preventative care,\textsuperscript{147} it is essential that undocumented migrant workers access treatment for symptoms and conditions before they “degenerate into emergencies that necessitate more elaborate procedures and care.”\textsuperscript{148} Law Professor Linda Bosniak noted that “people afraid to go to the doctor will simply create the conditions for a public health catastrophe and will end up costing the state more money later on.”\textsuperscript{149} Additionally, Michael Fix, of the Migration Policy Institute, argues,

\begin{quote}

some of the short-term cost savings from excluding [unauthorized] immigrants from health care reform would be lost through cost shifting to states and local providers. Ultimately taxpayers and health care consumers would have to pay for uncompensated care
\end{quote}

\begin{itemize}
\item \textsuperscript{143} Fee, \textit{supra} note 140.
\item \textsuperscript{144} Tony Pugh, \textit{Medicaid Complicates Immigrant debate; Program Now Requires Proof of Citizenship for Emergency Room Care}, \textit{CONTRA COSTA TIMES}, July 1, 2006.; see also Canedy, \textit{supra} note 141.
\item \textsuperscript{147} Jim Yardley, \textit{Immigrants' Medical Care is Focus of Texas Dispute}, \textit{N.Y. TIMES}, Aug. 12, 2001, at A18.
\end{itemize}
for uninsured immigrants as well as higher health care costs in the future.\(^{150}\)

Although appealing for political reasons,\(^ {151}\) prohibiting undocumented immigrants from accessing public health insurance or employer provided health care will likely result in serious public health consequences to our society as a whole. Furthermore, adding large numbers of unauthorized immigrants to health insurance risk pools could help reduce insurance premium costs for both legal immigrants and U.S. citizens.\(^ {152}\)

II. SOLUTIONS

A. Bi-national Health Care\(^ {153}\)

Despite the controversial nature of healthcare coverage for undocumented immigrants, the issue demands attention and a viable solution must come from both sides of the United States-Mexico border. In order to effectively provide health care to America's population of undocumented migrant workers, the United States and Mexico must work together to create a federally subsidized health plan for Mexican migrant workers. This plan would be implemented in a similar fashion to the United States' existing Medicaid plan. It would be passed by Congress and federally funded, yet implemented and run at the state level. The difference would simply be that Mexico would also provide federal funding to the United States, in addition to allowing Mexican enrollees to access the already existing Mexican health care system when in Mexico.

Over the past decade, there has been increased interest in developing health insurance coverage that is accessible in both the United States and Mexico for U.S. citizens and legally present immigrants.\(^ {154}\) Additionally, some private health insurance providers already offer such portable health

\(^{150}\) Capps, Rosenblum, & Fix, supra note 116, at 6.


\(^{152}\) See Capps, Rosenblum, & Fix, supra note 116, at 6.

\(^{153}\) The terms "bi-national" and "cross-border" will be used interchangeably through the Comment to refer to insurance coverage in both the United States and Mexico.

insurance coverage in the border regions between the U.S. and Mexico.\textsuperscript{155} However, such coverage is only offered to Mexican nationals who have \textit{legal} status in the United States.\textsuperscript{156} The solution presented here would make bi-national insurance plans available to \textit{all} Mexican nationals in the United States, specifically undocumented Mexican migrant workers.

The current plans, which are only available to legal immigrants in border-states such as California, allow temporary immigrant workers to obtain medical care in either American or Mexican hospitals.\textsuperscript{157} These bi-national plans are economically appealing as insurance premiums generally cost 40-60\% less than domestic-only coverage.\textsuperscript{158}

According to the Institute for Mexicans Abroad,\textsuperscript{159} there is a belief that a better-integrated immigrant, one who is healthy, "benefits the individual immigrant, the sending country, and the receiving country."\textsuperscript{160} Authorizing this sort of portable health insurance to \textit{undocumented} Mexican immigrants would create a "healthy immigrant" and create an enticing option for both the United States and undocumented Mexican immigrants currently present in the United States. While cross-border insurance policies offer an enticing

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159. Also known as the Instituto de los Mexicanos en el Exterior, the Institute for Mexicans Abroad is a program run by the Mexican government that "acknowledge[s] the importance of building the social and human capital of its migrants in the United States." See \textsc{Llagarón}, supra note 13, at 3.

160. \textit{Id}.
\end{flushleft}
path for providing insurance coverage for more workers from Mexico, the solution proposed here will also lower insurance premiums for legal immigrants and U.S. citizens, as more individuals would be placed in the insurance “risk pools.”

Employer-provided bi-national health insurance would offer undocumented Mexican migrant workers access to emergency rooms, hospital services, and basic preventive health care options while they are in the United States, and if they return home to Mexico. Unlike the existing plans that only offer insurance coverage in the United States, precluding care in Mexico, the solution proposed here will offer unfettered access to care in both countries, regardless of where the care is otherwise obtainable. This bi-national health insurance solution would provide “a network plan that includes U.S. and Mexican physicians, pharmacies, hospitals or other types of healthcare providers,” and would reimburse both “U.S. and Mexican providers for routine healthcare services.” The proposed solution will provide employer insurance coverage for Mexicans employed in the United States and their nuclear family members even if the family continues to live in Mexico.

This bi-national insurance solution will have important and positive implications for states with large uninsured Mexican immigrant populations, such as California, Arizona, and Texas, where unauthorized immigrants make up about a quarter of all uninsured working age adults. Since undocumented Mexican immigrants have been left out of health care reform, it will otherwise be expensive for these high-immigrant states to continue


162. CAPPS, ROSENBLUM, & FIX, supra note 116, at 25.


166. See CAPPS, ROSENBLUM, & FIX, supra note 116, at 19-20.
funding uninsured, undocumented immigrants' use of emergency rooms, community health facilities, and other public health care centers.167

Furthermore, this cross-border insurance solution will appeal to the population of undocumented Mexican immigrants who are excluded from receiving United States federal support, and cannot afford private insurance plans. This solution will allow more members of the immigrant's family to have health insurance, and will allow the family to use the same doctor for their primary care, regardless of where they currently reside.168

Additionally, this bi-national solution is economically appealing to American employers, the States, and the federal government for the following reasons. First, providing insurance to undocumented immigrants will result in "[a] significant reduction in the amount of uncompensated care rendered to employed uninsured patients[.]"169 Second, insurance coverage, and the preventive care it brings, is likely to lead to a healthier workforce of Mexican migrant workers, allowing for higher production, and an increased economic outlook for the United States.170 However, in order for this proposed solution to work, undocumented Mexican immigrants must not be fearful of being arrested and removed if they use public health services in the United States.171 In order to negate these fears, the United States must strategically limit its enforcement of immigration laws when it comes to undocumented immigrants accessing health care.

167. See id. at 19.

168. REPORT OF THE INTERIM COMMITTEE ON BINATIONAL HEALTH BENEFIT, supra note 165, at 2.

169. Id.

170. Id.

171. See Arredondo, Orozco, Wallace, & Rodriguez, supra note 154 (arguing that Mexican officials believe an obstacle to bi-national health insurance has arisen out of fears that undocumented immigrants present in the United States about being arrested and removed if they use public health services in the United States).
B. Private Enforcement of Immigration Laws

1. Limit the Private Enforcement of Immigration Laws

After the implementation of IRCA, there was a movement to shift immigration enforcement to private parties. See Huyen Pham, The Private Enforcement of Immigration Laws, 96 GEO. L.J. 777, 782-85 (2008). Since IRCA made it illegal to employ undocumented immigrants, employers have been forced to verify an employee’s immigration documents and thus have indirectly taken part in the private enforcement of federal immigration laws. Proponents of private enforcement argue that its use “multip[lies] the number of immigration law enforcers without adding significant costs.” These advocates attest that with more enforcement, “illegal immigration will decrease, as more unauthorized immigrants are deported, voluntarily return home, or are deterred from trying to immigrate in the first place.”

With private enforcement already prevalent, it is likely that the Affordable Care Act’s prohibition on undocumented immigrants’ access to health insurance subsidies will lead to an increase in its use by health insurance providers. Such private enforcement schemes, if enacted, would effectively chill an undocumented worker’s willingness to opt into the proposed bi-national health insurance solution outlined above.

To make matters worse, there was a legislative initiative to force hospitals to inquire about a patient’s immigration status before providing care, and to report undocumented immigrants to the Department of Homeland Security. Although the bill in question was defeated in the 108th Congress, fear of detection remains. Further exacerbating the problem,


173. Id. at 779.

174. Id. at 780.

175. Id.


some hospitals faced with limited funding and high numbers of uninsured patients are “choosing to return patients to their countries of origin by either plane or ambulance. Many hospitals in the United States repatriate patients to reduce the cost of providing uncompensated care for uninsured patients who are ineligible for government aid because of their immigration status.”

Even if private employers wished to conduct enforcement measures, determining an immigrant’s eligibility for subsidies and access to health insurance exchanges will raise logistical and political questions about how to implement such immigration-status restrictions. Furthermore, legal immigration status verifications would be difficult “because the United States lacks a reliable document-based identification system[].” Even if an individual’s identity could be established, the federal government, let alone hospitals, lacks “a simple and reliable electronic system for verifying citizenship or immigration status.” Requirements designed to screen out unauthorized immigrants may also entail high administrative costs and even delay coverage for some U.S. citizens.

Furthermore, forcing health care officials to perform the duties of Department of Homeland Security officials may even “hinder them from pursuing their professional duty to heal. . . [and] violate [a doctor’s] Hippocratic oath.” Dissimilar private enforcement schemes among states could also result in unequal reporting of immigration problems, interfering with the Founders’ goals of uniformity throughout the federal immigration

179. See Bosniak, supra note 149.


181. See CAPPs, ROSENBLUM, & FIX, supra note 116, at 26.

182. Id.

183. Id.

184. Id. at 27.

arena. Additionally, while private verification requirements are designed to prevent unauthorized immigrants from illegally accessing health benefits, experts have argued that a verification mandate, if poorly designed, could have the biggest impact on U.S. citizens.

2. Proposed Federal Verification Requirements and the Problems They Cause

There are two proposed federal verification systems to ensure immigrants’ eligibility for purchasing insurance under new health insurance systems: the Secure Alien Verification for Entitlements (SAVE) program, and the E-Verify program. The federal government currently uses SAVE to verify an individual’s immigration status and eligibility before they receive a public benefit, like Medicaid. The system compares an individual’s name, Social Security number, and alien identification number with information in the Department of Homeland Security databases to determine

186. See Paula Sue Smith, An Argument Against Mandatory Reporting of Undocumented Immigrants by State Officials, 29 COLUM. J.L. & SOC. PROBS. 147, 164-65 (1995) (arguing that mandatory reporting by state officials will undermine the federal immigration system and diminish uniformity across the states); see also Alexander Hamilton, James Madison, & John Jay, The Federalist No. 32 (1788), available at http://www.constitution.org/fed/federa32.htm (delineating immigration law as one of three instances where federal powers should completely usurp state’s autonomy to provide uniformity).

187. See CAPPS, ROSENBLUM, & FIX, supra note 116, at 26-27 (arguing that verification approaches might screen out US citizens and legal immigrants from programs they are eligible for, or force them to face delays in access to coverage).

188. SAVE was created in 1987 and is “an inter-governmental initiative designed to aid benefit-granting agencies in determining an applicant’s immigration status, and thereby ensure that only entitled applicants receive federal, state, or local public benefits and licenses. The Program is an information service for benefit-issuing agencies, institutions, licensing bureaus, and other governmental entities.” What is SAVE, U.S. CITIZENSHIP AND IMMIGRATION SERV., http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=dc4f2363d8928310VgnVCM10000082ca60aRCRD&vgnextchannel=dc4f2363d8928310VgnVCM10000082ca60aRCRD (last updated Oct. 1, 2012).

189. CAPPS, ROSENBLUM, & FIX, supra note 116, at 28-31.

190. SAVE, supra note 188.
immigration status.\textsuperscript{191} Using the SAVE model for health insurance screening will increase costs for any health insurance system—"an investment that may offer low returns given how few unauthorized immigrants were found to have been denied [health benefits in the past, such as] Medicaid . . . ."\textsuperscript{192}

While SAVE is intended to aid federal agencies in the screening process, E-Verify is a government database that allows employers to screen employees based on immigration status. \textsuperscript{193} Some lawmakers have proposed that insurance providers use the E-Verify system to screen an employees' immigration status before providing health insurance. \textsuperscript{194} According to immigration experts, "eligibility screening for private insurance based on immigration status would represent a significant new restriction on private insurance markets[,]" creating new costs on employers and insurance providers. \textsuperscript{195}

Allowing employers or insurance providers to privately enforce immigration laws through screening requirements will effectively limit unauthorized immigrants' access to health insurance coverage and will "represent an even sharper departure from the status quo." \textsuperscript{196} Additionally, these verification tools will create significant costs for businesses and raise the cost of insurance for all Americans, effectively reducing coverage for both immigrants and U.S. citizens. \textsuperscript{197}

\begin{itemize}
\item \textsuperscript{191} CAPPS, ROSENBLUM, & FIX, supra note 116, at 28.
\item \textsuperscript{192} Id.
\item \textsuperscript{193} Id.
\item \textsuperscript{194} CAPPS, ROSENBLUM, & FIX, supra note 116, at 31.
\item \textsuperscript{195} Id.
\item \textsuperscript{196} Id.
\item \textsuperscript{197} Id.
\end{itemize}
C. A Response to the Arguments Against Health Insurance for Undocumented Workers

In the years since IRCA created these private enforcement regimes, employer sanctions have not deterred illegal immigration; in fact, hardly any of IRCA’s intended provisions to deter illegal immigration have been effective. According to many experts, employment is the most effective attraction bringing undocumented immigrants to the United States. Since legal access to health care is not a factor that lures undocumented immigrants to the United States, preventing undocumented Mexican migrant workers from purchasing health insurance is not likely to limit the number of undocumented immigrants entering the United States.

In Hoffman, the Supreme Court denied back pay to undocumented workers whose labor rights were violated, with the idea that it “would encourage the successful evasion of apprehension by immigration authorities, condone prior violations of the immigration laws, and encourage future violations.” Many may criticize the proposals this Comment outlines for similar reasons—that providing healthcare benefits will incentivize immigrants to cross the border, obtain employment, and remain in the country illegally and indefinitely. However, when Congress enacted IRCA, they focused on employer conduct, arguing that


201. See id. at 150-151 (holding that providing employment “benefits” would encourage illegal border crossing).

"[e]mployment is the magnet that attracts aliens here illegally[.]" Immigrants come to this country illegally due to poverty in their country of origin, and the American demand for low-wage, low-skilled labor, not for the opportunity to obtain health care.

Furthermore, Mexican immigrants arrive from a country that provides subsidized health insurance to all citizens. Offering health insurance benefits to undocumented Mexican immigrants will not increase their determination to enter the United States. Contrary to public belief, undocumented immigrants rarely seek access to Medicaid or other federal benefits for which they are ineligible. According to a study by the House Committee on Oversight and Government Reform, for every $100 spent on Medicaid documentation requirements, the federal government saved only 14 cents as a result of denying coverage to unauthorized immigrants. Additionally, in a Government Accountability Office (GAO) survey of forty-four states, only one state reported savings as a result of unauthorized immigrants being denied coverage through changes in Medicaid documentation standards.


205. See Bosniak, supra note 199 (describing American demand for low-wage, low-skilled labor as one of many causes of illegal immigration).


207. CAPPS, ROSENBLUM, & FIX, supra note 116, at 27.

208. See Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions: Hearing Before the House Committee on Oversight and Government Reform, U.S. HOUSE OF REPRESENTATIVES, (July 24, 2007), http://oversight-archive.waxman.house.gov/documents/20070724110341.pdf (Study looked at six states and found evidence of only eight unauthorized immigrants who had enrolled in Medicaid. The Medicaid documentation requirements were authorized by the 2005 Deficit Reduction Act).

209. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-889, MEDICAID: STATES REPORTED CITIZENSHIP DOCUMENTATION REQUIREMENT RESULTED IN ENROLLMENT
Given all of the factors driving an individual to immigrate to the United States, the hope of gaining health insurance will likely not "alter an immigrant's calculus."\textsuperscript{210} As long as undocumented immigrants have the ability to earn wages up to ten times higher than in Mexico, and the United States continues to provide sound economic solitude, immigrants will have an incentive to enter American workplaces, regardless of the allowance of health care protections.\textsuperscript{211} Barring illegal immigrants from receiving health insurance coverage will not achieve a significant reduction in illegal immigration because social benefits are not the primary lure for these migrants.\textsuperscript{212}

III. CONCLUSION

The United States federal government should allow undocumented Mexican immigrants access to health services without the fear of removal, since universal health care availability is needed for the safety of the American public and the well-being of individuals. With the high number of undocumented Mexican migrant workers in the United States, it is sensible for both the United States and Mexico to work together in order to provide health care coverage to the many undocumented Mexican immigrants who migrate across the border. Regardless of one's viewpoint on the undocumented immigrant issue, it is undeniable that these migrants are in need of medical protection and services and do not always receive the adequate care they deserve.

In order to provide proper health care coverage for undocumented Mexican migrant workers, the U.S. and Mexican governments need to allow for employer-provided, federally subsidized bi-national insurance plans. To achieve this goal, it is imperative that the United States reduce its

\textsuperscript{210} See Keith Cunningham-Parmer, \textit{Redefining the Rights of Undocumented Workers}, 58 Am. U. L. Rev. 1361, 1396 (2009) (arguing that the Hoffman Court could not have believed that recovering backpay from a labor law violation would have encouraged an immigrant to enter the United States illegally).


\textsuperscript{212} \textit{Impact of Illegal Immigration on Public Benefit Programs and the American Labor Force: Hearing Before the Subcomm. on Immigration And Claims of the H. Comm. on the Judiciary}, 104th Cong. 12, 23 (1996).
dependence on private enforcement of immigration laws to deter illegal immigration. Undocumented Mexican immigrants will be unwilling to take part in cross-border health plans as long as their illegal status prevents them from accessing public health benefits. Furthermore, denying employer-provided bi-national health insurance to undocumented immigrants through the 'private enforcement' of immigration laws is ineffective and harmful.

Since most immigrants come to the U.S. illegally for jobs, not health insurance, allowing private employers or hospitals to inquire into an individual’s immigration status when granting a benefit such as health insurance offers a futile attempt at minimizing illegal immigration. Limiting the immigration enforcement rules of IRCA, and providing cross-border insurance options, will not only allow undocumented Mexican immigrants access to reasonable health care, but will also limit the financial burdens placed on the United States, cut employer insurance costs, and provide immigrant families with the health protections they need, regardless of where they legally reside. While health care reform should have taken place in conjunction with immigration reform, the issues are complex and the topics polarizing. While it may not be feasible for every individual to have health care in the United States, this bi-national insurance solution provides an affordable and efficient means of providing the much-needed care to those who have very few options.