

## THE SOCIAL PSYCHOLOGY OF LIMITING HEALTHCARE BENEFITS FOR UNDOCUMENTED IMMIGRANTS – MOVING BEYOND RACE, CLASS, AND NATIVISM

by Dayna Bowen Matthew\*

“[O]ur history tells us that immigration in the American story has always been controversial—associated always with both benefits and costs. . . . For native populations, European immigration meant death by disease, warfare, and social disorganization, a virtual genocide in which their populations fell by 90 percent by 1600. . . . When these death-bringing European immigrants became Americans by birth, their own response to further immigration was mixed. Industrious immigrants were indispensable in expanding colonial populations, and they were welcomed in the abstract and upon arrival. However, the quality of immigrants . . . was [and remains] a constant issue of concern.”<sup>1</sup>

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\* Professor of Law and Associate Dean for Academic Affairs, University of Colorado Law School. B.A., 1981, Harvard-Radcliffe; J.D. 1987, University of Virginia. I am grateful for the comments and support for this project that I received from colleagues Jennifer Smith and Elizabeth Pendo at the 2009 Southeast/Southwest People of Color Legal Scholarship Conference. I also appreciate the research assistance of Keith Scranton, Thomas Cordova, and Katherine Hermann.

<sup>1</sup> Otis L. Graham, *The Unfinished Reform: Regulating Immigration in the National Interest*, in *DEBATING AMERICAN IMMIGRATION, 1882 – PRESENT* 89, 91 (Roger Daniels & Otis L. Graham, Rowman & Littlefield Publishers, Inc., 2001). Despite the accuracy of this quote, and my own reasons for selecting it, the original context that Professor Graham intends must not be overlooked. His opening premise in the essay from which the quote is taken is to assert that the concept of America as a “nation of immigrants” is both “hackneyed” and inaccurate. Graham’s point is that “America is a nation of the native-born” despite the fact that “the immigration stamp is upon us.” I use this quote to introduce both the reality of the threat to native populations that unbridled immigration represents, and the irony that many of those

## I. INTRODUCTION

This essay offers a new tool to advance the discussion about how the law should respond to the presence of undocumented immigrants in American society. Borrowing the Group Identity Model formulated by social psychologists to explain the process of social categorization by which human beings naturally organize themselves into in-groups and out-groups and develop social perceptions to reinforce intergroup conflict, my thesis is that the problems that result from social categorization—prejudice, stereotyping, discrimination, hatred, conflict and violence—can be reversed by the process of what social psychologists call “re-categorization.” In short, re-categorization introduces members of two previously separate groups of people to the recognition of their combined membership in a single, inclusive, superordinate group. Researchers have repeatedly shown that if groups can be induced to conceive of themselves as one instead of two groups, changed cognitive representations will cause a reduction in intergroup bias. The result is that members of the two groups change their attitudes and behavior as they become involved in shared causes defined by the new in-group. Social psychologists have empirically shown that inter-group relations may be improved through the deliberate exercise of re-categorization. Thus, this essay explores the idea that immigration policy-makers might better address the problem of regulating undocumented immigrants in the United States by consciously employing the lessons learned from social psychologists’ understanding of the Group Identity Model in reforming immigration law.

I apply the Group Identity Model to the question of whether publically funded healthcare should be extended to undocumented immigrants. This is a question which the United States Congress as well as a flurry of state and local legislative bodies have recently addressed by enacting a wave of statutes to control the extent to which undocumented immigrants have access to publically funded benefits. These laws are motivated by perceptions that “illegals” compete against residents for jobs, education, health benefits, and other scarce resources. The narrative often is characterized by classic

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now native-born Americans who seek to limit immigration today are directly descended from the Europeans (and others) whose immigration virtually destroyed a civilization.

in-group vs. out-group rhetoric. Yet, especially in the case of the laws that restrict access to healthcare benefits services, the “us” against “them” dynamic is patently counterproductive. The generally restrictive trend in these laws to deny most healthcare benefits to an estimated 12 million non-citizens living in America<sup>2</sup> has created what one commentator has described as a “public health nightmare.”<sup>3</sup>

The laws that restrict non-citizens from receiving healthcare benefits are oddly both self-preserving and self-destructive. In general, the current legal policy regime responds to the problem of allocating limited public resources to a large and rapidly growing population of undocumented immigrants<sup>4</sup> who are characterized by high fertility rates, high incidence of communicable diseases, and are largely employed in food service/preparation, domestic household employment, and agriculture.<sup>5</sup> In these jobs, undocumented immigrants come into close contact with the entire population, citizens and non-citizens alike. Legislatively restricting their access to all healthcare except emergency and basic public healthcare in order to discourage an over-burdening of public resources, disregards the threat that untreated communicable diseases pose to the community’s overall health and safety. On its face, a restrictive policy saves public benefit money, but it also increases the threat of disease spreading throughout the entire population. Psychologists offer insights to help explain the motives behind this seemingly counterintuitive policy and offer ideas to improve the immigration laws in a way more consistent with the goal of protecting overall public health. This essay sets out a summary of those insights and seeks to begin a discussion of how immigration law and policy might

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<sup>2</sup> JEFFREY PASSEL & D’VERA COHN, PEW HISPANIC CENTER, A PORTRAIT OF UNAUTHORIZED IMMIGRANTS IN THE UNITED STATES, at i (April 14, 2009), <http://pewhispanic.org/files/reports/107.pdf>.

<sup>3</sup> Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-immigrant Provisions of the “Contract with America” Congress*, 90 KY. L. J. 1043, 1044 n.5 (2001-2002).

<sup>4</sup> U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, PROFILE OF THE FOREIGN-BORN POPULATION IN THE UNITED STATES: 2000, at 9 (2001). Following the increased annual cap on immigration that was part of the Immigration Act of 1990, the number of immigrants to the United States has increased rather steadily through the year 2000. The following two years saw a marked decline in the number of out of status immigrants.

<sup>5</sup> Fred Arnold, *Providing Medical Services to Undocumented Immigrants: Costs and Public Policy*, 13 INT’L MIGRATION REV. 706, 711 (1979); U.S. CENSUS BUREAU, *supra* note 4, at 5, 30.

take advantage of the lessons that social psychologists teach.

The proposition set forth in this thesis is that American immigration policy would benefit from the Group Identity Model in two ways. First, by embracing the understanding social psychologists have advanced about the fundamental nature of the human tendency toward social categorization, the conversation about inclusivity and exclusivity among citizens and non-citizen groups might discard much of the polarizing presumptions and rhetoric about the current group interaction that has characterized the immigration reform discussion. Second, by employing the theory's wisdom about re-categorization, at least with respect to the distribution of healthcare benefits, scarce resources might be allocated in a way that relies much more on functionality, shared purposes, and a realignment of currently competing interests rather than upon the differences between citizens and non-citizens that separate in-group and out-group members based upon their mode of arrival in this country, their length of stay in America, or fears associated with their immutable characteristics. In the end, I hope that by applying the Group Identity Theory to shed light on the policies underlying the law pertaining to non-citizens' access to health benefits, we might develop a fresh perspective that will introduce new solutions to the ongoing conversation about reforming immigration law.

## **II. THE PUBLIC POLICY PROBLEM: UNDOCUMENTED IMMIGRANT ACCESS TO PUBLICLY FUNDED HEALTHCARE**

This essay focuses specifically on one aspect of immigration policy: the question of how to regulate undocumented immigrants' access to the American healthcare system. For three reasons, the healthcare access restrictions concretely reveal the dilemma created by laws that build upon inter-group bias, and the benefit that could result from a shift in policy.

First, we know empirically that the sole or primary motivation to immigrate to the United States is *not* to participate in the healthcare system.<sup>6</sup> Of all the benefits and services excluded by immigration

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<sup>6</sup> See Dana P. Goldman et al., *Immigrants and the Cost of Medical Care*, 25 HEALTH AFFAIRS 1700 (2006) (showing evidence that undocumented immigrants underutilize the American

control statutes—education, public assistance, employment—access to American healthcare is the least likely lure to our American shores. While the world may look with envy upon the excellently trained practitioners, spectacularly well equipped facilities, and stunningly advanced medical technology and procedures available in the United States, approximately 46.3 million people who are already here do not have access to the wonders of American medicine until they need it emergently.<sup>7</sup> Thus, with some notable exceptions, the prospect of leaping over citizens to gain access to American medical services would be an irrational reason to come to this country. Discussing restrictions on immigrant access to healthcare squarely confronts the soundness of a public policy that assumes that withholding public benefits from one group of people—undocumented immigrants—will decrease the incentive for people to come across our borders illegally and consume resources belonging to another group—United States residents. By confronting the most basic assumptions about restrictions on healthcare benefits, we can evaluate the status-quo reasoning and form effective ways to allocate scarce resources in an independent society.

Second, the conversation among legal scholars about disparate access to healthcare is already proceeding but has not meaningfully included foreign born individuals. We have considerable data demonstrating that patterns of access and quality of healthcare are unequal, but most of the evidence fails to identify the incidence of disparities among immigrants specifically.<sup>8</sup> While the statistical evidence of disparities is abundant, we know much less about the causes of and reasons for disparities. This essay seeks to enlarge the

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healthcare system. For example, in 2000, although non-citizens accounted for an estimated 12% of the non-elderly adult population, they accounted for only 6% of healthcare spending: "The foreign-born (especially the undocumented) use disproportionately fewer medical services and contribute less to healthcare costs in relation to their population share, likely because of the better relative health and lack of health insurance").

<sup>7</sup> U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, 22 (2009). The enactment of the Patient Protection and Affordable Care Act will significantly reduce the number of uninsured Americans, however, the political vow that surrounds this new law is unlikely to signal that Americans welcome newcomers to it healthcare system.

<sup>8</sup> See generally INST. OF MED. OF THE NAT'L ACADEMICS, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et. al., eds., 2003).

conversation about disparate access to healthcare to address the circumstances unique to undocumented immigrants.

Finally, by considering the current trend toward enactments that deny access to undocumented immigrants particularly, we may learn more about our underlying motivations for distributing healthcare, as well as other goods and services, as we do throughout the whole society. I suggest here that this insight will advance immigration reform efforts more effectively than existing analytical discussions have. To the extent that they are accurate, continuing to rely upon the existing “stories” that explain the shortcomings of immigration policy generally, and public benefit provisions specifically, is unlikely to yield new solutions. The explanations that turn on proving a resurgence of nativism,<sup>9</sup> or that highlight the impact of class divisions on immigration policy,<sup>10</sup> may shed light to some degree. However, they seldom take serious note of the competing interest in managing scarce medical resources that necessarily also animates immigration policy. For example, in 1994, the Urban Institute conducted a systematic assessment of the economic impact of undocumented immigrants in the United States, focusing on the seven states in which approximately 86% of all undocumented immigrants live.<sup>11</sup> This study concluded that the costs imposed by undocumented immigrants include: criminal incarceration (\$471 million), education (\$3.1 billion), and Medicaid and emergency medical care (\$200–300 million).<sup>12</sup> These costs, the study estimated are offset by economic contributions by undocumented immigrants which include sales,

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<sup>9</sup> See generally Elliot R. Barkan, *Return of the Nativists?: California Public Opinion and Immigration in the 1980s and 1990s*, 27 SOC. SCI. HIST. 229–83 (2003) (refuting the charge that Californians are more anti-immigrant in their attitudes than other Americans).

<sup>10</sup> Timothy J. Hatton & Jeffrey G. Williamson, *A Dual Policy Paradox: Why Have Trade and Immigration Policies Always Differed in Labour-Scarce Economies?* (Inst. for the Study of Labor – Discussion Paper No. 2146 (May 2006) (“Thus, immigration policy is much tougher now than a century ago simply because there are far more potential immigrants from poor countries to keep out.”).

<sup>11</sup> Philip J. Romero, *Racing Backwards – The Fiscal Impact of Illegal Immigration in California, Revised*, 17 THE SOCIAL CONTRACT 230, 233–34 (2007).

<sup>12</sup> PETER M. SCHUCK, THE TREATMENT OF ALIENS IN THE UNITED STATES, IN PATHS TO INCLUSION – THE INTEGRATION OF MIGRANTS IN THE UNITED STATES AND GERMANY 203, 231 (Peter M. Schuck & Rainer Münz eds., Berghahn Books 1998).

property, and state income tax revenues (\$1.9 billion).<sup>13</sup> Moreover, these existing explanations do not necessarily point to a set of possible solutions or invite opposing sides of the debate to explore positions of consensus. At the very least, the discussion of social psychology tools presented in this essay will offer a new vocabulary and tool-box to consider when looking at ways to set policy pertaining to undocumented immigrants. With these three goals in view, I turn now to outlining the federal and state law provisions that control non-citizens' access to healthcare.

### III. THE CURRENT LAW

Much has been written about the shifting balance of authority between the federal and states government efforts to regulate immigration over the past quarter century. Whether and on what terms to distribute healthcare benefits to undocumented immigrants presents a curiously disorganized picture of one aspect of immigration policy. It is instructive, for our purposes, to highlight the ways in which old paradigms that underlie immigration policy have failed to yield any satisfactory approaches to immigration healthcare policy. The right to control immigration is constitutionally delegated to the federal government and is inherent, the Supreme Court has said, in the nation's sovereignty.<sup>14</sup> Yet, within the past twenty-five years Congress has boldly extended its authority to prohibit states from providing public benefits to immigrants, then retracted its prohibition, and finally, delegated to the states the responsibility to determine whether to extend or withhold public benefits from undocumented immigrants. States have responded in conflicting ways, some in the extreme. When states have gone too far, the federal courts have stepped in to reverse their actions.<sup>15</sup> This section

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<sup>13</sup> *Id.* at 231.

<sup>14</sup> *See, e.g.,* *Nishimura Ekiu v. United States*, 142 U.S. 659, 659 (1892); *Plyler v. Doe*, 457 U.S. 202, 225 (1982). Both cases construe Article I, section 8 of the United States Constitution which grants the federal government "the power to establish a uniform Rule of Naturalization," and to "regulate Commerce with foreign Nations." U.S. CONST. art. I, § 8, cl. 3-4.

<sup>15</sup> *See* discussion below of California's Proposition 187 held preempted by federal law in *League of United Latin American Citizens v. Wilson*, 997 F. Supp. 1244 (C.D. Cal. 1997).

provides a basic summary of the legal regime that I propose by briefly summarizing the recent federal and state enactments that affect access to healthcare by undocumented immigrants.

### **A. Federal Rules that Define Access for Undocumented Immigrants**

The list of major federal enactments that control undocumented immigrants' access to healthcare begins with a statute that is not specifically for immigrants at all.<sup>16</sup> Enacted in 1965 as Title XIX of the Social Security Act,<sup>17</sup> the Medicaid Act, created joint partnerships between the federal government and each state government to fund a safety net, making medical care available to the "categorically needy."<sup>18</sup> People are eligible to receive Medicaid's publically funded health insurance if they are unable to pay for their healthcare because their income is at or near the federal poverty level, they suffer from certain disabilities, or they are in need of long term care.<sup>19</sup> Because states have considerable discretion to define their Medicaid programs, it has been said that Medicaid is really a loose collection of fifty different healthcare programs for the poor, disabled, and chronically ill. Generally, however, some undocumented immigrants may be eligible to receive healthcare through Medicaid because of their low income levels—21.3% of foreign born non-citizens live in poverty as compared to 11.8% of the general population.<sup>20</sup>

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<sup>16</sup> This is not a comprehensive discussion of all federal immigration legislation, but only those laws that directly impact healthcare access for undocumented immigrants. For example, the centerpiece of the federal government's exercise of its constitutional authority to regulate immigration, the Immigration and Nationality Act ("INA") codified in Title 8 of the U.S. Code, is not discussed here. The INA describes the enforcement authority of federal officials charged with regulating the entry, terms and length of stay, and deportation related to aliens in the United States. In 1986, Congress passed the Immigration Reform and Control Act ("IRCA"), modifying the INA, to authorize amnesty for some undocumented immigrants who had been in the United States since January 1, 1982. At the same time, this amnesty program was coupled with grants of increased authority and resources for border enforcement and sanctions for employers who knowingly employ illegal aliens.

<sup>17</sup> 42 U.S.C. § 1396 (2009).

<sup>18</sup> U.S. SOCIAL SECURITY ADMIN., ANNUAL STATISTICAL SUPPLEMENT 2008 (2008), available at <http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2008/medicaid.pdf>.

<sup>19</sup> *Id.* at 2-3.

<sup>20</sup> U.S. CENSUS BUREAU, *supra* note 4, at 46.

The second relevant federal statute is the Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986 to grant access to emergency healthcare to all in an emergency medical condition.<sup>21</sup> The statute is colloquially known as the “Anti-Dumping Act” because it requires healthcare providers to provide emergency medical services to all patients, notwithstanding their ability to pay for those services and without any reference to their immigration status.<sup>22</sup> Thus, EMTALA guarantees that undocumented immigrants will receive free stabilizing emergency medical care, even if no other publicly funded healthcare services are accessible.

Next, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) established the terms and conditions upon which undocumented immigrants may receive public benefits in the United States.<sup>23</sup> The PRWORA divides immigrants into those who are “qualified aliens” eligible to obtain state funded benefits, and all other aliens who are not “qualified” to receive benefits.<sup>24</sup> Those qualified include legally admitted permanent residents under the INA, asylees, refugees, or those granted conditional entry under the INA.<sup>25</sup> Also, “qualified aliens” include certain Cuban and Haitian entrants, as well as victims of violent battering, and their children.<sup>26</sup> Access to publically funded healthcare is included among the benefits PRWORA regulates, along with other essential services such as housing, education, food stamps, and disability benefits.<sup>27</sup> Congress did, however, leave considerable discretion to state governments wishing to modify the PRWORA’s

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<sup>21</sup> 42 U.S.C. § 1395dd (2010).

<sup>22</sup> *Id.*

<sup>23</sup> Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, 2260-78 (1996). However, the Balanced Budget Act of 1997, restored some benefits to immigrants with legal status in the United States by limiting the PRWORA’s application only to those immigrants arriving after August 22, 1996. Pub. L. No. 105-33, 111 Stat. 251, 597-98 (1997).

<sup>24</sup> Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, 2260-78 (1996).

<sup>25</sup> *Id.* at 2274.

<sup>26</sup> *Id.* at 2138, 2266.

<sup>27</sup> *Id.* at 2268.

federal restriction of public benefits to only “qualified aliens.”<sup>28</sup> The statute creates exceptions to allow all immigrants to receive emergency medical services, immunizations, testing and treatment services for communicable diseases, and any other assistance necessary to protect life or safety.<sup>29</sup> Moreover, the federal law dictates that after August 22, 1996, any state legislature wishing to extend public benefits to unqualified immigrants could do so by affirmative enactment.<sup>30</sup> Finally, the PRWORA also permits states to further restrict the public benefits available to even “qualified aliens,” within certain time limits set by the federal law.<sup>31</sup> In short, the PRWORA set a broad federal agenda aimed at limiting access to public benefits by all immigrants, and then invited states to exercise their discretion to either expand or further limit those benefits to within their respective borders. All fifty state legislatures have accepted the federal invitation to follow PRWORA with public benefit laws of their own.<sup>32</sup> In 2006, state legislatures enacted eighty-four immigration measures which equal only half the number of immigration laws enacted by forty-one states in 2007.<sup>33</sup> Of approximately 1170 immigration related bills introduced in 2007, twenty-three states passed ninety-two laws to address immigrants’ eligibility to receive publically funded healthcare services.<sup>34</sup>

Since passage of the PRWORA, Congress has been working to reign in its harsh provisions, rolling back some of its most far-reaching restrictions. In 1997, the Balanced Budget Act (“BBA”) limited the group of immigrants affected by PRWORA to those

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<sup>28</sup> *Id.* at 2141.

<sup>29</sup> 110 Stat. at 2261.

<sup>30</sup> *Id.* at 2269.

<sup>31</sup> *Id.* at 2269–70.

<sup>32</sup> PETER H. ROSSI, *Research on PROWORA: What can be Learned from Large Scale Projects Currently Underway*, in *FOUR EVALUATIONS OF WELFARE REFORM-WHAT WILL BE LEARNED* 9, 30 (Douglas U. Besharou & Peter Germanis eds., 2001).

<sup>33</sup> Julia Preston, *Immigration is at Center of New Laws Around U.S.*, N.Y. TIMES, Aug. 6, 2007, at A12.

<sup>34</sup> NAT’L CONFERENCE OF STATE LEGISLATURES, *OVERVIEW OF STATE LEGISLATION RELATED TO IMMIGRATION AND IMMIGRANTS IN 2007* (April 18, 2007) (In 2007, all 50 states introduced 1169 immigration related bills and resolution; this is twice the number introduced by state legislatures in 2006).

arriving after August 1996.<sup>35</sup> Also, the BBA allocated \$25 million per year to each of twelve states with the “highest number of undocumented aliens . . . based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the INS, to cover the cost of covering emergency care provided under EMTALA to these patients.<sup>36</sup>

In 2003, Congress enacted the most recent federal provision to address immigrant access to healthcare. The Medicare Prescription Drug, Improvement, and Modernization Act (“MMA”) included a provision allocating \$1 billion over a three year period to reimburse hospitals for the cost of providing care to undocumented immigrants.<sup>37</sup> Court challenges to the PRWOA have also resulted in narrowing the statute’s prohibitory reach. For example, in *Lewis v. Thompson* the Second Circuit ruled that PRWORA’s denial of prenatal care to immigrant mothers not “qualified” to receive public benefits under its terms had a rational basis and thus did not violate the U.S. Constitution, but applying the act to deny automatic Medicaid coverage for the children of undocumented aliens born in this country violated the equal protection rights of these new Americans.<sup>38</sup>

The effect of these federal rules is to grant undocumented immigrants emergency medical assistance and medical care—including emergency disaster relief, and public health assistance for communicable diseases including immunizations, testing, and treatment of symptoms of communicable diseases (even if the symptoms turn out not to be caused by a communicable disease)—funded by the Medicaid program so long as that assistance is not

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<sup>35</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, III Stat. 251, 515 (1997) (providing payments for four consecutive years from 1998 to 2001).

<sup>36</sup> *Id.* at 515-16.

<sup>37</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2446 (2003); see also Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. REV. 223, 275 (Dec. 2006) (explaining that hospitals had only three sources of funds to reimburse for cost to care for undocumented immigrants before the MMA appropriation: (1) short term Medicaid coverage; (2) disproportionate share hospital reimbursements; and (3) the BBA payments available to 12 states with the highest numbers of undocumented immigrants).

<sup>38</sup> *Lewis v. Thompson*, 252 F.3d 567, 569 (2nd Cir. 2001).

related to an organ transplant procedure and the patient meets the relevant state's eligibility requirements<sup>39</sup> The federal government's patchwork of legislation that regulates the availability of these health benefits evinces an ambivalent series of line-drawing exercises, dividing the qualified from the un-qualified immigrants, distinguishing emergency from chronic care and public healthcare, and separating children from their parents once they have exited the womb of an undocumented alien. This Congressional approach leaves broad discretion to the states but provides little guidance. The result has been a conflicting and erratic flurry of immigration legislation passed at the state level. The next section describes some of the leading state provisions that control illegal immigrants' access to healthcare services.

## **B. Access to Healthcare Under State Immigration Laws**

In 2005, twenty states had enacted legislation to restrict access to publicly funded health benefits by non-citizens.<sup>40</sup> Examining the laws passed most recently by the nine states that enacted these statutes during the last five years<sup>41</sup> provides a current and comprehensive survey of the variety of legislative approaches that operate across the country to limit healthcare access to non-citizens.

Arizona enacted its statute in 2004 pursuant to passage of a state initiative called the "Arizona Taxpayer and Citizen Protection Act."<sup>42</sup> This voter initiative, also known as "Proposition 200," was approved by 56% of Arizona voters, and a remarkable 47% of Latino voters.<sup>43</sup> It

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<sup>39</sup> See 3 C.J.S. *Aliens* § 94.

<sup>40</sup> See Brietta R. Clark, *The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System*, 17 ANNALS OF HEALTH L. 229, 234 (2008). *But c.f. id.* at n.21 (explaining that several states have extended full Medicaid benefits to undocumented immigrants using state funds to cover those who do not qualify for federal aid).

<sup>41</sup> ARIZ. REV. STAT. § 46-140.01 (LexisNexis 2004); COLO. REV. STAT. § 24-76.5-103 (2006); GA. CODE ANN. § 50-36-1 (2006); VA. CODE ANN. § 63.2-503.1 (2006); IDAHO CODE ANN. § 67-7901 (2007); OKLA. STAT. ANN. tit. 56, § 71 (WEST 2007); S.C. CODE ANN. § 8-29-10 (2008); MISS. CODE ANN. § 71-11-1 (2008); UTAH CODE ANN. § 63G-11-104 (2009).

<sup>42</sup> ARIZ. REV. STAT. § 46-140.01 (2004); Raquel Aldana, *On Rights, Federal Citizenship, and the "Alien"*, 46 WASHBURN L.J. 263, 274-75 (2007).

<sup>43</sup> Aldana, *supra* note 42, at 274-75 (Proposition 200 went further, imposing voting restrictions, criminal reporting penalties, and more. Although it is beyond the scope of this essay, social

included the requirement that all state agencies verify the immigration status of those applying to avail themselves of public benefits, including medical services, and required the information be reported to federal immigration authorities.<sup>44</sup> Not only does the law make the failure to report a violation of federal immigration statutes a Class 2 misdemeanor, but it also creates a private cause of action for Arizona citizens wishing to sue any agent or agency for failure to comply with the verification and reporting requirements under the statute.<sup>45</sup>

In 2005 and 2006, Georgia, Virginia, and Colorado all enacted statutes to restrict access to healthcare and other public benefits to non-citizens; Idaho and Oklahoma followed in 2007.<sup>46</sup> The South Carolina, Utah, and Mississippi legislatures enacted statutes in 2008.<sup>47</sup> Virginia and Mississippi each took unique approaches to protecting their publicly funded resources. Virginia's legislature opted to specifically outline the narrow range of medical services that undocumented immigrants have access to in that state,<sup>48</sup> while Mississippi's law is void of any specific directives and instead announces a statement of legislative findings and purpose:

The Legislature finds that when illegal immigrants have been sheltered

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psychologists have described the phenomenon of in-group bias that may explain the support that Latino voters lent to Proposition 200's passage and other similar legal restrictions on immigrants and immigration. They theorize that excluded out-group members such as ethnic minorities seek to identify and draw themselves closer to the members of the majority in-group by placing distance between themselves and other, more vulnerable out-group members who share their characteristics. The idea is foreign born citizens may seek to decrease the distance between themselves and natives by voting to increase the disparity between themselves and other minorities in the out-group).

<sup>44</sup> ARIZ. REV. STAT. § 46-140.01 (LexisNexis 2010).

<sup>45</sup> *Id.*

<sup>46</sup> See GA. CODE ANN. § 50-36-1 (2006); VA CODE ANN. § 63.2-503.1 (2006); COLO. REV. STAT. § 24-76.5-103 (2006); IDAHO CODE ANN. § 67-7901 (2007); OKLA. STAT. tit., 56, § 71 (2007).

<sup>47</sup> See S.C. CODE ANN. § 8-29-10 (2008); MISS. CODE ANN. § 71-11-1 (2008); UTAH CODE ANN. § 63G-11-104 (2008).

<sup>48</sup> VA. CODE ANN. § 32.1-325.03 (2009) (stating "no person who is not a United States Citizen or legally present in the United States shall receive medical services under this chapter, except for . . . [those eligible for pre-existing] Medicaid benefits for those residing in long-term institutional facilities or participating in home and community based waivers on June 30, 1997 . . . [or] Medicaid benefits for those who . . . are under the age of 19 years and" would have been eligible for Medicaid prior to PRWORA of 1996).

and harbored in this state and encouraged to reside in this state through the benefit of work without verifying immigration status, these practices impede and obstruct the enforcement of federal immigration law, undermine the security of our borders, and impermissibly restrict the privileges and immunities of the citizens of Mississippi. The Legislature further finds that illegal immigration is encouraged when public agencies within this state provide public benefits without verifying immigration status.<sup>49</sup>

Colorado's prohibitive language is virtually identical to the public healthcare restriction contained in the Georgia, Oklahoma, South Carolina, and Utah laws. Colorado was one of the first states to act after PRWORA was passed to reinstate Social Security Income and Medicaid eligibility for legal immigrants excluded under the federal statute.<sup>50</sup> Yet Colorado's experience is instructive more because of what happened after the law's enactment than for the language of the provision itself. The stated legislative objective, as articulated in Colorado's House Bill 1023, was that "all persons eighteen years of age or older shall provide proof that they are lawfully present in the United States prior to receipt of certain public benefits."<sup>51</sup> Although Colorado taxpayer monies may be spent under the law to provide undocumented immigrants with access to a K-12 education or services of a soup kitchen, the core prohibition under the law restricts access to healthcare.<sup>52</sup>

The law requires medical providers to verify the lawful presence of any applicant for medical care before treatment, excluding services for medical emergencies, pre-natal care, immunizations, and treatment of communicable diseases.<sup>53</sup> As a consequence, hospitals, clinics, and treatment centers that serve the indigent have turned away patients in non-emergent conditions, until their health

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<sup>49</sup> MISS. CODE ANN. § 71-11-1 (2009).

<sup>50</sup> See H.B. 05-1086, 65th Gen. Assem., 1st Reg. Sess. (Colo. 2005); National Conference of State Legislatures, A Review of State Immigration Legislation in 2005, Aug. 11, 2005, <http://www.ncsl.org/default.aspx?TabId=13133>. See also S.1534, 2005-06 Sess. (Cal. 2006); H.P. 1242, 122d Leg., 2d Reg. Sess. (Me. 2006) (enacted) (showing two states, California and Maine, which enacted legislation to extend healthcare benefits to undocumented immigrants beyond the limits of PRWORA).

<sup>51</sup> See Restrictions on Public Benefits, art. 76.5; COLO. REV. STAT. § 24-76.5-101 (amended 2006).

<sup>52</sup> See COLO. REV. STAT. § 24-76.5-103 (2009).

<sup>53</sup> *Id.*

deteriorated enough to warrant treatment under the law's exception for medical emergencies.<sup>54</sup> On the other hand, there is evidence that private donations are being used in place of public funds to provide some medical services to undocumented immigrants,<sup>55</sup> thus reducing the state's cost of providing publically funded care. Nevertheless, the question of whether tougher immigration laws actually save Colorado taxpayer dollars is unsettled.<sup>56</sup>

The 2006 Colorado law reached far beyond the central limitation on healthcare benefits. It addressed many other aspects of the state government's relationship to undocumented immigration, including providing for tougher measures to penalize and control smuggling or human trafficking, greater authority for law enforcement to verify and report arrestees' immigration status, penalties against employers who hire undocumented labor, and prohibitions against unlawful voting.<sup>57</sup> For example, its employment provision requires employers to verify employees' work status or risk fines or loss of economic development awards.<sup>58</sup> Deliberately voting in an election without authorized immigration status is penalized as a Class 5 felony under the law.<sup>59</sup> Colorado's law heavily penalizes use of counterfeit identification documents, and creates a full time investigative position to find those using falsified immigration documents.<sup>60</sup>

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<sup>54</sup> See Jennifer Brown, et al., *ID Law Packs Fear Factor, Many Lack Documents: Hospitals and Nonprofits that Help Needy Say a Law Barring State Funds for Illegal Immigrants has Kept Away Those Eligible for Aid*, DENVER POST, August 5, 2007, at A1 (describing a homeless man without documentation to prove his immigration status whose tooth could not be pulled until his overdose on pain medication warranted an emergency room admission).

<sup>55</sup> *Id.* (detailing Sister Carmen Community Center in Lafayette as an example of a provider who now shifts to private donations to pay for some services to undocumented immigrants).

<sup>56</sup> *Id.* (suggesting the \$2 million cost of implementing HB 1023 is not cost effective since undocumented immigrants do not generally use public services in Colorado and therefore the state has not realized any appreciable reduction in public expenditures).

<sup>57</sup> See generally, NAT'L CONFERENCE OF STATE LEGISLATURES, 2006 STATE LEGISLATURE RELATED TO IMMIGRATION: ENACTED AND VOTED (Oct. 31, 2006), <http://www.ncsl.org/Default.aspx?Tabid=13137> (summarizing Colorado Senate Bill 007, 90, 206 and 207 and House Bill 1017).

<sup>58</sup> See H. 1343, 2006 Leg., Reg. Sess. (Colo. 2006).

<sup>59</sup> See S. 7A, 2006 Leg., Spec. Sess. (Colo. 2006).

<sup>60</sup> See S. 110, 2006 Leg., Reg. Sess. (Colo. 2006); H. 1306, 2006 Leg., Reg. Sess. (Colo. 2006).

Colorado's immigration law instructs the state's attorney general to seek reimbursement from the federal government for the cost of incarcerating, educating, and providing healthcare to illegal immigrants and requires police officers to report the suspected illegal status of any arrestees.<sup>61</sup>

Colorado's Governor declared the law to be "the toughest law in the country dealing with illegal immigration" and explained its purpose as "a major breakthrough in the fight to control the costs of illegal immigration," urging other states to follow Colorado's lead.<sup>62</sup> Since 2006, using Colorado's HB 1023 as a template, eight other states have enacted similar restrictions on undocumented immigrants' access to public services. These other states also vied for bragging rights to claim the "toughest immigration law."<sup>63</sup>

Idaho's benefit restriction law<sup>64</sup> takes a different tact altogether. Like the other statutes, Idaho's law requires verification that an applicant for certain public benefits is lawfully present in the United States before receiving benefits.<sup>65</sup> The last sentence of the statute contains a telling disclaimer: "The intent of the legislature is not to regulate immigration but to control public expenditures for certain public benefits not inconsistent with federal law."<sup>66</sup>

This cost containment language provides a dramatic contrast to the Mississippi pronouncement that its legislature "declare[d] that it is a compelling public interest of this state to discourage illegal immigration by requiring all agencies within this state to fully cooperate with federal immigration authorities . . ."<sup>67</sup> Distinguish

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<sup>61</sup> See S. 90, 2006 Leg., Reg. Sess. (Colo. 2006).

<sup>62</sup> Press Release, Owen Signs Immigration Legislation Considered Strongest in U.S.: Governor Approves Ten Bills Passed During Recent Special Session (July 31, 2006), available at <http://www.verificationsinc.com/pdf/co-e-verify-press-release.pdf>.

<sup>63</sup> The Dallas morning News referred to Oklahoma's H.B. 1804 as the "toughest law on illegal immigrants, making it a felony to harbor, transport, shelter or conceal undocumented immigrants." Robert T. Garrett, *Oklahoma's Crackdown on Illegal Immigration Draws Texas lawmakers' Interest: Crackdown on Illegal Immigration Draws Criticism, Texas Interest*, THE DALLAS MORNING NEWS, Feb. 13, 2008, at A1.

<sup>64</sup> IDAHO CODE ANN. § 67-7901 (2009).

<sup>65</sup> See *id.*

<sup>66</sup> IDAHO CODE ANN. § 67-7901(2) (2009).

<sup>67</sup> MISS. CODE ANN. § 71-11-1 (2008).

the Idaho disclaimer from the language of California's first attempt to limit access to public benefits afforded to undocumented immigrants in the ballot initiative, popularly called, Proposition 187.<sup>68</sup>

Proposition 187, passed overwhelmingly by California voters in 1994, contained ten sections which together required public service agencies to verify the citizenship status of those they served, notify federal INS officials of anyone suspected of being in the United States illegally, and deny benefits or services to those suspected of being undocumented immigrants.<sup>69</sup> Section 6 excluded undocumented immigrants from receiving non-emergency healthcare, while other sections penalized falsification of immigration documents, provided for cooperation between local, state and federal INS officials, and restricted access to other public benefits such as education and welfare assistance.<sup>70</sup> According to its preamble, Proposition 187 was intended to address "economic hardship" resulting from the cost of providing public services to "illegal aliens."<sup>71</sup> However, the preamble also referenced a desire to address suffering, injury, and damage caused by "the criminal conduct of illegal aliens in this state . . ."<sup>72</sup> This connection between economic hardship, criminal conduct, and providing public benefits has led many to consider Proposition 187 as an "anti-immigrant" measure, aimed at stopping the flow of immigration to California.<sup>73</sup> The initiative was quickly declared unconstitutional,<sup>74</sup> and its implementation permanently enjoined.

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<sup>68</sup> Proposition 187 was a ballot initiative passed by California voters on November 8, 1994. See *Illegal Aliens, Ineligibility for Public Services, Verification and Reporting*, 1994 Cal. Leg. Serv. Prop. 187, §§ 1, 6, 4 (Nov. 8, 1994) (preempted by federal law in *League of United Latin Am. Citizens v. Wilson*, 997 F. Supp. 1244 (C.D. Cal 1997)).

<sup>69</sup> See *id.*

<sup>70</sup> See generally, *id.* at §§ 2, 4, 6.

<sup>71</sup> See *id.* at § 1.

<sup>72</sup> *Id.*

<sup>73</sup> See Emilie Cooper, *Embedded Immigrant Exceptionalism: An Examination of California's Proposition 187, the 1996 Welfare Reforms and the Anti-Immigrant Sentiment Expressed Therein*, 18 GEO. IMMIGR. L.J. 345 (2004).

<sup>74</sup> See *League of United Latin American Citizens v. Wilson*, 1998 WL 141325 at 1 (C.D. Cal.) ("Sections 1, 4, 5, 6, 7, 8 and 9 of Proposition 187 are declared to be in violation of the Supremacy Clause, preempted by federal law, and of no force or effect. Defendants, their agents, employees, and successors in office are permanently enjoined from implementing and enforcing."); See also *Plyler v. Doe*, 456 U.S. 202 (1982) (declaring bans on access to

However, the objectives the Proposition sought to serve roused support even among Hispanic voters.<sup>75</sup>

Professor Brietta Clark has thoughtfully challenged the dominant narratives that the Mississippi statute and California's voter initiative embrace to create an "Us-Them" dichotomy and label immigrants as "outsiders" or "'others' in ways that fuel misunderstanding, fear, and mistrust."<sup>76</sup> She points to the use of stereotypes and threatening caricatures, and paints a vivid picture of "'the illegal immigrant' whom we should fear, punish, and exclude."<sup>77</sup> And thus, exclusionary statutes are explained as ways to deter immigrants from making the choice to come to the United States.<sup>78</sup>

Alternatively, the "Us-Them" dichotomy explains that immigrants threaten the availability of medical resources or that exclusionary rules are limited to the undeserving, who are "illegals" just as any other criminals but distinguishable from "legal aliens."<sup>79</sup> This discourse depends upon exciting the imagination to reinforce the picture of immigrants as outsiders who are criminals, welfare abusers, thieves, and threats to the safety and security enjoyed by insiders.<sup>80</sup> Clark points out that the Us-Them Dichotomy narrative is reinforced by highlighting the "foreignness" or "strangeness" of immigrants and the urgent need to protect everything familiar from their reach.<sup>81</sup> However, Professor Clark also reveals the ironic

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public education based upon immigration status unconstitutional). Ultimately, Governor Gray Davis settled the litigation over Proposition 187, effectively implementing the court's ruling. See Sandra Hernandez, *The Life After Death of Proposition 187*, BLACK ISSUES HIGHER EDUC., Sep. 2, 1999, available at <http://diverseeducation.com/article/247>; Philip Martin, *Proposition 187 in California*, 29 INT'L MIGRATION REV. 255, 259 (Spring 1995).

<sup>75</sup> According to exit polls, 31% of Hispanic voters supported Proposition 187 and 56% of African Americans supported the measure. See Preston, *Surge*, N.Y. TIMES, August 6, 2007.

<sup>76</sup> Brietta R. Clark, *The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 243 (2008).

<sup>77</sup> *Id.*

<sup>78</sup> *Id.* at 245.

<sup>79</sup> *Id.*

<sup>80</sup> The fact that the deterrence discourse is contradicted by studies showing that immigrants underutilize healthcare services rather than greedily and fraudulently steal these benefits from those who are entitled is irrelevant. See *id.* at 255, n.147.

<sup>81</sup> See Clark, *supra* note 76, at 247.

similarity between the “Us-Them” language of those who seek to exclude undocumented immigrants on one hand, and those who use it to advocate granting full access to immigrants as a matter of equity,<sup>82</sup> justice,<sup>83</sup> and common sense on the other hand.<sup>84</sup> Clark concludes that “by engaging restrictionists’ [sic] on their terms and under the existing healthcare paradigm, pro-access advocates can unwittingly reinforce the ‘Us-Them’ dichotomy that pervades health policy decision-making.”<sup>85</sup> Clark recognizes that the solution is to change more than just the narratives that describe healthcare, but to go deeper to change the fundamental notions of how citizens and non-citizens are connected, creating partnerships, coalitions, and collaborations between citizens and non-citizens that will result in “reforming the healthcare system in ways that may or may not be immigrant-specific, but that will ultimately benefit immigrants as well.”<sup>86</sup> It is here that the Common Group Identity Model can add structure and direction to operationalize the call for changes in the immigrant healthcare narrative that Professor Clark has raised.

#### IV. THE COMMON GROUP IDENTITY MODEL

Social Psychologists begin from the shared and established premise that “social categorization is a fundamental aspect of human functioning and perception.”<sup>87</sup> Since 1906, the basic state of conflict between “we groups” and “other groups” have been studied to yield

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<sup>82</sup> *Id.* at 256–57 (arguing that anti-immigration provisions irrationally exclude legal and illegal immigrants alike).

<sup>83</sup> Pointing out flaws in the restrictionists’ arguments that harm innocent and vulnerable children who are in fact citizens and nevertheless excluded from State Children Health Insurance Program eligibility. *Id.* at 260.

<sup>84</sup> Explaining the folly of limiting Medicaid benefits to those who will simply delay seeking care for fear of deportation and ultimately cost the healthcare system more when they do enter to obtain emergency care guaranteed under the law. *Id.* at 259.

<sup>85</sup> *Id.* at 273.

<sup>86</sup> Clark, *supra* note 76, at 275.

<sup>87</sup> John F. Dovidio et al., *Social Inclusion and Exclusion: Recategorization and the Perception of Intergroup Boundaries* in *THE SOCIAL PSYCHOLOGY OF INCLUSION AND EXCLUSION*, 245–46 (Dominic Abrams et. al., eds., 2005).

insight into the resulting ethnocentrism.<sup>88</sup> During the 1970's some psychologists called these group conflicts "realistic" or "rational in the sense that groups have incompatible goals and compete for scarce resources."<sup>89</sup> Still later, Social Identity Theorists made the claim that social group categorizations grow from a need to find a positive social identity by being valued as a member of an in-group, arguing that "in-group favouritism rather than out-group derogation" is the source of discrimination.<sup>90</sup> At the same time, however, these same theorists explained that even positive social identity motivation resulted in a persistent tendency by in-group members to allocate high rewards to other in-group members as against the resources allocated to out-group members, "ensuring that their group comes off best in the only available comparison between the groups . . ."<sup>91</sup> These theories provide important insight into the legal efforts to exclude undocumented immigrants from accessing healthcare goods and services.

Public benefit restriction laws can be explained as an institutionalization of rules and norms that explicitly operate to cause the in-group (American citizens) to win the competition for scarce resources against the out-group (non-citizens). These laws may be defined by gratuitous discrimination and ethnocentrism such as in the case of the California effort to enact Proposition 187 and the Mississippi legislature's effort to avoid "sheltering" or "harboring" illegal immigrants who "undermine the security of our borders."<sup>92</sup> Alternatively, they may be characterized by a seemingly innocuous attempt to "control public expenditures" and adhere to federal laws as in the Idaho case.<sup>93</sup>

Recognizing that normalness and value neutrality of the human tendency to separate themselves into "multiple groups or categories

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<sup>88</sup> See generally Miles Hewstone & Katy Greenland, *Intergroup Conflict*, 35(2) INT'L J. PSYCHOL., 136-144 (2000).

<sup>89</sup> *Id.* at 137.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> MISS. CODE. ANN. § 71-11-1 (2008).

<sup>93</sup> IDAHO CODE. ANN. § 67-7901 (2007).

gives structure to an otherwise bewildering world,"<sup>94</sup> removes the initial stigma attached to the simple fact that humans sort themselves into groups that include some and exclude others. Group membership, among humans in and of itself is not problematic. Indeed, social categorization—the ability to sort ourselves into smaller, meaningful categories to allow interdependent cooperation and minimize risks and costs—is a “universal facet of human perception essential for efficient functioning.”<sup>95</sup> Yet, it is unassailable that social group categorization comes at a cost. Groups divide and segregate not only for cooperative good, but also to exaggerate the differences between groups which nurtures stereotypes and prejudice.

In-group members favor one another in sharing resources, providing social support, and distributing rights and responsibilities within a larger community or society. Beyond the basic levels of inclusionary behavior, in-group members may also define societal boundaries by stigmatizing those outside the group—the out-group members—or even establishing institutional criteria, such as quotas for inclusion, to define members of the in-group and out-group categories.<sup>96</sup>

Here is how the “Us-Them” dichotomy plays out. Insiders argue that immigrants are lazy, criminal, and undermine the workplace by depressing wages and compromising working conditions,<sup>97</sup> when the empirical evidence is plainly contradictory. The evidence is that, as of 2009, an estimated 10.8 million undocumented immigrants are in the United States and 8.3 million in the labor force as of March 2008.<sup>98</sup>

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<sup>94</sup> Joachim I. Krueger & Theresa E. DiDonato, *Social Categorization and the Perception of Group Differences*, 2 SOC. & PERSONALITY PSYCHOL. COMPASS 733, 737 (2008) (Classifying human beings into distinct groups is a fundamental feature of social perception).

<sup>95</sup> Dovidio et al., *supra* note 87, at 246.

<sup>96</sup> Dominic Abrams et al., *A Social Psychological Framework for Understanding Social Inclusion and Exclusion*, in THE SOCIAL PSYCHOLOGY OF INCLUSION AND EXCLUSION 1, 17-18 (Dominic Abrams et al. eds., 2005).

<sup>97</sup> Sebastian Mallaby, op-ed, *Lazy, Job-Stealing Immigrants?*, WASH. POST, Apr. 30, 2007, available at <http://www.Washingtonpost.com/wp-dyn/content/article/2007/04/29/AR2007042901322.html>.

<sup>98</sup> Michael Hoefer et al., *Estimates of the Unauthorized Immigrant Population Residing the United States: January 2009*, (Office of Immigration Statistics, Homeland Security Directive,

America's in-group members ignore the fact that undocumented immigrants are largely taxpayers, contributing more in taxes withheld from their wages, than we will ever spend on providing social services.<sup>99</sup> Insiders have excluded immigrants, by law, based solely upon their race or country of origin.<sup>100</sup> To date, legal scholars like Professor Clark have been able to identify the irony, irrationality, or perhaps even travesty of the exclusionary tendencies of American immigration policies, but they have had no systemic paradigm for changing the way the Us-Them dichotomy controls the law.

The ironically self-destructive impact of public benefit restrictions is particularly troublesome in the case of restrictions on undocumented immigrants' access to healthcare. Empirically, we know that restricting access to preventative healthcare causes both undocumented and documented immigrants to delay seeking any type of medical treatment due to a fear of deportation.<sup>101</sup> Therefore, these people often arrive in emergency rooms only after their medical conditions have elevated to a crisis. Deferring appropriate preventative care gives rise to avoidable morbidity and mortality and escalates the costs of healthcare for all taxpayers. Moreover, these delays are likely to increase exposure to communicable diseases for the entire population, including citizens and non-citizens alike. While direct causal evidence is not yet available to demonstrate this likelihood, the case of tuberculosis in the United States may be instructive. Tuberculosis is 8.7 times more prevalent among America's immigrant population than among U.S. born residents.<sup>102</sup>

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Jan. 2010), available at [http://www.dhs.gov/xlibrary/assets/statistics/publications/ois\\_ill\\_pe\\_2009.pdf](http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2009.pdf); PASSEL & COHN, *supra* note 4.

<sup>99</sup> See generally IMMIGRATION POLICY CENTER, AMERICAN IMMIGRATION LAW FOUNDATION, UNDOCUMENTED IMMIGRANTS AS TAXPAYERS (2007), <http://www.immigrationpolicy.org/just-facts/undocumented-immigrants-taxpayers>.

<sup>100</sup> See Josh Effron, *Permanent Residency for Immigrants of Extraordinary Ability*, L.A. LAWYER, Sep. 2009, at 12 (referring to the quota laws of 1921 that originally limited the number of aliens from certain nationalities from entering the United States except those residing in independent countries of the Western Hemisphere).

<sup>101</sup> See, e.g., Mee Moua et al., *Immigrant Health: Legal Tools/Legal Barriers*, 30 J. L. MED. & ETHICS 189, 191 (2002); see also Tal Ann Ziv & Bernard Lo, *Denial of Care to Illegal Immigrants*, 332 NEW ENG. J. MED. 1095 (1995).

<sup>102</sup> Center for Disease Control and Prevention, *Trends in Tuberculosis - United States, 2005* (March 24, 2006) <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5511a3.htm> (last

For example, the incidence of tuberculosis is highly concentrated among migrant farm workers because of work and living conditions that make the spread of an infectious, airborne disease great and difficult to treat.<sup>103</sup> Despite some state laws that extend access for treatment of communicable disease, there is a great incentive for undocumented immigrants to avoid the complex and extended drug regimen required to treat Tuberculosis even when patients are asymptomatic.<sup>104</sup> It is not unreasonable, therefore, to consider whether a causal connection exists between the fact that the occurrence and spread of drug resistant strains of Tuberculosis is increasing in the United States, especially among the foreign-born, while the decrease in the incidence of Tuberculosis among the *entire* U.S. population has slowed. Though the incidence of Tuberculosis in the United States has continued to decline overall, the rate of decline has slowed from 7.3% per year during the period from 1993 to 2000, to approximately 3.8% per year during the period from 2000 to 2005.<sup>105</sup> This data suggests a non-negligible chance that by restricting access to healthcare for undocumented immigrants, public benefit restrictions may operate to increase both the cost of healthcare and the spread of communicable disease for American citizens and non-citizens alike. This would be difficult to explain apart from the insights from Group Identity theory.

Social Psychologists have shown that even when in-group actors attempt to be fair in their allocations of rewards and resources, they exhibit a persistent tendency to give higher benefits to fellow in-group members rather than work for the benefit of all.

The most striking finding to emerge from these studies was that participants, although they made some effort to be fair in their allocations, showed a persistent tendency to give higher rewards to another (unknown) in-group member than to another (unknown) out-group member. Participants were particularly keen to ensure that their

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visited Apr. 18, 2010) [hereinafter Trends].

<sup>103</sup> Center for Disease Control and Prevention, Epidemiologic Notes and Reports: Tuberculosis among Migrant Farm Workers—Virginia, July 25, 1986, <http://www.cdc.gov/mmwr/preview/mmwrhtml/00000769.htm>.

<sup>104</sup> Costich, *supra* note 3, at 1072; *see also* Ruqaiyah Yearby, *From the Mayflower to Border Patrols: Who Deserves Access to Health Care in the United States?*, 17 ANNALS HEALTH LAW i-ix (2008).

<sup>105</sup> Trends, *supra* note 102.

fellow in-group member received a higher reward than the out-group member, rather than to maximize rewards gained for the in-group or to maximize joint gain . . . for both groups.<sup>106</sup>

Yet, the most remarkable contribution that the Group Identity Theory offers is not the insight to explain the irony and perhaps irrationality of laws that restrict access to preventative healthcare, but the evidence that negative attitudes, conduct, and ultimately the law that grow out of patterns of inclusion and exclusion can be modified. For example, one group of social psychologists showed it is possible to manipulate perceptions of national and international identity that lead to negative attitudes towards immigrants and immigration by using persuasive communications in the form of four editorial articles written to target in-group and out-group attitudes held by a group of Canadian University students.<sup>107</sup> The editorial articles were “designed to induce a common, inclusive national identity” – in other words, to encourage re-categorization of in-group and out-group members among the study participants.<sup>108</sup> These researchers found they could promote a common national in-group identity among the Canadian students by presenting fictitious editorials that described the common ethnic roots among Canadians who all shared a common history and tradition of immigration to Canada, and emphasizing the national pride “ethnics” that Canadians commonly share.<sup>109</sup> The editorials that were written to “induce a common, inclusive national identity” produced more positive attitudes towards immigrants.<sup>110</sup> However, this part of the study did not produce any change in the participants’ attitudes towards immigration.<sup>111</sup>

In the second study, editorials emphasizing a common international identity, however, did prove to have a significant

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<sup>106</sup> Hewstone & Greenland, *supra* note 88, at 137 (emphasis added).

<sup>107</sup> See Victoria M. Esses et al., *Attitudes toward Immigrants and Immigration: The Role of National and International Identity*, in *THE SOCIAL PSYCHOLOGY OF INCLUSION AND EXCLUSION* 317, 328–32 (Dominic Abrams et al. eds., 2005).

<sup>108</sup> *Id.* at 329.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 330.

<sup>111</sup> *Id.*

impact on turning previously negative attitudes held by Canadian students towards immigration, into “significantly more favorable attitudes toward immigration following the persuasive communication that emphasized a common international identity . . . .”<sup>112</sup> These researchers conclude that the support their studies provide for the Common Group Identity Model translates into effective immigration policy for nations seeking to “foster acceptance of immigration and immigrants.”<sup>113</sup>

## V. CONCLUSION

To change the law, lawmakers and their constituents must have the opportunity to increase the importance of superordinate membership over and above the in- and out-group memberships that form to divide citizens from non-citizens. For example, American laborers might come to realize that the superordinate group is comprised of low paid workers seeking to achieve fair wages, improved working conditions, reasonable health and retirement benefits, but that citizens and non-citizens alike must be included in order to prevent the effect of being undermined by excluded workers whose interests are in fact consistent with their own.

Similarly, citizens in a locality may be convinced that all families are currently excluded from the assurance that basic healthcare benefits will be afforded them even in the event of catastrophic illness, without the threat of bankruptcy. Therefore, citizens might

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<sup>112</sup> Esses et al., *supra* note 107, at 331.

<sup>113</sup> *See Id.* at 334. Numerous other studies provide evidence that recategorization to create superordinate group structures can work to transform perceptions of group boundaries and reduce bias and prejudice against formerly perceived members of an out-group population. Experiments involving students at a multi-ethnic high school showed that psychologists’ interventions to provide cognitive representations of a single superordinate student body group significantly lowered bias among students who were black, Chinese, Latino, Japanese, Korean, Vietnamese, and white. Researchers show similar outcomes in experiments involving university students and the non-university residents of a small town, members of merged corporations, and sports fans supporting competing football teams. *See* S. Gaertner et al., *Revisiting the Contact Hypothesis: The Induction of a Common Ingroup Identity*, 20 INT’L. J. INTERCULTURAL REL. 271, 271-90 (1996); *see also* P. Anastasio et al., *Categorization, Recategorization and Common Ingroup Identity*, 33 J. OF EXPERIMENTAL SOCIAL PSYCHOL. 401 (1997).

perceive the superordinate group to be those seeking to cooperate to create a sustainable healthcare delivery system that eliminates the premium paid by the insured to cover acute emergency care for the uninsured, thereby driving up the cost of healthcare for all.

Superordinate groups form where two insider and outsider groups had previously existed. Women's rights advocates and immigration rights advocates work together to form a superordinate group of immigrants; immigrants fleeing domestic abuse and violence, to create exceptions to exclusionary healthcare laws, as they pertain to undocumented immigrants who have been battered.<sup>114</sup> This is an example of re-categorization.

First, policy makers must minimize the differences between in-group and out-group members so that these differences may be replaced. Second, the object becomes to disperse information about the shared objectives, needs, and priorities that both groups share so that these will be retained, even if for self-interested reasons. Finally, lawmakers can construct cooperative and interdependent solutions that serve the long term interests of all.

The quote that opens this essay portrays the circularity of those who are at once immigrants who arrived in America as outsiders, and later became insiders, precariously reliant on a new group of outsiders who threatened their existence and livelihoods just as the original European immigrants had once done. The Group Identity Model offers a way to progress beyond the law of inclusion and exclusion by re-defining the "national interest" to reflect the truth of the superordinate group to which both citizens and non-citizens belong.

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<sup>114</sup> See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1641(c).