

IMMIGRATION POLICY AND PUBLIC HEALTH

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It cannot be said too often: Public health in the United States is underfunded and dangerously fragmented. These longstanding woes are exacerbated each time Congress and state legislatures fail to take into account the public health consequences of policies they enact into law. Immigration policy is no exception. When we talk about immigration reform, public health is often ignored, even though federal policy with respect to non-citizens vitally affects state and local governments. Or worse, immigrants are misrepresented as health threats to the U.S. in ways they are not.

Our immediate public health emergencies in the U.S. have nothing to do with immigration or immigrants. Take, for instance, the fact that HIV is thriving in the South, and is the subject of a new presidential initiative to combat it nationwide.¹ Measles outbreaks, entirely preventable by vaccination, have occurred across the country in recent years, including in eleven states in the first two months of this year alone.² Hepatitis A, a third-world disease, has spread from city to city in the U.S.³ A strain of drug-resistant tuberculosis that originated at a homeless shelter in Atlanta killed four people, and has spread to at least eight other states.⁴ The opioid epidemic has brought with it skyrocketing rates of infectious diseases

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1. Charlene Flash, *San Francisco is Beating H.I.V. Why Can't Houston?*, N.Y. TIMES (Mar. 1, 2019), <https://www.nytimes.com/2019/03/01/opinion/hiv-aids-south.html> [https://perma.cc/LYH9-A87T]; Andy Miller, *In New Offensive Against HIV, Metro Atlanta is a Battleground*, WABE (Feb. 11, 2019), <https://www.wabe.org/in-new-offensive-against-hiv-metro-atlanta-is-a-battleground> [https://perma.cc/WX9R-HX56].

2. *See Measles Cases and Outbreaks*, CTRS. DISEASE CONTROL & PREVENTION (Mar. 4, 2019), <https://www.cdc.gov/measles/cases-outbreaks.html> [https://perma.cc/5CCX-U8TB] (reporting 206 confirmed cases of measles in 11 states in first 2 months of 2019); Saad B. Omer & Robert Bednarczyk, *Measles Was Eliminated. But We Can't Be Sure It'll Stay That Way*, WASH. POST (Feb. 11, 2019), <https://www.washingtonpost.com/outlook/2019/02/11/measles-was-eliminated-we-cant-be-sure-itll-stay-that-way> [https://perma.cc/QQM8-LMS8] (describing recent state of emergency declaration in Washington and outbreaks in seven states in 2015).

3. *Outbreaks of Hepatitis A in Multiple States*, CTRS. DISEASE CONTROL & PREVENTION (Mar. 15, 2019), <https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm> [https://perma.cc/N5GH-QFQU]; Lauren Weber, *Remember Last Year's Hepatitis A Outbreak? This Year It's So Much Worse*, HUFFINGTON POST (June 3, 2018), https://www.huffingtonpost.com/entry/hepatitis-a-outbreak-this-year-much-worse_us_5b204e83e4b09d7a3d7829bd [https://perma.cc/M475-BFEH].

4. Nancy Badertscher, *TB Real Concern at Atlanta Homeless Shelter*, POLITIFACT (Aug. 19, 2015, 12:00 AM), <https://www.politifact.com/georgia/statements/2015/aug/19/kasim-reed/tb-real-concern-controversial-atlanta-shelter> [https://perma.cc/UJ5M-3QMS].

related to intravenous drug use, such as HIV and hepatitis C.⁵

Add to this the fact that the U.S. has the highest percentage of citizens without health insurance in the industrialized world.⁶ Lack of preventive healthcare can mean low resilience in the population as a whole. A community's overall resilience in the face of a contagious disease outbreak is only as strong as the weakest link. Scientists say we are long overdue for a naturally occurring pandemic. The World Health Organization refers to it as "Disease X."⁷ Altogether, it is easy to understand why the possibility of a fast-spreading, deadly epidemic in the U.S. keeps scientists awake at night.⁸

Blame whoever you like—anti-vaxxers, counter-productive laws and policies, underfunded city services—but do not blame immigrants for these home-grown problems. Non-citizens living in or visiting the U.S. are on the whole healthier than the native-born U.S. population.⁹ Immunization rates among them are higher, too.¹⁰ An "imported" disease like SARS or avian flu is as likely to be spread by a returning U.S. traveler as a migrant at the border. Recall the public outcry that followed news that an Atlanta lawyer with drug-resistant tuberculosis had traveled on several international flights against the orders of public health officials, leading to Congressional hearings and renewed interest in federal

5. See Ripon Advance News Service, *Lance Introduces Bill to Counter Rise in Infectious Diseases Fueled by Opioid Epidemic*, THE RIPON ADVANCE (Mar. 23, 2018), <https://riponadvance.com/stories/lance-introduces-bill-counter-rise-infectious-diseases-fueled-opioid-epidemic/> [<https://perma.cc/XZR5-WNST>].

6. *America is a Health-Care Outlier in the Developed World*, THE ECONOMIST (Apr. 26, 2018), <https://www.economist.com/special-report/2018/04/26/america-is-a-health-care-outlier-in-the-developed-world> [<https://perma.cc/XZ56-NANN>].

7. *List of Blueprint Priority Diseases*, WHO, <https://www.who.int/blueprint/priority-diseases/en/> [<https://perma.cc/R63T-Z9M8>] ("Disease X represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease.").

8. See, e.g., Jonathan Quick, *The Looming Epidemic Threat*, THE GUARDIAN (Mar. 18, 2018), <https://www.theguardian.com/commentisfree/2018/mar/18/end-epidemics-aids-ebola-sars-sunday-essay> [<https://perma.cc/93E8-E5T4>]; Lauren Weber, *More Dangerous Outbreaks are Happening. Why Aren't We Worried About the Next Epidemic?*, HUFFINGTON POST (July 18, 2018, 5:23 PM), https://www.huffingtonpost.com/entry/outbreaks-epidemic-preparedness_us_5b4f85fbc4b0de86f4892daa [<https://perma.cc/6UHP-463R>].

9. See PATRICIA ILLINGWORTH AND WENDY E. PARMET, THE HEALTH OF NEWCOMERS: IMMIGRATION, HEALTH POLICY, AND THE CASE FOR GLOBAL SOLIDARITY 13 (2017) ("Indeed, with rare exceptions, newcomers—a term we use to refer to all nonnative residents, regardless of their citizenship or immigration status—are generally healthier than natives.").

10. Alex Nowrasteh, *Measles Vaccination Rates and Immigration*, CATO INST. (July 11, 2016, 1:20 PM), <https://www.cato.org/blog/measles-vaccination-rates-immigration> [<https://perma.cc/Y9WK-ZC7L>] (noting WHO and UNICEF report showing immigrant sending countries, including El Salvador, Mexico, Vietnam, Cuba, and China all have higher measles vaccination rates than the U.S.).

quarantine power.¹¹ As Wendy Parmet and others have reminded us, the U.S. has a long history of wrongly blaming immigrants both for diseases that spread globally through travel and trade as well as for our own governmental shortcomings.¹²

Immigration policy in the U.S. does have important ramifications for public health. But it is not because immigrants themselves pose a disproportionate health threat to citizens. And we cannot keep contagion out or protect ourselves from the world's pandemics by some fantasy of closing borders or erecting walls. Birds and mosquitoes, carriers of lethal viruses, are notorious disrespecters of walls. And we shouldn't forget that we export diseases to other countries, too. In short, the greatest public health threats in our nation today are ones that have originated here, not ones brought from the outside.

But it also makes no sense to create immigration policies that may increase the risk that contagious disease outbreaks will spread. Yet we are doing just that. As I describe below, the U.S. Department of Homeland Security proposes to treat immigrant access to healthcare in a punitive fashion that even it admits "could lead to . . . increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated." Local health departments in the U.S. already struggle against the odds. This new federal policy needlessly makes that struggle even harder.

I. THE CRITICAL ROLE OF THE LOCAL HEALTH DEPARTMENT

State and local health departments are key to protecting the nation from epidemics. The burden of public health defense falls to 2,684 state, tribal, and local health jurisdictions.¹³ Contrary to what many people might expect, the federal government is not in charge in the event of an epidemic outbreak affecting the nation. The CDC plays a very limited role in combatting contagious disease in the U.S. The CDC cannot intervene, direct, or provide assistance unless states individually invite them to do so.¹⁴ Even then, the CDC cannot provide medical treatment or take other steps we might expect, although its staff possesses the best scientific and medical expertise in the world.

11. Polly J. Price, *Do State Lines Make Public Health Emergencies Worse? Federal Versus State Control of Quarantine*, 67 EMORY L.J. 491, 521-22 (2018); David Brown, *The Two Faces of Tuberculosis*, WASH. POST (June 19, 2007), <http://www.washingtonpost.com/wp-dyn/content/article/2007/06/15/AR2007061502130.html> [https://perma.cc/5KE6-QDSN]; Vikki Valentine, *A Timeline of Andrew Speaker's Infection*, NPR (June 6, 2007), <https://www.npr.org/news/specials/tb/> [https://perma.cc/GW2X-CU7H].

12. ILLINGWORTH & PARMET, *supra* note 9; GUENTER B. RISSE, *PLAGUE, FEAR, AND POLITICS IN SAN FRANCISCO'S CHINATOWN* (2012); HOWARD MARKEL, *WHEN GERMS TRAVEL* (2004); ALAN KRAUT, *SILENT TRAVELERS: GERMS AND THE IMMIGRANT MENACE* (1995); Howard Markel & Alexandra Minna Stern, *The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society*, 80 MILBANK Q. 757 (June 6, 2003).

13. Price, *supra* note 11, at 516.

14. *Id.* at 514.

Local health departments, then, are the most essential barrier to stop the spread of contagious disease within neighborhoods, between cities, and among U.S. states. We rely on them to contain outbreaks of contagious disease before they can spread out of control. Yet as the “public health” responsibilities of local governments have become more broadly defined, their jobs have become more complicated. For example, while local health departments play a key role in ensuring food safety, their core function is to stop the spread of contagious disease—the reason health departments were established at the state and local level more than a century ago.¹⁵ This core function requires a number of steps that have not changed with advances in medical science: Investigate the source of an outbreak of contagious disease. Stop further spread of the disease through counter-measures that include isolating the sick if they are contagious. Find people who may have been exposed but do not know it. And, if necessary, quarantine those who have been exposed in order to prevent further spread.¹⁶

Health departments in the U.S. perform remarkably well, given that they are unevenly funded and must constantly solicit political support from elected officials. Heroic efforts of state and local health departments, for example, account for the fact that the U.S. has thus far contained the spread of drug-resistant tuberculosis below levels that globally have become alarming, though the system is precarious because of its fragmentation and the unwillingness of many local governments to pay for it.¹⁷

But the reality is that federal law and immigration policy create distinctions between citizens and non-citizens that make the jobs of local health departments harder. The mission of the local health department is to protect “population” health, the relevant criteria being “person,” not visa or citizenship status. The immigration status of the local population does not matter, and public health workers investigating an outbreak, or offering immunizations, do not ask. Some health departments go to great lengths to reassure residents that their citizenship or immigration status is irrelevant.¹⁸ Why? Among other reasons, because health departments need the cooperation of everyone in the event of a contagious disease outbreak or public health emergency. Public health workers need to be trusted,

15. For an insightful historical analysis of the peculiar form of public health federalism in the U.S., see Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267 (1992).

16. These traditional public health strategies are described in JAMES HODGE, JR., PUBLIC HEALTH LAW IN A NUTSHELL 12 (3d ed. 2017); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 421-50 (2d ed. 2008).

17. Polly J. Price, Opinion, *If Tuberculosis Spreads . . .*, N.Y. TIMES (July 9, 2014), <https://www.nytimes.com/2014/07/09/opinion/if-tuberculosis-spreads.html> [<https://perma.cc/T7T4-NM2P>].

18. See, e.g., ALAMEDA COUNTY PUB. HEALTH DEP’T, IMMIGRATION AND PUBLIC HEALTH: AN ISSUE BRIEF (July 2017), <http://www.acphd.org/media/470384/immigration.pdf> [<https://perma.cc/L4GK-YK9E>] (“Nearly 1 in 3 Alameda County residents is an immigrant. This includes at least 526,148 naturalized U.S. citizens, lawful permanent residents, temporary migrants, humanitarian migrants, and other foreign-born residents who were not U.S. citizens at birth.”).

not studiously avoided. People without documented status may have an incentive to avoid interacting with any government official, hence the extraordinary efforts of public health workers to distinguish their function from law enforcement. Many without legal immigration status have lived in the community for years and have U.S. citizen children or spouses. These long-term residents may inadvertently end up becoming a health threat, and yet be afraid to interact with government officials responding to a public health emergency, especially if there is a need to interact with police in the event of quarantine for suspected exposure. Contact tracing can be the most problematic if someone is afraid that disclosure of a person's contacts could somehow lead to "discovery" of immigration status.

An additional problem has to do with the way health departments become aware of local outbreaks in the first place. Hospitals and medical providers are required to report to their local health department anyone diagnosed with specified contagious diseases, like tuberculosis, measles, and hepatitis.¹⁹ The health department then begins an investigation to see if the case is isolated, or is part of an emerging pattern of reports that would constitute an "outbreak" or even a public health emergency. If people avoid seeking healthcare because they don't have insurance or are afraid their immigration status might become known, a contagion can get out of control before public health officials are even aware of it.

Most non-citizens, including millions who are present in the U.S. legally, are not eligible for any form of subsidized health insurance, nor are they eligible for insurance through an employer because they are prohibited from working.²⁰ Medicare and Medicaid are off limits for most non-citizens, with very few exceptions. Many visas for legal immigrants prohibit employment, meaning employer-subsidized insurance is not available to them. The Affordable Care Act, while expanding access to health insurance for millions of U.S. citizens, excluded undocumented immigrants and even many legal immigrants.²¹ Non-citizens, both those here legally and those who are not, are disproportionately uninsured compared to U.S. citizens, meaning they are less likely to receive preventive medical care or seek routine care at an early stage of illness.²² So while citizenship and immigration status matter for access to health care, citizenship remains irrelevant from the perspective of a local health department.

19. See, e.g., *Notifiable Conditions*, TEX. DEP'T STATE HEALTH SERVS. <https://www.dshs.texas.gov/idcu/investigation/conditions> [<https://perma.cc/AU5G-CBAN>].

20. See Jennifer Y. Seo, *Justice Not for All: Challenges to Obtaining Equal Access to Health Care for Non-Citizen Immigrants in the United States*, 3 GEO J. L. & MOD. CRITICAL RACE PERSPECTIVES 143 (2011); Tamara Forsys, *Left Out in the Cold: How the United States' Healthcare System Excludes Immigrants*, 17 ANNALS HEALTH L. 351 (2008).

21. Maggie Morgan, *Healthy Regardless of Status: Expanding Access to Healthcare for Non-citizens*, 15-02 IMMIGR. BRIEFINGS 1 (2015).

22. *Id.* at 1. It is also worth noting that all immigrant groups pay more in taxes than they consume in social benefits, including refugees. See *Rejected Report Shows Revenue Brought in by Refugees*, N.Y. TIMES (Sept. 19, 2017), <https://www.nytimes.com/interactive/2017/09/19/us/politics/document-Refugee-Report.html> [<https://perma.cc/8CE8-R2C8>].

Given that it's unlikely we will commit more federal resources to the health needs of non-citizens, it is all the more important for state legislatures to reinvest in public health after decades of declining financial commitments.²³ But even states with the foresight to invest in the health of all its residents might in the event of an epidemic see that investment quickly erode, given the speed with which viruses can travel across state lines and the financial incentives state and local governments have to pass along their public health problems to other jurisdictions.

And while from a public health perspective it might be desirable to make healthcare more broadly accessible, including to non-citizens who cannot afford it, I want to be clear that I am not arguing here that the U.S. should do so. Every nation restricts in some way the public services it provides to newcomers. My purpose instead is to highlight a new federal policy that penalizes immigrants if they use the few government-funded health services to which they are already entitled by law. To understand why this matters, I provide some background on what Congress has said about restricting publicly-funded health care on the basis of citizenship.

II. PRWORA AND ITS FORGOTTEN EXCEPTION

The U.S. used to be a bit more generous with the healthcare safety net for immigrants who were on the path to U.S. citizenship, but welfare reform legislation in 1996, the Personal Responsibility and Work Opportunity Act (PRWORA),²⁴ generally restricted non-citizens' eligibility for public benefits.²⁵ PRWORA barred all lawful permanent residents from receiving means-tested, federally funded assistance, including Medicare and Medicaid, for the first five years in the country. PRWORA also excluded entirely many others with legal status who were previously eligible. And it barred unauthorized immigrants from government-funded health assistance altogether, except for medical emergencies. Medicaid was previously available to lawful permanent residents with no waiting period, as well as to a vast number of non-citizens residing in the U.S. "under color of law," a catch-all category for non-citizens living in the U.S. legally but with an uncertain path to citizenship.²⁶

The immediate effect of PRWORA was to take away large amounts of federal

23. See, *A Funding Crisis for Public Health and Safety: State-By-State Health Funding and Key Health Facts*, TRUST FOR AMERICA'S HEALTH, <https://www.tfah.org/report-details/a-funding-crisis-for-public-health-and-safety-state-by-state-and-federal-public-health-funding-facts-and-recommendations> [<https://perma.cc/GG55-WTZC>].

24. PRWORA, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 8 and 42 U.S.C.).

25. Akiesha R. Gilcrist, *Undocumented Immigrants: Lack of Equal Protection and Its Impact on Public Health*, 34 J. LEGAL MEDICINE 403, 405 (2013).

26. Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the "Contract with America" Congress*, 90 KY. L.J. 1043, 1046 (2002) (explaining the PRUCOL doctrine).

healthcare money from states with the largest populations of non-citizens. In response, some states funded their own programs for impoverished non-citizens, and ever since have had to negotiate against attempts by the executive branch to eliminate them.²⁷

PRWORA included an exception for emergency medical care, regardless of citizenship or immigration status.²⁸ That exception is enshrined today in the Emergency Medical Treatment and Labor Act (EMTALA), a federal law that requires hospitals to treat and stabilize anyone coming to an emergency department, regardless of their insurance status or ability to pay. Hospitals can receive some reimbursement for emergency medical services provided to people without health insurance and no ability to pay, including undocumented immigrants. Congress recognized that it was unseemly to let people die because they couldn't afford emergency medical care.

But when Congress enacted PRWORA in 1996, it was also aware that communicable disease control is population-based, not citizenship-based. So, in addition to the emergency medical care provision, it included exceptions for “[p]ublic health assistance for immunizations” and “for testing and treatment of symptoms of communicable diseases.”²⁹

Congress did not say what “treatment of symptoms of communicable diseases” meant, or who pays for it. But it was at least a recognition that one reason to provide medical care for people with a contagious disease is to prevent further spread. Medical countermeasures necessary to protect the community were not to be withheld on account of citizenship or immigration status.

A scant legislative history sheds some light on what Congress meant by the odd phrasing, “treatment of symptoms of communicable diseases.” Differences between the House and Senate versions of PRWORA were resolved by a conference committee, including a disagreement over the wording of the “communicable diseases” exception. The original Senate version stated that “the exception for communicable diseases is limited to treatment of the disease itself and must be triggered by a finding by HHS that testing and treatment of a particular disease is necessary to prevent its spread.”³⁰ The House version did not require a finding by HHS.³¹

The Conference Committee ultimately adopted the language used in the House version, “treatment of symptoms of communicable disease,” explaining in its Report: “The allowance for treatment of communicable diseases is very narrow. The conferees intend that it only apply where absolutely necessary to prevent the spread of such diseases. This is only a stop-gap measure until the

27. For an overview of the complex rules concerning immigrant access to publicly-funded healthcare, see Mehda D. Makhoul, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235 (2019); Katherine G. Footracer, *Immigrant Health Care in the United States: What Ails Our System?*, 22 J. AMER. ACAD. PHYS. ASSTS. 33 (2009).

28. PRWORA, § 1115(f), Pub. L. No. 104-193, 110 Stat 2015 (1996).

29. *Id.*

30. H.R. Conf. Rep. 104-725, 104th Cong., 2d Sess. 1996, 1996 U.S.C.C.A.N. 2649, at 2767.

31. *Id.*

deportation of a person or persons unlawfully here. It is not intended to provide authority for continued treatment of such diseases for a long term.”³²

The Conference Committee’s explanation shows little understanding of the complexities of immigration law. “Until deportation” is a process that can take years because of a longstanding (and worsening) backlog in immigration courts, among other reasons. Moreover, the public health exception applies to *all* non-citizens, not just those illegally present. How does this explanation make sense for legal immigrants not subject to deportation at all, assuming the conferees were aware such persons might have come to the U.S. under two hundred different visa types?³³

This is an immigration law fantasy world. And it’s a public health fantasy world, too. How do medical professionals treat “symptoms only” of *any* communicable disease as a “stop-gap measure”?

Likely, both houses of Congress intended in a general way that treatment provided to a non-citizen in order to prevent a wider public health threat not morph into expensive treatment for non-contagious ailments a patient might also have—diabetes, dialysis for renal failure, cancer. They may also have had in mind HIV/AIDS. At that time, immigrants with positive HIV status were already barred from entering the country.³⁴ The cost of healthcare for anyone suffering from AIDS was (and remains) enormous. Perhaps Congress wanted to make clear that Medicaid funds could not be used to treat non-citizens with AIDS, and it gave no thought to whether treatment of “symptoms only” of a host of other contagious diseases would be at all effective as a public health measure.³⁵

But unlike the emergency medical care exception, no federal funds seem ever to have been allocated for medical treatment to prevent the spread of contagious disease. This “public health” exception was essentially an unfunded mandate for a task state and local governments already undertook. Health departments would continue to isolate cases of communicable disease when necessary to prevent further spread, carrying the costs of care for those patients who were uninsured.

In the same year that Congress enacted PRWORA, it also passed sweeping

32. *Id.* at 2767-68.

33. *Eligibility for U.S. Visas*, ELIGIBILITY.COM, <https://eligibility.com/visas> [<https://perma.cc/F8ZY-Y57L>] (last updated January 28, 2019); see generally Virgil Wiebe, *The Immigration Hotel*, 68 RUTGERS U.L. REV. 1673 (2016) (describing range of both immigrant and nonimmigrant visas).

34. See Rebecca Kidder, *Administrative Discretion Gone Awry: The Reintroduction of the Public Charge Exclusion for HIV-Positive Refugees and Asylees*, 106 YALE L.J. 389, 390 (1996) (describing Congress’s codification of the HIV exclusion in 1993); see also Sherryl S. Zounes, *Positive Movement: Revisiting the HIV Exclusion to Legal Immigration*, 22 GEO. IMMIGR. L.J. 529, 531-32 (2008) (recounting subsequent history). The restriction on immigrant visas was not removed until 2010.

35. Non-citizens may be refused entry to the United States on a variety of health grounds, including having “a communicable disease of public health significance.” 8 U.S.C.A. §1182(a)(1)(A) (2019). See also Polly J. Price, *Infecting the Body Politic: Observations on Health Security and the “Undesirable” Immigrant*, 63 U. KAN. L. REV. 917 (exploring history of health-based exclusions).

immigration legislation designed to address the growing population of undocumented immigrants in the U.S. Among other things, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA)³⁶ greatly expanded the grounds for deportation for crimes committed in the U.S. and made non-citizens convicted of those crimes subject to expedited removal.

IIRAIRA also strengthened the “public charge” ground of admissibility in the Immigration and Nationality Act.³⁷ For well over a century, immigration authorities have had the ability to exclude and deport non-citizens on poverty grounds—that they are or might in the future become reliant on government services or support.³⁸ Non-citizens can be denied entry to the U.S. if they are believed to be “likely at any time to become a public charge,” a term that is not defined in the statute.³⁹ In addition, immigrants can lose their visa status and be removed if they become a public charge within five years after admission, if the reason they became a public charge existed before they came to the U.S.⁴⁰

Congress did not further define “public charge” in IIRAIRA, but it specified that immigration authorities must take into account a person’s age, health, family status, financial resources, education, and skills when determining admissibility.⁴¹ Congress did not state whether the receipt of public benefits would count.

The new emphasis on “public charge” created immediate confusion among non-citizens about whether any form of public assistance for healthcare might make them a “public charge” in the eyes of immigration authorities. Non-citizens who were still eligible for Medicaid or state funded health programs disenrolled. Clinics serving migrant workers saw a dramatic decrease in patient visits. It was an alarming situation, all due to the uncertainty of whether acceptance of government-funded health insurance, reduced-fee or free healthcare could prevent legal immigrants from obtaining citizenship, or even lead to deportation. The State Department noted that confusion over PRWORA and the “public charge” provision “led many persons in the immigrant community to choose not to sign up for important benefits, especially health-related benefits, which they were eligible to receive, as they were concerned this would affect their or a family member’s immigration status.”⁴² The problem was of such magnitude that government experts “began to fear an adverse impact on public health and welfare.”⁴³

Concerned that fear of obtaining necessary medical care was jeopardizing the

36. IIRAIRA, Pub. L. No. 104-208, 110 Stat. 3009-546 (1996).

37. § 531, 110 Stat. at 3009-674 to 3009-675 (codified at 8 U.S.C. § 1182(a)(4)(B)).

38. Leo M. Alpert, *The Alien and the Public Charge Clauses*, 49 YALE L.J. 18 (1939).

39. *Id.*

40. See generally CONG. RESEARCH SERV., R43220, PUBLIC CHARGE GROUNDS OF INADMISSIBILITY AND DEPORTABILITY: LEGAL OVERVIEW (2017); Linton Joaquin & Braden Cancilla, *Protecting Immigrants and the Community: A New Approach to Public Charge Determinations*, 76 INTERPRETER RELEASES 885 (1999).

41. 8 U.S.C.A. § 1182(a)(4)(B) (2019).

42. Joaquin & Cancilla, *supra* note 39, at 886.

43. *Id.*

general public, HHS worked with the Immigration and Naturalization Service (INS)⁴⁴ to address the situation. In 1999, INS released a “Guidance Statement” clarifying that health services other than for long-term care would not be counted in “public charge” determinations.⁴⁵ The Guidance exempted Medicaid and other “health insurance and health services (other than public benefits for costs of institutionalization for long-term care),” including “public benefits for immunizations and for testing and treatment of symptoms of communicable diseases, and use of health clinics.”⁴⁶ The purpose of its action was to “reduce the negative public health consequences” generated by confusion over what type of public benefits would count.⁴⁷ The situation had become “particularly acute” for contagious disease control.⁴⁸ Non-citizens were avoiding medical care to an extent that it jeopardized the general public.⁴⁹

Contemporaneous with the INS policy announcement in 1999, HHS Deputy Secretary Kevin Thurm released a statement supporting it:

We have been concerned for quite some time about the confusion and fear in immigrant communities that accepting certain government benefits would jeopardize their ability to become legal U.S. residents. It’s especially important to ensure access to health care for immigrants, so I am particularly pleased that virtually all health services and benefits are exempt from the ‘public charge’ test for admission, adjustment, or deportation.⁵⁰

It had taken three years to resolve the confusion Congress had created in 1996 with respect to health services. Since 1999, the federal government has assured non-citizens they need not fear seeking health treatment, benefiting the efforts of local health departments throughout the nation to protect community health. But the Trump administration announced its desire to void that policy in early 2017, as part of what immigration scholar Mae Ngai and others denounced as a broader effort to punish legal immigrants for being poor.⁵¹

44. In 2003, Congress discontinued the federal agency known as the Immigration and Naturalization Service, transferring its functions to three new agencies: U.S. Citizenship and Immigration Services (“USCIS”), U.S. Immigration and Customs Enforcement (“ICE”), and U.S. Customs and Border Protection (“CBP”).

45. Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676 (May 26, 1999), <https://www.federalregister.gov/documents/1999/05/26/99-13188/inadmissibility-and-deportability-on-public-charge-grounds> [<https://perma.cc/4PPE-7XRC>].

46. *Id.* at 28682, 28685.

47. *Id.* at 28676.

48. *Id.*

49. *Id.*

50. *quoted in*: Hooper, Lundy & Bookman, Inc., *Feds Propose Exemption from Immigration Decisions for Specific Health Services*, 7 CAL. HEALTH L. MONITOR 8, 8 (June 7, 1999).

51. Torrie Hester, Mary E. Mendoza, Deirdre Moloney & Mae Ngai, *Perspective: Now the Trump Administration Is Trying to Punish Legal Immigrants for Being Poor*, WASH. POST (Aug. 9, 2018), <https://www.washingtonpost.com/news/made-by-history/wp/2018/08/09/now-the-trump->

III. THE NEW FEDERAL “PUBLIC CHARGE” RULE

On October 10, 2018, the Department of Homeland Security (DHS) published its long-expected proposed rule rescinding the 1999 INS policy and redefining “public charge.”⁵² DHS proposes to consider the use of any government benefit, including health services funded by states or public-private partnerships, in “public charge” determinations for admissibility, including requiring “all aliens seeking an extension of stay or change of status to demonstrate that they have not received, are not currently receiving, nor are likely to receive, public benefits as defined in the proposed rule.”⁵³ The rule redefines “public benefits” to include essentially all government-funded health services, a 180 degree turn from what it would replace: a sensible policy made with the input of HHS whose job it is to protect the nation from epidemics.

Even worse, DHS admits that its proposed rule “could lead to . . . increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated.”⁵⁴ But it’s not just vaccine-preventable diseases public health officials worry about. That statement is frighteningly naïve from a medical science standpoint, because it fails to recognize the host of viral diseases for which no vaccine is available. And those are the ones we know about, not some novel flu mutation or the World Health Organization’s “Disease X.”⁵⁵ This is the reason HHS and federal immigration authorities clarified the public charge rules in 1999—it was already evident that avoidance of health services had made the spread of communicable disease an increasing threat to everyone.

The proposed rule is not yet law as DHS must consider the comments it received before the rule becomes final. If finalized in its current form, however, the rule is almost certain to be reversed by a court under the Administrative Procedure Act, a fate that has happened to numerous Trump administration initiatives for failing to follow the basic rules of administrative lawmaking.⁵⁶

Other scholars have catalogued the numerous grounds upon which a court could invalidate the proposed rule,⁵⁷ and the City of Baltimore has filed a lawsuit

administration-is-trying-to-punish-legal-immigrants-for-being-poor [https://perma.cc/9NRP-J3T2].

52. Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114 (Oct. 10 2018), <https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds> [https://perma.cc/B2A2-DCWK].

53. *Id.* at 51,114.

54. *Id.* at 51,270.

55. World Health Organization, *supra* note 7.

56. *See, e.g.*, Margot Sanger-Katz, *For Trump Administration, It Has Been Hard to Follow the Rules on Rules*, N.Y. TIMES (Jan. 22, 2019), <https://www.nytimes.com/2019/01/22/upshot/for-trump-administration-it-has-been-hard-to-follow-the-rules-on-rules.html> [https://perma.cc/T237-7XA7].

57. *See, e.g.*, Janet M. Calvo, *Trump Order Mandating Deportation for Health Service Use: Not Legally Sufficient*, 107 AM. J. PUB. HEALTH 1240 (2017) (reviewing proposed Executive

for harm it has been caused by what it terms the Trump administration's "crusade" to change the definition of public charge behind closed doors.⁵⁸ Rather than repeat those arguments here, I address a point that threatens the general public, citizens and non-citizens alike. The proposed rule entirely ignores the basis for the agency's prior guidance—the need to clarify public charge rules to protect the nation's health from communicable disease threats. Nowhere in the 158-page document is there any acknowledgement of the public health concern that drove the policy the Trump administration now seeks to replace.

A new administration can change administrative rules and policies, of course, but they have to provide a reasoned explanation for doing so.⁵⁹ Failing to address the primary rationale for the rule an agency seeks to change is an obvious violation of the Administrative Procedure Act's requirement that a change in policy not be "arbitrary or capricious."⁶⁰ It's a pretty minimal standard to meet. But just proposing the rule probably accomplished the goal the Trump administration made known it would pursue from the beginning of his administration.⁶¹ It has already sown the kind of confusion that HHS used to think was important to prevent.⁶²

But the proposed rule also shows why making immigration policy in the absence of HHS input is such a bad idea. In implementing a policy to discourage would-be immigrants who are poor, the federal government has lost sight of "population" health that is the domain of the local public health department. Where is HHS in the public charge policy today? Did the HHS Assistant Secretary in charge of public health preparedness and defense have any say? HHS took the leading role after PRWORA to help ameliorate the threats to public health Congress had created. But that agency is notably absent in the process that brought about the proposed public charge rule. The proposed rule is an example of what can happen when immigration issues are viewed strictly from an enforcement perspective and not also from a population health perspective. This

Order).

58. Complaint for Declaratory and Injunctive Relief at 28, *Baltimore v. Trump*, Case 1:18-cv-03636-ELH (D. Md. Nov. 11, 2018), <https://democracyforward.org/wp-content/uploads/2018/10/FAM-Change-Complaint-AS-FILED.pdf> [<https://perma.cc/Z9X3-X2K2>]; Sarah Meehan, *Baltimore Sues Trump Administration over Immigration Policy City Says Keeps Residents from Seeking Benefits*, *BALT. SUN* (Nov. 29, 2018, 8:05 AM), <https://www.baltimoresun.com/news/maryland/politics/bs-md-ci-trump-immigration-lawsuit-20181128-story.html>.

59. *Motor Vehicle Mfrs. Ass'n v. State Farm*, 463 U.S. 29 (1983).

60. 5 U.S.C.A. §706(2)(A) (2019).

61. See Michael Fix & Randy Capps, *Leaked Draft of Possible Trump Executive Order on Public Benefits Would Spell Chilling Effects for Legal Immigrants*, *MIGRATION POL'Y INST.* (Feb. 2017), <https://www.migrationpolicy.org/news/leaked-draft-possible-trump-executive-order-public-benefits-would-spell-chilling-effects-legal> [<https://perma.cc/WVX4-46KD>].

62. See, e.g., Chris Fuchs, *Driven by Fear, Green-Card Holders Are Avoiding Government Aid, Advocates Say*, *NBC NEWS* (Dec. 6, 2018, 8:45 AM), <https://www.nbcnews.com/news/asian-america/driven-fear-green-card-holders-are-avoiding-government-aid-advocates-n944266> [<https://perma.cc/9X27-B936>].

may be one result of moving all immigration functions into the Department of Homeland Security after 9/11.

The “public charge” rule exposes a larger problem that transcends party politics and the identity of the person occupying the White House. The major conflicts between immigration policy and public health come from two features of American government. The first is structural—federal agencies with different missions. HHS governs the CDC and the U.S. Public Health Service, and it is the liaison between the federal government and state and local health departments. More importantly, HHS is in charge of ensuring that state and local governments are prepared for and can respond to public health emergencies in the United State, through the Office of the Assistant Secretary for Preparedness and Response (ASPR).⁶³ The mission of ASPR is “to save lives and protect Americans from 21st century health security threats,” including sustaining public health security capacity.⁶⁴ Yet HHS had no input into a DHS rule predicted to have an adverse effect on the containment of contagious disease and the control of epidemics.

The second reason for conflict between immigration and public health is federalism. Congress decides who can come into the country and under what terms. The federal government controls immigration status and what non-citizens can and cannot do, but states absorb the cost and remain responsible for public health. This is what’s wrong with public health in the U.S. generally, regardless of one’s views on the desirability of immigration. How can we improve this, to ensure state and local health departments have a voice in immigration policy in matters that are vital to public health?

IV. IMMIGRANT DETAINEES AT RISK; LOCAL HEALTH DEPARTMENTS ON THE LINE

I conclude by noting a few other ways in which immigration policy affects public health. Public health threats like outbreaks of flu can arise within migrant detention facilities, and when they do, it is the local health department’s responsibility to prescribe measures to prevent further spread. Immigration authorities do not reliably contact local health officials when they release migrants who need follow-up for a health condition. Other release practices are of concern to health departments because migrants can be placed into situations dangerous to their health and wellbeing if local officials don’t step in. Last Christmas Eve, the U.S. Customs and Border Protection (CBP) released hundreds of recently arrived asylum seekers in downtown El Paso with no notice to anyone, leaving aid groups scrambling to find temporary accommodation for them.⁶⁵

63. U.S. Dept. of Health & Human Servs., *Public Health Emergency: HHS Office of the Assistant Secretary for Preparedness and Response*, PUB. HEALTH EMERGENCY, <https://www.phe.gov/about/aspr/Pages/default.aspx> [<https://perma.cc/6TDD-2QWW>].

64. *Id.*

65. Sheri Fink & Caitlin Dickerson, *Border Patrol Facilities Put Detainees with Medical Conditions at Risk*, N.Y. TIMES (Mar. 5, 2019), <https://www.nytimes.com/2019/03/05/us/border-patrol-deaths-migrant-children.html> [<https://perma.cc/3S6E-K7FF>].

And we mustn't forget the health of immigrant detainees held throughout the U.S. Recent enforcement policies have threatened health outcomes for migrants in federal custody.⁶⁶ After the deaths of two children, CBP admitted it was overwhelmed, and DHS hastily arranged for Coast Guard medical professionals to help with medical screenings for children. Immigration authorities have been overwhelmed by a problem they saw coming. Consider also the ill-conceived policy that resulted in thousands of children being separated from their parents. Local health departments face many challenges in dealing with children who are living together in tent cities, group homes, or detention warehouses. Can any child reliably inform anyone of what vaccinations they have had, or of their health history? The Inspector General reported in January of this year that there are likely thousands more children than the officially reported number of 2,737.⁶⁷ The same report noted that the government has lost track of hundreds of children due to poor record keeping, and as a result some may never be reunited with their parents.

Once again, courts were forced to step-in to a chaotic situation the government itself created, overseeing the reunification efforts and ordering the government to find the children it has apparently lost track of.⁶⁸ As federal judge Dana M. Sabraw reminded us, “[t]he hallmark of a civilized society is measured by how it treats its people and those within its borders.”⁶⁹ From a public health perspective, a nation's “people” and “those within its borders” are one and the same.

As all of these recent examples indicate, the most pressing need now is for better coordination between HHS and DHS on public health and immigration policy. The proposed public charge rule is only the most recent example of the inability of two critically important federal agencies to talk to one another. None of these things require publicly funded health care for impoverished non-citizens, much as public health officials might desire it. None of these things require any change in the current administration's anti-immigrant policy, either.

There are other ways immigration enforcement policy affects population health, but it is not my goal to catalogue these here. In all instances, giving state and local public health officials a seat at the table would result in better policy without sacrificing federal enforcement goals. In the U.S., HHS is supposed to represent state and local health department interests in federal policy made by DHS, but it is unclear that it currently prioritizes that role.

66. *Id.*

67. Miriam Jordan, *Family Separation May Have Hit Thousands More Migrant Children than Reported*, N.Y. TIMES (Jan. 17, 2019), <https://www.nytimes.com/2019/01/17/us/family-separation-trump-administration-migrants.html?module=inline> [<https://perma.cc/FRV6-PC26>].

68. See Richard Gonzales, *Judge Says Government May Have to Reunite More Migrant Families Separated at Border*, NAT'L PUB. RADIO (Mar. 8, 2019, 11:26 PM), <https://www.npr.org/2019/03/08/701813103/judge-says-government-may-have-to-reunite-more-migrant-families-separated-at-bor> [<https://perma.cc/Z4A8-YTMF>].

69. Order Granting Plaintiffs' Motion to Modify Class Definition at 13, *Ms. L. v. U.S. Immigration & Customs Enf't*, No. 18cv0428 (S.D. Cal. Mar. 8, 2019).

But Congress, too, must find a way to demonstrate that public health is not a partisan issue. Mind-numbingly, the most recent Congress allowed funding to expire for the Pandemic and All-Hazards Preparedness Act, legislation first enacted in 2006 to help prepare the nation for pandemic flu and other public health emergencies. A reauthorization act is pending that would restore funding to help states respond to public health emergencies. May Congress take action soon for the safety of all, regardless of where we were born.