

# Immigration Law's Adverse Impact on COVID-19

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**SUMMARY.** Immigration law has played a large and deleterious role during the pandemic. In early 2020, the Trump administration relied on the Immigration and Naturalization Act to bar entry of non-nationals from affected areas. Once the pandemic spread widely in the United States, the administration imposed broad restrictions on immigration, including blocking entry at land borders, effectively overriding asylum laws. While furthering the administration's pre-pandemic, anti-immigration agenda, these measures did little to keep the virus out of the country, or reduce its impact. Immigrants have also suffered disproportionately from COVID-19 due to numerous factors, including high rates of employment as essential workers, substandard housing, and immigration-based restrictions on non-citizens' access to public benefits, including Medicaid. The recently promulgated public charge rule, plus ongoing immigration enforcement activities and anti-immigrant rhetoric, have compounded these vulnerabilities, leaving many immigrants afraid to access health care or interact with public health workers. SARS-COV-2 (the virus responsible for COVID-19) has also spread widely in immigration facilities, where detainees are unable to practice social distancing and lack access to adequate hygiene and health care.

## Introduction

Since the 19th century, immigration law has authorized the exclusion of immigrants with communicable diseases. These exclusions, grounded in racist and eugenicist conceptions of disease, have done little to protect the public's health, while immigration laws that limit immigrants' access to public benefits have left immigrants more vulnerable to communicable diseases.

Immigration law's potential to adversely affect public health has been clearly evident during the current pandemic. Initially, the Trump administration used its immigration powers to deny entry to non-U.S. nationals traveling first from China and then other countries. The administration credited these bans with stopping the virus, but they only offered the illusion of containment. Further, within the United States, restrictionist immigration laws and policies magnified the vulnerability of immigrants as well as their families and communities.

## Using the Pandemic as a Pretext for Restricting Immigration

The initial federal response to the pandemic relied heavily on immigration-based restrictions. On January 31, 2020, the same day that the secretary of Health and Human Services (HHS) declared COVID-19 a public health emergency, President Trump used Sections 212(f) and 215(a) of the Immigration and Naturalization Act (INA) to bar entry into the United States by most non-nationals who had been "physically present within the People's Republic of China" 14 days prior to their arrival in the United States. Although

the president has pointed to this ban as evidence that he took aggressive measures to protect the nation from the pandemic, the order was riddled with exceptions. Most importantly, it did not apply to U.S. nationals returning from China. Although this allowed citizens and legal permanent residents to return home, it also undermined the ban's supposed goal, as over 430,000 individuals entered the United States from China, including nearly 40,000 in the two months following the ban (Eder et al., 2020). The ban also did not prevent people traveling from other countries from bringing SARS-COV-2 into the United States.

By relying on the INA and basing travel restrictions on nationality rather than exposure, the "China ban" seemed to reflect and reassert the erroneous belief that non-nationals are riskier than Americans. This false equation of risk with nationality was also evident in several other orders issued by the president in the winter and spring of 2020. For example, on February 29, the president used his immigration powers to ban entry (with exceptions similar to those included in the China ban) to non-U.S. nationals who had been in Iran in the past 14 days. On March 11, a similar ban was extended to non-U.S. nationals who had been in the Schengen Area of the European Union. The hurried and unclear implementation of this order led thousands of Americans, who feared the ban would be extended to them, to rush home, only to be forced to wait for hours in overcrowded, chaotic and potentially infectious conditions at U.S. customs lines (Miller et al., 2020). Despite that chaos, the president banned non-national travelers from the United Kingdom on March 14, and from Brazil on March 24.

The travel bans, which potentially conflict with the International Health Regulations by exceeding the World Health Organization's guidance, were not the only pandemic response that seemed more designed to further the administration's anti-immigration agenda than protect public health. On April 22, the president ordered a 60-day ban on the issuance of legal permanent resident visas. That ban was largely symbolic; it contained numerous exceptions and had little impact because most consulate and immigration offices overseas were temporarily closed in March. However, pointing to the pandemic's impact on the labor market, on June 22, the president extended the ban for the rest of the year, and expanded it to include non-immigrant H-1B and H-2B visas. The president also directed the HHS secretary to provide guidance "for implementing measures that could reduce the risk that aliens seeking admission or entry to the United States may introduce, transmit, or spread SARS-COV-2 within the United States."

Even prior to that directive, the Centers for Disease Control and Prevention (CDC) relied on the Public Health Services Act to restrict entry by non-nationals. On March 20, CDC issued an interim final rule under 42 U.S.C. § 265 that amended the federal quarantine regulations to allow CDC to bar non-nationals from any country that it designated as having a communicable disease from which there is a "serious danger of the introduction of such communicable disease into the U.S." In contrast to the CDC's pre-existing quarantine regulations, the new rule, codified at 42 CFR 71.40, does not require any individualized assessment of risk; nor is it limited to quarantinable diseases. It also applies only to non-U.S. nationals, allowing CDC to base health decisions on nationality, rather than epidemiology.

Using this new rule, on March 26, CDC barred non-nationals from entering the United States from Mexico and Canada. Although the bar was originally set to lapse after 30 days, CDC extended it until it determined that COVID-19 is no longer a serious danger to the United States. Relying on that order, U.S. Customs and Border Patrol (USCBP) has been expelling immigrants at the southern border, including unaccompanied minors and asylum-seekers. The ACLU has filed a federal lawsuit challenging this practice as an evasion of the nation's asylum laws.

Critically, although Mexico now faces a significant outbreak, this was not the case when CDC first barred entry of non-U.S. nationals at land borders from Mexico (Rios, 2020). In addition, throughout the pandemic, the administration has continued to deport non-citizens, including individuals infected with COVID-19, thereby helping to spread the disease to nations that have fewer resources to contain the pandemic (Gallón, 2020).

### Immigration Law's Incidental Impact on COVID-19

In 2017, more than 40,000,000 individuals living in the United States were born in another country. Forty-five percent of immigrants are naturalized citizens; less than a quarter are unauthorized (Pew Research Center, 2020). Although the immigrant population is very heterogeneous, immigrant communities (which include legal and undocumented immigrants, naturalized citizens, and families of members of immigrants) have been especially hard hit by COVID-19. For example, the heavily immigrant community

of Chelsea, Massachusetts, had the highest rates of infection in that state (Barry, 2020). Immigrants also comprise a large share of the workforce in many of the meatpacking plants that have experienced significant outbreaks (Jabour, 2020).

This should not be surprising. Even before the pandemic, laws regulating immigrant's rights within the United States served as an adverse social determinant of health by limiting non-citizens' employment opportunities and access to a wide array of public benefits (Dondero & Altman, 2020). In the present pandemic, immigrant communities have also faced heightened risk due to high levels of employment in "essential services," overcrowded housing, and language barriers to receiving public health messages. In addition, as COVID-19 struck the United States, the federal government was seeking to limit immigration, build a wall on the southern border, and end the Deferred Action for Childhood Arrivals (DACA) program (which was granted at least a temporary reprieve by the Supreme Court's June 18, 2020 decision in *Department of Homeland Security v. Regents of the University of California*). These initiatives, plus heated, frequently racially charged, anti-immigration rhetoric from the president and public officials helped to sow a climate of fear among immigrants.

Even before the Trump administration, federal laws limited non-citizens' access to health and other public benefits. Under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), undocumented immigrants (including DACA recipients) are "unqualified" for federally-funded health benefits, except emergency Medicaid. Most lawfully present non-citizens are also ineligible for covered benefits for the first five years they have that status. PRWORA also allows states to further restrict coverage, or use their own funds to cover additional classes of non-citizens, including undocumented immigrants. Subsequent federal laws have given states the option to cover, with federal support, lawfully present children and pregnant people in Medicaid and the Children's Health Insurance Program (CHIP). According to Medha Makhoul, in 2019, 34 states offer Medicaid, and 23 offer CHIP to lawfully residing children. Twenty-five states cover lawfully residing pregnant women; 16 states also cover undocumented pregnant people. Six states cover some classes of non-citizens through state-funded programs (Makhoul, 2020). Lawfully present non-citizens can also access coverage and receive premium support to purchase insurance on the state and federal exchanges established under the Affordable Care Act (ACA). The ACA, however, maintains PRWORA's limitations on non-citizens' eligibility for Medicaid and CHIP.

As a result of the restrictions on coverage, as well as the fact that non-citizens are less likely than citizens to work for employers that provide insurance, in 2018, non-citizens were "significantly more likely to be uninsured than citizens" (KFF, 2020). Among the non-elderly population, 23% of lawfully present immigrants and more than 40% of undocumented immigrants were uninsured, as compared to less than 10% of citizens (KFF, 2020).

The Trump administration's new public charge rule creates additional barriers to health insurance and other public benefits for non-citizens. Under the INA, most non-citizens (excluding refugees and others granted humanitarian relief) must show that

they are “not likely to become a public charge” in order to gain entry into the United States or receive legal permanent resident status. Previously, receipt of non-cash benefits, other than for long-term care, did not factor into the public charge determination. However, on August 14, 2019, the U.S. Citizenship and Immigration Services (USCIS) issued its long-awaited public charge rule, which defines a “public charge” as a non-citizen who receives cash benefits, non-Emergency Medicaid, Supplemental Nutrition Assistance, or housing benefits for 12 out of 36 months. Past receipt of these benefits (excluding Medicaid for pregnant people and children) are treated as heavily weighted negative factors when USCIS determines if a non-citizen is likely to become a public charge in the future. In its comments in the Federal Register accompanying the original proposed rule (which differed from the final version in several key respects) in October 2019, USCIS conceded the rule would lead to increased spread of communicable diseases.

Shortly after the final public charge rule was published, several states and advocacy organizations sought to enjoin it. Although at least five lower courts granted preliminary injunctions finding that USCIS had likely exceeded its authority, on January 27, the Supreme Court allowed the rule to go forward. On February 24, just before the pandemic struck the United States, USCIS began enforcement (Parmet, 2020). On April 24, the Supreme Court rejected a petition by New York’s attorney general to block the rule due to its potentially adverse impact during the pandemic.

Nevertheless, in response to the pandemic, on March 13, USCIS announced that it would not “consider testing, treatment, nor preventive care (including vaccines, if a vaccine becomes available) related to COVID-19 as part of the public charge inadmissibility determination” even if they were paid for by public benefits. The guidance also stated that immigrants who lost their jobs due to the pandemic could submit evidence to that effect for their public charge determination. This guidance, however, did not apply to other health care-related expenses. Nor did USCIS suspend the operation of the already confusing rule. On July 29, a federal judge in the Southern District of New York issued a nationwide injunction citing the pandemic. The Administration will likely appeal that order.

Immigration enforcement adds an additional barrier to care. Although Immigration and Custom Enforcement (ICE) considers hospitals and clinics to be sensitive locations in which enforcement actions will not ordinarily be conducted, clinicians have reported that fear of ICE has led patients to forgo appointments and care (Parmet, 2020). It seems likely that this fear may also discourage cooperation with contact tracing.

Many non-citizens have also been denied access to some of the supports Congress established in response to the pandemic. Most importantly, the \$1,200 cash assistance provided under the Coronavirus Aid, Relief and Economic Security (CARES) Act was limited to citizens and immigrants who file taxes using a Social Security, rather than taxpayer identification number. Several lawsuits have challenged the law as discriminating against the citizen children and spouses of undocumented workers. To date,

no court decisions have been reported. Undocumented workers are also unable to access unemployment compensation provisions provided by the Families First Coronavirus Response Act.

Another example of how policies grounded in immigration law can harm the health of non-citizens and citizens alike is the July 6 decision by the White House not to extend an exemption put in place in the spring that allowed international students to stay in the United States if their courses were entirely online. By refusing to permit students to remain in the country if their classes are online, the Administration is pushing universities to open, even if they cannot do so safely. “This could have jeopardized the health of students, faculty, and staff, as well as university communities. After several universities and states attorney generals filed suit, USCIS reversed its decision on July 14.

### Immigration Detention

Immigration detention has created an additional health risk. Thousands of immigrants are detained in detention centers in border states, or local jails and prisons throughout the country.

Even before the pandemic, many detention facilities were unhygienic and overcrowded, allowing for the spread of contagious diseases such as influenza (Parmet, 2020). Given the close quarters and poor conditions, it is not surprising that SARS-COV-2 has spread widely in many detention facilities. As of May 23, 2020, more than 1,400 detainees and 44 employees had tested positive (Erfani et al., 2020). Given ICE’s relative lack of transparency about its testing results and policies, those numbers could be even higher.

In a positive move, ICE has reduced the population of detainees by nearly 30% (ICE’s goal is to reduce the population by 75%) and has worked with CDC to establish guidelines that call for social distancing, improved hygiene, and isolation and care for detainees who test positive (Erfani et al., 2020). Nevertheless, hundreds if not thousands of detainees have gone to federal court (usually seeking a writ of habeas corpus) arguing that their continued detention violates the Fifth Amendment. In response, several courts have ordered the release of petitioners who, because of their age or preexisting medical conditions, were at heightened risk for COVID-19. Courts have also ordered detention facilities to comply with CDC guidelines. Many courts, however, have rejected petitions from detainees who do not face any special risk. As the federal court in the Middle District of Pennsylvania explained in *Saillant v. Hoover* on April 16, (a case involving an ICE detainee held in a Pennsylvania prison) it is “not enough for a petitioner to allege that he is detained and presented with a risk of contracting COVID-19 that is common to all prisoners.”

Litigation has also centered on outbreaks in family detention centers. On June 26, in *Flores v. Barr*, federal Judge Dolly M. Gee of the Central District of California, who oversees the 1997 Flores Settlement that governs the treatment of minors in custody, stated that “family residential centers are on fire” and ordered the release of all children who had been in custody for more than 20 days by July 17.

### Assessment

Immigration law has been employed by the administration as a response to the pandemic; it also has had an indirect impact on pandemic within the United States. In both cases, the impact has been largely negative. Several months into the pandemic, it is apparent that nationality-based travel restrictions and immigration bans have not protected the United States from COVID-19. If anything, they have reinforced the false belief that the pandemic can be kept out by keeping out non-nationals. In addition, by denying non-citizens access to health and other benefits, detaining thousands of people in close and unsanitary conditions, and creating fear and distrust in immigrant communities, immigration laws and policies have increased the vulnerability of non-citizens and their families to COVID-19. 🦠

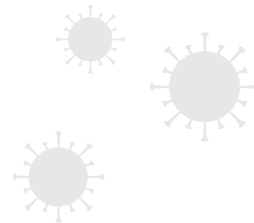
# Recommendations for Action

## Federal government:

- The federal government should base travel bans on epidemiological factors, rather than nationality or immigration status.
- CDC should repeal its new interim final rule and base exclusion orders on the risk presented by travelers rather than their nationality. CDC's orders should not be used to override asylum laws.
- ICE should declare that it will not enforce immigration laws within any health care facility, and that it will not use any information obtained from health or public health workers, including from contact tracers. This declaration should be widely messaged, in multiple languages, to immigrant communities.
- USCIS should repeal the public charge rule, or at least, suspend it for the duration of the pandemic. If USCIS does not act, Congress should repeal the rule.
- ICE should suspend immigration raids during the pandemic, except where they are necessary to prevent an imminent risk to public safety. A pandemic is not the time to add to fear and distrust in immigrant communities.
- ICE should further depopulate immigration detention facilities, holding only immigrants who pose an immediate risk to public safety. ICE should ensure that detainees who remain receive language-appropriate health information, adequate health care, and the means to practice good hygiene and social distancing.
- ICE should cease deporting individuals who are infected with COVID-19.

## State governments:

States should provide Medicaid and CHIP to all otherwise eligible non-citizens. States should also use their own funds to provide coverage to additional classes of non-citizens.



## About the Author

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