Immigration and Health: Law, Policy, and Ethics

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Immigration poses numerous challenges for health care professionals and public health lawyers. Health professionals must care for patients with different cultural backgrounds, some of whom have experienced traumas in their country of origin, may not speak English, or lack access to health insurance. Public health lawyers must untangle the multifaceted interactions between immigration law and health law, which add complexity, inefficiency and inequity to the U.S. health care system. These challenges are apt to intensify under the Trump Administration, which has pledged to increase deportations and repeal the Affordable Care Act (ACA). This paper offers an overview of some of these issues, as well as the arguments that are given for denying immigrants equal access to health care.

Immigrants’ Access to Health

The anti-immigrant sentiment evident in the 2016 election was not new. American history has been marked by periodic waves of nativism. Such anger towards immigrants often focuses on health. Throughout history, immigrants have been blamed, usually erroneously, for disease outbreaks. This association between immigrants and disease can be seen in the health-based exclusions in U.S. immigration law and the disproportionate use of coercive public health powers against immigrants as when San Francisco quarantined Chinese American residents in response to a smallpox outbreak in 1900.1

In 2015 there were 244 million people around the world living outside of their country of origin.2 In the last two years, rapid increases in immigration in Europe triggered a backlash of nationalism and xenophobia. The U.S. has not witnessed a similar surge in immigration, but xenophobia remains potent.

The U.S. is home to the largest number of immigrants in the world.3 In 2014, there were 42.2 million immigrants in the U.S., making up 13.2% of the population. Forty-seven percent of these immigrants are citizens; only 3.5% are undocumented.4

Immigrants are less likely to have health insurance than native-born citizens.5 This is due to many factors including their disproportionate employment in low-wage sectors that tend not to provide employer-sponsored insurance. Another reason is the exclusion of many classes of immigrants from publicly-funded health insurance programs.

Living in poverty is not enough to establish eligibility for federal health care coverage in the U.S. Immigration status also matters, not because of any logical or health care-related nexus between coverage and immigration, but because federal law restricts access to federally-funded benefits to numerous classes of immigrants, including many with legal status.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limits eligibility for public insurance, including Medicare and Medicaid, and imposes a mandatory waiting period on certain legal immigrants who must first demonstrate at least five years of continual qualified immigration status and residency in the U.S.6 PRWORA also bars “aliens who are not qualified aliens” from Medicaid, except for immigrants accessing emergency services7 or “lawfully residing” children or pregnant women in a state that has expanded Medicaid under the Chil
dren’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). PRWORA, however, exempts from the five-year bar certain qualified immigrants, such as asylees or refugees, who have been congres-
sionally designated as immigrants of special humani-
tarian concern. PRWORA does not prohibit states from establishing separate, state-funded insurance or health care benefits for their immigrant residents.

The ACA expanded coverage for some immigrants. Under that act, immigrants who are “lawfully present” within the terms of the ACA, a category that includes some who are either within PROWRA’s five-year wait period or not qualified within the meaning of that statute, may purchase insurance on the ACA marketplace if they can afford to do so. They may also be eligible for advance premium tax credits and other cost-sharing reductions to purchase qualified health plans during the five-year waiting period, depending on their income. Further, certain legal immigrants with incomes between 100% to 138% of the federal poverty level (FPL) are eligible for premium tax credits and cost sharing even though these federal benefits are only available to citizens with incomes over 138% FPL. However, immigrants who cannot demonstrate lawfully present status — even with incomes at or below 400% FPL — are ineligible for federal subsidies and are not permitted to purchase coverage on the marketplace, even if they pay full cost. In addition, even the poorest of legal immigrants, such as those with incomes under 100% FPL, may be ineligible for the ACA’s financial subsidies if they have a qualified immigration status under PRWORA — such as refugees and asylees — and reside in a state that declined to expand Medicaid. Moreover, although overall national uninsured rates declined under the ACA, President Trump and a Republican-controlled Congress may well repeal all or part of that act. Whether non-citizen immigrants will be able to participate in any programs that may be implemented in its stead remains questionable, given the new Administration’s stance on immigration.

Advocates have contested the exclusion of immi-
grants from public insurance programs as a violation of the principle of equal protection. New York’s Court of Appeals, for example, determined that a state law barring legal immigrants from Medicaid violated both the New York and U.S. Constitutions. As a result, the state provides nonfederally funded Medicaid to resi-
dents who do not qualify as lawfully present under the ACA but who are permanently residing under color of law. Similarly, in Finch v. Commonwealth Health Ins. Connector Auth., the plaintiffs successfully chal-
lenged under the state constitution a Massachusetts law ending public insurance to approximately 30,000 legal immigrants who had received coverage since the inception of that state’s health-care reform policy but who were subsequently terminated pursuant to a state law that purportedly adopted PRWORA’s classifications.

Advocates have also persuaded some states to expand coverage for their immigrant populations. For example, in 2016 California asked the Centers for Medicare and Medicaid Services to grant an innovation waiver under ACA Section 1332, to permit health plans in the state marketplace to sell nonsubsidized qualified health insurance to immigrants who are uninsured and not lawfully present provided that all costs are borne solely by the immigrants, thereby reducing the number of medically uninsured residents. The state withdrew the waiver after the election.

**Refugee Health Care**

Although many immigrants face difficulties accessing appropriate health services, refugees face particu-
lar challenges, especially with regard to their mental health needs. Under U.S. law, refugees are defined as those who have fled their countries due to a well-founded fear of persecution “for reasons of race, religion, nationality, membership in a particular social group, or political opinion.” In 2016, the U.S. took in 84,995 persons, making it the world’s largest reset-
ter of refugees; for 2017, the U.S. pledged to take in 110,000 with a new focus on Syrian refugees; however, the Trump Administration has indicated it will alter course. Most of those recently settled refugees came from five countries: the Democratic Republic of the Congo, Syria, Burma, Iraq, and Somalia. While there is a public misconception that refugees automatically gain entry to the U.S. merely by having fled any violent or unsafe country, they must undergo an extensive adjudication process. Of the 21.3 million refugees in the world at present, only 1% are referred for resettlement consideration by the United Nations High Commission on Refugees, the international agency tasked with protecting persons in need of humanitarian assistance. Refugees are then subject to an extended evaluation process with the U.S. Citi-
zenship and Immigration Services to determine their eligibility for refugee status, including whether they are credible and are otherwise admissible to the U.S.

Not surprising, rates of mental health difficulties amongst refugee groups are very high. By definition, many refugees have experienced a range of traumas prior to leaving their home countries including detention, torture, gender-based violations, or having been the victim of or witness to extraordinary violence. The process of flight often displaces and separates families and communities while exposing refugees to addi-
tional threats of violence, loss of property, and disease. Then, even in a “country of first refuge,” whether in urban milieus as was often the case for refugees in the Iraqi and Syrian diaspora, or in UN refugee camps, refugees continue to experience limited or no access to health care, education, employment, or economic opportunities, thus exposing them to additional risks of exploitation. Many refugees also describe the refugee adjudication process as highly traumatizing as they are required to describe the details of experiences in a credible and persuasive narrative during what divergent cultural beliefs about health and mental health. Research with refugees themselves identifies cultural, structural and psychological barriers to care, including a lack of understanding of mental health conditions related to trauma, a reluctance to initiate conversations about mental health symptoms, and mental health stigma. The variability of publicly-funded insurance and mental health services even at federally qualified health centers poses an additional structural barrier, as does the lack of insurance for interpretation services.

Discrimination against immigrants with respect to health undermines efficient and effective health policy. When we try to exclude immigrants to keep out disease, we divert attention from effective public health policies. When we apply coercive public health measures disparately to immigrants, we drive their communities away from the public health system and erode trust between public health workers and vulnerable communities. And when we deny immigrants access to health insurance, we cause them to delay treatment, shifting costs to U.S. safety net providers. Laws that treat immigrants disparately add enormous complexity to our health care system.

many describe as an adversarial set of interviews. For those invited to resettle in the U.S., the post-migration period can be unexpectedly stressful due to acculturation difficulties and disappointments in expectations. As a result, refugees are at increased risk of developing serious psychiatric disorders such as posttraumatic stress disorder (PTSD), major depression, and a variety of anxiety disorders with the rates varying by torture experiences and cumulative exposure to trauma. For example, a 2012 survey of Iraqi refugees who had lived in the U.S. 8-36 months found that 50% of participants reported anxiety, 49% depression, and 31% a need for further assessment for PTSD. During 2009–2012, the rate of suicides among Bhutanese refugees relocated to the U.S. was 20.3/100,000 persons, nearly twice the rate of suicide in the U.S. population as a whole (12.4/100,000). During 2009–2012, the rate of suicides among Bhutanese refugees relocated to the U.S. was 20.3/100,000 persons, nearly twice the rate of suicide in the U.S. population as a whole (12.4/100,000).

Although refugee resettlement agencies readily appreciate the need for mental health services and the CDC includes mental health screening in its guideline for initial health screenings, numerous barriers exist to mental health assessment and referral of refugees. Shannon et al. report that physicians and mental health providers experience difficulties with interpreters, establishing rapport, discomfort eliciting trauma histories, language and acculturation barriers, and

The Interdependency of Health

Many arguments are given for excluding immigrants from some public health insurance programs, as well as for the disparate application of coercive public health laws to immigrants. In enacting PRWORA, for example, Congress claimed that access to public benefits draws immigrants to the country. Similar claims were made in the United Kingdom prior to the Brexit vote. In fact, there is no empirical evidence that people immigrate in large numbers to access health care. Instead they come to escape violence or persecution, improve their economic lot, or reunite with their families.

Health-based exclusions and punitive public health policies are often justified as necessary because immigrants are thought to be sicker than non-immigrants and the source of dangerous diseases. These claims are also false. Although there is substantial heterogeneity, immigrants as a class tend to be healthier than the native-born population and have lower health care costs. Moreover, while some diseases can be imported into the U.S., they are as likely to come from travelers or international commerce as from immigrants.

Opponents of immigration also argue that undocumented immigrants, in particular, should be excluded
from public health insurance programs because they broke the law. This argument ignores the fact that native-born citizens who break the law don’t lose their access to health care. Even imprisoned felons have a constitutional right to health care.\(^26\) The mere fact that someone breaks a law doesn’t in itself justify the denial of access to health care.

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Critics sometimes argue that equal treatment for immigrants undermines the solidarity that undergirds support for health systems. In the current climate, this argument may seem to have some empirical support. It overlooks, however, the fact that with respect to health, immigrants and natives have shared goals — keeping communities healthy, and shared interactions, as patients and providers. Indeed, immigrants form a large percentage of the healthcare workforce. Moreover, immigrants and natives often utilize the same health care services and face shared health risks. When it comes to health, immigrants and natives are largely in it together. This interdependency binds across immigration status, calling upon us to care for one another regardless of country of origin.

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References


7. 8 U.S.C. § 1611(b)(1)(A); 42 U.S.C. § 1396(b)\(^2\).


11. 26 C.F.R. § 1.366-2 ("Eligibility for premium tax credit").

12. Certain legal immigrants with "modified adjusted gross income" (MAGI) under I.R.C. § 36B(d)(2) are deemed to be financially eligible for Medicaid expansion in states that choose to implement it, provided their income is at or below 138% FPL. See 42 U.S.C. § 1396a(e)(a)(14)(I)-(II) (2010) (authorizing a five (5) percent disregard from the MAGI income standard).


16. INA § 101(a)(42). U.S. law also includes additional admissibility and exclusion criteria.


