

Bevis 1

The University of Mississippi

**Deferred Action for Childhood Arrivals: A Comparative
Analysis of Access to Education and Healthcare for
Immigrants before DACA, under DACA, and under the
Dream Act**

By

Levi Cade Bevis

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Approved by:

Advisor: Dr. Melissa Bass

Reader: Dr. Christian Sellar

Reader: Dr. Douglas Sullivan-Gonzalez

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ABSTRACT

The United States has long been considered a nation of immigrants, welcoming individuals and families of every background to build a better future for themselves and the country. Throughout various periods of its history, however, the U.S. has fluctuated between welcoming and exceptionally restrictive immigration policies, with changes are often generating passionate debate from all ideological standpoints. A significant development in the modern U.S. immigration system is the implementation of the Deferred Action for Childhood Arrivals (DACA) program under the Obama Administration. This program allowed certain young undocumented immigrants who met established criteria to qualify for deportation protections. With approximately 700,000 DACA recipients currently, questions arise regarding these immigrants' ability to access critical services such as education and healthcare. The research presented seeks to analyze the accessibility of healthcare and education for current DACA recipients in addition to exploring under which circumstances these services would be most accessible for those recipients. Through documentary research, I find that healthcare and educational services would be most accessible to current DACA recipients under the DREAM Act. While DACA created new opportunities for numerous undocumented immigrants in education, the program did not significantly advance opportunities to access healthcare services. Due to these conditions, the DREAM Act is the most promising legislation to enhance both educational and healthcare service access for current DACA recipients.

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Chapter I: Introduction

The United States has long been considered a nation of immigrants, welcoming individuals and families of every background to build a better future for themselves and the country. Throughout various periods of its history, however, the U.S. has fluctuated between welcoming and exceptionally restrictive immigration policies, with changes are often generating passionate debate from all ideological standpoints. Each policy stance or alteration has had a direct effect on thousands of immigrants and their families, and the results of these changes have ultimately affected our local, state, and national economies. In addition to the economic importance of sound immigration policy, one must consider the social and cultural conditions created by immigration policies. In order to develop sound policies that produce the most desirable economic, social, and cultural outcomes, we need both a thorough analysis of current immigration policy and an evaluation of the differences in outcomes due to these policies. Immigration policy is of vital importance due to its profound impact on citizens' and noncitizens' lives in the United States, and sound policies must be enacted to ensure that the U.S. can truly be the land of opportunity for all.

In 2012, President Barack Obama signed an executive order to implement a program known as Deferred Action for Childhood Arrivals. This program allows immigrants who arrived in the U.S. when they were 16 years old or younger, were younger than 31 years old, and who have been in the U.S. since 2007 to apply for temporary protections from deportation. With this status, recipients are allowed to obtain work permits and are protected from deportation until it expires (U.S. Citizenship and Immigration Services, 2017). Since its implementation, over 800,000 immigrants have been granted DACA status with just under 700,000 recipients currently enrolled (Krogstad and Lopez, 2017). The program is currently in legal limbo, however; President Donald

Trump's administration attempted to phase out DACA in 2017 by stating that DACA recipients, known as Dreamers, would become eligible for deportation at the end of their current protection period (Shear and Davis, 2017). Numerous lawsuits were filed in federal courts across the nation as a result. While many cases are yet to be decided, the courts have currently enjoined the Trump administration's decision to end DACA completely and have allowed DACA recipients to continue reapplying for the program ("Status," 2018). Under these circumstances, a thorough analysis of DACA recipients' ability to access vital services is needed to determine the effect of the program on these immigrants.

DACA allows young immigrants, who often arrive in the U.S. through no choice of their own, with the opportunity to better themselves and the nation. These young immigrants are particularly important as they have the potential to become leaders, teachers, engineers, doctors, and more who will serve as tremendous long-term assets to the U.S. economy through educational advancement and workforce development. Under this program, immigrants are able to legally gain a post secondary education, obtain a job, serve in the military, and contribute to the U.S. economy without fear of deportation. By allowing young immigrants to utilize these opportunities, our nation is investing in a long-term generation of productive workers who will enhance our economic output. Without opportunities to pursue such educational or workforce skill development, current DACA recipients would not have the opportunity to contribute to their community, state, and nation. The DACA program ensures that immigrants with the most potential and in the most vulnerable position are not expelled to a land they do not know or forced into societal isolation. It ensures that undocumented immigrants who grew up in the U.S. and may now have families of their own are not torn away from loved ones. Such a program upholds the centuries' old idea that the U.S. is a nation of immigrants, welcoming all who seek to

better themselves and collectively move our nation forward. It is also consistent with the U.S. immigration policy goals of admitting immigrants with an emphasis on family reunification and the entry of highly skilled workers.

As DACA is a young program, relatively little data has been collected on its total societal impacts. The majority of data that does exist tends to focus on the economic benefits of the program. With extensive attention paid to this aspect of DACA, other benefits are often overlooked. Two such aspects include DACA recipients' access to health care and education and the effects of this access on communities. A deeper analysis into how DACA helps meet the basic needs of immigrants is needed to ensure that immigration reform is both effective and furthers economic and social opportunities for immigrants and native citizen communities. This thesis seeks to provide additional insight into the effects of DACA by answering the following questions: 1) How does access to education and healthcare for DACA recipients compare between the pre-DACA period, under DACA, and under the Dream Act, if enacted, and 2) Under which respective period have or will current DACA recipients receive the greatest access to quality services?

Methodology

One can determine whether current DACA recipients had or will have the greatest access to healthcare and education services prior to DACA's enactment, under DACA, or under the Dream Act, if enacted, through an evaluation of empirical studies, government documents, and other data sources. By employing a documentary research method, I thoroughly analyze the available data on DACA and DACA recipients to determine how the program has impacted them and the larger community. Most of the data comes from qualitative and quantitative secondary sources. The main sources of data are government documents and empirical studies. Supplemental

sources include, but are not limited to, university reports, government reports, and newspaper articles. I collected and compiled the data from these various sources to provide an overview of the current state of DACA recipients in terms of access to healthcare and education and under what legal situation these recipients would best be able to access these critical basic services.

Results

I found that current DACA recipients would have the most substantial access to educational institutions and healthcare services under DREAM Act protections. Access to healthcare services was neither protected by law nor prohibited prior to 1996. Since then, laws disqualify undocumented and some legal immigrants from receiving government assistance for medical treatment outside of emergency care services. DACA continued this trend, prohibiting recipients from qualifying for programs such as Medicaid or CHIP; recipients can only access more extensive medical care if they receive health insurance through their workplace. Under the DREAM Act, however, those granted Legal Permanent Residency (LPR) could qualify for government health assistance programs such as CHIP and Medicaid. Therefore, current DACA recipients would have the most access to healthcare services under the DREAM Act. In regards to educational attainment, opportunities to access higher education specifically has been limited. Undocumented students cannot qualify for federal financial aid or federal loans. Current DACA recipients are able to access in-state tuition and state financial aid in some states. Under the DREAM Act, current DACA recipients would automatically qualify for Conditional Protected Residency (CPR) and would qualify for LPR once they completed two years of their higher education institution. Such status would put them on a path to citizenship, and they would be able to access applicable federal financial aid as a result of LPR status. Therefore, current DACA recipients would have the most access to a higher education under the DREAM Act.

Analysis and Discussion

It is important to understand the real-life impacts policy has on individuals and our society as a whole. I share the stories of several DACA recipients and the impacts it had during its initial implementation on their own and their loved ones' lives. In regards to healthcare access, I examine the negative effects of PWRORA in addition to available data on the "chilling effects" created on all immigrant populations regardless of residency status by such restrictive laws. Little changes in terms of healthcare access under DACA, as the program still enforces PRWORA restrictions on DACA recipients' ability to qualify for government programs. One change under DACA, however, is that DACA recipients can receive full health insurance benefits through their employer, significantly improving their ability to access comprehensive healthcare services. Outside of employer-provided healthcare insurance, DACA recipients' must pay out-of-pocket for most expenses, putting a majority of healthcare services out of reach. Under the DREAM Act, current DACA recipients would automatically qualify for non-emergency healthcare services in addition to the ability to qualify for Medicaid and CHIP. Regarding educational access, under IIRIRA and other federal legislation, no undocumented student could receive federal government financial aid, loans, or other forms of aid open to students with citizenship. Under DACA, federal law still prohibits recipients from receiving any kind of federal financial aid or loans. The disparity in access to state and public institution aid in addition to the base rate charged of undocumented immigrants creates significant barriers to educational attainment based on location and socioeconomic status of the immigrating family. Under the DREAM Act, however, those currently enrolled in DACA would automatically qualify for conditional permanent residence, thereby qualifying for federal financial aid and loan services. Based on these conditions, the DREAM Act would create more opportunities in regards

to the accessibility of healthcare and education services. While DACA provided some protections from deportation, it did relatively little in the way of expanding access to these two essential services. It is therefore recommended that Congress enact the DREAM Act to expand access to comprehensive healthcare and higher educational services.

Immigration is one of the most pertinent policy issues in contemporary political discourse. The enactment of the Deferred Action for Childhood Arrivals program in 2012 was a significant step towards providing educational, employment, and healthcare access for young undocumented immigrants. While DACA created some opportunities, it did not go far enough in expanding access to critical services for hundreds of thousands of immigrants across the nation. As access to healthcare and educational institutions is vital to developing a more empowered society, the United States must ensure that immigrants and citizens alike have equitable opportunities to better the nation. Legislation such as the DREAM Act, if enacted, would significantly improve opportunities for immigrants of all legal statuses to receive the treatment they need and pursue opportunities to contribute to the local, state, and national economy.

Chapter II: Legal Evolution of U.S. Immigration Policy

Immigration policy in the United States, like much of the political landscape, has changed significantly throughout the nation's history. Though variant through time, immigration policy in the U.S. can be broken down into four periods. In the years following the formation of the U.S., no official immigration policy existed, meaning that the U.S. utilized an open immigration system ("Overview of INS History," 2012). This open immigration period persisted until the 1880s. At that point, our system shifted to a more controlled and selective model, specifically through the exclusion of immigrants based on race. This period of race based immigration policy persisted from the passage of the Chinese Exclusion Act of 1882 to the passage of the Immigration and Nationality Act of 1965. Immigration reform in the mid-1960s signaled that U.S. policy was becoming more accepting of immigrants from across the world than it had been since the late 1800s (Gjelten, 2015). This period, which I deem the Nationality Immigration Period, existed from 1965 to 1996. Additional changes came in the mid 1980s and mid 1990s, with policies that granted amnesty to some immigrants while imposing strict requirements on employers and criminal penalties on undocumented immigrants ("A Reagan Legacy," 2010; "Illegal Immigration Reform," 2018). Since 1996, no major immigration reform occurred until the implementation of DACA in 2012. The period of immigration policy changes between 1996 and today I refer to as the Stalemate Immigration Period due to the relative lack of progress in regards to immigration reform. As is evident from the plethora of immigration policy alterations, the U.S. has a long and shifting history with immigration policy. Upon studying this history further, one will understand that DACA is a program consistent with the goals of U.S. immigration policy since the 1960s.

From the very foundation of the country, the issue of immigration was ambiguous and complex, and the U.S. Constitution has little to offer in the way of clarity concerning such policy. Article I, Section 8 of the Constitution states that Congress may “regulate Commerce with foreign nations” and “establish an [sic] uniform Rule for Naturalization” (“The Constitution,” 2018). The vague authority established in this section of the Constitution remained unchallenged until the enactment of the Chinese Exclusion Act of 1882. This law, enacted after anti-Chinese sentiment in California led to attempts to reduce the number of Chinese immigrants entering the state following the Gold Rush and subsequent economic boom, established severe limitations over the number of Chinese workers allowed into the country. The Chinese Exclusion Act of 1882 was the first national law that implemented stringent restrictions on the ability of immigrants to enter the U.S., as it forbade Chinese workers from immigrating to the U.S. for a decade (“Chinese Immigration,” 2016). In 1885, additional restrictions on the admission of foreign workers were imposed through the Alien Contract Labor Law, which prohibited corporations from prepaying foreign workers’ transit to the U.S. or generally encouraging immigration to the country. This law significantly restricted the ability of companies to recruit foreign workers (Orth, 1907). Six years later, Congress passed the Scott Act; this law prevented Chinese Americans from entering the U.S. if they left this country, even if they had met previous residency requirements (“Chinese Immigration,” 2016). Congress then passed the Immigration Act of 1891, which established an office in the Treasury Department to oversee immigrant inspection at several U.S. ports (“1891: Immigration Inspection Expands,” 2014). In 1892, Congress reauthorized the Chinese Exclusion Act of 1882 for an additional decade (“Chinese Immigration,” 2016). These laws primarily restricted foreign workers, though most of the legislation specifically affected immigrants from Asia. A number of lawsuits challenged the

Chinese Exclusion Act. Through the rulings in a few key cases the Supreme Court determined immigration to be a federal instead of a state issue, thus changing the trajectory of immigration policy in the U.S. The first case to begin shaping the role of the federal government over immigration policy was *Chae Chan Ping v. United States* (1889). The majority opinion, delivered in 1889 by Justice Stephen J. Field, ruled in favor of California's denial of re-entry to a Chinese immigrant named Chae Chan Ping, who had lived in California for a number of years, after he returned from a trip to China (Field, 1889). Justice Field stated that the denial of re-entry was justified, and he also reasoned that, even though California had the ability to deny Ping as a local matter, it was a U.S. government matter as well.

The control of local matters being left to local authorities, and national matters being intrusted to the government of the Union, the problem of free institutions existing over a widely extended county, having different climates and varied interests, has been happily solved. For local interests the several states of the Union exist, but for national purposes, embracing our relations with foreign nations, we are but one people, one nation, one power (Field, 1889).

Justice Field's argument establishes immigration policy as a matter of federal concern as opposed to state control. He also states that the federal government may restrict the number of immigrants or prohibit immigration nationwide (Field, 1889). Subsequent Supreme Court cases on immigration, such as *Nishimura Ekui v. United States* and the combination of *Fong Yue Ting v. United States et al.*, *Wong Quan v. Same*, and *Lee Joe v. Same*, reinforced the role of the federal government in shaping national immigration policy (Gray, 1892; Gray, 1893). The Court's assertion that the federal government has explicit constitutional authority to oversee

immigration is an important advancement in settling the question of whether states have authority in immigration issues (“Chinese Immigration,” 2016).

Approximately two decades later, Congress passed the Immigration Act of 1917 to limit immigration into the U.S. and further erode the nation’s open immigration policies. This legislation, spurred on by anti-immigrant sentiment, sought to reduce immigration from eastern and southern Europe and Asia. To achieve this end, the law established a tax on immigrants, instituted literacy tests, and it effectively banned immigration from the “Asiatic zone” (Boissoneault, 2017). Increased literacy rates in Europe, however, allowed more immigrants to enter the U.S. than anticipated, and Congress stepped in to impose more restrictive immigration policies (Goldin, 1994). Congress passed the Emergency Quota Act of 1921 to establish strict limits on the number of immigrants allowed into the nation (“Closing the Door,” 2017). This policy created an annual limit on the number of immigrants allowed entry to three percent of a respective nation’s immigrant population in the U.S. based on the 1910 census (“Harding, Coolidge, and Immigration,” 2016).

The Immigration Act of 1924 reinforced the annual quota system based on nationality and race, and the law reveals how these factors and immigration rates influenced policymakers’ focus. This sweeping act doubled down on reducing immigration by granting visas equal to only two percent of the total percentage of immigrants from a respective country as recorded in the 1890 census (“Closing the Door,” 2017). As a result, predominantly white immigrants from northern and western European nations, such as Germany and Great Britain, were allowed substantially more visas than immigrants from southern or eastern Europe (“The Immigration Act of 1924 [Johnson-Reed Act],” 2016). In fact, from the early 1920s to 1965, the nations of Germany, Great Britain, and Ireland together were allotted more than two-thirds of all

immigration visas available under the quota system (“Chapter 1,” 2015). The preference for admitting white, western European immigrants was made blatantly apparent through the law, and it did not stop with immigrants from Europe.

The Immigration Act of 1924 reinforced existing immigration bans on several Asian nations in a region dubbed the “Asiatic Barred Zone”. Previous immigration laws had been developed to ensure that no immigrants were admitted from a majority of East Asia and Southeast Asian nations, with the exception of the Philippines and Japan (“The Immigration Act of 1924 [Johnson-Reed Act],” 2016). Filipino immigrants were excluded from the ban as the Philippines was a U.S. colony at the time, and Japan had self-imposed restrictions on the number of immigrants it sent to the United States in 1907 per the “Gentlemen’s Agreement” between the two nations. The Immigration Act of 1924 changed this dynamic, however, by barring Japanese immigrants from entering the U.S.; Filipino immigrants were still allowed. China was also not included in the “Asiatic Barred Zone” by this law, but previous legislation had placed a ban on Chinese immigration to the U.S. (“The Immigration Act of 1924 [Johnson-Reed Act],” 2016).

While placing stringent limits on European immigrants and bans on Asian immigrants, the Immigration Act of 1924 did not place any quotas on immigrants from the Western Hemisphere (“Harding, Coolidge, and Immigration,” 2016). The southern U.S. border with Mexico was largely unregulated until 1929, with immigrants coming from Mexico not needing a visa or any form of registration prior to that time. The lack of restrictions on the southern border was intentional, as the flow of inexpensive and abundant labor from Mexico was a principal reason for the agricultural industry’s success across the region (Mintz and McNeil, 2018). The immigration restrictions implemented by the Immigration Act of 1924 illustrate the racial

overtones of the legislation while also demonstrating interesting caveats that left doors of opportunity opened to many.

The next major policy shift occurred in the early 1950s with the passage of the Immigration and Nationality Act of 1952. This act, known as the The McCarran-Walter Act, collected all existing immigration statutes into one act, and it also indicates a shift from race based immigration policies towards a more uniform nationality-based system. The Immigration and Nationality Act of 1952 reinforced the restrictive quota system implemented over a quarter of a century earlier while providing the president with the authority to overrule it (Waxman, 2017). The law also formally ceased immigration bans on Asian nations established by the Immigration Act of 1924. This action brought an end to the absolute exclusion of Asian immigrants, though it did establish a quota system that often allotted visas to Asian immigrants based on race (Waxman, 2017). It also furthered the quota system to apply to all nations with a heavy preference given to western and northern Europeans. In addition to restructuring existing immigration policy, the Immigration and Nationality Act of 1952 introduced the nation's first immigration preference system, where visa preference was given to skilled immigrant workers and for the unification of families. The institution of a preference-based visa system based on family reunification and skill serves as the foundation of modern U.S. immigration policy (Campi, 2004). As the law was passed during the Cold War, it also introduced exclusions for immigrants based on extreme political beliefs or communist sympathies. The effects of the Immigration and Nationality Act of 1952 can still be seen in the current U.S. immigration system, and its passage was a noteworthy yet flawed step toward moving away from a race based immigration system in the United States ("The Immigration and Nationality Act of 1952," 2016).

Another major shift in U.S. immigration policy took place in the mid 1960s with the passage of the Immigration and Nationality Act of 1965. This law ended the decades-long practice of using a quota system based on immigrants' nation of origin and established an immigration policy model that is still used today (Gjelten, 2015). In place of a quota system, this legislation created an immigration system where entry preference was given to highly skilled immigrants and for family unification. Though the family unification preference was added as an incentive for promote white northern and western European immigration to the U.S., this provision actually provided opportunities for more non-white and non-European immigrants to enter. As a result of the law's enactment, the United States took a significant step away from its history of a race-based immigration system and created a more open system of entry for people of all nations (Gjelten, 2015).

The next significant change in immigration policy came in the mid 1980s. President Ronald Reagan advocated for immigration reform, which came in the form of the Immigration Reform and Control Act (IRCA) of 1986. This legislation called for additional funding and security measures for the southern U.S. border (NPR Staff, 2010). The law also made hiring undocumented immigrants illegal, with businesses that violated this provision facing stiff penalties (Chishti, 2016, Pgs. 8-9). In addition, the IRCA of 1986 contained a provision that appears to be an anomaly in the conservative immigration position: amnesty for certain undocumented immigrants. Undocumented immigrants who had entered the United States prior to 1982 were eligible for amnesty under the law, and approximately three million undocumented immigrants were granted legal status as a result (NPR Staff, 2010).

The 1990s were the last period of significant immigration reform before the implementation of the Deferred Action for Childhood Arrivals program. One key legal change

came through the Immigration Act of 1990. This law restructured the preference of immigrant entry by decreasing preferences for family-reunification and increasing preference for skilled workers. In addition to keeping the family reunification entry process, the law expanded opportunities for skilled and highly qualified labor to enter the U.S (Chishti, 2016, Pgs. 2-4). The law also created a diversity lottery, through which 55,000 visas were set aside to be distributed to immigrants from nations where less than 50,000 people had immigrated over the past five years (Chishti, 2016, Pg. 4). Another key component of the law was the creation of Temporary Protected Status (TPS). This legal status could be granted to immigrants arriving from nations where conflicts were raging or that were experiencing environmental disasters. These immigrants had to meet certain requirements to gain TPS, which include coming from a designated TPS nation, having not committed a felony, and having applied for TPS from inside the United States. Though it does not provide an opportunity to gain permanent resident status, TPS does provide recipients with work permits (Chishti, 2016, Pg. 7).

While providing new opportunities for immigrants to enter the U.S., the U.S. Immigration Act of 1990 also created additional opportunities for immigrants to be deported by broadening the definition of a felony, allowing immigrants who did not show up to deportation hearings to be deported, and ending judges' authority to recommend against deportation. It also implemented stiffer monetary penalties on firms and employers who hired undocumented immigrants (Chishti, 2016, Pgs. 8-9). In 1996, U.S. immigration policy furthered its more stringent tilt with the enactment of the Illegal Immigration Reform and Immigration Responsibility Act, known as IIRIRA. The law increased penalties against undocumented immigrants who committed crimes in the U.S., and for those who remained in the nation illegally beyond a certain time limit, and enacted criminal penalties for some offenses such as creating

fraudulent documents. It also allowed immigrants to be more easily deported if they had been charged with a misdemeanor or felony (“Illegal Immigration Reform,” 2018).

Another law, enacted in 1996, affected immigrants’ access to basic services and benefits. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) placed stringent regulations on eligibility requirements for government programs such as food stamps, Medicaid, and the Children’s Health Insurance Program (CHIP) (Gusmano, 2012). This law removed undocumented immigrants from the list of eligible applicants for Medicaid, Medicare, CHIP, and TANF benefits, though undocumented immigrants were able receive emergency medical care. Undocumented immigrants qualify for emergency health services under authorization from the Emergency Medical Treatment and Active Labor Act (EMTALA), which was enacted in 1986. According to this law, all patients must be stabilized before they are dismissed from the hospital, regardless of their ability to pay (Gusmano, 2012).

Since 1996, the most substantial alteration to the U.S. immigration system was the Deferred Action for Childhood Arrivals program, or DACA. DACA was instituted in 2012 via executive order by President Barack Obama. The program allows immigrants who meet some set criteria to gain deferred action on their immigration proceedings for two years, with the opportunity to renew every two years (U.S. Citizenship, 2017). Immigrants are only eligible if they meet the following criteria: they must be undocumented; be under 31 years old as of June 2012; have entered the country prior to turning 16 years old; resided in the U.S. from June 15, 2007 to present; been present in the U.S. on June 15, 2012; either be attending school or have a high school diploma; and not convicted of a felony (U.S. Citizenship, 2017). Recipients of DACA received deportation protections and qualify for work permits. They may also enroll in institutions of higher education, though they do not qualify for federal financial aid to pay for

school (American Immigration Council, 2017; “Financial Aid,” 2015). The program has protected approximately 800,000 recipients since its inception, with slightly fewer than 700,000 enrolled in September 2017 (American Immigration Council, 2017). Recipients, as of that date, were mostly female, were on average twenty-four years old, and hailed from all over the world (Krogstad and Lopez, 2017). DACA’s legal status has been called into question by the Trump administration, making the program’s future uncertain.

No comprehensive U.S. immigration system overhauls or reforms have been passed by Congress since the IIRIRA of 1996. This is not to say that efforts have not been made to facilitate such change. In 2001, the inaugural Development, Relief, and Education for Alien Minors Act, also known as the DREAM Act, was introduced in the U.S. Senate by Senator Dick Durbin (D-IL) (Fuchs, 2017). This bill would have provided a path to citizenship for millions of undocumented child immigrants. The bill, however, was not passed (Fuchs, 2017).

The most recent version of the bill was introduced to Congress in 2017, and it expanded on this central idea of creating a path to citizenship for undocumented children. The DREAM Act of 2017, co-sponsored by a bipartisan group of senators and representatives, provides a multi-step path to citizenship for undocumented immigrants with a high school diploma or equivalent. These steps involve qualifying for “conditional permanent residence” to obtaining “lawful permanent residence” to completing naturalization (“The Dream Act,” 2017). To qualify for “conditional permanent residence (CPR)” an immigrant must have entered the U.S. prior to age 18, entered the U.S. a minimum of four years prior to the bill’s enactment and remained in the U.S. since that time, not have been convicted of a crime, and have at least a high school diploma or equivalent or be enrolled in a college or university. DACA recipients would automatically qualify for this status. Recipients granted CPR would also be cleared to obtain

work permits and hold this special status for up to eight years (“The Dream Act,” 2017). After maintaining conditional permanent residence status, then recipients could qualify for lawful permanent residence (LPR), also known as qualifying for a “green card.” To meet conditions for LPR, applicants must have either completed a minimum of two years of higher education, served for at least two years in the U.S. military, or provide evidence of employment over a three-year period. Those who do not meet these requirements, especially those with disabilities, parents or guardians of minor children, or those whose removal from the nation would create “hardship” for a family member in the U.S., could file for a “hardship waiver” (“The Dream Act,” 2017). Once LPR-qualifying individuals have held such status for a minimum of five years, then they may seek to become U.S. citizens through naturalization (“The Dream Act,” 2017). According to a 2017 Migration Policy Institute fact sheet, if enacted, the DREAM Act of 2017 would allow approximately 2.1 million people to qualify for conditional permanent status and approximately 1.7 million to qualify for lawful permanent residence (Batalova, Soto, and Mittelstadt, 2017).

Efforts to pass similar versions of the DREAM Act of 2017 were made in 2007 and 2010. The bill was killed in 2007 in the U.S. Senate after a filibuster; in 2010, the House of Representatives passed the proposed legislation, but it was again stopped in the Senate (Alcindor and Stolberg, 2017). In 2013, the “Gang of Eight,” a group of four Republican and four Democratic senators, developed a bipartisan immigration reform bill similar in part to the DREAM Act. The reform provided additional funding for border security overhaul measures and implemented a national E-Verify work requirement screening process for employers in exchange for creating a thirteen-year path to citizenship for undocumented immigrants in addition to developing new opportunities for immigrant workers to enter the country (Kim, 2013). Though it

passed the Senate with more than two-thirds approval, it stalled in the House of Representatives (Alcindor and Stolberg, 2017).

U.S. immigration policy has undergone substantial change since the founding of the nation. The enactment of the Chinese Exclusion Act of 1882 marked the beginning of U.S. restrictive immigration policy heavily influenced by racial prejudice and pronounced preference for white, western European immigrants. Relaxing highly restrictive and race-based laws in the mid 1960s created new possibilities of entry for immigrants of all races and nationalities. After another shift in the mid 1990s towards stringent immigration policy enforcement, the U.S. saw no major policy change until DACA in 2012. With the future of DACA now uncertain, debate on the effectiveness of DACA and proposed immigration legislation has renewed public attention to immigration policy. In order to better understand on which policies may best benefit immigrant populations, it is important to examine the effects of immigration policy on both undocumented and documented immigrants.

Chapter III: Literature Review

Studies on the effects of immigration enforcement policies have long interested scholars across a number of areas. Some of these fields of interest include access to education, access to healthcare, and more. This chapter examines studies that address several of these issues and the findings that each study reveals about DACA, immigration enforcement, and its effects on immigrant populations. In addition to studies, this chapter also includes working papers and academic reports that provide more insight into immigrant well-being and access to critical services.

I will use each study listed for one of three purposes: 1) to provide direct data for discussion and analysis, 2) to show how other studies have conducted their research, or 3) to provide background information. Several of these studies form the basis for policy discussion and analysis in Chapters IV and V. I refer to additional studies because they use methods similar to mine. All remaining studies serve to provide background information or points of reference throughout the comparative analysis.

Access to Healthcare

Tara Watson's "Inside the Refrigerator: Immigration Enforcement and Chilling Effects in Medicaid Participation" looks into the issue of immigrants and their families not participating in the Medicaid program even when they qualify for it. The 2010 study indicates that immigrants living in cities with large immigrant populations and immigrant families with healthy children are most likely to opt-out of Medicaid depending on the perceived environment regarding immigration policy enforcement. The study also finds a correlation between immigration policy enforcement and a decrease in Medicaid participation rates. This study illustrates the negative effects of stringent immigration policy enforcement on immigrants' access to healthcare.

Without access to Medicaid, immigrants have few options in regards to clinics that will accept them, especially if they do not have the ability to pay for health expenses out of pocket.

A study entitled “‘There Is No Help Out There and If There Is, It’s Really Hard to Find’: A Qualitative Study of the Health Concerns and Health Care Access of Latino ‘DREAMers’” by Marissa Raymond-Flesch et al. explores access to health care for DACA eligible immigrants. Published in 2014, the qualitative study used a community-based participatory method to gather responses. Respondents hailed from either Los Angeles or the Bay Area and were contacted via Facebook, DACA-eligible interns, and other methods. A total of 61 people agreed to participate, a majority women and immigrants from Mexico, and were divided into multiple focus groups. From these focus groups, the researchers found that DACA eligible immigrants face significant barriers in accessing health care services. Participants indicated that the cost of health care services, a lack of knowledge of the health care system or lack of health care literacy, and fear of being deported all inhibited their willingness to access health care services. They also found that, for almost all medical issues, DACA eligible immigrants do everything possible to avoid using health care services. Respondents expressed that DACA improved their ability to access health care services, yet many barriers remain, such as a lack of information regarding which programs DACA recipients qualify to access. Though it is evident that DACA enhanced access to health care services for recipients, this research shows that much work must be done to ensure immigrants receive the care they need.

A 2018 factsheet report entitled “Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health” by Ninez A. Ponce et al. shows changes to the “public charge” test under consideration by the Trump administration could lead to significant negative economic consequences for California. The “public charge” test is used by officials to determine

which applicants for lawful permanent residency may require government assistance to meet basic needs. Those determined to be more likely to require assistance can be denied lawful permanent residency status if they utilized certain public assistance programs prior to their application, including but not limited to health care services and nutrition assistance. The proposed changes include expanding the number of programs considered for an individual's public charge test and develop more stringent requirements for "green card" qualification or entry into the nation. Such changes, the authors argue, could lead to substantial confusion and fear regarding utilization of public assistance programs, with 2.2 million immigrant families in California alone potentially being affected. Assuming between 15% and 35% of those families remove themselves from public programs, California could lose up to \$1.67 billion in federal public assistance benefits and potentially over 17,000 jobs. The loss of federal benefits could create wider negative effects on the state economy, with up to an estimated \$2.8 billion in lost revenue. The most heavily impacted sector would be health care, with an estimated 8,400 jobs lost from decreased demand. Outside the economic consequences of such rules on California, health and food insecurities are likely to worsen across the state, further depleting available resources for all state residents. This factsheet illustrates the significant negative impact of proposed federal rules for approving lawful permanent residency on the accessibility of health care and nutritional services for undocumented immigrant families.

A 2014 article entitled "Disparities in Health Outcomes of Return Migrants in Mexico" by Fernando A. Wilson et al. examines the differences in health outcomes for Mexican non-migrants, undocumented immigrants who were deported from the U.S., and legal immigrants to the U.S. The research was conducted through the Mexican Migration Project, a joint research project by Princeton University and University of Guadalajara in Mexico. The project collected

data from Mexican heads of household via an ethnosurvey method to examine migration patterns of approximately 200 families from each of 22 Mexican states. Each family was divided into subgroups based on their immigration and/or deportation record. A total sample size of 4,250 respondents was examined, which included 3,748 non-migrants, 101 legal immigrants, and 671 unauthorized immigrants. Using regression models, the researchers found that legal immigrants to the U.S. were not more likely to have health issues than non-migrants, while undocumented immigrants subject to deportation were much more likely to report health issues than non-migrants. Undocumented immigrants who were not deported were more likely to have early-onset heart conditions, hypertension, and poor mental health than non-migrants. Legal immigrants, on the other hand, often had better outcomes than non-Hispanic white U.S. citizens and all other non-citizen groups. While the study does not attempt to conclusively identify causes of these early-onset conditions, it does suggest that chronic stress may be a significant factor in further exasperating these conditions. The authors also suggest that barriers to healthcare access in the U.S. under laws such as the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that prevent undocumented immigrants and some legal immigrants from accessing non-emergency medical services, which may also be a factor in health outcomes. This report illustrates the barriers both legal and undocumented immigrants in the U.S. encounter when seeking medical treatment while also demonstrating that a lack of access to these critical services has significant negative outcomes on the health of those who need them.

Immigrants' Overall Well-Being

A study entitled "Children of Immigrants: Economic Well-Being" by Ajay Chaudry and Karina Fortuny analyzes immigrant families' income, financial well-being, and the use of public

services such as SNAP and TANF benefits. The 2010 Urban Institute study finds that certain groups of immigrants earn lower wages than others, are more likely to be impoverished, and are less likely to utilize public benefit programs. For instance, the authors determine that immigrants from Mexico and Latin America earn the lowest median hourly wages, while immigrants as a whole earn a lower hourly wage than native-born residents. The study also finds that children of immigrants are more likely to live in low-income families than native-born families, with 49 percent of children of immigrants living in families earning at or below 200% of the poverty line. In addition, the authors found that children of immigrants are less likely to use public benefit programs or to live in a family that uses public benefits, even if they qualify for the services. This study highlights the various economic outcomes and differences among immigrant groups while also demonstrating the challenges still facing immigrant communities.

A 2015 report entitled “From Undocumented to DACAmented: Impacts of the Deferred Action for Childhood Arrivals (DACA) Program” by Caitlin Patler and Jorge A. Cabrera investigates the effectiveness and impact of the DACA program. Based on interviews with 502 young adults (450 DACA recipients and 52 undocumented immigrants) in the Los Angeles area over two years, the researchers illustrate the benefits of DACA while also illuminating the challenges immigrant youth still face. In terms of education, over 85% of respondents indicated they had enrolled in a higher education program after high school. While approximately three-quarters of respondents said they had trouble paying for their higher education, approximately the same number reported that DACA had improved their ability to attend their educational institution. In terms of healthcare, DACA recipients were more likely to report better health than the undocumented respondents. DACA recipients were also less likely to report stress as a result

of immigration status. This report offers a rare look into the actual and perceived effects of DACA on recipients' access to healthcare and higher education. I draw upon it in my discussion.

Effects on Children and Family Structure

A 2012 study entitled “How Today’s Immigration Enforcement Policies Impact Children, Families, and Communities: A View from the Ground” by Joanna Derby examines the effects of immigration policy enforcement on families and children. The study incorporates interview responses and home/school visits for 92 families, including 201 individuals, concerning their experiences with immigration authorities and the resulting impact on themselves and their families. Individuals and families were surveyed in urban northeastern Ohio and central New Jersey. In both locations, the author identified commonalities across immigrant populations, including U.S. citizen immigrants, legal immigrants, and undocumented immigrants.

Interviewees expressed substantial fear of police, economic hardship as a result of sudden deportations, and children’s tendencies to conflate the terms “immigrant” and “undocumented.” The study also recommends policy actions to address deportation, including support for the Help Separated Families Act bill, Humane Enforcement and Legal Protections for Separated Children Act bill, and enforcing immigration policy in a more targeted way towards those with criminal records or activities.

A 2017 study entitled “Exploring the Effects of U.S. Immigration Enforcement on the Well-Being of Citizen Children in Mexican Immigrant Families” by Lauren Gulbas and Luis Zayas provides insight into how families, particularly children, are affected by immigration policy enforcement. The authors use data from interviews with eighty-three children participants living in mixed-status families (between the ages of eight and fourteen) to develop a conceptual framework to explain the numerous ways in which children react to immigration enforcement,

detainment, or deportation of a family member or friend. Gulbas and Zayas identified five categories of interrelated effects that influenced children's perceptions: immigration policy enforcement, the "cultural script of silence," the distribution of resources, the niche of the mixed-status family, and the outcomes of the children involved in each situation. The authors conclude that the five categories' interrelationships with each other and the children ultimately influence their overall well-being, which includes financial, educational, and social well-being. These findings lead the authors to advocate for immigration policy reform that focuses on avoiding family separation.

A 2017 study entitled "Protecting Unauthorized Immigrant Mothers Improves Their Children's Mental Health" by Jens Haimueller et al. explores the impact of immigration status on health outcomes of immigrant mothers and their children. This study examines data from Emergency Medicaid claims from over 5,600 immigrant mothers in Oregon born between 1980 and 1982 to determine the mental health outcomes of their children. The researchers found that diagnoses of adjustment disorder, acute stress disorder, and anxiety disorder were significantly reduced for children whose mothers qualified for DACA as opposed to those whose mothers did not qualify. Diagnoses for these mental health conditions was twice as high for children whose mothers did not qualify for DACA protections. The authors conclude that DACA eligibility for mothers has a significant effect on the well-being of a child's mental health, with DACA-eligible families less likely to suffer from stress-induced mental illness. This study highlights that families experience significantly less stress when protected by DACA. Legal protections under DACA ensure that families can focus on other pressing needs, such as education, health care, and finding work, instead of worrying about whether or not they will be deported. This study also demonstrates the diffusion of stress in an immigrant family from the parents to children when

legal protections are absent, which can lead to behavioral and mental health problems. I draw on this research when discussing healthcare access for DACA recipients.

Access to Education

A 2018 working paper entitled “U.S. Immigration Enforcement Policy and Its Impact on Teaching and Learning in the Nation’s Schools” by Patricia Gandara and Jongyeon Ee provides insight into the effects of immigration policy on educational opportunities for students across the nation. The study utilizes school administrators’, teachers’, and other school staff members’ responses to gauge the effects of immigration enforcement on the school’s students from the educators’ perspectives. The responses were gathered via an online survey. Forty-seven school districts across twelve states participated in the survey, with over 5,400 respondents, divided up based on the four U.S. Census regions. The survey revealed that educators in the South region identified the greatest effect of immigration policy on immigrant children, and the Northeast region the least effect. Over eighty percent of Southern respondents identified behavioral or emotional issues as being a problem. 84% of all respondents reported students expressing concern about immigration enforcement, with over one-third noting that these concerns were expressed frequently. The report also highlights increased absenteeism and lower grades as a result of immigration concerns, especially if ICE raids were reported in the area. This report demonstrates the impact of immigration enforcement on immigrant communities from people who interact with immigrant students and their families almost every day. Likewise, it illustrates that programs such as DACA may be able to improve immigrant students’ abilities to retain information and succeed in school by reducing the chance family members may be deported. Such studies provide valuable insight into the often unintended and potentially harmful consequences of immigration policy implementation.

A 2011 study entitled “Higher Education and Children in Immigrant Families” by Sandy Baum and Stella M. Flores explores the differences between groups of immigrants in the United States from around the world in terms of postsecondary educational attainment. In this study, the authors found that some groups of immigrants, such as those from Africa and Asia, are more likely to hold a college degree compared to other groups, such as those from Central and South America. Their research also indicates that educational attainment between generations tends to change. First generation immigrants, for instance, are less likely to hold a bachelor’s degree than their U.S. born children. The authors also discuss characteristics that indicate a better chance of success in attaining a higher education. Immigrants whose parents hold a college degree, who immigrated to the U.S. at or before age thirteen, and who enrolled their children in rigorous academic preparation for a postsecondary degree, had the best chances of attending college. Among immigrant groups, first generation immigrants aged twenty-five to thirty-four years old from East Asia and Southeast Asia are most likely to hold a bachelor’s degree, while first generation immigrants from Central and South America are least likely. The distinction, however, does not persist; the rates of degree attainment are similar for second generation immigrant families across the board. This study is significant because it indicates that the challenges to improving higher education access and attainment are more of a political problem than anything else. They also identify a number of obstacles that prevent immigrants from achieving a postsecondary degree, with one of the most significant hindrances being immigration status.

A 2017 study entitled “The Effects of Deferred Action for Childhood Arrivals on the Educational Outcomes of Undocumented Students” by Amy Hsin and Francesc Ortega examines the educational effects of DACA on DACA recipients. The researchers conducted a quantitative

analysis of the available data centered around two variables, a drop-out indicator and an enrollment indicator. Using these factors, they analyze the effects of DACA recipients' access to higher education in one unnamed state. The authors indicate that DACA as a whole incentivizes recipients to work instead of pursue educational opportunities, as recipients are given work permits through the program; however, DACA recipients tend to stay enrolled in educational institutions. They also found that DACA recipients attending community colleges were less likely to drop out than those attending four-year universities. In community colleges where a majority of students work, however, DACA reduced community college enrollment while not affecting enrollment levels of four-year institutions. This study indicates that DACA recipients attending four-year universities face an either-or situation when it comes to working or attending school. DACA recipients enrolled in community college, on the other hand, have an easier time balancing work and school. This study is interesting, as it shows the unintended consequences of DACA on recipients' access to higher education. It also explains why DACA policies both alleviate some issues faced by immigrants while also creating new problems for them as well.

Chapter IV: Results

Access to healthcare services and educational institutions is paramount to the well-being of any society. Immigrant communities, particularly in the U.S., face a number of difficulties in utilizing these services. For example, it is currently illegal under Section 561 and Section 562 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996 for undocumented immigrants to receive federal benefits including but not limited to Social Security, non-emergency healthcare services, educational funding, and unemployment benefits (“Pub. L. 104-208,” 1996). Undocumented immigrants found receiving these federal benefits face steep penalties, ranging from fines to 5 years in prison (“Pub. L. 104-208,” 1996). However, programs such as DACA create caveats that allow certain undocumented immigrants increased access to educational opportunities and medical services. Understanding the effects of immigration policy on the overall well-being of both documented and undocumented immigrant communities is vital in order to develop policies that best serve each community’s basic needs. After examining the data, it becomes apparent that access to these two critical services are most readily available to immigrants, especially those qualifying for DACA, under the DREAM Act.

Access to Healthcare

The ability to access healthcare services is a crucial part of life for every person, regardless of their citizenship status. However, both legal and undocumented immigrants face hurdles to accessing healthcare services that other citizens do not experience. It is well established that immigrants, regardless of status, are less likely to utilize social safety net services such as Medicaid even if they qualify for these services (Watson, 2010, Pgs. 2-4).

Available data suggests that such disparities exist due to numerous factors, but policy surrounding access to healthcare, especially for immigrants, shifted significantly beginning in the

mid 1980s. Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 to ensure that anyone, including undocumented immigrants, could access emergency medical services regardless of their citizenship or ability to pay. Per the law, patients in critical condition must be stabilized before being released (Gusmano, 2012). Access to government programs covering non-emergency medical services, however, was greatly reduced by the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 (Gusmano, 2012). PRWORA seeks to prevent government benefit fraud or abuse, and one set of provisions bans undocumented immigrants from utilizing services, including means-tested programs like Medicaid or the Children's Health Insurance Program (CHIP), and other programs such as Medicare (Gusmano, 2012). The Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA) of 1996, while creating some exemptions for special groups of undocumented immigrants, further restricted undocumented immigrant access to healthcare services by allowing states to refuse benefits to this community ("Illegal Immigration Reform").

While these laws apply to undocumented immigrants, studies indicate that they have widespread negative impacts on all immigrant communities regardless of residency status and decrease opportunities for noncitizen immigrant families to afford medical services. A study conducted in 2010 demonstrates that strict immigration enforcement in one's local area is correlated with a subsequent withdrawal in Medicaid participation among both non-citizen children and children of non-citizen parents. In fact, 9% of children from low socioeconomic status families and almost 5% of all children withdrew from Medicaid participation after stringent immigration enforcement in a given area (Watson, 2010, Pgs. 15-16). Another study published in 2009 reviews the effects of PRWORA on enrollment in Medicaid and CHIP among

immigrants, including both documented and undocumented. After PRWORA was enacted, noncitizen immigrant enrollment dropped significantly, even among those who were eligible for such services. During the same time, lack of private healthcare insurance coverage among noncitizen immigrants rose (Fix, Capps, and Kaushal, 2009, Pgs. 25-27).

Under DACA, recipients are still not able to qualify for government health benefit programs such as CHIP or Medicaid; healthcare access is still substantially limited as a result. One study indicated that only approximately 44% of DACA recipients surveyed in southern California in 2015 reported having health insurance (Patler et al., 2015, Pg. 6; 23). Likewise, this same sample group was two times more likely to delay seeking medical treatment due to their immigration status than undocumented immigrants not covered by DACA (Patler et al., 2015, Pg. 23). A 2014 study examining DACA recipients' access to healthcare in the Bay Area and Los Angeles, also confirmed that DACA recipients delayed utilizing healthcare services other than emergency services for as long as possible or avoided them entirely. Most respondents indicated that the high cost of treatment was the most significant reason for avoiding medical services, though healthcare illiteracy, mistrust of healthcare professionals, and experiences with discrimination in the healthcare industry also played a role (Raymond-Flesch et al., 2014, Pgs. 325-326). DACA does appear to have a positive effect on the mental health of recipients' families. A 2017 study examining the effects on children of having a parent qualify for DACA indicated that children whose mothers were DACA eligible were less likely to be diagnosed with mental health disorders than those whose mothers were not DACA eligible. The researchers' findings support the conclusion that a parent's residency status, especially if the parent is undocumented, can serve as a significant point of stress for a child (Hainmueller et al, 2017).

As the DREAM Act has not been enacted, data regarding the effects of the bill on current DACA recipients' access to healthcare is speculative at best. With this limitation in mind, analyses indicate that the DREAM Act would enhance opportunities for DACA recipients as they would automatically qualify for conditional permanent residence (CPR). This status, while not directly allowing them to access healthcare benefits like Medicaid, puts them on track to receive these government benefits once they reach legal permanent residence (LPR). Those receiving LPR are able to qualify for Medicaid, CHIP, and other government benefits without risk of penalty ("The Dream Act," 2017). The ability to qualify for such services and access non-emergency medical care previously not available to undocumented immigrants would prove to be tremendously beneficial to current DACA recipients.

Access to Education

When discussing immigrants' access to education, it is important to note that most of the discourse centers on access to higher education as opposed to primary and secondary education. The Supreme Court decided in *Plyler v. Doe* (1982) to address the question of whether undocumented children could enroll in public schools. The decision held that all children, undocumented or otherwise, must be allowed to enroll in primary and secondary schools ("Plyler v. Doe"). Immigrant children, both documented and undocumented, are thereby guaranteed the right to a kindergarten through high school education just like the children of U.S. citizens.

Access to higher education, however, is a different playing field. While there is no federal law explicitly prohibiting undocumented students from applying or being accepted into college, barriers exist most noticeably in access to funding. The enactment of the Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA) in 1996 prohibited any undocumented immigrant from receiving federal financial aid or federal loans to pay for college,

and that rule still applies today (“Illegal Immigration Reform,” 2018; McKeage, 2016). The inability to access federal financial aid is a significant barrier for undocumented students, especially low-income students (Huber et al., 2014, Pg. 5). After the enactment of IIRIRA, states also began instituting their own policies governing undocumented student access to state and public institutional aid and whether undocumented students were charged in-state or out-of-state tuition. Some states, such as South Carolina and Alabama, require undocumented students to pay out-of-state tuition (Quintero and Levesque, 2017). Other states, such as California, Texas, and New Jersey, allow resident undocumented students to qualify for in-state tuition in addition to accessing state and public institutional financial aid. Still other states, such as Idaho and Louisiana, do not have laws allowing undocumented students to access state financial aid or in-state tuition, though they also do not have laws requiring undocumented students to pay out-of-state tuition (Quintero and Levesque, 2017).

Under DACA, higher education became significantly easier to access for undocumented students. Some recipients may be inclined to apply to colleges and universities simply because they no longer have to fear deportation. In addition, DACA recipients may be encouraged to apply as they attain work permits through the program and can save more to put toward their education. They are also able to access state and institutional aid in some cases, further improving their access to a college degree (Quintero and Levesque, 2017). States, however, maintain their varied approaches to providing in-state tuition, state aid, and public institutional aid for undocumented students, including DACA recipients (Quintero and Levesque, 2017). One study indicated that DACA allowed 87% of recipients in southern California to enroll in a higher education program of some sort, though 75% stated that they had difficulty paying for such programs. Despite these difficulties, 78% of recipients in the study said that DACA made it

easier to pay for their education, and approximately 75% said DACA made it easier for them to enroll and remain in school. (Patler et al., 2015, Pgs. 17-18). In another study, respondents indicated that DACA allowed them to find better paying jobs, which prove helpful in covering college costs and allowing them to gain work experience (Huber et al., 2014, Pg. 5). One issue that arose, however, is that respondents from a study examining DACA recipients in southern California reported being largely unaware that college was a potential reality for them. After the enactment of AB 540, dubbed the “California Dream Act,” in 2001, only 58% of high school students reportedly knew about the law. Among low-income students, only around 50% were aware of the postsecondary educational opportunities afforded under the law (Patler et al., 2015, Pg. 15).

Similar to the issue of healthcare access, studies analyzing the effects of the DREAM Act on access to higher education are, at best, speculative because the bill is not law. Understanding this limitation, then, evidence suggests that current DACA recipients would see some improvements in access to higher education under this proposed law. Those recipients most likely to benefit from the DREAM Act’s enactment are those who currently hold college degrees, as their degree will qualify them for legal permanent residence (LPR). LPR status allows recipients to access federal financial aid and loans (“Student Citizenship Status,” 2019). Qualifying for LPR also provides a direct path to citizenship, a significant benefit not currently available to DACA recipients that includes full access to government resources (“The Dream Act,” 2017).

Access to healthcare and educational services for current DACA recipients would be most improved with the enactment of the DREAM Act. While creating new educational and employment opportunities, DACA falls short on improving recipients’ access to healthcare

services. In regards to educational development, lack of financial resources is the primary issue faced by undocumented students. The absence of federal law and the patchwork of varying state laws governing access to state educational institutions, financial aid, and tuition rates create inequity of educational access based on location. In regards to healthcare, DACA recipients lack access to government resources that would improve their ability to utilize non-emergency healthcare services. Many put off medical care until the condition is critical due to the inability to pay the bill out-of-pocket, while others fear the use of medical services will affect their immigration status. An in-depth examination of these issues is required to better understand why such problems persist and how they can be remedied.

Chapter V: Analysis and Discussion

Juan Escalante was an intern working without pay in 2012 when he found out about the Deferred Action for Childhood Arrivals program. After hearing a news program about it, he quickly called his mother to reassure her that he and his younger siblings would be protected from deportation and have the opportunity to obtain a driver's license and work ("Juan Escalante," 2017). Yamilet Sanchez remembers the day when her mother, who had Yamilet and her younger brother smuggled into the country from Mexico, arrived at their doorstep soaking wet from crossing a river into the U.S. After reconnecting with her father, who was already in the U.S., the family settled in Philadelphia. Sanchez's dream of pursuing an education became a reality after the enactment of DACA, and she now attends college while also working at a prestigious law firm ("Yamilet Sanchez," 2017). Nadia Rojas was only two years old when she arrived in California with her parents and two siblings in 1990. She attended UC Berkeley for her undergraduate degree, commuting several hours each day as she could not afford to live near campus without financial aid. After her entire family was required to undergo deportation proceedings, the enactment of DACA during that time allowed her and her sister to remain in the U.S. While the rest of her family was deported, Rojas received a Master's of Public Health degree and now works as a public health researcher, examining ways to reduce health disparities ("Nadia Rojas," 2017).

Immigration policy has substantial effects on all aspects of supposedly unrelated policy areas. As illustrated in Chapter IV, immigration policy has a significant effect on both documented and undocumented immigrants in terms of access to education and healthcare services. By understanding past and current policies and their effects on immigrant communities, policymakers will be able to enact laws and regulations that create more opportunities through

future policies. Likewise, thorough analysis of these topics will enhance understanding and discussion of the potential impact of proposed legislation, such as the DREAM Act.

Access to Healthcare

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 significantly inhibited undocumented immigrants' ability to access basic government assistance for healthcare services. Programs such as CHIP and Medicaid became unavailable, and undocumented immigrants attempting to utilize these programs were subject to harsh penalties ("Illegal Immigration Reform," 2018). The loss of these resources are significant, as a majority of immediately DACA eligible young adults live in families that make at or below 150% of the federal poverty level (Batalova et al., 2014, Pg. 17). The loss of government assistance left few options for many undocumented immigrants. One option specifically for DACA recipients is health insurance through one's employer. Undocumented immigrants are officially banned from being legally employed under the IIRIRA and do not have this opportunity; however, DACA recipients obtain work permits, allowing them to access employer-provided health insurance if offered ("Illegal Immigration Reform," 2018; Raymond-Flesch et al., 2014, Pg. 327). With employer-based health insurance benefits largely off the table, undocumented immigrants' options further narrowed in terms of being able to afford or even access healthcare services. PRWORA, especially when combined with IIRIRA, created a chilling effect on healthcare access among all immigrant populations regardless of residency status. Immigrants were afraid that accessing any medical services or accessing government healthcare assistance would lead to their deportation, even if they were authorized to access such services and benefits (Fix et al., 2007, Pgs. 18-19). All immigrants, regardless of residency status or

ability to pay, are able to access emergency medical services until they are in stable condition per EMTALA; however, undocumented immigrants had few other choices.

Over time, a few alternatives developed to help undocumented immigrants obtain the medical services they needed. As the federal government prevented ineligible non-citizens from receiving government benefits, some states stepped up to fill the gap. One example is the All Kids program in Illinois, in which all children from families with incomes below a threshold regardless of residency status are covered for health expenditures (Gusmano, 2012). In another case, the State of New York's Court of Appeals ruled in *Aliessa v. Novello* that the state could not bar undocumented immigrants who previously qualified for Permanent Residence Under Color of Law (PRUCOL) status from accessing Medicaid. Over 20 states allow children younger than 21, pregnant women, and many young adults granted deferred action to apply for Medicaid, CHIP, or enter a high-risk insurance pool (Gusmano, 2012). Such state actions extend healthcare access for some undocumented immigrants, but they also have numerous drawbacks. These programs rely entirely on state funds, which states either may not allot to programs for undocumented immigrants or may not have at all. Disparity in access thus becomes based on location, creating an environment for significant inequity in healthcare access. Likewise, many programs only apply to those under an age limit, which may lead to those aging out of the system left without any options. Few options, however, are certainly preferable to no options.

Other healthcare service alternatives are public and non-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers. These institutions are supported through their designation as "disproportionate share hospitals (DSHs), which is determined based on the number of low-income patients who may not be able to afford services (Gusmano, 2012). Since 1981, these institutions receive Medicaid and Medicare funds to

compensate for the high volumes of uninsured or low-income patients they treat. These centers also treat patients regardless of ability to pay or immigration status; thus, they often serve as a useful resource for low-income undocumented immigrants (Gusmano, 2012). Appropriations for these institutions grew under both the George W. Bush and Barack Obama administrations, and over 1,200 FQHCs and over 150 migrant health centers were operational nationally in 2010 (Gusmano, 2012). These alternatives, though limited in their ability to fully meet the needs of undocumented immigrants, provide some coverage for the gaps created by federal law.

The DACA program, while providing some additional access to medical services, did relatively little to improve undocumented immigrants' healthcare situation imposed by IIRIRA and PRWORA. DACA recipients remain ineligible for any government assistance for healthcare services, including Medicaid and CHIP. Likewise, even after the enactment of the Patient Protection and Affordable Care Act (ACA), DACA recipients were prohibited from accessing Medicaid programs or qualifying for state health insurance exchanges created under the law (Raymond-Flesch et al., 2014, Pg. 324; Gusmano, 2012). The continued lack of access to healthcare and health insurance services pose significant hurdles to DACA recipients. The literature reflects this harsh reality; among undocumented immigrant youth in California, 69% do not have health insurance and just over 50% have not been seen by a doctor in more than a year (Patler et al., 2015, Pg. 23). To make matters worse, over 70% of this population indicated that they needed to access medical services and just under 60% have turned to online services due to the lack of access (Patler et al., 2015, Pg. 23). Among DACA recipients in southern California, only 44% have health insurance, and they were also twice as likely to delay seeking medical services than undocumented immigrants who did not qualify for DACA (Patler et al., 2015, Pg.

23). These statistics offer a startling view into the daily realities of access to healthcare services for those receiving DACA protections.

While DACA remains limiting in many senses, it does provide an additional venue to access healthcare services: employer-provided health insurance. By receiving work permits and qualifying for legal work in the United States, DACA recipients have greater access than those who do not qualify for employer-provided health insurance (Raymond-Flesch et al., 2014, Pg. 327). This option, however, is not guaranteed. Even with this potential alternative, DACA recipients indicated that one of the most significant impediments they face is a general lack of information regarding their opportunities to access healthcare services and fear that accessing such services may negatively affect their immigration status (Raymond-Flesch et al., 2014, Pg. 327). Recipients also indicated that negative experiences with healthcare service staff played a role in their avoidance of medical institutions (Raymond-Flesch et al., 2014, Pg. 327). Available data supports this notion, as DACA-eligible youth are less likely to utilize healthcare services and more likely to suffer from sexually transmitted diseases or accidental injury. Likewise, studies show that DACA recipients have significant mental health needs due to stress associated with their undocumented status (Raymond-Flesch et al., 2014, Pg. 327). Health problems among immigrants resulting from long-term stress due to concerns of their residency status is a well-noted phenomenon. One study indicated that undocumented immigrants are more likely to experience heart problems, hypertension, diabetes, and mental health issues than legal immigrants or those who chose not to immigrate at all; the authors conclude that a lack of access to healthcare services and increased stress due to undocumented status is at least partially to blame for this disparity in health outcomes (Wilson et al., 2014, Pg. 3, 7). The data is clear: undocumented immigrants, including those protected by DACA, are negatively affected by the

lack of healthcare accessibility, and programs like DACA have done little to improve access to these essential services.

Due to these circumstances, future immigration reforms affecting healthcare services are of particular interest to both scholars and immigrant communities. The DREAM Act has potential to influence such access by creating a path to citizenship that is currently not afforded to DACA recipients or other undocumented immigrants. Such a path would also be shortened for current DACA recipients, as they would automatically qualify for CPR (“The Dream Act, 2017). After meeting one of three requirements, CPR recipients would be eligible to qualify for LPR, or “green card” status. This designation would authorize recipients to access government benefits, participate in state health insurance exchanges, and receive full work authorization (Fix and Haskins, 2002). Though providing limited immediate benefits to current DACA recipients, the long-term benefits of the DREAM Act are clear and significant. This proposed legislation could be significantly strengthened, however, by adding provisions allowing current DACA recipients to access healthcare services and government healthcare assistance. With these additions, the DREAM Act would certainly create more opportunities for current DACA recipients to access healthcare services that have not been afforded under other federal legislation or programs such as DACA.

Access to Education

With the question of access to K-12 education for undocumented immigrants now settled law per the Supreme Court’s decision in *Plyler v. Doe*, the discussion turns to undocumented immigrants’ access to higher education (“*Plyler v. Doe*”). Currently, no federal law explicitly prohibits undocumented students from enrolling in postsecondary public institutions; however, states have taken differing positions on who may and may not enroll in their public institution of

higher education. While the majority of states allow undocumented immigrants to enroll in their public institutions, three states (Alabama, Georgia, and South Carolina) have statewide bans that prevent undocumented students from enrolling in public colleges (Vasilogambros, 2016). This patchwork of state enrollment policies creates varying degrees of accessibility to institutions of higher education, serving as a barrier for many undocumented immigrants.

One of the most significant barriers for undocumented students, however, is the availability of state tuition assistance. Per IIRIRA, undocumented immigrants are not eligible to receive any federal financial aid or federal student loans to pay for their college education (“Understanding DACA,” 2017, Pg. 2). States, on the other hand, are able to provide assistance with state funds if they so choose, and states have addressed this situation in several ways.

Though most states only afford these opportunities to current DACA recipients, some states extend them to all undocumented immigrants (Brick and García, 2014). For instance, 24 states offer some form of tuition assistance or offer in-state tuition for undocumented students and/or DACA recipients (Brick and García, 2014). 18 states have no official laws on the books prohibiting undocumented students from enrolling in public institutions or granting in-state tuition to these students (Brick and García, 2014). Still others require undocumented students to pay out-of-state tuition exclusively while receiving no state financial aid (Vasilogambros, 2016). Prior to DACA’s implementation, attaining a college degree was exceptionally difficult for undocumented immigrants.

DACA significantly impacted access to higher education for undocumented immigrants by providing additional opportunities to obtain a college degree. One of the most substantial changes was the ability to access additional financial resources. DACA recipients qualify for in-state tuition or some form of financial aid through scholarships in a plurality of states (Brick and

García). As students gained access to additional funds, they had more opportunities to attain an education that cost alone had previously kept them from pursuing. In fact, one study found that 78% of DACA recipients in southern California indicated that DACA made it easier to pay for their education, and 70% reported that they had an easier time staying in school due to DACA protections (Patler et al., 2015, Pg. 18). In addition to increased funding for educational pursuits, DACA also gave undocumented students the opportunity to work. With work permits, undocumented students were able to work legally for higher wages and save money towards their education. At the same time, they received work experience and career training, neither of which they would have been able to do without DACA (Huber et al., 2014, Pg. 5).

As states began opening new financial resources to students, another issue arose: lack of information regarding these opportunities. The lack of information for undocumented high school students regarding college and postsecondary educational opportunities is a serious issue. For instance, after the enactment of a California law providing in-state tuition to eligible undocumented students in 2001, slightly less than 60% of graduating high school students were aware of this opportunity. Among low-income students, almost 65% reported being unaware of the law (Patler et al., 2014, Pg. 15). These statistics illustrate that lack of awareness of such laws, especially among undocumented high school students, serves as an impediment to DACA recipients' postsecondary educational attainment. However, knowing that they are protected from deportation through their legal status, DACA may encourage more recipients to apply to college overall (Quintero and Levesque, 2017).

Under the DREAM Act, educational opportunities have the potential to expand further. As DACA recipients automatically qualify for CPR, they are more likely to qualify for LPR as well. In order to qualify for LPR, applicants must have completed at least two years of a

postsecondary education program, served in the military for two years, or worked for three years (“The Dream Act”). By opening the path to LPR and citizenship, the DREAM Act would provide current DACA recipients with more funding opportunities for their education. Such resources would greatly improve access to higher education and remove a significant barrier standing in the way of talented young undocumented immigrants attending college: cost (Patler and Appelbaum, 2011, Pg. 2). Likewise, the educational component of the qualifications for LPR may serve as an incentive for more undocumented students to attend college or enroll in postsecondary educational institutions. The proposed legislation could be strengthened, however, by allowing undocumented immigrants receiving CPR status to qualify for federal financial aid and loans. Access to these resources would be a positive incentive for more undocumented immigrants to attain a college degree and pursue the path to citizenship created under this bill. Overall, the DREAM Act would expand access to higher education even further than DACA or federal legislation currently allow.

Chapter VI: Conclusion

Immigration policy in the United States has a long and winding history. Through most of its history, however, the U.S. has experienced relatively relaxed immigration enforcement policies that afforded significant flexibility to immigrant integration into American society. More recent legislation has seen a shift away from that precedent, and policies primarily affecting undocumented immigrants leave them with few options to successfully and fully integrate in their communities. Most notably, legal barriers to healthcare and higher education services have significant effects on the well-being of both documented and undocumented immigrant communities. DACA's emergence in 2012 reduced hardships in accessing these two essential services for undocumented immigrants. To fully understand the impact of this program and how to best meet the needs of immigrant communities, it is important to compare access to healthcare and education prior to DACA's enactment, under current DACA regulations, and what they could look like under proposed legislation such as the DREAM Act.

The available literature offers insight into how immigration policy affects documented and undocumented immigrants' over well-being, family structure, access to healthcare services, and access to higher education. The benefits of the DACA program are well-documented and continuously demonstrated through both academic studies and recipients' testimony. Strict immigration enforcement policies, however, often lead to negative outcomes in both documented and undocumented immigrant communities. The research is clear: immigration policies have a substantial effect on documented and undocumented populations, and policies should be carefully crafted to ensure the basic needs of every person in the country are met.

Based on the available research on immigrants' access to healthcare and education services before DACA, under DACA, and what future policies may look like, it appears that the

enactment of the DREAM Act would increase both access to healthcare and access to higher educational opportunities for current DACA recipients. Prior to DACA, healthcare access and higher education access were exceptionally limited by PWRORA and IIRIRA enacted in 1996. DACA opened numerous educational opportunities while offering little in the way of increasing access to healthcare services. Under the proposed DREAM Act, however, access to both services would be expanded over time, with immediate benefits limited in both areas. The DREAM Act, with minor adjustments, is the most promising legislation to open additional services to undocumented and documented communities. Healthcare and education are essential services that can greatly improve one's lived experience and overall well-being; as such, it is vital that these services be expanded for immigrant communities.

While this thesis provides a glimpse into DACA recipients' access to healthcare and post secondary education, there is substantial room for future research on these topics. One area of future research would be to examine additional policy alternatives that may be more politically expedient and better improve current DACA recipients' access to healthcare and education than the DREAM Act. Additional research could also be conducted on ways to improve access to these services for undocumented immigrants who do not qualify for DACA. Next steps for expanding on this research may include surveying DACA recipients in multiple locations across the nation to better ascertain access to healthcare and education by region, state, or city. It could also entail gathering additional data on the quality of healthcare and education services currently accessed by DACA recipients. By improving the scope and breadth of available research, policy advocates and political leaders will be able to advance policies that best serve all members of our society.

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