

# Health Care Sanctuaries

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Abstract:

It is increasingly common for noncitizens living in the United States to avoid seeing a doctor or enrolling in publicly funded health programs because they fear surveillance by immigration authorities. This is the consequence of a decades-long shift in the locus of immigration enforcement activities from the border to the interior, as well as a recent period of heightened immigration enforcement. These fears persist because the law incompletely constrains immigration surveillance in health care.

This Article argues that immigration surveillance in health care is a poor choice of resource allocation for immigration enforcement because it has severe consequences for health and the health care system; additionally, it compromises the legitimacy of the state vis-à-vis its noncitizen residents. The consequences include public health threats, health care system inefficiency, ethical dilemmas, and increased vulnerability in immigrant communities. Laws permitting immigration surveillance in health care also create legitimacy harms by obstructing noncitizens' access to health care and undermining their privacy and rights to public benefits. The COVID-19 pandemic starkly illustrates these dangers, but they exist even in the absence of a novel disease outbreak.

Health care access for noncitizens has largely been left to the vagaries of immigration policy. Immigration surveillance in health care should prompt us to consider the scope and limits of health law and the role of discretion in immigration law. Health care sanctuaries — durable legal protections against immigration surveillance in health care — recover some of the lost equilibrium between immigration enforcement and other goals and values of public policy.

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## INTRODUCTION

*Low-income immigrants with a serious medical condition are in an impossible situation. How much do you risk for medical care? Deportation would devastate your family but so would your illness and death.*<sup>1</sup>

A grandfather who visits a hospital emergency room for severe abdominal pain refuses to follow up with a gastroenterologist because he is worried that enrolling in Medicaid will affect his pending immigration application. A mother decides to skip prenatal care for her third pregnancy because she has seen Immigration and Customs Enforcement (ICE) officers in the parking lot of the health clinic. A fast-food worker with COVID-19 symptoms seeks relief from a *curandero* (traditional healer) instead of accessing publicly funded testing and treatment because he believes that the information will be tracked and reported to immigration authorities. These are examples of how fears of immigration surveillance serve as barriers to health care.

This Article focuses on concerns that arise from two modes of immigration surveillance in health care: (1) interrogation, arrest, search, or detention by immigration enforcement officers at health care sites; and (2) use of personal information disclosed for the purpose of obtaining health care to deny immigration benefits or for immigration enforcement purposes. Reluctance to seek health care or coverage because of fear of immigration consequences is a barrier to health care access for noncitizens.<sup>2</sup> Fear discourages noncitizens from seeking care even when they are legally entitled to do so.<sup>3</sup> It influences the care-seeking behaviors both of noncitizens with an array of legal statuses and of their U.S.-citizen family members.

This Article applies the sociological concept of “system avoidance” to avoidance of engagement with the health care system because of immigration-related concerns. System avoidance occurs when “individuals avoid[] institutions that keep formal records . . . and therefore heighten the risk of surveillance and apprehension by authorities.”<sup>4</sup> The migration research literature refers to

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1 LISA SUN-HEE PARK, ENTITLED TO NOTHING: THE STRUGGLE FOR IMMIGRANT HEALTH CARE IN THE AGE OF WELFARE REFORM 135 (2011).

2 Karen Hacker et al., *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 RISK MGMT. & HEALTHCARE POL’Y 175, 178 (2015).

3 *Id.* at 180.

4 Sarah Brayne, *Surveillance and System Avoidance: Criminal Justice Contact and Institutional Attachment*, 79 AM. SOCIO. REV. 367, 368 (2014). Brayne first used the term “system avoidance” to describe a behavioral response of individuals who had criminal justice contact and who thereafter limited their interactions with recordkeeping institutions such as schools, banks, and hospitals. *Id.* at 372. This research indicates that people who have had criminal justice contact avoid recordkeeping institutions in order to evade heightened surveillance and, implicitly, further involvement with the

avoidance of surveilling institutions by noncitizens with vulnerable legal statuses as “chilling effects.”<sup>5</sup> As immigration enforcement in homes, workplaces, schools, government offices, and the streets has become more commonplace, noncitizens have grown increasingly fearful that routine interactions at everyday places can lead to arrest and deportation. Health care sites are one such place. Health care system avoidance based on fear of immigration surveillance is an example of how the expansion of immigration enforcement in the interior of the United States has discouraged noncitizens from engaging in socially beneficial behavior.

The concept of health care system avoidance has spawned a rich literature about “legally vulnerable populations” that applies in broad contexts,<sup>6</sup> which raises

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criminal justice system. Brayne notes that although it has been suggested that system avoidance may be observed among other disadvantaged groups, such as undocumented immigrants, studies of the phenomenon in noncitizens are few. *Id.* at 387. Since publication of this landmark article, researchers have gathered evidence of system avoidance among noncitizens. *See, e.g.,* Caitlin Patler & Gabriela Gonzalez, *Compounded Vulnerability: The Consequences of Immigration Detention for Institutional Attachment and System Avoidance in Mixed-Immigration-Status Families*, SOC. PROBS., Dec. 2020, at 14 (noting that members of mixed-status families “express concerns that involvement in formal records-keeping institutions will damage the family’s uncertain legal future”).

5 Patler & Gonzalez, *supra* note 4, at 14 (noting the similarity between the concepts of system avoidance and chilling effects). Studies examining “chilling effects” or similar phenomena among noncitizens span numerous disciplines. Patler and Gonzalez note that in the sociological literature, “[i]t is well known that immigrants with vulnerable legal statuses—especially undocumented immigrants—are wary of surveilling institutions.” *Id.* at 2. Asad Asad builds on the sociological literature on system avoidance to introduce the concept of “system embeddedness,” observing that some undocumented immigrants avoid opportunities to legalize their immigration status because they believe that remaining illegible to the immigration system is less risky than engaging with it. Asad L. Asad, *On the Radar: System Embeddedness and Latin American Immigrants’ Perceived Risk of Deportation*, 54 L. & SOC’Y REV. 133, 161 (2020). Kathleen Page and Sarah Polk offer the medical clinician’s perspective, describing the experience of attempting to care for a pregnant noncitizen patient who was diagnosed with syphilis, but who did not pursue treatment because of fear of immigration surveillance at the clinic. Kathleen R. Page & Sarah Polk, *Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families*, 376 NEW ENG. J. MED. e20(1), e20(1) (2017). From a health policy perspective, Dhruv Khullar and Dave Chokshi observe that “aggressive immigration law enforcement” can cause chilling effects for noncitizens and their family members that persist even when a less aggressive enforcement regime is implemented. Dhruv Khullar & Dave A. Chokshi, *Challenges for Immigrant Health in the USA—The Road to Crisis*, 393 LANCET 2168, 2170 (2019). They also note the uptick in reports of ICE arrests at hospitals since 2017. *Id.* The link between immigration policies and chilling effects on public benefits access have been considered in the legal literature as well. *See, e.g.,* David A. Super, *The Future of U.S. Immigration Law*, 53 U.C. DAVIS L. REV. 509, 555-57 (2019). Asad highlights the need for further research on whether noncitizens’ involvement with the health care system and public benefits agencies influences their perceptions of risk of deportability. Asad, *supra*, at 161.

6 Patler & Gonzalez, *supra* note 4, at 14. *See, e.g.,* ALICE GOFFMAN, ON THE RUN: FUGITIVE LIFE IN AN AMERICAN CITY 34 (2014) (describing how policing in certain hospital emergency rooms effectively allocates access to health care based on social perceptions of criminality); Brooke A. Cunningham, *This, Too, Is What Racism Feels Like*, 39 HEALTH AFF. 2029 (2020) (describing health care system avoidance as a strategy to avoid exposure to racism in the health care system itself); Erin M. Kerrison & Alyasah A. Sewell, *Negative Illness Feedbacks: High-Frisk Policing Reduces*

the question: Why examine health care system avoidance as it applies to noncitizens? While it is true that awareness of health care system avoidance has motivated efforts to expand access to health care and address health care disparities, these efforts are inadequate if they do not address the unique and disproportionate risks of accessing health care as a noncitizen. Despite this, health care access for noncitizens has largely been left to the vagaries of immigration law and policy. Furthermore, an examination of system avoidance as a confluence of health and immigration policies can help to explain more generally how legally imposed categories stratify groups within the U.S. health care system.

This Article presents a rough framework for balancing health-related policy goals with immigration policy goals, each of which are vitally important and often contested. It bridges legal scholarship on health care access and immigration surveillance — two bodies of literature that have developed independently and that have consequential interactions. It contributes to the literature on health care access and marginalized communities by synthesizing insights from health law, immigration law, and sociology to examine law’s role in generating health care system avoidance behaviors. It contributes to the interdisciplinary literature on immigration as a social determinant of health by providing a case study of how legal status stratification shapes the health of noncitizens and their family members.<sup>7</sup>

This is also the first Article to comprehensively describe the laws and policies pertaining to the government’s conduct of immigration surveillance activities at health care sites. Even though some of these laws and policies treat health care sites as sanctuaries from immigration enforcement, fear of engaging with the health care system is widespread in immigrant communities. The failure of law to persuade in this context reflects beliefs among noncitizens and their family members that the government will not constrain interior immigration enforcement even when there are serious health-related tradeoffs. Correcting this misperception and reforming the law to create health care sanctuaries is in the government’s immediate and long-term interests. Most urgently, the government will benefit from renewed trust during its quest to make the coronavirus into a manageable

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*Civilian Reliance on ED Services*, 55 HEALTH SERVS. RSCH. 787, 788 (2020) (exploring the phenomenon of health care system avoidance in the context of racialized policing practices and police violence); Ji Seon Song, *Policing the Emergency Room*, 134 Harv. L. Rev. 2646 (2021) (analyzing the law’s role in facilitating racialized policing practices at health care sites).

<sup>7</sup> See, e.g., NAT’L ACADS. OF SCIS., ENG’G, & MED., IMMIGRATION AS A SOCIAL DETERMINANT OF HEALTH: PROCEEDINGS OF A WORKSHOP (2018); Heide Castañeda et al., *Immigration as a Social Determinant of Health*, 36 ANN. REV. PUB. HEALTH 375 (2015); Wendy E. Parmet, *Immigration Law as a Social Determinant of Health*, 92 TEMP. L. REV. 931 (2020); Meredith Van Natta, *Stratified Citizenship, Stratified Health: Examining Latinx Legal Status in the U.S. Healthcare Safety Net*, 220 SOC. SCI. & MED. 49 (2019).

threat through mass inoculation.<sup>8</sup> Transparency and inclusion in the distribution of COVID-19 vaccines, including to noncitizens, will protect the lives and livelihoods of all people living in the United States.

This Article argues that immigration surveillance in health care is a poor choice of resource allocation for immigration enforcement because it has severe collateral consequences for the U.S. health care system and compromises the legitimacy of the state vis-à-vis its noncitizen residents. Immigration surveillance resources should be concentrated on efforts that produce the greatest benefits and the fewest drawbacks. Although immigration surveillance in health care may be justified, even sensible in certain narrow circumstances,<sup>9</sup> it is a poor tradeoff in the general case.

This Article proceeds in five parts. Part I introduces the phenomenon of immigration-related health care system avoidance. It presents data showing that noncitizens and their family members avoid health clinics, hospitals, and enrollment in publicly funded health coverage because of immigration-related fears. It draws on sociological theories to demonstrate that these beliefs are grounded in legitimate concerns about the expanding web of immigration surveillance.

Part II describes the legal framework of immigration surveillance in health care. Although existing laws and policies partially protect noncitizens from immigration surveillance in health care, the gradual expansion and normalization of interior immigration enforcement motivates system avoidance behaviors among noncitizens and their family members. Immigration surveillance involves the mass collection and analysis of personal data and the delegation of immigration control activities to public and private actors who are not affiliated with immigration enforcement agencies.<sup>10</sup> It is related to a decades-long shift in the locus of

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8 Advocates, health care providers, and public health experts have long expressed concerns that immigration-related fears are a barrier to persuading undocumented noncitizens — many of whom live in areas hard-hit by COVID-19 and who are at high risk of exposure due to their work — to get the vaccine once it becomes available to them. *See, e.g.*, Catherine E. Shoichet, *Fear Could Stop the Coronavirus Vaccine from Reaching Some of the People Who Need It Most*, CNN (Dec. 22, 2020, 11:40 AM), <https://www.cnn.com/2020/12/22/health/undocumented-immigrants-coronavirus-vaccine/index.html>.

9 Justifications for criminal policing in health care settings may include providing security for health care personnel; responding to calls from hospitals based on certain types of injuries, for example, non-self-inflicted gunshot wounds; collecting evidence such as patient belongings and statements where crime is suspected; and remaining with an injured patient if they are already under arrest. *See Song, supra* note 6, at 13-15. These justifications are far less convincing as applied to immigration policing when no crime is suspected. However, disentangling policing in the criminal justice system from immigration enforcement has become more complicated as ties between the two systems have deepened. *See Developments in the Law: Policing*, 128 HARV. L. REV. 1707, 1773 (2015).

10 *See Anil Kalhan, Immigration Surveillance*, 74 MD. L. REV. 1, 27 (2014).

immigration enforcement activities from the border to the interior.<sup>11</sup>

Delegating immigration surveillance to public and private actors who are not affiliated with immigration enforcement agencies is an increasingly important part of immigration enforcement.<sup>12</sup> It casts a wider net for identifying noncitizens of interest to immigration enforcement agencies; at the same time, it discourages noncitizens from engaging in socially valuable behaviors, such as seeking COVID-19 testing from a publicly funded health clinic or enrolling in Medicaid in order to afford the costs of treatment.<sup>13</sup> Immigration enforcement officers routinely surveil noncitizens while they go about the ordinary tasks of life in their homes, places of employment, schools, courthouses, and hospitals. As a result, noncitizens perceive the prospect of interrogation or arrest by immigration enforcement officers at or near health care sites as a realistic risk.<sup>14</sup> Likewise, they avoid participating in publicly funded health programs if there is a possibility that the information they disclose will be shared with immigration agencies.

Laws and policies limiting immigration enforcement activity at health care provider sites and generally protecting the confidentiality of personal information submitted to public benefit agencies have not allayed noncitizens' fears of accessing health care or publicly funded health coverage.<sup>15</sup> This is, in part, due to gaps, uncertainties, and exceptions in the law. Noncitizens' skepticism about the law's protections may also be considered a rational response to the overt and covert expansion of immigration surveillance over time. For example, a regulation promulgated in 2019,<sup>16</sup> and since rescinded,<sup>17</sup> increased the risk that certain noncitizens who enrolled in Medicaid would be denied lawful permanent resident

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11 See, e.g., Eisha Jain, *The Interior Structure of Immigration Enforcement*, 167 U. PA. L. REV. 1463, 1466 (2019) (arguing that “immigration enforcement should not be conceptualized as synonymous with deportation; rather, deportation is merely the tip of a much larger enforcement pyramid”).

12 *Id.* at 1466-67 (describing interior immigration enforcement as “a low-cost way to achieve enforcement objectives”); see also Dennis Broeders & Godfried Engbersen, *The Fight Against Illegal Migration: Identification Policies and Immigrants' Counterstrategies*, 50 AM. BEHAV. SCIENTIST 1592, 1593 (2007) (describing this phenomenon in the European context).

13 Broeders & Engbersen, *supra* note 12, at 1595.

14 By “health care sites,” I mean the full spectrum of places where people go to access health care, including hospitals, outpatient clinics (whether they are private, public, volunteer-run, mobile, school-based, or inside retail stores), urgent care centers, state and local health departments, community-based organizations offering health services, pharmacies, and health fairs.

15 See, e.g., July Lee et al., *Opportunities for Supporting Latino Immigrants in Emergency and Ambulatory Care Settings*, 46 J. CMTY. HEALTH 494, 498 (2020) (describing noncitizen parents' “fear that health care settings will send their personal information to the government, allowing ICE to find their addresses and look for them in their homes”).

16 Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,295 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 245, 248).

17 Inadmissibility on Public Charge Grounds; Implementation of Vacatur, 86 Fed. Reg. 14,221 (Mar. 15, 2021) (to be codified at 8 C.F.R. pts. 103, 106, 212, 213, 214, 245, 248).

(LPR) status. As part of the immigration application process, noncitizens were required to provide details about their use of Medicaid and other public benefits.<sup>18</sup> They were also compelled to authorize U.S. Citizenship and Immigration Services to verify this information with other government agencies, including the Department of Health and Human Services.<sup>19</sup> This policy and others have exacerbated noncitizens' fears of accessing publicly funded health care because of the perception that any use of public benefits will increase the risk that a future immigration application will be denied.

Part III draws out the ways in which permitting surveillance in health care (or affirming conceptions that it occurs) creates tradeoffs between immigration and health policy. Laws that permit immigration surveillance in health care, and therefore generate fears of accessing health care among noncitizens and their family members, have serious collateral consequences for the health care system that should be considered in weighing their utility. First, when people delay or avoid seeking vaccines or treatment for infectious disease like COVID-19, they increase their risk of transmitting the infection to others, thereby contributing to disease burden. Second, it is harder for providers to generate good outcomes and practice cost-effective care when patients delay or avoid routine care — the risk of becoming seriously ill or dying from all kinds of medical conditions increases.<sup>20</sup> Third, permitting immigration surveillance in health care creates ethical dilemmas for health care providers. When health care providers become or are perceived as being complicit with immigration enforcement, it may contradict their professional duties to patients. Providers cannot act with single-minded devotion to the well-being of patients when patients' engagement with the health care system may have negative immigration consequences. As a result, providers are sometimes forced to alter clinical risk calculations and clinical recommendations for reasons relating to immigration enforcement.<sup>21</sup> Fourth, policies that increase the risks of people dying or suffering from treatable and preventable conditions may violate health equity norms, including commitments to reduce racial health disparities.

The state also compromises its legitimacy in several ways by permitting immigration surveillance in health care. This is the subject of Part IV. First, the laws regulating immigration surveillance in health care impose nearly insurmountable barriers for noncitizens to understand how and when they may

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18 See Inadmissibility on Public Charge Grounds, 84 Fed. Reg. at 41,419.

19 See U.S. CITIZENSHIP & IMMIGR. SERVS., DEP'T OF HOMELAND SEC., FORM I-944, DECLARATION OF SELF-SUFFICIENCY (2019).

20 See, e.g., Mark É. Czeisler et al., *Delay or Avoidance of Medical Care Because of COVID-19-Related Concerns – United States, June 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1250 (2020) (describing how delay or avoidance of medical care during the COVID-19 pandemic increased morbidity and mortality risk from treatable and preventable conditions).

21 Meredith Van Natta, *First Do No Harm: Medical Legal Violence and Immigrant Health in Coral County, USA*, SOC. SCI. & MED., Aug. 2019, at 1.



access health care without triggering immigration-related consequences. This is a severe and burdensome constraint on noncitizens. Second, they encourage or require noncitizens to relinquish their privacy rights in their public benefits records. Third, they undermine noncitizens' property rights in public benefits by threatening a deprivation of liberty based on exercise of those rights.

Part V explains how creating durable legal protections against immigration surveillance in health care — “health care sanctuaries” — and making them well known can allay fears of accessing health care in immigrant communities. Such legal changes will recover some of the lost equilibrium between immigration enforcement and other goals and values of public policy.<sup>22</sup> If legal health care sanctuaries are a political impossibility, health care institutions can still take steps to limit information sharing with immigration agencies, provide physical refuge from immigration enforcement, link noncitizens with legal services, and promote norms of justice and empathy in immigration policy. Institution-level policy changes designed to protect noncitizen access to health care may catalyze legal reform.

#### I. NONCITIZENS AND HEALTH CARE SYSTEM AVOIDANCE

This Part introduces the phenomenon of immigration-related health care system avoidance by describing who is affected and summarizing the sociological literature explaining how and why it occurs. While noncitizens face barriers to accessing health care that are common to many other socioeconomically marginalized groups,<sup>23</sup> immigration-related health care system avoidance is driven by fears of immigration surveillance while accessing health care.<sup>24</sup> When they perceive this risk, noncitizens and their family members avoid engaging with the

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<sup>22</sup> Amanda Frost, *Can the Government Deport Immigrants Using Information it Encouraged Them to Provide?*, 2 ADMIN. L. REV. ACCORD 97, 98 (2017) (stating that “[t]he federal government has always balanced immigration enforcement against other goals and values” in the context of analyzing whether the Trump Administration should use information submitted by Deferred Action for Childhood Arrivals (DACA) applicants to deport them).

<sup>23</sup> See, e.g., Timothy Callaghan et al., *Immigrant Health Access in Texas: Policy, Rhetoric, and Fear in the Trump Era*, 19 BMC HEALTH SERVS. RSCH. 342, 343 (2019) (summarizing prior research indicating that access barriers for Hispanic immigrants include “lack of insurance . . . the cost of care, transportation, the inability to take time away from work, child care, limited knowledge, language, gender, ethnicity, documentation status, and fear”); Scott D. Rhodes et al., *The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States*, 105 AM. J. PUB. HEALTH 329, 329 (2015) (noting barriers of “a lack of bilingual and bicultural services, low health literacy, insufficient public transportation, and limited knowledge of available health services”).

<sup>24</sup> See Rhodes et al., *supra* note 23, at 329 (highlighting “fear of deportation, a lack of required forms of documentation, interaction with law enforcement personnel, and racial profiling” as “factors . . . associated with reduced utilization of health services and worse health” among noncitizens identifying as Hispanic or Latino).

health care system. In practice, this involves delaying or canceling doctors' visits and declining to participate in health care programs in order to guard against negative immigration consequences.

A broad range of noncitizens as well as U.S. citizens may engage in health care system avoidance.<sup>25</sup> Undocumented noncitizens are the most obvious targets of immigration surveillance because they are not legally authorized to be in the country. This group comprises not only people who enter the country without inspection at the border, but also those who entered with legal status but who have violated the terms of their status. Typical ways of violating the terms of one's status are to stay in the country beyond the date of one's authorized period of stay or to perform work that is not authorized by one's status.<sup>26</sup> For example, a noncitizen may enter the country with a tourist visa that authorizes them to stay in the United States for three months. If that noncitizen stays in the country beyond three months, they are considered undocumented.

It is common for noncitizens to move across the documentation status continuum throughout their lives, with periods of authorized and unauthorized status.<sup>27</sup> Because of the backlog in processing for most immigration applications, applicants can wait months or years to receive a decision on an immigration application, all the while living in a kind of "twilight" status.<sup>28</sup> Long-term residence in the United States is a characteristic of most undocumented noncitizens' lives.<sup>29</sup> Despite this fact, undocumented noncitizens live with the knowledge that even routine interactions — such as going to the doctor — can result in arrest, detention, and deportation.<sup>30</sup>

Foreign-born people *with* legal status are not immune to the negative consequences of immigration surveillance. An environment of heightened immigration enforcement can affect health care-related behaviors of noncitizens

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25 As will be explained, U.S. citizens may fear that their interactions with health care institutions could put their noncitizen family members at risk of negative immigration consequences, such as denial of a pending or future immigration application or deportation. *See infra* text accompanying notes 36-38, 40-41. Jennifer Chacón proposes using the concept of "liminal legality" to describe the condition of a broad range of people whose lives are impacted by heightened monitoring of noncitizens by government agencies (among other trends in immigration policy). Jennifer M. Chacón, *Producing Liminal Legality*, 92 DENV. U.L. REV. 709, 712, 730 (2015).

26 Broeders & Engbersen, *supra* note 12, at 1594 ("Most typologies of irregular migration are . . . set up around three main criteria. There is legal and illegal *entry*, legal and illegal *residence*, and legal or illegal *employment*.").

27 *See, e.g.,* Jain, *supra* note 11, at 1473 (explaining that the distinction between "legal" and "illegal" noncitizens is not always clear because some who currently lack a valid status may acquire one in the future and some with a valid status may lose it).

28 DAVID A. MARTIN, MIGRATION POL'Y INST., TWILIGHT STATUSES: A CLOSER EXAMINATION OF THE UNAUTHORIZED POPULATION 1 (2005).

29 Jain, *supra* note 11, at 1464-65 (noting "the median length of residence being about fourteen years").

30 *Id.* at 1473-74.

who are not the “intended target[s]” of immigration enforcement.<sup>31</sup> One reason for this is that it can be confusing — both for noncitizens and for those to whom immigration surveillance duties have been delegated — to determine whether a particular status or quasi-status subjects a person to immigration enforcement.<sup>32</sup> Naturalized U.S. citizens may feel that their status is insecure, especially in light of the significant escalation of denaturalization proceedings from 2017 to 2020.<sup>33</sup> Even natural-born U.S. citizens, particularly those who are related to noncitizens or who are simply nonwhite, have reason to feel that their status is precarious.<sup>34</sup> In recent years, the media has reported on several cases of natural-born U.S. citizens who were deported to other countries or denied the rights of citizenship, such as obtaining a U.S. passport.<sup>35</sup>

Finally, members of “mixed-status” households — which may include U.S. citizens and noncitizens with various statuses or no status — may alter their care-seeking behaviors in response to immigration surveillance in order to avoid scrutiny of the noncitizen family members.<sup>36</sup> Heide Castañeda’s research has highlighted the analytical significance of mixed-status families in studying access to health care, noting that each family member may have a different relationship to the state and therefore different rights and opportunities with respect to health care access.<sup>37</sup> If there was any chance that enrollment would affect a family

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31 Lisa J. Hardy et al, *A Call for Further Research on the Impact of State-Level Immigration Policies on Public Health*, 102 AM. J. PUB. HEALTH 1250, 1250 (2012) (describing the effects of S.B. 1070 on noncitizens with legal status in Arizona); *see also* Van Natta, *supra* note 21, at 3 (describing how a person in asylum proceedings feared “becoming legible to federal bureaucracies” by applying for publicly funded health insurance).

32 Huyen Pham, *The Private Enforcement of Immigration Laws*, 96 GEO. L.J. 777, 782 (2008) (noting “[t]here is no one definitive document that establishes legal presence. . . . [T]o private parties who have no immigration law training, making that determination can be fraught with error.”).

33 Irina D. Manta & Cassandra Burke Robertson, *Inalienable Citizenship*, N.C. L. REV. (forthcoming) (manuscript at 4-5), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3691695&](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3691695&) (describing the politically driven increase, since 2017, in the number of denaturalization cases referred to the Department of Justice for prosecution).

34 Chacón describes how, over the last two decades, a shift in immigration policy has enhanced the sense of legal precarity among lawful permanent residents and U.S. citizens. Chacón, *supra* note 25, at 731, 734. She also describes how “many individuals experience overlapping forms of liminality because of their race, their geographic location and their immigration status.” *Id.* at 731.

35 Manta & Robertson, *supra* note 33, at 3 (describing the cases of five natural-born U.S. citizens who were denied rights of U.S. citizenship, including a Black teenager who was deported to Colombia even though she had no ties or familial connection to the country).

36 Patler & Gonzalez, *supra* note 4, at 4 (reporting “reductions in qualified Medicaid enrollment, healthcare-seeking, and accessing service-providing institutions among U.S. citizens who may share households with noncitizens”).

37 Heide Castañeda, *Stratification by Immigration Status: Contradictory Exclusion and Inclusion After Health Care Reform*, in UNEQUAL COVERAGE: THE EXPERIENCE OF HEALTH CARE REFORM IN THE UNITED STATES 37, 44-45 (Jessica M. Mulligan & Heide Castañeda eds., 2018) (noting that the complexity of immigration status-related eligibility rules governing subsidized health coverage is a barrier to enrollment for mixed-status families).

member's ability to remain in the United States or become a U.S. citizen, families would err on the side of caution, declining to enroll in or even withdrawing from programs.<sup>38</sup> Even members of mixed-status families who knew they were eligible for subsidized health coverage declined to enroll to avoid "being on the list" or owing any "debts" to the government, lest such actions impact their or their family members' ability to obtain immigration benefits.<sup>39</sup> Parents in mixed-status families face especially difficult choices between accessing public benefits that will support their children's health and development and risking either long-term family separation or having to raise their children — often U.S. citizens — in an unfamiliar country with fewer opportunities and, sometimes, dangerous conditions.<sup>40</sup>

This indicates that the chilling effects of immigration surveillance in health care extend to U.S. citizen family members of noncitizens.<sup>41</sup> For these reasons, references to noncitizen behavior in this Article may apply to their U.S. citizen household members. When family members decline to enroll in public benefits for which they are eligible, all family members suffer from the foregone support.<sup>42</sup>

Fear of deportation and other immigration consequences is a well-documented, longstanding, and widespread barrier to health care for noncitizens.<sup>43</sup>

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38 *Id.* at 45; Patler & Gonzalez, *supra* note 4, at 9-10 (observing that spouses of noncitizens in immigration detention or who had been deported "avoided accessing much-needed public benefits" based on a fear of negatively impacting their spouses' immigration case or future case). Applications for publicly funded health insurance typically require applicants to submit personal information about all members of the household, even if they are not applying for benefits.

39 Castañeda, *supra* note 37, at 44.

40 Super, *supra* note 5, at 559; *see also* Castañeda, *supra* note 37, at 47 (noting that such decisions were made "with an eye toward the greater good of the family"); Lee et al., *supra* note 15, at 6 ("Since the most recent public charge ruling was proposed, many [Latino immigrant] parents have disenrolled themselves from medical insurance but the overwhelming majority continue to keep their children enrolled."); Rhodes et al., *supra* note 23, at 334 (finding that parents' fear of being identified as undocumented led them to delay necessary diagnoses, care, and treatment for their children).

41 Patler & Gonzalez, *supra* note 4, at 14. *See generally* Rhodes et al., *supra* note 23, at 336 (finding that immigration-related health care system avoidance led some study participants to "sacrific[e] their own health and the health of members of their families"); Catherine J. Taylor, *Health Consequences of Laws and Public Policies That Target, or Protect, Marginalized Populations*, 14 SOCIO. COMPASS 1, 6 (2020) (describing how health-related consequences of laws and policies targeting undocumented noncitizens can spill over to lawfully present noncitizens and co-ethnic U.S. citizens who live in the same communities).

42 Super, *supra* note 5, at 548-49, 559.

43 *See, e.g.*, LEIGHTON KU & MARIELLEN JEWERS, *MIGRATION POL'Y INST., HEALTH CARE FOR IMMIGRANT FAMILIES: CURRENT POLICIES AND ISSUES* 11 (2013); PARK, *supra* note 1, at 46-47 (describing "possible negative ramifications for the individual and his or her family's immigration status" as one among several barriers to health care for noncitizens); Asad, *supra* note 5, at 150 (describing one noncitizen's deportation fears of returning to the hospital, where he also owes \$20,000 for an emergency gallstone surgery); Callaghan et al., *supra* note 23, at 346 ("[F]ear remains a pervasive and problematic barrier for undocumented immigrants and their families attempting to

Numerous studies show that fear of immigration consequences can motivate noncitizens' decisions to delay seeking health care.<sup>44</sup> Family members of people having medical emergencies hesitate to dial 911 over concern about whether an unpaid ambulance bill will invite scrutiny under the public charge law.<sup>45</sup> Burn victims arrive at the hospital too late to survive infection.<sup>46</sup> Women in labor show up at emergency rooms without having had any prenatal care;<sup>47</sup> some who suffer from untreated gestational diabetes during their pregnancies must have limbs amputated afterward.<sup>48</sup> Fears of immigration-related consequences are so intense that some noncitizens *decline care altogether*,<sup>49</sup> even in life-threatening situations.<sup>50</sup>

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access care.”); Shari B. Fallek, *Health Care for Illegal Aliens: Why It Is a Necessity*, 19 HOUS. J. INT'L L. 951, 973 (1997) (describing how “thousands of fearful immigrants have refrained from seeking medical aid and attending their appointments at California clinics” after the passage of Proposition 187, even though enforcement was enjoined); Hacker et al., *supra* note 2, at 178 (finding that 65% of articles in a medical literature review of barriers to health care for noncitizens without legal status identified fear of deportation as a barrier and noting that the phenomenon was observed in France and Denmark, as well as in the United States); Karen Hacker et al., *Providers' Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health*, 23 J. HEALTH CARE FOR THE POOR & UNDERSERVED 651, 660-61 (2012); Lee et al., *supra* note 15, at 4-6 (describing immigrant parents' “fear of being discovered and deported by [ICE] en route to the health care setting or once already there,” which leads them to delay seeking care); *id.* at 1-2 (describing Latino immigrants' fears of seeking testing or care for COVID-19); Sana Loue, *Immigrants, Immigration Law, and Tuberculosis*, 71 WASH. L. REV. 969, 985 (1996) (describing fear among undocumented immigrants that health care providers would report them to immigration); Helen B. Marrow & Tiffany D. Joseph, *Excluded and Frozen Out: Unauthorised Immigrants' (Non)Access to Care After U.S. Health Care Reform*, 41 J. ETHNIC & MIGRATION STUD. 2253, 2265 (2015) (describing patients' fear of using health care services due to possible surveillance by immigration and local law enforcement in Massachusetts and San Francisco); K-Sue Park, *Self-Deportation Nation*, 132 HARV. L. REV. 1878, 1486 (2019); Rhodes et al., *supra* note 23, at 329, 336 (finding that noncitizen study participants feared deportation and therefore avoided health services).

44 See, e.g., NOLAN KLINE, *PATHOGENIC POLICING: IMMIGRATION ENFORCEMENT AND HEALTH IN THE U.S. SOUTH* 151 (2019) (noting that the threat of immigration surveillance at health care sites in the Atlanta area “ultimately resulted in Grady [Memorial Hospital] becoming a place that some immigrants felt was safe only in case of an emergency”); Rhodes et al., *supra* note 23, at 332, 336 (finding that noncitizen study participants reported delaying preventive care, including prenatal care, and enduring illness rather than seeking diagnostic care); PARK, *supra* note 1, at 47.

45 PARK, *supra* note 1, at 46, 92 (describing cases involving choking and a heart attack).

46 *Id.* at 92

47 See *id.* at 93; Caitlin Dickerson, *Undocumented and Pregnant: Why Women Are Afraid to Get Prenatal Care*, N.Y. TIMES (Nov. 22, 2020), <https://www.nytimes.com/2020/11/22/us/undocumented-immigrants-pregnant-prenatal.html>.

48 PARK, *supra* note 1, at 93.

49 Callaghan et al., *supra* note 23, at 346 (noting that undocumented immigrants and their family members in Texas routinely forego necessary health care); Rhodes et al., *supra* note 23, at 332 (finding that noncitizens “did not access or utilize health services for which they were eligible, including preventive services” such as reproductive health services based on fears of immigration surveillance).

50 See, e.g., PARK, *supra* note 1, at 93 (describing how a patient diagnosed with uterine cancer

Having health insurance is critical for obtaining timely and adequate health care, and decades of research demonstrate that noncitizens and their family members will hesitate to enroll in publicly funded health insurance if there is a risk of negative immigration consequences.<sup>51</sup> Even a request for immigration documents, Social Security numbers (SSNs), or valid driver's licenses from a public benefit agency may be sufficient to provoke concerns about immigration surveillance and deter noncitizens from seeking coverage.<sup>52</sup> Immigration-related concerns are partially responsible for the twenty percent decline in Medicaid enrollment among noncitizen families with children between 1994 and 1997, when punitive immigration and welfare laws were enacted.<sup>53</sup> Similarly, during the Trump Administration, which vowed to increase immigration enforcement from day one and promulgated new public charge regulations that would penalize certain noncitizens for enrolling in Medicaid, enrollment among Latinx immigrant families decreased.<sup>54</sup>

Sometimes, immigration-related health care system avoidance is based on

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declined to proceed with the recommended treatment, a hysterectomy, because she was afraid that she or her family would be deported); Kathleen R. Page & Alejandra Flores-Miller, *Lessons We've Learned — Covid-19 and the Undocumented Latinx Community*, 384 NEW ENG. J. MED. 5, 5-6 (describing noncitizen fears of seeking testing and treatment for COVID-19, despite their higher risk of exposure to the virus).

51 See, e.g., Marcella Alsan & Crystal S. Yang, *Fear and the Safety Net: Evidence from Secure Communities* 27 (Nat'l Bureau of Econ. Rsch., Working Paper No. 24731, 2019) (finding decreased safety net participation by noncitizens and their family members based on deportation fear); Hacker et al., *supra* note 43, at 660 ("Patients feared that providing any documentation for insurance enrollment purposes would risk exposure."); Kimberly A. Johns & Christos Varkoutas, *The Tuberculosis Crisis: The Deadly Consequence of Immigration Policies and Welfare Reform*, 15 J. CONTEMP. HEALTH L. & POL'Y 101, 121 (1998); KU & JEWERS, *supra* note 43, at 11 ("Unauthorized immigrants often worry that seeking care, particularly at a public facility, may lead to exposure of their unauthorized status and increase the risk of sanctions such as deportation. Even legal immigrants may worry that using benefits could jeopardize their legal status and perhaps make it harder to gain citizenship or permanent residency."); Jeffrey T. Kullgren, *Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform*, 93 AM. J. PUB. HEALTH, 1630, 1632 (2003).

52 See, e.g., KLINE, *supra* note 44, at 59 (describing the impact of a Georgia law excluding passports as an acceptable form of identification when applying for public benefits); Castañeda, *supra* note 37, at 46 (describing the impact of new identification requirements in the ACA on members of mixed-status families who are eligible for publicly funded health insurance); Lee et al., *supra* note 15, at 5; Rhodes et al., *supra* note 23, at 332, 334.

53 Super, *supra* note 5, at 556.

54 Lee et al., *supra* note 15, at 6.

incorrect information,<sup>55</sup> but the fear is often warranted.<sup>56</sup> Researchers have gathered evidence of health care providers threatening to call immigration authorities for the purpose of discouraging noncitizens from seeking care.<sup>57</sup> In one case that received national media attention, staff at the medical clinic where Blanca Borrego arrived for a routine gynecological appointment called law enforcement when they suspected that she had provided a fake driver's license as identification, leading to her arrest in an exam room and putting her at risk of deportation.<sup>58</sup>

Such egregious behavior has the effect of reducing the number of places where noncitizens feel safe obtaining health care.<sup>59</sup> Just as studies of system avoidance have revealed that people who have had criminal justice contact will continue to engage with institutions perceived as “non-surveilling,”<sup>60</sup> many noncitizens feel that they are limited to underfunded, alternative, or nonmedical sources of care.<sup>61</sup> This indicates that it is the surveillance that discourages engagement, not “an

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55 See, e.g., Callaghan et al., *supra* note 23, at 346 (reporting a community health worker's observation that noncitizens may have erroneously connected decisions to seek health care with subsequent immigration decisions, “creating a cycle of misinformation”); Philip Kretsedemas, *Avoiding the State: Haitian Immigrants and Welfare Services in Miami-Dade County*, in IMMIGRANTS, WELFARE REFORM, AND THE POVERTY OF POLICY 107, 115 (Philip Kretsedemas & Ana Aparicio eds., 2004) (finding that nearly half of immigrants surveyed believed, erroneously, that obtaining services from a community health center would implicate public charge inadmissibility); Lee et al., *supra* note 15, at 6 (noting that some noncitizens declined to renew Medicaid coverage based on “mixed messages regarding the impact of public charge”).

56 Ella Wesson, *Interviewing William Lopez: The Health Impacts of United States Immigration Policy in the Context of the Trump Administration and COVID-19*, HARV. HEALTH POL'Y REV. (Nov. 10, 2020), <http://www.hhpronline.org/articles/2020/11/8/interviewing-william-lopez-the-health-impacts-of-united-states-immigration-policy-in-the-context-of-the-trump-administration-and-covid-19> (noting that undocumented noncitizens worry that accessing health care can lead to deportation because of a general fear of the government's ability to surveil).

57 See, e.g., KLINE, *supra* note 44, at 149.

58 See, e.g., Dan Solomon, *Undocumented Harris County Woman Faced Deportation After Being Arrested at Her OB-GYN*, TEX. MONTHLY (Sept. 16, 2015), <https://www.texasmonthly.com/the-daily-post/an-undocumented-harris-county-woman-faced-deportation-after-being-arrested-at-her-ob-gyn/>. It is unclear whether Ms. Borrego was ultimately deported.

59 KLINE, *supra* note 44, at 151; Rhodes et al., *supra* note 23, at 334 (finding that noncitizen study participants were “reoccupied [sic] with avoiding interactions with systems, suspicious of those in positions of power (including health care providers), and fearful of being detained and deported”); Harris Meyer, *Tougher Immigration Enforcement is Taking a Toll on Healthcare*, MODERN HEALTHCARE (Apr. 21, 2017), <https://www.modernhealthcare.com/article/20170421/NEWS/170429967/tougher-immigration-enforcement-is-taking-a-toll-on-healthcare> (quoting the chief medical officer of a community health center in Philadelphia who described the need to dispel rumors that the organization had shared information about patients with ICE agents).

60 Brayne, *supra* note 4, at 385.

61 See Rhodes et al., *supra* note 23, at 334 (reporting that noncitizen study participants “often rely on . . . self-diagnosing and self-treating and using medications purchased from Latino stores, brought from their home country, or left over from others' prescriptions”).

aversion to institutions in general.”<sup>62</sup>

Anecdotal evidence of immigration enforcement at health care sites abounds. Border Patrol agents monitor the corridors of hospital emergency departments, enter exam rooms, and discuss medical care with physicians.<sup>63</sup> Immigration enforcement agents and their local police delegates conduct surveillance from the parking lots of health care sites and detain noncitizen patients as they leave appointments.<sup>64</sup> One health care provider at a prenatal clinic in San Diego noted an increase in the number of patient “no-shows” on days when Border Patrol vans were parked in its lot.<sup>65</sup>

Undocumented noncitizens have been arrested while traveling to or from the hospital to obtain treatment for themselves or their ill family members, even in emergency situations.<sup>66</sup> Upon discharge, they may be transferred directly to detention facilities rather than being permitted to recuperate at home.<sup>67</sup> Near U.S.

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<sup>62</sup> Brayne, *supra* note 4, at 385.

<sup>63</sup> See Jaime La Charite et al., *Healthcare Professionals' Experience, Training, and Knowledge Regarding Immigration-Related Law Enforcement in Healthcare Facilities: An Online Survey*, 49 J.L., MED. & ETHICS 50, 52 (2021) (“Nearly 1 in 5 [providers surveyed] reported that they were aware of immigration enforcement activities in or near their workplace . . .”); Adriana Gomez Licon, *Border Patrol's Growing Presence at Hospitals Creates Fear*, AP (Oct. 17, 2019), <https://apnews.com/article/52a38ce1d4b84e289b8073b47674514e> (“The presence of immigration authorities is becoming increasingly common at health care facilities around the country, and hospitals are struggling with where to draw the line to protect patients' rights . . .”).

<sup>64</sup> See, e.g., KLINE, *supra* note 44, at 150-51 (describing observations of a Grady Memorial Hospital staff member about immigration policing); Altaf Saadi & Martin McKee, *Hospitals as Places of Sanctuary*, BMJ, May 17, 2018, at 1 (noting the occurrence of immigration enforcement at or near health facilities).

<sup>65</sup> PARK, *supra* note 1, at 122-23.

<sup>66</sup> See, e.g., Camilo Montoya-Galvez, *15-year-old Girl Who Spent Her Life in the U.S. Facing Deportation After Hospital Arrest*, CBS NEWS (Sept. 25, 2020), <https://www.cbsnews.com/news/15-year-old-girl-who-spent-her-life-in-the-u-s-facing-deportation-after-hospital-arrest/> (describing how an undocumented teenager and her aunt were arrested by CBP after the child was required to travel through an internal Border Patrol checkpoint in Texas to obtain emergency gallbladder surgery); Claudia Flores et al., *DHS Must Suspend Certain Immigration Enforcement Practices During the Coronavirus Outbreak*, CTR. FOR AM. PROGRESS (Mar. 10, 2020, 9:00 AM), <https://www.americanprogress.org/issues/immigration/news/2020/03/10/481471/dhs-must-suspend-certain-immigration-enforcement-practices-coronavirus-outbreak/> (describing the arrest of “35-year-old Joel Arrona-Lara at a gas station as he was driving his pregnant wife to the hospital for a scheduled cesarean section”); Licon, *supra* note 63; Barbara Campbell, *Girl Detained by Border Patrol After Emergency Surgery Released to Parents*, NPR (Nov. 3, 2017), <https://www.npr.org/sections/thetwo-way/2017/11/03/562003841/girl-detained-by-border-patrol-after-emergency-surgery-is-released-to-parents> (describing how ten-year-old Rosa Maria Hernandez was detained after attempting to pass through an internal Border Patrol checkpoint in Texas in order to obtain emergency gallbladder surgery).

<sup>67</sup> Campbell, *supra* note 66 (describing how Hernandez, who has cerebral palsy, was detained at a facility for children after receiving lifesaving surgery before eventually being released to her parents).



borders, immigration checkpoints prevent or complicate access to health care for family members of undocumented noncitizens, including U.S. citizen children with disabilities and premature babies.<sup>68</sup>

Since 9/11, federal agencies have increasingly cooperated to share information for the purpose of detecting and preventing all matter of threats.<sup>69</sup> These datasets, accessible to immigration enforcement agencies, include public health data gathered from public hospitals. It is not unreasonable to worry that the collection and analysis of such data could affect future immigration options.<sup>70</sup> When the cost of medical treatment is, potentially, deportation or denial of immigration benefits, health care system avoidance among noncitizens should be expected.

## II. IMMIGRATION SURVEILLANCE IN HEALTH CARE

This Part describes the legal framework of immigration surveillance in health care. In this Article, I use the term “immigration surveillance in health care” to refer to specific modes of immigration surveillance at specific types of sites. The first of two modes of immigration surveillance on which I focus is interrogation, arrest, search, or detention by immigration enforcement officers at health care sites. The second is use of personal information disclosed for the purpose of obtaining health care to deny immigration benefits or for immigration enforcement purposes. This Part begins with an overview of the policy context of immigration surveillance in health care. It then describes the laws and policies governing physical and informational surveillance of noncitizens by immigration agencies at

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<sup>68</sup> Tom Jawetz & Ed Chung, *Federal Immigration Officials Can Help Protect Public Health During the Coronavirus Pandemic*, CTR. FOR AM. PROGRESS (Mar. 18, 2020, 9:03 AM), <https://www.americanprogress.org/issues/immigration/news/2020/03/18/481865/federal-immigration-officials-can-help-protect-public-health-coronavirus-pandemic/>; Elena Mejia Lutz, *At Border Patrol Checkpoints, an Impossible Choice Between Health Care and Deportation*, TEX. OBSERVER (Feb. 13, 2018), <https://www.texasobserver.org/border-patrol-checkpoints-impossible-choice-health-care-deportation/> (describing a child with scoliosis whose necessary surgery was delayed for eleven years and a physician’s recollection of “cases in which premature babies born to undocumented parents near the border must travel alone by helicopter or ambulance” to the hospital, despite a longstanding CBP policy requiring “expedited transit” for families in such circumstances); Campbell, *supra* note 66.

<sup>69</sup> See, e.g., Danielle Keats Citron & Frank Pasquale, *Network Accountability for the Domestic Intelligence Apparatus*, 62 HASTINGS L.J. 1441, 1450-51 (2011). This type of information-sharing likely preceded 9/11 on a smaller scale. As David Super notes, “[i]n some southwestern towns, public benefits eligibility workers are married to border patrol officers and have reported suspected undocumented immigrants over the breakfast table.” Super, *supra* note 5, at 561-62.

<sup>70</sup> See Danielle Keats Citron, *A Poor Mother’s Right to Privacy: A Review*, 98 B.U. L. REV. 1139, 1147 (2018) (“Risk profiles [generated by the government] can be shared with a host of federal and state agencies, impacting poor mothers’ opportunities, from government employment to immigration.”).

health care sites. Although some legal protections against immigration surveillance in health care exist, gaps and uncertainties in the law explain why health care system avoidance persists among noncitizens and their family members.

### A. Policy Context

In general, as a prerequisite for seeking out health care or health coverage, people must have some sense that they will be safe in doing so.<sup>71</sup> Law sometimes provides assurances to patients that their pursuit of health care will not result in negative consequences — for example, law that broadly protects the confidentiality of information that patients share with their health care providers.<sup>72</sup> In general, and with limited exceptions, patients should feel comfortable coming to health care sites without fear of arrest or interrogation and sharing personal information with their providers without fear of disclosure to law enforcement. However, as Part I illustrates, law does not always ensure conditions that will overcome potential patients' fears of the negative consequences of seeking out health care.

Immigration surveillance in health care is one form of interior immigration enforcement.<sup>73</sup> Like other forms, it “draws the migration border inward,” occurring

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71 There are many examples of this. Pregnant women with opioid use disorder will not seek out prenatal care if they face a risk of criminal prosecution related to their drug use. Lynn Falletta et al., *Perceptions of Child Protective Services Among Pregnant or Recently Pregnant, Opioid-Using Women in Substance Abuse Treatment*, 79 CHILD ABUSE & NEGLECT 125, 126 (2018) (reporting that “several studies have found feared loss of custody to CPS as a potential barrier to prenatal care among women with substance use disorders”). Travelers suspected of having an infectious disease like COVID-19, Ebola, or multi-drug resistant tuberculosis will not submit to public health authorities for treatment unless they are assured of the limits and conditions of quarantine. See Valerie A. Earnshaw et al., *Medical Mistrust in the Context of Ebola: Implications for Intended Care-Seeking and Quarantine Policy Support in the United States*, 24 J. HEALTH PSYCH. 219, 225 (2016) (“[I]ndividuals who endorse medical conspiracy beliefs may oppose quarantine policies due to the control over individual autonomy that such policies grant authorities . . .”). People with psychiatric disorders will not request an adjustment to their medication if doing so would put them in danger of involuntary commitment. See Marvin S. Swartz, Jeffrey W. Swanson & Michael J. Hannon, *Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals*, 21 BEHAV. SCIS. & L. 459, 467 (2003) (reporting that “fear of involuntary hospitalization was the most frequently cited barrier to treatment” among subjects with schizophrenia). Patients who have experienced health care-induced trauma as children may avoid all preventive care as adults. See Chrystal L. Lewis et al., *Once BITTEN, Twice Shy: An Applied Trauma-Informed Healthcare Model*, 32 NURSING SCI. Q. 291, 293-94 (2019) (discussing the phenomenon of “medical trauma” and noting that “a patient with a history of trauma who is actively experiencing a PTS reaction might find it difficult to form a trusting relationship with his or her HCP during the medical encounter”).

72 See Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1938 (1996); 45 C.F.R. §§ 160, 164 (2021).

73 See Jain, *supra* note 11, at 1490 (describing how interior immigration enforcement may occur in various settings).

at sites of routine interaction that exist to support the health and wellbeing of members of society.<sup>74</sup> Laws and policies that increase immigration surveillance in the country's interior are designed not only to apprehend and eventually remove deportable noncitizens, but also to deter all kinds of noncitizens from settling in or even coming to the United States by imposing harsh living conditions.<sup>75</sup> This theory of deterrence has come to be known as “self-deportation,” and it operates by making ordinary — and even socially desirable — behaviors risky.<sup>76</sup> For a variety of reasons, heightened interior immigration enforcement is unlikely to persuade long-term undocumented noncitizens to leave.<sup>77</sup> It does, however, constrain their choices in everyday matters (such as whether to seek health care) that can have significant consequences.<sup>78</sup>

Uncertainty about the law complicates noncitizens' ability to calculate the risks of engaging in ordinary activities. One source of uncertainty among noncitizens is the discretion that is a hallmark of the U.S. immigration system.<sup>79</sup> Because immigration agencies have broad authority to decide, among other things, how to conduct immigration surveillance,<sup>80</sup> there is significant uncertainty among noncitizens about how the law will apply to them.<sup>81</sup> A second source of uncertainty

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74 Kalhan, *supra* note 10, at 60-61; *see also* PARK, *supra* note 1, at 116 (“Welfare and health policies . . . inconspicuously extend the power of the border far beyond the literal, physical fence.”). Put another way, “[t]he Border is everywhere.” Robert S. Chang, *A Meditation on Borders*, in IMMIGRANTS OUT!: THE NEW NATIVISM AND THE ANTI-IMMIGRANT IMPULSE IN THE UNITED STATES 244, 246 (Juan F. Perea ed., 1997).

75 *See* Jain, *supra* note 11, at 1467 (noting that “simple deterrence” is one rationale behind heightened immigration enforcement efforts in the Trump Administration); *see also* Broeders & Engbersen, *supra* note 12, at 1593 (describing, in the European context, how this strategy “is meant to complicate and frustrate living and working conditions to such a degree that [irregular migrants] will turn around and try their luck elsewhere”).

76 *See* Jain, *supra* note 11, at 1490; Park, *supra* note 43, at 1880-82.

77 Jain, *supra* note 11, at 1493 (describing factors such as having U.S.-citizen children, attenuated connections to their countries of origin, the financial costs of leaving, and the perceived low risk of detection if they continue to lay low).

78 *See* Broeders & Engbersen, *supra* note 12, at 1596 (“Panopticon Europe is designed as a ‘factory of exclusion and of people habituated to their status of the excluded’” (quoting Godfried Engbersen, *The Unanticipated Consequences of Panopticon Europe. Residence Strategies of Illegal Immigrants*, in CONTROLLING A NEW MIGRATION WORLD 222, 242 (Virginie Guiraudon & Christian Joppke eds., 2001))); Kalhan *supra* note 10, at 60-61 (describing the expansion of interior immigration enforcement as “a kind of immigration panopticism, which eliminates zones in society where immigration status is invisible and irrelevant”).

79 Shoba Sivaprasad Wadhia, *The Role of Prosecutorial Discretion in Immigration Law*, 9 CONN. PUB. INT. L.J. 243, 244-45 (2010) (describing the economic and humanitarian rationales for prosecutorial discretion in the immigration system).

80 *Id.* at 244 (“Prosecutorial discretion extends to decisions about which offenses or populations to target; whom to stop, interrogate, and arrest; whether to detain or to release a noncitizen; whether to initiate removal proceedings; whether to execute a removal order; and various other decisions.”).

81 Jain, *supra* note 11, at 1503 (“The vast majority of undocumented migrants do not experience removal; what they instead experience is uncertainty about how and when immigration enforcement

relates to unenforced<sup>82</sup> or proposed<sup>83</sup> immigration laws or policies. Noncitizens anticipating increased surveillance may reduce their interactions outside the home.<sup>84</sup> A third source of uncertainty is mixed messaging about immigration policies from official and unofficial sources.<sup>85</sup> For example, policymakers need not even propose new immigration laws or policies to encourage health care system avoidance; public rhetoric, media reports, and rumors can have the same effect.<sup>86</sup> Finally, immigration law is complex and can be difficult for laypeople to interpret without legal assistance.<sup>87</sup> The overall effect of uncertainty about the law is to make noncitizens more cautious, including when deciding whether to seek health care or coverage, even when serious injuries or illnesses are involved.<sup>88</sup>

The Trump Administration heightened immigration enforcement in numerous ways, contributing to the climate of fear for noncitizens and motivating them to disenroll from or forgo health care and coverage, as described in Part I.<sup>89</sup> Such

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may unfold.”).

82 See KLINE, *supra* note 44, at 60 (describing how the Georgia legislature’s passage of the Illegal Immigration Reform and Enforcement Act of 2011 (“H.B. 87”), which expanded immigration policing, promoted fear in immigrant communities even when provisions were unenforced).

83 Taylor, *supra* note 41, at 8 (“Political climates created by the social climate during the time of the attempt to pass a law, regardless of whether the law is ever actually passed, can also affect health outcomes.”).

84 *Id.* at 8 (describing how laws that are never passed or policies that are never finalized can negatively affect noncitizens’ health outcomes, making access to timely and quality health care even more important).

85 See Meyer, *supra* note 59 (stating that “official policy pronouncements [assuring noncitizens that immigration enforcement will not occur at health care sites] likely will do little to quell word-of-mouth alarms spread in frightened immigrant communities”).

86 Jain, *supra* note 11, at 1489; see also KLINE, *supra* note 44, at 45, 60 (noting, in the context of H.B. 87 in Georgia, that the latter methods may be considered socially acceptable expressions of nativism that are also politically expedient and symbolically powerful).

87 Hacker et al., *supra* note 2, at 176, 178.

88 Callaghan et al., *supra* note 23, at 345 (describing a “hyper-vigilance” that occurs in undocumented immigrant communities); Hailey Cleek, *Sanctuary Clinics: Using the Patient-Physician Relationship to Discuss Immigration Policy as a Public Health Concern*, 53 WAKE FOREST L. REV. 979, 989-90 (2018) (describing how uncertainty is warranted based on officer-level and state-level inconsistencies in enforcing immigration laws); Van Natta, *supra* note 21, at 112411. Khiara Bridges examines this phenomenon in a parallel context: the illusion of privacy rights for poor, pregnant women. KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* 11 (2017) (arguing that they have “no effective privacy rights” in health settings that are perceived as threatening, hostile, and unsafe).

89 See, e.g., SAMANTHA ARTIGA & PETRY UBRI, KAISER FAM. FOUND., *LIVING IN AN IMMIGRANT FAMILY IN AMERICA: HOW FEAR AND TOXIC STRESS ARE AFFECTING DAILY LIFE, WELL-BEING, & HEALTH* 1, 5 (2017); Lee et al., *supra* note 15, at 1-2 (describing noncitizens’ fears of seeking testing and treatment for COVID-19 as “an unfortunate consequence of the anti-immigrant rhetoric propagated in the past few years”); Lutz, *supra* note 68 (quoting a physician in Brownsville, Texas, who said that “[u]nder Trump, the climate for undocumented immigrants who need health care is ‘probably the worst’ in the last decade”); Meyer, *supra* note 59 (“Providers and others who work in immigrant communities say anxieties have spiked in the wake of President Donald Trump’s

behavior by noncitizens was not irrational, as these policy changes increased the likelihood that leaving the house for any reason, including to seek health care, would risk immigration surveillance.<sup>90</sup> For example, physicians have observed that immigration enforcement operations at or near health care institutions increased in the year after Trump’s inauguration.<sup>91</sup> During this period, a reporter documented how immigration agents along the U.S.-Mexico border were less likely to exercise discretion to not deport parents of ill or injured children who were travelling through internal Border Patrol checkpoints to access health care.<sup>92</sup>

As the next Section describes, the framework of immigration surveillance that enabled the Trump Administration’s enforcement crackdown developed over decades.<sup>93</sup> Specifically, laws and policies governing publicly funded health and welfare services have historically enhanced immigration agencies’ ability to identify “undeserving” or threatening noncitizens.<sup>94</sup> Political support for nativism is cyclical, which predictably results in anti-immigrant sentiments expressed through restrictions on health and welfare benefits.<sup>95</sup> The problems associated with

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election.”); Super, *supra* note 5, at 548 (describing how the Trump Administration’s public charge rule “would powerfully coerce families not to seek needed subsistence benefits if any of their members is not a citizen”); Van Natta, *supra* note 21, at 112415 (documenting health care providers’ observations that, after the 2016 election, it became more difficult to put noncitizen patients at ease because of the difficulty of obtaining timely information about policy changes). Researchers have documented how heightened immigration enforcement in other contexts can create a climate of fear and motivate health care system avoidance. *See, e.g.*, Hardy et al., *supra* note 31, at 1251-52 (“Broad application of enforcement practices has been shown to negatively affect health care seeking behaviors and access to health care in the U.S.-Mexico border communities and throughout the United States.”).

<sup>90</sup> See Jason A. Cade, *Sanctuaries as Equitable Delegation in an Era of Mass Immigration Enforcement*, 113 NW. U. L. REV. 433, 435 (2018) (“Across the United States, immigration enforcement in 2017 took a sharp turn in a less nuanced and more draconian direction.”); Lutz, *supra* note 68 (quoting a Texas immigration attorney in 2018 on the “alarming increase in the number of undocumented people . . . detained and deported at checkpoints while traveling to receive medical treatment for themselves or family members”).

<sup>91</sup> Saadi & McKee, *supra* note 64, at k2178.

<sup>92</sup> Lutz, *supra* note 68.

<sup>93</sup> *See, e.g.*, Kalhan, *supra* note 10 (describing the gradual expansion of immigration surveillance activities).

<sup>94</sup> PARK, *supra* note 1, at 116; Castañeda, *supra* note 37, at 42 (“Efforts to limit health care have remained a standard and predictable tool for enforcing immigration control in the United States.”); Pham, *supra* note 32, at 798-99 (describing federal legislation and a regulation proposed in 2004 that, together, would have required hospitals requesting federal reimbursement for uncompensated care to ask patients about immigration status and share information with ICE).

<sup>95</sup> KLINE, *supra* note 44, at 43, 129 (noting that “immigration enforcement laws represented smaller, rationalized ways of reducing health care to certain populations,” and explaining how Georgia’s passage of HB87 was linked to the state’s economic decline and “immigrant scapegoating”); Castañeda, *supra* note 37, at 42 (describing how even progressive laws such as the Affordable Care Act “classify and stereotype undocumented immigrants as illegal, immoral, and undeserving outsiders” by excluding them from its benefits).

immigration surveillance in health care long preceded the Trump Administration and will outlast it as well, as indicated by continuing reports of noncitizens refusing the COVID-19 vaccine based on fears that receiving it could lead to deportation.<sup>96</sup>

### B. *Legal Framework*

This Section provides an overview of the laws and policies governing immigration surveillance in health care. It begins by analyzing the circumstances in which surveillance of noncitizens seeking health care at provider sites is permitted and when it is discouraged. Next, it describes the laws and policies that require or permit information about noncitizens' use of publicly funded health programs to be shared with the Department of Homeland Security (DHS). Although there are some confidentiality protections for noncitizens who disclose information in order to obtain health care, the gaps and exceptions that permit information-sharing motivate immigration-related health care system avoidance. These analyses reveal the inevitability of widespread fears of immigration surveillance in health care among noncitizens. Throughout the Section, explanations are proposed for why these fears, rather than the letter of the law alone, primarily guide noncitizens' decisions about accessing health care.

#### 1. *Surveillance at Health Care Provider Sites*

This subsection describes the laws and policies that govern immigration surveillance of noncitizens at, near, or en route to health care provider sites. First, it analyzes protections and exceptions in DHS's "sensitive locations" policies, concluding that immigration authorities have wide discretion to interpret and apply the policies as they see fit. In addition, the policies lack adequate accountability measures for violations and are merely executive directives that can be rescinded if the President prefers a different approach. Therefore, it is unsurprising that noncitizens do not trust the sensitive locations policies to protect them from immigration enforcement at health care provider sites. Next, it turns to an

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<sup>96</sup> See, e.g., Juan Alfonso Nunez, *Undocumented Texans Are Eligible for the Vaccine. That Doesn't Mean They're Accessing It.*, TEX. MONTHLY (Apr. 28, 2021), <https://www.texasmonthly.com/news-politics/many-undocumented-texans-eligible-for-covid-vaccine-but-not-accessing-it/>; see also PARK, *supra* note 1, at 82 (warning, in the context of revised public charge regulations in 2011, of "[t]he need for constant vigilance of state practices, particularly with respect to immigrant populations, regardless of which political party [holds] state office"); Pham, *supra* note 32, at 779 (observing, in 2008, "a growing trend to shift some enforcement responsibilities onto private parties," such as public benefit agencies); Super, *supra* note 5, at 562 (describing a San Diego County policy in the late 1990s that would "report to immigration authorities every family receiving TANF-funded cash assistance or SNAP in which there was a member not receiving benefits whose immigration status was unknown or was thought to be unlawful unless the entire family . . . disenrolled by a certain date").

examination of health care information privacy laws and the extent to which they protect disclosure of information contained in noncitizens' medical records. It reveals why, notwithstanding the laws protecting patients' information from disclosure, noncitizens may be concerned about creating health care records that could potentially be disclosed to immigration authorities.

*a. "Sensitive Locations" Policies*

This subsection analyzes the effectiveness of DHS's sensitive locations policies at assuring noncitizens that they can go to health care sites without fear of surveillance. These policies, which limit enforcement activities at "sensitive locations," only partially shield noncitizens from immigration surveillance when they are physically at or near health care sites. Because the policies fail to define key terms with precision, contain numerous exceptions, can be rescinded quickly and easily by federal administrators, and lack adequate accountability measures, they do not completely assuage noncitizens' fears of being arrested while seeking health care.

It may be inferred from a review of DHS materials that discouraging system avoidance by noncitizens is one of the goals of the sensitive locations policies. DHS's subagencies responsible for immigration enforcement, ICE and U.S. Customs and Border Protection (CBP), have similar — but not identical — policies limiting the conduct of immigration enforcement activities at "sensitive locations."<sup>97</sup> Precedent for a policy that limits immigration enforcement at certain sites in order to avoid potential harm to the community dates to no later than 1993.<sup>98</sup> A 2008 version of the ICE policy describes it as "strik[ing] a balance between our law enforcement responsibilities and the public's confidence in the way ICE executes its mission" and "ensur[ing] that our personnel conduct enforcement operations in a manner that is safe and respectful of all persons."<sup>99</sup> The ICE policy currently in effect was established in 2011, and states that it is intended to "make substantial efforts to avoid unnecessarily alarming local

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<sup>97</sup> Memorandum from David V. Aguilar, Deputy Comm'r, U.S. Customs & Border Prot., on U.S. Customs and Border Protection Enforcement Actions at or Near Certain Community Locations 1-2 (Jan. 18, 2013), [http://file.lacounty.gov/SDSInter/bos/supdocs/US\\_Border.pdf](http://file.lacounty.gov/SDSInter/bos/supdocs/US_Border.pdf) [hereinafter CBP Sensitive Locations Policy]; Memorandum from John Morton, Dir., Dep't of Homeland Sec., on Enforcement Actions at or Focused on Sensitive Locations 1-2 (Oct. 24, 2011), <https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf> [hereinafter ICE Sensitive Locations Policy].

<sup>98</sup> See Memorandum from Julie L. Myers, Assistant Sec'y, U.S. Immigr. & Customs Enf't, on Field Guidance on Enforcement Actions or Investigative Activities At or Near Sensitive Community Locations 1 (July 3, 2008) (citing a 1993 INS policy directing officers to "avoid apprehension of persons . . . on the premises of schools, places of worship, funerals and other religious ceremonies").

<sup>99</sup> *Id.* at 1.

communities.”<sup>100</sup> An ICE website addressing frequently asked questions about the policy provides the clearest statement of purpose: “[T]o enhance public understanding and trust, and to ensure that people seeking to participate in activities or utilize services provided at any sensitive location are free to do so, without fear or hesitation.”<sup>101</sup> Preventing harm to community members who would avoid using services at a sensitive location based on a fear of deportation is a clear goal of the policy.

The ICE and CBP policies each list examples of sensitive locations, including “hospitals,”<sup>102</sup> but it is unclear whether the agencies would consider other sites where people obtain health care to be sensitive locations.<sup>103</sup> The ICE FAQ website provides some guidance, stating that, in addition to hospitals, the following health care sites are treated as sensitive locations: “doctors’ offices, accredited health clinics, and emergent or urgent care facilities.”<sup>104</sup> In March 2020 — after receiving inquiries from advocacy groups, members of Congress, and the press about changes to enforcement practices due to the COVID-19 pandemic<sup>105</sup> — ICE issued a statement citing its sensitive locations policy and noting that “[i]ndividuals should not avoid seeking medical care because they fear civil immigration enforcement.”<sup>106</sup> However, there was no indication that other sites where noncitizens may access health care or related services — such as “unaccredited” health clinics, pharmacies, health fairs, or COVID-19 testing sites — are considered sensitive locations.<sup>107</sup> This lack of clarity undermines noncitizens’

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100 ICE Sensitive Locations Policy, *supra* note 97, at 2.

101 *FAQs: Sensitive Locations and Courthouse Arrests*, U.S. IMMIGR. & CUSTOMS ENF’T, <https://www.ice.gov/about-ice/ero/sensitive-loc> (last updated May 19, 2021).

102 ICE Sensitive Locations Policy *supra* note 97, at 2; CBP Sensitive Locations Policy, *supra* note 97, at 1.

103 Both policies assure personnel that they have discretion to treat additional sites as sensitive locations. CBP Sensitive Locations Policy, *supra* note 97, at 1 (urging personnel consider whether a location not listed is “similar in nature, description, or function”); ICE Sensitive Locations Policy, *supra* note 97, at 2 (“This is not an exclusive list . . .”).

104 U.S. IMMIGR. & CUSTOMS ENF’T, *supra* note 101. Some advocacy organizations note that CBP also considers such sites to be sensitive locations, citing to a CBP website addressing frequently asked questions. *See, e.g.*, REBECCA ULLRICH & NAT’L IMMIGR. L. CTR., THE DEPARTMENT OF HOMELAND SECURITY’S “SENSITIVE LOCATIONS” POLICIES 1 (2018), [https://www.clasp.org/sites/default/files/publications/2018/06/2018\\_sensitive\\_locationsdetailed.pdf](https://www.clasp.org/sites/default/files/publications/2018/06/2018_sensitive_locationsdetailed.pdf). However, at the time of this writing, no such website existed.

105 *See* Jawetz & Chung, *supra* note 68.

106 *Updated ICE Statement on COVID-19*, U.S. IMMIGR. & CUSTOMS ENF’T, <https://www.ice.gov/news/releases/updated-ice-statement-covid-19> (Jan. 13, 2021) (confirming that the sensitive locations policy applied to the health care sites listed on the FAQ website).

107 *See* Flores et al., *supra* note 66 (discussing dismissive tweets from a DHS spokesperson in response to concerns about immigration enforcement at health care and testing sites). In February 2021, DHS issued a statement “encourag[ing] all individuals, regardless of immigration status, to receive the COVID-19 vaccine once eligible under local distribution guidelines” and noting that neither ICE nor CBP would “conduct enforcement operations at or near vaccine distribution sites or



confidence that they can avoid immigration surveillance by ICE while seeking health care at sites not listed in the ICE FAQ or by CBP at any non-hospital health care sites.

The policies also fail to describe with precision whether immigration enforcement actions are permitted within the vicinity of a health care site. This leaves noncitizens vulnerable to arrest immediately before or after receiving services at a health care site.<sup>108</sup> The ICE policy applies to enforcement actions “at or focused on” sensitive locations,<sup>109</sup> and notes that personnel should seek guidance from their supervisors if an enforcement operation “could reasonably be viewed as being at or *near* a sensitive location.”<sup>110</sup> Similarly, the CBP policy applies to enforcement activities “at or near” sensitive locations.<sup>111</sup> Confusion about how the policies apply is justified,<sup>112</sup> especially given media coverage of arrests occurring “near” unquestionably sensitive locations like hospitals.<sup>113</sup> In response to outcry over the arrest of a teenager at a bus stop just outside of a hospital in Portland, Oregon, an ICE spokesperson defended the action by arguing that the bus stop was not technically on hospital property.<sup>114</sup> Such public justifications of enforcement actions that plainly violate the intent of the sensitive locations policies sow distrust and generate more fear in immigrant communities.

Another source of potential confusion in DHS’s sensitive location policies is that ICE and CBP regulate enforcement activities at sensitive locations differently. The ICE policy applies to arrests, interviews, searches, and surveillance conducted for purposes of immigration enforcement.<sup>115</sup> It permits ICE officers to conduct a range of investigatory activities that may ultimately lead to immigration enforcement actions, including requesting records, providing notice to employees,

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clinics.” *DHS Statement on Equal Access to COVID-19 Vaccines and Vaccine Distribution Sites*, DEP’T OF HOMELAND SEC. (Feb. 8, 2021), <https://www.dhs.gov/publication/dhs-statement-equal-access-covid-19-vaccines-and-vaccine-distribution-sites>.

108 See Licon, *supra* note 63 (noting that ICE and CBP sometimes bring noncitizens to the hospital for treatment and then detain them after they are discharged).

109 ICE Sensitive Locations Policy, *supra* note 97, at 2.

110 *Id.* at 2 (emphasis added). The policy also provides guidance to personnel if, during an enforcement action, they are “led to or *near* a sensitive location.” *Id.* at 3 (emphasis added).

111 CBP Sensitive Locations Policy, *supra* note 97, at 1.

112 Meyer, *supra* note 59 (noting that the policy “appears to offer the agency some flexibility in where it can conduct raids”).

113 ULLRICH & NAT’L IMMIGR. L. CTR., *supra* note 104, at 3-4; La Charite et al., *supra* note 63, at 55 (noting that their “alarming” finding that nearly 20% of providers surveyed were aware of immigration enforcement occurring at their health care institution “corroborate[s] reporting of such events in the media”).

114 Katie Shepherd, *ICE Arrested an Undocumented Immigrant Just Outside a Portland Hospital*, WILLAMETTE WK. (Oct. 31, 2017), <https://www.wweek.com/news/courts/2017/10/31/ice-arrested-an-undocumented-immigrant-just-outside-a-portland-hospital/>.

115 ICE Sensitive Locations Policy, *supra* note 97, at 1.

serving subpoenas, or attending functions or meetings.<sup>116</sup> ICE officer presence at health care sites for any reason, such as to request information about noncitizens or to attend events, is likely sufficient to chill noncitizens from accessing services at that site. CBP's policy does not specify the meaning of enforcement actions, but it appears to limit officers' conduct of investigatory activities more than the ICE policy.<sup>117</sup> Since noncitizens do not know which agency may be surveilling them, they must assume that the less protective policy always applies.

Further undermining their goal of assuring noncitizens that it is safe to access health care, the ICE and CBP sensitive locations policies permit enforcement activities at sensitive locations in a wide range of circumstances.<sup>118</sup> First, ICE and CBP officers may request to carry out an enforcement action at or near a sensitive location and a senior DHS official may approve such action at their discretion.<sup>119</sup> There are no limitations on a DHS official's ability to approve such actions, merely exhortations to "take extra care" to assess potential disruptions to a sensitive location's operations.<sup>120</sup> The ICE policy provides an example of when an enforcement action at a sensitive location may be approved: "if the only known address of a target is at or near a sensitive location."<sup>121</sup> A second exception to the sensitive locations policies applies when "exigent circumstances" exist; in such cases, officers need not obtain prior approval to conduct enforcement activities at sensitive locations.<sup>122</sup> Exigent circumstances include situations involving national security, terrorism, imminent risks to public safety, and the "imminent risk of destruction of evidence material to an ongoing criminal case."<sup>123</sup> Even if one agrees that enforcement action at health care sites should be permitted in exigent circumstances, the chilling effects of such actions will reverberate unless details of the circumstances are shared with the community. Third, CBP may conduct enforcement actions in hospitals when noncitizens who are already in their custody must be hospitalized.<sup>124</sup> Fourth, both CBP and ICE may conduct enforcement

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116 *Id.* at 1.

117 CBP Sensitive Locations Policy, *supra* note 97, at 1 (describing how "investigative activities" at or near sensitive locations must receive written approval from senior CBP officials).

118 *See* Lee et al., *supra* note 15, at 6 (noting that the policy "is not applied evenly in the U.S.").

119 ICE Sensitive Locations Policy, *supra* note 97, at 2 (listing the officials from whom ICE officers must obtain prior approval); CBP Sensitive Locations Policy, *supra* note 97, at 1 (same).

120 ICE Sensitive Locations Policy, *supra* note 97, at 2. *See* CBP Sensitive Locations Policy, *supra* note 97, at 1 (directing officers to "consider alternative measures that could achieve the enforcement objective without causing significant disruption to the normal activities or operations" of the sensitive location).

121 ICE Sensitive Locations Policy, *supra* note 97, at 2.

122 *Id.* at 2; CBP Sensitive Locations Policy, *supra* note 97, at 2.

123 ICE Sensitive Locations Policy, *supra* note 97, at 2-3. *See* CBP Sensitive Locations Policy, *supra* note 97, at 2.

124 CBP Sensitive Locations Policy, *supra* note 97, at 2. *See* Licon, *supra* note 63 (describing the policy as "discretionary and ambiguous when an enforcement action begins before a trip to a

actions at or near international borders, including the “functional equivalent” of a border.<sup>125</sup> The CBP policy specifies, additionally, that enforcement activities “that bear nexus to the border” may occur at sensitive locations.<sup>126</sup> The border exception to the sensitive locations policy is too vague for noncitizens to determine when it can be invoked. However, it explains how CBP agents in Texas were able to follow ten-year-old Rosa Maria Hernandez, who was in an ambulance, from a border checkpoint to the hospital, surveil her from within the hospital, and arrest her in her hospital bed immediately upon discharge without violating its sensitive locations policy.<sup>127</sup> Communities along the U.S.-Mexico border have been hit hard by the COVID-19 pandemic, and as of this writing, there is still no assurance from DHS that people passing through interior U.S. Border Patrol checkpoints to seek health care during the pandemic will be spared from immigration enforcement.<sup>128</sup> Fifth, the sensitive locations policies do not apply to local law enforcement officers who cooperate with ICE to perform immigration enforcement activities under the 287(g) program.<sup>129</sup> This exception explains how Blanca Borrego was arrested in an exam room at her gynecologist’s office.<sup>130</sup>

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hospital or when an immigrant is already in custody”).

125 CBP Sensitive Locations Policy, *supra* note 97, at 2; U.S. IMMIGR. & CUSTOMS ENF’T, *supra* note 101 (stating that the policy does not apply to operations “within the immediate vicinity of the international border”). The functional equivalent of a border is “the first practical detention point after a border crossing or the final port of entry.” YULE KIM, CONG. RSCH. SERV., PROTECTING THE U.S. PERIMETER: BORDER SEARCHES UNDER THE FOURTH AMENDMENT 7 (2009).

126 CBP Sensitive Locations Policy, *supra* note 97, at 2.

127 See *Government Releases 10-Year-Old Rosa Maria Hernandez After ACLU Files Lawsuit*, ACLU (Nov. 3, 2017), <https://www.aclu.org/press-releases/government-releases-10-year-old-rosa-maria-hernandez-after-aclu-files-lawsuit>; see also Licon, *supra* note 63 (describing a case in which a person fainted after her family was pulled over by CBP agents in Florida and was subsequently surveilled at the hospital). In September 2020, an undocumented teenager was detained in the hospital under similar circumstances, before being transferred to a detention facility and placed in removal proceedings. Her aunt, also undocumented, who accompanied her to the hospital was also arrested and detained separately by ICE. Montoya-Galvez, *supra* note 66.

128 See Memorandum from Carla L. Provost, Acting Chief, U.S. Border Patrol, U.S. Customs & Border Prot., on Medical Conveyances Transiting Through Checkpoints 1 (Jan. 5, 2018) (noting that only “[m]edical conveyances engaged in immediate emergency operations should always receive expedited transit through or around a checkpoint”); Jawetz & Chung, *supra* note 68 (urging DHS to issue such a statement). See also Maya Srikrishnan, *Border Patrol Activity in Rural North County Alarms Farmworkers, Advocates*, VOICE OF SAN DIEGO (May 26, 2020), <https://www.voiceofsandiego.org/topics/government/immigration-enforcement-efforts-in-rural-north-county-alarm-farmworkers-advocates/> (suggesting that enforcement activity at interior checkpoints has increased since the COVID-19 pandemic began, including at checkpoints that some communities must traverse to access hospitals).

129 The 287(g) program deputizes state and local law enforcement agencies to perform certain immigration law enforcement actions. See *Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act*, U.S. IMMIGR. & CUSTOMS ENF’T, (last updated May 20, 2021), <https://www.ice.gov/identify-and-arrest/287g>.

130 See *supra* text accompanying note 58.

The DHS sensitive locations policies are best characterized as agency guidance — not enforceable law — without strong accountability measures. Both policies state that they do not create a private right of action or any rights enforceable by law.<sup>131</sup> On its website, ICE describes a process by which people may report ICE actions that they believe are inconsistent with its sensitive locations policy.<sup>132</sup> However, neither the policies nor the agencies' websites describe the steps they will take after receiving a complaint. Also, because the policies do not describe any recourse for noncitizens who were arrested during an enforcement operation that violated any of the policies, there is no guarantee that individual officers or the agencies will be held accountable for violations in any way.<sup>133</sup>

Finally, even though the sensitive locations policies are relatively longstanding, they are not codified in law. The CBP policy reminds the reader that it “may be modified, superseded, or rescinded by CBP at any time without notice.”<sup>134</sup> Both policies may be immediately modified or rescinded by senior DHS officials through issuance of a memorandum.

Overall, these features of the sensitive locations policies undermine their purpose of assuaging noncitizens' fears of accessing community services. Because so many important decisions are left to the individual discretion of immigration agency personnel — from what is considered a sensitive location, to how far from the site enforcement may occur, to whether exigent circumstances exist — the guarantee that the sensitive locations policies intend to provide is no guarantee at all. Considering the lack of clarity in the sensitive locations policies, the inadequate accountability for violations, and the absence of meaningful recourse for victims of policy violations, it should not be surprising to find that noncitizens take pains to avoid going to the doctor.

*b. Health Information Privacy*

Health information privacy laws protect citizens and noncitizens alike; however, noncitizens may have unique concerns that lead them to doubt the confidentiality of the information they share with health care providers. Fears that

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<sup>131</sup> CBP Sensitive Locations Policy, *supra* note 97, at 2; ICE Sensitive Locations Policy, *supra* note 97, at 3.

<sup>132</sup> U.S. IMMIGR. & CUSTOMS ENF'T, *supra* note 101 (describing how to report violations to ICE Enforcement and Removal Operations or the Civil Liberties Division of the ICE Office of Diversity and Civil Rights). Advocacy groups recommend reporting violations by CBP to the CBP Information Center. See ULLRICH & NAT'L IMMIGR. L. CTR., *supra* note 104, at 6 (providing a phone number and website).

<sup>133</sup> See ULLRICH & NAT'L IMMIGR. L. CTR., *supra* note 104, at 5 (“Without adequate accountability measures, ICE and CBP are effectively responsible for policing themselves.”).

<sup>134</sup> CBP Sensitive Locations Policy, *supra* note 97, at 2.

information disclosed or inadvertently revealed to health care providers may be shared with immigration authorities can discourage some noncitizens from seeking health care.

Health care providers are generally prohibited from disclosing personal information about their patients, which should be interpreted to include information about immigration-related matters so long as there is some relationship between the information and the provision of health care. The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules outline the protection of patient-specific information defined as “protected health information” (PHI).<sup>135</sup> The definition of PHI is broad and includes most but not all patient information that is within a health care provider’s possession.<sup>136</sup> Health care providers may not typically have reason to inquire about patients’ citizenship or immigration status, but such information can be clinically relevant.<sup>137</sup> Although there is very little case law analyzing whether certain categories of information constitute PHI and no case law addressing the question of whether immigration status should be considered PHI,<sup>138</sup> it is reasonable to argue that immigration status information should be considered PHI under the HIPAA Privacy Rules as long as a connection could be made to the patient’s health condition, the provision of health care to the patient, or the payment for health care provided to the patient.<sup>139</sup> However, because immigration status information is not explicitly protected under

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135 45 C.F.R. § 160.103 (2021).

136 PHI is most “individually identifiable health information” that is “transmitted or maintained in any . . . form or medium,” with limited exceptions. *Id.* Individually identifiable health information is defined as “a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provisions of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.” *Id.* See OFF. FOR CIV. RTS., U.S. DEP’T OF HEALTH & HUM. SERVS., GUIDANCE REGARDING METHODS FOR DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE 5-6 (Nov. 26, 2012), [https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveridentities/Deidentification/hhs\\_deid\\_guidance.pdf](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveridentities/Deidentification/hhs_deid_guidance.pdf) (indicating that, to assess whether information constitutes PHI, “[t]he relationship with health information is fundamental,” and “[i]dentifying information alone, such as personal names, residential addresses, or phone numbers, would not necessarily be designated as PHI”).

137 Scott J. Schweikart, *Should Immigration Status Information Be Considered Protected Health Information?*, 21 AMA J. ETHICS 32, 35 (2019). For example, it could come up during the medical history, in a screening for social determinants of health, when a patient requests medical evidence to support an immigration application, or to assist the patient with obtaining publicly funded health insurance.

138 *Id.* at 34.

139 *Id.* at 34; Cleek, *supra* note 88, at 1002 (concluding that disclosure of a patient’s personal health information to DHS by a health care provider would likely violate HIPAA).

the law, it is a source of uncertainty, and some immigrant advocacy groups advise health care providers to avoid documenting immigration-related information in medical and billing records.<sup>140</sup>

One exception to the HIPAA Privacy Rules that could implicate immigration enforcement activities is for disclosures required by law.<sup>141</sup> Under HIPAA, health care providers are permitted to provide information to law enforcement officials when a request is pursuant to a warrant or other court order.<sup>142</sup> This might come in the form of an administrative subpoena in an immigration matter, issued by an Administrative Law Judge of the Executive Office for Immigration Review. ICE officers may serve subpoenas or otherwise request records from health care providers without violating the ICE sensitive locations policy.<sup>143</sup> However, health care providers are not obligated to respond to such requests for information under HIPAA; disclosure in such cases is merely permitted.<sup>144</sup> Providers must read their state laws in conjunction with HIPAA in order to understand whether they are required to disclose patient information in certain circumstances.<sup>145</sup>

Another exception to the HIPAA Privacy Rules that permits health care providers to disclose PHI without patient authorization — and that may be a source of concern and confusion among undocumented noncitizens in particular — relates to the reporting of criminal activity.<sup>146</sup> In such cases, “a covered entity may disclose to a law enforcement official [PHI] that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.”<sup>147</sup> This exception would not apply in the case of an undocumented person who comes to a covered entity for the purpose of seeking health care or health coverage, because failing to have a valid legal status is not a violation of criminal law.<sup>148</sup> However, it explains why the health care providers who called the police on Blanca Borrego when they suspected that she had provided a fake driver’s license as identification were within their rights to do so.<sup>149</sup> Importantly,

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140 See, e.g., NAT’L IMMIGR. L. CTR., HEALTH CARE PROVIDERS AND IMMIGRATION ENFORCEMENT: KNOW YOUR RIGHTS, KNOW YOUR PATIENTS’ RIGHTS 3-4 (2017), <https://www.nilc.org/wp-content/uploads/2017/04/Protecting-Access-to-Health-Care-2017-04-17.pdf>.

141 45 C.F.R. § 164.512(f)(1)(ii)(C) (2021) (describing the requirements for an administrative request).

142 § 164.512(f)(1).

143 See ICE Sensitive Locations Policy, *supra* note 97, at 1.

144 § 164.512(f)(1); see NAT’L IMMIGR. L. CTR., *supra* note 140, at 2.

145 NAT’L IMMIGR. L. CTR., *supra* note 140, at 2.

146 § 164.512(f)(5).

147 *Id.*

148 Schweikart, *supra* note 137, at 35.

149 See Solomon, *supra* note 58. Federal regulators determined that the disclosure to law enforcement was allowed under HIPAA. However, they fined the health system \$2.4 million for subsequent disclosures of Borrego’s name to the media after the incident provoked outrage. Mike

even if a patient who a provider knows to be undocumented committed a crime on the premises of a health clinic, the clinic staff would not be obligated to disclose the PHI relating to the patient’s lack of immigration status.<sup>150</sup> The exception would permit, but not require, disclosure of PHI in that scenario.<sup>151</sup>

Finally, HIPAA permits health care providers to disclose PHI when a patient authorizes such disclosure, and some noncitizen patients may be required to do so as part of an immigration application process. Immigration officers may order a medical examination of an applicant for immigration benefits at any time.<sup>152</sup> Some immigration applicants, such as most LPR applicants, are required to undergo a medical examination in order to prove that they are not barred from admissibility to the United States for health-related reasons.<sup>153</sup> They do this by submitting a form that reports the results of a medical examination and that is completed by a doctor who is designated as a civil surgeon by U.S. Citizenship and Immigration Services (USCIS).<sup>154</sup> The completed form includes information relating to communicable diseases, any physical or mental health conditions with “associated harmful behavior,” substance use disorders, and vaccination history.<sup>155</sup> It also includes a broad authorization to release information to USCIS from “any and all . . . records” that may be necessary to determine eligibility for the immigration benefit sought, and requires the applicant to authorize the release of the information in the form to

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Hixenbaugh, *Memorial Hermann to Pay \$2.4M after Sharing Patient Name in Press Release*, CHRON.COM (May 10, 2017), <https://www.chron.com/local/prognosis/article/Memorial-Hermann-to-pay-feds-2-4-million-after-11136432.php>. The health system also agreed to implement policy changes to avoid breaches of patient privacy in the future. *Id.*; see also Michele Goodwin & Erwin Chemerinsky, *Pregnancy, Poverty, and the State*, 127 YALE L.J. 1270, 1285 (2018) (commenting that Borrego’s case illustrates the impotency of the medical privacy rights she supposedly possessed).

150 Schweikart, *supra* note 137, at 35.

151 See Song, *supra* note 6, at 41-42 (highlighting the permissive aspect of the law enforcement exceptions in HIPAA). Although the patient’s lack of immigration status may subsequently be discovered by law enforcement and shared with ICE, the likelihood that they will be subject to immigration enforcement as a result depends on the extent to which the jurisdiction cooperates with ICE and the seriousness of the crime. See, e.g., *Immigration 101: What is a Sanctuary City?*, AMERICA’S VOICE (Oct. 9, 2019), <https://americasvoice.org/blog/what-is-a-sanctuary-city/>. Some who are opposed to immigration surveillance in health care generally may argue that it is justified when it is alleged that a serious crime has occurred at a health care site. See discussion, *supra* note 9.

152 See *Chapter 3 – Applicability of Medical Examination and Vaccination Requirement*, U.S. CITIZENSHIP & IMMIGR. SERVS. (May 28, 2021) <https://www.uscis.gov/policy-manual/volume-8-part-b-chapter-3> (citing *Matter of Arthur*, 16 I. & N. Dec. 558 (B.I.A. 1978)).

153 See Immigration & Nationality Act of 1952, Pub. L. No. 414, § 212(a)(1)-(7), 66 Stat. 163, 182 (1952) (codified as amended at 8 U.S.C. § 1182(a)(1) (2018)).

154 U.S. CITIZENSHIP & IMMIGR. SERVS., FORM I-693, REPORT OF MEDICAL EXAMINATION AND VACCINATION RECORD 1, <https://www.uscis.gov/sites/default/files/document/forms/i-693.pdf>.

155 U.S. CITIZENSHIP & IMMIGR. SERVS., INSTRUCTIONS FOR REPORT OF MEDICAL EXAMINATION AND VACCINATION RECORD 6 (2019), <https://www.uscis.gov/sites/default/files/document/forms/i-693instr.pdf>.

any entity or person for immigration enforcement purposes.<sup>156</sup> Although, in this case, health information is being disclosed for a narrow purpose, the perception that private physicians are complicit with the administration and enforcement of immigration law may have a chilling effect.

Noncitizens' beliefs that their health care information is less protected under the law than the law mandates may be informed by knowledge of how health care institutions have participated in immigration enforcement in the past, anecdotal evidence of health care provider complicity with immigration enforcement in the present, and the general policy climate. Historically, state medical officials and hospital staff have identified noncitizens who were deportable based on mental health grounds, serving as important sources of information to immigration authorities.<sup>157</sup> In the current policy climate, in which undocumented noncitizens are cautiously optimistic about proposed immigration reforms after four years of heightened enforcement, accessing health care may still seem fraught with danger. For example, when the COVID-19 vaccination distribution began in early December 2020, state governors, state health officials, members of Congress, and others raised concerns about provisions in the Data Use Agreement between states and the Centers for Disease Control and Prevention (CDC) because the agreements mandated the collection of personal identifiable information and permitted this information to be shared with other federal agencies.<sup>158</sup> Although the CDC has since clarified that it will not seek SSNs, driver's license numbers, or passport numbers — information particularly likely to chill noncitizens from participation — and that vaccine administration data will not be used for immigration enforcement purposes,<sup>159</sup> health care providers and advocates for immigrants continue to report that noncitizens are afraid to obtain the vaccine.<sup>160</sup> News stories reporting that health care providers have declined to provide vaccines to

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156 U.S. CITIZENSHIP & IMMIGR. SERVS., *supra* note 154, at 2.

157 Polly J. Price, *Infecting the Body Politic: Observations on Health Security and the "Undesirable" Immigrant*, 63 KAN. L. REV. 917, 938, 940 (2015).

158 See, e.g., Sheryl Gay Stolberg, *Some States Balk After C.D.C. Asks for Personal Data of Those Vaccinated*, N.Y. TIMES (Dec. 8, 2020), <https://www.nytimes.com/2020/12/08/us/politics/cdc-vaccine-data-privacy.html>.

159 CTRS. FOR DISEASE CONTROL & PREVENTION, DATA USE AND SHARING AGREEMENT TO SUPPORT THE UNITED STATES GOVERNMENT'S COVID-19 EMERGENCY RESPONSE JURISDICTION IMMUNIZATION AND VACCINE ADMINISTRATION DATA AGREEMENT 24 app. G (n.d.), <https://www.cdc.gov/vaccines/covid-19/reporting/downloads/vaccine-administration-data-agreement.pdf>.

160 See, e.g., Jazmin Orozco Rodriguez, *Battling an Information Access Gap, State and Local Campaigns Work to Provide COVID-19 Vaccine Information to Latinos*, NEV. INDEP. (Feb. 14, 2021), <https://thenevadaindependent.com/article/battling-an-information-access-gap-state-and-local-campaigns-work-to-provide-covid-19-vaccine-information-to-latinos> (describing a targeted campaign in Nevada designed to address noncitizens' concerns such as "whether their private information will be shared and whether receiving the vaccine could affect their immigration status").



noncitizens who are not able to provide a SSN increase fear and confusion in immigrant communities.<sup>161</sup> Even a direct statement from DHS supporting “equal access to the COVID-19 vaccines and vaccine distribution sites for undocumented immigrants” appears to be insufficient to overcome noncitizens’ learned fears of immigration surveillance in health care.<sup>162</sup>

## 2. *Surveillance of Publicly Funded Health Care Programs*

This subsection describes the laws and policies that permit and prohibit information-sharing between the agencies that administer publicly funded health programs and DHS. These agencies collect a wide range of personal data about applicants, including immigration status. Under certain circumstances, immigration authorities can access this data, putting certain immigration applications in jeopardy and placing some noncitizens at increased risk of deportation. An analysis of the law validates some of noncitizens’ beliefs that information about their enrollment in Medicaid, the Children’s Health Insurance Program (CHIP), or insurance from the ACA Marketplace can compromise future immigration processes. However, it also reveals that fears of negative immigration consequences from enrolling in publicly funded health coverage are greater than warranted for many noncitizens.

Public benefit agencies possess a broad array of sensitive, personal information about applicants and recipients. Applications for Medicaid, “the single largest source of health coverage in the United States,”<sup>163</sup> typically request names, birthdates, SSNs, home and work addresses and telephone numbers, marital status, citizenship or immigration status, race and ethnicity, income, assets, certain household expenses, and tax filing information for every member of an applicant’s household, as well as each household member’s relationship to the applicant.<sup>164</sup> In

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<sup>161</sup> See, e.g., Anastasiya Bolton, *Rio Grande Valley Man Denied COVID Vaccine Due to Citizenship Status*, KHOU.COM (Feb. 24, 2021), <https://www.khou.com/article/news/deep-dive-texas/covid-vaccine-denied-citizenship/285-705a8c14-80ca-4eca-b83b-a94e43cedd9a> (noting that at least fourteen people were turned away from the vaccine site for this reason).

<sup>162</sup> *DHS Statement on Equal Access to COVID-19 Vaccines and Vaccine Distribution Sites*, *supra* note 107.

<sup>163</sup> *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited Feb. 16, 2021).

<sup>164</sup> See, e.g., PA. DEP’T OF HUM. SERVS., PENNSYLVANIA APPLICATION FOR BENEFITS (n.d.), <https://www.dhs.pa.gov/Services/Assistance/Documents/Benefits%20Applications/PA-600-2-20-Final.pdf>. In addition, applications may request information about a wide range of life circumstances, such as whether the applicant or household members are in school, the U.S. military, foster care, or treatment for drug or alcohol abuse; if they are pregnant, disabled, or survivors of domestic abuse; and if they have been disqualified from benefits in the past, have unpaid medical bills, have been offered health insurance from an employer, or have had health insurance coverage in the past. *Id.* Applicants are not required to submit all such information for household members who are not to be included in the application, even though there is space to provide it on the

order to qualify for certain categories of Medicaid or to obtain federal reimbursement for treatment of emergency medical conditions through emergency Medicaid, applicants must provide detailed information about medical diagnoses and treatments. Public benefits agencies possess a record of current and past recipients' applications for and enrollment in public benefits. Finally, all of the major subsidized health coverage programs — Medicaid, CHIP, and insurance on the Affordable Care Act (ACA) Health Insurance Marketplace — require noncitizen applicants to provide proof of a valid immigration status.<sup>165</sup>

The primary way in which immigration authorities access information about noncitizens held by public benefits agencies is by compelling noncitizens to authorize the release of such information. This occurs when certain noncitizens apply to become LPRs, an immigration process. The public charge law restricts the ability of certain noncitizens to become LPRs if they are considered likely to become dependent on the U.S. government for support. New regulations — anticipated from the first days of the Trump Administration in 2017, finalized by DHS in 2019, and rescinded in 2021 — expanded the scope of the law in many ways, including by adding Medicaid to the list of public benefits considered in the public charge analysis. The 2019 regulations chilled noncitizens from applying for Medicaid — even those who are exempt from the public charge determination altogether or whose use of public benefits would not be considered as a negative factor in the public charge analysis. Similarly, Trump-era policies relating to immigration sponsorship have discouraged noncitizens from enrolling in public benefits by increasing the risk that enrolling in such benefits will have immigration consequences. Finally, the Trump Administration's novel interpretations of what is considered "fraud" in immigration applications raised fears that any information submitted to public benefits agencies would be scrutinized and potentially used as a pretext for immigration enforcement activities.

Both DHS and the Department of Health and Human Services (HHS) have long acknowledged that collaboration between public benefits agencies and immigration authorities will chill noncitizen enrollment in public benefits and have thus taken some steps to counter it,<sup>166</sup> but the law still permits information sharing in certain circumstances. The laws relating to public charge determinations,

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application. *See, e.g., id.* at 2 (noting, for sections of the application relating to household members, "[a]nswer the questions below if you are applying for this person").

<sup>165</sup> *See* Social Security Act of 1935 § 1137(d), 42 U.S.C. § 1320b-7(d) (2018); 42 U.S.C. § 18081(b)(2) (2018) (providing for the ACA Health Insurance Marketplace); 42 C.F.R. § 457.340(d) (2021) (providing for CHIP). The eligibility criteria relating to immigration status for each of these programs is different and complex. For an overview, see Medha D. Makhoul, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680, 1699-72 (2020).

<sup>166</sup> *See, e.g.,* U.S. IMMIGR. & CUSTOMS ENF'T, CLARIFICATION OF EXISTING PRACTICES RELATED TO CERTAIN HEALTH CARE INFORMATION (2013), <https://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>.

immigration sponsorship, and the fraud exception to privacy protections in public benefits applications were in place prior to 2017; their impact was simply ratcheted up through regulations and rhetoric. Even as the Biden Administration begins to undo some of these regulations in the interest of public health, it may struggle to regain trust in immigrant communities.<sup>167</sup> The chilling effects of the laws still on the books — which also preexisted the Trump Administration — will likely persist.

a. Public Charge Determinations

One way in which immigration authorities obtain information about noncitizens' enrollment in public benefit programs is by requiring disclosure of this information from noncitizens who are subject to the public charge ground of inadmissibility and are applying to become LPRs. If USCIS determines that an LPR applicant is likely to become a public charge at any time in the future, their application is denied.<sup>168</sup> The public charge inadmissibility analysis involves weighing numerous factors relating to “age, health, family status, assets, resources and financial status, education, and skills, among other factors.”<sup>169</sup> One such factor is prior receipt of public benefits, including (for a time under the 2019 regulations) Medicaid for adults in most eligibility groups.<sup>170</sup> LPR applicants must provide this information to USCIS under penalty of perjury *and* authorize USCIS to verify this information with the agencies administering the public benefits in question.<sup>171</sup>

In order to receive LPRs' Medicaid enrollment information, USCIS must request it — as well as authorization for government agencies to disclose it — from LPRs directly, because such information is otherwise protected from disclosure

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<sup>167</sup> See, e.g., Orozco Rodriguez, *supra* note 160 (quoting an organizer with a COVID-19 vaccination campaign in Nevada who describes fear and mistrust in the Latino immigrant community as “*las secuelas* (the aftermath) of the last administration”).

<sup>168</sup> 8 U.S.C. § 1182(a)(4) (2018).

<sup>169</sup> Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,690 (Mar. 26, 1999).

<sup>170</sup> Letter from Tracy L. Renaud, Senior Off. Performing the Duties of the Dir., U.S. Citizenship & Immigr. Servs., to Interagency Partners 1-2 (Apr. 12, 2021), <https://www.uscis.gov/sites/default/files/document/notices/SOPDD-Letter-to-USCIS-Interagency-Partners-on-Public-Charge.pdf>. Under the current policy, which is the policy that was in effect prior to the 2019 public charge regulations, enrollment in Medicaid is considered only when it is used for coverage of long-term institutional care. *Id.* at 2. Under the 2019 rule, use of Medicaid was not considered for noncitizens under the age of 21 and women during pregnancy and for sixty days after the pregnancy ends. Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,297 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 245, 248). Use of emergency Medicaid, a reimbursement mechanism for treatment of emergency medical conditions in noncitizens who are excluded from Medicaid, was also not considered under the 2019 rule. *Id.* at 41,384.

<sup>171</sup> U.S. CITIZENSHIP & IMMIGR. SERVS., DEP'T OF HOMELAND SEC., OMB No. 1615-0023, FORM I-485, APPLICATION TO REGISTER PERMANENT RESIDENCE OR ADJUST STATUS 13, 15 (2021), <https://www.uscis.gov/sites/default/files/document/forms/i-485.pdf>.

under federal law. The federal Medicaid statute requires states to safeguard information received about Medicaid applicants, beneficiaries, and non-applicant household members by restricting disclosure “to purposes directly connected with the administration of the plan.”<sup>172</sup> Regulations specify that the types of activities that are “directly connected with” Medicaid administration are limited to: “(a) Establishing eligibility; (b) Determining the amount of medical assistance, (c) Providing services for beneficiaries; and (d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to administration of the [state Medicaid] plan.”<sup>173</sup> They further specify the types of information to be safeguarded, including names and addresses, SSNs, information used to verify income eligibility, medical information, and “[s]ocial and economic conditions or circumstances.”<sup>174</sup> Providing information to federal immigration authorities about a noncitizen’s receipt of Medicaid benefits is not a purpose directly related to Medicaid administration.<sup>175</sup> The Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for administering Medicaid, is required to have specific criteria regarding the release and use of information about applicants for and beneficiaries of Medicaid, and may only provide access to such information to agencies that are subject to standards of confidentiality comparable to CMS’s criteria.<sup>176</sup>

The major effect of the 2019 public charge regulations was to chill noncitizens from applying for public benefit programs, including publicly funded health insurance, because of the perception that any use of any public benefit would increase the risk that a future immigration application would be denied.<sup>177</sup> Many sources contribute to this widespread belief among noncitizens — even those whose enrollment in Medicaid would not trigger immigration consequences. First, there was confusion about how the 2019 public charge regulation applied. Second,

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172 42 U.S.C. §§ 1320b-7(a)(5), 1396a(a)(7)(A)(i) (2018); 42 C.F.R. § 431.300(b)-(c) (2021) (stating that such safeguards apply to non-applicants, in addition to applicants and beneficiaries).

173 42 C.F.R. § 431.302 (2021).

174 *Id.* § 431.305.

175 *See Id.* § 431.306(e) (stating that Medicaid agencies’ policies on safeguarding information “must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials”); NAT’L IMMIGR. L. CTR., *PRIVACY PROTECTIONS IN SELECTED FEDERAL BENEFITS PROGRAMS* 1-2 (2018), <https://www.nilc.org/wp-content/uploads/2018/03/privacy-protections-fed-programs-tbl-2018.pdf> (citing Letter from Sally Richardson, Ctr. for Medicaid and State Operations, to State Medicaid Directors (Dec. 17, 1997) (on file with National Immigration Law Center); *see also* 42 C.F.R. § 431.306(f)-(h) (2021) (specifying circumstances in which a Medicaid agency may release information to courts or other agencies).

176 § 431.306.

177 Medha D. Makhoul & Jasmine Sandhu, *Immigrants and Interdependence: How the COVID-19 Pandemic Exposes the Folly of the New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146, 151 (2020). The 2019 public charge rule stated that merely applying for a public benefit “may suggest a likelihood of future receipt” of public benefits. Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,366 (Aug. 14, 2019).

there may be confusion about the extent of the privacy protections in Medicaid because public benefits agencies are generally permitted and sometimes required to disclose information about applicants for other public benefit programs to immigration authorities. Third, prior interactions with immigration authorities may have left noncitizens distrustful of any official assurances. Consequently, noncitizens tend to err on the side of caution and decline to enroll in publicly funded health insurance. Each of these sources of belief about public charge are examined in detail in the remainder of this subsection.

For good reason, noncitizens were and remain confused about how the 2019 public charge rule changed the relationship between enrollment in publicly funded health insurance and eligibility for LPR status. The 217-page final rule is so complex that it is nearly impenetrable. Basic information about how the rule applied — such as who was subject to public charge, whose public benefits use was considered in the analysis, and which public benefit programs were considered — was frequently misinterpreted.<sup>178</sup> For example, CHIP and ACA Marketplace coverages were not considered to be public benefits in the public charge analysis,<sup>179</sup> but it appears that the 2019 regulations chilled noncitizen enrollment in those programs as well.<sup>180</sup> Misinformation about the operation of the rule was rampant, a consequence of its complexity but also of the anti-immigrant rhetoric that surrounded its promulgation. Various versions of the rule were leaked to the media multiple times before the rule was finalized, stoking fears. Some noncitizens declined to enroll in public benefits years before the rule began to be implemented, in anticipation of a change in the law that would view such enrollment unfavorably. Finally, since immigration officers have broad discretion to weigh an applicant’s use of public benefits against other factors in the public charge determination, some noncitizens may choose to “play it safe” by avoiding use of public benefits at all costs.<sup>181</sup> Moreover, despite the fact that the 2019 public charge rule has been

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178 See Makhoul & Sandhu, *supra* note 177, at 156.

179 In the proposed rule, DHS sought public comments on whether to add CHIP to the list of public benefits considered in the analysis. Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,173-74 (Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, 248).

180 See, e.g., KAISER FAM. FOUND., CHANGES TO “PUBLIC CHARGE” INADMISSIBILITY RULE: IMPLICATIONS FOR HEALTH AND HEALTH COVERAGE 4 (2019), <http://files.kff.org/attachment/Fact-Sheet-Changes-to-Public-Charge-Inadmissibility-Rule-Implications-for-Health-and-Health-Coverage> (describing reports of members of immigrant families declining to enroll in or disenrolling from CHIP due to fears relating to public charge); Charles Gaba & Emily Gee, *How Trump’s Policies Have Hurt ACA Marketplace Enrollment*, CTR. FOR AM. PROGRESS (Apr. 16, 2020), <https://www.americanprogress.org/issues/healthcare/news/2020/04/16/483362/trumpspolicies-hurt-aca-marketplace-enrollment/> (attributing, in part, declines in Marketplace coverage enrollment to the new public charge rule).

181 Makhoul & Sandhu, *supra* note 177, at 156-57; Super, *supra* note 5, at 556 (describing how immigration officers have interpreted public charge inadmissibility unevenly because of the broad discretion they have and noting that many immigration attorneys advise their clients to “avoid

rescinded, its chilling effects are likely to linger.<sup>182</sup> An attempt by a group of state attorneys general to defend the 2019 public charge rule, an effort abandoned by the Biden Administration, leaves open the possibility that the 2019 rule could be implemented again someday.<sup>183</sup>

Another reason why noncitizens may believe that enrolling in publicly funded health insurance could place future immigration applications at risk is that they are not aware of or do not trust the relatively strong privacy protections in the laws governing Medicaid,<sup>184</sup> CHIP,<sup>185</sup> and Marketplace coverage.<sup>186</sup> While public benefits agencies are restricted from disclosing information about applicants to or recipients of these programs for reasons unrelated to program administration, privacy protections in other public benefit programs are not as strong. Public benefits agencies are required or permitted to disclose information about applicants and recipients to immigration authorities in certain circumstances. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) created a new requirement for federal and state agencies administering certain federal public benefit programs to report to immigration authorities the names, addresses, and other identifying information about people who they know to be unlawfully present in the United States.<sup>187</sup> Among the programs subject to the

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virtually all public benefits”).

182 See ALMA GUERRERO ET AL., UCLA LATINO POL’Y & POL. INITIATIVE, FOREGOING HEALTHCARE IN A GLOBAL PANDEMIC: THE CHILLING EFFECTS OF THE PUBLIC CHARGE RULE ON HEALTH ACCESS AMONG CHILDREN IN CALIFORNIA 4, 6, 12 (2021), [https://latino.ucla.edu/wp-content/uploads/2021/04/LPPI\\_Foregoing-Healthcare-in-a-Global-Pandemic\\_04.07.2021.pdf](https://latino.ucla.edu/wp-content/uploads/2021/04/LPPI_Foregoing-Healthcare-in-a-Global-Pandemic_04.07.2021.pdf).

183 See John Krugel & Harper Neidig, *Supreme Court Rebuffs GOP Bid to Revive Trump’s ‘Public Charge’ Rule*, THE HILL (Apr. 26, 2021), <https://thehill.com/regulation/court-battles/550244-supreme-court-rebuffs-gop-bid-to-revive-trumps-public-charge-rule>.

184 See *supra* text accompanying notes 172-176. See generally U.S. IMMIGR. & CUSTOMS ENF’T, *supra* note 166 (confirming that information submitted in applications for Medicaid, CHIP, or Marketplace coverage are not used for immigration enforcement purposes).

185 42 C.F.R. § 457.1110(b) (2021) (requiring CHIP programs to comply with Medicaid’s privacy protections).

186 Patient Protection and Affordable Care Act § 1411(g)(2), 42 U.S.C. § 18081(g)(2) (2018) (stating that information obtained from applicants for coverage through the Health Insurance Marketplace must be used for the sole purpose of “ensuring the efficient operation of the Exchange”); 45 C.F.R. § 155.260(a) (2021) (stating that personally identifiable information may only be used or disclosed for specific functions, such as eligibility determination or enrollment in health insurance plans); § 155.260(e)(3) (stating that the Marketplace’s data-sharing arrangements with other agencies must “[b]e equal to or more stringent than the requirements for Medicaid programs”).

187 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) § 404(b), 42 U.S.C. §§ 608(g), 611a (2018); Responsibility of Certain Entities to Notify the Immigration and Naturalization Service of Any Alien Who the Entity “Knows” Is Not Lawfully Present in the United States, 65 Fed. Reg. 58,301, 58,302 (Sept. 28, 2000) (clarifying that state public benefits agencies subject to the reporting requirement are obligated to report information under this provision only when they find, through receipt of a Final Order of Deportation or similar documentation from an immigration agency, that an applicant is removable from the United States). The fact that this requirement has been interpreted narrowly does not weaken the argument that there are exceptions

requirement is the Supplemental Nutrition Assistance Program (SNAP), a program for which many Medicaid recipients qualify. Under PRWORA and a similar provision in the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) designed to facilitate information sharing between state and local government and federal immigration authorities, state and local government entities and officials may not be restricted by law from sending information about a person's immigration status to federal immigration authorities.<sup>188</sup> Although the constitutionality of these provisions is currently the subject of a circuit split, they remain enforceable in parts of the country.<sup>189</sup> Noncitizens' concerns about the risks of engaging with the public benefits system at all are understandable, given that privacy protections are uneven among programs. Such concerns are heightened when, as in many states, a single public benefits agency administers multiple public benefits programs, which often have a single application process.

Noncitizens' decisions about enrolling in publicly funded health care may also be influenced by distrust of the government, which is in turn informed by anecdotal evidence, prior interactions with immigration authorities, or their experiences applying for public benefits. If a person is arrested by immigration authorities after receiving medical treatment or enrolling in Medicaid, noncitizens may infer that the person's pursuit of health care triggered the arrest, even if there is no evidence of a connection. They may understand "medical deportations," about which news stories appear periodically, as immigration enforcement actions, even though they are privately arranged by hospitals.<sup>190</sup> Long-residing noncitizens may recall prior policies, some of which were ultimately struck down as unconstitutional, that

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to privacy protections in public benefits programs that could reasonably lead noncitizens to tread cautiously when considering whether to apply for public benefits. Without legal assistance to confirm that their information is not at risk of disclosure to immigration authorities, noncitizens may decline to apply.

<sup>188</sup> Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) § 642, 8 U.S.C. § 1373(a) (2018) (referring to the Immigration and Naturalization Service (INS), whose functions were largely assumed by USCIS, ICE, and CBP under the Homeland Security Act of 2002); PRWORA § 434, 8 U.S.C. § 1644 (2018).

<sup>189</sup> See Mary Ann McNulty, Comment, *A Doctrine Without Exception: Critiquing an Immigration Exception to the Anticommandeering Rule*, 169 U. PA. L. REV. 241, 243 (2020) (discussing the Second Circuit's decision finding the provisions to be constitutional and not in violation of the anticommandeering doctrine, which diverged from the decisions of the Third, Seventh, and Ninth Circuits). These provisions have gained renewed attention in the context of a 2017 federal regulation that threatened to withdraw federal police funding from jurisdictions that refused to certify compliance with them.

<sup>190</sup> Medical deportations typically feature noncitizens who have been injured and are in need of long-term care but cannot be discharged from the hospital because they do not have health insurance. In such cases, some hospitals have arranged to transport patients to their countries of origin to avoid incurring additional costs. See Price, *supra* note 157, at 938 (describing the historical context for today's fears of public charge, including the common early-twentieth-century practice of state mental health institution "engineering" the deportation of their noncitizen patients).

encouraged information-sharing between public benefits agencies and immigration authorities.<sup>191</sup>

The immigration or public benefits application processes themselves can be sources of distrust. For example, the “Declaration of Self-Sufficiency,” the form used by LPR applicants to prove that they were not inadmissible under the 2019 public charge regulations, requested information about current or past receipt of Medicaid even if such receipt was categorically excluded from consideration in the public charge analysis.<sup>192</sup> The fact that USCIS requested information about any prior receipt of Medicaid, regardless of the circumstances or how long ago one was enrolled, only confirmed suspicions that any receipt of public benefits would be viewed unfavorably by immigration authorities. Similarly, although the Medicaid statute and ICE policy<sup>193</sup> protect an applicant’s information from being used for immigration enforcement purposes, simply having to submit immigration documents to the public benefits agency for verification of immigration status can raise concerns about applying.<sup>194</sup> HHS has acknowledged the potential chilling effect of requests for information about immigration status and SSNs on noncitizens’ health care access,<sup>195</sup> and encourages state health and welfare officials to counter the effect by clarifying the laws relating to requests for such information

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191 See PARK, *supra* note 1, at 43-45 (describing the chilling effects of a San Diego County policy that required the public benefits agency administering Medicaid to put up posters stating “[p]lease be aware that we can send any information you give us to [Immigration and Naturalization Service]”).

192 U.S. CITIZENSHIP & IMMIGR. SERVS., *supra* note 19, at 8; U.S. CITIZENSHIP & IMMIGR. SERVS., DEP’T OF HOMELAND SEC., INSTRUCTIONS FOR DECLARATION OF SELF-SUFFICIENCY 8-9 (2019); see also Super, *supra* note 5, at 558 (describing how application forms for cancellation of removal and suspension of deportation, two highly discretionary forms of immigration relief, request information about the applicant’s and their family members’ receipt of public benefits even though “[t]he legal justification for these questions is unclear”).

193 U.S. IMMIGR. & CUSTOMS ENF’T, *supra* note 166, at 1 (stating that “ICE does not use information . . . that is obtained for purposes of determining eligibility for [health] coverage as the basis for pursuing a civil immigration enforcement action . . .”).

194 The Systematic Alien Verification for Entitlement (SAVE) system was established in 1986 to enable public benefits agencies to obtain immigration status information about noncitizen applicants in order to determine eligibility. Immigration Reform and Control Act of 1986 (IRCA), Pub. L. No. 99-603, § 121, 100 Stat. 3359, 3384-94 (1986). Although DHS is prohibited from using any information submitted to SAVE for immigration enforcement activities, simply requesting immigration documents may chill some noncitizens and their family members from applying for benefits. 42 U.S.C. § 1320b-7 note (Immigration and Naturalization Service to Establish Verification System by October 1, 1987) (stating that the system “shall not be used by the Immigration and Naturalization Service for administrative (non-criminal) immigration enforcement purposes”).

195 U.S. DEP’T OF HEALTH & HUM. SERVS. & U.S. DEP’T OF AGRIC., POLICY GUIDANCE REGARDING INQUIRIES INTO CITIZENSHIP, IMMIGRATION STATUS AND SOCIAL SECURITY NUMBERS IN STATE APPLICATIONS FOR MEDICAID, STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP), TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), AND FOOD STAMP BENEFITS (2013), <https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/tri-agency/index.html>.



and making certain changes to their application forms and processes.<sup>196</sup> For example, HHS advises states to refrain from requiring applicants to provide citizenship or immigration status information about household members who are not applying for benefits, in line with Medicaid regulations.<sup>197</sup> Not all states have taken such practical steps to address chilling effects, which likely continues to discourage members of mixed-status families from applying for benefits for which they are eligible.<sup>198</sup>

#### b. Immigration Sponsorship

Noncitizens who have immigration sponsors are subject to immigration surveillance of their enrollment in Medicaid or CHIP in certain circumstances, which can deter them from applying for these programs. Specifically, public benefits agencies are required to share information about sponsored immigrants who receive federal means-tested public benefits and their sponsors with the Attorney General. In addition, if a public benefits agency obtains a final judgment against an immigration sponsor for reimbursement of the cost of benefits provided to a noncitizen, it may provide a copy of the judgment to USCIS.<sup>199</sup> These modes of monitoring noncitizens' involvement with the public benefits system are part of the web of immigration surveillance that generates health care system avoidance.

The purpose of the immigration sponsor requirement for certain noncitizens is to ensure that they do not become a public charge. An immigration sponsor is a U.S. resident who assumes financial responsibility for a noncitizen, typically a family member, who intends to live in the United States permanently.<sup>200</sup> Certain

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<sup>196</sup> *Id.*; U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF AGRIC., POLICY GUIDANCE REGARDING INQUIRIES INTO CITIZENSHIP, IMMIGRATION STATUS AND SOCIAL SECURITY NUMBERS IN STATE APPLICATIONS FOR MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), AND FOOD STAMP BENEFITS: QUESTIONS AND ANSWERS (2006), <https://www.hhs.gov/sites/default/files/triagencyq%26as.pdf>.

<sup>197</sup> 42 C.F.R. § 435.907(e)(1) (2021) (prohibiting states from requiring applicants to provide information that is not strictly necessary to make an eligibility determination); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule, 77 Fed. Reg. 17144, 17164 (Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 457) (stating that citizenship and immigration status information of household members who are not applying for benefits is not strictly necessary to make an eligibility determination).

<sup>198</sup> *See* Super, *supra* note 5, at 560 (describing HHS Office of Civil Rights' investigations in the late 1990s and early 2000s finding that states continued to improperly request information from non-applicant household members). Requests for any information about an undocumented or ineligible noncitizen household member may, unfortunately, deter some eligible people from applying for Medicaid. *See id.* at 561 (noting that the process of verifying a household member's income could reveal their lack of immigration status). Such concerns are heightened in anti-immigrant policy climates. *Id.*

<sup>199</sup> *See* 8 C.F.R. § 213a.4(c)(1)-(2) (2021).

<sup>200</sup> 8 U.S.C. § 1183a; 8 C.F.R. § 213a.2(b)-(c) (2021). Generally, sponsors must prove that they

LPR applicants are required to submit an “affidavit of support” from one or more sponsors as evidence that they will not become a public charge.<sup>201</sup> When a sponsored immigrant applies for a public benefit, the agency is supposed to “deem” all of the sponsor’s income and resources to the sponsored immigrant when determining eligibility,<sup>202</sup> often disqualifying the noncitizen from financial eligibility for the benefit regardless of how much support their sponsor is in fact providing.<sup>203</sup> However, if the agency determines that a sponsored immigrant would “be unable to obtain food and shelter” if the benefit were not provided, considering the amount of support that the immigration sponsor is in fact providing, the agency may approve the application for benefits.<sup>204</sup> This is known as the indigence exception to the sponsor deeming rule.<sup>205</sup> An example of how it applies follows: A sponsored LPR is diagnosed with a chronic condition that is expensive to treat, like insulin-dependent Type II diabetes.<sup>206</sup> He does not have health insurance and therefore applies for Medicaid. If the public benefits agency determines that his immigration sponsor does not provide him with adequate support such that he would become indigent if he had to pay for treatment, they may approve the application.<sup>207</sup> In such cases, the agency must notify the Attorney General of the

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can support the sponsored immigrant at no less than 125% of the federal poverty line by providing evidence of sufficient income or assets. 8 U.S.C. § 1183a(a)(1)(A); § 213a.2(c)(2).

201 § 213a.2(a)(2) (describing who is required to submit an affidavit of support). Affidavits of support are legally enforceable contracts binding the sponsor to provide financial support to the immigrant. § 1183a(a)(B); § 213a.2(c)(2)(C)(2), (d). Under the 2019 public charge rule, affidavits of support were not dispositive in the public charge determination but were considered as one factor in the “totality of circumstances” analysis. Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,370 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 245, 248). Currently, LPR applicants can overcome public charge inadmissibility by submitting an affidavit of support alone, which was also the case prior to implementation of the 2019 rule.

202 8 U.S.C. § 1631(a) (2018).

203 Super, *supra* note 5, at 552 (noting that “deeming often will render the immigrant ineligible”).

204 § 1631(e).

205 *Id.* There are other exceptions to sponsor deeming, but public benefits agencies are not required to notify the Attorney General when they are applied. *See, e.g.*, § 1631(b)(2) (providing an exception for noncitizens who have worked or can be credited with 40 qualifying quarters); § 1631(f) (providing an exception for survivors of domestic violence); Social Security Act of 1935 §§ 1903(v)(4)(B), 2107(e)(1)(N), 42 U.S.C. §§ 1396b(v)(4)(B), 1397gg(e)(1)(N) (2018) (providing an exception for children 21 years of age or pregnant women); Letter from Calder Lynch, Acting Deputy Adm’r & Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials 2-3 (Aug. 23, 2019), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho19004.pdf> (providing an exception for applicants for emergency Medicaid).

206 Medication and supplies can cost up to \$1,300 per month. *See Insulin Prices: How Much Does Insulin Cost?*, SINGLECARE (Jan. 27, 2020), <https://www.singlecare.com/blog/insulin-prices/>.

207 This assumes that the LPR is eligible for Medicaid in their state of residence. Medicaid eligibility varies substantially across states, but in most states, LPRs who have held that status for five years or more qualify for Medicaid so long as they meet the other eligibility criteria. *See Makhoulf, supra* note 165, at 1706-09.

names of the sponsor and the sponsored immigrant.<sup>208</sup>

Receipt of public benefits by a sponsored immigrant may lead to another situation in which a public benefits agency shares information about sponsored immigrants and their sponsors with immigration authorities. When a noncitizen qualifies for public benefits — whether eligibility is based on the indigence exception or not<sup>209</sup> — their sponsor is generally liable to the government for the cost of the benefit provided.<sup>210</sup> If a public benefits agency pursues legal action against an immigration sponsor for reimbursement of the costs of the benefits provided to a sponsored immigrant<sup>211</sup> and obtains a favorable judgment, it must share a copy of the judgment with USCIS to inform the agency that the immigration sponsor has not met their obligations under the affidavit of support.<sup>212</sup>

These notification provisions may deter some sponsored immigrants from applying for Medicaid or CHIP because of concerns about the impact on future immigration applications. Specifically, they may believe that any use of public benefits will negatively affect their own ability or their sponsor’s ability to sponsor others.<sup>213</sup> When a noncitizen’s immigration sponsor is a family member who plans to sponsor other family members in the future, as is often the case, enrolling in public benefits is perceived as a risk to family reunification.<sup>214</sup>

Such beliefs have long influenced noncitizens’ decisions to apply for public benefits,<sup>215</sup> but they were validated and heightened during the Trump Administration. For example, chilling effects of the notification provisions were observed during prior administrations, even though immigration authorities at the time indicated that ICE used information obtained from the Attorney General only for “compiling statistical reports.”<sup>216</sup> Such concerns were heightened during the Trump Administration because it stepped up enforcement of affidavits of support,

208 § 1631(e)(2); *see* PARK, *supra* note 1, at 45 (describing how state agencies were not permitted to share information with immigration authorities prior to 1996).

209 State methodologies for counting immigration sponsors’ income and resources vary. *See* Letter from Calder Lynch, *supra* note 205, at 4.

210 8 U.S.C. § 1183a(a)(1)(B) (2018); 8 C.F.R. § 213a.2(d) (2021). *But see* §§ 1396b(v)(4)(B), 1397gg(e)(1)(N) (prohibiting states from seeking reimbursement for the costs of Medicaid and/or CHIP provided to lawfully present children and pregnant women).

211 State policies vary in terms of whether to pursue reimbursement from sponsors. *See* § 1183a(b); 8 C.F.R. § 213a.4(a)(1) (2021) (describing agencies’ discretion to seek reimbursement).

212 § 213a.4(c)(1)-(2).

213 *See* Super, *supra* note 5, at 554.

214 *See* TIM O’SHEA & CRISTOBAL RAMÓN, BIPARTISAN POL’Y CTR., IMMIGRANTS AND PUBLIC BENEFITS: WHAT DOES THE RESEARCH SAY? 10 (2018) (“[S]ome immigrants reduced their use of Medicaid to protect their ability to sponsor family members for immigration, which requires individuals to show an ability to financially support themselves and their family members.”).

215 *See, e.g.*, Super, *supra* note 5, at 553 (describing immigration sponsors’ reasons for discouraging sponsored immigrants from applying for public benefits).

216 *Id.* (noting the “profound” chilling effects of the notification requirement during the Clinton, Bush, and Obama Administrations).

including directing public benefits agencies to seek reimbursement for every dollar of public benefits provided to sponsored immigrants,<sup>217</sup> which is traditionally and legally a matter of state discretion.<sup>218</sup> It also proposed rules that would streamline information sharing between public benefits agencies and immigration authorities<sup>219</sup> and prevent immigration sponsors who had defaulted on their obligations in the past from serving in this role again.<sup>220</sup> The belief that one's own use of public benefits could jeopardize one's ability to serve as an immigration sponsor was often endorsed by immigration lawyers, despite the fact that DHS's policy under prior administrations was to *not* consider public benefits use by petitioning immigration sponsors when determining their ability to serve in the role.<sup>221</sup> The Trump Administration validated these concerns when it proposed a rule seeking to penalize petitioning immigration sponsors who had used public benefits, including Medicaid or CHIP, within the thirty-six-month period prior to filing an affidavit of support.<sup>222</sup> Although the Biden Administration has revoked

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217 See Memorandum from Andrew Bremberg on Executive Order on Protecting Taxpayer Resources by Ensuring Our Immigration Laws Promote Accountability and Responsibility to Donald J. Trump, President of the U.S. §§ 2(c), 3(a)(iv), 3(i)(i) (Jan. 23, 2017) (instructing public benefits agencies and the Department of Justice to prioritize sponsor reimbursement); Press Release, Ken Cuccinelli II, Acting Dir., U.S. Citizenship & Immigr. Servs., Presidential Memorandum on Enforcing the Legal Responsibilities of Sponsors of Aliens (June 14, 2019), <https://www.uscis.gov/news/news-releases/presidential-memorandum-on-enforcing-the-legal-responsibilities-of-sponsors-of-aliens> (directing USCIS officers "to remind individuals at their adjustment of status interviews of their sponsors' responsibilities"); Memorandum from Donald J. Trump, President of the U.S., on Enforcing the Legal Responsibilities of Sponsors of Aliens § 1 (May 23, 2019); see also Letter from Calder Lynch, *supra* note 205, at 4 (providing guidance to state officials administering Medicaid and CHIP on how to comply with the Presidential Memorandum on Enforcing the Legal Responsibilities of Sponsors of Aliens).

218 8 U.S.C. § 1183a(b) (2018); 8 C.F.R. § 213a.4(a)(1) (2021); see also O'SHEA & RAMÓN, *supra* note 214, at 5 (indicating that some states have chosen not to seek repayment from sponsors at all); ALISON SISKIN, CONG. RSCH. SERV., RL33809, NONCITIZEN ELIGIBILITY FOR FEDERAL PUBLIC ASSISTANCE: POLICY OVERVIEW 14-15 n.40 (2016) ("Despite the mandatory nature of the statutory language, Congress may lack constitutional authority to compel states to request reimbursement of state funds from sponsors, and the statute itself recognizes that the states have discretion on whether to follow up requests with further legal action.").

219 Affidavit of Support on Behalf of Immigrants, 85 Fed. Reg. 62,432, 62,447 (Oct. 2, 2020) (to be codified at 8 C.F.R. pt. 213a) (eliminating the requirement that public benefits agencies must subpoena USCIS to get a copy of an Affidavit of Support for purposes of enforcing sponsor reimbursement and revising the reporting procedure for reasons of efficiency).

220 *Id.* at 62,443 (describing a new requirement of a joint sponsor when the petitioning sponsor has been ordered to reimburse a public benefits agency for the cost of benefits provided to a noncitizen in the past).

221 See Super, *supra* note 5, at 554 (noting that this policy applied during the Clinton, Bush, and Obama Administrations); see also Affidavits of Support on Behalf of Immigrants, 71 Fed. Reg. 35,732, 35,738 (June 21, 2006) (to be codified at 8 C.F.R. pts. 204, 205, 213a, 299) (noting that any public benefits received are not considered as part of sponsor's income for purposes of meeting the income threshold, but not indicating that they are held *against* the petitioning sponsor in any way).

222 Affidavit of Support on Behalf of Immigrants, 85 Fed. Reg. at 62442 (noting that DHS

the Trump-era Presidential Memorandum that triggered heightened enforcement of sponsors' obligations,<sup>223</sup> surveillance of public benefits use by sponsored immigrants and their immigration sponsors is still required under law, and the proposed rules intensifying such surveillance remain pending.

### c. Fraud Investigations

Privacy protections in Medicaid, CHIP, and the ACA Marketplace do not apply when an applicant is suspected of committing health care fraud or abuse because enforcement actions relating to benefits fraud and abuse are considered a purpose directly connected with the administration of benefits programs.<sup>224</sup> State Medicaid agencies are required to investigate complaints of Medicaid fraud or abuse by beneficiaries and refer such cases to law enforcement if fraud is suspected.<sup>225</sup> The definition of fraud “includes any act that constitutes fraud under applicable Federal or State law” and generally refers to the use of deceit or misrepresentation to receive a benefit for which one does not qualify.<sup>226</sup> Beneficiary abuse is defined as “practices that result in unnecessary cost to the Medicaid program.”<sup>227</sup> The Office of Inspector General of HHS works with the Department of Justice to investigate and prosecute health care fraud and abuse in all publicly funded health insurance programs.<sup>228</sup> Fraud investigation units of state Medicaid agencies perform a similar function in conjunction with the state attorney general's office.

The precise process by which immigration authorities receive information about noncitizens who are investigated or prosecuted for health care fraud or abuse is not always clear,<sup>229</sup> but it is certain that ICE acts on such information to initiate

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considered “permanently barring” those who had ever received public benefits from becoming a sponsor but settled for a presumption that a petitioning sponsor who has received public benefits “may not have the ability to meet the support obligations while the Affidavit is in effect”).

<sup>223</sup> Exec. Order No. 14012, Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans § 6, 86 Fed. Reg. 8,277 (Feb. 2, 2021).

<sup>224</sup> 42 C.F.R. § 431.302 (2021) (describing the exception in Medicaid); *Id.* § 457.1110(b) (describing the exception in CHIP).

<sup>225</sup> The governing regulations describe methods for the identification, investigation, and referral of suspected Medicaid fraud. *Id.* § 455.13. Agencies are required to investigate complaints of Medicaid fraud received from any source. *Id.* § 455.14. They must refer cases of suspected fraud by beneficiaries “to an appropriate law enforcement agency.” *Id.* § 455.15(b).

<sup>226</sup> *Id.* § 455.2.

<sup>227</sup> *Id.*

<sup>228</sup> 42 U.S.C. §§ 1320a-7c, 1395i(k) (2018) (establishing and funding the fraud and abuse control program).

<sup>229</sup> See, e.g., NAT'L IMMIGR. L. CTR., UNTANGLING THE IMMIGRATION ENFORCEMENT WEB 1-2 (2017), <https://www.nilc.org/wp-content/uploads/2017/09/Untangling-Immigration-Enforcement-Web-2017-09.pdf> (discussing the difficulty of describing all of the ways in which information is

removal proceedings. The ICE website contains several press releases describing immigration enforcement actions initiated because of health care fraud.<sup>230</sup> For example, one press release describes the arrest of a Jamaican citizen and New York resident who used another person's SSN to qualify for Medicaid.<sup>231</sup> Another describes how an investigation by ICE's Homeland Security Investigations unit led to the conviction of an undocumented noncitizen for Medicaid and SNAP fraud after she failed to accurately report her husband's income; she was likely deported after serving her prison sentence and, if so, may not be able to enter the United States ever again.<sup>232</sup>

The fraud exception may deter noncitizens from applying for publicly funded health insurance because of a fear that an innocent error or misunderstanding could have negative immigration consequences. As illustrated in the examples described in the previous paragraph, a conviction for health care fraud can be the basis for a finding of deportability. It can also render a noncitizen inadmissible under immigration law, meaning that they can be denied entry to the United States in the future or that their application for LPR status will be denied.<sup>233</sup> Any finding of health care fraud in a noncitizens' record may be considered a negative factor in future immigration applications in which a favorable exercise of discretion is required.<sup>234</sup>

Such fears are not unfounded, given the punitive immigration policies

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shared between immigration and law enforcement agencies because of a lack of transparency); Kalhan, *supra* note 10, at 76 (“[I]mmigration agencies . . . have long suffered from major transparency and accountability deficits . . . . No framework statutes govern or constrain immigration surveillance activities, which . . . also fall outside of the limited privacy protections available under the Privacy Act.”).

230 See *News Releases*, U.S. IMMIGR. & CUSTOMS ENF'T, [https://www.ice.gov/newsroom/?field\\_news\\_release\\_topics\\_tag\\_target\\_id=165&field\\_field\\_location\\_administrative\\_area=All&field\\_published\\_date\\_value%5Bmin%5D=&field\\_published\\_date\\_value%5Bmax%5D=&combine=medicaid&field\\_field\\_location\\_country\\_code=All](https://www.ice.gov/newsroom/?field_news_release_topics_tag_target_id=165&field_field_location_administrative_area=All&field_published_date_value%5Bmin%5D=&field_published_date_value%5Bmax%5D=&combine=medicaid&field_field_location_country_code=All) (last visited July 16, 2021).

231 *HSI Arrests Jamaican Woman on Medicaid Fraud Charges*, U.S. IMMIGR. & CUSTOMS ENF'T (Aug. 23, 2013), <https://www.ice.gov/news/releases/hsi-arrests-jamaican-woman-medicaid-fraud-charges>.

232 See Report and Recommendation at 5, *United States v. Puac-Gomez*, No. 18-cr-3044-CJW (N.D. Iowa Feb. 7, 2019), ECF No. 31, [https://www.govinfo.gov/content/pkg/USCOURTS-iand-3\\_18-cr-03044/pdf/USCOURTS-iand-3\\_18-cr-03044-0.pdf](https://www.govinfo.gov/content/pkg/USCOURTS-iand-3_18-cr-03044/pdf/USCOURTS-iand-3_18-cr-03044-0.pdf). Although it is not clear from the facts publicly available, since Ms. Puac-Gomez was not charged with identity theft or falsely claiming to be a U.S. citizen — and would not be eligible for Medicaid or SNAP based on her immigration status — it is likely that she had applied for benefits on behalf of eligible members of her household, possibly U.S.-citizen children.

233 INA § 212(a)(6)(C)(ii); see also *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. at 41,305 (discussing how false claims to U.S. citizenship in public benefits applications can result in a finding of inadmissibility).

234 *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. at 41,305; see also *Jordan v. De George*, 341 U.S. 223, 232 (1951) (holding that a fraud conviction is unequivocally considered a “crime involving moral turpitude”).

embraced by the Trump Administration and, before that, similar rhetoric by other politicians as well as prior instances of cooperation between public benefits and immigration agencies. A priority of the Trump Administration was to target the “abuse” of the public benefits system by noncitizens.<sup>235</sup> DHS, during this period, stepped up its investigations of naturalization fraud, employing a broad definition of fraud to engage in unprecedented efforts to denaturalize U.S. citizens on that basis.<sup>236</sup> Simultaneously, it began implementing a shadow policy of rejecting immigration applications for clerical oversights, such as leaving a response blank instead of writing “N/A” when a question does not apply to an applicant or typing an applicant’s name when it was supposed to have been handwritten.<sup>237</sup> This contributed to a policy climate of intense scrutiny and suspicion of noncitizens in their applications for immigration and public benefits. However, such policies did not originate with the Trump Administration. In a 2006 congressional hearing titled “Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System,” for example, witnesses favoring stricter verification requirements of citizenship and immigration status in Medicaid testified about the “large and growing” problem of public benefits being provided to undocumented noncitizens.<sup>238</sup> A particularly egregious example of cooperation between immigration and public benefits agencies, purportedly to root out Medicaid fraud, occurred in California in the 1990s: the Port of Entry Detection (PED) program.<sup>239</sup> Immigration agents at the Los Angeles and San Francisco airports asked noncitizens returning to the United States whether they had

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235 See, e.g., White House, *President Donald J. Trump is Ensuring Non-Citizens Do Not Abuse Our Nation’s Public Benefit* (Aug. 12, 2019), [https://trumpwhitehouse.archives.gov/briefings-statements/president-donald-j-trump-ensuring-non-citizens-not-abuse-nations-public-benefit/?utm\\_source=twitter&utm\\_medium=social&utm\\_campaign=wh](https://trumpwhitehouse.archives.gov/briefings-statements/president-donald-j-trump-ensuring-non-citizens-not-abuse-nations-public-benefit/?utm_source=twitter&utm_medium=social&utm_campaign=wh).

236 See Cassandra Burke Robertson & Irina D. Manta, *(Un)civil Denaturalization*, 94 N.Y.U. L. REV. 402 (2019).

237 See, e.g., Maddy Garber, *Rejections of Correctly Filed Immigration Applications Are Senseless and Heartless*, NAT’L IMMIGRANT JUST. CTR. (Dec. 3, 2020), <https://immigrantjustice.org/staff/blog/rejections-correctly-filed-immigration-applications-are-senseless-and-heartless>.

238 *Examining the Impact of Illegal Immigration on the Medicaid Program and Our Healthcare Delivery System: Hearings Before the H. Comm. on Energy & Com.*, 109th Cong. 8 (2006) (statement of Rep. Marsha Blackburn, Member, H. Comm. on Energy & Com.). Some of the testimony characterizing the extent of the problem suffered from logical fallacies. For example, Abel C. Ortiz, a state policy advisor from Georgia, improperly presumed that a reduction in the Medicaid caseload after the implementation of stricter document verification rules was “strong evidence of fraud and abuse inherent” under the previous system, failing to acknowledge that the stricter rules could also pose access barriers to eligible applicants. *Id.* at 120 (statement of Abel C. Ortiz, Health & Hum. Servs. Pol’y Advisor, Off. of the Gov., State of Ga.). Dr. Marty Michaels, Chair of the Georgia Chapter of the American Academy of Pediatrics, made this point in his testimony, describing how the new rules denied access to Medicaid to low-income U.S. citizen children who did not have the required paperwork. *Id.* at 159-60 (statement of Dr. Marty Michaels, Chair, Ga. Ch., Am. Acad. of Pediatrics).

239 See PARK, *supra* note 1, at 59-65.

previously used Medicaid.<sup>240</sup> If they had, they were advised to voluntarily reimburse the state public benefits agency for the cost of the benefits provided in order to avoid future immigration-related problems.<sup>241</sup> The program targeted women — disproportionately Latinas and Asians — who had legally received Medicaid coverage for pregnancy-related care, who were not suspected of fraud, and who were not subject to a public charge determination.<sup>242</sup> The PED program was suspended after a class action lawsuit resulted in a settlement.<sup>243</sup> Still, noncitizens received a clear message: “using [Medicaid] can be detrimental to your immigration status.”<sup>244</sup>

### III. HEALTH CARE SYSTEM HARMS

This Part explains the health-related tradeoffs of permitting immigration surveillance in health care.<sup>245</sup> It does not purport to be a precise cost-benefit analysis of immigration surveillance in health care; rather, it is intended to contribute to analyses of the unintended consequences of the decades-long expansion of interior immigration enforcement.<sup>246</sup> When immigration policy fails to consider its health-related consequences, it incompletely assesses the risks of certain policy choices.<sup>247</sup> It appears to assume that any purported immigration enforcement gains outweigh the costs to public health, the health care system, and

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<sup>240</sup> *Id.* at 60.

<sup>241</sup> *Id.* at 62.

<sup>242</sup> *Id.* at 60-61, 63, 68-69.

<sup>243</sup> *Id.* at 63.

<sup>244</sup> *Id.* at 73.

<sup>245</sup> This analysis is inspired by the Health in All Policies framework, which aims to “integrate[e] considerations of health, well-being, and equity during the development, implementation, and evaluation” of laws and policies across sectors. Dawn Pepin et al., *Collaborating for Health: Health in All Policies and the Law*, 45 J.L. MED. & ETHICS 60 (2017); see also Taylor, *supra* note 41, at 9 (“Many laws and policies have health effects even when, at first glance, the laws and policies do not seem to be directly related to health outcomes.”). Studies have established that immigration enforcement directly impacts the health of noncitizens, including by causing psychological damage, raising cardiovascular risk factors, and reducing birth weight. See Rhodes et al., *supra* note 23, at 329; Saadi & McKee, *supra* note 64, at k2178; Taylor, *supra* note 41, at 3; cf. Taylor, *id.* at 6 (“Research has linked positive health outcomes to protective immigration laws and policies in the US.”). Although these are important health-related harms of immigration policy, this Part focuses on the specific harms of health care system avoidance motivated by immigration surveillance in health care.

<sup>246</sup> See, e.g., Cade, *supra* note 90, at 500 (noting health-related consequences of “[i]mmigration crackdowns and equity-blind enforcement”); Jain, *supra* note 11, at 1510 (“Immigration enforcement decisions should take into account the long-term public health consequences of trauma or stress relating to enforcement.”).

<sup>247</sup> See Jain, *supra* note 11, at 1466 (noting that “policymakers have failed to appreciate the hidden costs” of heightened interior immigration enforcement); Taylor, *supra* note 41, at 9 (urging academics to “assess the nonobvious health consequences of laws and policies as a way of better understanding the consequences of the law and public policy on human health . . .”).



health care providers.<sup>248</sup>

Permitting immigration surveillance in health care (or not countering perceptions that it occurs) involves making tradeoffs between immigration and health policy goals.<sup>249</sup> The main benefit of immigration surveillance in health care is to expand potential opportunities to enforce immigration laws against undocumented noncitizens and noncitizens who are unable to demonstrate “self-sufficiency.” But it is also likely to generate health care system avoidance and therefore have negative consequences for health and health care.<sup>250</sup> The benefits of immigration surveillance in health care are mostly symbolic, reinforcing the climate of fear for noncitizens, while the costs — as this Part shows — are measurable and far reaching.

#### A. Heightened Public Health Risks

When people avoid or delay seeking health care based on fears of immigration-related consequences, they increase the risk of spreading infectious disease. This is, of course, a major concern in the era of COVID-19.<sup>251</sup> DHS was permitted to begin implementing its new public charge rule just as people in the United States began to die from COVID-19.<sup>252</sup> Predictably, the 2019 rule has deterred noncitizens from accessing testing, treatment, and vaccination for

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248 See Castañeda, *supra* note 37, at 55 (“The political logic of utilizing access to affordable health care as a tool of immigration policy is faulty . . .”).

249 See Frost, *supra* note 22, at 98 (“The federal government has always balanced immigration enforcement against other goals and values . . .”); Jawetz & Chung, *supra* note 68 (describing how DHS typically issues statements during national disasters limiting immigration enforcement because “its ‘highest priorities . . . are to promote life-saving and life-sustaining activities.’” (quoting Press Release, U.S. Dep’t Homeland Sec., DHS Statement Regarding Safety and Enforcement During Hurricane Irma (Sept. 6, 2017), <https://www.dhs.gov/news/2017/09/06/dhs-statement-regarding-safety-and-enforcement-during-hurricane-irma>)); Kalhan *supra* note 10, at 73 (“[B]oth individuals and society as a whole have legitimate interests in preserving zones in which . . . immigration surveillance activities do not take place and in making sure that when they do take place those activities are appropriately limited and constrained.”).

250 See Brayne, *supra* note 4, at 385 (“[E]fforts to evade the gaze of different systems involves an attendant trade-off. That trade-off is full participation in society.” (quoting KEVIN D. HAGGERTY & RICHARD V. ERICSON, *THE NEW POLITICS OF SURVEILLANCE AND VISIBILITY* 619 (2006))).

251 See, e.g., Makhoul & Sandhu, *supra* note 177, at 159-62 (describing how the 2019 public charge rule discourages noncitizens from accessing health care for treatment of COVID-19 symptoms and public benefits that would enable them to better comply with social distancing recommendations); Achieving a Fair and Effective COVID-19 Response: An Open Letter to Vice-President Mike Pence, and Other Federal, State and Local Leaders from Public Health and Legal Experts in the United States 2 (Mar. 2, 2020), [https://law.yale.edu/sites/default/files/area/center/ghjp/documents/final\\_covid19\\_letter\\_from\\_public\\_health\\_and\\_legal\\_experts.pdf](https://law.yale.edu/sites/default/files/area/center/ghjp/documents/final_covid19_letter_from_public_health_and_legal_experts.pdf) (recommending that “[t]he COVID-19 response should not be linked to immigration enforcement in any manner.”).

252 Makhoul & Sandhu, *supra* note 177, at 166.

COVID-19.<sup>253</sup>

However, the threat that immigration-related health care system avoidance poses to the public's health transcends the current pandemic.<sup>254</sup> For example, if noncitizen parents avoid taking their children to the doctor for well-child appointments (or applying for health coverage that will enable them to attend those appointments), they may contribute to the loss of herd immunity for vaccine-preventable diseases, such as measles. Herd immunity provides some protection to members of the community who are unable to be vaccinated, because the spread of infectious disease is contained when a critical mass of the population is vaccinated. The health risks of losing herd immunity are borne primarily by infants who are too young to be vaccinated and people with compromised immune systems due to cancer treatment or other causes.

Even though the 2019 rule has been rescinded, it is likely to chill noncitizen access to health care for the long term.<sup>255</sup> The public health impact of chilling noncitizens' access to health care is a key rationale for protecting noncitizens from surveillance while accessing health care or coverage.<sup>256</sup> It is one of the "hidden costs" to larger society of expanding interior immigration enforcement to health care sites.<sup>257</sup> Immigration authorities have historically adopted this rationale for

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253 Lee et al., *supra* note 15, at 1-2; Flores et al., *supra* note 66; Raúl Grijalva et al., *An Equitable Distribution of COVID-19 Vaccine Must Include Noncitizens*, THE HILL (Jan. 26, 2021), <https://thehill.com/blogs/congress-blog/healthcare/535901-an-equitable-distribution-of-covid-19-vaccine-must-include> (explaining the importance of federal leadership to assure noncitizens that "vaccine recipients' information will not be shared with immigration agencies for enforcement purposes or to jeopardize future immigration applications under the public charge regulations"); Shoichet, *supra* note 8.

254 This is not to say that fears of contagion by noncitizens should be the primary motivation for limiting immigration surveillance in health care. Indeed, ethnic contagion is an antiquated trope that has justified flagrant violations of liberty against noncitizens in the past. For example, fears of bubonic plague in San Francisco in 1900 were the basis of public health orders that forcibly inoculated residents of Asian descent with an experimental vaccine and imposed an unjustified quarantine of Chinatown. *See, e.g., Wong Wai v. Williamson*, 103 F. 1, 6 (C.C.N.D. Cal. 1900); *Jew Ho v. Williamson*, 103 F. 10, 26 (C.C.N.D. Cal. 1900). During the COVID-19 pandemic, Anti-Asian hate crimes have surged in the United States, presumably because of the virus' origin in China. *See, e.g., Jaweed Kaleem et al., Anti-Asian Hate Crimes and Harassment Rise to Historic Levels during COVID-19 Pandemic*, L.A. TIMES (Mar. 5, 2021), <https://www.latimes.com/world-nation/story/2021-03-05/anti-asian-crimes-harassment>.

255 *See, e.g., GUERRERO ET AL., supra* note 182, at 4, 6, 12.

256 *See Cleek, supra* note 88, at 1000; Saadi & McKee, *supra* note 64, at k2178.

257 Jain, *supra* note 11, at 1491-92 (explaining that some of the costs of interior immigration enforcement are "structural" and "not unique to immigration"). Undocumented noncitizens are an important component of the U.S. essential workforce, especially in the fields of agriculture, housing and facilities, food services and production, transportation, and health. *See, e.g., FWD.US, IMMIGRANT ESSENTIAL WORKERS ARE CRUCIAL TO AMERICA'S COVID-19 RECOVERY* 8-9 (2020), <https://www.fwd.us/wp-content/uploads/2020/12/FWD-essential-worker-report-FINAL-WEB.pdf>. Therefore, barriers to care for this population should be considered a threat to the nation's critical infrastructure.

announcing the suspension of immigration enforcement at or near health care sites during national disasters and other public health emergencies.<sup>258</sup>

Immigration surveillance in health care is just one of many access barriers that create heightened public health risks among noncitizens,<sup>259</sup> but it is one for which there is a clear remedy. It is a reasonable, logical next step for policymakers to recognize immigration surveillance in health care as a perennial threat to public health.

### B. *Inefficient Use of Health Care Resources*

When immigration concerns cause people to delay or avoid seeking health care or coverage (a means to obtaining health care), it is harder for health care providers to generate good health outcomes and thereby reduces cost-effectiveness in the health care system.<sup>260</sup> Annual check-ups for older children and adults are an important way to identify emerging health issues. For younger children, more frequent well-child visits are critical for detecting growth or developmental issues and getting vaccines. It is particularly important for patients who have been diagnosed with chronic disease to see their health care provider regularly to ensure that the disease is appropriately managed.<sup>261</sup> When health issues are not identified early, treatment begins later — sometimes when a disease is at a more advanced stage.<sup>262</sup> When chronic diseases are poorly managed, the risks of becoming

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<sup>258</sup> Flores et al., *supra* note 66.

<sup>259</sup> Additional social determinants of health that increase noncitizens' risk of exposure to and negative outcomes from COVID-19 include reliance on underfunded health care providers with limited ability to manage patients' care due to lack of insurance, higher incidence of underlying health conditions linked to severe COVID-19 symptoms, "excessive stress related to poverty, trauma, and poor social support," the need to continue working jobs in which social distancing is not possible, reliance on public transportation, living in multigenerational households or with roommates, limited English proficiency, and limited access to cell phones or the internet. Eva Clark et al., *Disproportionate Impact of the COVID-19 Pandemic on Immigrant Communities in the United States*, PLOS NEGLECTED TROPICAL DISEASES, July 13, 2020, at 2-3.

<sup>260</sup> Cost-effectiveness or "better value" is a goal of U.S. health care policy. See Gustavo Mery et al., *What Do We Mean When We Talk About the Triple Aim? A Systematic Review of Evolving Definitions and Adaptations of the Framework at the Health System Level*, 121 HEALTH POL'Y 629, 633 (2017) (explaining that the Triple Aim, an organizing framework for U.S. health care system reform, can be understood as a proxy for cost-effectiveness).

<sup>261</sup> See Rhodes et al., *supra* note 23, at 329 (noting that delayed treatment by noncitizens who fear immigration enforcement can "lead to incomplete sequences of care [and] promote the use of nonstandard and unsafe contingencies for care").

<sup>262</sup> See, e.g., KLINE, *supra* note 44, at 126 ("[I]ncreasingly, chronic, long-term conditions are not naturally occurring ones, but are those for which the political will and economic resources are simply not brought to bear for a given community." (quoting Lenore Manderson & Carolyn Smith-Morris, *Introduction*, in CHRONIC CONDITIONS, FLUID STATES: CHRONICITY AND THE ANTHROPOLOGY OF ILLNESS 18 (Lenore Manderson & Carolyn Smith-Morris eds., 2010))); Arijit Nandi, Sana Loue & Sandro Galea, *Expanding the Universe of Universal Coverage: The Population Health Argument for Increasing Coverage for Immigrants*, 11 J. IMMIGRANT & MINORITY HEALTH 433, 435 (2009)

seriously ill or dying increase.<sup>263</sup> In both cases, delayed treatment is cost-ineffective and may also be less effective clinically.<sup>264</sup> One example of this is late or inadequate uptake of prenatal care, which can result in pregnancy complications that lead to extremely costly postnatal and pediatric care.<sup>265</sup>

Delayed treatment is a source of inefficiency in the health care system in several ways.<sup>266</sup> First, it can contribute to driving up insurance-related costs for all. When noncitizens are deterred from accessing routine health care and only seek care when health issues become more complex or emergent, the treatment can be costlier. Consider, for example, an insulin-dependent diabetic patient who skips a doctor's appointment and is later admitted to the hospital with severe hypoglycemia — a situation that could have been avoided with routine case management. This more expensive care translates to higher costs for insurers, including public health insurance programs, if the noncitizen has or later qualifies for coverage. This could drive up insurance premiums in the private market and the costs of taxpayer-funded public health insurance. Second, when noncitizens decline to enroll in public health insurance programs for which they are eligible and are ultimately unable to pay for health care costs out-of-pocket, it can increase uncompensated care costs for hospitals and physician' offices — especially hospitals that are obligated to provide treatment to stabilize patients in emergencies.<sup>267</sup> Third, immigration-related health care system avoidance causes inefficiency for physician practices. Every “no-show” appointment wastes providers' time and represents a loss of potential reimbursement. Also, poor patient

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(noting the higher likelihood of the undocumented population to delay seeking care and, when they do, to have preexisting disease); Saadi & McKee, *supra* note 64, at 1 (“[P]eople with preventable or chronic conditions risk delays that may worsen their condition and increase visits to emergency departments.”).

263 See Hacker et al., *supra* note 2, at 180 (describing the health consequences of the well-known fact that noncitizens underutilize health care services); Hacker et al., *supra* note 43, at 661 (noting patients with immigration concerns are often harder “to contact . . . to [e]nsure that recommendations on health conditions are met, leading to exacerbation of chronic conditions such as diabetes and hypertension.”).

264 Kullgren, *supra* note 51, at 1632 (noting that policies that cause noncitizens to delay seeking health care for conditions until they are emergent “prevents administrators from putting public resources to their most cost-effective use”); Nandi et al., *supra* note 263, at 435 (describing how delayed care-seeking by patients with diabetes and asthma can lead to unnecessary complications).

265 Lawrence O. Gostin, *Is Affording Undocumented Immigrants Health Coverage a Radical Proposal?*, 322 JAMA 1438, 1438 (2019).

266 Delayed treatment increases societal and economic costs in other ways as well, such as by increasing school absenteeism and parental work absence, but this discussion is limited to cost-effectiveness within the health care system. Lee et al., *supra* note 15, at 6.

267 See, e.g., U.S. GEN. ACCT. OFF., GAO-04-472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS' UNCOMPENSATED CARE COSTS 12 (2004), <https://www.gao.gov/assets/250/242452.pdf> (describing reports from state Medicaid officials and hospital association members that “fear of being discovered by immigration authorities is one factor that can deter undocumented aliens from enrolling” in emergency Medicaid).

health outcomes caused by interrupted case management can reduce the practice's reimbursement in value-based payment programs.

### C. *Interference with Professional Ethical Duties*

Permitting immigration surveillance in health care creates ethical dilemmas for health care providers. Providers cannot act with single-minded devotion to the well-being of patients when patients' engagement with the health care system may have negative immigration consequences. As a result, providers are sometimes forced to alter clinical risk calculations and clinical recommendations for reasons relating to immigration enforcement. In addition, laws and policies that make health care providers complicit with immigration enforcement — or create the perception of complicity — negatively impact the provider-patient relationship.

Immigration surveillance in health care limits health care providers' ability to care for noncitizen patients based on their best clinical judgment.<sup>268</sup> When they cannot guarantee that accessing health care or coverage will not lead to negative immigration consequences for noncitizen patients,<sup>269</sup> patients may withdraw from their care and perhaps seek alternative sources of care.<sup>270</sup> Patients who remain may trust their provider less.<sup>271</sup> After the 2016 election, health care providers reported having to alter their clinical risk calculations and recommendations: They discounted biological risks in order to account for “the social risks of detention, deportation, and family separation” in the new immigration policy climate.<sup>272</sup> Providers may feel compelled to consider the potential immigration consequences of a noncitizen patient enrolling in public health insurance in order to access health care against the risks of having an untreated medical condition.<sup>273</sup> Others may feel compelled, for financial reasons, to “push” patients to enroll in Medicaid so that they can be reimbursed for services provided, regardless of the potential impact on a patient's future immigration options.<sup>274</sup> Simply having to do this type of

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<sup>268</sup> See PARK, *supra* note 1, at 93-94.

<sup>269</sup> *Id.* (describing how the 1996 federal immigration law left health care providers “limited in what they can say or do for their patients”); Hardy et al., *supra* note 31, at 1250 (discussing the difficulty health care providers have with understanding their obligations under SB 1070, a 2010 Arizona law enhancing immigration policing); Licon, *supra* note 63 (quoting Dr. Elisabeth Poorman, “The ground is constantly shifting. I can tell the patient I am committed to your safety, but in the [Trump] administration we cannot tell everyone that they are 100% safe”).

<sup>270</sup> PARK, *supra* note 1, at 133 (describing how some noncitizens in San Diego who feel unsafe accessing health care self-diagnose, visit alternative healers, or obtain care and medicine from pharmacies in Mexico).

<sup>271</sup> *Id.* at 95.

<sup>272</sup> Van Natta, *supra* note 21, at 1; *see also* KLINE, *supra* note 44, at 124 (describing one doctor's consideration of patients' immigration status when making recommendations for follow-up care).

<sup>273</sup> Van Natta, *supra* note 21, at 3.

<sup>274</sup> See PARK, *supra* note 1, at 94.

calculation makes some providers feel complicit with immigration enforcement and contributes to provider burnout.<sup>275</sup>

When immigration laws and policies require health care providers to cooperate with immigration authorities, it can damage provider-patient relationships and arguably constitutes an unjustified interference with their practice. Health care providers may be asked to verify a patient's identity or immigration status (or lack thereof).<sup>276</sup> They may be asked by immigration enforcement officers to perform examinations of detainees who are suspected of carrying drugs.<sup>277</sup> Whether they choose to cooperate or not, it puts providers in a difficult situation. Members of the health care profession have an ethical obligation to "act for the good of all of their patients, irrespective of their category memberships."<sup>278</sup> This ethical principle, which originates in the Hippocratic Oath, is often restated as "do no harm."<sup>279</sup> The focus of the provider-patient relationship is healing. Actual or perceived complicity with immigration enforcement interferes with this goal, as well as with providers' broad ethical obligation to protect patient privacy.<sup>280</sup>

#### D. Violation of Health Equity Norms

Policies permitting immigration surveillance in health care primarily affect noncitizens, compounding disadvantage, particularly for undocumented people

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275 Van Natta, *supra* note 21, at 5-6. Patients' fears of immigration surveillance in health care can also leave providers feeling helpless in the face of their patients' suffering, which can be frustrating and distressing. PARK, *supra* note 1, at 135 (describing a health care provider's reactions to treating a patient with uterine cancer who needed a hysterectomy but repeatedly declined because of a fear of deportation).

276 See KLINE, *supra* note 44, at 117-18 (describing providers outrage over Georgia's HB 87, which limited providers' ability to provide care to undocumented people); PARK, *supra* note 1, at 123 (describing a case in which a CBP officer called a San Diego prenatal health clinic from a U.S.-Mexico border crossing to ask if a patient was indeed a U.S. citizen).

277 See, e.g., Melissa del Bosque, *Checkpoint Nation*, TEX. OBSERVER (Oct. 8, 2018), <https://www.texasobserver.org/checkpoint-nation/> (describing evidence that health care providers routinely cooperate with CBP to perform warrantless and consent-less body cavity searches and medical imaging of detainees, and how providers may feel compelled to comply with CBP officers requesting such procedures).

278 Jeff Sconyers & Tyler Tate, *How Should Clinicians Treat Patients Who Might Be Undocumented?*, 18 AMA J. ETHICS 229, 233 (2016).

279 See Song, *supra* note 6, at 41 (noting that the phrase itself is not contained in the original Hippocratic Oath); Robert H. Shmerling, *The Myth of the Hippocratic Oath*, HARV. HEALTH BLOG (Nov. 25, 2015), <https://www.health.harvard.edu/blog/the-myth-of-the-hippocratic-oath-201511258447> (noting that the original Hippocratic Oath includes a promise to avoid harming patients).

280 See Song, *supra* note 6, at 59 (discussing the expansive concept of privacy in the medical context, including the obligation "to protect patient privacy in all settings to the greatest extent possible" (quoting *Code of Medical Ethics Opinion 3.1.1*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/privacy-health-care>)).

and their family members.<sup>281</sup> Noncitizens are considered a disadvantaged, stigmatized, and vulnerable population in the health care sphere.<sup>282</sup> When people delay or avoid seeking health care because of concerns about immigration surveillance, their risk of suffering or dying from treatable and preventable conditions increases.

Such policies exacerbate racial and ethnic health and health care disparities, violating health equity norms in U.S. health policy.<sup>283</sup> Surveillance efforts in health care settings that are focused on undocumented noncitizens may result in discrimination against noncitizens generally and the Latinx population in particular, and the misapplication of enforcement-related policies to these groups.<sup>284</sup> Since immigration authorities know that undocumented noncitizens are typically limited to accessing health care at community health centers and hospital emergency rooms, they may focus surveillance efforts there. Such locations are also disproportionately likely to serve low-income people, lawfully present noncitizens, and communities of color; therefore, policies permitting immigration surveillance in health care contribute to the racial and class-based stratification of the health care system.<sup>285</sup>

#### IV. LEGITIMACY HARMS

This Part describes three ways in which the state compromises its legitimacy through laws and policies permitting immigration surveillance in health care. First, these laws and policies impose severe and burdensome constraints on noncitizens' ability to understand how and when they may access publicly funded health care without incurring negative immigration consequences. Second, they require applicants for immigration benefits to waive the confidentiality rights conferred by the statutes governing publicly funded health care programs. Third, they undermine noncitizens' property rights in health-related public benefits by

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281 See Taylor, *supra* note 41, at 7 (“[P]opulations with multiple disadvantaged statuses have increased risk of negative health outcomes . . .”); Brayne, *supra* note 4, at 387 (describing system avoidance as “implicated in the accumulation of disadvantage” of marginalized subpopulations).

282 See, e.g., Hacker et al., *supra* note 43, at 661; Taylor, *supra* note 41, at 1.

283 See KLINE, *supra* note 44, at 127 (describing one doctor’s opinion of an enhanced immigration policing law as racist, which threatens its legitimacy and potentially violates professional ethics); Callaghan et al., *supra* note 23, at 342 (describing politically-driven barriers to enrollment in health care programs among Hispanics); Hardy et al., *supra* note 31, at 1250 (positing that Arizona’s SB 1070, which enhanced immigration policing, could exacerbate racial and ethnic health disparities); Lee et al., *supra* note 15, at 1 (noting the impact of heightened immigration enforcement on Latinos’ participation in health care programs).

284 See KLINE, *supra* note 44, at 150 (describing racial profiling of Latinx patients in medical settings based on assumptions that they are undocumented); Rhodes et al., *supra* note 23, at 332; Taylor, *supra* note 41, at 6-7.

285 See Song, *supra* note 6, at 13 (describing race and class-based stratification of urgent and emergency care sites).

threatening a deprivation of liberty based on the exercise of those rights.

The complexity, inconsistency, and vagueness of the laws and policies regulating immigration surveillance in health care compromise the legitimacy of the state because they make it almost impossible for laypeople to understand their rights and the consequences of exercising those rights.<sup>286</sup> Studies have long documented how confusion about newly enacted laws impacting noncitizens' access to public benefits has chilled noncitizen enrollment in Medicaid. For example, chilling effects were observed after the 1996 immigration and welfare laws both complicated noncitizen eligibility for Medicaid and the application process.<sup>287</sup> The lack of clarity in the law helps to create the perception that accessing health care or public health insurance is inherently risky for all noncitizens.<sup>288</sup>

In addition, the laws permitting immigration surveillance in health care create legitimacy harms because they encourage or require noncitizens to relinquish their privacy rights in their public benefits records. This is especially apparent in the context of the 2019 public charge regulations, which used Medicaid, a safety-net benefit that supports health and well-being, as the means of “disciplining” noncitizens.<sup>289</sup> This approach makes the privacy laws appear less legitimate because it creates normative confusion around the state’s commitment to ensuring privacy in health-related matters.<sup>290</sup> It incentivizes behaviors that lead to unjust and arbitrary consequences for noncitizens’ health, as described in Part I. The gaps between privacy rights formally conferred by law and “whether the rights may be utilized and exercised” constitute a legitimacy problem for privacy law.<sup>291</sup>

Similarly, immigration surveillance in health care undermines noncitizens’ property rights in health-related public benefits because exercise of those rights can result in a deprivation of liberty: detention and deportation. It creates normative confusion around the state’s commitment to ensuring the health and

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286 See KLINE, *supra* note 44, at 128 (describing confusion among providers about how to interpret new immigration policing laws that implicate health care providers); Cleek, *supra* note 88, at 989-90 (describing how state variations in enforcement of sensitive locations policies and officer-level deviations from official policy create uncertainty); Goodwin & Chemerinsky, *supra* note 149, at 1293 (describing, in a parallel context, how “the state has compromised its legitimacy by imposing insurmountably severe and burdensome constraints on reproductive health and rights such that it would require the artistry of a magician or pertinacity of an elite athlete to overcome”).

287 PARK, *supra* note 1, at 36, 65 (discussing the lack of transparency and vagueness of public charge policy and “wide variations in . . . interpretation of fraudulent behavior” in the 1990s).

288 Callaghan et al., *supra* note 23, at 345 (describing how undocumented noncitizens rely on word-of-mouth information to learn about “safe” health care sites).

289 Van Natta, *supra* note 21, at 7.

290 See Frost, *supra* note 22, at 104 (discussing, in a related context, how use of information submitted with DACA applications to later deport noncitizens “would chill applications, undermining the purpose of these laws”).

291 Goodwin & Chemerinsky, *supra* note 149, at 1298.



wellbeing of noncitizens, expressed through laws making them eligible to receive health-promoting public benefits. The right to receive assistance from the state to access health care becomes a “paper right” — one that the right holder cannot sensibly exercise.<sup>292</sup> These normative issues could become legal issues if courts were to recognize a substantive due process right to information privacy based on data-sharing or collection practices that deprive noncitizens of dignity and liberty.<sup>293</sup>

## V. SANCTUARY AS SOLUTION

Sanctuary policies, whether public or private, “increase the ability of . . . noncitizens to engage with government or community institutions without detection or apprehension by federal immigration authorities.”<sup>294</sup> Noncitizens’ freedom to engage in the typical activities of daily life without fear of immigration surveillance is a “precedential touchstone” embraced by the U.S. Supreme Court, most evidently, in *Arizona v. United States*.<sup>295</sup> Health care sanctuaries can reduce immigration-related health care system avoidance by establishing and strengthening informational “safe harbors,” so that noncitizens interacting with health care institutions in routine and desirable ways are not at risk of surveillance.<sup>296</sup> Laws and policies can create health care sanctuaries, but non-governmental organizations can also do so by limiting their cooperation with immigration enforcement to what is minimally required under the law,<sup>297</sup> and by providing noncitizens with physical refuge, legal assistance, or other community aid.<sup>298</sup>

Health care sanctuaries restore some fairness to immigration policy by balancing the indiscriminate pursuit of immigration enforcement with other public policy goals and values.<sup>299</sup> The previous two Parts illustrate how preferences about immigration policies may change when health and legitimacy considerations are incorporated. Immigration surveillance in health care undercuts certain health policy goals and values and is particularly detrimental to health care institutions seeking to best serve their patients. It also compromises the legitimacy of the state

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<sup>292</sup> *Id.* at 1297.

<sup>293</sup> See BRIDGES, *supra* note 88.

<sup>294</sup> Cade, *supra* note 90, at 468.

<sup>295</sup> 567 U.S. 387 (2012); see Cade, *supra* note 90, at 490-92.

<sup>296</sup> Brayne, *supra* note 4, at 386 (noting that European regulations could serve as a model for a U.S. effort to limit noncitizens’ risks of apprehension when accompanying a child to an appointment or signing up for public health insurance).

<sup>297</sup> Cade, *supra* note 90, at 440 (explaining how such efforts by municipalities and campuses “impose an ‘equitable screen’ at the front end of the [immigration enforcement] system”).

<sup>298</sup> *Id.* at 468.

<sup>299</sup> *Id.* at 480, 495 (arguing that sanctuary policies “can promote legitimacy in the removal system” and “promote competing norms of justice and empathy” in immigration policy).

in several ways. This Part explains how law and institutional policies can act on those changed preferences as “an adaptive response” to the expansion of interior immigration enforcement.<sup>300</sup> Creating health care sanctuaries is a way to address the systemic costs of interior immigration enforcement.<sup>301</sup>

Once health care sanctuary policies are established, well-enforced, and well-known, there is reason to believe that their positive effect on care-seeking by noncitizens will endure even if future administrations crack down on immigration enforcement. Studies of system avoidance have found that subjects do not avoid institutions generally; they specifically avoid recordkeeping institutions.<sup>302</sup> If health care provider sites and public benefits agencies administering health benefits are designated as sanctuaries, they will likely be considered safe spaces for noncitizens even if the political climate changes. However, to be effective, it is critical that information about health care sanctuaries is communicated clearly and deliberately to immigrant communities by trusted messengers.<sup>303</sup>

### A. *Legal Reforms*

While the ultimate solution to health care system avoidance for undocumented noncitizens may be immigration reform that gives them a path to citizenship,<sup>304</sup> such reform may not come any time soon, nor would it address the larger issue of immigration surveillance in health care that deters lawfully present noncitizens from enrolling in public health insurance. In the meantime, there are legal reforms that can address this problem immediately. Health care sanctuary laws can address sources of health care system avoidance for both populations.

There is expressive value in legislation at any level that limits information-sharing from health care providers and public benefits agencies to immigration authorities.<sup>305</sup> Such laws influence cultural beliefs about where immigration enforcement activities should occur, which could ultimately influence courts’ interpretations of substantive due process rights to information privacy.<sup>306</sup> Similarly, positive law at any level limiting immigration enforcement activities at health care provider sites based on considerations of individual autonomy and

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300 Jain, *supra* note 11, at 1505.

301 *Id.* at 1468.

302 Brayne, *supra* note 4, at 385 (noting that subjects with prior criminal justice involvement continued to engage with volunteer organizations and religious groups); Patler & Gonzalez, *supra* note 4, at 10 (noting that formerly detained noncitizen subjects continued participating in church activities).

303 See Jain, *supra* note 11, at 1506; Saadi & McKee, *supra* note 64, at 1 (describing New York City Health and Hospitals’ messaging in the form of an “open letter to immigrant New Yorkers”).

304 See, e.g., Hacker et al., *supra* note 2, at 179.

305 Citron, *supra* note 70, at 1159 (explaining, in the context of the privacy rights of poor mothers enrolled in Medicaid, “[l]aw is our teacher and guide. It shapes social norms and behaviors”).

306 See BRIDGES, *supra* note 88; Citron, *supra* note 70, at 1159.

dignity could influence courts' interpretations of what is considered a reasonable expectation of privacy in health care settings.<sup>307</sup> This Section proposes some ways in which legislative bodies and executive branch agencies might consider creating health care sanctuaries.

The current administration has announced plans for both immigration and health reform. A national strategy on immigrant health could guide Congress, DHS, and HHS on how to balance immigration and health policy goals; national strategies are particularly well suited for addressing complex issues.<sup>308</sup> A national strategy arising from an executive order or federal legislation could be a catalyst for more interagency coordination on issues relating to immigrant health and health care access. It could be based on the Health in All Policies (HiAP) approach, which aims to “achiev[e] better public health outcomes through increased intersectoral collaboration.”<sup>309</sup> An immigrant health task force could coordinate HiAP efforts involving multiple agencies.<sup>310</sup>

Alternatively, the President and Congress may consider creating a new agency or consolidating existing agencies to prioritize the elimination of health care access barriers in vulnerable communities, including in immigrant communities.<sup>311</sup> In a different context, Emily Broad Leib and Margot Pollans discuss the value of “drawing together components of several preexisting agencies” to coordinate action on important national issues.<sup>312</sup> This option avoids the need to coordinate across agencies, which can become complicated.<sup>313</sup> A single agency focused on addressing inequitable access to health care could be particularly adept at analyzing how health care sanctuary policies might also eliminate race, ethnicity, and class-related barriers for U.S. citizens and lawfully present noncitizens.<sup>314</sup>

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307 See Song, *supra* note 6, at 58-62 (proposing a reasonable expectation of privacy standard in hospital emergency rooms that is based on the concept of medical privacy).

308 See, e.g., Emily M. Broad Leib & Margot J. Pollans, *The New Food Safety*, 107 CALIF. L. REV. 1173, 1240 (2019) (advocating for a national food strategy).

309 See Pepin et al., *supra* note 245, at 61.

310 See *id.*

311 See Broad & Leib, *supra* note 309, at 1244 (discussing how a consolidated agency can “prioritize a salient issue of national importance”).

312 *Id.* at 1244 (proposing new ways to regulate food safety and citing, as examples of consolidating existing agencies, the creation of the Environmental Protection Agency and the Department of Homeland Security).

313 Although there may be opportunities for several agencies to coordinate on eliminating health care access barriers for noncitizens, the two most important are HHS and DHS. Within HHS itself, several offices and operating divisions seek to address health disparities as part of their mission. These include the Office of Minority Health, the Agency for Healthcare Research and Quality, the National Institute on Minority Health and Health Disparities within the National Institutes of Health, the Office of Minority Health within the Center for Medicaid & Medicare Services, the Office of Minority Health & Health Disparities within the CDC, the Health Resources and Services Administration, and the Office for Civil Rights.

314 See Cade, *supra* note 90, at 493 (describing how sanctuary policies generally can discourage

Part of a national strategy on immigrant health could include enacting a federal Protecting Sensitive Locations Act, which would build on and improve DHS's sensitive locations policies. Political barriers in the past have prevented such an Act from being passed.<sup>315</sup> The Act addresses many of the weaknesses of the sensitive locations policies: It applies uniform standards to all individuals performing immigration enforcement functions; specifies a protected zone of 1,000 feet around a sensitive location; requires officers to discontinue enforcement actions that began at other locations but that move near sensitive locations; and considers "any medical treatment or health care facility" to be a sensitive location.<sup>316</sup> Enforcement actions that may occur at sensitive locations must have prior approval and be justified based on exigent circumstances; notably, exigent circumstances is defined with precision.<sup>317</sup> Finally, the Act provides some accountability measures. Most importantly, information obtained from enforcement actions that violate the law cannot be used against a noncitizen in removal proceedings, and the noncitizen may move to terminate the proceedings.<sup>318</sup> The Act also requires DHS to conduct annual training for officers about the sensitive locations law and to report to Congress about enforcement actions conducted at sensitive locations.<sup>319</sup> Passing the Protecting Sensitive Locations Act would be a positive step toward limiting immigration surveillance in health care. However, the final version of the Act should seek to limit DHS officers from conducting even the limited investigatory activities that they are permitted to conduct at sensitive locations, since such activities alone can deter noncitizens from accessing services.

DHS can immediately address concerns about surveillance at health care provider sites because it has significant discretion to set priorities and allocate resources toward this objective. Such action would fit squarely within the agency's mission of protecting life and safety, which is its highest priority, surpassing ordinary immigration enforcement practices.<sup>320</sup> One potential action would be to issue a new sensitive locations policy memo strengthening enforcement of the policies, clarifying points of confusion, and expanding their scope. This could be

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system avoidance among citizens and LPRs, especially Latinos).

315 See Katie Mettler, *Democrats Want to Limit ICE Power by Banning Agents from Courthouses, Bus Stops*, WASH. POST (Apr. 3, 2017), <https://www.washingtonpost.com/news/morning-mix/wp/2017/04/03/democrats-want-to-limit-ice-power-by-banning-agents-from-courthouses-bus-stops/>. The Act was introduced in both houses of Congress in 2019. S. 2097, 116th Cong. (2019); H.R. 1011, 116th Cong. (2019). The Act was most recently introduced in the House on January 28, 2021. H.R. 529, 117th Cong. (2021).

316 S. 2097 § 2; H.R. 1011 § 2.

317 S. 2097 § 2; H.R. 1011 § 2.

318 S. 2097 § 2; H.R. 1011 § 2.

319 S. 2097 § 2; H.R. 1011 § 2.

320 Flores et al., *supra* note 66.

done relatively quickly.

States could also play an important role as “privacy norm entrepreneurs” for noncitizens’ health-related information, a role they have played in other contexts.<sup>321</sup> State public benefits agencies that have not modified their applications for public health insurance to ensure that only applicants are required to provide their citizenship and immigration status and SSN should do so. These agencies should also provide clear information on the applications themselves about how they will use applicants’ personal information and the confidential protections that apply. For example, agencies could state explicitly that they will only use SSNs to verify income and will not share them with immigration authorities. This message should be reinforced throughout the eligibility determination process. States should also create applications for Medicaid and CHIP separate from applications for other public benefits because Medicaid and CHIP have stronger confidentiality protections and do not require families or households to apply for benefits as a unit. These relatively simple state-level reforms could go a long way toward addressing noncitizens’ fears of applying for public health insurance.

Community outreach should also be an essential part of the state’s strategy to regain the trust of immigrant communities that have felt betrayed by the punitive immigration policies of the Trump Administration. However, it will be an uphill climb. Efforts to build trust should begin at the institutions closest to the ground, such as the public benefits agencies where noncitizens apply for public health insurance.<sup>322</sup> A challenge for public benefits agencies is to increase trust between applicants and agency caseworkers, among whom turnover is high.<sup>323</sup> One strategy may be to co-locate agency caseworkers at trusted institutions, such as health care provider sites in immigrant communities.<sup>324</sup> Another strategy is to promote a welcoming culture at public benefits agencies and in official materials using signage, videos, and community presentations that emphasize noncitizens’ rights to access publicly funded health care and transparency about any possible immigration-related consequences.

### *B. Institutional Reforms*

In the absence of legal immigration reform that comprehensively addresses immigration surveillance in health care, health care institutions should consider what policies they can implement independently to become health care sanctuaries.<sup>325</sup> Health care providers have the unique role of safeguarding the

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321 Citron, *supra* note 70, at 1157.

322 See PARK, *supra* note 1, at 41.

323 See *id.*

324 See *id.*

325 Callaghan et al., *supra* note 23, at 346 (recommending that providers “explore strategies to increase trust in the health system and to disassociate health seeking from generalized immigration

health and wellbeing of their patients, and this role justifies limiting cooperation with immigration enforcement to the minimum degree necessary.<sup>326</sup> Providers are also respected spokespeople who can potentially shape public discourse in support of immigration policies that promote individual and public health.<sup>327</sup> Although some health care providers and professional organizations have spoken out and acted against immigration enforcement-related interference with their professional duties,<sup>328</sup> it is clear that there is much more work that can and should be done.<sup>329</sup>

Health care providers are becoming increasingly aware of the important role they can play in countering immigration-related health care system avoidance,<sup>330</sup> and some have taken steps to transform their institutions to this end.<sup>331</sup> For example, a recent commentary described the development and accomplishments of the Immigrant Task Force at Boston Medical Center, which was created in 2017 to respond to noncitizen patients' increasing fears of accessing health care.<sup>332</sup> Dr. Altaf Saadi has developed a website<sup>333</sup> and toolkit<sup>334</sup> based on her study of health

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fear"); Jain, *supra* note 11, at 1466; Song, *supra* note 6, at 62 (recommending institutional reform to limit law enforcement activities in hospital ERs).

326 See Cade, *supra* note 90, at 478 (arguing, in a parallel context, that colleges and universities have a unique role of educating and protecting their students, including undocumented students).

327 *Id.* at 441 (describing the importance of the credibility of institutions in the success of sanctuary efforts).

328 See, e.g., KLINE, *supra* note 44, at 122 (describing a 2017 statement by the American Academy of Pediatrics expressing its opinion that the Trump Administration's immigration policies harm children's health and a 2019 American Medical Association (AMA) statement calling for an end to family separation); Licon, *supra* note 63 (describing a 2019 AMA statement that "patients should not fear that entering a hospital will result in arrests or deportation"); Meyer, *supra* note 59 (describing initiatives undertaken by Puentes de Salud, a free clinic in Philadelphia, such as posting welcoming signs and demarcating certain areas as "private property").

329 See, e.g., La Charite et al., *supra* note 63, at 51 (noting that efforts to develop protocols to respond to immigration surveillance are "not widespread"); Licon, *supra* note 63 (describing the lack of universal policies for how hospital staff should interact with immigration authorities); Meyer, *supra* note 59 (describing health clinic leaders who claim there are "no good solutions" for addressing patients' fears of immigration enforcement).

330 See, e.g., Mark G. Kuczewski et al., *Good Sanctuary Doctoring for Undocumented Patients*, 21 *AMA J. ETHICS* 78 (2019); Altaf Saadi et al., *Making a Case for Sanctuary Hospitals*, 318 *JAMA* 2079 (2017); *Treating Fear: Sanctuary Doctoring*, NEISWANGER INST. FOR BIOETHICS & HEALTHCARE LEADERSHIP, <https://hsd.luc.edu/bioethics/content/sanctuary-doctor/>.

331 See, e.g., Altaf Saadi et al., *Assessment of Perspectives on Health Care System Efforts to Mitigate Perceived Risks Among Immigrants in the United States: A Qualitative Study*, *JAMA NETWORK OPEN*, Apr. 17, 2020, at 1 (describing policies and practices adopted by 25 health care institutions across five states to counter immigration-related health care system avoidance and generally address immigration-related fears among patients).

332 See Sondra S. Crosby et al., *The Boston Medical Center Immigrant Task Force: An Alternative to Teaching Immigration Law to Health Care Providers*, 49 *J.L., MED., & ETHICS* 59, 62 (2021).

333 *DRS. FOR IMMIGRANTS*, <http://doctorsforimmigrants.com/> (last visited July 16, 2021).

334 ALTAF SAADI, *DRS. FOR IMMIGRANTS, WELCOMING AND PROTECTING IMMIGRANTS IN HEALTHCARE SETTINGS: A TOOLKIT DEVELOPED FROM A MULTI-STATE STUDY*,

care institutions that have implemented policies to address immigration-related fears of their patients. And prominent national organizations such as the American Civil Liberties Union, the National Immigration Law Center, and Physicians for Human Rights have published resources that encourage health care providers to adopt policies and practices that protect noncitizens' ability to access health care.<sup>335</sup> For many health care providers, such efforts align with a more general mission of providing equitable access to health care, particularly for vulnerable populations.<sup>336</sup> The remainder of this Section describes reforms for aspiring health care sanctuaries that have been suggested by advocacy groups and described in the scholarly literature.

Health care institutions can develop internal protocols for protecting noncitizen patients from interrogation, search, and arrest if immigration authorities come onsite.<sup>337</sup> Some institutions have developed “rapid response teams” of designated staff who are available on-call to respond to such appearances.<sup>338</sup> Members of the team may be responsible for communicating the institution's policies, ensuring that immigration authorities are complying with the laws and policies that discourage immigration surveillance activities at health care sites, and otherwise resolving any requests or actions promptly and without causing alarm to any patients present. In large health systems, members of rapid response teams may include health care providers, attorneys from the office of general counsel, social workers, privacy officers, representatives from the medical records department, members of the clinical ethics consultation service, and high-level administrators focused on patient experience. Academic medical centers may also

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<https://doctorsforimmigrants.com/wp-content/uploads/2020/01/WelcomingProtectingImmigrants-toolkit-3.pdf> (last visited July 16, 2021).

<sup>335</sup> See, e.g., ACLU BORDER RTS. TEX. ET AL., HEALTH CARE PROVIDERS: PRESERVE ACCESS TO CARE AND PROTECT YOUR PATIENTS FROM BORDER PATROL AND ICE INTERFERENCE (2020), [https://www.aclu.org/sites/default/files/field\\_document/nilc\\_aclu\\_healthcareprovidersguide.pdf](https://www.aclu.org/sites/default/files/field_document/nilc_aclu_healthcareprovidersguide.pdf); NAT'L IMMIGR. L. CTR., *supra* note 140; PHYSICIANS FOR HUM. RTS., NOT IN MY EXAM ROOM: HOW U.S. IMMIGRATION ENFORCEMENT IS OBSTRUCTING MEDICAL CARE (2019), [https://phr.org/wp-content/uploads/2019/06/Not-in-my-Exam-Room\\_-PHR-Sanctuary-Hospitals-June-2019.pdf](https://phr.org/wp-content/uploads/2019/06/Not-in-my-Exam-Room_-PHR-Sanctuary-Hospitals-June-2019.pdf).

<sup>336</sup> See Saadi et al., *supra* note 332, at 8-9.

<sup>337</sup> See, e.g., Crosby, *supra* note 333, at 62 (describing how the Immigrant Task Force developed a protocol in consultation with the hospital's Public Safety department); La Charite et al., *supra* note 63, at 54 (noting that development of policies to guide staff action in such situations was suggested by health care providers); Lee et al., *supra* note 15, at 6; Saadi et al., *supra* note 332, at 4. See generally Saadi & McKee, *supra* note 64, at 1-2 (describing efforts by health care providers to encourage noncitizens to access care without fear).

<sup>338</sup> See La Charite et al., *supra* note 63, at 54 (noting that health care provider survey respondents recommended developing response teams); Lee et al., *supra* note 15, at 6; Saadi et al., *supra* note 332, at 5; Van Natta, *supra* note 21, at 5. This idea is loosely modeled on a proposal to create “rapid response teams” to address medical repatriation of immigrants upon discharge by hospitals. Nisha Agarwal & Liane Aronchick, A Matter of Life and Death: Advocates in New York Respond to Medical Repatriation 10 (Oct. 7, 2010) (unpublished manuscript) (on file with author).

draw on faculty members affiliated with the institution, such as law professors with relevant expertise and directors of law school clinics. Smaller institutions could pool their resources and coordinate community-based rapid response teams, consisting of pro bono and public interest attorneys, members of faith-based and other community groups, local government officials,<sup>339</sup> activists, retired physicians, students, and others willing to donate their services to the cause. Lawyers on rapid response teams should be prepared to represent patients in the event of arrests; advise patients and their family members about their rights in the ensuing legal process; and to address any ancillary legal issues that may arise. The medical-legal partnership model, which typically involves collaboration between health care provider staff and lawyers onsite, may be well-suited for this purpose.<sup>340</sup> Health care providers and social workers would advise patients who are arrested about any treatment needs, particularly if the patient is likely to be detained for a prolonged period. The medical records staff would be responsible for obtaining an arrested patient's consent to transmit records relating to any treatment needs to their family members and/or to the medical staff at the detention facility where the patient will be housed, to ensure continuity of care.

Health care providers can also designate certain spaces, such as private exam rooms, as “closed to the public” in order to prevent officers from conducting warrantless visual or oral surveillance of patients and patient records in supposedly “public” areas.<sup>341</sup> Under the plain view doctrine, an exception to the Fourth Amendment's warrant requirement, immigration officers can inspect items that are visible in plain view in locations where they are lawfully present.<sup>342</sup> Therefore,

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339 See SAADI, *supra* note 334, at 10.

340 Even though medical-legal partnerships are growing in popularity, few that provide immigration legal services have published scholarly articles about their work. See Avery League et al., *A Systematic Review of Medical-Legal Partnerships Serving Immigrant Communities in the United States*, 23 J. IMMIGRANT & MINORITY HEALTH 163, 173 (2021). Of those that have, “[a]ll partnerships concluded that the joint work was a positive step for the immigrants they served . . . .” *Id.* at 166; see also Sarah Kimball et al., *Advocacy for Patients with Vulnerable Legal Status: Piloting Immigration Legal Navigation in Primary Care*, 42 SGIM F., Apr. 2019, at 1 (noting that “there is a tremendous need for immigration legal support in our patient population, and we have a potent opportunity to provide crucial support for immigrant patients [through MLPs] when they come into clinic”); Altaf Saadi et al., *Building Immigration-Informed, Cross-Sector Coalitions: Findings from the Los Angeles County Health Equity for Immigrants Summit*, 3.1 HEALTH EQUITY 431, 433 (2019) (describing medical-legal partnerships as “a prime strategy” for addressing unmet immigration legal needs); Kimberly Montez et al., *Legal Relief for Children in Immigrant Families*, PEDIATRICS (Mar. 1, 2021), [https://pediatrics.aappublications.org/content/147/3\\_MeetingAbstract/659](https://pediatrics.aappublications.org/content/147/3_MeetingAbstract/659) (describing a pilot intervention that “demonstrates the need for immigration-related services in primary care settings that serve immigrant patients and the feasibility of implementing a novel screening tool and community-based medical-legal partnership with an immigration law firm”).

341 Cleek, *supra* note 88, at 1002-03; La Charite et al., *supra* note 63, at 54 (finding that the surveyed health care providers indicated a lack of training on this topic).

342 See Cleek, *supra* note 88, at 1002 (discussing the application of the doctrine to ICE officer searches of health care provider sites).



providers should ensure that patient charts are not visible from areas that are arguably open to the public, like waiting rooms, and that conversations about immigration status do not occur there.<sup>343</sup>

Health care providers can establish liberal policies about documents that satisfy identification requirements for patient registration purposes.<sup>344</sup> Although driver's licenses are the most frequently used document to establish patients' identities, many states do not permit undocumented noncitizens to acquire them.<sup>345</sup> Therefore, providers should clarify that a variety of documents may be used to establish identity, such as foreign passports or national identification cards, school or employee identification cards, or certain medical records, such as hospital birth records or others containing photographs and biographical information.

Health care institutions should ensure that their staff is well-trained on internal policies designed to limit immigration surveillance in health care.<sup>346</sup> Such trainings build understanding of the importance to the organization's mission of protecting health care access for all patients, regardless of citizenship or immigration status and regardless of any person's opinion about immigration policy. Additional trainings could seek to educate staff on the laws relating to immigration consequences of enrolling in public health insurance<sup>347</sup> and the confidentiality of patient information,<sup>348</sup> how to speak openly with patients about immigration-related barriers to health care, and how to assure patients that their care is not compromised because of their immigration status.<sup>349</sup>

Finally, community outreach to immigrant communities about health care sanctuary policies is critical to allaying fears of immigration surveillance in health care.<sup>350</sup> Health care institutions are uniquely situated to provide trusted information

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343 Crosby et al., *supra* note 332, at 62 (describing a change in Boston Medical Center's policy so that government-issued photo identification is no longer required); Saadi et al., *supra* note 332, at 5; Cleek, *supra* note 88, at 1002-03.

344 *Id.* at 1003.

345 *See id.* at 1003.

346 *See* Crosby et al., *supra* note 333, at 62 (describing Boston Medical Center's "Know Your Rights" presentations for employees); La Charite et al., *supra* note 63, at 56 (noting the "significant opportunity to further expand the knowledge base regarding healthcare facility preparedness and response to immigration-related law enforcement activity," based on survey respondents' lack of knowledge about their own institutions' policies); Saadi et al., *supra* note 332, at 5, 7.

347 Hacker et al., *supra* note 2, at 180.

348 Crosby et al., *supra* note 333, at 62 (describing Boston Medical Center's "training for professionals on how to document relevant facts in the medical record without revealing a patient's immigration status, (in the remote possibility of broad subpoenas)"); Lee et al., *supra* note 15, at 6; Van Natta, *supra* note 21, at 112416.

349 Lee et al., *supra* note 15, at 6; Rhodes et al., *supra* note 23, at 336 (emphasizing the importance of "linguistically and culturally congruent and immigrant-friendly [health care] services"); Saadi & McKee, *supra* note 64, at k2178.

350 *See* PARK, *supra* note 1, at 148; Crosby et al., *supra* note 333, at 62 (describing Boston Medical Center's "targeted messaging on the COVID-19 vaccine to immigrant communities").

to noncitizens about the limited circumstances in which accessing health care or coverage can have negative immigration consequences, and to direct patients to community resources to help support their decision-making.<sup>351</sup> Community outreach should be conducted by community health workers, patient navigators, and other trusted messengers.<sup>352</sup> Community outreach may include education for patients and their families about their rights in immigration enforcement actions and the health care institution's policies relating to noncooperation with ICE.<sup>353</sup> Such outreach should be linguistically appropriate and could be paired with information about noncitizen eligibility for public health insurance and confidentiality protections for applicants.<sup>354</sup>

Although laws restricting or deterring noncitizens from accessing health care or coverage may cause some noncitizens to lose trust in their health care providers,<sup>355</sup> providers who are knowledgeable about these issues and who can provide resources to noncitizen patients fare better.<sup>356</sup> For example, health care providers should consider forming medical-legal partnerships or having legal advocates on staff to advise patients about these issues, both for the benefit of patient families and to improve health outcomes.<sup>357</sup> Alliances between health care providers and legal advocates could also lead to natural opportunities to jointly advocate for immigrant patients' interests.<sup>358</sup>

#### CONCLUSION

Noncitizens living in the United States are increasingly fearful of being surveilled by immigration authorities while going about the typical activities of daily life, including going to the doctor or applying for health insurance. Although immigration surveillance in health care may be justified in certain circumstances, it is a poor tradeoff in the general case. This is because the collateral consequences for public health and the health care system are severe. Policymakers should take these health-related consequences into account when weighing the utility of indiscriminate immigration enforcement, especially during a pandemic. Health

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351 Lee et al., *supra* note 15, at 6.

352 Hacker et al., *supra* note 2, at 179.

353 See, e.g., Saadi et al., *supra* note 332, at 6 (describing Know Your Rights programs provided to patients at health care facilities).

354 Rhodes et al., *supra* note 23, at 336; Saadi et al., *supra* note 331, at 6.

355 See, e.g., PARK, *supra* note 1, at 80 (describing the impact of PRWORA and IIRIRA in 1996).

356 *Id.*

357 See *id.* at 130, 148; Lee et al., *supra* note 15, at 5; Saadi et al., *supra* note 332, at 6; Van Natta, *supra* note 21, at 5. Medical-legal partnerships may be theorized as non-governmental versions of HiAP, as they are cross-sectoral efforts to improve health. See Pepin et al., *supra* note 245, at 61.

358 See PARK, *supra* note 1, at 149; Lee et al., *supra* note 15, at 6 (describing the unique position of health care providers to support the rights of immigrant families).

care sanctuaries are a pragmatic, principled, and legitimacy-enhancing solution to the problems associated with immigration-related health care system avoidance. This approach suggests possibilities for balancing health-related policy goals with immigration policy goals in contexts beyond immigration surveillance in health care.