

2022

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Medha D. Makhlouf
Penn State Dickinson Law, mdm5849@psu.edu

Patrick J. Glen
pjg92346@gmail.com

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Recommended Citation

Medha D. Makhlouf & Patrick J. Glen, *Immigration Reforms as Health Policy*, 15 St. Louis U. J. Health L. & Pol'y (2022).

Available at: <https://scholarship.law.slu.edu/jhlp/vol15/iss2/5>

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IMMIGRATION REFORMS AS HEALTH POLICY

MEDHA D. MAKHLOUF* AND PATRICK J. GLEN**

ABSTRACT

The 2020 election, uniting control of the political branches in the Democratic party, opened up a realistic possibility of immigration reform. Reform of the immigration system is long overdue, but in pursuing such reform, Congress should cast a broad net and recognize the health policies embedded in immigration laws. Some immigration laws undermine health policies designed to improve individual and population health. For example, immigration inadmissibility and deportability laws that chill noncitizens from enrolling in health-promoting public benefits contribute to health inequities in immigrant communities that spill over into the broader population—a fact highlighted by the still-raging COVID-19 pandemic. Restrictions on noncitizen eligibility for Medicaid and other public benefits contribute to inequitable access to health care. Moreover, visa restrictions for noncitizen health care professionals run counter to health policies promoting access to health care during a time of severe shortages in the health care professional workforce. It is time that health policy be incorporated into the immigration-reform debate, with Congress considering whether and how such reforms are helping to achieve health policy goals relating to improving individual and population health.

* Associate Professor and Director, Medical-Legal Partnership Clinic, Penn State Dickinson Law; Assistant Professor, Department of Public Health Sciences, Penn State College of Medicine (MMakhlouf@psu.edu). The author's publications are available at <https://works.bepress.com/medha-makhlouf/>.

** Adjunct Professor, Georgetown University Law Center; Senior Litigation Counsel, Office of Immigration Litigation, Civil Division, United States Department of Justice. The views and opinions expressed in this Article are the author's own and do not necessarily represent the views of the Department of Justice or any component thereof.

I. INTRODUCTION

In a nation struggling to manage the disastrous health and economic impacts of the COVID-19 pandemic, it is imperative for political leaders to think about how legal reforms of any kind would affect individual and population health. A major goal of health policy is to improve individual and population health and well-being by expanding access to health care.¹ Given the disparate effects of the pandemic on noncitizens living in the United States, immigration law and policy reforms present opportunities to advance or hinder health policy goals.

Noncitizens' vulnerability to the pandemic's negative effects arise from their often precarious economic positions coupled with legal barriers to accessing health care.² First, noncitizens are overrepresented as a share of the total population in many of the industries hit hardest by early shutdowns, including hospitality and related work.³ Second, they are likewise overrepresented in "essential work" positions, where both lawful and undocumented immigrants continue to work long hours throughout the pandemic.⁴ Finally, there is a complicated maze of laws regulating noncitizens' access to health care and other public benefits, exacerbating the economic pain felt by unemployment and making it less likely that those with health problems, including from COVID-19 itself, would be able or willing to secure treatment.⁵

At the same time, some noncitizen health care professionals seeking to serve the country during this time of crisis have faced immigration-related legal barriers to doing so. During the COVID-19 pandemic, the nation became acutely aware of the shortage of health care professionals relative to need.⁶ This workforce issue both preceded and will outlast this pandemic.⁷ Noncitizen

1. *Health Care Access and Quality*, U.S. DEP'T. HEALTH & HUMAN SERVS., <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality> (last visited May 27, 2022).

2. Eunice Kim et al., *Labor & The Economy*, U. MINN., <https://immigrantcovid.umn.edu/labor-the-economy>.

3. See, e.g., *Immigrant Workers in the Hardest-Hit Industries*, NEW AM. ECON. RSCH. FUND (Apr. 30, 2020), <https://research.newamericaneconomy.org/report/immigrant-workers-in-the-hardest-hit-industries/>.

4. See Donald Kerwin & Robert Warren, *US Foreign-Born Workers in the Global Pandemic: Essential and Marginalized*, 8 J. ON MIGRATION & HUM. SEC. 282, 283 (2020); see also DONALD KERWIN ET AL., CTR. FOR MEDICARE & MEDICAID SERVS., *US FOREIGN-BORN ESSENTIAL WORKERS BY STATUS AND STATE, AND THE GLOBAL PANDEMIC 2* (2020), <https://cmsny.org/wp-content/uploads/2020/05/US-Essential-Workers-Printable.pdf>; see also Daniela Alulema, *DACA Recipients Are Essential Workers and Part of the Front-line Response to the COVID-19 Pandemic, as Supreme Court Decisions Looms*, CTR. MIGRATION STUD. (Mar. 30, 2020), <https://cmsny.org/daca-essential-workers-covid/>.

5. See *infra* Section II.B.

6. Yolanda Smith, *Physician Shortage*, NEWS: MED. LIFE SCIS. (Feb. 27, 2019), <https://www.news-medical.net/health/Physician-Shortage.aspx>.

7. *Id.*

health care professionals are vital to our health care system not only because they help to fill gaps in the general health care workforce, but also because they are disproportionately likely to provide care in medically underserved communities.⁸ In addition, they contribute to the diversity of the health care workforce, improving the health care system's ability to provide the best possible care to diverse patient populations.⁹

With the 2020 election resulting in unitary control of the political branches for the Democratic Party,¹⁰ and the pandemic still an omnipresent reality, now is the time to rethink the immigration laws and policies that have limited noncitizens' access to public benefits for decades and that contribute to the health care workforce shortage. To be sure, noncitizens' contributions to the United States' efforts at fighting the pandemic have received attention, and Congress is considering a number of measures that would lead to lawful residency and eventually citizenship for certain classes of noncitizens who have been engaged in essential work.¹¹ Although a step in the right direction, such a limited measure would leave untouched the most draconian provisions restricting noncitizen access to public benefits. They also leave intact the legislative framework limiting the availability of visas for noncitizen medical professionals. As part of any effort to comprehensively reform immigration law during and after the pandemic, Congress should consider how and whether such reforms are helping to achieve health policy goals relating to improving access to health care.

Part II presents three issues at the intersection of health policy and immigration law. These intersections are pervasive throughout the immigration process, beginning with bases for denying admission to noncitizens or removing previously admitted noncitizens, limiting the legal paths open to those who want to immigrate, and prohibiting or limiting access to public benefits *even after* a

8. FOREIGN-TRAINED DOCTORS ARE CRITICAL TO SERVING MANY U.S. COMMUNITIES, AM. IMMIGR. COUNCIL 1 (2018), <https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities#:~:text=Foreign%2DTrained%20Doctors%20are%20Critical%20to%20Serving%20Many%20U.S.%20Communities,-Immigration%20101&text=There%20are%20more%20than%20247%2C000,one%2Dquarter%20of%20all%20doctors.>

9. *The Importance of Diversity in Health Care: Medical Professionals Weigh In*, ST. GEORGE'S U. (Aug. 19, 2021), <https://www.sgu.edu/blog/medical/pros-discuss-the-importance-of-diversity-in-health-care/>.

10. Katherine Gypson, *With Control of White House and Congress, Democrats Have 2 Years to Make Big Changes*, VOICE AM. (Jan. 22, 2021, 2:25 AM), https://www.voanews.com/a/usa_us-politics_control-white-house-and-congress-democrats-have-2-years-make-big-changes/6201047.html.

11. See, e.g., Citizenship for Essential Workers Act, S. 747, 117th Cong. (2021); Citizenship for Essential Workers Act, H.R. 1909, 117th Cong. (2021); see also American Dream and Promise Act, H.R. 6, 117th Cong. (2021); Farm Workforce Modernization Act, H.R. 1603, 117th Cong. (2021).

noncitizen has been lawfully admitted to the United States. Using this foundation, Part III describes opportunities for reform relating to these three distinct intersections between health policy and immigration law: (1) repealing the public charge ground of deportability and revising the public charge ground of inadmissibility; (2) expanding immigrant access to health coverage by eliminating eligibility restrictions tied to immigration status and repealing punitive laws targeting employers of undocumented immigrants; and (3) establishing distinct visas for physicians and other health care professionals and relaxing occupational licensing criteria in order to ease noncitizens' admission to the United States, cure the deficit in the health care workforce, and provide more and higher quality services to underserved communities in the United States. Part IV discusses opportunities to more fully realize the goals of statutory reforms through conforming administrative actions, including providing access to subsidized health coverage to beneficiaries of Deferred Action for Childhood Arrivals (DACA), ensuring enforcement of the Department of Homeland Security's (DHS) sensitive locations policy, limiting information-sharing between health care providers and immigration enforcement agencies, providing clear and accurate information to immigrant communities about eligibility for and immigration consequences of accessing public benefits, and encouraging state-level action to expand immigrant access to subsidized health coverage.

II. INTERSECTIONS OF HEALTH POLICY AND IMMIGRATION LAW

Immigration law influences individual and population health in numerous ways. Part II focuses on three of the more fundamental intersections of health policy and immigration law that warrant immediate attention by Congress. First, immigration laws that discourage noncitizens from enrolling in health-supporting public benefits for which they qualify interfere with health policy goals of ensuring that people's basic needs are met in order to support individual and population health and well-being.¹² Section II.A introduces the public charge grounds of inadmissibility and deportability, and the administrative process for denying entry to, or removing a noncitizen from, the United States. Second, federal and state laws limiting immigrant eligibility for public benefits frustrate health policy goals of expanding access to subsidized health coverage for all who cannot otherwise afford it. Section II.B reviews the legal framework excluding unlawfully present noncitizens from most public benefits and limiting eligibility for certain categories of lawfully present noncitizens. Finally, noncitizen health care professionals play an important role in supporting individual and population health in the United States by providing access to health care, but opportunities for such professionals to immigrate are inadequate

12. Tanya Broder et al., *Overview of Immigrant Eligibility for Federal Programs*, NAT'L IMMIGR. L. CTR. 2 (Oct. 2021), <https://www.nilc.org/issues/economic-support/overview-immelig-fedprograms/>.

to fully meet the health care needs of the population.¹³ Section II.C describes existing options for certain noncitizen health care professionals to lawfully enter the United States for the purpose of providing health care services, the conditions imposed pursuant to each distinct visa category, and the qualifications that a visa applicant must possess before the visa may be approved.

A. *Public Charge Law's Chilling Effect on Public Benefits Enrollment*

A determination that a noncitizen is inadmissible to, or removable from, the United States is made in an administrative proceeding before an immigration judge.¹⁴ This proceeding is called a “removal proceeding,” and the first Subsection explains the history and structure of this mechanism.¹⁵ The following Subsections address the public charge grounds of inadmissibility and deportability, which authorize immigration officials to determine a noncitizen is inadmissible to, or removable from, the United States based on their assessed likelihood of becoming dependent on the government for support.¹⁶

1. Immigration Inadmissibility and Deportability

The “removal proceeding” is how the government pursues civil immigration enforcement against noncitizens who are charged with being inadmissible to, or deportable from, the United States.¹⁷ The charges that may be brought against a noncitizen depend on their legal position—not their physical position—in relation to the United States.¹⁸ Prior to 1996, the statute “distinguished between aliens who have ‘entered’ the United States and aliens still seeking to enter (whether or not they are physically present on American soil.)”¹⁹ Given this legal distinction, “[i]mmigration proceedings, as historically understood, . . .

13. FOREIGN-TRAINED DOCTORS ARE CRITICAL TO SERVING MANY U.S. COMMUNITIES, *supra* note 8, at 2.

14. 8 U.S.C. § 1229a(a)(1).

15. *Id.*

16. *Public Charge Fact Sheet*, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/archive/public-charge-fact-sheet> (last visited May 15, 2022).

17. § 1229a(a)(1). Inadmissibility determinations may also be made outside of removal proceedings, for instance, by consular officers reviewing visa applications, 8 U.S.C. § 1182(a) (“aliens who are inadmissible under the following paragraphs are ineligible to receive visas”), and officials of DHS adjudicating applications for adjustment of status. *See* 8 U.S.C. § 1255(a) (an applicant for adjustment of status must establish, *inter alia*, that he “is eligible to receive an immigrant visa and is admissible to the United States for permanent residence”).

18. *See* § 1229a(a)(3).

19. *Jama v. Immigr. & Customs Enf't*, 543 U.S. 335, 349 (2005) (citing *Leng May Ma v. Barber*, 357 U.S. 185, 187 (1958), which states, “It is important to note at the outset that our immigration laws have long made a distinction between those aliens who have come to our shores seeking admission . . . and those who are within the United States after an entry, irrespective of its legality.”).

comprised two distinct sets of proceedings depending on the position of the alien—exclusion or inadmissibility proceedings and deportation proceedings.”²⁰ As the Supreme Court explained, “[t]he deportation proceeding is the usual means of proceeding against an alien already physically present in the United States, and the exclusion hearing is the usual means of proceeding against an alien outside the United States seeking admission.”²¹

Congress simplified this scheme in 1996, creating a unitary “removal proceeding” that encompassed both inadmissible and deportable noncitizens.²² Nonetheless, the Immigration and Nationality Act (INA) “retained the distinction between being inadmissible and being deportable by retaining the separate statutory provisions providing for grounds of inadmissibility and deportability.”²³ General categories of inadmissibility relate to health, criminal activity, national security, public charge, lack of labor certification, fraud and misrepresentation, prior removals, unlawful presence in the United States, and other miscellaneous categories.²⁴ The inadmissibility grounds do overlap with certain grounds of deportability, including criminal grounds, terrorism and other security-related grounds, and public charge.²⁵ But these provisions also diverge in important ways, too, for the obvious reason that each statutory provision targets a discrete class of noncitizen presenting its own distinct issues: Inadmissibility grounds pertain to noncitizens seeking to come to the United States, whereas deportability grounds pertain to noncitizens already present in

20. Patrick Glen, *Judulang v. Holder and the Future of 212(c) Relief*, 27 GEO. IMMIGR. L.J. 1, 4 (2012).

21. *Landon v. Plasencia*, 459 U.S. 21, 25 (1982).

22. See *Illegal Immigration Reform and Immigrant Responsibility Act* § 304(a)(3), Pub. L. No. 104-208, 110 Stat. 3009-546 (1996); see also § 1229a(a).

23. Glen, *supra* note 20, at 4 (citing 8 U.S.C. § 1182(a)) (grounds of inadmissibility); 8 U.S.C. § 1227(a) (grounds of deportability).

24. § 1182(a). The health-related grounds of inadmissibility intersect with health policies promoting population health by restricting the entry of persons diagnosed with certain communicable diseases, physical conditions, or mental health conditions that would pose a threat to self or others; or substance use disorder; or who have not provided documentation of required immunizations. § 1182(a)(1). However, because we do not propose reforms to improve individual or population health relating to these grounds, we do not discuss them in detail.

25. See Glen, *supra* note 20, at 4 & nn.17–20 (citing examples). There are no explicit health-related grounds of deportability. However, a noncitizen who “has failed to comply with terms, conditions, and controls that were imposed” under Section 1182(g), a provision allowing waiver of certain grounds of inadmissibility based on health-related concerns, is deportable from the United States. § 1227(a)(1)(C)(ii). Also, the deportation statute provides for the removal of “[a]ny alien who is, or at any time after admission has been, a drug abuser or addict.” § 1227(a)(2)(B)(ii). This provision is included within the criminal-grounds of deportation, but it is identical in wording and intent to the health-related ground of inadmissibility pertaining to drug abusers and addicts. Compare § 1182(a)(1) (“Health-related grounds,” including drug abusers or drug addicts), with § 1227(a)(2) (“Criminal offenses,” including a comparable ground regarding individuals with substance use disorders).

the United States.²⁶ The public charge grounds of inadmissibility and deportability highlight this divergence.²⁷

2. Public Charge Ground of Inadmissibility

The public charge law deems inadmissible noncitizens who may not have the financial means to fully support themselves without government assistance.²⁸ The statute provides that “[a]ny alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible.”²⁹ Under administrative guidance drafted in 1999 and currently in effect, the term “public charge” is defined as “likely to become . . . primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense.”³⁰ In making this determination, the adjudicator should consider the totality of the noncitizen’s circumstances, as well as any statutory or other factors relevant to the question.³¹ The statute’s non-exhaustive list of factors includes the noncitizen’s age, health, family status (whether they are married and/or have children), assets, resources, financial status, education, and occupational skills.³² Also of relevance is any affidavit of support by the visa petition’s sponsor, which in many cases is a required component of an application for admission.³³

3. Public Charge Ground of Deportability

The INA’s deportability grounds relate to a noncitizen already present in the United States.³⁴ Therefore, they do not serve as a screening mechanism in the same way as the inadmissibility grounds.³⁵

The deportation statute includes a public charge provision, which provides that “[a]ny alien who, within five years after the date of entry, has become a

26. Glen, *supra* note 20, at 5.

27. § 1182(a)(4)(A); § 1227(a)(5).

28. *Public Charge Fact Sheet*, *supra* note 16.

29. § 1182(a)(4)(A).

30. Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,689 (Mar. 26, 1999).

31. *See id.* at 28, 690; *see also* Matter of Harutunian, 14 I. & N. Dec. 583, 583 (BIA 1974) (adopting the totality-of-the-circumstances inquiry for public charge inadmissibility determinations).

32. *See* § 1182(a)(4)(B)(i)(I)–(V).

33. *See* § 1182(a)(4)(B)(ii), (C)(ii); *see also* 8 U.S.C. § 1183a.

34. Katherine Brady & Dan Kesselbrenner, *Grounds of Deportability and Inadmissibility Related to Crimes*, NAT’L IMMIGR. PROJECT 1, 1–2 (2012), https://www.nationalimmigrationproject.org/PDFs/practitioners/practice_advisories/crim/2012_Oct_grounds-deport-admiss.pdf.

35. *Id.*

public charge from causes not affirmatively shown to have arisen since entry is deportable.”³⁶ Public charge deportability is distinct from public charge inadmissibility; the terms of the statute place a temporal limitation on when a lawfully admitted noncitizen may be charged with deportability based on this provision, and the statute ties its applicability back to the time of admission—causes of the financial distress that post-date entry are not relevant to the determination of deportability.³⁷ Under long-standing Board of Immigration Appeals’ precedent, agency adjudicators use a three-part inquiry to determine deportability under the public-charge ground:

- (1) The State or other governing body must, by appropriate law, impose a charge for the services rendered to the alien . . . (2) [t]he authorities must make demand for payment of the charges upon those persons made liable under State law. And
- (3) there must be a failure to pay for the charges.³⁸

B. *Restrictions on Immigrant Eligibility for Public Benefits*

The specific immigration status of a noncitizen determines whether that individual is eligible for a range of subsidized health coverage and other health-supporting public benefits.³⁹ Prior to the early 1970s, the public benefits programs that existed were open to those present in the United States, regardless of immigration status.⁴⁰ Beginning in the 1970s, however, the eligibility criteria for existing programs were amended to exclude unlawfully present individuals, while new programs were limited to a subclass of those lawfully present in the United States.⁴¹ Nonetheless, individuals unlawfully present in the United States

36. 8 U.S.C. § 1227(a)(5).

37. *Id.*; *Public Charge & Deportation FAQ for Advocates and Community Members*, PROTECTING IMMIGRANT FAMS. 2 (2019), <https://protectingimmigrantfamilies.org/wp-content/uploads/2019/07/PIFdeportationFAQjuly.pdf>.

38. *In the Matter of B-----*, 3 I. & N. Dec. 323, 326 (BIA 1948).

39. Janet M. Calvo, *Alien Status Restrictions on Eligibility for Federally Funded Assistance Programs*, 16 N.Y.U. REV. L. & SOC. CHANGE 385, 418 (1987–88).

40. See Cybelle Fox, *Unauthorized Welfare: The Origins of Immigrant Status Restrictions in American Social Policy*, 102 J. AM. HIST. 1051, 1057–58 (2016). Stating that:

Between 1935 and 1971 no federal laws barred noncitizens, even unauthorized immigrants, from social security benefits, unemployment insurance, [Old Age Assistance], or [Aid to Dependent Children]. . . . With the enactment of additional public assistance legislation—creating the food stamp program or Medicaid, for example—the same rules applied. Under federal law, both authorized and unauthorized immigrants were eligible for these programs on the same basis as citizens. *Id.*

Richard A. Boswell, *Restrictions on Non-Citizens’ Access to Public Benefits: Flawed Premise, Unnecessary Response*, 42 UCLA L. REV. 1475, 1492–93 (1995) (“It was not until approximately 1972 that Congress began to enact restrictions on access to benefit programs based on either immigration or citizenship status.”).

41. See 42 U.S.C. §§ 1396a(ee)(1), 1396(e)(13)(A)(i)(IV); 7 U.S.C. § 2015(f) (limiting eligibility for SNAP to either citizens or certain classes of lawfully present noncitizens); 42 U.S.C. § 1382c(a)(1) (for purposes of Supplemental Security Income, defining “aged, blind, or disabled

are eligible for certain limited benefits and coverage of the costs of medical treatment under current law.⁴² These include Emergency Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children,⁴³ as well as a limited number of other programs outside the regulatory definition of “federal public benefit.”⁴⁴

Despite the generally more favorable treatment of lawfully present noncitizens in the public benefits eligibility framework, that class has also seen its eligibility for benefits curtailed in the last five decades.⁴⁵ For much of the existence of the modern welfare state, and even after unlawfully present noncitizens were barred from most forms of benefits, eligible lawfully present noncitizens continued to enjoy access to benefits on similar terms as U.S. citizens.⁴⁶ This, too, began to change in the 1960s and 1970s, as Congress began enacting durational requirements before a lawfully present noncitizen could access benefits, such as Medicare.⁴⁷ Although lawfully present noncitizens

individual” as, *inter alia*, “a resident of the United States,” and “either . . . a citizen or . . . an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law”); 42 U.S.C. § 608(e) (applying the Title VIII definitions of “qualifying alien” to limit eligibility for the Temporary Assistance for Needy Families program); *see also* Calvo, *supra* note 39, at 418 (“The first federal restriction on the availability of Medicaid to aliens was a regulation which limited eligibility to legal permanent residents and aliens permanently residing in the United States under color of law.”) (citing 45 C.F.R. § 248 (1973)).

42. Calvo, *supra* note 39, at 418.

43. *See* 42 U.S.C. § 1395dd(a) (“In the case of a hospital that has a hospital emergency department, if any individual (*whether or not eligible for benefits under this subchapter*) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment of a medical condition, the hospital must provide for” appropriate care, dependent on whether an “emergency medical condition” ultimately is shown to exist) (emphasis added); § 1395dd(e)(1)(A). An “emergency medical condition” is defined as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part[.]

Id.

The definition also includes conditions impacting the health and safety of pregnant women and their unborn children, regarding delivery and transfers between hospitals. 42 U.S.C. § 1786(d)(1)–(2)(A) (defining eligibility for the Special Supplemental Nutrition Program in relation to income, rather than citizenship or immigration status); § 1786(a) (“Congressional findings and declaration of purpose”).

44. *See* Medha D. Makhoul, *The Public Charge Rule as Public Health Policy*, 16 IND. HEALTH L. REV. 177, 187–88 (2019) (citing 8 U.S.C. §§ 1611(b), 1613(c); 83 Fed. Reg. 51,114, 51,128, 51,131–32 (Oct. 10, 2018)).

45. *See id.* at 187.

46. *See, e.g.*, 45 C.F.R. § 248.50 (1974).

47. *See* 42 U.S.C. § 1395o(2) (1970) (barring eligibility for participation in Medicare, unless the noncitizen has been admitted to the United States for permanent residency *and* has resided in the United States for at least five years following that admission).

challenged these limitations, the Supreme Court upheld their constitutionality.⁴⁸ Noting that “the responsibility for regulating the relationship between the United States and [its] alien visitors has been committed to the political branches of the Federal Government,” the Court opined that its standard of review over the durational requirement was “narrow.”⁴⁹ Proceeding from the “obvious” baseline “that Congress has no constitutional duty to provide all aliens with the welfare benefits provided to citizens,” the Court held that “it is unquestionably reasonable for Congress to make an alien’s eligibility [for benefits] depend on both the character and the duration of his residence.”⁵⁰

These two trends culminated in the enactment of twin bills in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act.⁵¹ Through these bills, Congress enacted a unitary scheme for addressing *who* was eligible for *what* benefits and *when* that eligibility vested.

First, eligibility for benefits is generally limited to “qualified alien[s].”⁵² The statute restrictively defines “qualified alien” to include seven classes of noncitizens: (1) lawful permanent residents; (2) noncitizens granted asylum; (3) refugees admitted under 8 U.S.C. § 1157; (4) noncitizens “paroled into the United States . . . for a period of at least 1 year”; (5) noncitizens granted withholding of deportation or withholding of removal; (6) noncitizens granted conditional entry under former law, 8 U.S.C. § 1153(a)(7); and (7) certain Cuban and Haitian entrants.⁵³ Any noncitizen who falls outside the class of “qualified alien” is ineligible for public benefits, with certain narrow exceptions, encompassing, *inter alia*, Emergency Medicaid, certain immunizations, and short-term in-kind assistance.⁵⁴

Second, PRWORA limits the eligibility of otherwise “qualified alien[s]” by imposing a five-year waiting period for certain Federal means-tested public benefits.⁵⁵ This limitation pertains to Medicaid, among other public benefit

48. *Mathews v. Diaz*, 426 U.S. 67, 68 (1976).

49. *Id.* at 81–82.

50. *Id.* at 82–83.

51. Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.); Illegal Immigration Reform and Immigrant Responsibility Act, Pub. L. No. 104-208, Div. C, 110 Stat. 3009 (1996) (codified as amended at 8 U.S.C. § 1101, et seq.).

52. *See, e.g.*, 8 U.S.C. § 1611(a) (“[A]n alien who is not a qualified alien . . . is not eligible for any Federal public benefit[.]”).

53. 8 U.S.C. § 1641(b)(1)–(7).

54. *See* § 1611(b)(1)(A)–(E).

55. §§ 1611(c)(2)(A)–(C), 1613(a). This limitation is itself subject to several exceptions, including for noncitizens granted asylum and related protection from removal, refugees, and noncitizens admitted to the United States under specific programs. *See* § 1613(b)(1)(A)–(E).

programs.⁵⁶ Qualified noncitizens are also generally not eligible for so-called “specified federal programs,” defined to include Supplemental Security Income and the Supplemental Nutrition Assistance Program (SNAP), before accruing five years in status.⁵⁷ Certain classes of “qualified alien[s]” are not subject to the five-year waiting period for eligibility for these specified federal programs, including lawful permanent residents who have forty qualifying quarters of work history, as well as those classes of noncitizens exempted from the five-year bar on means-tested public benefits (although this exception applies only for the first seven years of residence in a qualifying status).⁵⁸ There are also program-specific eligibility criteria that enable a subset of “qualified alien[s]” to access benefits, such as the SNAP provision extending eligibility to those under the age of eighteen.⁵⁹

Finally, although the federal statute generally sets the eligibility criteria for public benefits, it also allows the states to alter those criteria in both directions, loosening or tightening eligibility criteria for certain benefits. Under the statute, “a State is authorized to determine the eligibility of an alien who is a qualified alien . . . for any designated Federal program,”⁶⁰ which is defined to include Temporary Assistance for Needy Families, social services block grants, and Medicaid.⁶¹ This may benefit the noncitizen, as states have, for example, the authority and federal financial support to eliminate the five-year waiting period for Medicaid eligibility for certain categories of noncitizens.⁶² At the same time, however, the statute also allows states to impose stricter guidelines in some circumstances, such as denying Medicaid eligibility for qualified noncitizens even after the five-year waiting period, unless they have ten years of work history.⁶³ The statute does place limitations on what criteria states may impose, upon whom such criteria may be imposed, and the timing of the stricter eligibility criteria.⁶⁴ For instance, for certain noncitizens granted relief and protection from persecution or torture, no state-based limitation on eligibility for Medicaid may be imposed until seven years after the noncitizen assumed the relevant status as a “qualifying alien.”⁶⁵ Nonetheless, the broad grant of

56. See CONG. BUDGET OFF., FEDERAL MANDATORY SPENDING FOR MEANS-TESTED PROGRAMS, 2009 TO 2029, at 1 (2019).

57. See 8 U.S.C. § 1612(a)(1), (3).

58. See § 1612(a)(2)(A), (B); see also § 1612(a)(2)(C) (exempting certain veterans and active-duty military personnel).

59. See § 1612(a)(2)(J).

60. § 1612(b)(1).

61. § 1612(b)(3)(A)–(C).

62. See *Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*, KAISER FAM. FOUND. (Feb. 12, 2009), <https://www.kff.org/wp-content/uploads/2013/01/7863.pdf>.

63. See § 1612(b)(2)(B) (mandating that lawful permanent residents who have “worked 40 qualifying quarters of coverage” are “eligible for any designated Federal program”).

64. § 1612(b)(2)(A)(ii).

65. See § 1612(b)(2)(A)(i)–(ii).

authority to states to impose different eligibility criteria for these programs has created a hodge-podge of both stricter and looser eligibility provisions across the United States.⁶⁶

A similar “intent to limit the eligibility of noncitizens for federal public benefits was largely carried over” to the Affordable Care Act (ACA).⁶⁷ Participation in the insurance exchanges that the ACA established, for instance, is limited to citizens and nationals of the United States, or noncitizens lawfully present in the United States.⁶⁸ While “the ACA made no change to the alienage restrictions on eligibility for Medicaid” and related programs, such as the Children’s Health Insurance Program (CHIP),⁶⁹ it did contemplate a broader category of “lawfully present” noncitizen than that embodied in PRWORA.⁷⁰ Under final regulations adopted in 2010, “lawfully present” noncitizens includes qualified aliens as defined under PRWORA, noncitizens with valid nonimmigrant visas, recipients of Temporary Protected Status and Deferred Enforced Departure, certain noncitizens granted employment authorization, noncitizens with pending applications for adjustment of status, asylum, and Special Immigrant Juvenile Status, and “[a]liens currently in deferred action status,”⁷¹ although recipients of deferred action under the DACA policy were later explicitly excluded from eligibility.⁷²

C. *The Inadequacy of Visa Availability for Health Care Professionals*

Noncitizen health care professionals have some options to lawfully enter the United States in order to practice in the health care field. This entry may be pursuant to a nonimmigrant or an immigrant visa, the difference of which relates to the intended duration of the noncitizen’s stay in the United States.⁷³ “Nonimmigrant visas are issued to foreign nationals seeking to enter the United States on a temporary basis for tourism, business, medical treatment, and certain types of temporary work.”⁷⁴ In contrast, “[i]mmigrant visas are issued to foreign nationals intending to relocate permanently to the United States.”⁷⁵ There are

66. See *The Public Charge Rule as Public Health Policy*, *supra* note 44, at 194.

67. Medha D. Makhoul & Patrick J. Glen, *A Pathway to Health Care Citizenship for DACA Beneficiaries*, 12 CAL. L. REV. ONLINE 29, 34 (2021).

68. See 42 U.S.C. § 18032(f)(3).

69. Makhoul & Glen, *supra* note 67, at 35.

70. *Id.*

71. See 45 C.F.R. § 152.2 (2012).

72. See § 152.2(8); Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614, 52,615 (Aug. 30, 2012) (to be codified at 45 C.F.R. pt. 152).

73. *Requirements for Immigrant and Nonimmigrant Visas*, U.S. CUSTOMS & BORDER PROT. (Jan. 3, 2018) <https://www.cbp.gov/travel/international-visitors/visa-waiver-program/requirements-immigrant-and-nonimmigrant-visas#:~:text=Immigrant%20visas%20are%20issued%20to,study%2C%20or%20other%20similar%20reasons>.

74. *Gomez v. Trump*, 485 F. Supp. 3d 145, 158 (D.D.C. 2020).

75. *Id.*

several options for both doctors and nurses to enter the United States in order to practice in health care fields, but all involve potential hurdles to be cleared.⁷⁶

Addressing nonimmigrant visas first, a noncitizen medical professional—typically foreign-educated—is most likely to enter the United States on an H-1B visa, which permits temporary employment in the United States for members of “specialty occupations.”⁷⁷ This process begins with the filing of a “Labor Condition Application” (LCA) with the Department of Labor, which is required to include information about the position for which the H-1B visa is sought, including wage and working condition information, whether there are any labor disputes at the place of employment, and that the position has been advertised at the place of employment.⁷⁸ That application is also required to make representations regarding the effect of hiring a nonimmigrant on the domestic labor force: that “the employer did not displace and will not displace a United States worker . . . employed by the employer” for certain time periods before and after filing of the visa application,⁷⁹ and that the employer attempted to recruit within the United States or offered the position to an equally or better-qualified domestic candidate.⁸⁰

Once the LCA has been certified, the employer may proceed with obtaining the H-1B visa through DHS and the Department of State.⁸¹ Noncitizen physicians seeking to provide patient care in the United States must have “a license or other authorization required by the state of intended employment to practice medicine,” or demonstrate exemption from any such requirement, and establish either full licensure in a foreign state or graduation from medical school in either a foreign state or the United States.⁸² The presumptive employer must also provide evidence establishing that the physician has graduated from a United States medical school *or* has passed the requisite licensing exam for foreign-educated doctors, is competent in written and oral English, and has

76. *Health Care Worker Certification*, U.S. CITIZENSHIP & IMMIGR. SERVS. (July 30, 2021), <https://www.uscis.gov/working-in-the-united-states/temporary-workers/health-care-worker-certification>; *Immigration Options for Physicians*, IMMIGR. SOLS., <https://immsolutionsllc.com/work-visas/non-immigrant-visas/immigration-options-physicians> (last visited Apr. 20, 2022).

77. See 8 U.S.C. § 1101(a)(15)(H)(i)(b) (classes of nonimmigrants includes noncitizens “coming temporarily to the United States to perform services . . . in a specialty occupation described in section 1184(i)(1) of this title”); 8 U.S.C. § 1184(i)(1)(A)–(B) (“specialty occupation” means an occupation that requires—(A) theoretical and practical application of a body of highly specialized knowledge, and (B) attainment of a bachelor’s or higher degree in the specific specialty (or its equivalent) as a minimum for entry into the occupation in the United States.”).

78. See 8 U.S.C. § 1182(n)(1)(A)(i)(I),(ii)–(C)(i)–(ii).

79. § 1182(n)(1)(E)(i).

80. § 1182(n)(1)(G)(i)(I)–(II).

81. *H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers and Fashion Models*, U.S. CITIZENSHIP & IMMIGR. SERVS. (Feb. 25, 2022), <https://www.uscis.gov/working-in-the-united-states/h-1b-specialty-occupations>.

82. See 8 C.F.R. § 214.2(h)(4)(viii)(A)(1)–(2) (2021).

graduated from a duly accredited medical school.⁸³ There is a narrow exception for physicians intending to provide direct patient care who are “of national or international renown in the field of medicine,”⁸⁴ defined to mean a physician “who is widely acclaimed and highly honored in the field of medicine within one or more countries, so long as the achievements leading to national renown are comparable to that which would result in renown in the United States.”⁸⁵ A physician may be granted an H-1B visa without meeting some of the licensing and educational requirements, *if* he or she “[i]s coming to the United States primarily to teach or conduct research, or both, at or for a public or nonprofit private educational or research institution or agency, and that no patient care will be performed, except that which is incidental to the physician’s teaching or research.”⁸⁶

Noncitizen nurses may also be able to obtain an H-1B visa,⁸⁷ but this will depend on whether a particular position can be classified as a “specialty occupation,” including the all-important factor of whether at least a bachelor’s degree is necessary for work in that field.⁸⁸ As late as 2015, United States Citizenship and Immigration Services (USCIS) was advising that “[r]egistered nurses [RNs] *generally* do not qualify for H-1B classification[,] . . . [b]ecause most RN positions do not normally require a U.S. bachelor’s or higher degree in nursing . . . as the minimum for entry into these particular positions[.]”⁸⁹ At the same time, prevailing guidance recognizes that certain positions do require both specialized knowledge and advanced training, which in turn may mean that certain RN “positions *may* qualify as specialty occupations” and warrant an H-1B visa.⁹⁰ Positions requiring so-called “[a]dvanced practice registered nurses” will also often, but not invariably, qualify as a “specialty occupation,” since these positions involve “a level of nursing practice that utilizes extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required.”⁹¹ Ultimately, the petitioner has the burden of establishing that a nursing position qualifies as a specialty occupation.⁹² And, importantly, regardless of whether the position

83. See § 214.2(h)(4)(viii)(B)(2)(i)–(ii).

84. § 214.2(h)(4)(viii)(C).

85. U.S. CITIZENSHIP & IMMIGR. SERVS., PM 602-0140, *MATTER OF T-O-S-U-*, ADOPTED DECISION 2017-01 (AAO Jan. 4, 2017) (2017).

86. § 214.2(h)(4)(viii)(B)(1).

87. See 8 U.S.C. § 1101(a)(15)(H)(i)(c) (nurses are eligible for nonimmigrant status, provided certain requirements are met); 8 U.S.C. § 1182(m)(1) (establishing criteria to assess whether a nurse qualifies for an H-1B visa).

88. U.S. CITIZENSHIP & IMMIGR. SERVS., PM 602-0104, *ADJUDICATION OF H-1B PETITIONS FOR NURSING OCCUPATIONS* (2015).

89. *Id.* (emphasis added).

90. *Id.* (emphasis added).

91. *Id.*

92. *Id.*

can be so-classified, noncitizen nurses must still establish that they meet all relevant licensing and educational requirements, have passed all relevant exams, and establish that they are not otherwise inadmissible to the United States.⁹³

Noncitizen physicians are statutorily ineligible for a nonimmigrant H-2B (temporary non-agricultural worker) or H-3 (temporary education or training) visa.⁹⁴ The only exception to this prohibition is for attendees of a foreign medical school who extern at a U.S. hospital during breaks in their educational year; such individuals may obtain an H-3 visa.⁹⁵ Noncitizen nurses are not statutorily *ineligible* for either visa, but are not likely to be approved for an H-2B visa, because nursing jobs generally will not involve “*temporary* services or labor.”⁹⁶ Nurses may qualify for an H-3 visa, “if it can be established that there is a genuine need for the nurse to receive a brief period of training that is unavailable in the [nurse’s] native country and such training is designed to benefit the nurse and the overseas employer upon the nurse’s return to the country of origin.”⁹⁷

Finally, a noncitizen physician may be eligible for an O visa, reserved for noncitizens who have “extraordinary ability in the sciences . . . which has been demonstrated by sustained national or international acclaim[.]”⁹⁸ To establish eligibility for this visa, the noncitizen must submit significant evidence of national and international awards, publications, and other evidence that establishes the claimed “extraordinary ability” and “international acclaim.”⁹⁹ Although this visa does not require the same educational and licensing requirements as the H-1B visa, the O visa recipient will likely enter the United States for the purposes of research and incidental patient care, not for the purposes of treatment in a clinical setting.¹⁰⁰ If the noncitizen were seeking to enter and conduct more than incidental patient care, they would have to comply with all relevant educational and licensing requirements.¹⁰¹

93. See 8 U.S.C. § 1182(a)(5)(C)(i)–(iii), (r)(1)–(2).

94. See 8 U.S.C. § 1101(a)(15)(H)(ii)(b) (regarding H-2B classification, providing that “this clause shall not apply to graduates of medical schools coming to the United States to perform services as members of the medical profession”); § 1101(a)(15)(H)(iii) (regarding H-3, excepting from that category those coming to the United States to “receive graduate medical education or training, in a training program that is not designed primarily to provide productive employment”).

95. See § 1182(a)(5)(C), (r).

96. See § 1101(a)(15)(H)(ii)(b); 8 C.F.R. § 214.2(h)(6)(i)(A) (2021) (emphasis added).

97. § 214.2(h)(7)(i)(B); see generally § 214.2(h)(7)(i)(B)(1)–(2) (educational, licensing, and certification requirements for nurses), (h)(7)(ii) (evidence required for the trainee), (iii) (restrictions on the type of program that will qualify).

98. § 1101(a)(15)(O)(i); § 214.2(o)(1)(ii)(A)(1).

99. See § 214.2(o)(3)(iii) (establishing “[e]videntiary criteria” for the O-1 visa).

100. *O-1 Visa Frequently Asked Questions*, CURRAN, BERGER & KLUDT IMMIGR. L., <https://cbkimmigration.com/achievement-based/o-1-temporary-visa/o-1-visa-frequently-asked-questions/> (last visited Apr. 12, 2022).

101. *Practicing Medicine in the U.S. as an International Medical Graduate*, AM. MED. ASS’N, <https://www.ama-assn.org/education/international-medical-education/practicing-medicine-us-in>

The H-1B visa is thus the primary path for a noncitizen medical professional to practice medicine or nursing in the United States. That being said, noncitizens may also enter the United States on a nonimmigrant visa in order to *study* medicine.¹⁰² For instance, a noncitizen may enter the United States on a student visa to attend medical or nursing school full-time.¹⁰³ Or the noncitizen could enter as part of a cultural or educational exchange and training program.¹⁰⁴ Although neither of these visas would allow the noncitizen to practice medicine or nursing, both would allow the noncitizen to obtain educational credentials that would likely assist in ultimately procuring an H-1B visa or an immigrant visa.¹⁰⁵

There are a number of ways in which noncitizen physicians and nurses may qualify for an immigrant visa. The first preference category for employment-based immigrants, the EB-1 category, covers, as relevant here, noncitizens of “extraordinary ability in the sciences . . . which has been demonstrated by sustained national or international acclaim and whose achievements have been recognized in the field through extensive documentation.”¹⁰⁶ Although this standard is similar to the O-1 nonimmigrant visa, the requirements for the EB-1 are distinct, and the prior approval of an O-1 nonimmigrant visa does not establish *prima facie* eligibility for the EB-1 immigrant visa.¹⁰⁷ To establish the requisite “extraordinary ability,” the applicant must present “evidence of a one-time achievement (that is, a major, international recognized award),”¹⁰⁸ or evidence falling within at least three other categories indicating such ability, including “lesser” national or international prizes, society memberships,

ternational-medical-graduate (last visited Apr. 12, 2022); *Educational Commission for Foreign Medical Graduates Certification*, AM. MED. ASS’N, <https://www.ama-assn.org/education/international-medical-education/educational-commission-foreign-medical-graduates> (last visited Apr. 12, 2022).

102. See § 1101(a)(15)(F), (J).

103. See § 1101(a)(15)(F).

104. See § 1101(a)(15)(J).

105. *Immigration Information for International Medical Graduates*, AMA, <https://www.ama-assn.org/education/international-medical-education/immigration-information-international-medical-graduates#:~:text=The%20most%20common%20visa%20international,for%20the%20J%2D1%20visa> (last visited May 16, 2022); *H-1B for Nurses*, VISANATION, [immi-usa.com/h1b-visa/h1b-nurses/](https://www.visanation.com/h1b-visa/h1b-nurses/) (last visited Apr. 12, 2022).

106. 8 U.S.C. § 1153(b)(1).

107. See, e.g., *Policy Manual*, U.S. CITIZENSHIP & IMMIGR. SERVS. 1651 (Apr. 7, 2022), <https://www.uscis.gov/book/export/html/68600>. Stating that:

Though the prior approval of an O-1 petition may be a relevant consideration in adjudicating an immigrant petition for a person with extraordinary ability, it is not determinative. Eligibility as an O-1 nonimmigrant does not automatically establish eligibility for immigrant extraordinary ability classification. Each petition is separate and independent and must be adjudicated on its own merits, under the corresponding statutory and regulatory provisions. *Id.*

108. 8 C.F.R. § 204.5(h)(3) (2021).

publications, leadership positions in organizations, and high remuneration.¹⁰⁹ This is an attractive visa option because it requires neither an employment offer or employer sponsorship, nor a labor certification, *i.e.*, beneficiaries can pursue the visa on their own.¹¹⁰ At the same time, it is a demanding standard, and although physicians *may* be able to establish an evidentiary basis for the granting of the EB-1, it is by no means a foregone conclusion.¹¹¹

The second preference EB-2 visa provides a second option for noncitizen physicians and may also provide an option for certain classes of noncitizen nurses.¹¹² This visa category is for noncitizens “who are members of the professions holding advanced degrees,” or those who possess “exceptional ability.”¹¹³ The term “professional” is defined under the INA to include physicians and surgeons,¹¹⁴ and if seeking to qualify for the visa as a professional, the petitioner must submit evidence of an advanced degree or evidence of a bachelor’s degree with significant professional experience post-dating conferral of that degree.¹¹⁵ Alternatively, the petitioner may proffer evidence demonstrating “exceptional ability,” which is similar to that required for other visa categories: professional memberships, licensures, professional recommendations, and other academic evidence.¹¹⁶

Besides these distinct standards, the EB-2 also differs from the EB-1 in that the former visa normally requires a labor certification and offer of employment.¹¹⁷ A noncitizen physician may obtain a waiver of this requirement, however, if the noncitizen “agrees to work full time as a physician in an area or areas designated . . . as having a shortage of health care professionals or at a health care facility under the jurisdiction of the Secretary of Veterans Affairs,” and such employment would be “in the public interest.”¹¹⁸ Applicants for the EB-2 visa must establish that they are not inadmissible, that they have the

109. See § 204.5(h)(3)(i)–(x).

110. See § 204.5(h)(5) (“Neither an offer for employment in the United States nor a labor certification is required for this classification.”).

111. See, e.g., *Immigrant Petition for Alien Worker as an Alien of Extraordinary Ability Pursuant to Section 203(b)(1)(A) of the Immigration and Nationality Act*, 8 U.S.C. § 1153(b)(1)(A), U.S. CITIZENSHIP & IMMIGR. SERVS., 1, 2–3 (June 11, 2008), https://www.uscis.gov/sites/default/files/err/B2%20-%20Aliens%20with%20Extraordinary%20Ability/Decisions_Issued_in_2008/Jun112008_01B2203.pdf (sustaining the petitioner’s appeal of a visa denial and finding “extraordinary ability” of a pediatric cardiologist, but noting the high standard applicable to this category).

112. *Policy Manual*, *supra* note 107, at 689–90.

113. 8 U.S.C. § 1153(b)(2)(A).

114. See 8 U.S.C. § 1101(a)(32).

115. See § 204.5(k)(3)(i).

116. See § 204.5(k)(3)(ii).

117. See § 204.5(k)(4)(i).

118. § 1153(b)(2)(B)(ii); see 8 C.F.R. § 204.12 (2021).

requisite educational qualifications, and that they have passed all required exams.¹¹⁹

Noncitizen nurses seeking an EB-2 visa may face obstacles if the position for which they are applying does not meet the educational criteria that would qualify an applicant for the EB-2 visa.¹²⁰ As the USCIS Policy Manual notes, “in nursing, only managerial jobs [] or advanced level jobs (such as clinical nurse specialist, nurse practitioner) generally require advanced degrees. A registered nurse job, by contrast, usually does not require an advanced degree.”¹²¹

Finally, the third preference EB-3 visa provides another option for noncitizen physicians and the best option for noncitizen nurses.¹²² This visa is available to “[q]ualified immigrants who hold baccalaureate degrees and who are members of the professions,” including physicians and surgeons,¹²³ as well as others “capable . . . of performing skilled labor (requiring at least 2 years training or experience), not of a temporary or seasonal nature[.]”¹²⁴ This visa requires a labor certification.¹²⁵

Noncitizens seeking to work in the United States as health care professionals, including physicians, nurses, and others, face specific inadmissibility criteria. Section 1182(a)(5)(B) renders inadmissible “[u]nqualified physicians.”¹²⁶ This ground of inadmissibility applies to a narrow class of noncitizens who are seeking visas under the second or third employment-based preference categories,¹²⁷ and who are “coming to the United States principally to perform services as a member of the medical profession.”¹²⁸ Such individuals are inadmissible to the United States, *unless* they: (1) have “passed parts I and II of the National Board of Medical Examiners Examination” and (2) are “competent in oral and written English.”¹²⁹

119. See 8 U.S.C. § 1182(a)(5)(B).

120. *Policy Manual*, *supra* note 107, at 669.

121. *Id.*

122. *Id.* at 630.

123. § 1153(b)(3)(A)(ii); see 8 U.S.C. § 1101(a)(32) (defining “professional” to include physicians and surgeons); see also 8 C.F.R. § 204.5(l)(2) (defining in part the term “professional”), (l)(3)(ii)(C) (evidentiary requirements to establish that the noncitizen is within the class of “professional”).

124. § 1153(b)(3)(A)(i); see § 204.5(l)(2) (defining in part the term “skilled worker”), (l)(3)(ii)(B) (evidentiary requirements to establish that the noncitizen qualifies as a “skilled worker”).

125. See § 1153(b)(3)(C); § 204.5(l)(3)(i).

126. 8 U.S.C. § 1182(a)(5)(B).

127. See § 1182(a)(5)(D) (limiting scope of inadmissibility to those two categories); 22 C.F.R. § 40.52 (2021); see also § 1153(b)(2) (“Aliens who are members of the professions holding advanced degrees or aliens of exceptional ability”); § 1153(b)(3)(i)–(iii) (“Skilled workers, professionals, and other workers”).

128. § 1182(a)(5)(B).

129. *Id.*

Whereas Section 1182(a)(5)(B) applies only to “physicians,” Section 1182(a)(5)(C) applies to noncitizens “who seek[] to enter the United States for the purpose of performing labor as a health-care worker, *other than a physician.*”¹³⁰ Foreign-educated noncitizens covered under this provision must provide a certificate from the Commission on Graduates of Foreign Nursing Schools, or an equivalent independent organization approved by the Department of Justice (DOJ) and Department of Health and Human Services (HHS).¹³¹ Such a certificate may be issued if a noncitizen establishes certain threshold educational, training, licensing, and experiential qualifications comparable to a U.S.-educated health care professional of the same type.¹³² The noncitizen must also demonstrate the requisite competence in written and spoken English,¹³³ and have passed any exam in the relevant field of practice, if required in a majority of states licensing that practice.¹³⁴ Foreign-educated noncitizens seeking to enter “for the purpose of performing labor as a nurse” are subject to slightly different criteria.¹³⁵ Nurses must have: (1) a valid license in the state in which they will practice, and the state authorities must have verified the authenticity of the applicant’s foreign license, if applicable;¹³⁶ (2) passed the National Council Licensure Examination;¹³⁷ and (3) graduated from certain qualifying nursing schools, where the language of instruction was English, and that have been in operation since before November 12, 1999, or have been approved as an institution whose graduates may be certified under Section 1182(r).¹³⁸

Although the preceding paragraphs dealt with employment-based paths for lawful entry, it is worth noting that noncitizen medical professionals may also enter the United States through the family-based visa categories. They could qualify as an immediate relative by, for instance, marrying a United States citizen, or they could otherwise fall within one of the family-based visa preference categories.¹³⁹ Accordingly, family, rather than employment, could provide a path to residence in the United States. But to practice medicine *after* admission, the noncitizen would have to comply with all relevant licensing and

130. § 1182(a)(5)(C) (emphasis added); see 8 C.F.R. §§ 212.7(a)(1), 212.15(b)(1)–(2); 8 C.F.R. § 1212.15(a) (2021).

131. See 22 C.F.R. § 40.32(a) (2021).

132. See § 1182(a)(5)(C)(i)(I)–(III); § 212.15(d)–(e) (2021); § 1212.15(f)(6)–(9).

133. § 1182(a)(5)(B); § 212.15(g); § 1212.15(g).

134. § 1182(a)(5)(B); § 212.15(f)(iv); § 1212.15(f)(9).

135. See § 1182(r); § 212.15(g)(4)(ii); § 1212.15(g)(ii)–(iii).

136. § 1182(r)(1); § 212.15(d)–(f); § 1212.15(f)(9).

137. § 1182(r)(2); § 212.15(h)(2)(ii); § 1212.15(g)(4)(ii)–(iii).

138. § 1182(r)(3)(A)–(C); § 212.15(h)(2)(v); § 1212.15(f)(6)–(9).

139. See 8 U.S.C. § 1151(b)(2)(A)(i) (defining “immediate relatives” not subject to numerical bars on visas as “the children, spouses, and parents of a citizen of the United States”); 8 U.S.C. § 1153(a)(1)–(4) (establishing the four preference categories for family-based immigration subject to annual visa limitations).

educational requirements otherwise applicable to his or her chosen profession.¹⁴⁰ In other words, although family-based immigration could provide a second path to lawful admission to the United States, it could not be used as a shortcut to gaining admission *for the purposes* of practicing medicine if the noncitizen otherwise fails to meet domestic professional standards.

III. OPPORTUNITIES FOR CONGRESS TO ADVANCE HEALTH POLICY THROUGH IMMIGRATION REFORMS

Congress has the opportunity to advance health policy at all three points in the immigration process highlighted in Part II, and this Part offers discrete recommendations for what those reforms could look like. Section III.A recommends repealing the public charge ground of deportability and eliminating consideration of public benefits use from the public charge inadmissibility determination. These reforms would address the fear, commonplace in immigrant communities, that enrolling in public benefits, including Medicaid, can have negative immigration consequences. Since the public charge deportation ground is already rarely utilized in removing noncitizens from the United States, the reforms are unlikely to have any significant adverse operational effect on enforcement but would promote uptake of health-promoting public benefits in immigrant communities. Section III.B turns to noncitizen access to health coverage, recommending the elimination of extant restrictions on noncitizens' eligibility for subsidized health coverage and the repeal of the employer sanctions regime that discourages employers from providing coverage to undocumented employees. Finally, Section III.C addresses the problem of meeting the health care needs of patients in the United States due to the shortage of health care providers and a potential solution in the increased admission of noncitizen health care professionals. This Section proposes that Congress create discrete visas to promote and simplify the admission of health care professionals needed to address current and projected shortages, modeled on prior successful statutes Congress passed to address nursing shortages in the 1980s and 1990s.¹⁴¹ In addition, Congress and the states should loosen licensing criteria for foreign-educated health care professionals—in essence, making permanent many of the emergency measures states enacted during the COVID-19 pandemic to maximize the number of health care professionals operating in the system.

140. See *Educational Commission for Foreign Medical Graduates Certification*, *supra* note 101; *Practicing Medicine in the U.S. as an International Medical Graduate*, *supra* note 101.

141. Wakina Scott, *Nurse Workforce: Condition Critical*, NAT'L HEALTH POL'Y F., 5 (June 2001), https://www.ncbi.nlm.nih.gov/books/NBK559756/pdf/Bookshelf_NBK559756.pdf.

A. *Repeal the “Public Charge” Ground of Deportability and Revise the “Public Charge” Ground of Inadmissibility*

The public charge grounds of inadmissibility and deportability are barriers to noncitizens’ access to health-supporting public benefits. Many noncitizens and their U.S. citizen family members avoid enrolling in any public benefit based on fears that doing so could have negative immigration-related consequences for them or their family members.¹⁴² These longstanding fears within the immigrant community are sometimes based on misunderstandings of how the law is interpreted and enforced.¹⁴³ In recent years, these fears have increased due to new regulations promulgated by the Trump administration that expanded the scope of the public charge law, including increasing the types of public benefits that would be considered as negative factors in public charge inadmissibility determinations.¹⁴⁴ For example, under prior public charge guidance issued in 1999, DHS has disregarded noncitizens’ receipt of most public benefits, only considering enrollment in programs that provide long-term institutionalization or cash benefits.¹⁴⁵ In regulations promulgated in 2019, DHS also considered noncitizens’ enrollment in housing, nutrition, and health care programs.¹⁴⁶ Parallel regulations relating to public charge deportability were reportedly in development at the DOJ but were never proposed.¹⁴⁷ During the COVID-19 pandemic, when many more people have had to rely on public benefits to survive due to unemployment and health-related concerns, noncitizens and their U.S. citizen family members have continued to avoid enrolling in public benefits for which they are eligible.¹⁴⁸

Although the Biden administration repealed the prior administration’s public charge inadmissibility regulations in March 2021, the status quo interpretation of the law does not address noncitizens’ longstanding and recently heightened concerns about accessing public benefits.¹⁴⁹ Immigrant advocacy organizations have documented the ongoing “chilling effect” of the public

142. *The Public Charge Rule as Public Health Policy*, *supra* note 44, at 195.

143. *Id.* at 196.

144. *Id.* at 199–200.

145. *Id.* at 184–85.

146. *Id.* at 198.

147. PROTECTING IMMIGRANT FAMS., PUBLIC CHARGE UPDATE: WHAT ADVOCATES NEED TO KNOW NOW 1 (2021), <https://www.nilc.org/wp-content/uploads/2020/03/Public-Charge-What-Advocates-Need-to-Know-Now.pdf>.

148. PROTECTING IMMIGRANT FAMS., RESEARCH DOCUMENTS HARM OF PUBLIC CHARGE POLICY DURING THE COVID-19 PANDEMIC 2–3 (2021), <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

149. Gabriel R. Sanchez, *It’s Time for the Biden Administration to Let Immigrants Know About the Public Charge Rule Change*, BROOKINGS (Jan. 19, 2022), <https://www.brookings.edu/blog/how-we-rise/2022/01/19/its-time-for-the-biden-administration-to-let-immigrants-know-about-the-public-charge-rule-change/>.

charge law.¹⁵⁰ The 1999 Field Guidance issued by the Immigration and Naturalization Service (INS) is once again in effect, but advocates have urged the administration to take steps to reach out to immigrant communities to provide clear information about that policy and to rebuild trust in those communities.¹⁵¹

DHS has begun the process of codifying new regulations relating to public charge inadmissibility,¹⁵² but any regulatory reform may be inadequate to address the inherent tension of a law that gives certain noncitizens rights to enroll in public benefits on the one hand and punishes them with negative immigration consequences for exercising those rights on the other.¹⁵³ In August 2021, DHS issued an Advance Notice of Proposed Rulemaking seeking input from the public on fundamental questions relating to the interpretation of the public charge law, including the definition of public charge¹⁵⁴ and whether DHS should consider receipt of public benefits in the inadmissibility determination.¹⁵⁵ To relieve the “underlying tension between excluding and providing”¹⁵⁶ in the public charge law, DHS could have proposed to exclude use of public benefits from the public charge determination entirely, since the statute does not include use of public benefits among the factors to be considered.¹⁵⁷ At the time of this writing, DHS has not yet issued a final rule and it is unlikely DHS will go so far, given that certain types of public benefits has long been considered in the public charge determination.¹⁵⁸

150. RESEARCH DOCUMENTS HARM OF PUBLIC CHARGE POLICY DURING THE COVID-19 PANDEMIC, *supra* note 148, at 1.

151. PROTECTING IMMIGRANT FAMS., THAWING THE PUBLIC CHARGE CHILL 3 THINGS ELECTED OFFICIALS CAN DO, at 1 (2021), <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/10/3-Things-Electeds-Can-Do.pdf>.

152. *See* Public Charge Ground of Inadmissibility, 86 Fed. Reg. 47,025, 47,025 (Aug. 23, 2021) (to be codified at 8 C.F.R pt. 212).

153. Joseph Daval, *The Problem with Public Charge*, 130 YALE L.J. 998, 1046 (2021). Medha D. Makhoul has argued that this “tension” is also a legitimacy problem because it undermines noncitizens’ property rights in public benefits. Medha D. Makhoul, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL’Y, L., & ETHICS 1, 55–57 (2021).

154. Public Charge Ground of Inadmissibility, 86 Fed. Reg. at 47,028.

155. *Id.* at 47,031; In February 2022, DHS proposed new regulations that largely mirror the 1999 Field Guidance. Public Charge Grounds of Inadmissibility, 87 Fed. Reg. 10,570, 10,667 (Feb. 24, 2022).

156. Daval, *supra* note 153, at 1046.

157. 8 U.S.C. § 1182 (a)(4)(B) (listing “age; health; family status; assets, resources, and financial status; and education and skills” as factors to be considered in public charge inadmissibility determinations).

158. *See* Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,692 (Mar. 26, 1999). This federal regulation explains this distinction by stating:

Although there are legislative proposals to improve noncitizens' access to subsidized health coverage¹⁵⁹ and to reform the immigrant visa system,¹⁶⁰ none of them address the impact of the public charge grounds of deportability and inadmissibility.¹⁶¹ Scholars and advocates have urged Congress to amend the public charge statute to provide clarity about the factors that may be considered in public charge determinations and to reduce DHS's discretion to interpret the public charge statute in as broad and punitive a way that it did in 2019.¹⁶² Before the Biden administration's rescission of the 2019 public charge regulation and shortly after the 2019 regulation was finalized, Congressmembers introduced legislation to defund DHS's activities relating to administration of public charge.¹⁶³ There were also congressional efforts to eliminate the public charge ground of deportability.¹⁶⁴ Since the March 2021 rescission of that regulation, however, it appears that their interest in taking action to address ongoing concerns relating to public charge has waned.

In order to address noncitizens' reluctance to access the public benefits to which they are legally entitled, Congress should repeal the public charge ground of deportability and revise the public charge ground of inadmissibility to prohibit consideration of public benefits use.

Repealing the public charge ground of deportability would take away DHS's ability to remove noncitizens on the basis that they had become reliant on public benefits for support.¹⁶⁵ Since deportations based on public charge are virtually

It has never been Service policy that any receipt of services or benefits paid for in whole or in part from public funds renders an alien a public charge, or indicates that the alien is likely to become a public charge. The nature of the public program must be considered. *Id.*

The Public Charge Rule as Public Health Policy, *supra* note 44, at 184.

159. *See, e.g.*, Lifting Immigrant Families Through Benefits Access Restoration Act of 2021, H.R. 5227, 117th Cong. § 2(i) (2021) (enacted); Health Equity and Access under the Law for Immigrant Families Act of 2021, S. 1660, 117th Cong. § 3(a) (2021) (enacted).

160. *See, e.g.*, Build Back Better Act, H.R. 5376, 117th Cong. § 60002(a), (b) (2021) (enacted); U.S. Citizenship Act, H.R. 1177, 117th Cong. (2021).

161. PUBLIC CHARGE UPDATE: WHAT ADVOCATES NEED TO KNOW NOW, *supra* note 147, at 1.

162. *See, e.g.*, Daval, *supra* note 153, at 1038, 1044, 1046; Shanzeh Daudi, *Choosing Between Healthcare and a Green Card: The Cost of Public Charge*, 70 EMORY L.J. 201, 239, 241–42, 245 (2020); Caroline La Rochelle, *The Case for Congressional Action on Public Charge*, CHILDS. HOSP. PHILA. (Oct. 27, 2021), <https://policylab.chop.edu/blog/case-congressional-action-public-charge>; Katherine Villeda, *It's Time for Congress to "HEAL" and "LIFT the BAR" for Immigrants' Access to Health Care*, CMTY. CATALYST (Aug. 31, 2021), <https://communitycatalyst.org/blog/its-time-for-congress-to-heal-and-lift-the-bar-for-immigrants-access-to-health-care#.YY6UA2Bok2y>.

163. No Federal Funds for Public Charge Act of 2019, H.R. 3222, 116th Cong. § 3 (2019) (enacted).

164. *See* No Public Charge Deportation Act of 2019, H.R. 5814, 116th Cong. § 2 (2020) (enacted).

165. *See The Public Charge Rule as Public Health Policy*, *supra* note 44, at 184–85, 198.

nonexistent,¹⁶⁶ the major impact of the repeal would not necessarily be a reduction in the number of public charge deportations; rather it would reduce noncitizens' concerns about the consequences of enrolling in public benefits.¹⁶⁷ In a statement regarding the No Public Charge Deportation Act, U.S. Representative Grace Meng noted that eliminating public charge deportation was necessary to “*change the perception* that just because you are poor or need safety net programs to feed and house your family, it doesn't make you less worthy of legally remaining in this great country.”¹⁶⁸ This is tacit acknowledgement that the law on the books, although rarely enforced, is perceived as a threat by immigrant communities and alters their behavior with real-life consequences.¹⁶⁹

Prohibiting consideration of public benefits use in public charge inadmissibility determinations would both alleviate noncitizens' fears of accessing public benefits and provide clear limitations on future administrations' ability to expand the use of public charge without adequate justification. Interpretations of how to determine who is a public charge have changed over the decades due, in part, to the expansions of forms of public benefits.¹⁷⁰ When the statute was enacted in 1882, the main form of state-funded aid was the “poorhouse,” which provided room, board, and health care to people who were destitute, many of whom were sick, disabled, or elderly.¹⁷¹ Today, by contrast, there is a complex scheme of benefits and subsidies that provide less-than-full support for people who need assistance to get by.¹⁷² Given the ubiquity and diversity of these programs, a definition of public charge that considers use of public benefits would make almost everyone a public charge.¹⁷³ Congressional action to eliminate consideration of public benefits use from public charge inadmissibility determinations would be the simplest and clearest way to ensure that noncitizens can access the public benefits to which they are entitled without fear.

These proposals may be opposed by those who are concerned about the amounts of government spending on public benefits generally, or the amount

166. Public charge deportations have been rare since 1948. *Id.* at 183.

167. *Id.* at 184, 196.

168. Press Release, Congresswoman Grace Meng, Meng Introduces Legislation to Remove Public Charge as a Reason for Deportation (Feb. 14, 2020) (emphasis added).

169. *Id.*

170. Daval, *supra* note 153, at 1025.

171. *Id.* at 1009; *History of 19th Century American Poorhouses*, THOMPSON CONN. (Oct. 20, 2013), https://www.thompsonct.org/sites/g/files/vyhlf5076/f/uploads/3_backgroundpoorhouse_system.pdf.

172. Jeanne Batalova et al., *Millions Will Feel Chilling Effects of U.S. Public-Charge Rule That Is Also Likely to Reshape Legal Immigration* (Aug. 2019), <https://www.migrationpolicy.org/news/chilling-effects-us-public-charge-rule-commentary#:~:text=Chilling%20effects%20are%20likely%20to,programs%20for%20immigrants%20ineligible%20for>.

173. See Daval, *supra* note 153, at 1046–47.

spent on providing public benefits to noncitizens particularly. These concerns are valid but misplaced. Our proposals do not seek to expand noncitizen eligibility for public benefits. Rather, they seek to resolve the tension in a legal scheme that entitles noncitizens to access health-promoting public benefits and then discourages them from doing so.

Others may oppose our proposed reforms because they believe they do not go far enough. After all, DHS would still be permitted to consider—and therefore discriminate on the basis of—“age; health; family status; assets, resources, and financial status; and education and skills” in public charge inadmissibility determinations.¹⁷⁴ We agree that our proposals leave open the possibility that future administrations could, once again, leverage the public charge law to exclude categories of noncitizens in ways that many consider unjust. However, the proposals are modest by design. They aim to address a discrete, longstanding, and important issue, ideally through consensus. They do not foreclose future reforms to the public charge law that would more completely end discrimination in the immigration system against people who did not have the good fortune to be born wealthy, to have avoided illness and injury, and to have the opportunity to obtain substantial education or training.

B. Expand Noncitizen Access to Health Coverage

Congress should also act to maximize noncitizen access to health coverage by repealing immigration-status-based limitations on subsidized health coverage programs. To this end, Section III.B.1 recommends that Medicaid, CHIP, and subsidized ACA coverage should be available to all noncitizens in the United States, regardless of lawful immigration status. Section III.B.2 recommends repealing laws that limit eligible noncitizens’ access to Medicaid, including temporal bars and provisions permitting states to impose additional limitations on noncitizen access to federal public benefits. Finally, recognizing the importance of employer-provided health insurance, Section III.B.3 recommends repeal of the employer-sanctions regime under the INA, which eliminates incentives for employers to offer such coverage while pushing noncitizen workers into grey-market jobs that are less likely to provide benefits.

1. Expand Eligibility for Medicaid and ACA Coverage to All Noncitizens Residing in the United States

The current framework governing noncitizen eligibility for subsidized health coverage is complicated. Without health insurance, health care is unaffordable for most people.¹⁷⁵ Lack of access to health insurance is linked to

174. 8 U.S.C. § 1182(a)(4)(B).

175. Anika Veeraraghav, *Healthcare in the US Is Largely Unaffordable: This Needs to Change*, DAILY CAMPUS (Oct. 5, 2021), <https://dailycampus.com/2021/10/05/healthcare-in-the-us-is-largely-unaffordable-this-needs-to-change>.

health inequities by race, socioeconomic status, gender, and sexuality.¹⁷⁶ For example, the United States has some of the worst pregnancy-related morbidity and mortality outcomes among high-income nations, and these burdens are more likely to harm people who are Black, Indigenous, Latinx, Asian, and Pacific Islander, including immigrants from those groups.¹⁷⁷ As the COVID-19 pandemic has highlighted, underlying health inequities in a population weakens everyone's ability to weather a health-related threat and can increase risks for every member of the community.¹⁷⁸

Since the passage of PRWORA in 1996, Congress has restored public benefits eligibility to some groups of lawfully present noncitizens, but these reforms incompletely address the stark disparities in access to health insurance for low-income noncitizens.¹⁷⁹ For example, in 1997 and 1998, respectively, Congress restored eligibility for Supplementary Security Income (SSI) and Food Stamps, now called SNAP, to certain groups of lawfully present noncitizens who arrived prior to PRWORA's enactment.¹⁸⁰ In 2009, Congress gave states the option to expand Medicaid and CHIP eligibility to lawfully present children and lawfully present people who are pregnant.¹⁸¹ However, not all states have elected this option, contributing to the patchwork nature of noncitizen eligibility for subsidized health coverage.¹⁸² In 2020, Congress restored Medicaid eligibility for Compacts of Free Association migrants from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau as part of a COVID relief bill.¹⁸³ These reforms still leave many categories of lawfully present noncitizens ineligible for coverage and do not address the lack of access to health insurance for undocumented people.¹⁸⁴

Immigrant eligibility to purchase subsidized or unsubsidized health coverage on the ACA exchanges is limited to lawfully present noncitizens, excluding undocumented noncitizens whose lack of access to health care poses

176. Health Equity and Access Under the Law for Immigrant Families Act of 2021 (hereinafter "HEAL Act"), S. 1660, 117th Cong. § 2(a)(1) (2021).

177. HEAL Act § 2(a)(9).

178. Lauren Paremoer et al., *Covid-19 Pandemic and the Social Determinants of Health*, BMJ (Jan. 29, 2021), <https://www.bmj.com/content/372/bmj.n129>.

179. See Shawn Fremsted, *Immigrants and Welfare Reauthorization*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (2002), <https://www.cbpp.org/sites/default/files/atoms/files/1-22-02tanf4.pdf>.

180. *Id.*

181. *Facts About Federal Funding for States to Provide Health Coverage to Immigrant Children and Pregnant Women*, NAT'L IMMIGR. L. CTR. (2010), <https://www.nilc.org/wp-content/uploads/2016/05/ICHIA-facts-2010-08-06.pdf>.

182. *Id.*

183. Consolidated Appropriations Act, Pub. L. No. 116-260, § 208, 134 Stat. 1182 (Dec. 21, 2020).

184. *See id.*

potential public health and economic risks described above.¹⁸⁵ Since the ACA was enacted in 2010, there have been no expansions of immigrant eligibility for participation in the exchanges.¹⁸⁶ In 2012, however, when the DACA policy was announced, the HHS explicitly excluded beneficiaries of the policy from eligibility to participate in the ACA exchanges—a right they presumably would have had if not for HHS’s rulemaking, given that similarly situated beneficiaries of other forms of deferred action are considered lawfully present for this purpose.¹⁸⁷

The Health Equity & Access under the Law for Immigrant Families Act of 2021 (HEAL Act), which is currently under consideration in Congress and is supported by more than eighty lawmakers and over 250 national and state organizations, proposes, among other reforms, to (1) eliminate eligibility restrictions for Medicaid and CHIP for all noncitizens who are lawfully residing in the United States and (2) permit all noncitizens residing in the United States who are ineligible for Medicaid because of their immigration status to purchase subsidized health coverage on the ACA exchanges.¹⁸⁸ The latter provision would eliminate the major legal barrier preventing low-income undocumented noncitizens from obtaining affordable coverage,¹⁸⁹ although it still does not expand Medicaid and CHIP to undocumented noncitizens.¹⁹⁰ Moreover, it leaves behind undocumented noncitizens who do not meet the financial eligibility requirements for Medicaid, *i.e.*, they earn too much to qualify for Medicaid.¹⁹¹ Subsidized health coverage on the ACA exchanges is generally available to people who earn income that is less than 400% of the Federal Poverty Guidelines (FPG).¹⁹² This includes many middle-income households.¹⁹³

185. *Health Coverage of Immigrants*, KAISER FAM. FOUND. (Apr. 6, 2022), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>.

186. *Immigrant Eligibility for Health Care Programs in the United States*, NAT’L CONF. STATE LEGISLATURES (Oct. 19, 2017), <https://www.ncsl.org/research/immigration/immigrant-eligibility-for-health-care-programs-in-the-united-states.aspx>.

187. *Immigrants and the Affordable Care Act (ACA)*, NAT’L IMMIGR. L. CTR. (Jan. 2014), <https://www.nilc.org/issues/health-care/immigrantsshr/>.

188. HEAL Act, S. 1660, 117th Cong. § 3(a)–(b), 5 (2021).

189. HEAL Act § 5. It separately defines lawfully present for purposes of the ACA to mean “all individuals granted federally authorized presence in the United States,” thereby restoring eligibility to purchase subsidized health coverage on the ACA exchanges to DACA beneficiaries. HEAL Act § 4.

190. HEAL Act § 3(a)–(b).

191. *The Health Equity and Access Under the Law (HEAL) for Immigrant Families Act*, NAT’L ASIAN PAC. AM. WOMEN’S F., <https://www.napawf.org/assets/download/heal/HEAL-Fact-Sheet-2021.pdf> (last visited Apr. 18, 2022).

192. *About the Affordable Care Act*, HHS.GOV (Mar. 17, 2022), <https://www.hhs.gov/health-care/about-the-aca/index.html>.

193. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAM. FOUND. (Oct. 29, 2021), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/>.

By contrast, the income limit for Medicaid is 138% of the FPG in states that have expanded Medicaid under the ACA and even lower in non-expansion states.¹⁹⁴ The HEAL Act would expand access to health coverage for undocumented noncitizens with the lowest incomes, but there would still be a gap in coverage eligibility for low- and middle-income undocumented noncitizens.¹⁹⁵

The HEAL Act explicitly recognizes that “[d]enying health insurance coverage . . . on the basis of immigration status unfairly hinders immigrants’ ability to reach and maintain their optimal levels of health and undermines the economic well-being of their families.”¹⁹⁶ It also acknowledges that “[i]t is . . . in our collective public health and economic interest to remove legal and policy barriers to affordable health insurance coverage that are based on immigration status.”¹⁹⁷ These findings alone represent a remarkable evolution of opinion on immigrant access to health coverage compared with mainstream and even progressive viewpoints of Democratic lawmakers during debates over the ACA. However, because these findings are equally applicable to undocumented noncitizens, it does not make sense from a health policy perspective to limit the Medicaid and CHIP expansions to lawfully residing noncitizens. Undocumented noncitizens who have bolstered publicly funded health programs through tax dollars (some for decades) and whose income falls below the limit for Medicaid and CHIP are arguably no less deserving of support than noncitizens whose presence is federally authorized. Undocumented noncitizens are also just as vulnerable—or more vulnerable, in some cases, due to the nature of their employment—as other uninsured people to contract and spread infectious disease.¹⁹⁸ The HEAL Act is an important step forward, but it does not go far enough.

Congress should eliminate eligibility restrictions for Medicaid and CHIP that are based on immigration status, permitting all people residing in the United States to access these programs. The health of all who live in the United States—regardless of immigration status—is connected.¹⁹⁹ Although immigration status restrictions may seem, at first glance, too ingrained in our public benefits system to discard, lawmakers should be reminded of the long history of states extending aid to destitute newcomers, the fact that undocumented noncitizens were eligible for Medicaid in the past, and that there is currently an array of federal programs that support the health of low-income noncitizens regardless of status, including

194. *About the Affordable Care Act*, *supra* note 192.

195. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, *supra* note 193.

196. HEAL Act § 2(a)(7).

197. § 2(a)(10).

198. *Health Coverage of Immigrants*, *supra* note 185.

199. *Health Status*, U.S. ENV’T PROT. AGENCY, <https://www.epa.gov/report-environment/health-status> (last visited Apr. 21, 2022).

emergency Medicaid, funding for community health centers, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the National School Lunch Program.²⁰⁰ Considered in this context, adding Medicaid and CHIP to the list of programs that do not discriminate on the basis of immigration status is not as radical as it may initially seem.

There are additional reforms that Congress should consider including in the HEAL Act to assure undocumented noncitizens that accessing health care and publicly funded coverage will not have negative immigration-related consequences in the future.²⁰¹ Legislators should consider enacting laws that would effectively fill the gaps in the framework of laws and policies intended to protect noncitizens from immigration surveillance in health care.²⁰² They could build on existing laws and policies, such as the DHS Sensitive Locations Policies; the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules; confidentiality protections in Medicaid, CHIP, and ACA programs; and the INS's 1999 Field Guidance on public charge.²⁰³ More ambitiously, legislators might consider working with the White House on designing a national strategy on immigrant health to balance immigration enforcement priorities with health care access.²⁰⁴ Given that there is, at times, tension between enforcing immigration laws and encouraging people residing in the United States to access health care in a timely manner, a statutory directive prohibiting or limiting immigration surveillance in health care would provide valuable guidance to DHS, HHS, health care providers, and the immigrant community.

2. Repeal Temporal Bars to Access Benefits and Disallow State Imposition of Additional Requirements

The temporal bars that hinder noncitizens' access to public benefits—including Medicaid, SNAP, and SSI—and the discretion that states have to impose additional eligibility requirements effectively prevent future U.S. citizens from obtaining support that would promote their short- and long-term health.²⁰⁵ PRWORA contained both a federal “ceiling” and a “floor” of benefits

200. TANYA BRODER ET AL., NAT'L IMMIGR. L. CTR., OVERVIEW OF IMMIGRANT ELIGIBILITY FOR FEDERAL PROGRAMS 1 (2021), <https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/>.

201. See Medha D. Makhoul, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL'Y L. & ETHICS, no. 1, 2021, at 1, 59 (presenting data on immigration-related health care system avoidance and describing the serious collateral consequences for the health care system of permitting immigration surveillance in health care).

202. See *id.* at 58 (describing the framework).

203. *Id.* at 23, 29, 60–61 (identifying gaps in protection in these laws and policies).

204. *Id.* at 59.

205. *Id.* at 2.

eligibility.²⁰⁶ The existence of the ceiling means that most noncitizens, even if they fall into the category of “qualified alien,” are ineligible for Medicaid for the first five years in that status. With limited exceptions,²⁰⁷ if states wish to expand eligibility for subsidized health coverage to a broader group of noncitizens, they must pay for it entirely out of state funds.²⁰⁸ The floor of Medicaid eligibility—the categories of noncitizens that states must cover—is minimal.²⁰⁹ This structure of the law makes it difficult for states to expand access to health coverage for noncitizens and easy for states to restrict it.²¹⁰

In 2009, Congress gave states options to expand Medicaid and CHIP access to lawfully residing children and lawfully residing pregnant women,²¹¹ but this legislative intervention benefits only a small proportion of the noncitizens who are subject to the five-year waiting period.²¹² Only about half of the states have elected the option to expand Medicaid or CHIP to lawfully residing children, and a smaller number have elected the option to expand eligibility for these programs to lawfully residing pregnant women, contributing to the arbitrary national patchwork of immigrant access to health care.²¹³ Moreover, the statute did not expand Medicaid or CHIP access to other qualified immigrants who may have greater needs for health coverage, including elderly, disabled, or injured people.²¹⁴ By contrast, the statute did not address states’ ability to impose heightened eligibility criteria for noncitizens, going above and beyond the five-year bar.²¹⁵

The Lifting Immigrant Families Through Benefits Restoration Act of 2021 (“LIFT the BAR Act”) proposes to eliminate the five-year waiting period for federal public benefits eligibility for qualified noncitizens and “raises the floor” of immigrant eligibility for federal public benefits by requiring states to deem a larger category of noncitizens categorically eligible.²¹⁶ It would align Medicaid

206. Medha D. Makhoulf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680, 1706, 1708 (2020).

207. See 8 U.S.C. § 1613(b) (listing categories of qualified noncitizens who are exempt from the five-year bar).

208. *Id.*

209. 8 U.S.C. § 1612(b)(2).

210. Makhoulf, *supra* note 206, at 1768.

211. *Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)*, U.S. DEP’T LAB., <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf> (last visited Apr. 28, 2022).

212. *Health Coverage of Immigrants*, *supra* note 185.

213. *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women*, MEDICAID.GOV, <https://www.medicare.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women> (last visited Apr. 21, 2022).

214. § 1612 (a)(1).

215. § 1612 (b)(2)(V).

216. Lift the Bar Act, H.R. 5227, 117th Cong. § 2(a) (2021) (repealing PRWORA §§ 403, 412, 422).

and CHIP eligibility with the immigrant eligibility provisions of the ACA.²¹⁷ If passed, this law would address the harms associated with PRWORA's five-year bar and the federal "floor" of Medicaid eligibility.²¹⁸

The major obstacle to the passage of the LIFT the BAR Act is, expectedly, the anticipated cost of increasing access to health-promoting public benefits to a much larger group of noncitizens,²¹⁹ but such objections may be overcome with arguments based on fairness, public health, and economics. For example, studies have found that noncitizens who pay insurance premiums subsidize health care costs for U.S. citizens because, on average, they incur disproportionately low health care expenditures.²²⁰ Some of those noncitizens would be barred from eligibility for Medicaid or CHIP if they were to lose access to private insurance—an outcome that many would consider unfair.²²¹ It is well established that increasing access to health insurance for noncitizens “reduces deaths, increases preventable care, and cuts preventable hospital readmissions[,]” all of which contribute to improved health screening and outcomes, particularly during public health emergencies.²²² Finally, studies have found that expanding access to certain health-promoting public benefits can “boost the economy.”²²³

3. Encourage Employer-Provided Coverage by Repealing the Employer Sanctions

Although much of this Article has addressed the exclusion of noncitizens from many forms of public health benefits, it is worth noting that “the lack of coverage under governmental programs would be less harmful if more [undocumented] immigrants worked in professions that extended health insurance coverage.”²²⁴ As other commentators have noted, “[n]ot only are

217. *Id.*

218. *Id.*

219. Caroline Simon, *Democrats Unveil Bill to Expand Immigrant Health Care Access*, ROLL CALL (May 12, 2021, 10:00 AM), <https://rollcall.com/2021/05/12/democrats-unveil-bill-to-expand-immigrant-health-care-access/>; Leighton Ku, *Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States*, 99 AM. J. PUB. HEALTH 1322, 1322 (2009).

220. *See, e.g.*, Ku, *supra* note 219, at 1324.

221. *See Support and Pass the LIFT the BAR Act*, NAT'L IMMIGR. L. CTR. (Aug. 2021), https://www.nilc.org/issues/economic-support/support-and-pass-the-lift-the-bar-act/#_ednref8 (citing a poll revealing that a majority of likely voters would support eliminating PRWORA's five-year-bar on federal public benefits eligibility for tax-paying Lawful Permanent Residents and a poll “finding that 82% of voters think the president and Congress should ensure that everyone has access to comprehensive health care coverage”).

222. *Id.*

223. *Id.*

224. Patrick Glen, *Health Care and the Illegal Immigrant*, 23 HEALTH MATRIX: J.L.-MED. 197, 234 (2013).

[undocumented immigrants] ineligible for most government insurance programs, but they are also often forced to work in ‘off-the-books’ occupations that offer no health benefits.”²²⁵ The issue is not an absolute prohibition on the provision of employer-sponsored coverage for noncitizens. In fact, perhaps as many as a quarter of undocumented workers have coverage through their employer.²²⁶ But this number badly lags the number of citizens who have such coverage.²²⁷ The problem is, rather, one of a lack of incentives on the part of employers to offer coverage, stemming from the prohibition on undocumented immigrants to obtain employment. Employers have no incentive to offer coverage to known undocumented immigrants, whose very employment is illegal, while the illegality of employment itself pushes undocumented workers into more gray-area, off-the-books, employment opportunities that inherently lack provision of health coverage.²²⁸

The illegality of employing undocumented immigrants is a relatively recent policy development. “Before 1986, employers could legally hire or employ persons who lacked work authorization from the Immigration and Naturalization Service (INS), although non-citizens present in this country without permission were subject to arrest and deportation, and the INS regularly conducted worksite raids as part of its broader interior enforcement strategy.”²²⁹ This changed with the enactment of a series of statutory reforms beginning in 1986, that: (1) made it illegal for employers to hire or retain undocumented workers;²³⁰ (2) implemented civil and criminal sanctions for employers who did hire or retain such workers;²³¹ and (3) imposed criminal penalties on certain undocumented workers who seek or obtain employment with fraudulent documents.²³² As the Supreme Court observed:

Under the [Immigration Reform and Control Act of 1986 (IRCA)] regime, it is impossible for an undocumented alien to obtain employment in the United States without some party directly contravening explicit congressional policies. Either the undocumented alien tenders fraudulent identification, which subverts the

225. Sarita N. Shah & Olveen Carrasquillo, *Twelve-Year Trends in Health Insurance Coverage Among Latinos, by Subgroup and Immigration Status*, 25 HEALTH AFFS. 1612, 1617 (2006).

226. See Kathryn Pitkin Derosé et al., *Immigrants and Health Care: Sources of Vulnerability*, 26 HEALTH AFFS. 1258, 1260 (2007).

227. See *id.* at 1264.

228. Thomas C. Buchmueller et al., *Immigrants and Employer-Sponsored Health Insurance*, 42 HEALTH SERVS. RSCH. 286, 287 (2007); Michael J. Wishnie, *Emerging Issues for Undocumented Workers*, 6 U. PA. J. LAB. & EMP. L. 497, 501 (2004).

229. Wishnie, *supra* note 228, at 499–500; see Robert I. Corrales, *Did Hoffman Plastic Compounds, Inc., Produce Disposable Workers?*, 14 BERKELEY LA RAZA L. J. 103, 114–17 (2003) (recounting the history of employment of undocumented workers from pre-enactment of the 1952 Immigration and Nationality Act through the Immigration Reform and Control Act of 1986).

230. See 8 U.S.C. § 1324a.

231. See § 1324a(e)(4)(A) (civil fines); § 1324a(f)(1) (criminal prosecution).

232. See § 1324c; see also 18 U.S.C. § 1546(b).

cornerstone of IRCA's enforcement mechanism, or the employer knowingly hires the undocumented alien in direct contradiction of its IRCA obligations.²³³

These provisions were enacted for the purpose of assisting in stemming the tide of illegal immigration: "Congress intended for employer sanctions to be the primary method of deterring unlawful immigration. The legislation was based on the assumption that employment is the 'magnet' that attracts aliens to the United States and that employers would be deterred from hiring undocumented immigrants by threat of penalty, which in turn, would deter immigrants from entering illegally."²³⁴

IRCA's punitive employment regime has not stemmed illegal immigration.²³⁵ Contemporary estimates of the undocumented population are over three times what they were around the date of IRCA's passage; 3.5 million undocumented immigrants in 1990, compared with 10.5 million in 2017, down from a peak of over 12 million in 2006.²³⁶ Of course, "[m]any factors have influenced the growth in the undocumented population . . . and no reliable regression analysis exists to determine the precise causal role of any one factor, but at first glance, these figures do not suggest IRCA has been a success."²³⁷ Beyond the increase in the undocumented population, these workers have become a core component of the U.S. labor market.²³⁸ There were nearly eight million undocumented workers in 2017, representing five percent of the total U.S. workforce.²³⁹ But even this number understates their importance, as they are disproportionately represented in certain industries. Undocumented workers make up approximately ten percent of all workers across food industries, with fifteen percent represented in food production and between five to seven percent in food distribution and retail.²⁴⁰ In farming, undocumented workers are twenty-

233. *Hoffman Plastic Compounds, Inc. v. N.L.R.B.*, 535 U.S. 137, 148 (2002).

234. Christine N. Cimini, *Undocumented Workers and Concepts of Fault: Are Courts Engaged in Legitimate Decisionmaking?*, 65 VAND. L. REV. 389, 398 (2012); see *Hoffman Plastic*, 535 U.S. at 147 ("IRCA 'forcefully' made combating the employment of illegal aliens central to '[t]he policy of immigration law.'") (quoting *INS v. Nat'l Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 194 n.8 (1991)).

235. See Glen, *supra* note 224, at 234 ("These penalties have not stopped the employment of illegal immigrants[.]").

236. See Mark Hugo Lopez et al., *Key Facts About the Changing U.S. Unauthorized Immigrant Population*, PEW RSCH. CTR. (Apr. 13, 2021), <https://www.pewresearch.org/fact-tank/2021/04/13/key-facts-about-the-changing-u-s-unauthorized-immigrant-population/>.

237. Michael J. Wishnie, *Prohibiting the Employment of Unauthorized Immigrants: The Experiment Fails*, 2007 U. CHI. LEGAL F. 193, 206 (2007).

238. See Jens Manuel Krogstad et al., *A Majority of Americans Say Immigrants Mostly Fill Jobs U.S. Citizens Do Not Want*, PEW RSCH. CTR. (June 10, 2020), <https://www.pewresearch.org/fact-tank/2020/06/10/a-majority-of-americans-say-immigrants-mostly-fill-jobs-u-s-citizens-do-not-want/>.

239. *Id.*

240. *Id.*

two percent of the total work force; in construction, fifteen percent; and in hospitality, production, and manufacturing, approximately eight percent of each sector's employees.²⁴¹

The employment sanctions regime put into place by IRCA and subsequently tweaked by acts in 1990 and 1996 should be jettisoned as a failure, which should in turn bring undocumented workers out of the shadows and permit the extension of work-based benefits, including health insurance. Repeal would reflect practicalities on the ground. As has previously been noted, repeal of the employment regime “would recognize that the employment of illegals has continued, even if it has moved more to the shadows, and that [U.S.] employers are gaining real benefits from their employment of these workers.”²⁴² Given the abject failure of the employment sanctions regime to stem the tide of undocumented workers, it should be repealed; having failed to fulfill its purpose, there is no compelling rationale for leaving these statutes on the books. And that is especially true where repeal merely reestablishes the pre-1986 status quo; employment of undocumented immigrants functioned well for the almost four decades between the enactment of the INA and IRCA, and there is little reason to believe that it could not work well again with repeal of the post-1986 statute.²⁴³

Beyond recognizing the policy failure of the IRCA amendments, decriminalizing employment of undocumented workers would also increase their protection from unfair labor practices. Currently, “millions of undocumented workers labor for long hours for substandard wages, often in dangerous conditions, and these workers have increasingly pressed claims for better treatment in the workplace.”²⁴⁴ Undocumented workers have been recognized as covered employees under the National Labor Relations Act of 1935 (NLRA).²⁴⁵ At the same time, the most beneficial remedies to unfair labor practices, such as the award of backpay, are not permitted to undocumented workers, even if the employer is otherwise at fault under the terms of the

241. *Id.*

242. Glen, *supra* note 224.

243. *Id.*

244. Wishnie, *supra* note 228, at 500; *see also* NICOLE PRCHAL SVAJLENKA, CTR. AM. PROGRESS, PROTECTING UNDOCUMENTED WORKERS ON THE PANDEMIC'S FRONT LINES: IMMIGRANTS ARE ESSENTIAL TO AMERICA'S RECOVERY 9 (2020), https://americanprogress.org/wp-content/uploads/2020/12/Making-The-Case-For-Legalization.pdf?_ga=2.44633060.112158236.1655417901-1663894472.1655417901 (“Undocumented immigrants are simultaneously vulnerable to being coerced into accepting dangerous work situations and may be among the first workers to be laid off, particularly if they raise concerns.” (internal citations omitted)).

245. *See* *Sure-Tan, Inc. v. N.L.R.B.*, 467 U.S. 883, 891–92 (1984) (holding that “[s]ince undocumented aliens are not among the few groups of workers expressly exempted by Congress, they plainly come within the broad statutory definition of ‘employee’”); *see also* *Hoffman Plastic Compounds, Inc. v. N.L.R.B.*, 535 U.S. 137, 152 (2002) (recognizing the permissibility of certain sanctions entered against an employer for unfair labor practices targeting undocumented workers).

NLRA.²⁴⁶As the Supreme Court held in *Hoffman Plastic Compounds, Inc. v. N.L.R.B.*, “awarding backpay in a case like this [involving undocumented workers] not only trivializes the immigration laws, it also condones and encourages future violations.”²⁴⁷ In *Hoffman Plastic*, the Supreme Court did recognize the permissibility of imposing other sanctions and conditions on an employer found in violation of the NLRA, including enforcement of cease and desist orders, posting notices regarding the violations, contempt, and other “traditional remedies.”²⁴⁸ But these remedies do nothing for the undocumented worker whose labor rights have been violated, and that is likely salt in a wound; for instance, the undocumented worker in *Sure-Tan* was required to depart the United States or face a formal removal proceeding, thereby losing his place of residence along with backpay and related remedies.²⁴⁹ Along with their placement outside these important remedial provisions, there is a more fundamental erosion of the labor rights of undocumented workers, since they work in the shadows and may fear reporting even the most outrageous violations by employers.²⁵⁰

If the current employment regime were repealed, there would be a strong case for more robust remedies for undocumented workers hurt by unfair labor practices, including backpay. Prior to IRCA, the Supreme Court seems to have contemplated the award of backpay to undocumented workers, so long as they remained in the United States at the time the backpay was awarded.²⁵¹ And the National Labor Relations Board (NLRB) itself seems to have endorsed this view.²⁵² Otherwise, employment would be broken into two distinct classes with vastly different rights: citizens and lawful immigrants, entitled to the full protection of the labor laws, and undocumented workers, a “subclass . . . without a comparable stake in the collective goals of their legally resident co-workers, thereby eroding the unity of all the employees and impeding effective collective bargaining.”²⁵³

246. *Hoffman Plastic Compounds, Inc.*, 535 U.S. at 149.

247. *Id.* at 150; *see id.* at 151 (“We . . . conclude that allowing the [NLRB] to award backpay to illegal aliens would unduly trench upon explicit statutory prohibitions critical to federal immigration policy, . . . condone prior violations of the immigration laws, and encourage future violations.”).

248. *Id.* at 152.

249. *Sure-Tan, Inc.*, 467 U.S. at 887.

250. *See* Wishnie, *supra* note 228, at 211–13.

251. *See Sure-Tan, Inc.*, 467 U.S. at 903 (“[I]n computing backpay, the employees must be deemed ‘unavailable’ for work (and the accrual of backpay therefore tolled) during any period when they were not lawfully entitled to be present and employed in the United States.”); *see also id.* at 900–05.

252. *See Hoffman Plastic Compounds, Inc. v. N.L.R.B.*, 535 U.S. 137, 146 (2002) (characterizing the NLRB’s view that “read in context, [the *Sure-Tan*] limitation applies only to aliens who left the United States and thus cannot claim backpay without lawful reentry”).

253. *Sure-Tan, Inc.*, 467 U.S. at 892.

Lifting the IRCA employment restrictions and encouraging or mandating the provision of health care to workers is also fundamentally fair, since it places the burden of coverage on those obtaining the benefits of work.²⁵⁴ The “[e]mployment of illegal immigrants by private businesses does not give rise to any obligation on the part of the *government* to provide coverage, but there is a very strong argument that it should, as a matter of fairness, give rise to an obligation on the part of the businesses who take advantage of illegal immigrant labor.”²⁵⁵ Imposing an employer mandate “would place the costs of illegal immigrant health care on those reaping the benefits from their presence within the United States.”²⁵⁶ Given the practical realities of the continuing large-scale employment of undocumented workers, the unfair practices to which they are subjected, and the ethically dubious proposition of being able to benefit from that labor while eschewing basic costs of the employment, there are simply no compelling policy rationales for maintaining the strictures of the current employment-sanctions regime.

C. Create Targeted Visas for Health Care Professionals

The United States is currently experiencing an acute shortage of health care professionals that is only expected to worsen in the coming decade.²⁵⁷ One commentator noted a forecasted shortage of 90,000 physicians and 500,000 nurses by 2025,²⁵⁸ while “[t]he Association of American Medical Colleges recently predicted a shortage of up to 139,000 physicians by 2033, including a shortage of 55,200 primary care physicians alone.”²⁵⁹ This shortage is also expected to be worse in certain practice areas, with obstetrics facing a particularly significant short fall of possibly 16,000 physicians by 2030.²⁶⁰ Along with a practice-area focus, the shortage will also likely adversely affect rural areas more than urban, and hit economically depressed and already under-

254. Glen, *supra* note 224, at 234–35.

255. *Id.*

256. *Id.* at 235.

257. TIM DALL ET AL., IHS MARKIT LTD., ASS’N AM. MED. COLLS., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2019 TO 2034, at viii, 19 (2021), <https://www.aamc.org/media/54681/download>.

258. Ryan Corrigan et al., *State Legislative Update*, J. DISP. RESOL., 2018, at 197, 208; Lenny Bernstein, *U.S. Faces 90,000 Doctor Shortage by 2025, Medical School Association Warns*, WASH. POST (Mar. 3, 2015), <https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/>.

259. Ariel Cohen, *Sanders Says US Physician Shortage Is a ‘Solvable Problem’*, ROLL CALL (May 21, 2021, 8:41 PM), <https://rollcall.com/2021/05/20/sanders-says-us-physician-shortage-is-a-solvable-problem/>.

260. See Elizabeth Kukura, *Better Birth*, 93 TEMPLE L. REV. 243, 267 (2021) (“[A]nalysts predict that, by 2030, the United States will have a shortage of between nine thousand and sixteen thousand obstetricians to meet the needs of the projected population.”).

served communities particularly hard.²⁶¹ Rural hospitals are more distant from the centers of medical education,²⁶² while “residencies in rural and underserved areas struggle to attract as many trainees as those in big cities, . . . creat[ing] doctor shortages in places that need care most.”²⁶³

The United States will be unable to address this shortage on its own through either domestic employment initiatives or increased medical school graduates.²⁶⁴ Writing recently in *USA Today*, Dr. Raghuvver Kura noted that “[i]n 2018, there were 27 open health care practitioner jobs for every unemployed health care worker in the country.”²⁶⁵ In other words, the current shortage is a function of a dearth of qualified candidates; even if every unemployed U.S. citizen with a health care focus found gainful employment in that sector, there would be a pronounced shortage of physicians and nurses.²⁶⁶ But the United States also has little ability to provide the currently-lacking qualified candidates.²⁶⁷ There are not enough domestic medical schools and qualifying residencies to keep up with demand, let alone make a dent in, the growing physician shortage—which is the most severe among the health care professions and the focus of this Section’s reform.²⁶⁸ Efforts to increase the numbers of domestically trained nurses, midwives, mental health professionals, certified nursing assistants, medical assistants, home health aides, and others have not relieved chronic shortages in those professions either.²⁶⁹

Rather than attempt domestic solutions that have little chance of meaningfully closing the gap between needed supply and demand, the United States should look to noncitizen health care professionals. This is not a novel idea, as Congress did enact a series of immigration reforms in the late 1980s

261. Bernstein, *supra* note 258.

262. See Mary H. Rose & Rebecca J. Winthrop, *So Many Troubled California Health Care Districts, So Many Have Filed Chapter 9 – Lessons to be Learned*, 35 CAL. BANKR. J. 189, 194 (2020).

263. Cohen, *supra* note 259.

264. DALL ET AL., *supra* note 257, at ix.

265. Raghuvver Kura, *In Midst of Coronavirus Pandemic, Rural America Desperately Needs More Doctors Like Me*, USA TODAY (Nov. 5, 2020, 3:40 PM), <https://www.usatoday.com/story/opinion/voices/2020/11/05/rural-america-covid-19-exacerbating-doctor-and-hospital-bed-shortages/6160363002/>.

266. *Id.*

267. Patrick Boyle, *Medical School Enrollments Grow, but Residency Slots Haven’t Kept Pace*, AAMC (Sept. 3, 2020), <https://www.aamc.org/news-insights/medical-school-enrollments-grow-residency-slots-haven-t-kept-pace>.

268. See *id.*

269. Michael Ollove, *Health Worker Shortage Forces States to Scramble*, PEW CHARITABLE TRS.: STATELINE (Mar. 25, 2022), <https://www.pewtrusts.org/en/research-and-analysis/blogs/state-line/2022/03/25/health-worker-shortage-forces-states-to-scramble>.

through the early 2000s to address a shortage of qualified nurses.²⁷⁰ In 1989, Congress recognized a shortage of over 130,000 nurses in hospitals and nursing homes, with over seventy-five percent of hospitals reportedly affected by the shortage, which had necessitated closure of beds and sometimes entire hospital wings.²⁷¹ To address these issues, Congress enacted the Immigration Nursing Relief Act.²⁷² This Act lifted numerical limitations on visa issuance for certain qualifying nonimmigrant nurses, and made it easier for nurses in the United States on nonimmigrant visas to adjust their status to permanent residence.²⁷³ Easing the admission of nonimmigrant nurses was accomplished by establishing the H-1A visa category.²⁷⁴ The Act required that a “need based” attestation be filed by the U.S. health care provider, which also placed “a responsibility on the facility to take certain steps in recruiting and retaining U.S. nurses.”²⁷⁵ In essence, the Act sought to serve as a stop-gap, addressing the shortage at present while buying additional time to devise a more comprehensive and lasting solution to the root causes of the shortage.²⁷⁶ Thus, while the Act permitted hospitals and other health care providers to use noncitizens to fill the shortage, it also required these providers to “take a minimum of two steps to reduce reliance on foreign nurses,”²⁷⁷ including providing recruitment and training programs, professional development opportunities, higher salaries with the possibility of further financial advancement, and freeing nurses from administrative and other non-nursing duties.²⁷⁸

The H-1A program was initially authorized for a five-year period, but the authorized period of admission for H-1A nonimmigrants was ultimately extended through September 30, 1997.²⁷⁹ The Act was then repealed in January 1999, when Congress enacted the Nursing Relief for Disadvantaged Areas Act.²⁸⁰ This Act replaced the H-1A category with the H-1C visa, but limited the number of visas available to “500 a year” and imposed strict requirements on

270. Diomedes J. Tsitouras & Maria Pabon Lopez, *Flatlining: How the Reluctance to Embrace Immigrant Nurses Is Mortally Wounding the U.S. Health Care System*, 12 J. HEALTH CARE L. & POL’Y. 235, 250–51 (2009).

271. H.R. REP. NO. 101-288, at 2 (1989).

272. *Id.*; Immigration Nursing Relief Act of 1989, Pub. L. No. 101-238, 103 Stat. 2099.

273. *See* Immigration Nursing Relief Act § 2(a), (d); *see also* H.R. REP. NO. 101-288, at 2–3 (“[A]bsent this legislation, these desperately needed health care professionals will be prohibited from becoming a permanent part of the workforce until the crisis has gotten much worse.”).

274. H.R. REP. NO. 101-288, at 4–5.

275. *Id.*

276. *See id.* at 5 (the Act “allow[s] the shortage to be addressed during an interim period until a comprehensive approach can be devised”).

277. *Id.* at 6.

278. Immigration Nursing Relief Act § 3(b)(2)(B).

279. *See* Act of Oct. 11, 1996, Pub. L. 104-302, § 1(a), 110 Stat. 3656.

280. *See* Nursing Relief for Disadvantaged Areas Act of 1999, Pub. L. No. 106-95, § 2(c), 113 Stat. 1312, 1316.

which “‘in-need’ hospitals” could petition for immigrant nurses.²⁸¹ In passing the Act, Congress opined that “[t]here does not appear to be a national nursing shortage today; however, a number of hospitals with unique circumstances are still experiencing great difficulty in attracting American nurses. Hospitals serving mostly poor patients have special difficulties. Some hospitals in rural areas might also.”²⁸² In terms of substantive requirements, the 1999 Act differed little from the 1989 Act; the main differences related to the imposition of a cap on visas under the 1999 Act, whereas there had been no limit under the terms of the 1989 Act, and the more rigorous limitations on *who* could petition for an H-1C nonimmigrant nurse.²⁸³ Regarding the latter point, the potential employer had to be located in a health professional shortage area, as designated by HHS, and have at least 190 acute care beds.²⁸⁴ The hospital’s patient population also had to be comprised of at least thirty-five percent Medicare recipients, and at least twenty-eight percent Medicaid recipients.²⁸⁵ The H-1C program was reauthorized in 2006,²⁸⁶ but expired without reauthorization or extension in December 2009.²⁸⁷

Congress is currently considering bills to address the health care professional shortage through some level of immigration reform. A bill in the Senate, the Conrad State 30 and Physician Access Reauthorization Act, would extend the Conrad waiver program.²⁸⁸ The Conrad Waiver program allows foreign medical graduates receiving training in the United States pursuant to a J-1 visa to “waive” the two-year mandatory return to their home country before they may seek further employment in the United States, so long as they work at an HHS-designated facility in a Health Profession Shortage Area, Medically Underserved Area, or work with a Medically Underserved Population.²⁸⁹ The House of Representatives is considering the Healthcare Workforce Resilience Act, which aims to recapture unused visas to allocate to physicians and nurses, exempts beneficiaries from per-country caps on immigrant visas, and expedites the processing of qualifying petitions.²⁹⁰ The bill does impose a requirement that

281. H.R. REP. NO. 106-135, at 2 (1999).

282. *Id.* at 5.

283. *Id.*

284. *Id.*; Nursing Relief for Disadvantaged Areas Act of 1999 § 2(b)(6).

285. H.R. REP. NO. 106-135, at 5; Nursing Relief for Disadvantaged Areas Act of 1999 § 2(b)(6)(ii)–(iii).

286. Nursing Relief for Disadvantaged Areas Reauthorization Act of 2005, Pub. L. No. 109-423, 120 Stat. 2900.

287. *Id.* § 2.

288. Conrad State 30 and Physician Access Reauthorization Act, S. 1810, 117th Cong. § 2 (2021).

289. *Conrad 30 Waiver Program*, U. S. CITIZENSHIP & IMMIGR. SERVS. (May 15, 2020), <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>.

290. Healthcare Workforce Resilience Act, H.R. 2255, 117th Cong. (2021).

the petitioning employer attest “that the hiring of the alien has not displaced and will not displace a United States worker.”²⁹¹

These bills are a step in the right direction but are grossly inadequate to address the current and forecasted health care professional shortage. Extension of the waiver program would increase the number of physicians able to remain in the United States, but not at a level that would make a significant impact on the shortage—the program contemplates a yearly per-state cap of only thirty waivers.²⁹² Likewise, there is no evidence to establish that capturing unused visas for reallocation will significantly cut the projected six-figure shortage in physicians, especially where domestic supply is likely to continue to lag demand.²⁹³ Instead, Congress should look to the H-1A program and its lifting of *any* yearly cap on qualifying nurses, and institute a new visa for medical professionals. At least so long as the shortage persists, Congress should place no numerical limitations on the ability of foreign medical professionals to come to the United States as nonimmigrant physicians and nurses. Also, in line with the H-1A program, Congress should streamline the ability of those who do come as nonimmigrants to adjust their status to permanent residence and become a fixed part of the domestic health care workforce. Only through such a dramatic step could the United States hope to close the gap between the supply of physicians and nurses and the demand for such professionals. To address concerns about the impact on the development of domestic professionals, Congress could set an expiration date for these provisions, while holding out the possibility of reauthorization should the shortage persist. But, in any event, domestic concerns are a weak argument against lifting the numerical caps for health care professionals—as Dr. Kura notes, the shortage is not a function of failing to employ qualified United States citizens, but rather a function of a significant lack of qualified citizens to fill health care jobs.²⁹⁴

Establishing a discrete nonimmigrant visa for medical professionals is just an initial step, however, as the biggest hurdles to closing the gap between supply and demand lie elsewhere. Some of these limitations are inherent in the existing H-1B framework; “[d]octors on the temporary H-1B visa are restricted to their employer and not allowed to start their own practices, work outside their

291. *Id.*

292. Sherman Immigration Lawyers, P.C., *Practical Guide to the Conrad State 30 J1 Visa Waiver Program for Physicians and Employers*, CONRAD30.COM, www.conrad30.com/basics.html (last visited Apr. 18, 2022).

293. See Andrew Kreighbaum, *Hospitals, Foreign Health-Care Workers Press Congress for Action*, BLOOMBERG L. (Nov. 19, 4:30 AM), <https://news.bloomberglaw.com/daily-labor-report/hospitals-foreign-health-care-workers-press-congress-for-action>; see also *How the Doctor Shortage Is Affecting Patients*, ADAPTIVE MED. PARTNERS, <https://adaptivemedicalpartners.com/how-the-doctor-shortage-is-affecting-patients/> (last visited Apr. 19, 2022).

294. See Kura, *supra* note 265.

specialty area or even volunteer.”²⁹⁵ These restrictions limit the ability of nonimmigrants to provide additional services in their communities, which has the further effect of disproportionately harming minority and economically disadvantaged areas.²⁹⁶ As the American Immigration Council has noted, foreign-trained doctors and nurses—the vast majority of whom are noncitizens—disproportionately work in economically disadvantaged and ethnic and racial-minority areas.²⁹⁷ Tied to their employer, a noncitizen physician may not start his or her own practice to serve a local immigrant community and may not even be permitted to provide no-cost services to members of that community.²⁹⁸ Rather than tie the health care professional to a specific employer, the new visa should consider the employer-employee relationship as only the first step of the health care professional’s path to the United States. Once here, noncitizen health care professionals should be free to change employers or start their own practices (if that is within their practice authority), at least after an initial one-year period with the petitioning employer. This ability to change employment should be conditioned on the noncitizen health care professional working in an HHS-designated shortage area, so that the portability of the visa would be explicitly conceived as a tool to address that issue. The noncitizen health care professional would be deemed to remain in status so long as they continued to be employed in health care commensurate with the terms of their initial admission. Along with portability, the terms of the visa should allow volunteer work in health care, regardless of the noncitizen health care professional’s area of expertise, whether at community clinics, with non-governmental organizations, or through any other mechanism that would aim to serve patients in areas currently underserved by health care professionals.

Reforming the visa system addresses only one small part of the equation and is possibly not the most important factor in addressing the shortage. The suggested reforms would ease the path into the United States for certain noncitizens seeking to enter this country in order to work in health care. But as noted above, many noncitizens are able to enter the United States on other visas, perhaps because of family relationships, or through other mechanisms, such as asylum.²⁹⁹ Many of these individuals have professional degrees from non-U.S. institutions but have not complied with the onerous and state-specific licensing

295. *Id.*

296. AM. IMMIGR. COUNCIL, FOREIGN-TRAINED DOCTORS ARE CRITICAL TO SERVING MANY U.S. COMMUNITIES 8 (2018).

297. *Id.*; Jessica Kurtz, *Foreign-Born Doctors Fill Physician Shortages in the West*, HIGH COUNTRY NEWS (Feb. 25, 2021), <https://www.hcn.org/issues/53.3/south-public-health-foreign-born-doctors-fill-physician-shortages-in-the-west>.

298. *See* Kura, *supra* note 265.

299. 8 U.S.C. § 1641(b).

requirements to practice medicine or a related profession.³⁰⁰ These requirements can include additional training in the United States, passage of a number of qualifying examinations, and certification of the individual's prior educational and training experience.³⁰¹ This population of noncitizen health care professionals is thus locked out of practice entirely, or, if able to find a job within health care, likely underemployed.³⁰²

Licensing requirements do, of course, serve vitally important public interests—they ensure that health care professionals have at least minimal qualifications, thereby safeguarding the health and well-being of patients.³⁰³ At the same time, mandating that physicians and nurses must have some level of training in the United States and pass domestic examinations in order to practice may be more than what is necessary in order to fulfill the salutary goals of state licensing regimes.³⁰⁴ Comparatively, the hurdles that health care professionals must clear in the United States are substantially more significant than those in other countries of similar economic development.³⁰⁵ For instance, “European countries not only require licenses for fewer health care occupations, but their licensing regulations tend to be less prescriptive,” with the vaunted Nordic countries having some of the laxest standards in Europe.³⁰⁶ Studies have also shown that the strictness of a particular licensing regime does not correlate with the quality of practitioners within that field, meaning that the safety and quality goals undergirding licensing regimes could still be met with less onerous requirements.³⁰⁷ In fact, a forthcoming article establishes that the benefits of strict licensing regimes run more towards regulators and existing providers than consumers, while concluding that there is little reason to believe that market

300. Robert Morlock, *Addressing International Physician Credentialing in Arizona*, 30 ANNALS HEALTH L. & LIFE SCI.: ADVANCE DIRECTIVE 203, 204–05 (2021).

301. *Id.* at 205.

302. *Id.* at 208 (“[T]here is a population of internationally trained health care workers who [are] either underemployed or unemployed in the United States due, in part, to licensing requirements.”); Shanique C. Campbell, “*What’s a Sundial in the Shade?*”: *Brain Waste Among Refugee Professionals Who Are Denied Meaningful Opportunity for Credential Recognition*, 68 EMORY L.J. 139, 147 (2018) (“Highly educated refugees are frequently unemployed or significantly underemployed . . . due to various barriers to re-entry in their professions.”).

303. See Drew Carlson & James N. Thompson, *The Role of State Medical Boards*, 7 ETHICS J. AM. MED.: ASS’N VIRTUAL MENTOR 311, 311 (2005); see generally DAVID A. JOHNSON & HUMAYUN J. CHAUDHRY, *MEDICAL LICENSING AND DISCIPLINE IN AMERICA: A HISTORY OF THE FEDERATION OF STATE MEDICAL BOARDS 2* (2012).

304. Robert Orr, *Too Little for Too Much*, MILKEN INST. REV. (Jan. 24, 2001), <https://www.milkenreview.org/articles/too-little-for-too-much>.

305. *Id.*

306. *Id.*

307. Morris M. Kleiner & Robert T. Kudrle, *Does Regulation Improve Outputs and Increase Prices?: The Case of Dentistry 2–3* (Nat’l Bureau of Econ. Rsch., Working Paper No. 5869, 1997).

forces would not serve to ensure a baseline of quality within the field.³⁰⁸ This can be seen in the expansion of the scope of practice for nurse practitioners, who provide (at the least) sufficient care, and often times better service, than that provided by physicians,³⁰⁹ as well as for midwives, who are filling the gaps in areas where the physician shortage is most acute, thereby increasing access to care with no concomitant drop in the quality of care.³¹⁰

The truth of this can also be seen in recent events, where many states have, in light of the combination of the COVID-19 pandemic and an acute physician shortage, loosened the licensing requirements for foreign-trained medical graduates.³¹¹ These policies run the gamut, both in terms of the threshold for a noncitizen's ability to practice medicine in the state, and the scope of the license granted. Massachusetts, for instance, granted a full license, with no limitations on the scope of practice, to foreign medical school graduates, so long as they had completed at least two years of postgraduate medical training in the United States.³¹² Idaho waived licensure, with no limitation on the scope of practice, for any noncitizen licensed in good standing in another country, although this waiver is good only for the duration of the declared public health emergency occasioned by COVID-19.³¹³ Pennsylvania also waived licensure for those noncitizens licensed in good standing in another country, but permitted such individuals to practice only telemedicine and only during the declared state of emergency.³¹⁴ Both Michigan and New Jersey imposed slightly stricter threshold criteria, with both requiring not only licensure in another country, but also a minimum of five years' practice experience, with the individual having practiced for at least one year in the last five.³¹⁵ At the same time, neither state placed any limitations on the scope of practice, with both contemplating the treatment of patients in in-person clinical settings.³¹⁶ Nevada took a hybrid approach, requiring a license to practice in another country and a waiver and exemption from state licensing requirements by the state's Chief Medical Officer.³¹⁷ But as with Michigan and New Jersey, the noncitizen was not limited

308. Jonathan B. Berk & Jules H. van Binsbergen, *Regulation of Charlatans in High-Skill Professions* 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23696, 2017).

309. PETER BUERHAUS, AM. ENTER. INST., *NURSE PRACTITIONERS: A SOLUTION TO AMERICA'S PRIMARY CARE CRISIS* 9 (2018).

310. Brittany L. Ranchoff & Eugene R. Declercq, *The Scope of Midwifery Practice Regulations and the Availability of the Certified Nurse-Midwifery and Certified Midwifery Workforce, 2012-2016*, 65 *J. MIDWIFERY & WOMEN'S HEALTH* 119, 127 (2020).

311. JEANNE BATALOVA ET AL., *MIGRATION POL'Y INST., BRAIN WASTE AMONG U.S. IMMIGRANTS WITH HEALTH DEGREES* 2 (2020).

312. *See id.* at 12–14, tbl.A-1.

313. *See id.*

314. *See id.*

315. *See id.*

316. *See* BATALOVA ET AL., *supra* note 311, at 12–14, tbl.A-1.

317. *See id.*

in the scope of his or her practice once the waiver was granted.³¹⁸ New York provided a limited permit to practice medicine to graduates of foreign medical schools with at least one year of post-graduate training, whether or not in the United States, but limited practice to certain institutions and required the supervision of a state-licensed physician.³¹⁹

The sky did not fall in any of these states with the loosening of licensure requirements, with no indication that foreign medical graduates who were able to take advantage of these orders underperformed or committed malpractice at above average rates. And although the pandemic did present a special case, the existing and looming physician shortage will be a similarly exacting crucible. A lack of primary care physicians may put pressures on the availability of preventative care, leading to the development or exacerbation of medical conditions that could have been more easily treated if caught earlier.³²⁰ That same lack may lead to pressure on other medical resources, including emergency and other non-preventative care, complicating the provision of services to individuals in actual need of emergency and related treatments.³²¹ Similarly, specialists may become overly taxed and take a role that primary care physicians have previously served, putting increased pressure on the provision of specialty care.³²² High workloads across all types of doctors, both primary care and specialists, will lead to shorter patient interactions, increasing the risk that health risks and problems are not adequately conveyed by the patient and understood by the doctor, and thus increasing the possibility of suboptimal outcomes for the patient.³²³ The reality is that an acute physician shortage increases the risks of death from preventable medical conditions, as well as the likelihood that treatable conditions morph into something more serious.³²⁴ Given these possibilities, there is every reason to believe that the existing and looming shortage could have long-term effects at least as grave as the current pandemic, if not more significant.

States should thus act proactively to ease the ability of foreign-trained physicians and nurses to practice, taking into account both what is necessary to protect their populations *and* how overly restrictive licensing requirements will keep otherwise competent and able professionals out of the workforce at this

318. *See id.*

319. *See id.*

320. *See How the Doctor Shortage is Affecting Patients*, *supra* note 293; *see also* Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1785 (2011) ("Instead of upfront investments in prevention and wellness, the nation spends billions of dollars on high-technology interventions to treat conditions that might otherwise have been prevented or reduced in severity.").

321. *See How the Doctor Shortage is Affecting Patients*, *supra* note 293.

322. *See* Smith, *supra* note 6.

323. *See How the Doctor Shortage is Affecting Patients*, *supra* note 293; Smith, *supra* note 6.

324. *How the Doctor Shortage is Affecting Patients*, *supra* note 293.

critical time. This loosening need not be a one-size-fits-all proposition, and there may be state-specific reasons why one approach is better than another given that context. But a model approach could provide a provisional license to foreign-trained physicians who have a license in good standing in another country, with the license converted to a permanent and unlimited license in the granting state after a set period of time practicing medicine and in the absence of any competency or other concerns.

As a matter of state law, the federal government has no ability to *direct* states to alter their medical profession licensing schemes.³²⁵ But it could lead the way on its own and hope that states both take note and follow. First, assuming Congress could establish a new visa category for medical professionals, it should exempt noncitizens seeking this visa from the existing examination requirements mandated under the H-1B program. The requirement that beneficiaries of the H-1B visa must have taken and passed the United States Medical Licensing Examination (USMLE), for instance, should be abandoned as a condition of admission. Instead, the applicant should only be required to establish that they have graduated from a medical school, have a license in good standing in their home country, and can meet the requirements for licensing in the state in which they will begin their employment. Second, the federal government can itself act, given its role in the provision of health care for certain segments of the population. It could establish licensing requirements for physicians in Veterans' Administration hospitals and clinics in line with what is proposed above—permitting foreign medical graduates to be employed based on education and licensing in the country of origin.³²⁶ And given the borderless nature of the medical profession, with patients and doctors often traveling across state lines to receive and provide treatment, there could even be an argument that the federal government could enact a uniform licensure regime for foreign-trained physicians.

These recommendations will be controversial. Lifting numerical limitations on noncitizen medical professionals and easing their path to residency will grate with the more restrictionist crowd, while loosening licensing guidelines and eliminating examination requirements may find opposition with a different kind of protectionist: medical associations keen to serve as the profession's gatekeepers and maintain high barriers to entry.³²⁷ These criticisms are unavailing. Admitting more qualified medical professionals will not displace U.S. workers, as it is both the dearth of such workers and the unquestioned

325. Bob Kocher, *Doctors Without State Borders: Practicing Across State Lines*, HEALTH AFFS. (Feb. 18, 2014), <https://www.healthaffairs.org/doi/10.1377/forefront.20140218.036973>.

326. See Department of Veterans Affairs, *Authority of VA Professionals to Practice Health Care*, 85 Fed. Reg. 71,838, 71,838 (Nov. 12, 2020) (noting that the Veterans Administration may set the licensing requirements for medical professionals working in VA clinics and hospitals).

327. Orr, *supra* note 304.

inability of the United States to produce more workers in sufficient quantity that has led to the worsening shortage.³²⁸ And high barriers to entry are not in themselves a good thing; the question is whether entry barriers serve the requisite function of providing the public with competent and safe medical care, and on that question a substantial loosening for foreign medical graduates is unlikely to compromise public health. To be sure, the reform proposed here is significant. But the urgency of the situation demands a dramatic action.

IV. OPPORTUNITIES FOR THE BIDEN ADMINISTRATION TO ADVANCE HEALTH POLICY THROUGH REGULATORY ACTION ON IMMIGRATION ISSUES

Beyond statutory reform, the Biden administration could also pursue various executive and administrative actions in the immigration policy space that would advance health policy goals relating to improving individual and population health. Some of these options are complementary to our proposed statutory reforms and could be undertaken regardless of whether Congress advances immigration and health-related statutory enactments. Others provide a regulatory bandage to the problems we have identified in Part II, and in that sense, are second-best options if statutory reforms prove impossible.

A. Delete the DACA Carve-Out

The Biden administration should pursue rulemaking to revoke the regulation excluding DACA beneficiaries from subsidized health coverage under the ACA. When the ACA was enacted, it conditioned eligibility for benefits, *e.g.*, participation in the insurance exchanges, to citizens and nationals of the United States, or noncitizens who are “lawfully present.”³²⁹ In 2010, HHS enacted a regulation defining “lawfully present” to include, *inter alia*, “[a]liens currently in deferred action status.”³³⁰ After the announcement of DACA in June 2012,³³¹ however, HHS issued an Interim Final Rule specifically excluding DACA beneficiaries from the definition of “lawfully present” for ACA-related purposes.³³² HHS justified its exclusion of DACA beneficiaries, despite the

328. *The Shortage of Healthcare Workers in the U.S.*, DUQUESNE U. SCH. NURSING, <https://onlinenursing.duq.edu/post-master-certificates/shortage-of-healthcare-workers/> (last visited Apr. 21, 2022).

329. See 42 U.S.C. § 18032(f)(3).

330. 45 C.F.R. § 152.2 (2010); see Pre-Existing Condition Insurance Plan Program, 75 Fed. Reg. 45,014, 45,030 (July 30, 2010) (to be codified at 45 C.F.R. pt. 152).

331. See JANET NAPOLITANO, U.S. DEP’T HOMELAND SEC., MEMORANDUM: EXERCISING PROSECUTORIAL DISCRETION WITH RESPECT TO INDIVIDUALS WHO CAME TO THE UNITED STATES AS CHILDREN (June 15, 2012), <http://www.dhs.gov/xlibrary/assets/sl-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>.

332. See 45 C.F.R. § 152.2(8) (2012). The Interim Final Rule states:

Exception: An individual with deferred action under the Department of Homeland Security’s deferred action for childhood arrivals process, as described in the Secretary of

general inclusion of deferred-action beneficiaries, on two grounds: (1) because obtaining subsidized health coverage was not a rationale DHS noted in implementing DACA, there was no reason for HHS to extend the definition of “lawfully present” to provide such benefits; and (2) granting benefits beyond what DHS granted under its authority would conflict with the intent behind limiting the benefits associated with DACA.³³³

As we recently argued, however, HHS’s justifications do not withstand close scrutiny. HHS, under its own statutory authorities, “is entitled to determine the eligibility criteria for subsidized health coverage, and [] interpreting ‘lawfully present’ to include DACA beneficiaries does not expand the scope of DACA or otherwise infringe on the authority of DHS.”³³⁴ The exclusion of DACA beneficiaries is especially irrational given the regulation’s initial—and continuing—coverage of *all other* non-DACA deferred action beneficiaries.³³⁵ Moreover, “[w]hatever justification there may have been for excluding DACA beneficiaries in 2012 has been undermined by [the] continued existence [of DACA for nearly a decade] and the need to provide some access to subsidized health coverage to that class.”³³⁶ Accordingly, we proposed that the Biden administration issue an Interim Final Rule repealing the DACA carve-out, with additional conforming guidance from the Centers for Medicare and Medicaid Services addressing state-option Medicaid and CHIP benefits.³³⁷ This action could be a stop-gap measure on at least two fronts. First, if Congress does act on immigration reform, DACA beneficiaries may be placed on a path to citizenship which would ultimately entail eligibility for public benefits without regard to the carve-out. Second, if Congress pursues statutory reforms to the public-benefits programs like those we advance in this Article, the DACA carve-out would be a dead-letter along with the status-based limitations on which it was based. Failing

Homeland Security’s June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (7) of this definition. *Id.*

See also Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614, 52,615 (Aug. 30, 2012) (to be codified at 45 C.F.R. pt. 152).

333. See Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. at 52,615.

334. Makhoul & Glen, *supra* note 67.

335. See *id.* (“Moreover, HHS should point to the legally indistinguishable class of deferred action beneficiaries that is *already* included in the definition of ‘lawfully present’ that denotes eligibility for Medicaid, CHIP, and ACA benefits.”).

336. *Id.*

337. See *id.* at 40–42. Following the 2012 Interim Final Rule, the Centers for Medicare and Medicaid Services (CMS) sent a guidance letter to states expressing its view that DACA beneficiaries should not be eligible for Medicaid or CHIP benefits under any state option, justifying this guidance by reference to the rationales used by HHS in the 2012 Interim Final Rule. See *id.* at 42. Once the new Interim Final Rule was promulgated, CMS could revoke its prior guidance and replace it with new guidance providing for eligibility for DACA beneficiaries under the same terms as other deferred action beneficiaries.

the realization of either of these statutory options, repealing the DACA carve-out makes sense on its own terms, and would be a “simple and straightforward way to begin addressing” some of the inequities that characterize access to health care in the United States.³³⁸

B. Strengthen the DHS Sensitive Locations Policy

The Biden administration should ensure that the “sensitive locations” policy protects health care settings from immigration enforcement to the maximum extent possible.³³⁹ The sensitive locations policy traces back to a 2013 memorandum from then-Director of Immigration and Customs Enforcement John Morton addressing enforcement actions at or near so-called sensitive locations, which were defined to include “hospitals.”³⁴⁰ This policy required prior approval of ICE officials before an enforcement action could be taken at or near a covered sensitive location,³⁴¹ but included a range of broad exceptions which contemplated action even in the absence of prior approval.³⁴² Morton’s memorandum regarding the sensitive location policy notes:

This policy is meant to ensure that ICE officers and agents exercise sound judgment when enforcing federal law at or focused on sensitive locations and make substantial efforts to avoid unnecessarily alarming local communities. The policy is not intended to categorically prohibit lawful enforcement operations when there is an immediate need for enforcement action . . .³⁴³

In practice, however, it is unclear to what extent the policy limited or cabined enforcement discretion, as “[t]here is evidence that ICE does not always follow its sensitive locations policy.”³⁴⁴ In addition, the policy lacks clarity

338. Makhlof & Glen, *supra* note 67, at 41–42 (“The COVID-19 pandemic has highlighted problems of access and equity in the U.S. health care system, including issues that disproportionately affect noncitizens. Eliminating the DACA carve-out provides a simple and straightforward way to begin addressing a source of these inequities.”).

339. NAT’L IMMIGR. L. CTR., HEALTH CARE PROVIDERS AND IMMIGRATION ENFORCEMENT: KNOW YOUR RIGHTS, KNOW YOUR PATIENTS’ RIGHTS 1–2 (2017), <https://www.nilc.org/wp-content/uploads/2017/04/Protecting-Access-to-Health-Care-2017-04-17.pdf>.

340. JOHN MORTON, U.S. IMMIGR. & CUSTOMS ENF’T, POLICY NO. 10029.2, MEMORANDUM: 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>.

341. *Id.* at 2.

342. *Id.* at 2–3. Exceptions included:

[T]he enforcement action involves a national security or terrorism matter; there is an imminent risk of death, violence, or physical harm to any person or property; the enforcement action involves the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or any other individual(s) that present an imminent danger to public safety; or there is an imminent risk of destruction of evidence material to an ongoing criminal case. *Id.*

343. *Id.* at 2.

344. Mambwe Mutanuka, *The Intersection of Health Policy and Immigration: Consequences of Immigrants’ Fear of Arrests in U.S. Hospitals*, 30 ANNALS HEALTH L. ADVANCE DIRECTIVE

about which kinds of health care sites are considered sensitive locations and the size of the perimeter of a sensitive location.³⁴⁵ For instance, “there have been reports of immigration officers going to medical facilities to arrest undocumented immigrants.”³⁴⁶ Two unlawfully present noncitizens were detained and subject to deportation proceedings after bringing their two-month old child to a Texas hospital for emergency treatment.³⁴⁷ And in a case that made national news, a ten-year old girl suffering from cerebral palsy was taken into custody after her medical transport vehicle was stopped by U.S. Customs and Border Protection (CBP) agents.³⁴⁸ These stories have prompted action on the part of the Biden administration, but its implementation of a new “protected areas” policy largely tracks the outlines of the older “sensitive locations” policy—officers and agents still need approval for enforcement actions at or near protected areas, which have been more broadly and specifically—though not exhaustively—defined, while the policy provides similar exceptions for when pre-approval is not feasible.³⁴⁹

In short, the policy remains entirely discretionary with few hard guidelines to limit enforcement actions at or near medical settings. Additionally, it is not clear what recourse there could be for even ostensibly clear violations of the policy. As the protected areas memorandum itself notes, “[t]his guidance is not intended to, does not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.”³⁵⁰ Moreover, traditional Fourth Amendment remedies are inapplicable to immigration proceedings.³⁵¹ For instance, “[t]he ‘body’ or

217, 222 (2021); see Huyen Pham & Pham Hoang Van, *Subfederal Immigration Regulation and the Trump Effect*, 94 N.Y.U. L. REV. 125, 146 (2019) (“Though ICE maintains that a sensitive locations policy remains in effect, which should limit immigration enforcement actions in these areas, it is clear that the Trump administration conducts immigration enforcement actions in areas previously thought to be off-limits.”).

345. *Health Care Sanctuaries*, *supra* note 201, at 24–27.

346. Rose Cuison Villazor & Pratheepan Gulasekaram, *Sanctuary Networks*, 103 MINN. L. REV. 1209, 1235 n.136 (2019).

347. John Burnett, *Border Patrol Arrests Parents While Infant Awaits Serious Operation*, NAT’L PUB. RADIO (Sept. 20, 2017, 7:06 PM), <https://www.npr.org/2017/09/20/552339976/border-patrol-arrests-parents-while-infant-awaits-serious-operation>.

348. Scott Neuman & John Burnett, *10-Year-Old Girl Is Detained by Border Patrol After Emergency Surgery*, NAT’L PUB. RADIO (Oct. 26, 2017, 8:00 PM), <https://www.npr.org/sections/thetwo-way/2017/10/26/560149316/10-year-old-girl-is-detained-by-ice-officers-after-emergency-surgery>.

349. See ALEJANDRO N. MAYORKAS, U.S. DEP’T HOMELAND SEC., MEMORANDUM: GUIDELINES FOR ENFORCEMENT ACTIONS IN OR NEAR PROTECTED AREAS 1, 3–4 (Oct. 27, 2021), https://www.dhs.gov/sites/default/files/publications/21_1027_opa_guidelines-enforcement-actions-in-near-protected-areas.pdf.

350. *Id.* at 5.

351. Michael Kagan, *Immigration Law’s Looming Fourth Amendment Problem*, 104 GEO. L.J. 125, 127 (2015).

identity of a defendant or respondent in a criminal or civil proceeding is never itself suppressible as a fruit of an unlawful arrest.”³⁵² And application of suppression or exclusion in removal proceedings “would require the courts to close their eyes to ongoing violations of the law.”³⁵³ DHS could implement a policy of granting prosecutorial discretion in cases where the policy was violated, but that would likely only constitute a limited remedy; the identity and status of the individual would be known, and further enforcement action would not be foreclosed. Most, if not all, of these concerns would also survive implementation of the policy in a more “legal” format, such as a regulation.

Given these concerns, the focus must be on proper implementation of the policy, in good faith, by the enforcement authorities, since post-enforcement remedies are unlikely to restore the status quo. DHS must ensure proper training on the fundamentals of the policy, including reinforcing the general rule that prior approval must be sought and that enforcement actions in the absence of such approval should be rare and meet a very high standard of imminent risk or dangers that would justify such prompt enforcement. The officials charged with enforcing and implementing the policy should also do so by adhering to the spirit of the guidance as much as its letter. The purpose is to not cause undue alarm or inject enforcement authorities into sensitive locations absent compelling reasons for the action coupled with no adequate alternative. Enforcement in protected and sensitive locations should be an option of last resort, undertaken because the agency was left with no viable alternative. Finally, DHS should discipline violations of the policy and, by doing so, give greater form to the standards management believes should govern enactment of the policy on the ground. Discipline cannot restore the status quo for the noncitizen caught up in a rogue enforcement action, but it can serve to limit future violations and constitute a reference point for agents and officers in assessing the permissibility of other enforcement actions.

C. *Limit Information-Sharing between Health Care Providers and Immigration Agencies*

The administration should prohibit information sharing between health care providers and public health agencies and the immigration enforcement authorities. “Health care providers have no affirmative legal obligation to inquire into or report to federal immigration authorities about a patient’s immigration status.”³⁵⁴ The question of whether they are *prohibited* from doing so under current law is less clear.³⁵⁵ HIPAA’s privacy provisions protect all

352. *Immigr. & Naturalization Serv. v. Lopez-Mendoza*, 468 U.S. 1032, 1039 (1984).

353. *Id.* at 1046.

354. HEALTH CARE PROVIDERS AND IMMIGRATION ENFORCEMENT: KNOW YOUR RIGHTS, KNOW YOUR PATIENTS’ RIGHTS, *supra* note 339, at 2.

355. *Health Care Sanctuaries*, *supra* note 201, at 28–33.

patients, and so are applicable to undocumented immigrants as fully as to citizens and lawful residents.³⁵⁶ “[I]mmigration status or evidence of foreign birth is not alone considered protected health information under HIPAA.”³⁵⁷ At the same time, immigration status information is likely useless for enforcement purposes without additional information, including the name and address of the patient, which *is* likely protected under HIPAA.³⁵⁸ There is also no reason to believe, in most cases, that reportage of immigration status in conjunction with other protected health information would fall into a HIPAA exception permitting such disclosure.³⁵⁹ It thus seems likely that any actionable reportage of immigration status of an undocumented immigrant would constitute a HIPAA violation.³⁶⁰

The administration could act more forcefully to close any perceived or real gap in the prohibitions on reporting immigration status between health care providers and immigration enforcement authorities. HHS could implement a rule or provide guidance classifying immigration-status as personal health information that would be protected under HIPAA. Likewise, DHS could implement a rule or provide guidance prohibiting the provision or use of information from health care providers in initiating enforcement actions. Ensuring the prohibition of this information *ex ante* is likely the only way to fully address the issue; although health care providers may pay penalties from significant HIPAA violations, that does little to assist the noncitizen now caught up in a removal proceeding, and again, under current law there are likely no

356. NETWORK FOR PUB. HEALTH L., ISSUE BRIEF: UNDOCUMENTED IMMIGRANTS AND PATIENT PRIVACY LAWS 2 (2019), <https://www.networkforphl.org/wp-content/uploads/2020/02/Issue-Brief-Undocumented-Immigrants-and-Patient-Privacy-Laws-5-31-19.pdf>.

357. CAL. OFF. THE ATT’Y GEN., PROMOTING SAFE AND SECURE HEALTHCARE ACCESS FOR ALL: GUIDANCE AND MODEL POLICIES TO ASSIST CALIFORNIA’S HEALTHCARE FACILITIES IN RESPONDING TO IMMIGRATION ISSUES 10 (Oct. 2018); *but see* Scott J. Schweikart, *Should Immigration Status Information Be Considered Protected Health Information?*, 21 AMA J. ETHICS 32, 33 (2019) (arguing that immigration status information fits the definition of protected health information under HIPAA).

358. *See* CAL. OFF. THE ATT’Y GEN., *supra* note 357, at 10 (noting a patient’s identifying information, used “in combination with health information” is protected under HIPAA); *see also* OFF. C.R., DEP’T HEALTH & HUM. SERVS., SUMMARY OF THE HIPAA PRIVACY RULE 3–4 (2003) (listing information deemed to fall within the HIPAA privacy provisions).

359. *See* 8 C.F.R. § 164.506(c) (2021) (allowing disclosure for certain treatment, payment, and health care operations); § 164.512 (providing additional exceptions to privacy rules and bases for disclosing personal health information).

360. *See* William Maruca, *Did Practice Violate HIPAA by Tipping Off Immigration Authorities?*, FOX ROTHSCHILD LLP (Sept. 25, 2015), <https://hipaahealthlaw.foxrothschild.com/2015/09/articles/articles/did-practice-violate-hipaa-by-tipping-off-immigration-authorities/> (urging HIPAA covered entities to use caution when deciding whether to disclose someone’s immigration status).

avenues to suppress or limit the use of immigration status information that is unlawfully obtained.³⁶¹

D. *Improve Health Care for Detained Noncitizens*

Steps must be taken to improve health care for detained immigrants. In a September 2020 report, the House Committee on Homeland Security found that even before the pandemic, ICE was “ignoring medical issues raised by detainees, offering poor mental health care services, and, in one case, allowing medical care to deteriorate to the point that it became necessary to transfer detainees to different facilities.”³⁶² This is, in large part, due to a lack of services at detention facilities.³⁶³ “[T]he presence of health care services—including critical preventative services—is minimal. Instead, detention facility staff often ignore medical issues until they rise to the level of emergencies.”³⁶⁴ Likewise, detention centers provide, at best, “inconsistent access to quality medical, dental, or mental health care, and lack [] appropriate developmental or educational opportunities.”³⁶⁵

The close proximity of noncitizens detained together, coupled with a lack of adequate preventative services and treatment options, means that there is a high risk of infectious disease and other physical health concerns for those detained.³⁶⁶ These concerns unquestionably affect adults, but they present even greater risks to children.³⁶⁷ Studies have consistently found a high-level of mental-health related problems in children both during and following detention.³⁶⁸ Detention of children, for even short periods of time, significantly

361. *See* *Immigr. & Naturalization Serv. v. Lopez-Mendoza*, 468 U.S. 1032, 1039, 1046 (1984).

362. U.S. HOUSE OF REPS. COMM. ON HOMELAND SEC., *ICE DETENTION FACILITIES: FAILING TO MEET BASIC STANDARDS OF CARE* 13 (2020).

363. Isaac Chotiner, *The Troubling State of Medical Care in ICE Detention*, *NEW YORKER* (Sept. 25, 2020), <https://www.newyorker.com/news/q-and-a/the-troubling-state-of-medical-care-in-ice-detention>.

364. Nora Ellmann, *Immigration Detention is Dangerous for Women’s Health and Rights*, *CTR. FOR AM. PROGRESS* (Oct. 21, 2019), <https://www.americanprogress.org/article/immigration-detention-dangerous-womens-health-rights/>.

365. Julie M. Linton et al., *Detention of Immigrant Children*, *PEDIATRICS*, May 2017, at 107, 112.

366. *See* Charles A. Czeisler, *Housing Immigrant Children—The Inhumanity of Constant Illumination*, 379 *NEW ENG. J. MED.* E3(1), E3(2) (2018) (describing how facility conditions can affect children’s sleep patterns, circadian rhythm synchronization, growth, and development); Bara Vaida, *Separated Migrant Children Face Infectious Disease and Other Health Threats*, *ASS’N HEALTH CARE JOURNALISTS* (June 21, 2018), <https://healthjournalism.org/blog/2018/06/separated-migrant-children-face-infectious-disease-and-other-health-threats/> (describing reports of outbreaks of diseases like scabies, lice, and measles among children in detention centers).

367. M. von Werthern et al., *The Impact of Immigration Detention on Mental Health: A Systematic Review*, 18 *BMC PSYCHIATRY* 382, 396 (2018).

368. *Id.*

increases the risk of future mental-health related issues and even developmental regression.³⁶⁹

Detention may interfere with health care in more prosaic ways, for instance, in the refusal to permit unhindered access to the patient or freeing them entirely from restraints during examinations.³⁷⁰ As recounted by *Physicians for Human Rights*:

The patient's doctor was unable to adequately examine him due to the fact that the patient had restraints running across his body, despite not posing a danger to anyone due to his weakened state. The doctor requested that detention officers remove the restraints, to no avail. In another case, a patient in immigration custody receiving medical attention was shackled; agents gave no response as to why the restraints were necessary for this critically ill patient when repeatedly asked by the patient's doctor.³⁷¹

These issues may be addressed by the Executive Branch without the need for action by Congress. DHS should ensure adequate provision of basic medical services, including preventative care, at both publicly and privately run detention centers. Mental health counseling and treatment for children should be prioritized, given the long-term negative consequences otherwise associated with the detention of children. Detention officers should ensure unfettered access to detained patients absent extraordinarily compelling circumstances related to the dangerousness of the specific patient being treated. The administration should treat these issues at their source by limiting both the number and types of noncitizens it detains, and the duration of their detention. It may be inevitable that certain classes of noncitizens must be detained for at least short periods of time, especially unaccompanied minor children, but this detention should not be punitive and should last only so long as necessary to find adequate sponsors or guardians for the detained children. A less crowded detention system could go some way to addressing the most significant issues of access and care.

E. Increase Engagement with Noncitizen Communities

Communication with the noncitizen community should be a priority for the administration. The issues surrounding public benefits and immigration status

369. See Sarah A. MacLean et al., *Mental Health of Children Held at a United States Immigration Detention Center*, 230 SOC. SCI. & MED. 303, 305 (2019) (describing how children at detention centers experienced emotional and behavioral issues and trauma); Rachel Kronick et al., *Asylum-Seeking Children's Experiences of Detention in Canada: A Qualitative Study*, 85 AM. J. ORTHOPSYCHIATRY 287, 292 (2015) (noting that children can experience stress and trauma as a result of being detained).

370. Sarah Stoughton & Kathryn Hampton, *Not in My Exam Room: How U.S. Immigration Enforcement Is Obstructing Medical Care*, PHYSICIANS FOR HUM. RTS. (June 10, 2019), <https://pfor.org/our-work/resources/not-in-my-exam-room/>.

371. *Id.*

are rife with confusion, which has significant negative consequences for the health and well-being of both noncitizens and citizens alike.³⁷² The Biden administration should clarify what public benefits noncitizens may be eligible for and communicate that to the nonimmigrant community. Along with notifications regarding the range of benefits for which noncitizens may qualify, the communications should also address fears noncitizens could harbor on their removability or future eligibility for relief based on their receipt of public benefits. This involves not only clarifying the circumstances in which the public charge ground of deportability or inadmissibility may be applied, but also rebutting myths about how the receipt of benefits to which the noncitizen is lawfully entitled could affect their ability to remain in the United States (or seek permanent status). The administration should clearly communicate its intent on how it will undertake enforcement actions at public health-related facilities. It should seek to calm immigrant communities that may fear enforcement action any time they set foot within a hospital or clinic. These communications should have the effect of maximizing noncitizen access to health care and other related public benefits. Noncitizens seeking preventative care will be healthier than those who decline to address medical issues early and instead seek only emergency care once the situation has deteriorated.³⁷³ Clarification that receiving such assistance will not render them inadmissible or deportable should cure fears of seeking treatment in the first place, as should the administration's ostensibly narrower protected-areas policy.³⁷⁴

F. Encourage State-Level Action

The federal government should encourage state-level action. It obviously has little room to compel action by state governments, but as explained in the foregoing, there are sufficient statutory authorities for states to expand noncitizen access to public benefits, and they should be encouraged to do so. States that have yet to expand Medicaid eligibility or elect the CHIP option should do so, while states that currently do not offer any state-level health programs for noncitizens should consider implementing such an option. States

372. HAMUTAL BERNSTEIN ET AL., URB. INST., AMID CONFUSION OVER THE PUBLIC CHARGE RULE, IMMIGRANT FAMILIES CONTINUED AVOIDING PUBLIC BENEFITS IN 2019, at 4 (2020), https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf.

373. See *Preventive Care*, HEALTHY PEOPLE 2030, <https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care> (last visited Apr. 21, 2022) (noting “getting preventive care reduces the risk for diseases, disabilities, and death”).

374. See Alexia Elejalde-Ruiz, *Fear, Anxiety, Apprehension: Immigrants Fear Doctor Visits Could Leave Them Vulnerable to Deportation*, CHI. TRIBUNE (Feb. 22, 2018), <https://www.chicagotribune.com/business/ct-biz-immigration-fears-hurt-health-care-access-0225-story.html> (noting many immigrants “worry that going to the doctor or signing up for health benefits could leave them or their family members vulnerable to deportation”); MAYORKAS, *supra* note 349, at 1.

should also take more prosaic actions, such as ensuring that COVID-19 vaccine information is available in all relevant languages and that immigration status is not a barrier to receiving the vaccine. Although the best option remains federal reform of the statute governing eligibility for public benefits, state governments do have substantial leeway to make life easier and healthier for the noncitizen residents of their states.³⁷⁵ Whatever role the federal government could play in making states realize this and act would be a marked improvement on the current status quo.

V. CONCLUSION

Immigration law and health policy are intricately linked, and Congress has the opportunity to advance reform efforts in both areas that would be mutually reinforcing.³⁷⁶ Repealing the public charge ground of deportation, while excluding public benefits from consideration in assessing inadmissibility as a public charge, would free noncitizens from the fear of utilizing benefits to which they are entitled, which in turn would contribute to better health outcomes in the immigrant community. As the COVID-19 pandemic has shown, the health of citizens and noncitizens is interconnected, and improving and safeguarding noncitizen health will necessarily safeguard the health and well-being of the citizen population, too. Liberalizing the conditions for admitting noncitizen medical professionals would similarly benefit citizens and noncitizens alike. It would provide a path to residency in the United States for thousands of additional immigrants each year, while serving to bridge the gap between the demand for such professionals and the supply, which is widening with each passing year.³⁷⁷ Again, this is an immigration reform that can better serve the *entire* population of the United States by addressing the shortage of health care professionals for all communities, while also providing opportunities for health care professionals who may be better poised to serve the many immigrant communities in the United States. Expanding noncitizen access to health coverage is in the same vein by promoting access to important preventative care at a lower cost than the existing alternatives, while improving the health

375. See Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAM. FOUND. (Jan. 31, 2017), <https://www.kff.org/medicaid/issue-brief/current-flexibility-in-medicaid-an-overview-of-federal-standards-and-state-options/> (discussing the flexibility and variety within state Medicaid programs, including the ability for a state to decide “who is eligible” for benefits).

376. See Jeffrey Douaiher et al., *The Intersection of National Immigration and Healthcare Policy*, 31 J. AM. BD. FAM. MED. 163, 163 (2018) (discussing the links between immigration policy and health care policy and how not attending to either could harm certain populations in the United States).

377. *AAMC Report Reinforces Mounting Physician Shortage*, AM. ASS’N MED. COLLS. (June 11, 2021), <https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage> (estimating a “shortage of between 37,800 and 124,000 physicians by 2034”).

outcomes of noncitizens with the obvious spillover benefits to the health of the entire U.S. population. Considering that the reforms recommended in this Article track with reforms either previously enacted or currently being considered speaks to their reasonableness. The only real question is whether Congress will recognize immigration law's impact on health policy and act to bring them into alignment.