



Policy Note

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IMMIGRATION POLICY UNDERMINES THE US PANDEMIC RESPONSE

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The US response to the COVID-19 pandemic will be hobbled by its increasingly punitive and stigmatizing approach to immigration policy. The administration’s “zero tolerance” immigration campaign creates a public health risk in the context of this pandemic. In addition to the systemic obstacles noncitizens face in their access to healthcare, the recent implementation of the “Inadmissibility on Public Charge Grounds” final rule penalizing noncitizen recipients of some social services will further restrict their access to treatment and hinder the fight against the coronavirus.

During disease outbreaks, attacks on marginalized groups are not an exception, but the norm. Racism and xenophobia are heightened by discourse that targets certain ethnic groups, suggesting they are at fault for spreading the disease or are free riders who take resources that should not be available to them. Examples are found throughout the history of the United States: European colonists blamed for America’s smallpox epidemic in the sixteenth century; Jewish communities targeted during the bubonic plague; and Irish immigrants blamed for typhoid in the 1800s. In recent days, Jeung (2020) found a 50 percent increase in the number of news articles related to the coronavirus and anti-Asian discrimination, both physical and verbal. Nonwhite legal residents are also scrutinized for their use of public services and labeled as undeserving. Refugees are often accused of draining resources and struggle to counter extremist narratives and social distrust in host communities.

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Immigration policies in the United States have intensified these sentiments and could undermine efforts to detect and combat COVID-19. Those apprehended after crossing the border are put in detention facilities that do not provide any protective gear, cleaning supplies, or space to allow social distancing. Some private prison companies that operate the detention centers have forced detainees to sign waivers, relinquishing all rights related to coronavirus, in exchange for masks (Merchant 2020). The centers are crowded and cramped environments, which are detrimental to epidemic management. In April 2020, there were 33,800 people held in detention by the Immigration and Customs Enforcement agency (ICE), including people who were apprehended months or years earlier for civil violations, and over 5,800 people who passed government asylum screenings but are awaiting the government's appeal. ICE claims to have released 693 individuals considered medically vulnerable and not a security or flight risk (Merchant 2020).

In this COVID-19 crisis, migrants are at a dangerous disadvantage when facing segregationist measures such as “English only” policies meant to expel languages other than English from the public sphere. For example, in Arizona—where 30 percent of the residents are Hispanic—the state's department of health services had updated information on its website about the pandemic that, until mid-March, was not available in Spanish.¹ Similar exclusionary measures, whether driven by oversight or explicit policy, mean that the large number of people who do not read in English will be missing critical information and directions that would help them take precautions to reduce the danger of being infected, and families will not be prepared in case they get sick or the government orders confinement.

The administration's zero tolerance² approach to immigration poses an obstacle to treatment and will hinder the fight against the pandemic. Undocumented immigrants already in the United States might not seek care out of fear of deportation. Infected individuals may prefer to avoid scrutiny and keep working, increasing the chance of spreading the virus. Nuzzo (2019) studied a mumps outbreak in an immigrant community in Pennsylvania where many people in the community spoke little or no English, and some did not have health insurance or official immigration documentation. The study found that the outbreak was exacerbated because some cases and their contacts may have been deterred from seeking care, since they were afraid to be identified as undocumented immigrants and reported to immigration officials.

Similar problems can be found in the US treatment of legal immigration, and a recent rule change regarding individuals considered to be a public charge only worsens the confusion and public health risks. During the early years of the United States, individuals who became dependent on the government were institutionalized in asylums or placed in almshouses for the poor. As the welfare state developed, a model of limited-purpose public assistance was established against the backdrop of the public charge concept used in immigration law beginning in the late 1800s. Since its appearance in the 1882 Immigration Act, the concept has been used to deny admission or (later) change of status on the basis that a prospective or current immigrant would be, in the words of the Immigration Act, “unable to take care of himself or herself” without reliance on public assistance.

The concept, ostensibly driven by an aversion to “dependency” on the state, also informed the changes introduced by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) program of welfare reform signed by President Clinton, which imposed new restrictions on noncitizens' eligibility for federal, state, and local public benefits. The eligibility restrictions did not include receipt of emergency medical assistance; short-term, in-kind, emergency disaster relief; public health assistance related to immunizations and treatment of a communicable disease; certain in-kind services (e.g., soup kitchens, etc.) designated by the attorney general as necessary for the protection of life and safety; or assistance under certain Department of Housing and Urban Development programs.

In 1999, seeking to provide a better guide to the types of public benefits considered in public charge determinations, the Immigration and Naturalization Service (INS) defined the term public charge to mean: “an alien who has become (for deportation purposes) or who is likely to become (for admission or adjustment purposes) ‘primarily dependent on the Government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at Government expense’” (INS 1999).

The rule held that certain non-cash benefits do not directly provide subsistence and are thus not to be considered for public charge purposes. Specifically, it excluded programs designed to aid individuals in gaining and maintaining employment, increasing access to healthcare, and helping people to become self-sufficient, namely: Medicaid, food stamps, the Children's

Health Insurance Program (CHIP), and their related state analogues; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); housing benefits; transportation vouchers; and certain kinds of special-purpose non-cash benefits provided under Temporary Assistance for Needy Families (TANF).

Under the 1999 rule, immigrants were legally eligible to accept these benefits, as well as other state and local cash assistance programs, but such acceptance may result in an individual being deemed a public charge and affect a noncitizen's right to remain in the United States (a person is also considered a public charge if they are institutionalized at the government's expense, other than imprisonment for conviction of a crime).³ The rule stated that, in terms of immigration status, the non-citizens that receive any form of cash assistance for income maintenance or are institutionalized for long-term care are not *necessarily* inadmissible, ineligible to adjust status, or deportable on the grounds that they are a public charge: "the law requires that a variety of other factors and prerequisites must be considered as well" (INS 1999).

Despite the attempt to clarify the distinction between cash and non-cash benefits,⁴ fear of the negative consequences of being deemed a public charge led many noncitizens to avoid non-cash benefits, posing a danger to public health, especially for the treatment of communicable diseases. If a large segment of the population fears obtaining necessary medical treatment, it will not only cause considerable harm to families, but will jeopardize the general public. For example, infectious diseases may spread as a large percentage of the population declines immunization or refuses to seek—or are refused—treatment during a pandemic.

This tension between immigration and welfare laws has only been exacerbated by the changes to immigration laws pushed by the Trump administration. In January of this year, the US Supreme Court intervened to allow the administration's new public charge rule to take effect, and on February 24, 2020, the "Inadmissibility on Public Charge Grounds" final rule was implemented nationwide. Citing the basic principle of self-sufficiency in the United States since the earliest immigration waves of the 1800s, the government expanded the application of the section of the Immigration and Nationality Act that says those unable to care for themselves without becoming a public charge are inadmissible in the United States. The rule makes it more difficult for noncitizens to preserve, extend, or change their immigration status if they have used or are likely to use

public benefits like food stamps and Medicaid over a designated threshold—benefits that the 1999 rule had not included in public charge determinations.

As the coronavirus spreads across the United States, citizens and noncitizens should be encouraged to access health insurance and medical care. In March 2020, a coalition of 18 attorneys general called on the administration to delay implementation of its public charge rule as the coronavirus progressed nationwide (Ferguson 2020).

On their website, the US Citizenship and Immigration Services (USCIS) office encourages "all those, including aliens, with symptoms that resemble Coronavirus 2019 (COVID-19) (fever, cough, shortness of breath) to seek necessary medical treatment or preventive services. Such treatment or preventive services will not negatively affect any alien as part of a future Public Charge analysis" (USCIS 2020). The website also stresses that the public charge rule implemented on February 24, 2020 "does not restrict access to testing, screening, or treatment of communicable diseases, including COVID-19. In addition, the rule does not restrict access to vaccines for children or adults to prevent vaccine-preventable diseases."

Unfortunately, USCIS does not clarify if receiving treatment or testing for COVID-19 will hinder noncitizens' immigration status. The alert leaves open the possibility that the use of Medicaid and public benefits might be considered to weigh the admissibility of noncitizens, thus encouraging noncitizens to use the resources offered by the private sector and discouraging them from applying for or accepting public aid—even if they desperately need it. USCIS also mentions the consequences of social distancing or quarantine to prevent the spread of COVID-19. Since noncitizens might be prevented from working or attending school, some might rely on public benefits, like food stamps, for the duration of the outbreak and recovery phase; thus, they must provide an explanation and relevant supporting documentation. USCIS will determine if their claim is relevant and credible, and if it will be considered in the totality of the circumstances.

By labeling those that receive social programs and benefits as a public charge, the administration decides who is deserving, creating a model that stigmatizes, excludes, and menaces those that do not belong. The term "public charge" reflects the needs-tested social assistance model that prevails in the United States. The social humiliation of those in need, which extends to noncitizens, includes benefits pegged to low standards in a stratified model that targets public benefits to the genuinely

poor. Denying access to noncitizens increases the risk of spreading COVID-19, since public benefits might be the only option for undocumented individuals to survive and recover from the virus. During this pandemic, even when noncitizens are granted legal or policy rights to healthcare, they might disenroll from Medicaid, which would—as the Department of Homeland Security has conceded—lead to an “increased prevalence of communicable diseases” (Ferguson et al. 2020). Given the zero-tolerance discourse, undocumented workers might be afraid to seek medical attention in fear of being detained by ICE. The health implications for mobile populations subjected to this kind of discrimination can be profound and can have a serious impact during this epidemic—making a mockery of the argument that the public charge rule was designed to “defend and protect Americans’ health” (USCIS 2020).

Notes

1. The website has since been updated and now includes a Spanish version: <https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/covid-19/index.php#novel-coronavirus-home>
2. The zero tolerance policy was initiated in April 2017, and in April 2018 US Attorney’s Offices along the southwest border were directed to “adopt a policy to prosecute all Department of Homeland Security referrals of section 1325(a) violations, to the extent practicable” (DOJ 2018).
The policy aimed to enforce criminal cases, making immigration offenses higher priorities. The offenses included harboring aliens, aiding or assisting criminal aliens, felony prosecution of those evading provision of immigration laws, and deterring first-time improper entrants. As a result of this policy, several families were separated. Parents were referred for prosecution while their children were placed with the Department of Health and Human Services’ Office of Refugee Resettlement. Alien children may also present an individual claim for asylum and, depending on the circumstances, may undergo separate immigration proceedings (DHS 2018).
3. The public charge rule also states that a person can be deported if they fail to comply with a legally enforceable duty to reimburse the assistance agency for the costs of any care incurred within the initial five-year period after entry into the United States.
4. Although the public charge rule assures that noncitizens will not be automatically deemed a public charge, it leaves open the possibility that receiving aid might impact their

status later: “The rule will provide rules of decision that will apply in proceedings before the Executive Office for Immigration Review (EOIR), as well as proceedings before the Service. The Department anticipates, based on the Service’s consultations, that the State Department will adopt the same view and will issue guidance to consular officers accordingly” (INS 1999).

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