



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

# Toward a new standard of health for immigrants in the United States



Jin K. Park,<sup>a</sup> and Dave A. Chokshi<sup>b,c,\*</sup>

<sup>a</sup>Harvard Medical School, Boston, MA, USA

<sup>b</sup>New York City Department of Health and Mental Hygiene, New York, NY 10013, USA

<sup>c</sup>NYU School of Medicine, New York, NY, USA

## Summary

The COVID-19 pandemic has caused massive disruptions in social life, created significant morbidity and mortality, and has exacerbated pre-existing disparities in health and welfare. In the United States, the pandemic has also catalyzed debate regarding how our health and social services infrastructure can be improved and bolstered going forward. An important part of these discussions revolves around the vulnerability experienced by immigrant populations during the pandemic. However, the debate has too often left unquestioned what fundamental standard of health is owed to immigrants. Here, we offer a set of proposals that can chart a course for a new standard of health for immigrants in the US, some of which, as a matter of statute, can ensure that the health of immigrant populations is not contingent on the policy prerogatives of various governmental administrations. Though these proposals would establish a novel standard for immigrant health, we argue that a broader approach is needed—encompassing local, state, and federal initiatives—to ensure that all members of society are provided fundamental resources and social support.

The Lancet Regional Health - Americas 2022;10: 100238

Published online 19 March 2022

<https://doi.org/10.1016/j.lana.2022.100238>

**Copyright** © 2022 The Author(s). Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>)

As we enter an uncertain phase of the pandemic, it is time to appraise what went wrong, and how we can improve our preparedness for the next pandemic. Central to this assessment is a reckoning with the fundamental underpinnings of our public benefits systems. For the first time in recent memory, we find ourselves in an environment where, instead of incremental tinkering, we are called to interrogate the underlying logic of our welfare, healthcare, and public benefits infrastructure. Part of this reckoning has been a reimagining of the scope and size of government in the 21st century. In the U.S. context, policies to ensure that our infrastructure, social welfare, public health, and anti-racism meet the needs of all Americans have all been put on the table, with serious proposals being debated in the U.S. Congress.

In an era of globalized capital and increasingly consolidated corporate control, the pandemic has also challenged traditional power dynamics in the workplace. What the pandemic has magnified is that safeguarding public health is not ancillary to maintaining a robust workforce, but rather a necessary condition for productive work itself. What has received little attention during the pandemic, however, is the role of immigrant labor. To be sure, many have turned a critical eye to high-profile US federal policies such as Title 42 that have been

used to turn away migrants at the border. Moreover, important attention has been brought to the unequal distribution of workplace hazards, many of them borne out by immigrants.<sup>1</sup> In healthcare, for example, more than a quarter of US nurses who lost their lives due to COVID-19 were Filipino.<sup>2</sup> Furthermore, many meat processing plants that disproportionately rely on immigrant labor became sources of outbreak during the early pandemic in addition to preexisting occupational health hazards.<sup>3</sup> Yet a more comprehensive assessment must encompass the unique precarity and health inequities experienced by immigrant communities during the pandemic.

Since at least the Clinton-Gingrich Era “Contract with America,” however, there has been resistance against the very notion that immigrants would benefit from welfare and public benefits, exemplified in Gingrich’s retort that “It is wrong for us to be the welfare capital of the world.”<sup>4</sup> The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, in addition to replacing an entitlement-based system of welfare to a work-based one, limited legal immigrant participation in public benefits in the first five-years of their residency in the US.<sup>5,6</sup> Though the scope of immigrants excluded from the original statute was “legal” immigrants arriving after 1996, it has still had a so-called “chilling effect” on utilization of Medicaid and other welfare programs by different cohorts of immigrants.<sup>7,8</sup>

\*Corresponding author.

E-mail address: [dchokshi@health.nyc.gov](mailto:dchokshi@health.nyc.gov) (D.A. Chokshi).

Off the heels of PRWORA, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) to counter the rise in the population of undocumented immigrants —migrants who are present in the United States without legal authorization. IIRIRA created dramatic effects on undocumented immigrant deportability by expanding the criteria for removal proceedings.<sup>9</sup> Furthermore, it created changes to so-called “public charge” provisions of immigration law. This is significant because although long-standing immigration law had promulgated that an immigrant may be deportable or inadmissible on public charge grounds, the definition of public charge had never been specified.<sup>10</sup> The Trump Administration in 2018 proposed a change in public charge grounds of inadmissibility to include receipt of benefits from programs such as Medicaid.<sup>8</sup> Though the Trump Administration’s public charge rule was repealed in March 2021, the chilling effect and rules under IIRIRA still largely remain.

As Carole Pateman argues, “Each new generation has to be kept healthy, educated in appropriate ways, and exposed to cultural life...social reproduction is not something that can be undertaken by mothers and fathers alone, or through purely individual endeavors, but requires public provision.”<sup>6</sup> Immigrants participate in civic, cultural, and economic life, often in ways essential to the health of the nation. During the pandemic, low-wage workers disproportionately suffered wage cuts and layoffs.<sup>11</sup> Immigrants disproportionately occupy jobs in food service, agriculture, manufacturing compared to the native population. Workers in these industries, far from the “work-from-home” revolution, faced outbreaks and experienced occupational hazards that worsened during the pandemic.<sup>1,12,13</sup> The pandemic has also had a disproportionate effect on learning for immigrant youth given the linguistic barriers many immigrant families face, as well as the lack of workplace flexibility in many occupations disproportionately held by immigrants.<sup>14</sup> Far from being a hidden, peripheral, or unassimilable faction of the nation’s workforce, immigrants have taken on a disproportionate share of essential labor.

And yet, largely by virtue of statutes passed by a legislative majority elected decades ago and responding to needs different from today’s, there is a distinctly different social minimum afforded to immigrants. The fundamental question we should therefore ask at this juncture is not “how do we patch up what COVID has broken,” but rather “how do we reimagine the role of health in a fair system of social cooperation.” Seen in this way, all members of society—including immigrants—who play a role in perpetuating the succession of American society over time cannot be seen as peripheral, but rather crucial components. Therefore, a safety net that is porous to immigrants is not only harmful to immigrant health. Health is also central—just like education—to averting what the US Supreme Court in

*Plyler v. Doe* called “the significant social costs borne by our Nation when select groups are denied the means to absorb the values and skills upon which our social order rests.”<sup>15</sup>

Immigrants, therefore, are owed a fundamental standard of health. We recommend policy proposals at three levels (federal, state, and local) to reimagine a new standard for immigrant health. We believe these reforms can furnish essential health resources that will not depend on fluctuations of administrative priorities. This is important because although administrative priorities frequently change, the statutory background that different administrations act within largely define the scope of the social safety net that immigrants can rely on.

Federally, we propose a ‘floor’ for certain aspects of immigrant health. One example could be prenatal care for immigrant women and coverage for children. Under the “Legal Immigrant Children’s Health Improvement Act,” which was ultimately included in the 2009 CHIPRA, states can receive federal dollars to cover lawfully present immigrants (i.e. legal permanent residents, asylees, etc.) who nonetheless lack eligibility for Medicaid/CHIP eligibility due to a five-year waiting period imposed by PRWORA.<sup>16</sup> Thus, states can elect to cover lawfully-residing immigrant pregnant women and children without a five-year waiting period.<sup>17</sup> As of 2021, 25 states have expanded coverage to lawfully-residing immigrant pregnant women, and 25 states expanded coverage for lawfully-residing children, without the five-year wait.<sup>17</sup> The Biden Administration should make this universal across all states as a matter of statute, as currently the majority of states have taken advantage of the waiver opportunity.

A bolder proposal at the federal level would be to make all U.S. Preventive Services Task Force (USPSTF) grade ‘A’ and ‘B’ preventive services, such as mammograms and blood pressure screenings, reimbursable via emergency Medicaid. Emergency Medicaid is one of the only types of healthcare for undocumented immigrants reimbursed by the federal government, focusing on downstream emergent care, and not prevention. This is detrimental for both immigrant health and may also increase overall costs.<sup>14</sup> USPSTF grade ‘A’ and ‘B’ preventive services includes interventions for conditions with significant mortality and morbidity for many uninsured populations, including vision and dental screening (for children through the age of 5), screening for certain STIs, primary hypertension, and depression, among others. Though this is ambitious, it would fundamentally reshape immigrant health in the US, as undocumented immigrants disproportionately seek care in safety-net hospitals and emergency departments on an emergency basis.<sup>5</sup>

The federalist structure of the American political system allows for significant state-based policy innovation for immigrant health. Thus, at the state level, we highlight the ability for states to extend Medicaid/CHIP

benefits to immigrant children, regardless of immigration status. Although undocumented immigrants are not eligible for federally-funded healthcare outside of emergency Medicaid—including in the 2009 CHIPRA—many states have created their own programs to provide benefits to immigrant children regardless of status. Some states have expanded Medicaid funding to children regardless of immigration status using state funds, including California, Illinois, New York, Massachusetts, and Washington.<sup>5</sup> California in particular has since expanded its Medicaid program (Medi-Cal) to all residents under age 26 (from <19 in the original bill) to older immigrants (>50) without status.<sup>18</sup>

Furthermore, states can utilize various waivers to promote immigrant health beyond children. The most commonly-used waivers—ACA Section 1332 and Medicaid Section 1115 waivers—allow for significant state innovation in both the implementation of the ACA and Medicaid. It is well-known that the ACA limits participation in state exchanges to “qualified” lawful residents. It has been proposed that states could submit ACA Section 1332 waivers to allow enrollment of undocumented immigrants in state exchanges, even if they would not be eligible for federal subsidies.<sup>19</sup> In 2016, California’s State Senate Bill 10 would have allowed undocumented immigrants to enroll in exchanges, was withdrawn due to fear that the information would be used by the federal government for enforcement.<sup>20</sup> Medicaid Section 1115 waivers have also been proposed for state to receive reimbursement for uncompensated care for uninsured and underinsured patients, including undocumented immigrants.<sup>20</sup>

At the local and municipal levels, we are calling attention to programs in major cities across the country to provide safety net care for immigrants regardless of status. Prominent examples are “NYC Care” in New York City, “MassHealth” in Massachusetts, “Healthy San Francisco” in San Francisco and “My Health LA” in Los Angeles which provides free healthcare for low-income patients over the age of 26 who are otherwise unable to receive health insurance. These programs should be supported with additional state and federal funding to expand to other municipalities, especially given that interventions to address local- and community-based drivers of health and morbidity—which city and municipal entities are closest to—are generally underinvested, despite being cost-effective.<sup>21</sup> At all three levels—federal, state, and municipal—there should also be efforts to ensure that personal health and identifying data collected when immigrants use these expanded services are not then used for enforcement. Initiatives to expand health services to immigrants must also be met lockstep with safeguards, especially for undocumented immigrants who are especially vulnerable.

Healthcare is a fundamental human right, but social institutions’ duty to furnish its provision is politically determined. Our recommendations are constrained by

democratic feasibility since they must ultimately be taken up by legislative majorities in Congress. If implemented, however, we believe that these measures would provide a fundamental standard of health for immigrants in the US which—in the absence of a clear path to comprehensive immigration or health reform—can act as a much-needed stopgap measure for immigrant communities devastated by the COVID-19 pandemic. Importantly, even if these measures are adopted (with the exception of expanding emergency Medicaid), it would largely leave existing statutes intact. During the Trump Administration, much of the public debate and discussion around immigrants in our society has understandably revolved around particularly high-profile federal policies—the initial travel ban, family separation, and the rescission of the executive order that established Deferred Action for Childhood Arrivals. During the Biden Administration, the immigration policy debate is largely confined within the same statutory background, and not necessarily whether the pandemic should move us to reimagine these statutes. Thus, the underlying logic of our health, welfare, and immigration systems have often gone unchallenged.

It would seem, then, that we need broader engagement with the more fundamental matter at hand, which is not what social *minimum* immigrants are owed, but rather how to properly distribute the *fundamental benefits and burdens of social cooperation*. The example of France (Aide Médicale de l’Etat) and other liberal democracies that have included migrants into some or all portions of their welfare programs can be instructive to this end. In the US, to properly address the entire enterprise—and not just the safety net—we need to develop a proper understanding of the relationship between immigrant labor, integration and social support, workplace democracy, political participation, and the social determinants of health—and how these dimensions hang together as a whole. This first-order task will be essential if we are to avert another public health disaster, and to prevent the perpetuation of unjust social arrangements.

### Authors’ contributions

JP and DC both conceptualized this article. Both authors were involved in the analysis, writing, and editing of the final manuscript.

### Declaration of interests

The authors declare no competing interests.

### References

- 1 Sparber C, Zavodny M. Immigration, working conditions, and compensating differentials. *ILR Rev.* 2021;1–5. Jun 7;00197939211021379.
- 2 Young JL, Cho MK. The invisibility of Asian Americans in COVID-19 data, reporting, and relief. *Am J Bioeth.* 2021;21(3):100–102.

- 3 Reid A, Ronda-Perez E, Schenker MB. Migrant workers, essential work, and COVID-19. *Am J Ind Med.* 2021;64(2):73–77.
- 4 Fairchild AL. Policies of inclusion. *Am J Public Health.* 2004;94(4):528–539.
- 5 Khullar D, Chokshi DA. Challenges for immigrant health in the USA—the road to crisis. *Health Policy.* 2019;393:7.
- 6 Mead LM, Beem C. *Welfare Reform and Political Theory.* editors. New York: Russell Sage Foundation; 2005:284.
- 7 ME. Fix, JS. Passel Trends in noncitizens' and citizens' use of public benefits following welfare reform 1994–97. *Urban Inst. Rep.* 1999 Mar 1;16. <https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform>.
- 8 Katz MH, Chokshi DA. The “Public Charge” proposal and public health: implications for patients and clinicians. *JAMA.* 2018;320(20):2075–2076.
- 9 Kerwin D. From IIRIRA to trump: connecting the dots to the current US immigration policy crisis. *J Migr Hum Secur.* 2018;6(3):192–204.
- 10 Congressional Research Service. *Public Charge Grounds of Inadmissibility and Deportability: Legal Overview.* Congressional Research Service Report; 2017. Feb 6;R43220:16.
- 11 Dennerlein JT, Burke L, Sabbath EL, et al. An integrative total worker health framework for keeping workers safe and healthy during the COVID-19 Pandemic. *Hum Factors.* 2020;62(5):689–696.
- 12 Matthew OO, Monaghan PF, Luque JS. The novel coronavirus and undocumented farmworkers in the United States. *New Solut.* 2021;31(1):9–15.
- 13 Lancet The. The plight of essential workers during the COVID-19 pandemic. *Lancet N Am Ed.* 2020;395(10237):1587.
- 14 Doãn LN, Chong SK, Misra S, Kwon SC, Yi SS. Immigrant communities and COVID-19: strengthening the public health response. *Am J Public Health.* 2021;111(S3):S224–S231.
- 15 Plyler v. Doe, 457 U.S. 202 (1982).
- 16 T. Brooks, K. Wagnerman, Mar 21 ECP, 2018. Medicaid and CHIP eligibility, enrollment, renewal, and cost sharing policies as of january 2018: findings from a 50-state survey [Internet]. KFF. 2018 [cited 2021 Nov 24]. Available from: <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/>.
- 17 Medicaid/CHIP coverage of lawfully-residing immigrant children and pregnant women [Internet]. KFF. 2021 [cited 2021 Nov 24]. Available from: <https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/>.
- 18 M. Gutierrez California expands medi-cal, offering relief to older immigrants without legal status [Internet]. Los Angeles Times. 2021 [cited 2021 Nov 25]. Available from: <https://www.latimes.com/california/story/2021-07-27/medi-cal-expansion-immigrants-budget-california-newsom-legislature>.
- 19 Seifert R.W., Gershon, R., London, K. Using waivers to improve health care affordability and access in connecticut. Connecticut Health Foundation. 2015 [Internet]. [cited 2021 Nov 25]. Available from: <https://www.cthealth.org/publication/waivers-affordability-access/>.
- 20 Kelley AT, Tipirneni R. Care for undocumented immigrants — rethinking state flexibility in medicaid waivers. *N Engl J Med.* 2018;378(18):1661–1663.
- 21 Khullar D, Chokshi DA. Moving to action on place-based health. *JAMA.* 2020;323(8):698–699.