DACA, public health, and immigrant restrictions on healthcare in the United States

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Introduction

The DACA (Deferred Action for Childhood Arrivals) program is the result of an executive action by President Barack Obama in 2012 to serve as a temporary stopgap measure for a small subset of the undocumented population in the United States. The DACA program does not provide formal immigration status, but rather is a form of prosecutorial discretion that provides work authorization and deportation deferral. Because DACA was implemented through executive action, some critics have argued that it does not reflect the result of compromise that is often required for major pieces of legislation. However, providing some form of protection for DACA recipients has consistently enjoyed bipartisan support.[1]

A recent decision in the federal Fifth Circuit Court of Appeals in the case of *Texas v. United States* held that the DACA program is unlawful. The decision also barred new DACA applications. The court returned a portion of the case back to the district court, where some speculate the DACA program will be terminated.[2] This Viewpoint discusses the consequences of these developments for broader efforts to expand access to healthcare for immigrant populations in the United States. Although the potential end of DACA creates urgent issues regarding continuity of care, it also affords a crucial opportunity to rethink long-standing restrictions on government-sponsored healthcare subsidies.

DACA's 10-year run in context

At its height, there were more than 700,000 active participants in the DACA program, though that number has declined since then. The legal status of the DACA program has been in flux since then-President Trump sought to terminate the program in 2017. Although a 2020 U.S. Supreme Court decision prevented President Trump from doing so, it was understood that the future of the program was far from settled, as illustrated by the Fifth Circuit's recent decision. These recent developments also mark an important inflection point in efforts to expand health coverage for immigrant populations in the United States, who face unique vulnerabilities and structural barriers to care.

Although the DACA program was not implemented primarily as a health policy intervention, the immense benefits of the DACA program have been widely recognized. The work authorization provided under DACA has allowed its beneficiaries to access employer-sponsored health insurance, and state-funded health insurance in states such as New York. In the intervening years since its inception in 2012, a significant body of scholarship has demonstrated the positive effects of DACA on individual beneficiaries, their families, and the broader U.S. economy.[3–5] Several longitudinal qualitative studies have demonstrated the differentiating impact of DACA status on the health prospects of young undocumented youth.[6–8] The particularly beneficial role that DACA has played in mental health has also been noted, both for beneficiaries and for their U.S. citizen family members.[9,10] The number of active DACA beneficiaries has been steadily decreasing over time (largely due to the court-ordered injunction on new DACA applications).[11]

This uncertainty is coupled with the immensely detrimental impact of the Covid-19 pandemic on immigrant populations. Although states had some flexibility to cover testing and treatment for uninsured immigrants with Covid-19, it is unclear whether persons with long-term Covid-related sequelae will be able to receive coverage for their health care, particularly after the declared public health emergency ends.[12] Some DACA recipients—through the 2-year work authorization documents afforded by the program—receive health coverage through their employer. However, for many others, full health care coverage remains a challenge. Recent scholarship has documented that a significant share of DACA grantees remain underinsured.[13] To ensure that this population does not lose access to health insurance if courts terminate the DACA program, policies that provide continuity of care for this population are urgently needed. There are several paths for policymaking going forward, and we highlight several approaches below.

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COVID-19 and DACA—Policymaking in the face of overlapping challenges

First, some have proposed to extend access to health care for DACA grantees through rulemaking in the executive branch. However, this approach will face uncertain prospects in the event of a court-ordered termination of the DACA program. Currently, undocumented immigrants and DACA recipients are barred from participating in the health exchanges created by the Affordable Care Act (ACA). The Biden administration's recently promulgated rule on DACA declared that DACA beneficiaries are considered "lawfully present" for specific purposes under the jurisdiction of the Department of Homeland Security (DHS), and indicated that the question of eligibility for entry into ACA exchanges would be up to the Department of Health and Human Services. But health exchange eligibility for DACA recipients will likely not be helpful if the courts declare the DACA program unlawful.

Another approach is to leverage the unique system of federalism in healthcare in the US, and use state policymaking to expand coverage to this population—a strategy that has been frequently proposed as a possible solution to barriers that exist at the federal level.[14] For example, thanks to decades of community organizing and policymaking at the state level, California, Colorado, Oregon, and Washington have made plans to expand coverage to all residents regardless of immigration status. By January 2024, California will provide public health coverage in its Medi-Cal program to low-income residents, regardless of their age or immigration status. California currently covers noncitizens regardless of status who are under 26 or 50 or older. Most recently, during COVID-19, at least 12 states made changes to their Emergency Medicaid programs to including testing, treatment, and care for COVID-19.[12] However, state funding for immigrant health programs can fluctuate.[15] Moreover, immigrants live in all 50 states, and as the pandemic has shown, excluding some residents can have detrimental impacts on public health. And as debates regarding ACA Medicaid expansion have shown, extending healthcare coverage often faces political opposition in some states.

Although innovative proposals to open federal health exchange participation to DACA recipients have been proposed before,[16] in a possible world without DACA, policymakers should take this opportunity to consider the complex system of immigration status-based exclusion *as a whole* to address gaps in coverage for noncitizen populations. Although the formal end of the DACA program will have the most direct implications for current grantees, for other DACA-eligible individuals who have been unable to apply for the program since the court-ordered injunction, the benefits of the program have effectively already been eliminated. Although it may reasonably be argued that policymaking for immigrant populations should focus on DACA recipients, who have garnered significant public sympathy, the sharp distinction between DACA-eligible and non-eligible individuals within the undocumented population is slowly being eroded both because new DACA applications are no longer being accepted, and because the characteristics of the DACA population has changed over time.[17] As such, this may be a unique moment to reassess the overall structure of federal alienage restrictions on healthcare subsidies—the most significant barrier to expanding coverage to noncitizen populations.

Although noncitizen restrictions for welfare benefits date at least back to the 1970s,[18] the current restrictions on immigrant eligibility for federal welfare programs were imposed by Congress in 1996 as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). That law excluded many lawfully residing immigrants from access to federal health coverage programs, including the five-year bar for lawful permanent residents and the categorical exclusion of many lawfully present and undocumented immigrants from federal Medicaid benefits (emergency Medicaid remained available to otherwise eligible individuals).

The harm from categorical immigrant restrictions in government subsidies for healthcare resources reaches far beyond undocumented immigrants. Scholarship in the decades following the 1996 law has documented the so-called "chilling effect" of eligibility restrictions on U.S. citizens in immigrant families who are eligible for federal benefits and yet choose not to seek them.[19] Others have demonstrated that DACA is associated with an increase in uptake of public insurance and other safety net programs.[4,20] PRWORA creates considerable state-by-state disparities in health care access for all immigrant populations, and is an important starting point for rethinking federal immigration status-based exclusions for health care to protect public health.

Ensuring access to health care is critical for maintenance of public health. This is demonstrated through outbreaks of infectious diseases such as tuberculosis, the Ebola Virus Disease, and most recently, monkeypox, which are exacerbated if significant segments of the population are uninsured and are afraid to seek health services. Indeed, the Covid-19 pandemic demonstrated the detrimental effects of lack of health care access, when large gaps in health coverage adversely affected the nation's public health.

Although Congressional efforts to reform PRWORA have been proposed before, several bills have been introduced in the current Congress to address some of these restrictions. The Health Equity and Access under the Law (HEAL) for Immigrant Families Act of 2021 (H.R. 3149) would remove the five-year (or longer) waiting period for lawfully residing immigrants, including DACA grantees (but not undocumented

immigrants) who are otherwise eligible for full scope Medicaid and the Children's Health Insurance Program, and would allow undocumented immigrants to access the health insurance exchanges and subsidies established by the Affordable Care Act.

For decades, some U.S. policy makers have been reluctant to rethink restrictions on benefits for undocumented immigrants. Some critics deemed this population as undeserving of healthcare, or that the cost of providing this care is too burdensome. From a comparative health systems perspective, the United States is not unique in facing the challenge of balancing health care access for unauthorized migrants with other competing values.[21] There is shifting political consensus on this question, however. For example, all candidates seeking nomination for one of the two main political parties in the United States during the 2020 presidential election stated that undocumented immigrants should receive some form of government-sponsored healthcare in the US.[22] Particularly since the onset of the pandemic, several states have recognized that the health of their residents is interconnected, and have taken concrete steps toward expanding health care for all low-income residents, regardless of their immigration status.

New laws that lift exclusions of immigrants from federal programs such as Medicaid would not necessarily require states to use state funding to cover them. Under Section 402(b) of PRWORA, the federal government *already requires* states to include certain groups of noncitizens in their Medicaid programs, including noncitizens who have served in the military, certain refugees and asylees, and others.[23] Lifting federal alienage restrictions could offer states flexibility—not a mandate—to cover excluded populations. Rethinking eligibility requirements to meet current needs—as Congress has done before—is appropriate for a federal-state partnership such as Medicaid.

Critics will argue that expanding health insurance eligibility to undocumented immigrants could overburden an already overwhelmed healthcare system. However, many undocumented immigrants are forced to rely on emergency departments and community health centers for routine care that could otherwise be more efficiently treated and reimbursed in other settings.[23] From a health systems perspective, increasing the number of individuals covered may expand the coverage pool and improve systems-level efficiency, ultimately decreasing costs. Researchers have shown that in both private and public insurance schemes, immigrants often contribute more through taxes and premiums than they receive in benefits.[24–26] Although the composition of eligible immigrants differs by state, evidence from emergency Medicaid in California—the state with the greatest number of immigrants in the country—has shown that the cost of emergency services for undocumented immigrants is lower compared to U.S. citizens and other immigrant groups.[27]

Ongoing research and evaluation of the political, legal, and social bases of health outcomes—including immigration status—are critical. For immigrant populations in particular, research has shown that prevailing political and social sentiments may significantly impact health-seeking behavior.[28,29] Moments of crisis afford opportunities to rethink aspects of a system that were largely taken for granted, and to build new legislative majorities around evolving needs. In the face of several overlapping public health challenges, this is an important moment for national discussion regarding how best to ensure all populations have equal access to health care resources in the United States, and how to fairly distribute the costs of care.

Contributors

JKP led initial conceptualization of the manuscript with assistance from SYL and GK. JKP led the initial drafting of the manuscript, and SYL and GK contributed to analysis of relevant case law and legislation. All authors contributed to editing and reviewing the manuscript.

Declaration of interests

The authors declare no competing financial interests.

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