2023

Reversing A “Chilling” Mistake: Reforming U.S. Immigration Policy to Expand Health Care Access to Children of Immigrant Families (“CIF”)

Farida Shawkat

INTRODUCTION

Children of immigrant families (CIF) have become the fastest growing and most ethnically diverse segment of the US child population.[1] The 1990 US census revealed that about 15% of all children living in the United States were immigrant children or children of immigrant parentage (CIF).[2] Lack of health insurance among immigrants remains a major public health problem. Child birthplace and parental birthplace have been found to affect insurance status and access to preventive health and dental services among US children and adolescents.[3] Because of disparities in earnings, historically lower education levels, and their role as primary caretakers, women disproportionately make up the poor in this nation.[4] Women of color, in particular, disproportionately rely on public assistance programs for themselves and their children.[5] As a result, women and children of immigrant families make up a large and vulnerable percentage of the uninsured in the United States.

United States immigration policy has done little to relieve the vulnerabilities that CIF face. Immigration policies such as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the 1952 Immigration and Nationality Act (INA) have codified the long history of negative sentiment towards immigrants. The Trump administration's crack down on immigration, principally through the administration's harsh interpretation of "public charge," resulted in a well-documented "chilling effect." Thousands of eligible, lawful

[1] Zhihuan Jennifer Huang et. al., *Health Status and Health Services Access and Use Among Children in U.S. Immigrant Families*, National Center for Biotechnology Information (NBCI), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470552/.
[2] Id.
[3] Id.
[4] *See* U.S. Commission on Civil Rights, *Women and Poverty*, June 1974; and U.S. Commission on Civil Rights, *Women Still in Poverty*, Clearinghouse Publication 60, July 1979.
[5] Id.

immigrants withdrew from federally funded public health programs, fearing that they would be deemed public charges and refused permanent residency or deported.[6]

This paper discusses in detail the implications of United States immigration policy and welfare reform, particularly PRWORA, on healthcare access for CIF who are legally residing in the United States. It then proposes that PRWORA be repealed, or at the very least, amended to ease eligibility restrictions for programs that fall within the sweep of its restrictions. Part I of this paper addresses the history of federal immigration law, the healthcare system in the United States and the mechanisms available for healthcare coverage. Part II addresses the low rates of health insurance coverage among immigrant communities and the corresponding poor health outcomes, particularly in CIF. Part III then expands on Part I, specifically discussing the INA and PRWORA. Finally, Part IV discusses the "chilling effect" of immigration policy in the United States and presents both large- and small-scale recommendations for policy reform.

I. Immigrants and the United States Healthcare System

Understanding the historical roots of American immigration, and American attitudes toward immigrants, helps to place today's policy debates into perspective. Strong sentiments opposing the immigration of individuals that would become dependent on government support developed in the United States well before the advent of any federal immigration agencies.[7] The roots of the "burdensome immigrant" go back to the exclusionary "poor laws" of the Colonial Period, during which several colonies passed protective measures to prevent the entry of immigrants who might

[6] Medha D. Makhlouf, *The Public Charge Rule as Public Health Policy*, 16 IND. HEALTH. L. REV. 177 (2019).
[7] U.S. Citizenship and Immigration Services, *Public Charge Provisions of Immigration Law: A Brief Historical Background*, https://www.uscis.gov/about-us/our-history/history-office-and-library/featured-stories-from-the-uscis-history-office-and-library/public-charge-provisions-of-immigration-law-a-brief-historical-background (last visited Winter 2021).

become public charges.[8] In the nineteenth century, eastern seaboard states such as New York and Massachusetts enacted state laws that restricted the immigration of aliens they deemed likely to become dependent on public assistance programs such as poor houses.[9] The Eastern States' concerns about poor immigrants and the cost of caring for them found expression in the first general federal immigration statute in 1882. [10] The 1882 law excluded "any person unable to take care of himself or herself without becoming a public charge."[11] The law was then amended numerous times into what is now referred to as the 1952 Immigration and Nationality Act (INA).[12]

Healthcare is a major issue in American politics, with important debates related to health care coverage and the underlying cost of health care.[13] Health care in the United States can be very expensive. An important role of healthcare coverage is to insulate people from high healthcare spending burdens and facilitate access to healthcare.[14]. Currently, the U.S. health system is a mix of public and private, for-profit and nonprofit insurers and health care providers.[15] The federal government provides funding for the national Medicare program for adults age 65 and older and some people with disabilities as well as for various programs for veterans and low-income people, including Medicaid and the Children's Health Insurance Program (CHIP).[16] States then manage and pay for aspects of local coverage that fall through the cracks of federal funding;

---

[8] Id.
[9] *Immigration and Nationality Act*, U.S. Citizenship and Immigration Services (USCIS), https://www.uscis.gov/laws-and-policy/legislation/immigration-and-nationality-act.
[10] *See* Medha D. Makhlouf, *Laboratories of Exclusion, Medicaid, Federalism & Immigrants,* 95 N.Y.U. L. REV. 1680, 1702-22 (2020) (discussing how different states expanded access to Medicaid to different categories of noncitizens).
[11] *Immigration and Nationality Act supra* note 9.
[12] Id.
[13] Matthew Fiedler & Christen Linke Young, *Current debates in health care policy: A brief overview*, Policy 2020, https://www.brookings.edu/policy2020/votervital/current-debates-in-health-care-policy-a-brief-overview/.
[14] Id.
[15] *International Health Care System Profiles*, The Commonwealth Fund, https://www.commonwealthfund.org/international-health-policy-center/countries/united-states.
[16] Id.

States may jointly fund federal programs such as Medicaid and CHIP .[17] Private insurance, the dominant form of coverage in the United States, is provided primarily by employers.[18] The uninsured rate in the United States was 8.5% of the population, as of June 2020.[19]

II. Poor Health Outcomes in Immigrant Families

Immigrant families are particularly vulnerable to low insurance rates and poor health outcomes. Nearly 25% of lawfully present immigrant adults are uninsured.[20] Similarly, nearly 1 in 5 lawfully present CIF are uninsured. There are a number of hurdles to gaining coverage that put immigrant families at higher risk of being uninsured. Most US residents are insured through their employers.[21] Immigrants are more likely to be employed in the informal economy or in low-wage jobs, which typically do not offer health insurance.[22] Even if an employer provides health insurance, it may be cost-prohibitive.[23]

Low insurance rates and ineligibility for government programs is strongly correlated to poor health outcomes in immigrant families. In a national evaluation of health conditions in immigrant populations, nearly a third (27.7%) of those from Mexico, the Caribbean, and Central America had hypertension, 71.5% suffered from obesity, and 9.6% had diabetes, compared with the age-

[17] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey Insurance Component 2018 Chartbook*, AHRQ Publication No. 19-0077 (AHRQ, Sept. 2019), https://meps.ahrq.gov/data_files/publications/cb23/cb23.pdf.
[18] E.R. Berchick et al., *Health Insurance Coverage in the United States: 2018—Current Population Reports* (U.S. Census Bureau, Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.
[19] Id.
[20] Rushina Cholera, et. al., *Sheltering in Place in a Xenophobic Climate: COVID-19 and Children in Immigrant Families*, American Academy of Pediatrics, https://publications.aap.org/pediatrics/article/146/1/e20201094/37023/Sheltering-in-Place-in-a-Xenophobic-Climate-COVID.
[21] Katie Kiefer, *The Health Insurance Gap in New York City: Promoting Citizenship for a Healthier Tomorrow*, Center for Migration Studies, https://cmsny.org/citizenship-health-nyc-kiefer-061721/#:~:text=In%20New%20York%20City%2C%2047,percent%20of%20native%2Dborn%20citizens.
[22] Id.
[23] Id.

adjusted prevalence of 45.4%, 42.4%, and 8.2%, respectively, in the US general population.[24] Immigration status is a social determinant of health (SDH).[25] Depending on their mode of entry into the US, many immigrants may be at risk for excessive stress related to poverty, trauma, and poor social support, which leads to mental health conditions such as post-traumatic stress disorder, depression, and anxiety.[26]

The relationship between children's well-being and various factors such as their parents' immigrant status, racial disparities, family income, and health care status and use are interwoven and complex.[27] No studies have examined the joint and independent contributions of all of these factors to health insurance coverage and health care access among CIF.[28] However, studies show that CIF are more likely to experience poverty, food insecurity, housing instability, and lower educational achievement compared with national averages.[29] Child birthplace and parental birthplace have been found to affect insurance status and access to preventative health and dental services among US children and adolescents.[30] Children's access to care may be limited by their parents' knowledge and understanding of healthcare needs and resources, as well as language barriers. [31] When addressing CIF, pediatricians may be caught between encouraging families to participate in programs that keep them healthy and navigating confusing regulations around eligibility based on immigration status.[32]

---

[24] Eva Clark et. al., *Disproportionate impact of COVID-19 pandemic on immigrant communities in the United States*, The Public Library of Science (PLOS), https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0008484.
[25] Rushina *supra* note 2.
[26] Clark *supra* note 22.
[27] Huang *supra* note 1.
[28] Id.
[29] Id.
[30] National Immigration Law Center, *Update on access to health care for immigrants and their families* (2020), https://www.nilc.org/issues/health-care/update-on-access-to-health-care-for-immigrants-and-their-families.
[31] Id.
[32] Huang *supra* note 1.

III. Exacerbating Health Vulnerability Through Poor Policy

A. The Immigration and Nationality Act (INA)

Immigration law and policy in the U.S. has exacerbated the vulnerability of immigrant families through several different mechanisms with the first being the Immigration and Nationality Act (INA). The Immigration and Nationality Act (INA) was enacted in 1952.[33] The INA collected many provisions and reorganized the structure of immigration law in the United States.[34] The statute has been amended many times over the years and contains many of the most important provisions of immigration law.[35] Section 212(a)(4)(A) of the INA is referred to as the Public Charge Rule. Section 212(a)(4)(A) "allows for the denial of entry to the United States of any applicant who is considered likely to become public charge at any time".[36] The public charge ground of inadmissibility has been a part of the U.S. immigration law for more than 100 years.[37]

Historically, immigration laws have not clearly or expressly defined how an immigrant's likeliness to become a public charge should be decided and the policy has largely been determined by judicial decisions, administrative interpretations, and the subjective discretion of enforcing officials.[38] In fact, at times, reliance on administrative discretion produced divergent interpretations of how a public charge should be defined.[39] In general, the Immigration Service chiefly excluded immigrants with significant physical or mental incapacities that prevented them

[33] *Immigration and Nationality Act Supra* note 9
[34] Id.
[35] Id.
[36] *Public Charge Fact Sheet,* U.S. Citizenship and Immigration Services, https://www.uscis.gov/archive/public-charge-fact-sheet#:~:text=Introduction,become%20a%20lawful%20permanent%20resident.
[37] Id.
[38] Id.
[39] Id.

from working.[40] For most of the twentieth century, only immigrants who depended primarily on public aid or had experienced long term institutionalization were subject to deportation as public charges.[41] Welfare reform during the 1990s greatly reduced immigrant's access to federal means-tested public benefits which brought new attention to immigrant's use of public aid.[42]

The Trump administration undertook a series of policy changes, in February of 2020, that fortified the barriers to healthcare access for legal immigrants.[43] In particular, changes to public charge policy allowed federal officials to consider the use of certain non-cash programs, including Medicaid for non-pregnant adults, when determining whether to provide certain individuals a green card or entry into the US.[44] These changes meant that noncitizens who received one or more public benefits, including food assistance and subsidized housing, for more than 12 months within a three-year period, were deemed a public charge.[45] Prior to the Trump administration's rule, immigrants who used noncash benefits like the Supplemental Nutrition Assistance Program, or SNAP, and Medicaid were not generally considered to be public charges.[46] DHS officers therefore have enormous discretion over individual cases and this increases the risk of inconsistent rulings and discrimination. While it does not provide a clear definition of public charge, the statute lists some specific factors that DHS officers must consider in their review, including age; health; family status; assets, resources, and financial status; and education and skills.[47] This results in discrimination against marginalized communities who often have

[40] *See* 8 U.S.C. § 1601(1) (2018) ("Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes.").
[41] Id.
[42] Id.
[43] Id.
[44] Id.
[45] *New 'Public Charge' Rule Excludes Noncash Benefits,* Law 360, https://www.law360.com/health/articles/1466333?utm_source=shared-articles&utm_medium=email&utm_campaign=shared-articles.
[46] Id.
[47] INA § 212(a)(2)(B)(i) (codified as amended at 8 U.S.C. § 1182(4)(C)(i) (2018)).

poor health outcomes because of systemic racism and other barriers as discussed earlier.[48] There is no appeals process for a denial.[49] The Trump administration's policy was challenged by many immigrant advocacy groups but soon after the Biden administration took office, the White House stopped defending the Trump policy, allowing a court order to vacate the earlier rule.[50] In February of 2022, the Biden administration reverted to the historical understanding of the term "public charge," excluding noncash public benefits from DHS officers' consideration.[51]

A 2021 study examined immigrants' knowledge, attitudes, and health-seeking practices as a result of the public charge proposal.[52] Thirty semi-structured interviews were conducted in English or Spanish with foreign-born adults at an urban safety-net hospital in Boston from May 2019 to August 2019. [53] Twenty-seven percent of Boston's population is foreign-born.[54] Results showed that overarching fear of deportation and institutional authority, coupled with the perception of risk in public places, presented challenges when seeking healthcare services.

> In particular, participants described fear of leaving their homes for appointments. One participant shared that he cannot stay "more than ten minutes" at the hospital before wanting to leave due to fear of arrest and deportation. Participants expressed worries within their communities about ICE "picking up people" in the workplace and public spaces. One participant shared his community's term for deportation as "doomsday" and concerns about commuting into the city to pick up medication. Another participant talked about her neighbor who was afraid to call 911 during a critical health emergency due to their immigration status. Participants cited media reports about ICE "deport[ing] everyone" and the US government's lack of "interest in foreigners," which worsen their fear of entering healthcare facilities.[55]

---

[48] Id.
[49] Donald S. Dobkin, *Challenging the Doctrine of Consular Nonreviewability in Immigration Cases,* 24 GEO. IMMIGR. L.J. 113, 114 (2010).
[50] *New 'Public Charge' Rule Excludes Noncash Benefits Supra* note 45
[51] Id.
[52] Rachel Wang, ET AL., *Examining the Impact of Restrictive Federal Immigration Policies on Healthcare Access: Perspectives from Immigrant Patients across an Urban Safety-Net Hospital,* 2 J. Immigr. & Minority Health (2022)
[53] Id.
[54] Id.
[55] Id.

The results of this study support a finding that immigration law and policy has negatively impacted the way immigrant families view and approach the healthcare system.

B. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

An important example of the welfare reform that took place in the 1990s is the passing of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, also known as the Welfare Reform Act) (hereinafter "the Act"). The Act established a set of overarching rules that restrict the eligibility of non-U.S. nationals (aliens)[56] for public benefits.[57] These restrictions apply to a wide range of federal and state benefits, including health care, housing, welfare, unemployment, and retirement benefits, among many others.[58] The basic goal of PRWORA was to drastically reduce dependence on public assistance and encourage economic self-sufficiency through work.[59] The key provision is codified at 8 U.S.C. § 1611(a) and states that "notwithstanding any other provision of law . . . and alien who is not a 'qualified alien' . . . is not eligible for any Federal public benefit."[60] The term "qualified alien" is defined to include only eight categories of aliens—lawful permanent residents, refugees, asylees, and some other groups.[61] "Federal public benefit" is defined expansively to cover a range of benefits that are

---

[56] 8 U.S.C. § 1101(a)(3) ("The term 'alien' means any person not a citizen or national of the United States."). Some have criticized the term as offensive, but it is woven so deeply into PRWORA and the wider body of federal immigration statutes that avoiding its use when analyzing them would be difficult.

[57] See, e.g., Pimentel v. Dreyfus, 670 F.3d 1096, 1099 (9th Cir. 2012) ("[T]he Welfare Reform Act (or 'PRWORA') . . . dramatically altered alien-eligibility requirements for federal public benefits and for state and local public benefits."); Lewis v. Thompson, 252 F.3d 567, 577 (2d Cir. 2001) ("In the 1996 Welfare Reform Act, Congress altered the terrain . . . by imposing sweeping restrictions on aliens' access to federally sponsored government aid.").

[58] 8 U.S.C. §§ 1611, 1621; see Pimentel, 670 F.3d at 1099.

[59] Neeraj Kaushal & Robert Kaestner, *Welfare Reform and Health Insurance of Immigrants,* Health Services Research (2005).

[60] Id.

[61] Id.

federally funded or provided by federal agencies, including grants, loans, postsecondary education benefits, and unemployment benefits.[62]

PRWORA abolished open-ended funding and replaced it with the Temporary Assistance for Needy Families (TANF) state block grant program, preventing states from using federal funds to provide Medicaid and State Children's Health Insurance Program (SCHIP) coverage for most immigrants who have resided in the United States for less than 5 years.[63] Rather than aiding recipients in the direction of productive activities that lead to self-sufficiency, the Act instituted rough requirements and restrictions on eligibility for public assistance. The 1996 law expanded restrictions that had previously only applied to undocumented immigrants to legal immigrants.[64] The Act now generally bars undocumented individuals from accessing most federally funded benefits, but more shockingly, blocks even lawfully present non-citizens from eligibility for the first five years in which they have that status.[65]

Before PRWORA, an array of federal statutes established alien eligibility rules for particular types of federal benefits.[66] There was no overarching eligibility rule—instead, statutes specified the eligibility restrictions for aliens, if there were any.[67] The Medicaid statute, an important example, generally denied eligibility to non-PRUCOL aliens (i.e., aliens not "permanently residing under color of law"), not excluding legal immigrants.[68] While the PRWORA did not

---

[62] Id.
[63] 8 U.S.C. § 1621.
[64] *See* U.S. Commission on Civil Rights, *A New Paradigm for Welfare Policy: Recommendations to Congress on the Reauthorization of PRWORA,* July 2002.
[65] 8 U.S.C. § 1613 (2021)
[66] U.S. Commission on Civil Rights *Supra* note 64.
[67] See H.R. REP. NO. 104–725, at 379 (1996) ("Current law limits alien eligibility for most major Federal assistance programs, including restrictions on, among other programs, Supplemental Security Income, Aid to Families with Dependent Children, housing assistance, and Food Stamps programs. Current law is silent on alienage under, among other programs, school lunch and nutrition, the Special Supplemental Food Program for Women, Infants, and Children (WIC), Head Start, migrant health centers, and the earned income credit.")
[68] 42 U.S.C.A. § 1396b(v)(3); see Lewis v. Thompson, 252 F.3d 567, 574 (2d Cir. 2001) (describing legislative history).

expressly repeal the eligibility requirements in preexisting program statutes[69], the Act did provide that its baseline "qualified alien" requirement applies '[n]otwithstanding any other provision of law."[70] Federal courts interpret "notwithstanding" clauses to override inconsistent provisions in other statutes.[71] Given its "notwithstanding" provision, PRWORA most notably changed legal immigrants' access to public health insurance in two days: directly, by denying Medicaid benefits to immigrants who arrived in the U.S. after August 1996, and indirectly, by denying or limiting immigrant participation in Temporary Aid to Needy Families (TANF), which is an important entry point into Medicaid.[72]

However, the law gave states discretion to structure programs, as long as they met basic requirements, while urging them to enforce strict sanctions. [73] Many state governments responded to the immigrant provisions in PRWORA by creating substitute means-tested programs for those immigrants who were adversely affected by the Federal policy.[74] Twenty-five states, including some large immigrant states such as California and Illinois, created substitute Medicaid programs that got rid of the 5-year waiting period. [75] Nonetheless, the PRWORA adversely affected the health insurance of immigrant families and specifically, low-educated, single mothers.[76]

[69] See 8 U.S.C. § 1611(c); see, e.g., 42 U.S.C. § 1396b(v)(3).
[70] 8 U.S.C. § 1611(c).
[71] See Cisneros v. Alpine Ridge Group, 508 U.S. 10, 17-18 (1993) ("[T]he use of such a 'notwithstanding' clause clearly signals the drafter's intention that the provisions of the 'notwithstanding' section override conflicting provisions of any other section."); Field v. Napolitano, 663 F.3d 505, 511 (1st Cir. 2011).
[72] Kaushal *Supra* note 56.
[73] U.S. Commission on Civil Rights *Supra* note 64.
[74] Kaushal *Supra* note 56.
[75] *See* Medha D. Makhlouf, *Laboratories of Exclusion, Medicaid, Federalism & Immigrants,* 95 N.Y.U. L.REV. 1680, 1702-22 (2020) (discussing how different states expanded access to Medicaid to different categories of noncitizens).
[76] Kaushal *supra* note 56.

Affordable Care Act (ACA), a comprehensive health care reform law enacted in March 2010, mitigated some of the effects of the PRWORA on immigrant families.[77] The law had three primary goals: (1) to make affordable health insurance available to more people, (2) to expand the Medicaid program, and (3) support innovative medical care delivery methods designed to lower the costs of healthcare generally.[78] The ACA expanded some immigrants' access to health care, but also left many holes in place by not repealing PRWORA. The ACA does not override PRWORA expressly but does extend eligibility to "lawfully present" aliens, a more expansive category than "qualified aliens" under PRWORA.[79] The ACA also permits lawfully present immigrants to purchase insurance through state marketplaces, for premium tax credits and lower copayments.[80]

The effort to restrict immigrant eligibility was largely promised on false perceptions about the group's reliance on public assistance.[81] Data shows that contrary to widespread and misled public perceptions, immigrant families are less likely to receive welfare than citizen families, as was the case prior to 1996.[82] In fact, 14 of 19 new growth states (i.e., states that have seen significant increase in immigration) offer no public assistance for new immigrants.[83] Additionally, the eligibility restrictions of the PRWORA are complex and confusing to both states and recipients, particularly with respect to who is eligible for what services.[84] As a result, significantly fewer legal immigrants, although eligible, received TANF assistance, food stamps,

---

[77] Id.
[78] Id.
[79] *Compare* 42 U.S.C. §§18001, 18032 *with* 8 U.S.C. § 1611 (restricting access to federal public benefits, including health benefits, to "qualified aliens")
[80] *American Rescue Plan and the Marketplace,* Centers for Medicare & Medicaid Services, https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace. (March 2021).
[81] Micheal E. Fix & Jeffrey S. Passel, *Scope and Impact of Welfare reform's Immigrant Provisions,* Urban Institute, http://webarchive.urban.org/publications/410412.html.
[82] Id.
[83] Id.
[84] Id.

and Medicaid as compared to the number of participants before PRWORA.[85] 60 percent fewer legal immigrants, although eligible received TANF assistance in 2000 than in 1995.[86] The changes to eligibility have had a significant impact on children of immigrant parents and, studies have shown, that even the participation of U.S. citizen children who live in immigrant families has declined.[87] The unduly restrictive rules of the 1996 law places many immigrant women, particularly, at a disadvantage, making it difficult for them to sustain productive employment and care for their children.[88] Collectively, these policies send a signal to legal immigrants that they should avoid federally funded healthcare programs, such as Medicaid, even if they are uninsured and eligible.[89]

IV. The Chilling Effect

Despite the inclusive approach adopted by several states in response to harsh and over-inclusive federal policy, immigrants' dependence on assistance programs such as TANF, Medicaid, and Food Stamps fell sharply subsequent to the passage of the PRWORA.[90] The fear or stigma associated with PRWORA, and other federal immigration laws, have had a "chilling" effect, causing even those immigrants who were eligible for benefits not to seek them.[91] Research demonstrates that PRWORA, specifically, adversely affected the health insurance of

[85] U.S. Commission on Civil Rights *supra* note 64.
[86] Id.
[87] Id.
[88] U.S. Commission on Civil Rights *supra* note 64.
[89] Huang *supra* note 1.
[90] Kaushal *supra* note 56.
[91] Hamutal Bernstein, et. al., *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019*, Urban Institute, https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019#:~:text=Between%202018%20and%202019%2C%20there,through%20future%20green%20card%20applications.

low-educated, unmarried, immigrant women and their children.[92] The "chilling effect" of PRWORA is particularly interesting because although the act made it more difficult for immigrants to obtain benefits, it did not impose any penalties on people who used benefits that they qualified for. One specific study compared research groups to estimate the effect of welfare reform on the health insurance coverage of low-educated, foreign and U.S. born unmarried women and their children.[93] Heterogenous responses by states to create substitute Temporary Aid to Needy Families or Medicaid programs for newly arrived immigrants was used to investigate whether the estimated effect of PRWORA is related to the actual provisions of the law, or the result of fears engendered by the law.[94] The research suggested that PRWORA may have engendered fear among immigrants and dampened their enrollment in safety net programs.[95]

Children of foreign-born single mothers registered a great decline in Medicaid coverage since the passage of PRWORA.[96] Private insurance of children of foreign-born single mothers increased by a lower proportion as compared with the increase in the case of children of U.S. born single mothers.[97] The result was an increase of 8.7 percentage of uninsured children after the passage of PRWORA compared to a 2 percent increase in uninsured children of U.S. born mothers with the same education and marital status.[98] These results are consistent with a 2000 study showed that half of the quarter million legal recently arrived children who were SCHIP and Medicaid eligible and lived in states allowing coverage were uninsured.[99] However, studies

[92] Kaushal *supra* note 56.
[93] Id.
[94] Id.
[95] Id.
[96] Id.
[97] Id.
[98] Id.
[99] *Health Coverage of Immigrants,* Kaiser Family Foundation, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/. (July 2021)

support the proposition that a substantial portion of the relative decline in welfare usage among noncitizens after PRWORA's passage can be explained by shifts in naturalization.[100] A more cautious interpretation of results about the effects of welfare reform on immigrants is called for.

The American Rescue Plan Act (ARPA) enacted in 2021 increased access to health coverage through temporary increases and expansions in eligibility for subsidies to buy health insurance through the health insurance marketplaces.[101] It also includes incentives to states that have not yet adopted the ACA Medicaid expansion to do so and provides a new option for states to extend the length of Medicaid coverage for postpartum women.[102] With the temporary changes under ARPA, nearly eight in ten (79%) uninsured lawfully present immigrants were eligible for ACA coverage, including 27% who were eligible for Medicaid and 52% who were eligible for tax credit subsidies.[103] Yet, many lawfully present immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers.[104] These barriers include: fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges.[105] The Trump administration implemented a range of policies to curb immigration, enhance immigration enforcement, and limit use of public assistance programs among immigrant families.[106] When the Trump administration unleashed its crackdown on immigration, people without legal status scrambled to erase the traces of their existence to avoid being swept up.[107] The proposed rule was criticized by

[100] Jennifer Van Hook, *Welfare Reform's Chilling Effects on Noncitizens: Changes in Noncitizen Welfare Recipiency or Shifts in Citizenship Status?,* 84 Soc. Sci. L.Q., 613-631 (2003).
[101] *American Rescue Plan and the Marketplace Supra* note 80.
[102] Id.
[103] Id.
[104] *Health Coverage of Immigrants supra* note 99.
[105] Leah Zallman et. al., *Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care,* JAMA Pediatrics, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2737098.
[106] Id.
[107] Id.

advocacy organizations focused on immigrants' rights and access to health care.[108] Thousands dropped out of welfare programs to steer clear of the new immigration policies.[109] Although the policy contained exemptions for some vulnerable groups, including pregnant women, within days of when the public charge policy became public, medical clinics saw no-show rates for prenatal care appointments rise sharply.[110] Doctors said they saw a spike in the number of women arriving in emergency rooms with serious complications, or already in labor, without having been to a single prenatal appointment.[111] This "chilling" effect has become a major public health concern.

Amid confusion over the Public Charge Rule, immigrant families continued to avoid public benefits after the change in administration. Data recorded by the Center for Migration Studies (CMS) supports a finding that the change in administration and the reversal of the Trump administration's public charge new rule of admissibility, did not eliminate immigrants' fear or other barriers to accessing public benefits.[112] A CMS report notes that large numbers of respondents feared the use of public benefits, including by their children, due to misinformation about the impact of the new public charge rule and their ability to secure permanent residence.[113] Notably, many immigrants expressed fear that the public charge rule would be amended back.[114]

---

[108] *Inadmissibility on Public Charge Grounds: USCIS Proposed Rule*, 19-01 IMMIGR. BREIFINGS 1, 22 (Jan. 2019) (noting that the proposed rule "has come under fire from a number of individuals and organizations that represent or lobby on behalf of immigrants" and that "over 200,000 comments had been submitted").
[109] Bernstein *supra* note 91.
[110] Id.
[111] Id.
[112] Daniela Alulema & Jacquelyn Pavilon, *Immigrants' Use of New York City Programs, Services, and Benefits: Examining the Impact of Fear and Other Barriers to Access,* Center for Migration Studies, https://cmsny.org/publications/nyc-programs-services-and-benefits-report-013122/.
[113] Id.
[114] Id.

V. Implications of COVID-19

The treatment of immigrants residing within the United States has always made them more vulnerable to outbreaks.[115] A climate of fear and uncertainty for immigrant families underlined the health impacts of the COVID-19 pandemic.[116] The lack of readily accessible, affordable healthcare was particularly consequential during the COVID-19 pandemic.[117] First, early diagnosis and monitoring of persons with COVID-19 was critical both to optimize the individual patient's outcome and to prevent further community transmission.[118] However, many immigrants are under- or entirely uninsured and depend upon Federally Qualified Health Centers (FQHCs), safety-net public health systems, or free clinics.[119] Unfortunately, these organizations are often under-funded.[120] During the COVID-19 pandemic, immigration laws and policies continued to exclude millions of immigrants from accessing healthcare and other critical social supports. [121] Amid the unprecedented challenges presented by COVID-19, baseline inequities in health care access and delivery for CIF were exacerbated.[122] The pandemic amplified existing inequities and introduced new ones as immigrant families navigated school closures and lack of health insurance and paid leave.[123] The "chilling effect" prevented immigrant families from seeking

[115] Patricia Illingworth & Wendy E. Parmet, *The Health of Newcomers: Immigration, Health Policy & The Case for Global Solidarity* (New York Univ. Press 2017).
[116] Cholera *supra* note 21.
[117] Margarita Alegria et. al., *Health insurance coverage for vulnerable populations: contrasting Asian Americans and Latinos in the United States*, The Journal of Health Care Organization, Provision, and Financing, https://journals.sagepub.com/doi/10.5034/inquiryjrnl_43.3.231.
[118] Id.
[119] Clark *supra* note 22.
[120] Id.
[121] Parmet, *supra*, note 112, at 210-12
[122] American Academy of Pediatrics, *Sheltering in Place in a Xenophobic Climate: COVID-19 and Children in Immigrant Families, https://publications.aap.org/pediatrics/article/146/1/e20201094/37023/Sheltering-in-Place-in-a-Xenophobic-Climate-COVID,* (last visited Winter 2021).
[123] Id.

medical and mental health care for COVID-19.[124] CIF at high risk of complications, including children with immunosuppressing conditions or underlying pulmonary pathology, faced particular vulnerability to severe outcomes with delayed care. [125] Additionally, immigrant families are more likely to live in multigenerational household,[126] heightening the risk of COVID-19 for multiple family members. Nearly 29% of Asian, 27% of Hispanic, and 26% of Black Americas live in multigenerational households.[127] Studies show that immigrants and their families are less likely to have cell phones or internet access or be proficient in English.[128] In Texas, for example, approximately 50% of undocumented immigrants lack English proficiency.[129] These families with limited English proficiency had to decipher rapidly evolving public health directives, such as "shelter-in-place" orders and recommendations for mask-wearing, without multilingual and culturally relevant messaging.[130] Consequently, immigrant communities with limited English skills may be less likely to receive and understand public health messages, warnings, and updates.[131]

Moreover, even though the Biden administration has reversed many immigration policy changes made by the Trump administration, recent data suggests that ongoing immigration related fears are contributing to reluctance to access assistance and services as well as COVID-

[124] Chikara Ogimi et. al., *Characteristics and Outcomes of Coronavirus Infection in Children: The Role of Viral Factors and an Immunocompromised State,* J. Ped. Inf. Dis. Soc., https://academic.oup.com/jpids/article/8/1/21/4856016?login=true.
[125] Id.
[126] Pew Research Center, *Fighting Poverty in a Bad Economy, Americans Move in with Relatives, https://www.pewresearch.org/social-trends/2011/10/03/fighting-poverty-in-a-bad-economy-americans-move-in-with-relatives/.*
[127] Cohn D, Passel JS., *A record 64 million Americans live in multigenerational households,* Pew Research Center, https://www.pewresearch.org/fact-tank/2018/04/05/a-record-65-million-americans-live-in-multigenerational-households/.
[128] Clark *supra* note 22.
[129] Id.
[130] Id.
[131] *Unauthorized Immigrant Population,* Migration Policy Institute, https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/TX.

19 vaccines.[132] For example, surveys of Hispanic adults and Asian community health center patients show some are continuing to avoid participating in assistance programs for health, housing, or food due to immigration related fears.[133]

VI. PRWORA's "Notwithstanding" Clause

The federal government must expressly amend or override PRWORA to ease eligibility restrictions for programs that fall within the sweep of its restrictions. PRWORA raises a number of legal issues with respect to federal benefit programs. For the most part, these legal issues involve determining which federal programs are governed by the statute's overarching eligibility restrictions. The language of the statute as it stands presents different issues of statutory interpretation both for immigrants and state governments. A major point of contention is whether PRWORA's eligibility rules override restrictions from other statutes. PROWRA provides that its blanket elgibility rules apply "[n]othwithdtanding any other provision of law". However, when Congress creates new benefit programs without mentioning PRWORA or establishing clear rules for alien eligibility, confusion can arise as to whether the PRWORA restrictions apply. PRWORA's applicability is clear for four major federal benefit programs – Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Supplemental Nutritional Assistance Program (SNAP), and Medicaid[134] – its applicability to other federal programs is often ambiguous. For example, an issue of statutory interpretation arises when Congress creates new benefits that appear to constitute "federal public benefits" under the

[132] Clark *Supra* note 22.
[133] *Health Coverage of Immigrants supra* note
[134] *See* 8 U.S.C. § 1612(a) (framework of rules for the "specified federal programs" or SSI and SNAP), (b) (framework for rules for the "designated federal programs" of TANF, SSBG, and Medicaid).

PRWORA definition.[135] This is because PRWORA's applicability is unclear where a federal program delivers benefits of a type that PRWORA does not specifically reference but that are arguably similar to referenced benefit types[136], and where the federal benefits in question were created after PRWORA's enactment.[137]

If a new law that creates the benefit does not clarify whether they are subject to PRWORA's restrictions on alien eligibility, complicated questions emerge and must be resolved about whether Congress intended PRWORA to apply.[138] To elaborate, when agency guidance imposes immigration-related eligibility rules that appear to derive from PRWORA, but the agency fails to clearly explain the legal reasoning behind the rules, unresolved questions may linger about how PRWORA applies and what limitations it imposes. Alternatively, where an agency remains silent about PRWORA's impact on a federal program's eligibility for immigrants, significant doubt may persist about whether it applies. Much case law supports the proposition that the statutory language "notwithstanding any other provision of law" unambiguously overrides inconsistent provisions of other statutes, However, some courts have alternatively recognized limitations to this proposition, finding that other principles of statutory interpretation may be invoked in favor of the eligibility criteria in specific program statutes.

The prospective power of the "notwithstanding" clause of the PRWORA was the center of a legal debate concerning the power of the phrase to limit eligibility of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The list of federally funded benefits that the CARES Act created in response to the COVID-19 pandemic is long but the act is mostly silent

[135] Id.
[136] *See infra* "Category 3: Programs that Deliver Non-enumerated Benefits That Are Arguably "Similar" to Enumerated Benefits."
[137] *See infra* "Emergency Financial Aid Under the CARES Act."
[138] Id.

about alien eligibility.[139] Courts generally disfavor interpreting statutes to repeal earlier statutes by implication, unless "the earlier and later statutes are irreconcilable." The district courts are breaking new ground on these questions. "There is little existing authority on PRWORA's prospective application to new federal programs, or, more specifically, on what kind of language or legislative context suffices to render the "qualified alien" rule inapplicable absent express repeal." Short of express exceptions every time a new public benefit is codified, the PRWORA eligibility rules will continue to generate confusion and impact participation in federally funded healthcare programs.

Congress must address whether PRWORA's "notwithstanding" clause governs new benefits. To alleviate the confusion, PRWORA should be amended to repeal the "notwithstanding" clause. If Congress intents to refer to PRWORA's alien eligibility requirements in new benefits, it should address PRWORA expressly in the new legislation at the time of enactment. The CRS Report recommends that alternatively, Congress establish clear rules for alien eligibility that conflict irreconcilably with PRWORA in any new legislation as to implicitly override the "notwithstanding" clause.

VII. State and Local Governments

In addition to lack of health insurance, children's access to care may be limited by their parents' knowledge and understanding of health care needs and resources, as well as language barriers.[140] Despite welfare reform efforts, poverty rates remain high and many former recipients

[139] U.S. Congressional Research Service. PRWORA and the CARES Act: What's the Prospective Power of a "Notwithstanding" Clause? (LSB10526; Jul. 3, 2020), by Ben Harrington. Text in: Congressional Research Digital Collection; Accessed March 10, 2022. n.,17.
[140] Elisa Sobo et. al., *Parent-identified Barriers to Pediatric Health Care: A Process-Oriented Model,* Health Serv. Res., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681532/.

of public assistance struggle to earn a livable wage.[141] Small scale support services critical to the successful transition from welfare to work, such as child care, transportation, job training, continuing education, and counseling, have been inadequate or unavailable.[142] Many of the non-cash services, such as counseling, training, English instruction, and education, would benefit new immigrants and help lift them out of low-paying, and insurance providing, jobs.[143] Community outreach can provide immigrant families with the support and information they need to navigate the complex and daunting immigration system in the United States. Local governments should promote the development of tools to rapidly disperse culturally and linguistically appropriate public health messages to at-risk immigrant communities. This would help improve health education, preparedness, and response time to illness.

Healthcare facilities, particularly in immigrant and low-income communities should be designed as locations where immigration enforcement is prohibited. Additionally, for states that have not already done so, opting into Medicaid expansion would increase health insurance coverage for more low-income adults, including documented immigrants. Most importantly, states should change their eligibility criteria for the CHIP to allow all children, regardless of immigration status, consideration. This would increase the number of immigrant children with healthcare coverage.

PRWORA's provisions about state benefit programs also raise significant issues of statutory interpretation, federalism, and constitutional law. Many of these issues concern the reach of the state's statutory and constitutional authority to create their own restrictions on alien eligibility for

[141] U.S. Commission on Civil Rights *supra* note 64.
[142] Id.
[143] Id.

benefits that they administer.[144] In its 1982 decision, *Plyler v. Doe*, the Supreme Court held that states cannot constitutionally deny student a free public education on account of their immigration status.[145] It is time for the United States to recognize the constitutional right of all children to healthcare and a meaningful chance at a healthy life. A number of state constitutions contain provisions relating to healthcare services.[146] State constitutions may provide rights that are more expansive than those found under the Constitution since federal rights set the minimum standards for the states.[147] Recognizing that much of the financial burden of healthcare costs falls on state governments and that state constitutions allow for more expansive coverage rights, states are uniquely positioned to implement changes and expand healthcare coverage to children of immigrant families.

Conclusion

Acting at the local, state, and national levels to improve healthcare access as well as economic and legal protections for immigrant communities is critical. Navigating the healthcare system in the United States is a daunting feat for many, even natural born citizens. The history of

---

[144] U.S. Congressional Research Service. PRWORA's Restrictions on Noncitizen Eligibility for Federal Public Benefits: Legal Issues (R46510; Sept. 3, 2020), by Ben Harrington. Text in: Congressional Research Digital Collection; Accessed March 10, 2022. n.,17. *See, e.g., Bruns v. Mayhew*, 750 F.3d 61, 63 (1st Cir. 2014) (rejecting equal protection challenge to Maine's termination of state-funded health care benefits for aliens ineligible for Medicaid under PRWORA); *Korab*, 797 F.3d at 583-84 (rejecting equal protection challenge to Hawaii's reduction of state-funded health benefits for certain nonimmigrants ineligible for Medicaid under PRWORA); *Pimentel v. Dreyfus*, 670 F.3d 1096, 1098 (9th Cir. 2012) (rejecting similar challenges to Washington State's termination of state-funded food assistance program for some aliens); *but see Aliessa ex. rel. Fayad v. Novello*, 96 N.Y. 2d 418, 433 (N.Y. 2001) (holding that PRWORA cannot "constitutionally authorize New York to determine for itself the extent to which it will discriminate against legal aliens for State Medicaid eligibility").

[145] *See Plyer v. Doe*, 457 U.S. 202 (1982).

[146] *See* discussion and survey of state constitutional provisions relating to health care in article by Elizabeth Weeks Leonard, "State Constitutionalism and the Right to Health Care" (updated August 13, 2009), available at http://works.bepress.com/elizabeth_weeks/3/.

[147] *See e.g.*, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 280-182 (1990), where the Court recognized that Missouri was entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life-support.

strong sentiment opposing immigrants and categorizing them as public charges has only further complicated access to proper healthcare for many immigrant families. CIF present a particularly vulnerable group because of the research suggesting that parental birthplace is a social determinant of health (SDH). Particularly in the United States, where the dominant form of healthcare coverage is through employment and private insurance, CIF present a large population with little to no healthcare coverage as a result of employment statistics in immigrant communities. Immigrants tend to work for employers who do not offer private insurance benefits, leaving them dependent on government funded programs or purchasing expensive insurance coverage independently. Immigration policy in the last 30 years has only fortified the barriers to proper healthcare access for many of these families and children.

The Trump administration's categorization of 'public charge' resulted in a "chilling" effect across the country. Hundreds of thousands of immigrant families withdrew from federal healthcare programs they remained eligible for out of fear of deportation and denial of their citizenship applications. The Trump administration's sentiment towards immigrants was consistent with the passing of the PRWORA in 1996. The PRWORA's incredibly restrictive list of public benefits available to immigrants, and some specifically to immigrant children, has received criticism since the day of its signing. While the PRWORA's goal was to incentivize Americans to pursue job opportunities and rely less on federal funded public assistance programs, it engendered fear among immigrants and dampened their enrollment in safety net programs.

This "chilling" effect was amplified in response to the COVID-19 pandemic which became a particularly devastating public health crisis. Immigrant families tend to live in multigenerational households, increasing the risk of transmission, and children with underlying

autoimmune diseases were forgoing healthcare. To expand healthcare access and dampen the "chilling effect", the federal government must expressly amend or override PRWORA to ease eligibility restrictions for programs that fall within the sweep of its restrictions. Additionally, to alleviate language barriers and misinformation, state and local governments should promote the development of tools to rapidly disperse culturally and linguistically appropriate public health messages to at-risk immigrant communities.