An unprecedented global pandemic that knows no borders has brought into sharp focus the intersection of U.S. immigration and public health policy, and the unique challenges that immigrants face in the United States today. The Trump administration, which before the outbreak of the novel coronavirus (COVID-19) pandemic had introduced some of the most stringent immigration restrictions in modern times, has raced to put in place a sweeping series of measures in response to the crisis. In the process, it has further advanced its longstanding immigration goals, including summarily ending asylum at the U.S.-Mexico border.

The first action taken by the administration in response to the COVID-19 outbreak that originated in China was a ban on travel from that country for non-U.S. citizens or residents; those restrictions have been extended to many more countries since, including Iran and all of Europe. In perhaps one of the administration’s starkest actions, it also effectively ended asylum at U.S. land borders by invoking the power given to the Surgeon General in 1944 to block the entry of foreign nationals who pose a public health risk. As a result, asylum seekers and other migrants are being pushed back into Mexico or returned to their countries. Working with the Canadian and Mexican governments, the United States has closed its northern and southern borders to nonessential travel—the first time such action has been taken. And in an extraordinary advisory, the State Department has urged Americans not to travel overseas and is encouraging those abroad to return to the United States.

While the coronavirus restrictions on air and land travel and related policies have received major attention, less focus has been given to the fact that the impact of the pandemic and dramatic economic fallout resulting from social distancing have and will hit immigrant populations in the United States particularly hard. The anxiety triggered by the pandemic for long-term residents and recently arrived immigrants alike, legal and unauthorized, is exacerbated by fear of immigration enforcement, suspension of immigration benefit processing, and the high number of asylum seekers and other migrants in immigration detention.

Immigrants are also disproportionately represented in some of the critical occupations on the frontlines of the war against the pandemic—from health care to elder care, food services and delivery workers, to day care. Most of these workers can ill afford to fall sick or not report to work, considering that immigrants on average have
less access to safety-net benefits, are more likely to lack health insurance coverage, and have lower median incomes than the U.S. born. More broadly, they also are disproportionately represented in industries among the hardest hit by the economic fallout, including the hospitality industry, personal services, and child-care workers among them. And though the Senate on March 25 endorsed an estimated $2 trillion COVID-19 aid package, with House consideration expected March 27, the bill excluded some of the most vulnerable immigrants from even the most modest economic aid and access to medical testing and health care.

Restricting Travel and Entry

After the novel coronavirus was detected in Wuhan, China in December, the first U.S. action to prevent the virus from entering the United States was taken on January 31, when President Donald Trump issued a proclamation to block the entry of any foreign national who had been present in China in the preceding 14 days. The ban was extended on February 29 to Iran, on March 11 to the Schengen Area of Europe, and March 14 to the United Kingdom and Ireland.

These proclamations apply to the processing of visas at U.S. consulates abroad, preflight screenings, and screenings at ports of entry, making them the most extensive public health-inspired bans in U.S. history. The hurried, seemingly unplanned execution of these policies created chaotic situations at a number of U.S. airports as arriving passengers encountered conditions that left them exposed to one another, in some cases for as long as seven hours, waiting in tightly packed lines to go through the additional screening.

In mid-March, the administration implemented the unprecedented closures of the U.S. land borders with Mexico and Canada, invoking little-known, decades-old statutes that give the federal government sweeping powers during public health threats and national emergencies. Relying on a 1944 statute that allows the administration to block the entry of public health threats, the director of the federal Centers for Disease Control and Prevention (CDC) issued an order temporarily (currently through April 19) barring the entry of asylum seekers and others arriving at the border without prior authorization to enter. “The danger to the public health that results from the introduction of such persons into congregate settings at or near the borders is the touchstone of this order,” wrote CDC Director Robert Redfield, citing the “serious danger” of the transmission of the COVID-19 virus to ports of entry and Border Patrol facilities. A number of other countries, including Canada, Greece, and Hungary, have similarly suspended some or all asylum applications.

Soon after the CDC order, U.S. Customs and Border Protection (CBP) issued two rules temporarily suspending (currently through April 20) tourist travel across the northern and southern borders. These rules draw from a power established in the Tariff Act of 1930, which implemented protectionist trade policies during the Great Depression. The power allows the Treasury Secretary to respond to a national emergency by taking “any action that may be necessary.” It also allows the CBP commissioner to close any port of entry or “take any other lesser action” to respond to a specific threat. The regulations limit transit through ports of entry at the northern and southern borders to “essential” travel, but include broad exceptions for U.S. citizens and permanent residents; members of the military; and foreign nationals traveling for a variety of purposes, including school, work, medical or public health purposes, trade, or government work—effectively only ending tourist travel. The limitations apply to hundreds of thousands of daily commuters.
The International Response

At least 173 other countries, according to the International Organization for Migration (IOM), had implemented travel bans, border closures, and other mobility restrictions of their own to contain and mitigate the pandemic—totaling a minimum of 33,712 restrictions as of March 23.

In addition to closing its border with the United States to nonessential travel, Canada now allows only its citizens and permanent residents to enter the country, with limited exceptions. And the Canadian government also has temporarily blocked the entry of asylum seekers who cross the U.S. land border between ports of entry, a phenomenon that has been on a significant uptick over the past few years as the Trump administration moved to end Temporary Protected Status (TPS) designations and sharply narrow access to asylum. The European Union has similarly sealed its borders to nonessential travel by foreigners, with many Member States unilaterally re-erecting full or partial border closures.

Amid the rapid spread of international travel restrictions, the UN High Commissioner for Refugees (UNHCR) and IOM on March 17 announced the temporary suspension of refugee resettlement worldwide. After the announcement, the State Department suspended U.S. refugee admissions, hindering a program that was already on track to fall 2,000 refugees short of the historically low 18,000 ceiling set by the administration.

In prior public health crises, many public health experts have been skeptical of the efficacy of travel restrictions. Indeed, the World Health Organization (WHO) says: “In general, evidence shows that restricting the movement of people and goods during public health emergencies is ineffective in most situations and may divert resources from other interventions.”

Restrictions on movement typically are most useful in the very early containment stages of an outbreak, especially when the disease is concentrated to a very few places. However, once a virus hops locations and borders, and moves into community transmission, as occurred with COVID-19, it is overwhelmingly recognized that the most effective mitigation measure is to create widespread social distancing and to keep infected people isolated. As a result, restrictions on international travel can be effective as one piece of a broader array of measures limiting all forms of mobility.

When Public Health and Immigration Enforcement Imperatives Collide

While the Trump administration’s restriction of foreign air arrivals and nonessential legal border crossings into the United States can be viewed as a rational and possibly well-thought through response to the pandemic, its management of the crisis inside the United States, especially its policies affecting immigrants and their communities, has come in for significant criticism.

The approach has been criticized by immigrant-rights advocates, service providers, some public health experts, and others as incoherent and frequently counterproductive, with important implications for public safety and health.

U.S. Immigration and Customs Enforcement (ICE) continued its routine enforcement operations until March 18—weeks after the virus was first detected in the United States and more than a month after the president’s
first COVID-19 travel restrictions. Following widespread criticism for driving unauthorized immigrants underground during the crisis, the agency announced it would temporarily adjust its protocols away from randomized enforcement, instead focusing on public-safety risks and individuals subject to mandatory detention based on criminal grounds. It also announced that it will exercise discretion to delay enforcement actions for noncitizens falling outside of these priorities. This means that most of the estimated 11 million unauthorized immigrants in the United States should be shielded from enforcement. Yet that official announcement was almost immediately undercut by Ken Cuccinelli, the second in command at the Department of Homeland Security (DHS), leading to confusion for immigrant communities. On Twitter, Cuccinelli indicated that ICE agents will not be prevented from enforcement outside of the newly designated priorities.

ICE also announced that it has shifted its detention priorities to focus on public-safety risks and noncitizens convicted of certain crimes, but there is no indication yet that the detained population has declined. As of March 21, three days after the announced priority shift, the immigrant detainee population rose to 38,058 individuals, just 39 percent of whom were convicted criminals. Many others are asylum seekers or unauthorized immigrants awaiting their hearings in immigration court. Across the country, groups of immigrant and civil-rights organizations sued, asking federal courts to order the release of families, immigrants particularly vulnerable in the event of COVID-19 exposure, and other noncitizens who are not public safety risks. Already, a foreign national in ICE detention in New Jersey has tested positive for the virus.

Recognizing the unique challenges that detention of immigrants poses during a public health crisis, other countries have begun releasing their detained immigrant populations. The United Kingdom, for example, has released one-third of the 900 people in immigrant detention amid fear of coronavirus outbreaks in institutional settings.

ICE says it has implemented plans to screen new detainees and isolate those with symptoms related to COVID-19, and has temporarily suspended visits by family members and friends. Despite these precautions, crowded conditions, constant human contact, and limited medical services make prison and jail settings particularly vulnerable to disease transmission, and ICE facilities are no exception. In recent years, ICE detention facilities have been hotspots for disease outbreaks including the flu, measles, mumps, and chicken pox. In December, ICE changed its detention standards: loosening the requirements for timeliness in providing medical care, and no longer requiring health care and medical operations at its detention centers to be under the direction of a licensed physician, but instead a “health services administrator.” Since April 2018, at least 21 people have died in ICE custody.

International travel restrictions may place additional strains on the detention system. Canada, Panama, Honduras, and other countries have blocked the entry of U.S. nationals, which may also apply to the removal of foreign nationals from the United States. Both Guatemala and El Salvador suspended deportation flights from the United States, only to walk back the suspensions days later. From 2014-18, the United States removed an average 337,703 people per year, in other words about 925 a day. Any restrictions on carrying out removals will inevitably add to the detained noncitizen population unless ICE decides to release detainees on parole or otherwise.
After immigration judges, a union of ICE attorneys, and the association of immigration attorneys joined together in a rare action to call for the emergency closure of the immigration courts, the Executive Office for Immigration Review (EOIR) suspended all hearings for nondetained individuals as of March 18. However, to the dismay of attorneys and judges alike, at this writing EOIR was continuing with hearings for detained immigrants. Judges are being encouraged to make use of continuances and prehearing conferences to limit the number of necessary hearings. The closure of some part of the courts’ operations will naturally result in a significant growth in a backlog already exceeding 1 million cases.

In a related development, EOIR delayed the hearings of asylum seekers enrolled in the Migrant Protection Protocols (MPP, better known as Remain in Mexico), a program that forces migrants to wait in Mexico while their cases in the United States are pending. Suspension of hearings, though, does not change the fact that the migrants are still waiting in precarious conditions, many in camps close to the border that will be exceedingly vulnerable to the virus based on the close quarters, difficult water and sanitation conditions, and lack of access to regular health care.

Health Care in a Time of Pandemic

Containment of the pandemic demands that all who are ill come forward and seek care. Yet the outbreak has occurred just as U.S. Citizenship and Immigration Services (USCIS) has begun implementing a new rule that will potentially chill millions from accessing health services and benefits. The public-charge rule, which went into effect February 24, will block eligibility for green cards for immigrants who have used—or who the government deems likely to use in the future—public benefits. The rule dramatically expands the circumstances under which immigrants can be denied green cards, whether those already present in the United States and seeking to adjust from another status or those abroad applying for legal permanent residence.

Care received at the emergency room, a community health center, or a free clinic does not trigger the public-charge rule, but the confusion and uncertainty that led up to the implementation of the rule, coupled with a rising anti-immigration narrative, will likely inhibit many immigrants and their U.S.-citizen family members from seeking care. To be sure, USCIS issued a statement clarifying that any treatment or preventive services related to COVID-19 will not negatively affect any individual as part of a public-charge analysis. But the agency created confusion when it said applicants for immigration benefits will still need to submit evidence of any benefits used for such testing or treatment.

Even without the “chilling effects” of the public-charge rule, noncitizens in the United States face significant hurdles in accessing health care, particularly in their first five years as legal permanent residents. Many noncitizens, and especially those who are unauthorized, are unable to afford adequate health-care coverage, relying heavily on community health centers and public hospitals, where they often confront limited capacity and language barriers. The foreign born are also less likely to be covered by health insurance: while 93 percent of the U.S. born are covered by health insurance, the share falls to 80 percent for the foreign born overall, and just 47 percent for unauthorized immigrants.

Figure 1. Health Insurance Coverage by Nativity and Legal Status, FY 2016-18
Lack of health-care coverage may cause those who are exposed to the coronavirus to delay or go without needed medical care—posing risks not just for themselves and their families but for the broader community. Indeed, public-health experts caution that testing and treatment during this pandemic should be offered to all residents, regardless of nativity or legal status.

As the COVID-19 outbreak upends social and economic lives around the globe, it has—in an unprecedented way—brought home for some the importance of the collective: treating immigrants differently from others endangers all.

### The Suspension of Immigration-Benefit Processing

The pandemic is posing complications for immigrants already in the United States and intending immigrants outside the country as the processing and adjudication of various immigration benefits have been dramatically curtailed. All U.S. embassies and consulates around the world have suspended routine visa services. And USCIS has halted in-person services, including interviews and naturalization ceremonies.

The most recently available numbers suggest there are approximately 2.3 million nonimmigrants (the term for those on temporary visas such as students or temporary workers) residing in the United States. Their ability to extend or change their nonimmigrant status, or to apply for permanent residence, depends on USCIS. Suspended interviews mean that applications for asylum, permanent residence, and naturalization will not move forward. This will place nonimmigrants already in the process of applying for green cards at risk of overstaying and violating the terms of their visa, making them vulnerable to ICE enforcement.

USCIS also suspended biometric services, which are required for processing certain applications, including many employment authorization documents. Recipients of Deferred Action for Childhood Arrivals (DACA)
and applicants for employment-based green cards need employment authorization documents to work lawfully and must submit their fingerprints to renew their documents. Without this USCIS service, these groups will begin to lose their work authorization. As of September, there were 652,880 DACA recipients, most of whom have employment authorization documents.

As more states are placed into lockdown, USCIS adjudications may increasingly be limited to the small number of online applications. However, just ten of the agency’s more than 80 application forms are available online. As a result, adjudication of applications such as H-1B visas, employment-based green cards, travel documents, and more may freeze for the duration of the widespread office closures.

The longer the crisis keeps USCIS offices closed, the greater the backlog once offices are running, increasing processing times and posing further complications for immigrants who need timely adjudications to remain lawfully and work legally.

**Little Learning from Past Public Health Crises?**

While the scale and threat of this pandemic may be unprecedented in contemporary history, this is not the first tango between the immigration system and a public health crisis. The last global pandemic occurred in 2009, when a novel influenza A (H1N1) virus emerged and spread quickly across the world, including the United States. In response, some airports in the United States and abroad installed thermal screening devices to detect arriving passengers’ body temperature, and many adopted questionnaires to identify travelers with recent fever symptoms.

There has been little progress since then on immigration-based responses to global health crises, and the bungled initial rollout of health screenings at U.S. airports earlier this month suggests lessons from the Ebola, Zika, and other outbreaks may not have been remembered. Following the Ebola epidemic in Africa in 2014, the United States intensified screening, testing, and surveillance of travelers arriving from certain West African countries. Thousands of arriving passengers were then selected for active monitoring, but not one turned out to be infected.

At that time, the Obama administration also extended Temporary Protected Status (TPS) to immigrants already in the United States from Guinea, Liberia, and Sierra Leone. This provided a needed reprieve to those migrants from returning to their home countries amid the epidemic; it also gave them the opportunity to work temporarily in the United States. The Obama administration initiated the end of TPS once it was determined that the widespread transmission of Ebola virus in the three countries had ended. The protections fully ended in May 2017.

In the present pandemic, the Trump administration has yet to issue any similar reassurances to anxious foreign nationals. In New York and New Jersey, CBP is allowing some tourists the opportunity to extend their stay in the United States for up to 30 days. A crisis of this scale demands more far-reaching and nationwide action, which could include suspending filing deadlines, waiving some biometric requirements, or automatically extending work authorization. In the near future advocates will inevitably call for much more ambitious measures to provide protections across the board so that noncitizens do not feel vulnerable to being returned to their countries amidst this pandemic.
Relief for Some, But Not All

Once the severity of the health and economic crisis precipitated by the pandemic became evident, Congress passed—and the president signed—two emergency aid packages offering economic and other assistance. A far larger, “Phase 3” estimated $2 trillion-dollar package has been approved by the Senate, awaiting House action. It would provide important medical coverage for Americans who are uninsured and an economic cushion in the form of cash payments, extended unemployment insurance benefits, and other income supports for many impacted by the sharp economic decline and rising joblessness. But the aid package excludes a large section of the noncitizen population. For the medical benefits, the bill excludes even a substantial-share of green-card holders—those who have held legal permanent residence for less than five years. And the economic relief and tax rebate provisions exclude more than 4 million immigrant workers, typically unauthorized, who pay income taxes but use Individual Taxpayer Identification Numbers (ITINs) instead of Social Security numbers to file their tax returns. Advocates had been able to get these provisions included in a House draft that ultimately was not considered; they undoubtedly will plan to push for these to be addressed in future coronavirus-relief legislation.

Immigrant advocates note that foreign-born workers, legal and unauthorized alike, not only constitute a sizeable number of those in critical occupations on the frontlines of fighting the pandemic, they also work disproportionately in non-salaried, nonpermanent jobs, living close to the margin. At the other end of the debate, some conservatives have argued in favor of reserving taxpayer funds for the U.S. born, and in particular object to including unauthorized immigrants. Yet excluding workers who are among the most vulnerable in society from critical safety-net benefits would compromise the effectiveness of the entire aid package and recovery from a virus that makes no distinction based on national origin, immigration status, or income level, experts have noted.

There are no parallels to the multidimensional challenges that the COVID-19 pandemic has presented the United States and the world in this globalized and economically interdependent era in which we live. The vast public health crisis and resulting economic freefall require a global response, and certainly a unified and robust national response where all institutions and individuals are responding to their fullest potential. A set of policies that intentionally or inadvertently discourages a subset of the population from fully participating—without fear or repercussion—in this war against the invisible enemy compromises the wellbeing and lives of all of us.

Resources

- Presidential proclamation suspending foreign national entries from China
- Presidential proclamation suspending foreign national entries from Iran
- Presidential proclamation suspending foreign national entries from the Schengen Area of Europe
- Presidential proclamation suspending foreign national entries from the United Kingdom and Ireland
- S. Customs and Border Protection (CBP) notification of temporary travel restrictions applicable to land ports of entry and ferry service between the United States and Canada
- CBP notification of land port of entry and ferry service between the United States and Mexico
- Notice by the Centers for Disease Control (CDC) Director of “Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons from Countries Where a

https://www.migrationpolicy.org/print/16722
Communicable Disease Exists”

- CDC/Department of Health and Human Services Regulation, “Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes”
- International Organization for Migration report, DTM-Covid19 Travel Restrictions Output
- Executive Office for Immigration Review website showing the operational status of immigration courts during the pandemic
- Press release by Immigration judges, U.S. Immigration and Customs Enforcement prosecutors, and immigration attorneys calling for the nationwide closure of the immigration courts
- ICE 2019 National Detention Standards
- DHS Fact Sheet on travel screenings during the Ebola epidemic
- MPI coronavirus-related resources

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