# DO NO HARM: COMBATTING HEALTH CARE-RELATED IMMIGRATION ENFORCEMENT AND SURVEILLANCE TO ENSURE PATIENT RETENTION

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*Immigration rules and regulations fluctuate in terms of priorities and goals, but deportation always remains a scary possibility for immigrants and their loved ones. This Note seeks to analyze the ways in which this fear leads immigrants and their families to avoid essential health care services, the legal tools that can protect immigrant health from this avoidance, and the resulting legal considerations of establishing such "health sanctuary" policies. In contrast to the substantial legal discussion regarding the restriction or provision of health benefits to immigrants, this sociological barrier to health care represents a small subsection of the legal literature.[1] Improving health outcomes for undocumented immigrants requires accessible, immigration-enforcement-free health care centers. Consequently, this Note presents several legal interpretations and strategies that encourage health care use and discourage immigration-related enforcement and surveillance in health care centers.*

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1. The notable exception being the writings of Professor Medha D. Makhlouf of Penn State Dickinson Law School. *See* Medha D. Makhlouf, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL'Y, L., & ETHICS 1 (2021); Medha D. Makhlouf, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680 (2020); Medha D. Makhlouf & Jasmine Sandhu, *Immigrants and Interdependence: How the Covid-19 Pandemic Exposes the Folly of the New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146 (2020).

## INTRODUCTION

Immigrant and mixed-status families often fear immigration enforcement, which can lead to health care deterrence from family members out of fear of immigration authorities coming for them or their immigrant family members.[2] Yet, within the complex legal schemes of health care and immigration law, provisions in the Health Insurance Portability and Accessibility Act ("HIPAA"), the Emergency Medical Treatment and Active Labor Act ("EMTALA"), and other related statutes and regulations provide legal protections and evidence of federal intent to protect immigrant and mixed-status families' health care access.[3] Protection of health care information relating to a patient's immigration status, federal allocation of funds to reimburse health care providers for care administered to undocumented patients, and agency directives to resist enforcement actions near health centers all promote health care use by immigrant communities in different forms. Given

2. *See infra* Part I.
3. *See infra* Part II.

these federal protections, states and municipalities can supplement federal legal protections with their own "health sanctuary" laws and policies to address health care disparities for immigrant residents.[4]

This Note will analyze the problem of health care avoidance among immigrant communities, explore current legal protections for immigrant health care in the context of federal preemption law, and argue for interpretations that limit "anti-sanctuary" policies' impact on immigrant health care. Part I begins with an overview of the issue, including the economic, public health, and moral implications of this deterrent effect. Part II continues with a discussion of federal action that demonstrates a "health sanctuary" attitude, as well as legal mechanisms to supplement these federal protections. Part III reviews federal preemption law and its impact on the existence and reach of federal immigrant health protections. Finally, Part IV overviews current "anti-sanctuary" laws' effects on immigrant health and finishes with suggestions and guides for fortifying the health protections and rights of a population that is often forced to underutilize necessary health care services.

## I. Overview of System Avoidance and Health Disparities

System avoidance describes the sociological deterrent effect of legal surveillance and enforcement on individuals' uptake of health care and other forms of public engagement.[5] Unfortunately, many recent events illustrate this social phenomenon, particularly in the aftermath of President Donald Trump's executive order purporting to rescind the Sensitive Locations Policy, a policy dating back to 1993 that restricted immigration enforcement in specified sensitive locations.[6] This policy previously barred on-the-ground Immigrations and Customs

4. *See infra* Parts III, IV.

5. *See* Makhlouf, *Health Care Sanctuaries*, *supra* note 1, at 3–6; Asees Bhasin, *The Telehealth "Revolution" & How It Fails to Transform Care for Undocumented Immigrants*, 24 N.C. J.L. & Tech. 1, 41–42 (2022); Sarah Desai et al., *Legacies of Marginalization: System Avoidance Among the Adult Children of Unauthorized Immigrants in the United States*, 54 Int'l Migration Rev. 707 (2020).

6. Press Release, Dep't of Homeland Sec., Statement from a DHS Spokesperson on Directives Expanding Law Enforcement and Ending the Abuse of Humanitarian Parole (Jan. 21, 2025), https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-enforcement-and-ending-abuse [https://perma.cc/82DW-BG2K] [hereinafter Trump Administration DHS Press Release] ("The first directive rescinds the Biden Administration's guidelines . . . that thwart law enforcement in or near so-called 'sensitive' areas."); Elizabeth Jacobs, *History of the 'Sensitive Areas' Policies and What Is in Place Now*, Ctr. For Immigr. Studs. (Mar. 7, 2025), https://cis.org/Jacobs/History-Sensitive-Areas-Policies-and-What-Place-Now [https://perma.cc/9GFY-AJJ3]; Memorandum from James A. Puleo, Acting Assoc. Comm'r, Immigr. & Naturalization Serv., to District Dirs. and Chief Patrol Agents (May 17, 1993).

Enforcement ("ICE") officers' enforcement actions in hospitals, requiring prior approval from supervisors in the agency.[7] Trump's order, reflecting his disdain for bureaucracy, instead gave discretion to on-the-ground officers to determine when enforcement in a sensitive location is necessary.[8] Given the public news on the subject, health care professionals documented an immediate impact on their patients. "We immediately heard from concerned patients, wondering whether it was safe to come to the clinic, asking to switch to telehealth appointments, and questioning whether they should disenroll their children (in many cases US citizens) from public benefits," writes Dr. Kathleen R. Page, medical director of several immigrant and Latino-focused medical outreach programs.[9]

System avoidance often results from a fear of deportation for immigrants or their family members and manifests as a distrust of essential services and systems.[10] This phenomenon also affects citizens and residents with legal status, especially those in "mixed-status" families.[11] As Dr. Page's report indicates, U.S.-born citizens, naturalized citizens, and immigrants with legal status avoid health care services to protect more precarious community members.[12] Illustrating the powerful

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7. Press Release, Dep't of Homeland Sec., Secretary Mayorkas Issues New Guidance for Enforcement Action at Protected Areas (Oct. 27, 2021), https://www.dhs.gov/archive/news/2021/10/27/secretary-mayorkas-issues-new-guidance-enforcement-action-protected-areas [https://perma.cc/HAA7-SHQU]; Memorandum, Alejandro N. Mayorkas, Sec'y, Dep't of Homeland Security, Guidelines for Enforcement Actions in or Near Protected Areas (Oct. 27, 2021), https://www.ice.gov/doclib/news/guidelines-civilimmigrationlaw10272021.pdf [https://perma.cc/YHZ2-MF5P].

8. Trump Administration DHS Press Release, *supra* note 6, ("The Trump Administration will not tie the hands of our brave law enforcement, and instead trusts them to use common sense.").

9. Kathleen Page et al., Opinion, *Detained at the Doctor's Office: US Immigration Policy Endangers Health*, BMJ (2025), https://www.bmj.com/content/388/bmj.r304 [https://perma.cc/3BEC-G38B].

10. Elizabeth Farfán-Santos, *Undocumented Motherhood: Gender, Maternal Identity, and the Politics of Health Care*, 38 Med. Anthropology 523 (2019) (maternal care avoidance); Benjamin Weiser, *Judge to ICE: Don't Ambush Immigrants at New York Courthouses*, N.Y. Times (June 10, 2020), https://www.nytimes.com/2020/06/10/nyregion/ice-courts-immigrants-new-york.html [https://perma.cc/LQB2-ST6U] (court avoidance). However, this Note will focus exclusively on system avoidance in health care.

11. *See, e.g.*, Cassaundra Rodriguez, *Experiencing 'Illegality' as a Family? Immigration Enforcement, Social Policies, and Discourses Targeting Mexican Mixed-Status Families*, 10 Socio. Compass 706 (2016).

12. Page et al., *supra* note 9; Desai et al., *supra* note 5, at 727; Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. Pa. J.L. & Pub. Affs. 235, 246 (2019). This is particularly notable as it is estimated that 16.6 million people are members of mixed-status families, which includes approximately 4.5 million U.S.-born children with at least one undocumented parent. Laura E. Enriquez, *Multigenerational Punishment:*

fear that deportation instills in immigrants, one undocumented patient in Houston, Texas explained his health care avoidance by characterizing ICE as "more terrifying than illness."[13] This avoidant effect creates detrimental health effects for the sick who decline to seek treatment and negative externalities for their entire community in the form of lost economic and social contributions.[14] These avoidant behaviors depend on individual and environmental factors. For example, avoidant behaviors tend to be more prominent within the first years of an immigrant's life in America.[15] Other influential circumstances include the immediate (emergency) health needs of a patient (increasing health care use) or high-profile forms of immigration enforcement/surveillance like workplace raids (decreasing health care use).[16] This paper examines the malleable nature of system avoidance, as it provides an opportunity to mitigate or even eliminate this health care avoidance by cultivating "health care sanctuary" policies. Put simply, even the strictest immigration enforcement regime cannot justify an outcome where immigrants avoid health care and die out of fear of ICE.

### *A. The Case for Immigrants' Right to Health*

Discussions of immigrant health care often refer to their burden on the health care system, making two key mistakes.[17] First, this

*Shared Experiences of Undocumented Immigration Status Within Mixed-Status Families*, 77 J. Marriage & Fam. 939, 942 (2015).

13. Mambwe Mutanuka, *The Intersection of Health Policy and Immigration: Consequences of Immigrants' Fear of Arrests in U.S. Hospitals*, 30 Annals Health L. Advance Directive 217, 222 (2021).

14. *See, e.g.*, Roxanne P. Kerani & Helena A. Kwakwa, *Scaring Undocumented Immigrants Is Detrimental to Public Health*, 108 Am. J. Pub. Health 1165, 1166 (2018) ("Maintaining immigrant health, in addition to optimizing public health at minimal cost, is essential to preserve an optimal workforce.").

15. Sheela Maru et al., *Utilization of Maternal Health Care Among Immigrant Mothers in New York City, 2016-2018*, 98 J. Urb. Health 711, 715 (2021) ("Immigrant women living in the US for the shortest length of time had the highest . . . differences [in health care utilization] . . . with differences in healthcare utilization decreasing as time spent in the US increased . . . .").

16. Karen Hacker et al., *The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA*, 73 Soc. Sci. & Med. 586, 591 (2011) ("I was always afraid to go to the hospital, but I forced myself when my son got sick . . . but as soon as I heard about [the nearby workplace raid], I called . . . so they can cancel it. I wanted to minimize the risk of getting caught.").

17. *See, e.g.*, Jamie Joseph, *Newsom Asks for Nearly Another $3B for State Health Program Overwhelmed by Illegal Immigrants*, Fox News (Mar. 18, 2025, 12:11 PM), https://www.foxnews.com/politics/newsom-asks-nearly-another-3b-state-health-program-overwhelmed-illegal-immigrants [https://perma.cc/H7CX-27ZM]; Phil Galewitz, *More States Extend Health Coverage to Immigrants Even as Issue Inflames GOP*, KFF Health News (Dec. 29, 2023, 5:00 AM), https://www.npr.org/sections/health-shots/2023/12/29/1221780712/more-states-extend-

misinterprets the relationship between U.S. citizens and immigrants when it comes to health benefits and encourages stereotypes of immigrants fraudulently or greedily taking public benefits. Yet, far more commonly, immigrants pay taxes in various forms while being barred from receiving these benefits; therefore, immigrants often subsidize the benefits of U.S. citizens.[18] Second, overemphasis on the costs of immigrant health care implicitly prioritizes the economic well-being of citizens over the physical and mental well-being of noncitizens. The central basis for protecting immigrant access to health care should focus on the social and emotional losses of preventable death and disease, with the economic loss merely reinforcing that the moral response also serves as the economical one.

Untreated disease is often associated with early death or disability, which can lead to severe economic and social costs.[19] Many immigrants work without authorization, disproportionately in manual labor jobs.[20]

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health-coverage-to-immigrants-even-as-issue-inflames-gop [https://perma.cc/FKG6-URXN]; Deirdre Heavey & Emma Woodhead, *Lawmakers Reveal Whether Americans Should Pick up the Medicaid Tab for Illegal Immigrants*, Fox News (Apr. 12, 2025, 5:00 AM), https://www.foxnews.com/politics/should-illegal-immigrants-qualify-medicaid [https://perma.cc/5LQ3-3JKX]; The National News Desk, *California and New York Face Medicaid Crisis as DOGE Claims Illegal Migrant Enrollment*, Fox Baltimore News (Apr. 7, 2025, 9:24 AM), https://foxbaltimore.com/news/nation-world/california-new-york-face-medicaid-crisis-as-doge-claims-illegal-migrant-enrollment-elon-musk-dr-oz-gavin-newsom-medical [https://perma.cc/J65T-PYGX]; The National News Desk, *$27B Used to Fund Healthcare Coverage for Illegal Immigrants, Washington Insider Says*, NBC 10 WJAR (Apr. 7, 2025, 11:34 AM), https://turnto10.com/news/nation-world/27b-used-to-fund-healthcare-coverage-for-illegal-immigrants-washington-insider-says-medicaid-medical-procedures-health-medicine-doctors-nurses-the-national-news-desk-jan-jeffcoat-armstrong-williams [https://perma.cc/T5FS-PNMP].

18. Steven Sacco, *In Defense of the Eligible Undocumented New Yorker's State Constitutional Right to Public Benefits*, 40 N.Y.U. Rev. L. & Soc. Change 181, 233 (2016).

19. *See, e.g.*, Philip J. Candilis & Mark H. Pollack, *The Hidden Costs of Untreated Anxiety Disorders*, 5 Harv. R. Psychiatry 40 (1997) (anxiety); Julie M. Donohue & Harold Alan Pincus, *Reducing the Societal Burden of Depression*, 25 PharmacoEconomics 7 (2007) (depression); Melissa Knauert et al., *Clinical Consequences and Economic Costs of Untreated Obstructive Sleep Apnea Syndrome*, 1 World J. Otorhinolaryngology-Head & Neck Surgery 17 (2015) (sleep apnea); John M. Blandford & Thomas L. Gift, *Productivity Losses Attributable to Untreated Chlamydial Infection and Associated Pelvic Inflammatory Disease in Reproductive-Aged Women*, 33 J. Am. Sexually Transmitted Diseases Ass'n S117 (2006) (chlamydia); Ronald Wall et al., *Social Costs of Untreated Opioid Dependence*, 77 J. Urban Health 688 (2000) (opioid dependence).

20. *See* Susan Eckstein & Giovanni Peri, *Immigrant Niches and Immigrant Networks in the U.S. Labor Market*, 4(1) Russell Sage Found. J. Soc. Scis. 1 (2018) (finding high rates of Central and South American immigrants employed as farmworkers and construction laborers).

These manual labor jobs provide significant occupational hazards and greater risk of injury or illness.[21] While employment of individuals without valid work authorization is illegal, in reality, the American economy depends on this labor.[22] In addition to the economic impact of illness causing workers to leave the workforce, family members and community members suffer an incalculable emotional harm when untreated disease leads to premature death or disability in their loved ones.

Even putting aside the impacts on noncitizens, social and legal barriers to health care for noncitizens harm the noncitizen and xenophobe alike, especially in the context of communicable disease. The COVID-19 pandemic presents a salient example, with the documented immigrant vaccination gap stemming in part from general distrust in the government among immigrant communities.[23] Communicable disease presents a collective problem requiring collective responses.[24] If immigrants already fear health care facilities, COVID-19 vaccination programs and other public health responses face uphill battles. Once a sufficient portion of the population gets vaccinated against a disease, it becomes far more difficult to spread due to the lack of available carriers.[25] This high rate of vaccination creates "herd immunity," whereby the vaccinated protect the unvaccinated, preventing future outbreaks and pandemics.[26] With respect to COVID-19, researchers estimated that immunization levels would need to reach as high as

21. *Id.*

22. The ethics of this dependence on the illegal labor of an exploited workforce notwithstanding, these workers suffer greater risks of workplace injuries with even fewer workplace protections than the average worker.

23. Sarah Ann M. McFadden et al., *Confidence and Hesitancy During the Early Roll-Out of COVID-19 Vaccines Among Black, Hispanic, and Undocumented Immigrant Communities: A Review*, 99 J. URB. HEALTH 3, 9–10 (2022); Danielle Daniels et al., *Vaccine Hesitancy in the Refugee, Immigrant, and Migrant Population in the United States: A Systematic Review and Meta-Analysis*, 18 HUM. VACCINES & IMMUNOTHERAPEUTICS 168, 168 (2022).

24. *See, e.g.*, Wolfgang Hein, *Control of Communicable Diseases as a Global Public Good,* 5(1) MED. ONE J. 1, 4–5 (2020); Chris Degeling & Jane H. Williams, *Making the Public Protect Public Health: The Ethics of Promoting Collective Action in Emergencies,* J. MED. ETHICS, Mar. 3, 2025, at 1, 3; Rizwanul Islam, *Promptly Notifying Infectious Diseases Likely to Cause Pandemics: Individual State Responsibility, Shared Collective Burden,* 56 TEX. INT'L L.J. 35, 39, 46, 56 (2021).

25. *Herd Immunity*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/articles/22599-herd-immunity [https://perma.cc/3ZTT-JWSL] ("Herd immunity refers to enough people being immune to a disease that the infection can't spread from one person to another. This lack of movement protects those who aren't immunized.").

26. *Id.*

eighty percent of the population in order to achieve herd immunity.[27] Further complicating issues, herd immunity depends on local levels of immunization, meaning that communities with higher proportions of immigrants depend even more on securing the trust of these residents.[28] However, the misuse of COVID-19-related data impeded this goal of vaccinating all U.S. residents regardless of immigration status. During the pandemic, the Department of Health and Human Services ("HHS") issued notices of its intent to exercise enforcement discretion during COVID-19 for providers providing good faith telehealth services.[29] Consequently, some state health departments transmitted names and information of patients with COVID-19 to law enforcement offices.[30] In Tennessee, the state government utilized a HIPAA exception that permits disclosure to law enforcement regarding serious or imminent health risks to justify sharing vaccination information with the police.[31] A lack of trust among a significant portion of the population drastically hinders communicable disease responses that require high rates of testing and treatment. Consequently, the entire public's health suffers;

27. Apoorva Mandavilli, *Reaching 'Herd Immunity' Is Unlikely in the U.S., Experts Now Believe*, N.Y. Times (May 3, 2021), https://www.nytimes.com/2021/05/03/health/covid-herd-immunity-vaccine.html?searchResultPosition=1 [https://perma.cc/F4QW-LX2A].

28. *Id.*

29. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, 85 Fed. Reg. 22024, 22024–25 (Apr. 21, 2020); *see also HIPAA and Telehealth*, Dep't of Health & Hum. Servs. (Oct. 18, 2023), https://www.hhs.gov/hipaa/for-professionals/special-topics/telehealth/index.html [https://perma.cc/Z6UD-LAEG].

30. John Bowden, *Multiple States Sharing Info on Coronavirus Patients with Law Enforcement: Report*, Hill (May 19, 2020, 3:17 PM), https://thehill.com/policy/healthcare/498575-multiple-states-sharing-info-on-coronavirus-patients-with-law-enforcement/ [https://perma.cc/QA3D-KTQK]; Kimberlee Kruesi, *COVID-19 Data Sharing with Law Enforcement Sparks Concern*, Associated Press (May 19, 2020, 10:48 AM), https://www.pbs.org/newshour/health/covid-19-data-sharing-with-law-enforcement-sparks-concern [https://perma.cc/V3MC-M9TA]; April Glaser & Jon Schuppe, *Tested Positive for Coronavirus? Health Workers May Share Your Address with Police*, NBC News (Apr. 8, 2020, 5:01 AM), https://www.nbcnews.com/news/us-news/tested-positive-coronavirus-health-workers-may-share-your-address-police-n1178696 [https://perma.cc/DD7P-XXB4]; Steve Wirth, *Feds Tell Hospitals They May Share Information About COVID-19 Patients with First Responders*, Police1 (Mar. 29, 2020, 10:55 P.M.), https://www.police1.com/coronavirus-covid-19/articles/feds-tell-hospitals-they-may-share-information-about-covid-19-patients-with-first-responders-ZkBnoV5ipZc9zGl8/ [https://perma.cc/8AY2-KCFH].

31. Jessica Bliss, *Tennessee's Decision to Release Public Health Data Leaves a Trade Off Too Great for Vulnerable Communities, Some Say*, Tennessean (May 13, 2020), https://www.tennessean.com/story/news/2020/05/13/tennessee-public-health-data-release-diminish-trust-vulnerable-communities/3112180001/ [https://perma.cc/BE88-UZ4L]; *see generally infra* Section II.A (discussing HIPAA). The HIPPA exception is outlined in 45 C.F.R. § 164.512(j)(1)(i).

the very nature of public health makes it difficult to permit the sick to remain sick without also permitting some degree of negative spillover effects on those politicians deem "worthy" of health care.

### *B. The Law and System Avoidance*

The immediate aftermath of significant changes to immigration law and policy, especially anti-immigrant changes, provides the clearest depiction of system avoidance.[32] In addition to Trump's rescission of the Sensitive Locations Policy, the President signed Executive Order 13767 during his first administration.[33] This Executive Order sought to ramp up immigration enforcement, and health care providers across the country subsequently reported a sudden increase in canceled appointments.[34] Other examples include drops in health care utilization during debates on California's Proposition 187, which mandated medical professionals to report suspected undocumented immigrants to authorities, and Arizona's SB 1070, a program that empowered local law enforcement to assist in immigration enforcement efforts similar to the federal "Secure Communities" program.[35]

The efforts of Florida Governor Ron DeSantis to collect data on immigrant use of local hospitals explicitly sought to prevent said use. In 2023, Governor DeSantis signed into law section 395.3027 of the Florida Statutes.[36] The statute requires each hospital to survey patients on their immigration status and record the number of hospital admissions and emergency department visits provided to lawfully present and

32. For example, after an anti-immigrant executive order was signed in 2017, a California hospital reported twice as many cancellations immediately after the announcement. After SB 1070 passed in Arizona, there was a drop in overall health care usage including doctors visits and vaccinations. Mambwe Mutanuka, *The Intersection of Health Policy and Immigration: Consequences of Immigrants' Fear of Arrests in U.S. Hospitals*, 30 ANNALS HEALTH L. ADVANCE DIRECTIVE 217, 225–26 (2021).

33. Exec. Order No. 13,767, 82 Fed. Reg. 8973 (Jan. 25, 2017).

34. Ike Swetlitz, *Immigrants, Fearing Trump's Deportation Policies, Avoid Doctor Visits,* PBS NEWS (Feb. 25, 2017), https://www.pbs.org/newshour/health/immigrants-trump-deportation-doctor [https://perma.cc/GJ73-38CC].

35. Mark L. Berk & Claudia L. Schur, *The Effect of Fear on Access to Care Among Undocumented Latino Immigrants,* 3 J. IMMIGR. HEALTH 151, 151–52 (2001); Russell B. Toomey et al., *Impact of Arizona's SB 1070 Immigration Law on Utilization of Health Care and Public Assistance Among Mexican-Origin Adolescent Mothers and Their Mother Figures*, 104 AM. J. PUB. HEALTH 28, 29 (2014).

36. Press Release, Ron DeSantis, Governor, Governor Ron DeSantis Signs Strongest Anti-Illegal Immigration Legislation in the Country to Combat Biden's Border Crisis, (May 10, 2023), https://www.flgov.com/eog/news/press/2023/governor-ron-desantis-signs-strongest-anti-illegal-immigration-legislation-country [https://perma.cc/SYG7-N473].

non-lawfully present patients.[37] Hospitals must report that information to the Florida Agency for Health Care Administration, Governor, President of the Senate, and Speaker of the House of Representatives.[38] Patients have the right to refuse to answer the question and respondents receive a disclaimer that "the response will not affect patient care or result in a report of the patient's immigration status to immigration authorities."[39] Nonetheless this disclaimer is ineffective at calming immigrants' fears when the survey's drafters seek to identify counties with the highest rates of undocumented patients utilizing health care services. In support of the bill, the Governor pointed to the unfairness of undocumented immigrants using public resources, illustrating the intention behind the law's deterrent effect.[40]

While presumptively unlawful due to federal preemption issues,[41] the law still creates deplorable conditions within the state. Following the passage of section 395.3027, the state reported a fifty-four percent decrease in Medicaid expenditures for emergency care for undocumented immigrants.[42] Members of the Florida government highlighted these reduced expenditures as "shedding light on the true cost burden of illegal immigration" and emphasized that, although EMTALA still requires treatment of emergency conditions, "the state's health care system . . . serve[s] and prioritize[s] legal United States citizens."[43] This statement not only reflects the state's xenophobic values but also mischaracterizes

37. FLA. STAT. § 395.3027 (2023).

38. *Id.*

39. *Id.*

40. Matt Dixon, *Ron DeSantis Signs Immigration Crackdown as Biden Prepares to End Title 42*, NBC NEWS (May 10, 2023), https://www.nbcnews.com/politics/2024-election/ron-desantis-signs-immigration-crackdown-rcna83726 [https://perma.cc/M2JL-97MR] ("'People are going to come if they get benefits,' DeSantis said. 'You are either here as a native or come here legally, both fine things, but to come across the border and end up getting benefits in Florida does not make sense.'"); *see also* Press Release, Ron DeSantis, *supra* note 36.

41. The Florida statute intrudes on federal powers in violation of Constitutional delegations of power. *See infra* Part III.

42. Arek Sarkissian, *Florida Medicaid Spending on Undocumented Immigrants Plummets After New Law*, POLITICO (June 23, 2024, 7:00 AM), https://www.politico.com/news/2024/06/23/desantis-florida-medicaid-immigration-00164519 [https://perma.cc/2GP2-KETP]. However, this drop in spending may also be related to the "exodus of migrants in Florida" and not solely Florida residents avoiding health care due to the law's hospital reporting requirements. *Id.*; *see also* Gisela Salomon, *Uncertain and Afraid: Florida's Immigrants Grapple with a Disrupted Reality Under New Law*, U.S. NEWS (Sep. 16, 2023), https://apnews.com/article/florida-immigration-law-effects-immigrants-desantis-6997fe6cdbcfa9d0b309bb700690e747 [https://perma.cc/24H6-6TP8] (discussing the general impact the new law has had on Florida immigrants, including many leaving the state as a result).

43. Sarkissian, *supra* note 42 (quoting Alecia Collins, spokesperson for Florida Agency for Health Care Administration).

EMTALA by claiming it prioritizes some citizens in the provision of health care.[44]

### *C. Documented Impact of System Avoidance on Health Outcomes*

Despite evidence of reduced health care usage among immigrants, system avoidance renders medical research about the resulting health needs and outcomes of undocumented individuals incredibly difficult to procure. Amongst undocumented and/or noncitizens receiving care, the risk associated with deportation means that patients and doctors hesitate before disclosing or recording immigration status in the medical context.[45] Even when patients willingly provide their immigration status, the aversion of doctors to document their status understandably impedes research on this community. To prepare health care providers for this situation, the American Medical Association ("AMA") released training material on a paradigmatic case of a pediatric patient who suffers from symptoms of anxiety and fears of ICE taking away her mother after seeing similar events on the news.[46] In this example, while the mother's immigration status is medically relevant to the daughter's condition, the AMA discourages recording this information out of concern for the mother's precarious status.[47] The health impacts of immigration-related stressors often contribute to diseases and symptoms like anxiety, high blood pressure, depression, hair loss, and headaches.[48] The full health impacts of immigration-related stressors remain unclear due to the aforementioned hesitancy to document immigration status in medical records.[49]

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44. *See infra* Section II.B.

45. Grace Kim et al., *Should Immigration Status Information Be Included in a Patient's Health Record?*, 21 Am. Med. Ass'n J. Ethics 8, 8 (2019).

46. *Id.* at 8–9.

47. *Id.*

48. Hacker et al., *supra* note 16, at 592.

49. *See, e.g.*, Leo R. Chavez, *Undocumented Immigrants and Their Use of Medical Services in Orange County, California*, 74 Soc. Sci. & Med. 887, 888 (2012) ("Although undocumented immigrants are a 'shadow' population, making research difficult, there have been some important contributions to understanding their social circumstances and health-related behavior. Studies using U.S. census data have relied on a number of assumptions to estimate undocumented immigrant characteristics . . . ."); Jeffrey S. Passel, *Measuring Illegal Immigration: How Pew Research Center Counts Unauthorized Immigrants in the U.S.*, Pew Rsch. Ctr. (July 12, 2019), https://www.pewresearch.org/short-reads/2019/07/12/how-pew-research-center-counts-unauthorized-immigrants-in-us/ [https://perma.cc/L7CM-BPFT] (describing research challenges and workarounds for undocumented populations); Deborah Onakomaiya, *Challenges and Recommendations to Improve Institutional Review Boards' Review of Community-Engaged Research Proposals: A Scoping Review*, 7 J. Clinical &

In the face of these methodological challenges, especially in the context of maternal health, researchers often rely on demographic assumptions to estimate which subjects are undocumented.[50] For some researchers, undocumented Latina mothers utilizing emergency Medicaid for labor care are an imperfect proxy for undocumented immigrant or noncitizen communities.[51] Following the implementation of the section 287(g) "Secure Communities" immigration enforcement program in North Carolina, Latina mothers waited until later in their pregnancy to begin prenatal care and missed a greater number of check-ups, citing growing fears of immigration enforcement and surveillance.[52] The study found that across North Carolina, Hispanic/Latina mothers were more likely to have late prenatal care than non-Hispanic/Latina mothers following implementation of section 287(g).[53] During this same time period, a San Diego study found that 11.5% of undocumented mothers received "inadequate" prenatal care, either no care or prenatal care beginning only in the third trimester, a rate nearly three times higher than that of legal immigrant mothers and the general maternal population (3.6% and 3.8% respectively).[54] Despite other studies finding generally lower rates of low birth weight amongst babies born from undocumented women compared to all other women,[55] undocumented women were found to face an increased risk of low birth weights in areas with increased immigration enforcement—presumably as a result of health care avoidance behaviors.[56] Regardless of the base health of a patient, these findings indicate that underutilization of health care

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TRANSNAT'L SCI. 1, 12 (2013) (describing undocumented immigrants' hesitancy to participate in research).

50. *See* Chavez, *supra* note 49, at 888.

51. *See, e.g.*, Brittany J. Raffa et al., *Immigration Policy and the Health of Latina Mothers and Their Infants*, 25 J. IMMIGR. MINOR HEALTH 775, 777 (2023) (using Emergency Medicaid as a proxy for undocumented status in North Carolina because "over 99% of those using it are undocumented").

52. Scott D. Rhodes et al., *The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States*, 105 AM. J. PUB. HEALTH 329, 329 (2015).

53. *Id.* at 331 ("In the individual-level analysis that compared Hispanic/Latina with non-Hispanic/Latina mothers throughout North Carolina . . . for late prenatal care, the difference between Hispanic/Latina and non-Hispanic/Latina mothers was significantly greater during the postimplementation period of section 287(g) than during the preimplementation period after adjusting for county and section 287(g) implementation status.").

54. Leo R. Chavez et al., *Utilization of Health Services by Mexican Immigrant Women in San Diego*, 11 WOMEN & HEALTH 3, 9 (1986).

55. Mary M. Reed et al., *Birth Outcomes in Colorado's Undocumented Immigrant Population*, 5 BMC PUB. HEALTH 1, 4 (2005).

56. Catalina Amuedo-Dorantes et al., *Immigration Enforcement and Infant Health*, 8 AM. J. HEALTH ECONS. 324, 336–38, 350 (2022).

negatively impacts health outcomes. To reiterate, the underdiagnosis of undocumented immigrants' health conditions likely dampens the perceived severity of health care avoidance. In response to the myriads of problems presented by this phenomenon, legal protections are crucial to the mitigation of health care avoidance.[57]

## II. Federal Protections of Immigrant Health Care Access

In response to the dire situation described above, the federal government has demonstrated both an awareness of this problem and a willingness to address it. In addition to providing different types of legal protections in their own right, the following federal statutes and policies demonstrate the federal government's enforcement goals and priorities, highly relevant in discussions of conflict preemption of sanctuary laws that purportedly contravene federal aims.[58]

HIPAA and EMTALA are influential health laws that broadly grant health privacy and a basic right to emergency health care, which, for purposes of addressing health care avoidant behaviors and stressors for immigrants, are impactful largely because of their broad aims and coverage. Nonetheless, these laws fail to replace the need for robust health systems that immigrants currently lack and come with legal gaps themselves. Immigrants still face the prospect of emergency conditions left untreated, worse health outcomes from waiting until a health condition becomes an emergency to seek care, and the sharing of their private health information leading to their deportation. Furthermore, the Department of Homeland Security ("DHS") has had a long-standing policy of discouraging immigration enforcement actions in sensitive locations, an ever-expanding term that now includes hospitals and a variety of health care facilities. While the second Trump Administration's impact on legal precedent continues to develop, the current attempts to claw back this policy's protections illustrate the largest flaw in this unstable protection. Despite these shortcomings, HIPAA, EMTALA, their related regulations and statutes, and the DHS Sensitive Locations Policy constitute protections that can also serve as greater than the sum of their parts.[59] These policies can be supplemented by private actors and legal actors alike to further promote health care use for fearful immigrant patients.

57. While the economic cost of care is a substantial burden to access and should not be overlooked, it is outside the scope of this paper.

58. *See infra* Part III.

59. *See infra* Part III.

### *A. Health Insurance Portability and Accountability Act*

HIPAA directed HHS to promulgate regulations to strengthen the privacy and security of health information.[60] Pursuant to this mandate, the "Privacy Rule," effective April 14, 2001, established a federal set of standards for covered entities handling individually identifiable health information ("IIHI").[61] HHS defines IIHI as any information created by a health care provider relating to a past, present, or future health condition of an individual or relating to payment for health care.[62] Therefore, Professor Makhlouf argues that immigration status indeed falls under HIPAA protections when related to a health condition—such as the aforementioned example of the daughter with anxiety.[63] However, given the ambiguity of what counts as protected IIHI and the gaps in health privacy discussed in the following subsections, HIPAA fails to fully address the health privacy concerns of undocumented patients.

#### *1. Group Identification*

By definition, protected health information ("PHI") only includes IIHI.[64] Yet, concerningly, such a narrow definition overlooks the potential harm presented by *community identification*. For example, HIPAA's privacy protections do not bar the kind of general information collected under section 395.3027 of the Florida Statutes, particularly because the state statute explicitly forbids the collection of individually identifying information.[65] The data collected pursuant to section 395.3027 only looks at the number of undocumented immigrants receiving care within hospitals across the state.[66] With no specific geographic subdivisions identified beyond the first three digits of the zip code, this qualifies as de-identified information.[67] While de-identified health information

60. Health Insurance Portability and Accountability Act, Pub. L. 104-191, § 264, 110 Stat. 1936, 2033–34 (1996).

61. *General Overview: HIPAA*, Dep't of Health & Hum. Servs., https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/general-overview/index.html [https://perma.cc/43DH-PP5G] (last updated Nov. 5, 2015); 45 C.F.R. §§ 160, 164 (2003).

62. 45 C.F.R. § 160.103 (2003).

63. *See supra* Section I.C.

64. 45 C.F.R. § 160.103 ("Protected health information means individually identifiable health information.").

65. "The rules may not require the disclosure of patient names or any other personal identifying information to the agency." Fla. Stat. § 395.3027 (2023); 45 C.F.R. § 164.502(d)(2) ("Uses and disclosures of de-identified information. Health information that meets the standard and implementation specifications for de-identification under § 164.514(a) and (b) is considered not to be individually identifiable health information, i.e., de-identified."); 45 C.F.R. § 164.514.

66. Fla. Stat. § 395.3027 (2023).

67. 45 C.F.R. § 164.514(b)(2)(i).

requires the deletion of various bits of information including names and geographical units like city and address, HIPAA permits the inclusion of the first three digits of a patient's zip code in geographic units with populations in excess of 20,000.[68] HIPAA only prohibits the use of de-identified health data in cases with a substantial risk of re-identification, a separate concern for patients fearing group identification.[69] As such, HIPAA fails to address the potential outcome whereby section 395.3027, or other similar laws, identify broad areas of health care utilization by undesired groups, in an attempt to curb this health care use.[70] Far from hypothetical, reports from Florida doctors indicate a growing number of patient absences in the aftermath and as a result of Florida's health supervision policies.[71]

### *2. Required and Permitted Disclosures of PHI*

HIPAA contains an exception permitting disclosure of PHI when "required by law" in order to avoid conflicts with existing legal processes.[72] This means a legal mandate "contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law."[73] For example, judicial or administrative proceedings may demand disclosure of PHI, with HIPAA requiring notification to the patient of their information's disclosure.[74] However, if a patient fears that outcome, HIPAA affords them the right to *request* amendment to their PHI to exclude any sensitive information.[75] As such, legal avenues exist for hospitals wishing to establish themselves as safe for immigrant patients, including policies to not disclose immigration-related PHI (or any PHI) unless required by law. Policies that prospectively expedite the process for amendment requests to remove immigration status from one's health

68. *Id.*
69. *Id.* §§ 164.502(d)(2), 164.514(b)(1)(i), 164.514(c).
70. Florida Agency for Health Care Administration Deputy Secretary Kim Smoak said in a statement that "[t]he agency remains dedicated to fulfilling Governor DeSantis' commitment to protecting taxpayer dollars from being used on individuals who are not lawfully present in the United States." Billal Rahman, *Florida Spent $660M on Health Care for Illegal Immigrants,* NEWSWEEK (Mar. 13, 2025, 11:58 AM), https://www.newsweek.com/florida-health-care-illegal-immigrants-2044101 [https://perma.cc/XL8Q-XVSK].
71. The "costs of uncompensated care for aliens who are not lawfully present in the United States" is specifically referenced within the statute itself. FLA. STAT. § 395.3027(3). *See also supra* text accompanying note 43.
72. 45 C.F.R. § 164.512(f).
73. *Id.* § 164.103.
74. *Id.* § 164.512(c)(1)(i).
75. *Id.* § 164.526(a)(1).

records provide another opportunity to reassure immigrant patients that their information is safe at these hypothetical "sanctuary hospitals."[76] However, HIPAA also contains exceptions that limit the ability of individuals to amend PHI.[77] Administrative subpoenas are allowed to pierce HIPAA's protections provided that the information is relevant, sufficiently limited in scope, and de-identified information could not reasonably be used.[78] If these three regulatory requirements are not met, HIPAA does not permit disclosure of PHI pursuant to administrative requests including warrants and subpoenas.[79]

Aside from mandated disclosure, HIPAA allows but does not require disclosure in other instances. Most relevant to the topic of deportation-related health concerns, HIPAA allows for disclosure of PHI to the police when covered entities possess a good faith belief that the PHI serves as evidence of criminal conduct that is occurring "on the premises."[80] While immigration officials may argue that hospitals should disclose PHI on this basis, the risk of deportation for "illegal" immigrants stems from illegal civil violations of immigration law, not criminal activity as referred to in HIPAA.[81] As a result, mere immigration violations provide an insufficient basis to constitute a good faith belief of criminal activity occurring on the premises for purposes of the relevant HIPAA exception.

Yet, in practice, the REAL ID Act of 2005 made illegal immigration a violation of criminal law for immigrants who wished to drive, travel, or perform any of the many other activities that require an ID.[82] In the wake of the 9/11 terrorist attacks, this law required a social security number, or "verification that the applicant is not eligible" for a social security number, to obtain an identification card ("ID"), seeking

76. The standard statutory requirement is for action within sixty days of the request being received. *Id.* § 164.526(b)(2). Also, the law would permit changes to a hospital's privacy practices with respect to existing patients if they included a statement retaining their right to alter existing privacy practices when a patient initially agreed to the hospital's privacy notice. *See id.* § 164.520(b)(1)(v)(C).

77. *Id.* § 164.526(a).

78. *Id.* § 164.512(f).

79. *Id.*

80. *Id.* ("Disclosures for law enforcement purposes. A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official . . . .").

81. *See, e.g.*, Harisiades v. Shaughnessy, 342 U.S. 580, 594 (1952) ("Deportation, however severe its consequences, has been consistently classified as a civil rather than a criminal procedure."); Zheng v. U.S. Dep't of Just., 409 F.3d 43, 46 (2d Cir. 2005).

82. 18 U.S.C. § 1028 (defining identity theft and fraud and accompanying criminal penalties); REAL ID Act, Pub. L. No. 109-13, § 202(c)(2)(B), 119 Stat. 231, 313 (2005) (requiring some form of lawful immigration status before being issued a driver's license or identification card and amending the criminal penalties outlined in 18 U.S.C. § 1028).

to prevent foreign terrorist attempts.[83] For undocumented residents, the act forced them into a "Sophie's Choice"—violate the REAL ID Act and risk criminal liability or lose access to essential services that require identification, like health care.[84] For undocumented patient Blanca Borrego, this law ultimately resulted in her detainment.[85] After using a fake ID at her gynecologist's office, the receptionist noticed the invalidity of Ms. Borrego's ID and called the police to report this observation.[86] Typically, HIPAA classifies a driver's license used for identification at a health clinic as PHI.[87] However, HIPPA's "Crime on the Premises" exception could be used as a legal justification to report fake driver's licenses to police.[88] In practice, such as in the case of Ms. Borrego, health care staff can use HIPPA to weaponize undocumented people's status against themselves, creating genuine fear of accessing health care services in their community. Nineteen states and the District of Columbia issue non-REAL ID Act compliant ID cards to residents without social security numbers.[89] However, these are

83. Aaron R. Gary, *The Federal REAL ID Act and Its Fate in Wisconsin*, 81 Wis. L. 8, 8–9 (2008).

84. For example, a Pennsylvania survey found that 85% of immigrants had to miss medical visits due to the lack of a driver's license. Soc. Just. Lawyering Clinic, Temp. Univ. Beasley Sch. L., Driver's Licenses for All 17 (2015). *See also* Miranda Sasinovic, *Removing Roadblocks: Alternatives to Lawful Status and Social Security Number Requirements for Pennsylvania Driver's Licenses*, 126 Dick. L. Rev. 305, 335 (2021).

85. Tom Dart, *Mexican Woman's Arrest at Clinic 'May Deter Migrants from Seeking Healthcare,'* Guardian (Sept. 14, 2015), https://www.theguardian.com/world/2015/sep/14/mexican-woman-arrest-clinic-undocumented-migrants-health [https://perma.cc/6V5K-HZMD].

86. *Id.*

87. 45 C.F.R. § 164.514(b)(2)(i) (HIPAA safe harbor rule that rejects birthdays, names, and the majority of identifying information on an identification card). Furthermore, identification cards provided at a clinic relate to "the provision of health care to an individual" qualifying as health information as defined under 45 C.F.R. § 164.501.

88. Michael Barajas, *Woman Arrested at Gynecologist Appointment Could Face Deportation,* Hous. Press (Sep. 11, 2015), https://www.houstonpress.com/news/woman-arrested-at-gynecologist-appointment-could-face-deportation-7754827 [https://perma.cc/CR23-85VF] ("Exemptions to federal patient privacy laws, commonly known as HIPAA, do exist so that healthcare providers can alert law enforcement when, for instance, a patient threatens to do physical harm to himself or others. But Guajardo [the attorney of Blanca Borrego] doubts such exemptions apply to clinic staff who suspect a patient of being undocumented or presenting a fake ID . . . . Guajardo still has questions about the legitimacy of Borrego's arrest at the women's healthcare clinic . . . .").

89. 6 C.F.R. § 37.71 (permitting states to issue non-REAL ID Act compliant IDs). *See generally States Offering Driver's Licenses to Immigrants*, Nat'l Conf. State Legislatures, https://www.ncsl.org/immigration/states-offering-drivers-licenses-to-immigrants [https://perma.cc/ADD6-GB6C] (last updated Mar. 13, 2023) (providing a chart of states that issue licenses to undocumented immigrants). These states are California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts,

an insufficient remedy to the problems that the REAL ID Act created for undocumented, otherwise law-abiding immigrants who are not the terrorist-threat targets of this law.[90] Worse, in states that do not offer any other forms of identification cards other than REAL ID Act compliant IDs, residents like Ms. Borrego may use false identification in order to access basic necessities, thereby risking related criminal liability.

### *B. Emergency Medical Treatment and Active Labor Act*

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, citizenship and residency requirements sought to prevent perceived immigrant overuse of benefits.[91] However, EMTALA importantly reserves emergency care as a requirement for all indigent patients regardless of citizenship or immigration status.[92] EMTALA was a legal response to the growing concern around patient dumping, the practice of hospitals refusing to treat indigent populations and often "dumping" them off the premises.[93] The law effectively

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Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Virginia, Washington, and the District of Columbia. Sasinovic, *supra* note 84, at 313–14.

90. To issue non-REAL ID Act compliant IDs, states must clearly specify that the ID card is not a REAL ID Act compliant card. *See* 6 C.F.R. § 37.71. However, distinct markings on ID cards can act as signals to law enforcement that the individual cannot establish lawful presence and is likely undocumented. To address these concerns, New York State enacted its human rights laws to bar DMV workers from asking about immigration status when issuing non-compliant licenses, and California prohibits police officers from discriminating on the basis of non-compliant IDs. *See* Sasinovic, *supra* note 84, at 318; N.Y. VEH. & TRAF. LAW § 502(1) (McKinney 2021) ("Neither the commissioner nor any agent or employee of the commissioner shall inquire about the citizenship or immigration status of any applicant for a non-commercial driver's license or learner's permit which does not meet federal standards for identification."); CAL VEH. CODE § 12801.9 (West 2023).

91. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2261, 2107 ("Subtitle A – Eligibility for Federal Benefits"); Mark E. Douglas, *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, 5 IND. HEALTH L. REV. 277, 289 (2008).

92. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1986). Jennifer Prah Ruger et al., *The Elusive Right to Health Care Under U.S. Law*, 372 NEW ENG. J. MED. 2558, 2558 (2015); W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, 16 J. GENDER RACE & JUST. 139, 179 (2013); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432–35 (2003); 42 C.F.R. § 440.255 ("Limited services available to certain aliens"). While this was restricted to participating hospitals accepting Medicare and Medicaid payments, this is, in practice, not much of a limitation given the economic infeasibility of not participating in either program. Nicolas T. Sawyer, Editorial, *Why the EMTALA Mandate for Emergency Care Does not Equal Healthcare "Coverage,"* 18 W.J. EMERGENCY MED. 551, 551 (2017).

93. Jeffrey Kahntroff & Rochelle Watson, *Refusal of Emergency Care and Patient Dumping*, 11 AM. MED. ASS'N J. ETHICS 49, 49 (2009).

outlawed this practice, requiring hospitals to treat these patients.[94] In reality, EMTALA simply requires screenings based on emergency medical conditions ("EMCs") and stabilization if the screening finds an EMC.[95] EMTALA-based emergency care serves as the sole affirmative right to health care for undocumented patients, but this Act utterly fails as a comprehensive health system.[96] Delaying care until a health condition deteriorates into an EMC can potentially lead to worse health outcomes and increased health care costs.[97] At the same time, EMTALA remains a unique and important federal affirmation of a particular right to health care regardless of one's economic or immigration status.

Undocumented patients' overreliance on emergency care comes as a direct result of the disproportionate amount of uninsured undocumented immigrants.[98] Fifty percent of undocumented immigrants and eighteen percent of authorized immigrants are uninsured and consequently more likely to wait longer before seeking care and to prioritize emergency clinics.[99] After such delays, medical costs skyrocket and health outcomes nosedive.[100] Furthermore, screenings for EMCs occasionally yield false negatives, at which point EMTALA permits a hospital to turn a patient away.[101] Only substandard hospital screenings for EMCs

94. 42 U.S.C. § 1395dd(c).

95. *Id.* § 1395dd(a).

96. This is despite claims that EMTALA provides health care for Americans. For example, President George W. Bush, during a speech in 2007, noted that "people have access to health care in America. After all, you just go to an emergency room." Koeninger, *supra* note 92, at 154.

97. *See, e.g.*, Joel S. Weissman et al., *Delayed Access to Health Care: Risk Factors, Reasons, and Consequences*, 114 Annals Internal Med. 325, 325, 329–30 (1991) (noting that patients who delayed care had longer hospital stays compared to the control group); Gregg A. Pane et al., *Health Care Access Problems of Medically Indigent Emergency Department Walk-In Patients*, 20 Annals Emergency Med. 730, 730 (1991); Laura D. Hermer & William J. Winslade, *Access to Health Care in Texas: A Patient-Centered Perspective*, 35 Tex. Tech L. Rev. 33, 70–71 (2004) ("Children who are uninsured risk health problems through delayed or skipped care and are also . . . more likely to use the emergency room, at greatly increased cost . . . .").

98. Immigrants are 16% of the uninsured adult population despite only comprising 3% of the population. Helen B. Marrow & Tiffany D. Joseph, *Excluded and Frozen Out: Unauthorised Immigrants' (Non)Access to Care After US Health Care Reform*, 41 J. Ethnic Migration Stud. 2253, 2255 (2015).

99. This is compared to average uninsured rates of 6% and 8% among naturalized adult citizens and U.S.-born adult citizens, respectively. *Key Facts on Health Coverage of Immigrants*, KFF (Jan. 15, 2025), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/ [https://perma.cc/R4W4-3QAJ].

100. Aleli D. Kraft et al., *The Health and Cost Impact of Care Delay and the Experimental Impact of Insurance on Reducing Delays*, 155 J. Pediatrics 281, 281, 284 (2009).

101. Marshall v. E. Carroll Par. Hosp. Serv. Dist., 134 F.3d 319, 322 (5th Cir. 1998) ("We agree with the other courts which have interpreted EMTALA that the statute was not intended to be used as a federal malpractice statute, but instead was enacted to

risk legal liability for violating EMTALA, leaving patients without remedy if they received an adequate screening that nonetheless resulted in a false negative.[102] Finally, the limiting definition of emergency care ensures that care is only provided to patients on the brink of imminent death.[103] For those with long-term care needs, this "creates significant medical and psychological distress for patients and their families and is associated with increased mortality."[104] For example, EMTALA covers emergency dialysis for those suffering from kidney failure but not the routine dialysis required for regular treatment.[105] Even when a hospital decides to treat, the courts have restricted this definition of emergency care even further, denying reimbursement for long-term care under federal programs that allocate funds for EMTALA-based services. In *Szewczyk v. Department of Social Services*, an undocumented patient with leukemia required a month-long round of chemotherapy.[106] However, the Connecticut Supreme Court denied reimbursement for the hospital because it defined an emergency condition as only including risks of immediate death.[107] Similarly, the Second Circuit rejected a reimbursement claim on behalf of patients with serious head injuries in *Greenery v. Hammon*, holding that EMTALA does not cover long-term rehabilitative care, only immediate treatment and stabilization.[108] Clearly, a system that only protects immigrants from imminent death

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prevent 'patient dumping,' which is the practice of refusing to treat patients who are unable to pay.").

102. Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden It Places on Hospitals*, 7 J.L. Soc'y 146, 151–52 (2005); *Marshall*, 134 F.3d at 322 ("[A]n EMTALA 'appropriate medical screening examination' is not judged by its proficiency in accurately diagnosing the patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms.").

103. *See, e.g.*, Tenet Hosps. Ltd. v. Boada, 304 S.W.3d 528, 535 (Tex. App. 2009) (citation omitted) ("An emergency medical condition exists only if a patient is in 'imminent' danger of death or a worsening condition which could be life-threatening."); Tolton v. Am. Biodyne, Inc., 854 F. Supp. 505, 511 (N.D. Ohio 1993), *aff'd*, 48 F.3d 937 (6th Cir. 1995).

104. Shamsher Samra et al., *Undocumented Patients in the Emergency Department: Challenges and Opportunities,* 20 W.J. Emergency Med. 791, 792 (2019).

105. *See* Greenery Rehab. Grp., Inc. v. Hammon, 150 F.3d 226, 232–33 (2d Cir. 1998) (finding that "stabilization" required care for the immediate aftermath of head trauma, but not the long-term care necessitated afterwards).

106. 822 A.2d 957, 959, 971 (Conn. App. Ct. 2003), *rev'd*, 881 A.2d 259 (Conn. 2005).

107. *Id*. at 961, 965–66 (finding that the patient, "would not have died if he did not receive treatment the day he was admitted" and looking at the factors of severity, temporality, and urgency of the medical condition).

108. 150 F.3d at 232–33.

fails to adequately provide the necessary care and resources to ensure a healthy population.

### *1. Federal Appropriations for Emergency Care for Undocumented Residents*

EMTALA originally imposed additional requirements on hospitals without any appropriated money, earning it the nickname of an "unfunded mandate."[109] This lack of funding most impacted hospitals providing emergency care to the poor, including undocumented low-income patients ineligible for Medicaid because of their undocumented status.[110] The Balanced Budget Act of 1997 provided $25 million annually between the fiscal years of 1998 and 2001, allocated amongst the twelve states with the highest shares of undocumented aliens, in order to cover emergency care costs for these Medicaid-ineligible patients.[111] In 2003, Congress allocated $250 million in reimbursements each fiscal year for four years under section 1011 of the Medicare Modernization Act.[112] Eligible patients included undocumented patients, border crossing cardholders, and noncitizens paroled through the border.[113] Based off the 2000 census, states received two-thirds of the allocated funds based on U.S. immigrant population.[114] The six states with the highest number of DHS "undocumented alien apprehensions" received the final third of the funds.[115] However, the process of determining what care is eligible for repayment proved difficult.

Eligible providers within the state generally apply to the Center for Medicare and Medicaid Services ("CMS") for reimbursement.[116] Section 1011 grants authority to HHS to establish the process under which eligible providers located in a state request reimbursement.[117] Exercising this delegated authority, CMS drafted a "Provider Payment Determination"

109. Sawyer, *supra* note 92, at 552; Jay M. Brenner et al., *Ethical Issues in the Access to Emergency Care for Undocumented Immigrants*, 2 J. Am. Coll. Emergency Physicians Open 1, 3 (2021).

110. Lebedinski, *supra* note 102, at 162–63.

111. Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C. L. Rev. 223, 275 (2006); Makhlouf, *supra* note 12, at 256.

112. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432 (2003).

113. *Id.*

114. *Id.*

115. *Id.* § 1011(b)(2)(A).

116. Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB), 70 Fed. Reg. 25578, 25579 (May 13, 2005).

117. Medicare Prescription Drug, Improvement, and Modernization Act § 1011.

form for hospitals to apply for emergency care reimbursement.[118] As part of the administrative notice and comment procedure, HHS invited comments on its proposed reimbursement application process.[119] The proposed eligibility determination process directed hospitals to make a good faith effort to determine a Medicaid-ineligible uninsured patient's citizenship or immigration status.[120] It also initially suggested that providers ask direct questions about the citizenship of patients.[121] Responding to this suggested direct questioning of patients on their immigration status, providers and patient advocacy groups expressed concern about the potential for this to deter immigrants from seeking care.[122] In response, CMS's final regulation proclaimed that "[t]o mitigate these concerns and the potential negative health consequences of patients not seeking emergency care when it is needed, we are adopting an indirect measure to determine patient eligibility status."[123] Throughout the final regulation notice, CMS reiterated its desire to "not compromise public health by discouraging undocumented aliens from seeking necessary treatment."[124] The new "Payment Provider Determination" form explicitly states that "[a] provider should not ask a patient if he or she is an undocumented alien."[125] Instead, CMS directed providers to determine eligibility based on verification of a patient's foreign place of birth, with a foreign birth certificate, passport, or other foreign identification card establishing presumptive eligibility.[126] CMS also permits eligibility determinations based on patient attestations

118. *See* Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB), 70 Fed. Reg. at 25579.

119. Agency Information Collection Activities: Proposed Collection; Comment Request, 70 Fed. Reg. 36613, 36613 (June 24, 2005);

120. *See* Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB), 70 Fed. Reg. at 25588.

121. *Id.* at 25586.

122. *Id.* at 25586 ("Initially, we proposed that a patient specific approach that required hospitals and other providers to request direct eligibility information from patients. In response to the public concerns regarding the negative public health consequences of asking for this information, we have decided not to ask hospitals and other providers to ask a patient if he or she is a citizen of the United States.").

123. *Id.* at 25587.

124. *Id.* at 25586–87 ("We believe that asking a patient to state that he or she is an undocumented alien in an emergency room setting may deter some patients from seeking needed care. Moreover, if providers were required to request a Social Security number or other independently verifiable information from a patient, providers would need a mechanism to verify the authenticity of the information submitted . . . . The sole purpose for requesting information contained on the Provider Payment Determination form is to obtain the information necessary to determine provider payment.").

125. Ctrs. of Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., OMB No. 0938-0952, Section 1011 Provider Payment Determination 1 (2013).

126. *Id.*

that they lack a social security number.[127] In addition, CMS provided bonuses for hospitals that furnish services to undocumented patients.[128] CMS provided this bonus because of its assumption that, since "one in every 10 people that a hospital would treat, who would otherwise be an alien described under section 1011(c)(5), will refuse or be unable to furnish the required eligibility information, we are going to create an additional payment . . . ."[129] This federal action evidences the federal government's awareness of health care avoidance, as well as a desire to reduce its impact, at least when it comes to emergency care.

### *C. DHS's Sensitive Locations Policy*

Since 1993, the federal government has deprioritized immigration enforcement in sensitive locations, initially defined to include schools, places of worship, funerals, and religious ceremonies.[130] While not an absolute prohibition, the INS commissioner at the time dissuaded enforcement at these locations.[131] In 2008, under the Bush Administration, Assistant Secretary Julie Myers issued a memorandum to ICE upholding the 1993 policies, albeit with exceptions for non-enforcement activities.[132] In 2011, the Obama Administration issued guidance, titled "Enforcement Actions at or Focused on Sensitive Locations," expanding the definition of these protected "sensitive locations" to include hospitals.[133] In 2013, Customs and Border Patrol ("CBP") adopted this policy via Secretary David Aguilar's memo titled "U.S. Customs and Border Protection Enforcement Actions at or Near Certain Community Locations."[134] Even after the 2017 inauguration of President Trump, one of the most aggressively anti-immigrant presidents

127. *Id.*
128. *See* Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB), 70 Fed. Reg. at 25591.
129. *Id.*
130. Jacobs, *supra* note 6; Memorandum from Julie L. Myers, Assistant Sec'y, U.S. Immigr. & Customs Enf't, to All Field Office Dirs. And All Special Agents in Charge 1 (July 3, 2008); Memorandum from Marcy M. Forman, Dir., Off. of Investigations, U.S. Immigr. & Customs Enf't, to All Assistant Dirs., All Special Agents in Charge, and All Deputy Assistant Dirs. 1 (Dec. 26, 2007); Memorandum from James A. Puleo, Acting Assoc. Comm'r, Immigr. & Naturalization Serv., to District Dirs. and Chief Patrol Agents (May 17. 1993).
131. Jacobs, *supra* note 6.
132. *Id.*
133. *Id.*
134. Memorandum from David V. Aguilar, Sec'y, U.S. Customs & Border Prot., U.S. Customs and Border Protection Enforcement Actions at or Near Certain Community Locations (Jan. 18, 2013).

in American history, the policy remained in effect.[135] In 2021, Secretary Alejandro Mayorkas expanded the policy, citing the "foundational principle" that "[t]o the fullest extent possible, we should not take an enforcement action in or near a location that would restrain people's access to essential services or engagement in essential activities."[136] Mayorkas' memorandum provided a list of health care-related sensitive locations, including "[a] medical or mental health care facility, such as a hospital, doctor's office, health clinic, vaccination or testing site, urgent care center, site that serves pregnant individuals, or community health center."[137] It also defined sensitive locations far more broadly, taking into account the importance of the activities occurring at that location (with respect to the community's wellbeing) and whether enforcement actions would disincentivize engagement with these locations.[138] Therefore, the Sensitive Locations Policy discourages enforcement actions at non-traditional places essential to public health not explicitly listed in the previous memos, such as mobile clinics and vaccination campaigns, considering the importance of the services provided at these facilities.[139]

Agencies generally have control over how to manage and guide their employees; as such, courts hesitate to review guidance policies.[140] However, litigation surrounding Deferred Action for Childhood Arrivals

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135. Jacobs, *supra* note 6; *see also* Luis Ferré-Sadurní & Ashley Cai, *Trump's Immigrant Crackdown in New York: More Arrests, Longer Detention,* N.Y. Times (Aug. 4, 2025), https://www.nytimes.com/2025/08/04/nyregion/new-york-immigrant-arrests-trump.html [https://perma.cc/TG7C-LBKZ] (comparing predictive fears of the Trump administration raiding schools, hospitals, and churches with the reality that the administration's immigration enforcement activity in New York City has centered on detaining immigrants appearing at immigration court).

136. Memorandum from Alejandro N. Mayorkas, Sec'y, U.S. Dep't of Homeland Sec., to Tae D. Johnson, Acting Dir., U.S. Immigr. & Customs Enf't, Troy A. Miller, Acting Comm'r, U.S. Customs & Border Prot., Ur M. Jaddou, Dir., U.S. Citizenship & Immigr. Servs., Robert Silvers, Under Sec'y, Off. of Strategy, Pol'y & Plans, Katherine Culliton-Gonzalez, Officer for Civ. Rts. & Liberties, Off. of Civ. Rts. & Liberties, and Lynn Parker Dupree, Chief Priv. Officer, Priv. Off. 2 (Oct. 27, 2021).

137. *Id.*

138. *Id.*

139. *See, e.g.*, Matthew M. Davis, *Successes and Remaining Challenges After 10 Years of Varicella Vaccination in the USA,* 5 Expert Rev. Vaccines 295, 299 (2006) (concluding that "entry mandates are a remarkably effective tool to address major barriers to childhood vaccination"); Nelson C. Malone et al., *Mobile Health Clinics in the United States,* 19 Int'l J. for Equity Health 1, 1 (2020) ("Mobile health clinics serve an important role in the health care system, providing care to some of the most vulnerable populations.").

140. *See generally* Arizona v. Biden, 40 F.4th 375, 387–88 (6th Cir. 2022) (finding guidance policies not reviewable because they did not "evoke binding legal effect"). However, there are some limitations placed on judicial review. *See* Dep't of Homeland Sec. v. Regents of the Univ. of Cal., 591 U.S. 1, 19 (2020) ("Because the DACA

("DACA") illustrates the nuances to this general rule.[141] On June 15, 2012, then-Secretary of Homeland Security Janet Napolitano issued a memorandum regarding the exercise of prosecutorial discretion with respect to individuals who came to the United States as children.[142] In the eyes of many courts, DACA appeared to be "manifestly contrary" to the Immigration and Nationality Act ("INA") and more than a simple non-enforcement policy.[143] Even after DHS codified DACA into a formal rule, the District Court for the Southern District of Texas held that the final DACA rule differed from normal prosecutorial discretion because it granted lawful presence and conferred "eligibility for otherwise unavailable benefits based on that change."[144] However, SCOTUS has affirmed that federal enforcement discretion is a "principal feature" of DHS's removal power.[145] In contrast to DACA, the Sensitive Locations Policy operates as a general (non)enforcement policy usually permitted by the courts, dissimilar to the kinds of benefits granted under DACA.[146]

Even in its strongest form, the Sensitive Locations Policy fails to wholly eliminate the arrest of undocumented patients seeking care. A DHS report on enforcement actions within these generally off-limit sensitive locations found thirty-nine ICE arrests or investigations occurred in sensitive locations between October 2017 and October 2020, with two occurring in hospitals specifically.[147] However, public concern, especially in undocumented communities was much larger

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program is more than a non-enforcement policy, its rescission is subject to review under the APA.").

141. *See Dep't of Homeland Sec.*, 591 U.S. at 19.

142. Press Release, U.S. Dep't of Homeland Sec., Secretary Napolitano Announces Deferred Action Process for Young People Who Are Low Enforcement Priorities (Jun. 15, 2012); Memorandum from Janet Napolitano, Sec'y, Dep't of Homeland Sec., Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children (Jun. 15, 2012).

143. *See, e.g.*, Texas v. United States, 549 F. Supp. 3d 572, 615 (S.D. Tex. 2021), *aff'd in part, vacated in part, remanded*, 50 F.4th 498 (5th Cir. 2022), *aff'd in part, modified in part*, 126 F.4th 392 (5th Cir. 2025), *supplemented*, No. 1:18-CV-00068, 2023 WL 5950808 (S.D. Tex. Sept. 13, 2023), *aff'd in part, modified in part*, 126 F.4th 392 (5th Cir. 2025), *supplemented*, 691 F. Supp. 3d 763 (S.D. Tex. 2023), *aff'd in part, modified in part*, 126 F.4th 392 (5th Cir. 2025).

144. Texas v. United States, 50 F.4th 498, 526 (5th Cir. 2022) (footnote omitted) (citation omitted) (citing Texas v. United States, 809 F.3d 134, 167 (5th Cir. 2015).

145. Arizona v. United States, 567 U.S. 387, 396 (2012) ("Removal is a civil, not criminal, matter. A principal feature of the removal system is the broad discretion exercised by immigration officials. . . . Federal officials, as an initial matter, must decide whether it makes sense to pursue removal at all.")

146. *Dep't of Homeland Sec.,* 591 U.S. at 18 (noting DACA's formal application, standardized review process, and formal decision notices).

147. U.S. Immigr. & Customs Enf't, Immigration Enforcement at Sensitive Locations 49–51 (2022).

than this number would suggest.[148] In addition, there may have been much more enforcement than this low number suggests, as ambiguity about the exact extent of this policy permits ICE to underreport arrests and investigations. One estimate showed that "[o]n an average day in November 2017, ICE had custody of thirty-eight individuals in ten hospitals across five states."[149] Moreover, ICE skirts the edges of this policy by arresting immigrants just off the premises of a health facility, such as an adjacent sidewalk or bus stop.[150] In border states with interior checkpoints, the Sensitive Locations Policy apparently permits enforcement actions for families en route to a protected health care facility. In an emblematic and highly publicized detention, ICE detained a ten-year-old girl with cerebral palsy at a checkpoint in Texas.[151] Around two A.M., the girl was traveling from her hospital in Corpus Christi to a specialty hospital for emergency gall bladder surgery when agents stopped her ambulance.[152] While the officers decided not to detain her at that moment, they followed her and detained her upon her release from the hospital.[153] Exploitation of the loopholes in this policy exacerbate the very health care avoidance that the policy seeks to prevent.

148. There were frequent reports of immigration officers going to medical facilities to arrest immigrants under the Trump Administration. *See, e.g.*, Press Release, Chris Murphy, Senator, As Trump Prepares to Launch Indiscriminate ICE Raids Sunday, Blumenthal Leads Legislation to Block Immigration Enforcement at Sensitive Locations (July 15, 2019); Muzaffar Chishti & Jessica Bolter, *The Trump Administration at Six Months: A Sea Change in Immigration Enforcement*, Migration Pol'y Inst. (noting Trump's more aggressive strategy within sensitive locations); Maya Rhodan & Elizabeth Dia, *Immigration Agents Arrested Men Outside a Church. But Officials Say It Was Just a Coincidence*, Time (Feb. 17, 2017, 3:44 PM), https://time.com/4674729/immigrations-church-sensitive-policy-concerns/ [https://perma.cc/VN9F-EQJH].

149. Mutanuka, *supra* note 13, at 222.

150. In one case, ICE officials arrested someone at a bus stop "just outside a Portland hospital after watching him leave." ICE asserted that the arrest did not violate their internal policy because it occurred *near*, but not on, the hospital's property. *Id* at 222–23. In another case, ICE arrested several men leaving a homeless shelter housed inside a church. Again, they emphasized that the arrest occurred *near* the protected location, across the street from the church rather than inside it. Aleksandar Dukic et al., *Key Legal Considerations Relating to "Sanctuary Campus" Policies and Practices*, 44 J.C. & U.L. 23, 28 (2018). In a case that made national news, a ten-year-old girl with cerebral palsy was being transferred to another hospital for surgery when she was stopped by U.S. Customs and Border Protection. Officers proceeded to follow her to the hospital and arrested her after she was discharged from surgery. *See* Vivian Yee & Caitlin Dickerson, *10-Year-Old Immigrant Is Detained After Agents Stop Her on Way to Surgery*, N.Y. Times (Oct. 25, 2017), https://www.nytimes.com/2017/10/25/us/girl-cerebral-palsy-detained-immigration.html [https://perma.cc/PQR9-UNU4].

151. Yee & Dickerson, *supra* note 150.

152. *Id.*

153. *Id.*

If an officer violates the Sensitive Locations Policy, ambiguity remains over whether the violation provides any recourse for the detained immigrant. The *Accardi* doctrine stands to allow courts to bind agencies to their own policies.[154] Various courts have hinted that guidance and policy directives could become less voluntary when violation could potentially harm the rights of individuals.[155] This doctrine is characterized as forbidding agencies from violating "their own rules and regulations to the prejudice of others."[156] Given the statutory right to emergency care created under EMTALA, violations of the Sensitive Locations Policy that penalize an immigrant for seeking emergency care implicate the rights of individuals, invoking the *Accardi* doctrine.[157] In *Ixchop-Perez v. Barr*, the Ninth Circuit remanded to the Board of Immigration Appeals, requesting it consider the *Accardi* doctrine's impact on the Sensitive Locations Policy following an immigrant's

154. Battle v. Fed. Aviation Admin., 393 F.3d 1330, 1336 (D.C. Cir. 2005); Joseph T. Small, Jr., *Criminal Prosecutions Initiated by Administrative Agencies: The FDA, the* Accardi *Doctrine and the Requirement of Consistent Agency Treatment*, 78 J. Crim. L. & Criminology 87, 116–17 (1987); Ixchop-Perez v. Barr, 821 F. App'x 690, 694–95 (9th Cir. 2020) (citing United States *ex rel.* Accardi v. Shaughnessy, 347 U.S. 260 (1954)).

155. Alcaraz v. Immigr. & Naturalization Serv., 384 F.3d 1150, 1162 (9th Cir. 2004) (quoting Morton v. Ruiz*,* 415 U.S. 199 (1974)) ("Where the rights of individuals are affected, it is incumbent upon agencies to follow their own procedures."). At issue in *Alcaraz,* the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("IIRIRA") modified eligibility requirements for suspension of deportation. To avoid retroactively disadvantaging otherwise eligible applicants, section 309(c)(3) of the IIRIRA delegates authority to the Attorney General to terminate deportation cases predating the IIRIRA. This process, called "repapering," was not codified in a formal rule but was outlined through various memoranda issued by the Immigration and Naturalization Services ("INS") acting under the Attorney General's delegated authority. After the Alcaraz family applied and was denied for repapering, they appealed to the courts. The Court, reviewing the appeal, noted that section 309(c)(3) grants broad discretion to the Attorney General, suggesting judicial review is inapplicable under *Heckler v. Chaney*. However, they found that the memoranda issued by the INS created guidelines to permit such review. Referring to the *Accardi* doctrine which holds that some agency memoranda can bind an agency, the Court remanded for the Board of Immigration Appeals to consider in the first instance whether the doctrine bound the INS.

156. *See, e.g.*, *Battle*, 393 F.3d at 1336 ("*Accardi* has come to stand for the proposition that agencies may not violate their own rules and regulations to the prejudice of others.").

157. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (1986) ("In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.").

arrest in violation of the policy.[158] Considering the presently insufficient remedies for violations of administrative policy, hospitals seeking to protect immigrant patients should preemptively cite the Sensitive Locations Policy, perhaps to prohibit ICE agents from entering without a legally enforceable mandate.[159]

On January 21, 2025, DHS released a statement that Secretary Bejamine Huffman rescinded the Biden Administration's version of the Sensitive Locations Policy.[160] However brief, the statement from the DHS spokesperson cited criminals hiding "in America's schools and churches to avoid arrest" as the basis for his memorandum.[161] The memo further spoke of not wanting to "tie the hands of our brave law enforcement, and instead trust[] them to use common sense."[162] Such a policy, far from a compete rejection of immigrant health, focuses on more traditional sanctuary schools and churches (which seek to protect the individual primarily from immigration enforcement itself) compared to hypothetical "sanctuary hospitals" (which primarily seek to treat the individual, while secondarily requiring the patient's maintained presence in the hospital and country). The references to officer autonomy and "common sense" indicates a return to Bush-era perspectives on sensitive locations, albeit with a further emphasis on individual officer autonomy.[163] While the current administration presents an uncertain and chaotic legal landscape, the previous Trump Administration demonstrates some recognition of the need to protect access to health care through immigration enforcement discretion. During the COVID-19 pandemic, the first Trump Administration's DHS released a statement affirming its commitment to the protected areas policy and agreeing that "[i]ndividuals should not avoid seeking medical care because they fear civil immigration enforcement."[164] It appears that even in the most hostile of regimes, some form of an immigrant right to health endures.

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158. 821 F. App'x at 695 ("Because the IJ and BIA did not address whether the *Accardi* doctrine, properly understood, governs the directive, we grant the petition in part. We remand for 'further factual development regarding the nature and extent of agency statements regarding' arrests at sensitive locations and a determination of whether there was a policy that bound the agency.").

159. *Our Toolkit*, DOCTORS FOR IMMIGRANTS, https://doctorsforimmigrants.com/ourwork/#ourtoolkit [https://perma.cc/Q5Q6-GNEM].

160. Trump Administration DHS Press Release, *supra* note 6.

161. *Id.*

162. *Id.*

163. *Id.*

164. *Updated ICE Statement on COVID-19,* IMMIGR. & CUSTOMS ENF'T, U.S. CUSTOMS & BORDER ENF'T (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19 [https://perma.cc/6GNU-H38J].

## III. Federal Preemption of State Law

U.S. common law strongly and repeatedly affirms the exclusive power of the federal government to regulate and control immigration,[165] based on the many links between immigration and foreign policy, including foreign governments' expectations of fair treatment of their nationals by the U.S. federal government.[166] The idea that state interference in this legal realm hampers national interests, including foreign policy goals, underscores federal preemption challenges.[167] Most cases focus on foreign policy implications of policies directed at lawful immigrants. However, *Arizona v. United States* recognized this preemptive effect for policies directed at undocumented immigrants as well, finding that "[p]erceived mistreatment of aliens in the United States may lead to harmful reciprocal treatment of American citizens abroad."[168] As a result, any immigration-related state law, including those protecting immigrants' access to health care, risks preemption under federal law.[169] "Conflict preemption" serves to strike down any state law that "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[170] In addition to explicit claims from the federal government of exclusivity in an area, i.e., "express preemption," "field preemption" restricts state power in instances when "Congress has legislated so comprehensively that it has left no room for supplementary state legislation."[171] Determining whether field preemption applies requires line-drawing of the field(s) in which the state and federal law conflict and whether the state law intrudes on a field wholly occupied by federal law.[172]

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165. DeCanas v. Bica, 424 U.S. 351, 354–55 (1976) ("Power to regulate immigration is unquestionably exclusively a federal power.").

166. Lucas Guttentag, *Immigration Preemption and the Limits of State Power: Reflections on* Arizona v. United States, 9 Stan. J.C.R. & C.L. 1, 31 (2013).

167. *See, e.g.*, Chy v. Freeman, 92 U.S. 275, 280 (1875) ("The passage of laws which concern the admission of citizens and subjects of foreign nations to our shores belongs to Congress, and not to the States . . . . If it be otherwise, a single State can, at her pleasure, embroil us in disastrous quarrels with other nations.").

168. Arizona v. United States, 567 U.S. 387, 395 (2012); *see* Guttentag, *supra* note 166, at 17.

169. Guttentag, *supra* note 166, at 27 ("A key principle emerging from this analysis is that the procedural and structural limits embedded in the immigration statute constitute not just self imposed limits on federal agents but broader federal policy judgments that apply to all immigration enforcement and thereby impose preemptive parameters on state authority.").

170. *Arizona*, 567 U.S. at 399–400 (citing Fla. Lime & Avocado Growers v. Paul, 312 U.S. 132, 142–43 (1963)).

171. R.J. Reynolds Tobacco Co. v. Durham Cnty., 479 U.S. 130, 140 (1986).

172. Kansas v. Garcia, 589 U.S. 191, 208 (2020).

A finding of federal preemption under any theory of conflict, express, or field preemption requires an individual assessment of each case and the allegedly conflicting statutory language.[173] Further, the Supreme Court hesitates to imply preemption, emphasizing that "it is Congress rather than the courts that preempts state law."[174] However, the Court also narrowly construed expressly preemptory language found in the Immigration Reform and Control Act of 1986 ("IRCA") in *Kansas v. Garcia*.[175] At issue, a Kansas benefits fraud law resulted in the arrest of three undocumented workers who used false Social Security numbers on work tax forms.[176] The IRCA expressly preempts state and local laws "imposing civil or criminal sanctions (other than through licensing and similar laws) upon those who employ, or recruit or refer for a fee for employment, unauthorized aliens."[177] Holding that the "plain wording of the clause . . . necessarily contains the best evidence of Congress' preemptive intent,"[178] the Court focused on the federal statute's focus on *employers* to reject the challenge to the state law regulating *employees*.[179] The Court similarly dismissed the parallel field preemption challenge.[180] The respondents analogized to *Arizona v. United States*, a prior Supreme Court decision that held the Immigration and Nationality Act and IRCA preempted Arizona state law.[181] In its *Kansas* holding, the Court distinguished the *Arizona* decision as focusing on discrete areas of federal interest, including the employment of undocumented people and the tracking and detention of undocumented people within U.S. borders.[182] In contrast, the Court found no strong federal interest or legislative scheme with respect to the state employment-related tax information at issue in *Kansas*, including

173. *See, e.g.*, Wyeth v. Levine, 555 U.S. 555, 565 (2009) (quoting Medtronic, Inc. v. Lohr, 518 U.S. 470, 486 (1996) ("[There are] two cornerstones of our pre-emption jurisprudence. First, 'the purpose of Congress is the ultimate touchstone' in every pre-emption case."); *Medtronic, Inc.,* 518 U.S. at 486 ("Congress' intent, of course, primarily is discerned from the language of the pre-emption statute and the statutory framework surrounding it.").

174. Chamber of Com. of U.S. v. Whiting, 563 U.S. 582, 607 (2011) (quoting Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 111, 112 (1992)).

175. *Garcia*, 589 U.S. at 208.

176. *Id.* at 199.

177. 8 U.S.C. § 1324a(h)(2).

178. *Whiting*, 563 U.S. at 594 (quoting CSX Transp., Inc. v. Easterwood, 507 U.S. 658, 664 (1993)).

179. *Garcia*, 589 U.S. at 208.

180. *Id.*

181. *Id.* at 210 (discussing Arizona v. United States, 567 U.S. 387 (2012)).

182. *Id.* at 209.

state tax forms not required under the federal IRCA.[183] As a result, courts have yet to develop a predictable common law with respect to federal immigration law preemption.

Distinct from immigration law preemption, as a matter of statutory law, HIPAA expressly permits state regulation in the field of health privacy so long as the regulations are "more stringent" than HIPAA.[184] The law defines "more stringent" as a law that prohibits or restricts a disclosure that HIPAA otherwise permits.[185] For example, California's health privacy laws prohibit disclosure of abortion-related health information but expressly excepts disclosures required by federal law.[186] Such a law protects reproductive privacy for all patients, including immigrant patients fearful of disclosure to immigration enforcement, while escaping federal preemption. In addition to states, municipalities and counties can similarly enact various "health sanctuary" laws to protect the health privacy and access of residents, even in areas where the state may forbid "sanctuary policies."

## IV. Protecting Sanctuary Laws

Despite all the federal affirmations of non-interference in the realm of immigrant health discussed in Part II, some states have sought to restrict any form of immigrant protection deemed contrary to federal immigration objectives.[187] These "anti-sanctuary" laws often, paradoxically, base their authority to regulate this federal issue in misinterpretations of, and/or incorrect assumptions about, the federal immigration objectives they purport to supplement and uphold.[188] Additionally, section 1373 of title 8 of the United States Code purports to ban any policies that restrict information sharing with DHS. However, at the state and local level, careful legislative drafting can ensure that

183. *Id.* (holding that a federal I-9 preempts state use of information contained within an I-9).

184. 45 C.F.R. § 160.203(b).

185. 45 C.F.R. § 160.202.

186. Cal. Civ. Code § 56.108 (West 2022) (restricting sharing of abortion-related health information); *id.* § 56.109 (West 2023) (restricting sharing of gender-affirming care-related health information).

187. *See, e.g.*, Ark. Code Ann. § 14-1-103 (West 2020) (broadly defining prohibited sanctuary policies to include any requirement that ICE obtain a warrant before complying with "legal and valid" ICE requests); Tenn. Code Ann. § 7-68-103 (West 2024) ("No local governmental entity or official shall adopt or enact a sanctuary policy. A local governmental entity that adopts or enacts a sanctuary policy is ineligible to enter into any grant contract with the department of economic and community development until the sanctuary policy is repealed, rescinded, or otherwise no longer in effect."); Fla. Stat. § 908.104 (2024).

188. Fla. Stat. § 908.104 (2024).

laws and policies that protect the health rights of residents, including immigrant residents, are not invalidated under section 1373 or a state "anti-sanctuary" law.

"Sanctuary" generally refers to any policy that insulates immigrants from federal law enforcement or surveillance.[189] The sanctuary movement began in the 1980s as a form of religious expression, viewing deportation as antithetical to Judeo-Christian beliefs.[190] Churches defied anti-alien smuggling statutes and harbored undocumented congregants facing deportation.[191] While some asserted authority under Nuremburg principles of personal accountability, others found authority in moral principles demanding legal disobedience and referred to sanctuary churches as a new "Underground Railroad."[192] Today, sanctuary policies rely on legal principles of federalism and preemption to establish legitimacy. These laws, also referred to as "non-cooperation laws," often come in the form of states or municipalities restricting information sharing with immigration officers and refusing access to private spaces.[193] Despite the hostility with which federal law regards undocumented patients, clear arguments exist in favor of state and local health sanctuary policies that navigate around the legal restrictions in place.

### *A. 8 U.S.C.A. § 1373*

Section 1373 of title 8 of the United States Code functions as a federal "anti-sanctuary" law that prohibits federal, state, and local policies that discourage or restrict information-sharing with DHS.[194]

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189. *See* Ava Ayers, *Missing Immigrants in the Rhetoric of Sanctuary*, 2021 WIS. L. REV. 473, 486 (2021). California provides multiple examples of sanctuary policies, such as a provision of its state laws prohibiting employers from allowing immigration enforcement agents into "nonpublic areas of a place of labor [. . .unless] the immigration enforcement agent provides a judicial warrant." CAL. GOV'T CODE § 7285.1 (West 2018). Another law prohibits local and state governments from imposing electronic employment verification on employers. The primary exception is when such verification is required by federal law or as a condition of receiving federal funds. CAL. LAB. CODE §§ 2811–2814 (West 2024).

190. Rose Cuison Villazor & Pratheepan Gulasekaram, *Sanctuary Networks*, 103 MINN. L. REV. 1209, 1228–29 (2019).

191. Susan Gzesh, *Central Americans and Asylum Policy in the Reagan Era*, MIGRATION POL'Y INST. (Apr. 1, 2006), https://www.migrationpolicy.org/article/central-americans-and-asylum-policy-reagan-era [https://perma.cc/RE7P-4N4S].

192. *Id.*

193. *See, e.g.*, Jennifer C. Critchley & Lisa J. Trembly, *Historical Review, Current Status and Legal Considerations Regarding Sanctuary Cities*, 306 N.J. LAW. 32 (2017) ("While there is no single definition of a sanctuary city, it generally means a city where local law enforcement will decline to aid the federal government in locating and detaining undocumented immigrants."); S.F., CAL., ADMIN. CODE §§ 12H, 12I (1989) (San Francisco's sanctuary city ordinance).

194. 8 U.S.C.A. § 1373 (West).

Specifically, the law forbids any government entity or official from preventing the sharing of information about one's citizenship or immigration status.[195] Navigating around this, states and localities have found ways to protect immigrant residents while asserting compliance with section 1373. The city of San Francisco enacted an ordinance and guidance that limited sharing information with federal immigration officials, with a crucial savings clause for legally required disclosures.[196] Among other information, the ordinance and guidance restricted sharing the release dates of undocumented inmates in the city.[197] The Ninth Circuit held that section 1373, under a textualist analysis, only prohibited limitations on the sharing of an individual's immigration status, rendering the ordinance in compliance with section 1373.[198] Other circuits read similar information-restricting state laws to comply with section 1373.[199]

Adding to the complexity, section 1373 limits state governmental actors from infringing on federal governmental interests. The Supreme Court recently clarified in *Murphy v. NCAA* that federal law only preempts when it regulates private parties, but not governmental actors, based on principles of state autonomy, anti-federal commandeering, and the federal authority to regulate private actors.[200] In *Murphy*, a federal law prohibited states from enacting laws that authorized gambling.[201] As the law created a limitation on state governments rather than regulating private parties, the Court found the federal provision incapable of actually preempting conflicting state laws.[202] In addition, the Tenth Amendment, granting power to the states, prohibits the federal government from

195. *Id.* A community hospital is considered a "governmental entity" and a "political subdivision" under several states' tort laws. *See* MISS. CODE ANN. § 11-46-1(g), (i) (West 2024); OKLA. STAT. ANN. tit. 51, § 152(11)(d) (2024). In Illinois, courts have looked to factors including the use of private funding over public sources and taxes and the amount of governmental control exercised over the facility. Carroll v. Paddock, 317 Ill. App. 3d 985, 994–95 (App. Ct. 2000), *aff'd*, 199 Ill. 2d 16 (2002) ("We conclude that the Hospital is not government funded, nor is it almost entirely government funded. Further, the Hospital has not shown that it participates in the business of government.").

196. Steinle v. City & Cnty. of S.F., 230 F. Supp. 3d 994, 1003 (N.D. Cal. 2017), *aff'd*, 919 F.3d 1154 (9th Cir. 2019).

197. *Id.*

198. *Id*. at 1014–16; City & Cnty. of S.F. v. Barr, 965 F.3d 753, 757 (9th Cir. 2020).

199. *See supra* Part III (discussing federal preemption).

200. 584 U.S. 453, 477 (2018) ("To preempt state law . . . since the Constitution 'confers upon Congress the power to regulate individuals, not States' . . . [federal law] must be read as one that regulates private actors."); *see also* Ocean Cnty. Bd. of Comm'rs v. Atty. Gen. of N.J., 8 F.4th 176, 181 (3d Cir. 2021).

201. *Murphy*, 584 U.S. at 458–59.

202. Kasia Parecki, *Colorado Examples and Six Paths Forward*, DENV. L. REV. F. Vol. 97, Article 15, 15 (2019).

"commandeering" state power and state actors to enact its will.[203] While the Supreme Court previously established the inability of the federal government to mandate state legislation, the Supreme Court extended this to prohibitions as well, finding little difference between the two.[204] This holding renders federal laws prohibiting certain forms of state legislation presumptively unconstitutional. As a result, some courts have extended these principles to section 1373 to take away its preemptive "bite," essentially allowing state laws to stand in defiance of the potentially unconstitutional federal law.[205]

From another angle, throughout the 2010s, in an attempt to provide some enforcement measures for section 1373, Congress proposed multiple bills requiring compliance with section 1373 as a condition of federal funding.[206] However, none of these were signed into law.[207] Later, President Trump issued Executive Order 13768, which, in part, directed the Attorney General of the United States to withhold federal grants from sanctuary jurisdictions.[208] The Department of Justice subsequently required compliance with section 1373 in order to continue receiving the Byrne Justice Assistance Grant, which provides federal money for "additional personnel, equipment, supplies, contractual support, training, technical assistance, and information systems for criminal justice or civil proceedings."[209] This led the First, Second, Third, Seventh, and Ninth Circuits to render differing holdings on the issue, with the Supreme Court denying certiorari review to address this split.[210] Some circuits found the conditions not substantially related to the purpose of the grant,

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203. Parecki, *supra* note 202, at 1.

204. *Murphy*, 584 U.S. at 480 ("Neither respondents nor the United States contends that Congress can compel a State to enact legislation, but they say that prohibiting a State from enacting new laws is another matter . . . . [T]his distinction is empty. . . . The basic principle—that Congress cannot issue direct orders to state legislatures—applies in either event.").

205. *See Ocean Cnty.*, 8 F.4th at 181. In contrast, the 7th Circuit came to its holding avoiding the implications of *Murphy*. McHenry Cnty. v. Raoul, 44 F.4th 581, 588 (7th Cir. 2022) ("In the end, however, we need not map the precise limits of *Murphy*'s preemption holding.").

206. Heather Odell, Comment, *Are Sanctuary Cities Safe? Evaluating the DOJ's Authority to Impose Immigration Conditions on Criminal Justice Grants*, 62 B.C. L. Rev. E-Supplement II. 102, 106 (2021).

207. *Id.*

208. Exec. Order No. 13,768, 82 Fed. Reg. 8799 (Jan. 25, 2017).

209. 34 U.S.C.A. § 10152 (West 2025).

210. *See* City of Providence v. Barr, 954 F.3d 23, 44 (1st Cir. 2020); N.Y. v. U.S. Dep't of Just., 951 F.3d 84, 123 (2d Cir. 2020), *cert. denied*, 141 S. Ct. 1291 (2021); City of Chicago v. Sessions, 888 F.3d 272, 292 (7th Cir. 2018), *reh'g en banc granted in part on other grounds, vacated in part on other grounds*, No. 17-2991, 2018 WL 4268817 (7th Cir. June 4, 2018), *reh'g en banc vacated*, No. 17-2991, 2018 WL 4268814 (7th Cir. Aug. 10, 2018); City of Philadelphia v. Att'y Gen., 916 F.3d 276, 279

holding that the Attorney General lacks statutory authority to impose the conditions.[211] The First and Ninth Circuit construed the Attorney General's authority to impose "special conditions" on grants to not extend to the kind of limitations included in the executive order.[212] The Second Circuit, standing alone, read the statute to permit the Attorney General to impose "special conditions" on grants as permitting the forced compliance with section 1373.[213] It also held that application of section 1373 did not violate the anticommandeering clause.[214] Despite the Second Circuit's diverging holding, the Third and Seventh Circuits held that the law results in the "direction, supervision, or control," of state officers, violating anticommandeering principles."[215] Due to this circuit split, the questions surrounding sanctuary policies and section 1373 remain unsettled.

Nonetheless, this ambiguity suggests potential for courts to further entertain or overlook potential conflicts with section 1373, including within federal law. If governmental actors can be forced to comply with section 1373, declining to share health-related immigration information under HIPAA would provide a valid excuse that compliance with both would be impossible. Furthermore, private actors are not beholden to section 1373 and can design policies they find to be in the best interests of their patients. While section 1373 at first glance seems to prevent the sorts of policies described throughout this Note, conflicting federal mandates to protect patient health information and ensure patient access to emergency care indicate that health care is a unique area where the general rule is less applicable.

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(3d Cir. 2019)*, reh'g denied* (June 24, 2019); City of Los Angeles v. Barr, 941 F.3d 931, 934 (9th Cir. 2019).

211. Odell, *supra* note 206, at 111–21.

212. *City of Providence*, 954 F.3d at 43–44; Colorado v. U.S. Dep't of Just., 455 F. Supp. 3d 1034, 1040 (D. Colo. 2020) (finding that the required conditions did not bear a sufficient connection to the grant's purpose and that the Attorney General was not authorized to impose the conditions as a result).

213. *N.Y. v. U.S. Dep't of Just.*, 951 F.3d at 101.

214. *Id.*

215. *City of Philadelphia*, 916 F.3d at 291; City of Chicago v. Barr, 961 F.3d 882, 886 (7th Cir. 2020). *See also* Jessica Bulman-Pozen, *Preemption and Commandeering Without Congress*, 70 STAN. L. REV. 2029, 2045–47 (2018) (arguing that § 1373 violates the 10th Amendment anticommandeering doctrine). *But see* City of Chicago v. Barr, 513 F. Supp. 3d 828, 833 (N.D. Ill. 2021) ("Accordingly, the Court withdraws its declaration that §§ 1373 and 1644 are unconstitutional" due to the 7th Circuit reaching its decision without addressing the issue of § 1373's constitutionality); *N.Y. v. U.S. Dep't of Just.*, 951 F.3d at 108–09 (holding that § 1373 does not violate the anticommandeering doctrine because "[i]t does not mandate that State or local law enforcement authorities cooperate with federal immigration officers," but simply "requires only that nothing be done to prohibit voluntary communication about citizenship or immigration status among such officials").

### *B. State Laws*

Just as the federal government sought to address the proliferation of sanctuary jurisdictions, state governments engage in similar efforts with respect to sanctuary cities.[216] Some state anti-sanctuary state laws refer to section 1373 and establish penalties for its violation.[217] Others use broad language; Indiana and North Carolina prohibit any restriction on involvement with immigration officials to anything "less than the full extent permitted by federal law."[218] The definition of prohibited conduct varies by state: Georgia's definition includes sanctuary policies restricting communication or cooperation with federal officials,[219] Texas's definition includes patterns or practices that materially limit the enforcement of immigration laws,[220] and Iowa even prohibits unwritten, informal policies.[221] Enforcement measures also vary by state. Georgia established an "Immigration Enforcement Review Board" to review complaints about Georgia's anti-sanctuary law.[222] Tennessee also allows for citizen complaints.[223] However, similar to section 1373, the state anti-sanctuary laws primarily provide revocation of funds as the primary enforcement mechanism.[224] In contrast to federal law, state anti-sanctuary laws do not raise anti-commandeering issues, but rather municipal home rule issues.[225]

Each state determines the proper allocation of power between itself and lower levels of government within it.[226] Municipalities legislate subordinately to states and rely on their home state to delegate power. Under Dillon's Rule, a legal principle that favors state supervision

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216. Rick Su, *Have Cities Abandoned Home Rule?*, 44 Fordham Urb. L.J. 181, 187 (2017) ("[A]s the original sponsor of the [anti-sanctuary] bill explained, the target of the law was actually Arizona cities like Phoenix, Tucson, and Flagstaff, which had enacted policies limiting the circumstances in which local law enforcement officials could participate in federal immigration enforcement.").

217. Tenn. Code Ann. § 7-68-102(4)(C) (West 2019).

218. Ind. Code Ann. § 5-2-18.2-4 (West 2024); N.C. Gen. Stat. Ann. § 153A-145.5 (West 2024).

219. Ga. Code Ann. § 36-80-23 (West 2024).

220. Tex. Gov't Code Ann. § 752.053(a)(2) (West 2017).

221. Iowa Code § 27A (2025).

222. Amy Pont, *Sanctuary Policies: Local Resistance in the Face of State Anti-Sanctuary Legislation*, 21 CUNY L. Rev. 225, 242–43 (2018).

223. Tenn. Code Ann. § 7-68-103 (West 2024).

224. Iowa Code § 27A.9 (2025).

225. *See* Fred O. Smith, Jr., *Federalism in the States: What States Can Teach About Commandeering*, 2021 Wis. L. Rev. 1257, 1265 (2021).

226. *See, e.g.*, Hunter v. City of Pittsburgh, 207 U.S. 161, 178 (1907); National League of Cities, *Principles of Home Rule for the 21st Century*, 100 N.C. L. Rev. 1329, 1330 (2022) ("Because the Federal Constitution is silent about local governments, home rule is defined by state law.").

of localities, localities require specific enabling legislation from the state to legislate, with courts construing ambiguities in these enabling statutes in favor of state rule.[227] On the other end of the spectrum, state constitutions sometimes delegate all legislative authority to the localities while states retain the authority to restructure or preempt local law.[228] No matter what, localities generally retain broad powers to self-rule over matters of local concern.[229] Matters of local concern referenced in the text of these laws often include the health of the jurisdiction's residents.[230] This power over local matters also permits regulation over matters of "mixed" state and local concern.[231] Naturally, however, courts strike down local laws that conflict with state laws in these areas.[232]

227. Dillon's Rule is a legal interpretation of municipal power that favors state control of political subdivisions like counties and municipalities, hence the requirement for state enabling legislation to authorize a locality to legislate. This rule is named after Judge John Forrest Dillon who espoused this principle after recognizing the uniqueness of American municipalities and the lack of legal precedent from British common law. *See generally* JOHN FORREST DILLON, TREATISE ON THE LAW OF MUNICIPAL CORPORATIONS (1872); City of Clinton v. Cedar Rapids & Mo. R.R. Co., 24 Iowa 455 (1868); Su, *supra* note 216; Albany Area Builders Ass'n v. Town of Guilderland, 74 N.Y.2d 372, 376 (1989) ("It is a familiar principle that the lawmaking authority of a municipal corporation, which is a political subdivision of the State, can be exercised only to the extent it has been delegated by the State."); DoorDash, Inc. v. City of New York, 692 F. Supp. 3d 268, 298 (S.D.N.Y. 2023).

228. The New York constitution and the Municipal Home Rule Law, for example, require that these powers granted to local governments be "liberally construed." N.Y. CONST. art. IX, § 3(c); N.Y. MUN. HOME RULE LAW art. 6, § 51 (McKinney 2024). Maine extends the full extent of legislative power to municipalities so long as they are not preempted implicitly or expressly under ME. STAT. tit. 30-A, § 4351 (1989). California follows this model as well, granting full authority over "municipal affairs" except as modified by state law. *See* CAL. CONST. art. XI, §§ 5, 7; *see also* TEX. CONST. art. XI, § 5 (granting authority to cities with populations over 5,000 to adopt and/or amend municipal charters by public vote).

229. GA. CONST. art. IX, § 2, ¶ II; N.Y. CONST. art. IX, § 2; GA. CODE ANN. § 36-35-3 (West 2024). New York's Municipal Home Rule Law permits local governments to enact laws relating to local affairs that are 1) not expressly preempted by state law, 2) not inconsistent with the state Constitution or statutes, and 3) for "[t]he government, protection, order, conduct, safety, health and well-being of persons or property therein." N.Y. MUN. HOME RULE LAW § 10(1)(a)(12) (McKinney 2024).

230. *See, e.g.*, N.Y. MUN. HOME RULE LAW § 10(1)(a)(12) (McKinney 2024); ILL. CONST. art. VII, § 6(a); 53 PA. STAT. AND CONS. STAT. ANN. § 2962 (West 1996).

231. For example, under Colorado law, if a home rule ordinance and a state statute conflict with respect to a local matter, the home rule provision supersedes the conflicting state provision. Caldara v. City of Boulder, 955 F.3d 1175 (2020), *cert. denied*, 141 S. Ct. 849 (2020).

232. City of Brookside Vill. v. Comeau, 633 S.W.2d 790, 796 (Tex. 1982) ("Clearly, an ordinance which conflicts or is inconsistent with state legislation is impermissible."). Many state constitutions grant legislative power to localities over a broad number of subject matters so long as it is "not in conflict with general laws." *See, e.g.*, OHIO CONST. art. XVIII, § 3; CAL. CONST. art. XI, § 7.

The power of localities to regulate health,[233] combined with the strong link between immigration-based system avoidance and the health of the community, likely renders potential ordinances relating to immigrant health a matter of mixed local and state concern. Therefore, sanctuary jurisdictions in anti-sanctuary states face preemption concerns unless the courts interpret the local and state law harmoniously. As a result, tailored sanctuary policies protecting immigrant health rights but permitting legally mandated disclosures and actions, while far short of the protections that immigrant residents deserve, can coexist with anti-sanctuary state laws and still insulate immigrant patients seeking care.

### *C. Affirmative Actions in Sanctuary Jurisdictions*

Despite the complexities and ambiguities in this area of the law, a variety of actors possess a variety of powers and tools to protect immigrant health, including state and municipal health sanctuary provisions. For example, New York City's Human Rights Law includes immigration and citizenship status as protected classes in its public accommodations laws.[234] The City's Commission on Human Rights subsequently issued guidance stating that it interprets the Human Rights Law to prohibit threats or attempts to contact immigration authorities when motivated by discriminatory animus based on one's actual or perceived immigration status and/or national origin.[235] This law only allows providers of public accommodations, which include many health care facilities, to inquire about immigration status when relevant to the services provided or required to determine benefits eligibility.[236]

Furthermore, health care providers seeking to protect immigrant patients can coordinate around the current legal landscape. First and foremost, hospitals can designate private spaces for patients. This would allow immigrant patients to reduce their interaction with immigration

233. Health is considered a matter of local concern in New York. *See* N.Y. CONST. art. IX, § 2(c)(10).

234. *See* N.Y.C. ADMIN. CODE tit. 8.

235. N.Y.C. COMM'N ON HUM. RTS., LEGAL ENFORCEMENT GUIDANCE ON DISCRIMINATION ON THE BASIS OF IMMIGRATION STATUS AND NATIONAL ORIGIN 23 (2019). This notice details that threats to report someone to ICE can be discriminatory if in retaliation for a tenant or employee exercising their rights against a landlord or employer, respectively. The guidance notes that "while reporting a violation of the law to the police is otherwise permitted, it is a violation of the NYCHRL when such action is taken or threats to take such action are made based solely on a discriminatory or retaliatory motive." *Id.*

236. *Id*. The guidance further discourages "unnecessary" inquiries into patrons of public accommodations. When inquiries are relevant to services offered by a provider, they should be limited to necessary inquiries. When required by law, the provider should explain that the inquiry is required by law.

officials and protect them from other unwanted interactions with law enforcement.[237] Providers can examine their policies about the identification required for patient registration, and whether other forms of identification may be substituted.[238] As the focus on immigrant health grows, Dr. Altaf Saadi created a toolkit to address health care avoidance among immigrant patients.[239] Portrayed via cartoon informational videos, Dr. Saadi similarly advocates for designated private spaces.[240] Additional recommendations from Dr. Saadi include establishing policies to address ICE attempts to enter premises, discussing immigration status with patients but limiting written records of such conversations, designating an immigration task force to keep up-to-date on legal changes, establishing trusted legal partnerships for patient referrals, and increasing patients' awareness of their rights.[241]

## Conclusion

The myriads of federal protections for immigrant health care establish a solid basis from which passionate advocates can strategize and advocate for further patient protections. Private actors can develop policies that restrict information sharing, and health care professionals can utilize HIPAA to protect patient information. Governmental actors can utilize sanctuary policies within the confines of existing federal limitations to supplement federal health protections, further encouraging access to care for all residents. Nonetheless, the existing legal tools are wildly insufficient to fully address the real fears of patients in using health care services.

This Note does not touch on every possible legal immigrant health protection,[242] but it provides some useful examples of protective actions hospitals and institutions may take. Most importantly, this Note serves to emphasize the importance of immigrants' ability to safely access health

237. Makhlouf, *Health Care Sanctuaries*, *supra* note 1, at 64–65.

238. *Id.*

239. Altaf Saadi, Doctors for Immigrants, Welcoming and Protecting Immigrants in Healthcare Settings: A Toolkit Developed from a Multi-State Study (2020), https://doctorsforimmigrants.com/wp-content/uploads/2020/01/WelcomingProtectingImmigrants-toolkit-3.pdf [https://perma.cc/9TRP-9TTN].

240. *Our Videos*, Doctors for Immigrants, https://doctorsforimmigrants.com/ourwork/#ourvideos [https://perma.cc/UK4X-BU8N].

241. *Id.*

242. For example, further research could be done on workarounds for federal funding restrictions. The Personal Responsibility Act expressly does not apply to public health programs, such as vaccination clinics, which could provide another tool to reach undocumented communities. *See* Wendy E. Parmet, *The Worst of Health: Law and Policy at the Intersection of Health & Immigration*, 16 Ind. Health L. Rev. 211, 219 (2019).

care services and the power of a broad range of actors to utilize and expand upon existing legal frameworks to further this end. Ultimately, the sociological phenomenon of immigrant health care avoidance is largely impacted by real legal threats and social perceptions of individuals' safety. However, by changing legal realities to truly protect and care for the health of immigrant patients, social perceptions will gradually shift as well.