ARTICLE

INTERAGENCY DYNAMICS IN MATTERS OF HEALTH AND IMMIGRATION

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ABSTRACT

When Congress delegates authority to an executive agency, it tells us something important about the expertise that Congress wishes to harness in policymaking on an issue. In the legal literature on interagency dynamics and cooperation, issues at the nexus of health and immigration are largely understudied. This Article extends this literature by examining how delegations of authority on issues at the intersection of health and immigration influence policymaking. In an analysis of how administrative law models apply to three topics in the shared regulatory space of the Department of Health and Human Services ("HHS") and the Department of Homeland Security ("DHS"), I demonstrate that health-related expertise is frequently marginalized rather than leveraged. Specifically, health policy expertise and priorities are subordinated to an administration's immigration policy preferences, contravening Congress's purpose in establishing related or overlapping jurisdictional assignments to HHS and DHS. Administrative law theories of shared regulatory space inadequately account for the predictable subordination of certain policy areas to others, as illustrated in this Article's case studies on issues at the intersection of health and immigration. The routine capitulation of health policy actors to immigration enforcement actors reveals a need to extend the theory to accommodate this evidence. Although structural solutions may address some sources of health policy marginalization, effective dissemination of health-related expertise in matters of health and immigration may require changing the

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way that political leaders prioritize health issues and acknowledge collateral consequences of immigration enforcement.

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INTRODUCTION

When Congress delegates related or overlapping authority to agencies with different missions, priorities, and expertise, it typically seeks to leverage those differences to improve policy development and implementation. However, in high-profile matters at the intersection of health and immigration policy, it is not unusual to observe health policy goals and expertise subordinated to immigration enforcement priorities. Consider these scenarios: High-ranking officials underestimate the profound consequences of family separation on the health and wellbeing of immigrant children when developing a policy intended to deter migrant families from coming to the southern U.S. border. The politically appointed Director of the Centers for Disease Control and Prevention ("CDC"), under pressure from the White House, disregards public health experts' disapproval of pandemic-related border restrictions. The Centers for Medicare and Medicaid Services ("CMS"), attempting to deflect criticism that the agency is soft on immigration, diverges from longstanding policy by specifically excluding beneficiaries of Deferred Action for Childhood Arrivals ("DACA") from eligibility for subsidized health coverage. These examples reveal a pattern of prioritizing immigration policy concerns over health policy concerns on issues within the shared regulatory space of the Department of Health and Human Services ("HHS") and the Department of Homeland Security ("DHS").

The theoretical literature on shared regulatory space provides a useful framework for analyzing how agencies interact in policymaking on issues within their shared regulatory space. In a landmark article, Professors Jody Freeman and Jim Rossi describe the concept of shared regulatory space succinctly: It is when "Congress . . . assigns more than one agency the same or similar functions or divides authority among multiple agencies, giving each responsibility for part of a larger whole."[1] This Article adopts a broad conception of shared regulatory space that includes administrative areas where multiple agencies have relevant expertise, a significant stake in the outcome of policymaking, or authority to regulate a related topic, even if Congress has not assigned overlapping responsibility to multiple agencies.[2] Shared regulatory space is common and

[1] Jody Freeman & Jim Rossi, *Agency Coordination in Shared Regulatory Space*, 125 HARV. L. REV. 1131, 1134 (2012). Other scholars have used different terms to describe shared regulatory space. *See, e.g.*, Sharon B. Jacobs, *The Statutory Separation of Powers*, 129 YALE L.J. 378, 395 (2019) ("[A] statutory separation of powers will seek to divide authority among administrative actors so that no one actor can fully control the direction of substantive policy within a discrete subject-matter area."); Daniel A. Farber & Anne Joseph O'Connell, *Agencies as Adversaries*, 105 CALIF. L. REV. 1375, 1386 (2017) ("administrative redundancy"); Todd S. Aagaard, *Regulatory Overlap, Overlapping Legal Fields, and Statutory Discontinuities*, 29 VA. ENV'T L.J. 237, 238 (2011) ("regulatory overlap"); Jacob E. Gersen, *Overlapping and Underlapping Jurisdiction in Administrative Law*, 2006 SUP. CT. REV. 201, 210 ("overlapping jurisdiction").

[2] Scholars have identified various categories of shared regulatory space, including broad conceptions similar to the way I use the term in this Article. *See, e.g.*, Joseph Daval, Note,

may even be considered "a defining feature of the American bureaucracy."[3] Scholars have theorized various benefits and challenges of policymaking in shared regulatory space. The benefits, in addition to leveraging agency expertise, can include safeguarding against agency abuses of power, ensuring political accountability, facilitating agency learning, and mitigating presidential power.[4] The challenges relate to conflicting policy objectives and unproductive competition among the agencies involved.[5] Interagency coordination mechanisms are widely heralded as structural interventions to maximize the benefits and minimize the challenges of policymaking in shared regulatory space. Although interagency coordination can increase agency decision costs in the short term,[6] in theory it reduces inefficiency over the long term by supporting decision-making that anticipates and addresses problems, reduces inconsistency and waste, and effectuates Congress's purposes.[7] Agencies operating in shared regulatory space that do not coordinate effectively may be less likely to achieve Congress's purpose in creating shared regulatory space.[8]

HHS and DHS have very different missions, histories, and functions, but share significant regulatory space. HHS—established in 1980, when Congress

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The Problem with Public Charge, 130 YALE L.J. 998, 1040-41 (2021) (observing express overlap or conflict of delegated authority is not required to create tension or conflict between agencies); Freeman & Rossi, *supra* note 1, at 1145 (describing "related jurisdictional assignments" to be "where Congress assigns closely related but distinct roles to numerous agencies in a larger regulatory or administrative regime"); Gersen, *supra* note 1, at 207-14 (identifying conceptual models in which Congress does not clearly authorize any agency to regulate issue in order to create "a race to produce expertise and assert jurisdiction").

[3] Peter Bils, *Policymaking with Multiple Agencies*, 64 AM. J. POL. SCI. 634, 634 (2020); *see also* Graham T. Allison, *Conceptual Models and the Cuban Missile Crisis*, 63 AM. POL. SCI. REV. 689, 698 (1969) ("[F]ew important problems fall within the domain of a single organization thus government behavior relevant to any important problem reflects the independent output of several organizations, partially coordinated by government leaders.").

[4] *See, e.g.*, Jacobs, *supra* note 1, at 384, 387-88, 394 (describing benefits of shared agency authority); Farber & O'Connell, *supra* note 1, at 1386 (acknowledging benefits include longer and more involved decision-making processes); Jason Marisam, *Interagency Administration*, 45 ARIZ. ST. L.J. 183, 191 (2013); Neal Kumar Katyal, *Internal Separation of Powers: Checking Today's Most Dangerous Branch from Within*, 115 YALE L.J. 2314, 2324-27 (2006).

[5] *See* Daval, *supra* note 2, at 1040.

[6] *See* Freeman & Rossi, *supra* note 1, at 1182.

[7] *Id.*; Jacobs, *supra* note 1, at 438-39 (describing how Congress can use interagency coordination to recalibrate authority among agencies when their policies diverge from Congress's priorities).

[8] *See* Rachel E. Sachs, *Encouraging Interagency Collaboration: Learning from COVID-19*, 4 J.L. & INNOVATION 71, 73-74 (2021) (describing how lack of interagency collaboration led to failures in developing adequate COVID-19 tests and in effectively distributing vaccines).

dismantled the Department of Health, Education, and Welfare[9]—is charged with promoting the health and wellbeing of Americans through the provision of health and human services and support of scientific research.[10] Well-known entities within HHS include CDC, CMS, the Administration for Children and Families, the Food and Drug Administration, the National Institutes of Health, and the Indian Health Service.[11] HHS is responsible for a broad range of activities, among them providing care and services to unaccompanied immigrant children ("UCs"), mitigating infectious disease threats, and administering health-supporting public benefit programs for people living in or near poverty.[12] DHS's mission is similarly broad, as it is tasked with protecting the American people and territory, with primary responsibility for securing borders, regulating immigration, and countering terrorism.[13] It was established in 2003, as a new "mega-agency" into which Congress consolidated the functions of more than forty agencies.[14] One of the agencies that was dismantled in the process was the Immigration and Naturalization Service ("INS").[15] Responsibility for immigration services and enforcement was then delegated to new entities within DHS.

Despite their very different missions, HHS and DHS must coordinate on a number of issues. These issues include preventing, assessing, and responding to terrorist threats involving chemical, biological, radiological, and nuclear agents;[16] supporting programs that respond to public health emergencies;[17]

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[9] *Why is CMS in Baltimore?*, CMS.GOV, https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/CMSInBaltimore.pdf [https://perma.cc/JE3U-HVNQ] (last visited Apr. 18, 2023).

[10] *Introduction: About HHS*, HHS.GOV, https://www.hhs.gov/about/strategic-plan/introduction/index.html [https://perma.cc/E3DM-GKJ7] (last updated Mar. 28, 2022) ("The mission of [HHS] is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.").

[11] *HHS Organizational Charts Office of Secretary and Divisions*, HHS.GOV, https://www.hhs.gov/about/agencies/orgchart/index.html [https://perma.cc/CBY7-WE3V] (last updated Sept. 2, 2022).

[12] *See Introduction: About HHS*, *supra* note 10.

[13] *Mission*, HOMELAND SEC., https://www.dhs.gov/mission [https://perma.cc/U4WR-SK6Y] (last updated Feb. 26, 2023) ("With honor and integrity, we will safeguard the American people, our homeland, and our values.").

[14] Freeman & Rossi, *supra* note 1, at 1152-54 (analyzing formation of DHS as example of agency reorganization to improve efficiency and effectiveness).

[15] *See id.*

[16] *See* Public Health Services Act § 319C-1, 42 U.S.C. § 247d-3a(f) (describing consultation and reporting requirements relating to current and emerging threats); § 247d-6b(c)(2) to (4) (describing similar threat response coordination); § 247d-7e(b)(2) (requiring collaboration to develop security countermeasures to protect civilian health from material threats); Homeland Security Act, 6 U.S.C. § 184.

[17] *See, e.g.*, 42 U.S.C. § 247d-4 (regarding maintenance of an information-sharing network to enhance public health emergency response); § 247d-6b(a) (regarding maintenance of Strategic National Stockpile); § 247d-7b (regarding maintenance of health care volunteer

ensuring border and transportation security;[18] securing appropriate placements[19] or the safe repatriation[20] of UCs in federal custody; determining the health eligibility and vaccine requirements for visas and admission to the United States;[21] performing medical examinations of noncitizens;[22] providing health care to detained noncitizens;[23] admitting noncitizen graduates of foreign medical schools;[24] and determining public benefits eligibility for noncitizens.[25]

Issues at the nexus of health and immigration are largely understudied in the legal literature on interagency dynamics.[26] This Article fills the gap by applying

network that is activated during public health emergencies); 6 U.S.C. § 467 (regarding information-sharing during declared and potential public health emergencies).

[18] 6 U.S.C. § 235 (requiring DHS to consult with HHS and other relevant agencies to ensure sharing of information regarding inspection of imported articles).

[19] 6 U.S.C. § 279(b)(2)(A) (requiring interagency consultation); William Wilberforce Trafficking Victims Protection Act of 2008 § 235(c)(3)(C), 8 U.S.C. § 1232(c)(3)(C) (requiring DHS to share information when HHS is determining where to house UCs); § 1232(b)(4) (requiring collaboration in developing procedures to determine age of children in either agencies' custody to protect them from trafficking and exploitation); § 1232(c)(1) (requiring coordination in developing policies to protect UCs from traffickers).

[20] 8 U.S.C. § 1232(a)(1), (5) (requiring collaboration in policy development and joint reporting to Congress).

[21] Immigration & Nationality Act § 212(a)(1)(A), 8 U.S.C. § 1182(a)(1)(A).

[22] 8 U.S.C. § 1222(b); 42 U.S.C. § 252.

[23] 42 U.S.C. § 249(a); *see also* U.S. IMMIGR. & CUSTOMS ENF'T, HEALTH SERVICE CORPS: FISCAL YEAR 2020, at 7 (2020), https://www.ice.gov/doclib/ihsc/IHSCFY20Annual Report.pdf [https://perma.cc/KY2D-WU9N] (describing statutory authority supporting provision of health care to detained noncitizens, including origin of Division of Immigration Health Services within HHS and subsequent transfer of authority to DHS in 2007); *ICE Health Service Corps Focused on Best Patient Outcomes*, ICE, https://www.ice.gov/features /health-service-corps [https://perma.cc/R6N3-SC5K] (explaining that ICE Health Service Corps, which is responsible for providing direct patient care to immigrant detainees, consists of officers of the U.S. Public Health Service) (last updated Jan. 10, 2023).

[24] 8 U.S.C. § 1182(a)(5)(B) (giving HHS discretion in prescribing DHS eligibility criteria for immigrating physicians).

[25] *See, e.g.*, Patient Protection & Affordable Care Act § 1411(b)(2)(B), 42 U.S.C. § 18081(b)(2)(B) (requiring HHS to consult with DHS to determine appropriate immigration status information to request from noncitizen participants in Affordable Care Act ("ACA") Exchange).

[26] There is a rich literature on interagency dynamics in other contexts. *See, e.g.*, Bils, *supra* note 3, at 635-38 (discussing overlapping authority of Securities and Exchange Commission and Commodity Futures Trading Commission to regulate financial products); Jacobs, *supra* note 1, at 405-427 (examining allocation of federal energy authority between Department of Energy and Federal Energy Regulatory Commission); Ming H. Chen, *Administrator-in-Chief: The President and Executive Action in Immigration Law*, 69 ADMIN. L. REV. 347, 400-12 (2017) (describing coordination among DHS, HHS, Department of Justice ("DOJ"), and State Department in 2014 response to increasing numbers of asylum seekers from Central America at Mexico-U.S. border); Bijal Shah, *Uncovering Interagency Adjudication*, 128 HARV. L. REV. 805, 814-20 (2015) (examining interagency coordination in immigration adjudications involving DHS and DOJ); Aagaard, *supra* note 1, at 249-67 (examining shared regulatory space between Environmental Protection Agency and Occupational Safety and Health

theories drawn from this literature to three case studies involving health and immigration policy. It demonstrates that health-related expertise is frequently marginalized—rather than leveraged—in this shared regulatory space. Specifically, health policy expertise and priorities are subordinated to an administration's immigration policy preferences, impeding balanced policymaking on issues at the intersection of health and immigration.[27] This pattern has had a negative impact on individual and population health, often exacerbating health inequities in low-income groups and for people of color.[28] This contravenes Congress's purpose in establishing related or overlapping jurisdictional assignments to HHS and DHS: Drawing on typically siloed expertise and perspectives to inform policymaking in the interest of the common good.[29]

The Article is organized as follows. Part I summarizes the theorized benefits and challenges of policymaking in shared regulatory space, using illustrative examples from other contexts. It describes how Congress's decisions to delegate

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Administration); Stephen Lee, *Monitoring Immigration Enforcement*, 53 ARIZ. L. REV. 1089, 1096-1105 (2011) (analyzing allocation of worksite enforcement authority between Department of Labor and Immigration and Customs Enforcement); William E. Kovacic, *Downsizing Antitrust: Is It Time To End Dual Federal Enforcement?*, 41 ANTITRUST BULL. 505, 508-09 (1996) (analyzing federal antitrust enforcement authority allocated to Federal Trade Commission and DOJ). Within the field of health law, Rachel E. Sachs has analyzed interagency coordination as a tool for improving innovation in health care. *See generally* Sachs, *supra* note 8; Rachel E. Sachs, *Mobile Health Innovation and Interagency Coordination*, ANNALS HEALTH L., Summer 2017, at 1. A notable exception to the dearth of scholarship on interagency dynamics in matters of health and immigration is Joseph Daval's Note on the interagency negotiations during the development of a 1996 public charge policy, involving HHS and the DHS's predecessor agency, the former Immigration and Naturalization Service. *See generally* Daval, *supra* note 2.

[27] This Article assumes that some degree of balance among policy priorities is desirable and protects the public interest while recognizing that political preferences and circumstances may, at times, justify immigration or health policy dominance. *See* Richard B. Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1667, 1683-84 (1975) (describing evolution of judicial decisions requiring agencies to balance all interests in policymaking and noting that "[t]he required balancing of policies [by agencies] is an inherently discretionary, ultimately political procedure"); *see also* Daniel E. Walters, *The Administrative Agon: A Democratic Theory for a Conflictual Regulatory State*, 132 YALE L.J. 1, 75-79 (2022) (proposing structural changes to promote representational balancing in administrative process, focusing on amplifying "absent, marginalized, or unrepresented" voices).

[28] *See infra* Part II (describing health impacts of regulatory policy dominated by immigration enforcement priorities in three case studies); *see also* Cass R. Sunstein, *Some Costs & Benefits of Cost-Benefit Analysis*, DAEDALUS, Summer 2021, at 208, 209-10, 213 (describing how cost-benefit analysis—administrative process designed to rein in "expressivism" and focus regulators on human consequences of policies—inadequately accounts for welfare effects, particularly its distributional effects).

[29] Walters, *supra* note 27, at 25-26 (describing influential civic republicanism strand of democratic theory that defends political accountability of agency policymaking by emphasizing goal of achieving common good).

authority over an issue to one or more agencies are intended to leverage their unique expertise in policymaking. Part II analyzes three case studies at the intersection of health and immigration policy in which health policy concerns are uniformly subordinated to immigration enforcement policy concerns. The case studies illustrate the impact of political influence, and how it can run counter to Congress's goal of leveraging health-related expertise when enacting a statute. The case studies were selected to highlight relatively recent or ongoing issues, which means that the COVID-19 pandemic and the priorities of members of the Trump and early Biden Administrations feature prominently. The roots of these issues run deep, however, and these roots are examined alongside their present-day manifestations to avoid overreliance on the particular and unusual events and personalities that appear in the case studies.[30]

The case studies focus on three topics already introduced: responsibility for the care of UCs, CDC's "Title 42" order permitting the expulsion of asylum seekers at international land borders, and the exclusion of DACA beneficiaries from eligibility for subsidized health coverage. Part II.A describes Congress's allocation of authority to secure appropriate placements for UCs who have arrived at an international border alone and are in federal custody. In 2003, Congress transferred principal authority for this task from immigration authorities to the Office of Refugee Resettlement ("ORR"), an agency within HHS, based on ORR's expertise in caring for children who have experienced trauma.[31] However, this reallocation of authority has not resolved serious problems with the treatment of UCs in federal custody. Part II.B examines the development and implementation of a pandemic border policy ordered by CDC. The order permits the expulsion of asylum seekers who arrive at U.S. land borders as a COVID-19 mitigation measure, even as travelers in other categories are permitted to cross.[32] Although Congress delegated sole authority to HHS to enact border policies to protect public health under the Public Health Services Act, there is substantial evidence that the policy originated in the White House as an immigration enforcement measure and was not based on public health science.[33] Part II.C analyzes a 2012 decision by CMS to exclude DACA beneficiaries from subsidized health coverage. Advocates for noncitizens were surprised by this decision, which reversed long-established HHS policy on

[30] Sachs, *supra* note 8, at 75 (warning against "overlearn[ing] lessons drawn from a singular, crisis event—or a singular individual" in her analysis of interagency collaboration failures and successes during COVID-19 pandemic).

[31] 6 U.S.C. § 279(b) (transferring authority over noncitizen children).

[32] Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060, 17061 (Mar. 26, 2020).

[33] *See* STAFF OF SELECT SUBCOMM. ON THE CORONAVIRUS CRISIS, 117TH CONG., "IT WAS COMPROMISED": THE TRUMP ADMINISTRATION'S UNPRECEDENTED CAMPAIGN TO CONTROL CDC AND POLITICIZE PUBLIC HEALTH DURING THE CORONAVIRUS CRISIS 3 (Comm. Print Oct. 2022) [hereinafter 117TH CONG. REPORT ON TRUMP ADMINISTRATION'S COVID-19 RESPONSE] ("Trump Administration officials exploited CDC's Title 42 authority to effectively close the southern border under the guise of mitigating spread of the virus.").

noncitizen access to subsidized health coverage and undermined the health policy rationales that drove the passage of the Affordable Care Act ("ACA").[34]

Part III describes the common challenge among the three case studies—the inability to leverage health-related expertise in support of agency mission—and the role of political influence in preventing policymakers from doing so. Part IV concludes with an analysis of existing administrative law tools for coordinating agencies in shared regulatory space and ensuring representational balance in policymaking. To the extent that institutional design or structure is a source of health policy marginalization, this Part describes apolitical mechanisms to rebalance power between the agencies to achieve Congress's purpose of leveraging health expertise in certain immigration contexts. However, administrative law theories of shared regulatory space inadequately account for the predictable capitulation by certain agencies/actors to other agencies/actors concerned with different policy areas. Part IV.B proposes extending the theory to accommodate the evidence from the case studies about immigration enforcement policy dominance. In order to effectively and sustainably disseminate health-related expertise in matters of health and immigration, a broad movement to change the way that political leaders prioritize health issues will be necessary.

I. BENEFITS AND CHALLENGES OF SHARED REGULATORY SPACE

This Part describes the theorized benefits of shared regulatory space generally. Notably, when Congress decides to delegate authority over an issue to one or more agencies, it is presumed that Congress intends for each agency to leverage its unique expertise in policymaking.[35]

Of the models of shared regulatory space described by scholars, two seem to best capture the HHS-DHS dynamic: "interacting jurisdictional assignments" and "related jurisdictional assignments."[36] In the former model, "Congress assigns agencies different primary missions but requires them to cooperate on certain tasks."[37] In such scenarios, there is "situational interdependence among agencies that have different and potentially incompatible primary missions."[38] Several of the topics within the shared regulatory space of HHS and DHS fit this model, based on congressional directives to cooperate.[39] Related jurisdictional assignments, by contrast, are those in which "multiple agencies have authority

[34] Telephone Interview with Jenny Rejeske, Dir. of Pol'y & Advoc., Nat'l Immigr. L. Ctr. (Nov. 18, 2021) (recalling she had attended many meetings with HHS staff regarding ACA implementation and accessibility for noncitizens).

[35] Farber & O'Connell, *supra* note 1, at 1385.

[36] Freeman & Rossi, *supra* note 1, at 1145-49 (cataloging "four types of multiple-agency delegations"). Scholars acknowledge, however, that "actual delegations do not necessarily fit neatly into just one category." *See* Bils, *supra* note 3, at 636-37.

[37] Freeman & Rossi, *supra* note 1, at 1145.

[38] *Id.* at 1148.

[39] *See supra* notes 16-25 and accompanying text (cataloging statutory directives that agencies cooperate).

over different issues, but each issue is closely related to the others."[40] On these topics, even though Congress has not explicitly required interagency coordination, the need to coordinate is implied.[41] Agencies often coordinate voluntarily and informally on overlapping areas of interest and to perform tasks to fulfill their missions.[42] Agencies may reach out to other agencies to leverage relevant expertise or outsource certain tasks.[43] An agency may also be motivated to intervene in other agencies' policy decisions when those decisions could negatively impact its ability to fulfill its mission.[44] No theoretical model is likely to fully capture the complex, dynamic relationship between agencies operating in shared regulatory space.[45]

Of the many explanations for why legislators delegate interpretive authority to administrative agencies, one of the most basic is "the need to leave technical questions to experts."[46] Also referred to as "the informational rationale for delegation," this explanation is premised on the assumption that actors with specialized knowledge will design more effective policies.[47] Although there are other reasons why Congress may choose to delegate authority to agencies,[48]

[40] Bils, *supra* note 3, at 636. Daval's note on the HHS-INS dynamic in the context of public charge policy characterizes the relationship as a variety of the related jurisdictional assignment model. Daval, *supra* note 2, at 1040 (noting that neither agency "share[s] jurisdiction over the same set of policy questions—at least not officially" and HHS and INS policies "exist on parallel tracks, never quite intersecting").

[41] *See supra* notes 26-29 and accompanying text (describing various instances of implied interagency coordination). In a novel examination of interagency coordination in agency adjudications, Bijal Shah notes that Congress does not typically mandate coordination but assigns "separate authority over different parts of the same adjudicative process." Shah, *supra* note 26, at 808.

[42] Freeman & Rossi, *supra* note 1, at 1156-57 (noting frequency of informal agency interactions in federal bureaucracy).

[43] *See* Marisam, *supra* note 4, at 190 (describing how Bureau of Alcohol, Tobacco, and Firearms outsources testing of alcoholic beverages for health hazards to Food and Drug Administration due to its relevant scientific expertise and laboratory capacity).

[44] *Id.* at 201 (describing ways agencies can influence other agencies' decisions).

[45] *See* Gersen, *supra* note 1, at 210 ("In practice, jurisdictional boundaries between political institutions are . . . fuzzy or ambiguous.").

[46] Matthew C. Stephenson, *Legislative Allocation of Delegated Power: Uncertainty, Risk, and the Choice Between Agencies and Courts*, 119 HARV. L. REV. 1035, 1036 (2006) [hereinafter Stephenson, *Delegated Power*].

[47] Jonathan Bendor & Adam Meirowitz, *Spatial Models of Delegation*, 98 AM. POL. SCI. REV. 293, 294, 308 (2004) ("[B]osses delegate primarily to make good outcomes more likely and bad ones less so . . . ."). This may be especially so on health policy topics. *See, e.g.*, ANDREW TWINAMATSIKO & KATIE KEITH, SLOUCHING TOWARDS DEREGULATION: THE THREAT TO HEALTH POLICY 1 (2022) (relying on informational rationale in explaining Congress' practice of enabling federal agencies to implement its legislative agenda)).

[48] *See* Stephenson, *Delegated Power*, *supra* note 46, at 1036-37 (listing additional reasons, including "politicians' desire to duck blame for unpopular choices or to create new opportunities for constituency service, the inability of multimember legislatures to reach

there is general agreement in the scholarly literature that agencies—as compared with legislatures and the judiciary—have valuable expertise and access to information about certain subjects.[49] When agencies can effectively leverage their expertise in policymaking, they are presumed to be better positioned to effectuate the goals of Congress or, according to some theorists, better positioned to enact policies that promote the common good.[50]

In shared regulatory space, delegation of authority to more than one agency permits Congress to draw on each agency's expertise to address a complex problem.[51] This is among the most discussed theorized benefits of shared regulatory space.[52] When agencies with *different types* of expertise are required to coordinate in policymaking, they must address the concerns and priorities of the other agencies involved.[53] A policy that draws on the expertise of multiple agencies arguably contributes to more informed decision-making, in the sense that it incorporates broader perspectives[54] and anticipates and responds to more potential problems than a policy drafted by a single agency.[55] An example of this is a joint rulemaking by the Environmental Protection Agency ("EPA") and the National Highway Transportation Safety Administration ("NHTSA") on

stable consensus, and the impossibility (or excessive cost) of anticipating and resolving all relevant implementation issues in advance" (footnotes omitted)).

[49] *Id.* at 1042-43.

[50] *See* Walters, *supra* note 27, at 25-31 (arguing that common good justification for democratic accountability in delegation is hallmark of civic republicanism and deliberation theories of administrative state).

[51] Farber & O'Connell, *supra* note 1, at 1385 (stating shared agency authority brings "differing expertise, information bases, constituencies, and values into policy decisions").

[52] *See, e.g.*, *id.* (describing value of agency conflicts, including enabling various forms of expertise to enter policy discussions); Freeman & Rossi, *supra* note 1, at 1142 (arguing that overlapping authority is useful when it would be too costly to create new agency and when two existing agencies will reach better outcome than lawmakers or single agency would reach); Gersen, *supra* note 1, at 212-13 (arguing that because expertise is not static, allowing agencies with overlapping authority to compete against each other improves outcomes); Matthew C. Stephenson, *Informational Acquisition and Institutional Design*, 124 HARV. L. REV. 1422, 1462-64 (2011) (describing groupthink benefits to agency collaboration) [hereinafter Stephenson, *Informational Acquisition*].

[53] Similarly, mandates for agencies to *consult with* other agencies in policymaking can help to ensure that relevant perspectives and information from outside of the lead agency are considered. *See* Freeman & Rossi, *supra* note 1, at 1192.

[54] *See id.* at 1184 (explaining how agency coordination "can force agencies to consider valuable information they might otherwise overlook, would prefer to overlook, or lack the expertise to produce themselves . . . [and] can also help pierce a closed decisionmaking culture and overcome group polarization effects by introducing viewpoints that do not identify with the dominant agency culture").

[55] *See id.* at 1173 (noting that joint rulemaking can positively influence functionality of potential policy, as opposed to its substance, by "address[ing] the timing and order of regulation . . . or to clarify how different program elements—for which each agency may be independently responsible—will interact"); *id.* at 1184 ("Coordination . . . can help agencies to think more holistically and can help to mitigate systemic risk.").

reducing greenhouse gas emissions through regulation of motor vehicle manufacturing standards. In developing the proposed rule, the agencies had to balance EPA's priority of slowing climate change with NHTSA's focus on ensuring the safety of vehicles manufactured under the new standards.[56] Some scholars have described this interagency dynamic as a "competition" in which agencies are incentivized to make the best possible case for their preferred policy choice by using all of their relevant expertise and developing further expertise.[57] However, the majority of scholars tend to adopt the position that successful interagency coordination requires cooperation and compromise in order to avoid unhealthy and unproductive competition.[58]

At times, Congress may create statutory schemes that seem to promote incompatible objectives. Such schemes may be intentional if Congress believes that agencies are best suited to resolve the conflict based on their expertise.[59] An example of this is an issue that could have been a fourth case study in this Article: the development of a policy in the late 1990s interpreting the public charge law, which permits INS/DHS to deny certain immigration applications if the agency determines that the applicant is likely to become dependent on the U.S. government for support.[60] Noncitizens' use of public benefits—including some that are administered by HHS—has been considered a negative factor in this determination.[61] Based on fears of jeopardizing future immigration applications and confusion about when and how the public charge law applies, many noncitizens avoid enrolling in public benefits altogether, even when there would be no public charge implications.[62] Extensive interagency negotiations facilitated by the White House resulted in a 1999 policy that aimed to balance HHS's interest in encouraging noncitizens to enroll in public benefits that support their health and wellbeing with INS/DHS's interest in denying

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[56] *See id.* at 1172.

[57] Gersen, *supra* note 1, at 212-13.

[58] *See* Walters, *supra* note 27, at 43-45; Marisam, *supra* note 4, at 189-91; Sachs, *supra* note 8, at 97 (noting that among HHS agencies, "personal connections and professional networks" along with established collaborative channels have been identified as common source of valuable interagency collaborations).

[59] *See* Farber & O'Connell, *supra* note 1, at 1385 ("[Interagency] conflict plays an important and often productive role in the functioning of the modern administrative state."). Walters writes that scholarly theories celebrating interagency conflict for its potential benefits are "at odds with the basic goal of the classical theories of democratic administration to reduce conflict and promote consensus in order to harmonize democratic expectations and administrative policymaking." Walters, *supra* note 27, at 45. However, if the ultimate purpose of setting up an interagency conflict is to come to a better resolution than Congress may have reached on its own, this arrangement fits comfortably within the pluralist accounts of competition within the marketplace of interests. *See id.* at 21-24.

[60] Daval, *supra* note 2, at 1044 (describing perception that "Congress had charged the administrative state with fulfilling two conflicting objectives, without any clear indication of how it wanted them reconciled" in context of enforcement of public charge law).

[61] *Id.*

[62] *Id.* at 1021.

immigration benefits to people who would become totally dependent on the government for sustenance.[63] Joseph Daval's study of these negotiations reveals how different interpretations of the public charge law can either create or resolve tension between the agencies' objectives.[64] When the agencies adopt policies that resolve tensions in their goals, priorities, and missions, they help to effectuate congressional aims in both health and immigration policy.[65]

There are also challenges associated with shared regulatory space, limiting its application as an ideal model for allocating authority among agencies in all circumstances and for all purposes.[66] Delays in decision-making are likely.[67] Additional inefficiencies can arise from "socially unproductive turf battles."[68] Monitoring and enforcement by both Congress and agencies is duplicative and can be considered another cost.[69] Crucially, although coordination can function as a conflict resolution mechanism, it may lead agencies to resolve conflicts about the best course of action through compromises that are "arbitrary and not based on sound technocratic reasoning."[70]

Scholars have written extensively about the need for coordination among agencies working in shared regulatory space to effectively carry out their statutory mandates.[71] Interagency collaborations have become increasingly common in recent decades.[72] This Article does not take a position on whether interagency coordination to come to a consensus or interagency conflict to determine a winner is the better mode of addressing value-laden differences in agencies' preferences. Rather, it highlights the unambiguous benefits of

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[63] *Id.* at 1005-06 (outlining INS's development of 1999 Field Guidance on Deportability and Inadmissibility on Public Charge Grounds).

[64] *See id.* at 1044 (describing how eliminating consideration of public benefits use in public charge determination would resolve tension between HHS and DHS's missions).

[65] *See id.* at 1046 (noting that decision to eliminate consideration of public benefits use in public charge determination "would recognize Congress's pattern of using eligibility instead of public charge to control immigrants' access to benefits, and decouple the success of immigration enforcement from the failure of benefits regimes").

[66] *See id.* at 1040 ("[R]egulatory overlap is regarded as an obstacle to policy objectives, leading to an array of relationships characterized by some degree of incompatibility, competition, or conflict." (footnotes omitted)).

[67] *See* Marisam, *supra* note 4, at 212.

[68] Stephenson, *Informational Acquisition*, *supra* note 52, at 1464.

[69] *See* Gersen, *supra* note 1, at 214 ("[R]edundancy in the assignment of bureaucratic tasks can also create duplicative monitoring and enforcement costs.").

[70] *See* Marisam, *supra* note 4, at 210. Such a result may occur when interagency coordination functions imperfectly as a conflict-resolution mechanism. *See* Farber & O'Connell, *supra* note 1, at 1408-09.

[71] *See, e.g.*, Freeman & Rossi, *supra* note 1, at 1193; Jacobs, *supra* note 1, at 397; Farber & O'Connell, *supra* note 1, at 1385.

[72] *See* FREDERICK M. KAISER, CONG. RSCH. SERV., R41803, INTERAGENCY COLLABORATIVE ARRANGEMENTS AND ACTIVITIES: TYPES, RATIONALES, CONSIDERATIONS 1 (2011), https://sgp.fas.org/crs/misc/R41803.pdf [https://perma.cc/AT5T-LU76] (describing interagency coordinative arrangements' recent growth in frequency and prominence).

leveraging the information that agencies possess in a shared regulatory space to inform policy outcomes.

Although the presumed superior expertise of agencies as compared with the legislature and courts is a central assumption of administrative law, it is also important to acknowledge that agencies are not immune to political influence.[73] Indeed, agencies are political entities, and policymaking tends to follow the President's preferences, especially in the area of immigration policy.[74] Technical expertise alone is not sufficient to make many policy decisions; values are almost always at play as well.[75]

II. CASE STUDIES OF INTERAGENCY DYNAMICS

This Part discusses three case studies at the nexus of health and immigration in which HHS failed to leverage its health-related expertise to influence policy. These case studies are the basis for the discussion in Part III, which identifies how, in each scenario, HHS is unable to leverage its health-related expertise because its mission has been coopted by immigration enforcement concerns.

A. *Care of Unaccompanied Immigrant Children*

In 2003, Congress transferred responsibility for the care and placement of UCs from DHS to ORR within the Administration for Children and Families of HHS.[76] One of the rationales for shifting the responsibility of caring for UCs from DHS to HHS was ORR's expertise in child welfare.[77] This decision reflects a strategy identified in the literature in which Congress chooses to reallocate authority away from agencies that fail to invest in the development of relevant

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[73] Walters, *supra* note 27, at 18-20 (describing how early conceptions of modern administrative process as "transmission belt" for political decisions made by Congress did not reflect reality that agency administrators were making political decisions); *id.* at 65 ("[I]t is still taboo for agencies to transparently assert political justifications for their decisions . . . .").

[74] *See* Michael Kagan, *Binding the Enforcers: The Administrative Law Struggle Behind President Obama's Immigration Actions*, 50 U. RICH. L. REV. 665, 705-709 (2016) (summarizing rise of political control model of administrative agencies).

[75] *See* Walters, *supra* note 27, at 19-20 (evaluating theory that administrators' expertise "render[s] apolitical even discretionary decisions"); Stephenson, *Delegated Power*, *supra* note 46, at 1043 ("[T]hough information is certainly important, many decisions ultimately come down to value choices."); Mark Seidenfeld, *A Civic Republican Justification for the Bureaucratic State*, 105 HARV. L. REV. 1511, 1513 (1992) (critiquing New Deal-era understanding of agency decisions as based on expertise rather than flowing from outside political influence).

[76] 6 U.S.C. § 279(a)-(b).

[77] *See* Joseph Carlton Elliott, Comment, *Sleeping with One Eye Open: The Result of Non-Transparent Oversight by the Office of Refugee Resettlement on Facilities Sheltering Unaccompanied Alien Children*, 68 ADMIN. L. REV. 153, 155-56 (2016) (noting expertise of ORR and its failing, leading to targeting by Obama-era reforms); Jessica G. Taverna, Note, *Did the Government Finally Get It Right? An Analysis of the Former INS, the Office of Refugee Resettlement and Unaccompanied Minor Aliens' Due Process Rights*, 12 WM. & MARY BILL RTS. J. 939, 964-66 (2004).

expertise to agencies that develop such expertise.[78] Agency splitting and reorganization is also considered an appropriate intervention when some portion of an agency's responsibilities conflicts with its primary mission, and has occurred fairly frequently among agencies authorized to regulate immigration.[79] The mission of ORR is to help refugees and other humanitarian immigrants create the foundation for successful lives in the United States, including becoming economically self-sufficient and socially integrated.[80] ORR already had experience caring for and identifying appropriate placements for refugee children, some of whom may have experienced trauma.[81] As a result of the transfer of responsibility for UC custody from DHS to HHS, ORR created the Unaccompanied Alien Children program—now referred to as the Unaccompanied Children program.[82] ORR was considered a more appropriate agency for this responsibility because it operated on the principle of the "best interests of the child."[83] This rationale aligns with the literature's observation that Congress may create interacting jurisdictional assignments when "they wish to harness the unique expertise and competencies of different agencies" in the face of a complex issue and "mitigate the dysfunctions" of prior regimes.[84]

HHS and DHS each have authority over different but closely related issues involving UCs. DHS—specifically, Customs and Border Protection ("CBP")—is responsible for apprehending and initially caring for UCs before transferring them to HHS custody.[85] HHS is primarily responsible for the care and placement of UCs, including repatriation, if appropriate.[86] DHS or the Executive Office of Immigration Review within the Department of Justice ("DOJ") determine

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[78] *See* Gersen, *supra* note 1, at 213 (noting that Congress and courts encourage expertise by allocating jurisdiction between agencies).

[79] *See* Lee, *supra* note 26, at 1110-12.

[80] *See* Taverna, *supra* note 77, at 942 ("ORR has been given the grave responsibility of assisting refugees, unaccompanied minors and other special groups in achieving social and economic self-sufficiency." (footnote omitted)).

[81] *See Unaccompanied Refugee Minors Program*, OFF. OF REFUGEE RESETTLEMENT, https://www.acf.hhs.gov/orr/programs/refugees/urm [https://perma.cc/43QK-4HBT] (last updated Mar. 17, 2023) (describing program as serving "some of the most vulnerable minors in the world"); Taverna, *supra* note 77, at 966-67.

[82] Press Release, Admin. for Child. & Fams., Fact Sheet: Unaccompanied Children (UC) Program (July 21, 2021), https://www.hhs.gov/sites/default/files/uac-program-fact-sheet.pdf [https://perma.cc/HCU9-MACN].

[83] *See* 6 U.S.C. § 279(b)(1)(a)(B); Taverna, *supra* note 77, at 969.

[84] Freeman & Rossi, *supra* note 1, at 1142-44.

[85] *ORR Unaccompanied Children Policy Guide: Section 1*, OFF. OF REFUGEE RESETTLEMENT, https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-1 [https://perma.cc/HY9N-9EQF] (last updated Mar. 26, 2023).

[86] 6 U.S.C. § 279(b)(1) (listing functions of ORR which includes implementing care and placement of UCs).

children's eligibility for immigration benefits.[87] Given the interrelated and, at times, overlapping nature of these tasks involving UCs, Congress likely presumed that the agencies would voluntarily coordinate their work in this shared regulatory space—and they have—using a variety of coordination tools.[88]

Nevertheless, Congress has created specific coordination requirements for HHS and DHS at critical points to support HHS's mission of ensuring the health and wellbeing of UCs in its custody. At the time of the initial transfer of responsibility for the care and placement of UCs from DHS to HHS in 2003, Congress mandated coordination on only one topic: determining appropriate placements of UCs in federal custody. The Homeland Security Act states that "the Director of the Office of Refugee Resettlement . . . shall *consult* with . . . the Director of the Bureau of Citizenship and Immigration Services, and the Assistant Secretary of the Bureau of Border Security" to coordinate the release of UCs to safe and appropriate placements that are conducive to ensuring their appearance at any future immigration proceedings.[89] This is an example of a formally symmetrical interagency relationship in which Congress has required coordination in the form of interagency consultation. The outcome—securing a suitable placement that accounts for the child's age, country of origin, travel companions, relatives living in the United States who might serve as sponsors, health-related issues, and criminal or behavioral concerns—depends on effective agency coordination.[90]

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[87] *Id.* § 279(c) (noting continued responsibility of DOJ and DHS over adjudicating immigration benefits).

[88] These include interagency agreements acknowledging shared goals relating to the care of UCs and documenting protocols for interagency cooperation. *See* STAFF OF PERMANENT SUBCOMM. ON INVESTIGATIONS, OVERSIGHT OF THE CARE OF UNACCOMPANIED ALIEN CHILDREN 23 (2018). DHS and HHS have also created venues for leadership intermingling to influence policymaking, including a Senior Leadership Council and Interagency Work Group to resolve complaints about the process. *Id.* DHS and HHS have established procedures for information sharing that go beyond the minimal requirements in the Trafficking Victims Protection Reauthorization Act ("TVPRA"), discussed *infra* at note 91. *See, e.g.*, Memorandum of Agreement Among the Office of Refugee Resettlement of the U.S. Department of Health and Human Services and U.S. Immigration and Customs Enforcement and U.S. Customs and Border Protection of the U.S. Department of Homeland Security Regarding Consultation and Information Sharing in Matters Relating to Unaccompanied Children 1 (Mar. 11, 2021) (describing purpose of memorandum to implement processes for information sharing about unaccompanied minors); Memorandum of Agreement Among the Office of Refugee Resettlement of the U.S. Department of Health and Human Services and U.S. Immigration and Customs Enforcement and U.S. Customs and Border Protection of the U.S. Department of Homeland Security Regarding Consultation and Information Sharing in Unaccompanied Alien Children Matters 1 (Apr. 13, 2018) (setting forth expectations and processes for information sharing between ORR and DHS until termination on March 11, 2021).

[89] 6 U.S.C. § 279(b)(2)(A) (emphasis added).

[90] *See* Bils, *supra* note 3, at 636 (describing relationship between agencies when there are interacting jurisdictional assignments).

Five years later, with the passage of the Trafficking Victims Protection Reauthorization Act ("TVPRA"), Congress created additional and more specific coordination requirements for HHS and DHS for the purpose of protecting UCs from trafficking.[91] Congress used various coordination tools and structured the agencies' relationship differently depending on the topic. Regarding the provision of safe and secure placements for UCs, the TVPRA largely preserved the formally symmetrical interagency relationship between HHS and DHS and expanded on the prior consultation requirement by directing the agencies to "establish policies and programs to ensure that [UCs] in the United States are protected from traffickers."[92] This is an example of joint policymaking as a coordination tool and was likely selected in order to leverage the expertise of each agency for mutual benefit. However, Congress chose to create a hard hierarchical relationship with HHS as the principal agency within the subtopic of information sharing: Upon request from HHS, DHS must "provide information necessary to conduct suitability assessments" for potential placements for UCs within two weeks.[93] Here, DHS must contribute specific information it possesses to aid HHS in determining safe and suitable placements for UCs—a decision over which HHS has ultimate authority.[94] Regarding age determinations of noncitizens in federal custody, Congress used the coordination tool of joint policymaking to structure an advising and monitoring relationship between the agencies where HHS, the principal agency, was directed to develop procedures "in consultation with" DHS.[95] Regarding the repatriation of UCs, Congress again required HHS and DHS—as well as the Secretary of State and the Attorney General—to engage in joint policymaking "to ensure that [UCs] in the United States are safely repatriated to their country of nationality or of last habitual residence."[96] On this topic, Congress largely preserved symmetrical interagency relationships, but gave HHS and the State Department primary responsibility for reporting to Congress—another coordination mechanism[97]—on improvements in repatriation programs for UCs.[98]

By creating shared regulatory space relating to the processing of UCs and delegating primary responsibility for their care and placement to ORR, Congress sought to improve the treatment of UCs. Agency coordination theory would predict that HHS and DHS would coordinate to leverage HHS's expertise in

[91] 8 U.S.C. § 1232.

[92] *Id.* § 1232(c)(1).

[93] *Id.* § 1232(c)(3)(C).

[94] *Id.* § 1232(c)(3)(A).

[95] *Id.* § 1232(b)(4).

[96] *Id.* § 1232(a)(1); *see also id.* § 1232(a)(5)(A) (directing Secretary of State, in conjunction with HHS and DHS, to "create a pilot program . . . to develop and implement best practices to ensure the safe and sustainable repatriation and reintegration of [UCs] into their country of nationality or of last habitual residence").

[97] Katyal, *supra* note 4, at 2341 (suggesting reporting requirements are significant in combating consolidated power within executive branch).

[98] 8 U.S.C. § 1232(a)(5)(C).

child welfare. However, HHS has faced unending and high-profile criticism of its failure to ensure the health and wellbeing of UCs.[99] The result has been repeated litigation, settlements, and near-continuous oversight by internal and external watchdogs.[100] In 2008, the HHS Office of Inspector General found that no agency had assumed responsibility for assuring the physical, mental, and financial wellbeing of UCs after they had been released to sponsors, and that interagency coordination relating to the care of UCs was inadequate.[101] This situation did not change for many years. In 2014, concerns about the inadequate care of UCs motivated the Obama Administration to create an interagency working group to improve the conditions of care for UCs.[102] Care of UCs by HHS and DHS has been subject to ongoing oversight by the Permanent Subcommittee on Investigations of the Senate Committee on Homeland Security and Governmental Affairs since 2015.[103] In a report published that year, the U.S. Government Accountability Office found deficiencies in the process by which UCs were transferred from DHS to HHS custody and recommended that DHS and HHS "jointly develop and implement a documented interagency process with clearly defined roles and responsibilities, as well as procedures to disseminate placement decisions, for all agencies involved in the referral and placement of [UCs] in HHS shelters."[104] The following year, the Subcommittee found that there was still no agreement in place defining the agencies' responsibilities relating to the care of UCs.[105] In 2018, the Subcommittee cited several recent examples of HHS administrators continuing to deny responsibility for UCs who had been released to non-parental sponsors.[106]

The recent family separation crisis highlights the degree to which HHS has been unable to leverage its expertise to adequately carry out its mission to care for UCs. This crisis arose from a change in immigration policy that appears to have caught HHS unprepared: the development and implementation of the

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[99] *See, e.g.*, Elliott, *supra* note 77, at 165-66 (summarizing disputes that arose after sexual abuse became rampant within detention centers). Some consider ORR's failures to be a continuation of the dysfunctional system it inherited. Taverna, *supra* note 77, at 971 (discussing how reliance on detention centers to house children, coupled with lack of guidance, meant unaccompanied children often remained detained without help from ORR).

[100] *See* Elliott, *supra* note 77, at 165.

[101] OFF. OF INSPECTOR GEN., DEP'T OF HEALTH & HUM. SERVS., OEI-07-06-00290, DIVISION OF UNACCOMPANIED CHILDREN'S SERVICES: EFFORTS TO SERVICE CHILDREN, at ii (2008).

[102] *See* Elliott, *supra* note 77, at 155-56.

[103] STAFF OF PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 88, at 1.

[104] U.S. GOV'T ACCOUNTABILITY OFF., GAO-15-521, UNACCOMPANIED ALIEN CHILDREN: ACTIONS NEEDED TO ENSURE CHILDREN RECEIVE REQUIRED CARE IN DHS CUSTODY 69 (2015).

[105] *See* STAFF OF PERMANENT SUBCOMM. ON INVESTIGATIONS, *supra* note 88, at 26 (discussing various reports showcasing when both agencies denied responsibility for UCs).

[106] *Id.* at 26-28.

Trump Administration's "Zero Tolerance" policy.[107] Under this policy, thousands of newly arrived immigrant children were separated from their parents and classified as UCs, dramatically increasing the number of UCs for whom HHS was responsible.[108] This policy generated outrage around the world, particularly the images of crying children who had been separated from their parents and reports on the poor and overcrowded conditions in which these children were held because of HHS's inability to handle the volume.[109] A former HHS official traced recent crises in caring for migrant children to immigration policies: "In previous Administrations—and not just the Obama Administration—the fluctuations in the population we were dealing with were related to factors in the countries of origin—to drought, to an increase in violence. We didn't have any control over them. This time, it is a direct result of policy."[110]

Confusion among the general public about which government bodies were responsible for the crisis exacerbated the problem. For example, HHS officials reported difficulty hiring staff for its shelters for migrant children because the topic "has become a highly charged, political issue, with critics often making no distinction between Border Patrol jails and the health department's shelters."[111] Former HHS official Maria Cancian described how the "[t]he individuals and organizations that provide shelter services to unaccompanied children have been put in an untenable position, by virtue of the choices that the Administration has made."[112] The situation has also contributed to the erosion of any remaining trust in the government's ability to care for UCs in its custody.[113]

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[107] *See* OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., OEI-BL-18-00510, COMMUNICATION AND MANAGEMENT CHALLENGES IMPEDED HHS'S RESPONSE TO THE ZERO-TOLERANCE POLICY 19 (2020) [hereinafter HHS-OIG REPORT], https://oig.hhs.gov/oei/reports/oei-BL-18-00510.pdf [https://perma.cc/K39S-GLDV] ("[T]he UAC Program was left in the position of reacting to changes as they occurred rather than taking proactive measures that might mitigate risk to children.").

[108] *Id.* at 20-21 (noting sharp increase of UCs in same month Zero Tolerance policy was enacted).

[109] *See id.* at 21 (describing how HHS was forced to open emergency influx care facilities to accommodate numerous new UCs, how such facilities are "exempt from some licensing requirements," and how some facility investigations revealed inappropriate conditions at such shelters); Alexandra Schwartz, *The Office of Refugee Resettlement Is Completely Unprepared for the Thousands of Immigrant Children Now in Its Care*, NEW YORKER (June 21, 2018), https://www.newyorker.com/news/news-desk/the-office-of-refugee-resettlement-is-completely-unprepared-for-the-thousands-of-immigrant-children-now-in-its-care.

[110] Schwartz, *supra* note 109 (quoting Maria Cancian, a former HHS Deputy Assistant Secretary for Policy in the Administration for Children and Families).

[111] Michael D. Shear, Zolan Kanno-Youngs & Eileen Sullivan, *Young Migrants Crowd Shelters, Posting Test for Biden*, N.Y. TIMES (June 14, 2021), https://www.nytimes.com/2021/04/10/us/politics/biden-immigration.html.

[112] Schwartz, *supra* note 109.

[113] *See id.* ("One terrible irony of the current crisis is that a government office whose explicit goal is to reunify children with their families is now being used to hold children who

Media accounts described HHS Secretary Xavier Becerra's frustration with being the public face of the migrant child "crisis," even though DHS held more responsibility for creating the conditions allowing the influx to occur.[114] On the other hand, DHS officials have expressed frustration with Secretary Becerra's handling of the processing of migrant child arrivals and his comments criticizing DHS's role in creating the crisis.[115] This is an example of the kind of unproductive blame game that can occur between agencies operating in shared regulatory space. When neither agency feels fully responsible for creating or

have entered its jurisdiction because the government has forcibly removed them from their parents' care.").

[114] *See* Adam Cancryn, Anita Kumar & Sabrina Rodriguez, *Border Fiasco Spurs a Blame Game Inside Biden World*, POLITICO: IMMIGR. (Apr. 16, 2021, 6:56 PM), https://www.politico.com/news/2021/04/16/hhs-becerra-biden-migrant-kids-482582 [https://perma.cc/HQG4-72BZ] ("Though Biden has tasked [Vice President Kamala] Harris with tackling the root causes of migration through the southern border, and [DHS Secretary] Mayorkas has emerged as the primary defender of the administration's policies, officials have made clear that Becerra is responsible for managing the influx of migrant children."). Immigration policies other than Zero Tolerance have also contributed to HHS's inability to adequately care for UCs, but, for the sake of brevity, extensive discussion of these policies is omitted. News accounts reporting on the agency heads' frustration with the handling of the migrant child crisis reflect their reactions to several such policies. One of these is the Biden Administration's suspension of new enrollments in the prior administration's Migrant Protection Protocols ("MPP") in January, 2021. *See Migrant Protection Protocols*, HOMELAND SEC. (Jan. 24, 2019), https://www.dhs.gov/news/2019/01/24/migrant-protection-protocols [https://perma.cc/94X7-A9SR] (displaying archived policy). Better known as the "Remain in Mexico" policy, MPP requires asylum seekers arriving at the U.S.-Mexico border to wait in Mexico until the day of their asylum hearing in the United States, at which point they are permitted entry. *Id.* Because UCs are exempt from MPP, some migrant families have felt compelled to send minor members of the family to cross the border alone rather than wait indefinitely in harsh conditions in Mexico. *See* Mike LaSusa, *DHS Hears Trump-Era Policies at Fault for Family Separations*, LAW360 (Jan. 25, 2022, 6:47 PM), https://www.law360.com/immigration/articles/1458214/dhs-hears-trump-era-policies-at-fault-for-family-separations. There is some evidence indicating that the Biden Administration's decision to suspend new enrollments in MPP functioned as a deterrent for asylum seekers—including UCs—to attempt to enter the country. *See* U.S. DEP'T OF HOMELAND SEC., EXPLANATION OF THE DECISION TO TERMINATE THE MIGRANT PROTECTION PROTOCOLS 23-24 (2021) (noting that migration flows decreased during months when MPP was fully implemented and that suspension of new MPP enrollments coincided with influx of asylum seekers entering country). The Trump Administration's public health order requiring expulsion of most asylum seekers arriving at the border—which the Biden Administration chose to continue implementing—also exempts UCs, putting additional pressure on families fearing persecution in their native countries to send children to the border alone. *See* LaSusa, *supra*. This "Title 42 policy" is the subject of Section II.B.

[115] *See* Eileen Sullivan, *For Migrant Children in Federal Care, a 'Sense of Desperation,'* N.Y. TIMES (Aug. 9, 2021), https://www.nytimes.com/2021/05/18/us/politics/biden-migrant-children.html ("Mr. Becerra said he blamed the immigration system for the situation. 'If we're going to have to function with this broken immigration system, let's at least do it right, let's do what we can,' he said."); Cancryn et al., *supra* note 114 ("Top White House officials have grown increasingly frustrated with Health Secretary Xavier Becerra over his department's sluggish effort to house thousands of unaccompanied minors . . . .").

addressing the problem of caring for the large number of UCs arriving at the southern border, it is harder to hold any agency accountable.[116] A senior Biden Administration official stated, "On every front, [ORR is] confronted with challenges that are more than a little bit outside their comfort zone."[117] Moreover, the migrant child crisis has also infringed on Secretary Becerra's ability to achieve the administration's other health policy objectives.[118] As described in Parts II.B and II.C, these dynamics—an inability to leverage health expertise and a lack of accountability for policymaking in shared regulatory space—can also arise in contexts in which HHS has sole authority to make policy.

B. *Pandemic Border Expulsions*

Scholars predict that the COVID-19 pandemic will reshape many areas of law and policy for decades to come, much as the September 11, 2001, attacks reshaped legal institutions, laws, and policies across the board.[119] One such area that has already begun restructuring is the management of international borders.[120] Border management has been used as a public health tool for as long as infectious diseases and international borders have existed.[121] It is likely that health considerations will become more important in post-pandemic border management, just as security concerns dominated post-9/11 border management.[122]

DHS is primarily responsible for migration and border management and employs an extensive legal apparatus for regulating the entry of certain individual noncitizens whose health conditions would present a danger to public health as determined by HHS.[123] Among the various health-related grounds of inadmissibility that DHS can invoke to exclude a noncitizen from entry is excluding noncitizens who have been diagnosed with "a communicable disease of public health significance."[124] DHS partners with HHS on migration-related public health issues in several ways, including supporting CDC-operated

[116] *See* Freeman & Rossi, *supra* note 1, at 1187.

[117] Cancryn et al., *supra* note 114.

[118] *Id.*

[119] *See, e.g.*, Meghan Benton & Demetrios G. Papademetriou, *COVID-19 Is Becoming a '9/11 Moment' for Borders and Health*, 40 HEALTH AFFS. 1162, 1163-66 (2021) (examining long-term effects of 9/11 security measures on humanitarianism and efficiency in light of similar COVID-19 responses along U.S. border).

[120] *See id.* at 1168.

[121] *History of Quarantine*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/quarantine/historyquarantine.html [https://perma.cc/H96G-8HXS] (last updated July 20, 2020) (attributing practice of quarantine to 14th Century Venetian ports attempting to protect coastal cities from plague by limiting access to ports).

[122] *See* Benton & Papademetriou, *supra* note 119, at 1163.

[123] 8 U.S.C. § 1182(a)(1).

[124] *Id.* § 1182(a)(1)(A)(i).

Quarantine Stations at ports of entry,[125] establishing the "Do Not Board" List to prevent "people who are contagious with certain diseases of public health concern" from flying on commercial airlines,[126] establishing the Public Health Lookout to screen people in the same condition before crossing the U.S. border,[127] and administering medical examinations of noncitizens for immigration purposes.[128]

However, HHS—as the agency primarily responsible for "preventing the introduction, transmission, and spread of communicable diseases in the United States"[129]—has authority over border management for public health purposes under section 362 of the Public Health Service Act, codified in title 42 of the U.S. Code.[130] This authority, conferred in 1944, permits HHS to "prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate" for the purpose of avoiding the introduction of a communicable disease.[131] Neither section 362 nor the regulations promulgated under it distinguish between the treatment of citizens and noncitizens, given that citizenship and immigration status are not relevant risk factors for contagion from a public health perspective.[132] Congress did not require HHS to consult or

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125 *U.S. Quarantine Stations*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/quarantine/quarantine-stations-us.html [https://perma.cc/8KZY-DH78] (last updated Apr. 21, 2022) (describing location of CDC quarantine stations and authority of CDC to detain persons with contagious disease).

126 *FAQs for Public Health Do Not Board and Lookout Lists*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/quarantine/do-not-board-faq.html [https://perma.cc/FR6U-LF8H] (last updated Jan. 28, 2022).

127 *Id.*

128 8 U.S.C. § 1222(b) ("The physical and mental examination of arriving aliens . . . shall be made by medical officers of the United States Public Health Services, who . . . shall certify, for the information of the immigration officers . . . any physical and mental defect or disease observed . . . .").

129 *Specific Laws and Regulations Governing the Control of Communicable Diseases*, CTRS. FOR DISEASE CONTROL & PREVENTION (citing 42 U.S.C. § 264(a)), https://www.cdc.gov/quarantine/specificlawsregulations.html [https://perma.cc/2CKC-F9KZ] (last updated Mar. 29, 2022).

130 42 U.S.C. § 265.

131 Public Health Services Act, ch. 373, 58 Stat. 682 (1944) (codified at 42 U.S.C. § 265). This authority under section 362 of the Act was transferred from the Surgeon General to the Secretary of Health, Education, and Welfare in 1966, and the agency was later redesignated as the Department of Health and Human Services in 1979. *See* Reorganization Plan No. 3 of 1966, 31 Fed. Reg. 8855 (1966); Department of Education Organization Act, Pub. L. No. 96-88, § 509(a), 93 Stat. 668, 695 (1979). Later, the authority was delegated to CDC. *See* Lucas Guttentag, *Coronavirus Border Expulsions: CDC's Assault on Asylum Seekers and Unaccompanied Minors*, JUST SEC. (Apr. 13, 2020), https://www.justsecurity.org/69640/coronavirus-border-expulsions-cdcs-assault-on-asylum-seekers-and-unaccompanied-minors/ [https://perma.cc/KEH8-WZMC] ("Relying on an obscure 1944 provision . . . the Centers for Disease Control purports to authorize summary Border Patrol expulsions of asylum seekers.").

132 *See* Guttentag, *supra* note 131.

otherwise coordinate with any other entity in making such determinations under section 362, even though border management is a topic on which DHS has relevant expertise, a significant stake in the outcome of policymaking, and authority to regulate. A reasonable interpretation of this sole delegation of authority to HHS is that Congress sought to reserve the authority to judgments based on public health science, rather than immigration or political concerns.

On March 20, 2020, CDC Director Robert Redfield issued an order barring the entry of travelers arriving at U.S. land borders if they would be required under immigration law or policy to be detained in a congregate setting.[133] Within days, CDC also promulgated an emergency Interim Final Rule amending the regulations interpreting § 362 and providing a procedure for implementing the CDC order.[134] The stated justification for the order was "to protect the public health from an increase in the serious danger of the introduction of [COVID-

[133] Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060 (Mar. 26, 2020) (order issued Mar. 20, 2020). The March 2020 Order was subsequently extended and amended. *See* Extension of Order Under Sections 362 and 365 of the Public Health Service Act; Order Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 22424 (Apr. 22, 2020); Amendment and Extension of Order Under Sections 362 and 365 of the Public Health Service Act; Order Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 31503 (May 26, 2020). In October 2020, CDC issued an order replacing the March order. *See* Order Suspending the Right to Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists, 85 Fed. Reg. 65806 (Oct. 16, 2020). In February 2021, CDC began excepting UCs from the October order under a temporary order. *See* Notice of Temporary Exception From Expulsion of Unaccompanied Noncitizen Children Pending Forthcoming Public Health Determination, 86 Fed. Reg. 9942 (Feb. 17, 2021). In July 2021, CDC officially excepted UCs from the October order. *See* Public Health Determination Regarding an Exception for Unaccompanied Noncitizen Children from the Order Suspending the Right to Introduce Certain Persons from Countries Where a Quarantinable Communicable Disease Exists, 86 Fed. Reg. 38717 (July 22, 2021). The October 2020 order was replaced and superseded by an order issued in August 2021, which incorporated the exception for UCs and for individuals on a case-by-case basis and added an exception "for programs approved by [DHS] that incorporate appropriate COVID-19 mitigation protocols as recommended by CDC." *See* Public Health Reassessment and Order Suspending the Right to Introduce Certain Persons from Countries Where a Quarantinable Communicable Disease Exists, 86 Fed. Reg. 42828 (Aug. 5, 2021). All of these CDC orders are substantially similar in that they suspend the right of certain noncitizens from entering the United States at the U.S. borders with Mexico and Canada. They are collectively referred to as the "Title 42 Order" throughout this Article.

[134] Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes, 85 Fed. Reg. 16559 (Mar. 24, 2020). A final rule was issued in September 2020. *See* Control of Communicable Diseases; Foreign Quarantine: Suspension of the Right to Introduce and Prohibition of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes, 85 Fed. Reg. 56424 (Sept. 11, 2020).

19]."[135] However, it effectively singled out asylum seekers without documentation, permitting virtually all other categories of travelers at the same ports of entry—such as tourists, students, and workers—to cross the border.[136] In effect, the Order has halted nearly all asylum processing at the U.S.-Mexico border, without any analysis of how to balance public health concerns with existing obligations to asylum seekers and UCs under immigration law.[137] For the first time since the United States joined the Refugee Convention in 1980, the vast majority of people arriving at land borders seeking protection from persecution are turned away without a formal determination of their eligibility for asylum.[138] Instead, they are "expelled" to Mexico or their home countries, typically "driven by bus to the nearest port of entry and told to walk back to Mexico, often without their luggage and other belongings."[139] As of February 2023, more than 2.7 million people have been expelled at the southern U.S.

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[135] Notice of Order Under Sections 362 and 365 of the Public Health Service Act Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060; Order Suspending the Right to Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists, 85 Fed. Reg. 65806.

[136] *See* Guttentag, *supra* note 131; Molly O'Toole, *Biden Promised Change at the Border. He's Kept Trump's Title 42 Policy To Close It and Cut Off Asylum*, L.A. TIMES: POL. (Mar. 19, 2021, 5:12 PM), https://www.latimes.com/politics/story/2021-03-19/a-year-of-title-42-both-trump-and-biden-have-kept-the-border-closed-and-cut-off-asylum-access ("In a year of Title 42, of more than 650,000 encounters with migrants at the U.S.-Mexico border, fewer than 1% have been able to seek protection . . . . [O]nly 2% even made it to the initial step of claiming fear of being sent back to their home country . . . .").

[137] O'Toole, *supra* note 136.

[138] James Bandler, Patricia Callahan, Sebastian Rotella & Kirsten Berg, *Inside the Fall of the CDC*, PROPUBLICA (Oct. 15, 2020, 1:12 PM), https://www.propublica.org/article/inside-the-fall-of-the-cdc [https://perma.cc/KPZ7-LQQV]. Policies similar to the Title 42 order were implemented in other countries as well, likely contributing to an intensification of public health crises in the places where asylum seekers were forced to wait worldwide. *See* Benton & Papademetriou, *supra* note 119, at 1165, 1168 (outlining effect of border closures on migrants such as stranding without ability to go home, increasing risk of disease, more precarious work, and increasing reliance on dangerous smuggling operations).

[139] AM. IMMIGR. COUNCIL, A GUIDE TO TITLE 42 EXPULSIONS AT THE BORDER 3 (2022) (citing Ursula Muñoz-Schaefer, *Undocumented Immigrants Continue To Be Expelled from the U.S. Under Title 42 COVID-19 Measures*, TEX. OBSERVER (July 1, 2021, 9:08 AM), https://www.texasobserver.org/undocumented-immigrants-continue-to-be-expelled-from-the-u-s-under-title-42-covid-19-measures/ [https://perma.cc/SG5P-J3Y8]), https://www.americanimmigrationcouncil.org/research/guide-title-42-expulsions-border [https://perma.cc/UMX2-WVQA].

border.[140] Migrants expelled to Mexico—including families with children—are frequent targets of violence and extortion by criminal cartels.[141]

CDC's border closure under Title 42 is unprecedented. It has never before used this authority to regulate immigration in any way, much less close borders and suspend a swath of humanitarian and due process protections otherwise required under immigration law.[142] Indeed, the legislative history of the statute under which the order was promulgated suggests that Congress delegated quarantine power to health authorities—rather than to the President—precisely because of concerns about discrimination against noncitizens.[143] Polly J. Price has written about the long history of "[t]he modern conflation of public health vigilance with immigration control" in the United States and elsewhere, noting that "'blame the immigrant' political rhetoric obscures a clearer view of both immigration law and public health policy."[144]

Nevertheless, it has become clear that the initial impetus for the Title 42 order was not public health concerns, but rather the Trump administration's agenda to restrict immigration generally and asylum specifically.[145] Government records disclosed during litigation over the Title 42 order reveal that the President's immigration policy advisor, Stephen Miller, proposed using CDC's authority to

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[140] *Nationwide Encounters*, U.S. CUSTOMS & BORDER PROT., https://www.cbp.gov/newsroom/stats/nationwide-encounters [https://perma.cc/FQM4-FZDM] (last updated Apr. 14, 2023). Filtering results to include "Title 42" under "Authority" provides annual totals from March 2020 through February 2023. *Id.*

[141] AM. IMMIGR. COUNCIL, *supra* note 139, at 6 ("Advocates have documented through surveys and public media coverage nearly 10,000 reports of violence against migrants expelled back to Mexico under Title 42.").

[142] *See* Guttentag, *supra* note 131.

[143] *See Q&A: US Title 42 Policy To Expel Migrants at the Border*, HUM. RTS. WATCH (Apr. 8, 2021, 4:15 PM), https://www.hrw.org/news/2021/04/08/qa-us-title-42-policy-expel-migrants-border [https://perma.cc/CMK9-JTKV] ("In debating the law's predecessor provision, Congress specifically kept any reference to immigrants or immigration out of the law's text because of concerns that public health authority could be used to discriminate against immigrants. The 1944 version was enacted to shift quarantine authority from the president to the surgeon general."); *see also* Guttentag, *supra* note 131 (describing legislative history regarding decision to exclude references to immigration in 1892 legal predecessor).

[144] Polly J. Price, *Sovereignty, Citizenship, and Public Health in the United States*, 17 N.Y.U J. LEGIS. & PUB. POL'Y 919, 921 (2014).

[145] *See* 117TH CONG. REPORT ON TRUMP ADMINISTRATION'S COVID-19 RESPONSE, *supra* note 33, at 3 ("Trump Administration officials exploited CDC's Title 42 authority to effectively close the southern border under the guise of mitigating spread of the virus."); *id.* at 28 ("The . . . investigation has found that the Title 42 order did not originate at CDC and that key CDC experts disagreed that there was a sufficient public health basis for the order."); *see also* Opinion, *It's Time To End the Pandemic Emergency at the Border*, N.Y. TIMES (Nov. 13, 2021), https://www.nytimes.com/2021/11/13/opinion/immigration-trump-biden-covid.html ("[C]ongressional investigators released excerpts from testimony by a former senior C.D.C. official who admitted that there was little public health rationale for instituting the policy, since the virus was already spreading in the United States by the time the Title 42 order was signed.").

close the border and that CDC officials strenuously objected to the proposal as "overstat[ing] the threat."[146] Ultimately, Vice President Mike Pence—alongside the acting Secretary of Homeland Security Chad Wolf—directed CDC to issue the order despite the resistance from the agency's scientists.[147] The Director of CDC's Division of Global Migration and Quarantine at the time, Dr. Martin Cetron, reported that he expressed concerns about the motivations behind the order, telling a colleague, "It's just morally wrong to use a public authority that has never, ever, ever been used this way. It's to keep Hispanics out of the country. And it's wrong."[148] The Select Subcommittee on the Coronavirus Crisis found in its investigation that the Trump Administration ignored CDC's "extensive analysis" of the public health risks posed by admitting migrants and its conclusion that Title 42 was "not justified on public health grounds."[149] CDC Director Redfield, a Trump appointee, ultimately signed the order.[150] At least one high-level CDC staffer resigned shortly thereafter as the administration's callousness on topics relating to migrants at the southern border intensified.[151]

[146] Bandler et al., *supra* note 138. Prior to the COVID-19 pandemic, Stephen Miller had proposed using CDC's authority to restrict immigration, including for noncitizens diagnosed with mumps and the flu. *See* Caitlin Dickerson & Michael D. Shear, *Before Covid-19, Trump Aide Sought to Use Disease To Close Borders*, N.Y. TIMES (May 3, 2020), https://www.nytimes.com/2020/05/03/us/coronavirus-immigration-stephen-miller-public-health.html.

[147] *See* Jason Dearen & Garance Burke, *Pence Ordered Borders Closed after CDC Experts Refused*, AP NEWS (Oct. 3, 2020), https://apnews.com/article/virus-outbreak-pandemics-public-health-new-york-health-4ef0c6c5263815a26f8aa17f6ea490ae [https://perma.cc/3Q7W-6KHX].

[148] 117TH CONG. REPORT ON TRUMP ADMINISTRATION'S COVID-19 RESPONSE, *supra* note 33, at 28-29.

[149] *Id.* at 28.

[150] *Id.* at 29.

[151] *See* Bandler et al., *supra* note 138 (describing July 2020 resignation of Kyle McGowan, CDC Chief of Staff, after administration made exception to allow entry of pet dog improperly vaccinated against rabies but continued to expel UCs under Title 42 Order).

From its inception, public health[152] and immigration experts[153] have argued that the Title 42 order is not based on sound public health science. First, there

[152] *See, e.g.*, Letter from Anika Backster, MD, Jennifer Balkus, PhD, MPH, Assistant Professor, Univ. of Washington Sch. of Pub. Health, Jacqueline Bhabha, Professor of the Prac., Harvard T.H. Chan Sch. of Pub. Health, Ietza Bojorquez, MD, PhD, Professor, El Colegio de la Frontera Norte, Mexico, Kimberly Brouwer, PhD, Professor, UC San Diego, Baltica Cabieses, PhD, Professor of Soc. Epidemiology, UDD Chile, Megan Coffee, MD, PhD, Adjunct Assistant Professor, Columbia Univ. Mailman Sch. of Pub. Health, Joanne Csete, PhD, MPH, Adjunct Assoc. Professor, Columbia Univ. Mailman Sch. of Pub. Health, Kacey C. Ernst, MPH PhD, Professor, Univ. of Arizona, Paul J. Fleming, PhD, MPH, Assistant Professor, Univ. of Michigan, Linda P. Fried, MD, MPH, Dean, Columbia Univ. Mailman Sch. of Pub. Health, Lynn R. Goldman, MD, MPH, MS, Dean of Pub. Health, The George Washington Univ., M. Claire Greene, PhD, MPH, Postdoctoral Rsch. Sci., Columbia Univ. Mailman Sch. of Pub. Health, Anjum Hajat, PhD, MPH, Michele Heisler, MD, MPA, Professor, Univ. of Michigan Med. Sch. and Sch. of Pub. Health, Cesar Infante Xibille, S. Patrick Kachur, MD, Professor, Columbia Univ. Mailman Sch. of Pub. Health, Michel Khoury, MD, Assistant Professor, Emory Univ. Sch. of Med., Ling San Lau, MBBS, MPH, Senior Program Officer, CPC Learning Network, Columbia Univ., William Lopez, PhD, MPH, Clinical Assistant Professor, Univ. of Michigan Sch. of Pub. Health, Joseph B. McCormick, MD, Ayman El-Mohandes, MBBCh, MD, MPH, Dean, CUNY Graduate Sch. of Pub. Health & Health Pol'y, Rachel T. Moresky, MD, MPH, FACEP, Assoc. Professor, Columbia Univ. Mailman Sch. of Pub. Health & Coll. of Physicians and Surgeons, Kathleen Page, MD, Assoc. Professor, Johns Hopkins Univ., Kathleen A. Parker, MA, MPH, Anne R. Pebley, PhD, Professor, UCLA Fielding Sch. of Pub. Health, Amanda Phipps, Paulina Rebolledo, MD, MSc, Assistant Professor of Med. and Glob. Health, Emory Univ., Les Roberts, MSPH, PhD, Professor, Columbia Univ., Leonard Rubenstein, JD, LLM, Professor of the Prac., Johns Hopkins Bloomberg Sch. of Pub. Health, Wafaa El-Sadr, MD, MPH, MPA, Professor, Columbia Univ., Goleen Samari, PhD, MPH, Assistant Professor, Columbia Mailman Sch. of Pub. Health, John Santelli, MD, MPH, Professor, Columbia Univ., Craig Spencer, MD MPH, Assoc. Professor, Columbia Univ. Med. Center, Paul B. Spiegel, MD, MPH, Professor of the Prac., Johns Hopkins Bloomberg Sch. of Pub. Health, Steffanie A. Strathdee, PhD, Assoc. Dean of Glob. Health Scis., UC San Diego, Parmi Suchdev, MD, MPH, Professor, Emory Glob. Health Inst., Patrick Vinck, PhD, Assistant Professor, Harvard Univ., Ronald Waldman, MD, MPH, Professor Emeritus of Glob. Health, The George Washington Univ., Monette Zard, MA, Dir. of the Forced Migration and Health Program, Columbia Univ. Mailman Sch. of Pub. Health & Amy Zeidan, MD, Assistant Professor, Emory Univ. to Hon. Xavier Becerra, Sec'y, U.S. Dep't of Health & Human Servs., Dr. Rochelle Walensky, Dir., Ctrs. for Disease Control & Prevention & Hon. Alejandro Mayorkas, Sec'y, U.S. Dept's of Homeland Sec. (Sept. 1, 2021) (on file with author) [hereinafter 2021 Letter from Public Health Experts to HHS] (objecting that the Title 42 Order lacks public health justification and is an attempt to exploit the Covid-19 pandemic to expel asylum seekers); Letter from Joe Amon, Clinical Professor, Dornsife Sch. of Pub. Health, Drexel Univ., Mary Bassett, MD, Professor, Harvard T.H. Chan Sch. of Pub. Health, Chris Beyrer, MD, MPH, Professor, Johns Hopkins Bloomberg Sch. of Pub. Health, Jacqueline Bhabha, JD, MsC, Professor, Harvard T.H. Chan Sch. of Pub. Health, Joanne Csete, PhD, MPH, Assoc. Professor, Columbia Univ. Mailman Sch. of Pub. Health, Ayman El-Mohandes, MBBCh, MD, MPH, Dean, CUNY Graduate Sch. of Pub. Health & Health Pol'y, Wafaa El-Sadr, MD, MPH, MPA, Professor, Columbia Univ., Glenn J. Fennelly, MD, MPH, Rutgers New Jersey Med. Sch., Hope Ferdowsian, MD, MPH, FACP, FACPM, Assoc. Professor of Med., Univ. of New Mexico Sch. of Med., Linda P. Fried, MD, MPH, Dean, Columbia Univ. Mailman Sch. of Pub. Health, Lynn Goldman, MD, MPH, Dean, Milken Inst. Sch. of Pub.

are too many exceptions to the travel restrictions to effectively prevent the spread of the virus across the border, including for U.S. citizens and lawful permanent residents, travelers arriving for purposes relating to education, trade, or commerce, and travelers arriving by plane or ship, which HHS describes as "congregate settings with *higher* risk of disease transmission than land travel."[154] Second, there are conceivable alternatives available for DHS to avoid detaining noncitizens in congregate settings for public health purposes without violating its humanitarian obligations, such as "parole, release from detention, field processing, and other measures to alleviate the crowding and the danger of contagion."[155] CDC justified its decision to permit movement of U.S. citizens and lawful permanent residents across the border by stating that "quarantine, isolation, and conditional release . . . while not perfect solutions, can mitigate

Health at The George Washington Univ., Lawrence O. Gostin, JD, LLD, Professor, Georgetown Univ., Marsha Griffin, MD, FAAP, Director, Univ. of Texas Rio Grande Valley Sch. of Med., Michele Heisler, MD, MPA, Professor, Univ. of Michigan Sch. of Pub. Health, Monik C. Jiménez, ScD, Assistant Professor, Harvard T.H. Chan Sch. of Pub. Health & Harvard Med. Sch./Brigham and Women's Hosp., S. Patrick Kachur, MD, MPH, FACPM, FASTMH, Professor, Columbia Univ., Joseph B. McCormick, MD, MS, Professor, Univ. of Texas, Terry McGovern, JD, Professor, Columbia Univ. Mailman Sch. of Pub. Health, Ranit Mishori, MD, MHS, FAAFP, Professor, Georgetown Sch. of Med., Rachel T. Moresky, MD, MPH, FACEP, Assoc. Professor, Columbia Univ. Mailman Sch. of Pub. Health, Kathleen Page, MD, Assoc. Professor, Johns Hopkins Univ., Anne R. Pebley, PhD, Professor, UCLA Fielding Sch. of Pub. Health, Parveen Parmar, MD, MPH, Assoc. Professor, Univ. of Southern California, Nalini Ranjit, PhD, MS, Assoc. Professor, Univ. of Texas, Les Roberts, MSPH, PhD, Professor, Columbia Univ., Leonard Rubenstein, JD, LLM, Professor of the Prac., Johns Hopkins Bloomberg Sch. of Pub. Health, Samantha Sabo, DrPH, MPH, Assoc. Professor, Northern Arizona Univ., William M. Sage, MD, JD, Professor, The Univ. of Texas at Austin, John Santelli, MD, MPH, Professor, Columbia Univ., Jaime Sepulveda, MD, MPH, MSc, DrSc, Professor, Univ. of California San Francisco, Joshua M. Sharfstein, MD, Professor, Johns Hopkins Bloomberg Sch. of Pub. Health, Goleen Samari, PhD, MPH, Assistant Professor, Columbia Mailman Sch. of Pub. Health, Craig Spencer, MD MPH, Assoc. Professor, Columbia Univ. Med. Center, Paul Spiegel, MD, MPH, Professor of the Prac., Johns Hopkins Bloomberg Sch. of Pub. Health, Andrew Springer, DrPH, MPH, Assoc. Professor, Univ. of Texas Health Sci. Ctr.—Austin, Steffanie Strathdee, PhD, Assoc. Dean of Glob. Health Scis., UC San Diego, Patrick Vinck, PhD, Rsch. Dir., Harvard Univ., Ron Waldman, MD, MPH, Professor Emeritus of Glob. Health, The George Washington Univ., Jill Guernsey de Zapien, Dir., Border, Transborder, and Binational Pub. Health Collaborative Rsch. at Univ. of Arizona & Monette Zard, MA, Dir. of the Forced Migration and Health Program, Columbia Univ. Mailman Sch. of Pub. Health to Alex Azar, Sec'y, U.S. Dep't of Homeland Sec. & Robert R. Redfield, Dir., Ctrs. for Disease Control & Prevention 1 (May 18, 2020) (on file with author) [hereinafter 2020 Letter from Public Health Experts to HHS & CDC] ("The CDC order is based on specious justifications and fails to protect public health.").

[153] *See* Guttentag, *supra* note 131 (arguing that CDC "order is designed to accomplish under the guise of public health a dismantling of legal protections governing border arrivals that the Trump administration has been unable to achieve under the immigration laws").

[154] 2020 Letter from Public Health Experts to HHS & CDC, *supra* note 152, at 1.

[155] Guttentag, *supra* note 131; *see also* 2021 Letter from Public Health Experts to HHS, *supra* note 152, at 1, 3.

any transmission or spread of COVID-19," but failed to explain why such measures could not be used to mitigate risk for other travelers.[156] The order mentions the high risk of transmission among asylum seekers staying in camps and shelters just over the Mexican border as a justification for halting asylum processing.[157] However it fails to note that this is a problem of the administration's own making, as it arises from the Migrant Protection Protocols ("MPP"), the border processing program better known as the "Remain in Mexico" policy.[158] A feasible alternative to the border closure that would not contribute to the public health crisis in these camps and shelters—and that was evidently rejected by the Trump Administration—was to suspend MPP.[159] Both administrations have also favored Title 42 expulsions for asylum seekers over evidence-based measures that are used for other categories of travelers and that would substantially mitigate risks, such as testing, masking, and social distancing.[160] Under the Trump Administration, even UCs who tested negative for COVID-19 were expelled under the order.[161]

Although the Biden administration pledged to rescind the Title 42 order, it voluntarily kept the policy in place for more than two years.[162] During that

[156] Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes, 85 Fed. Reg. 16559, 16564 (Mar. 24, 2020) (to be codified at 41 C.F.R. pt. 71).

[157] *See* Order Under Sections 362 & 365 of the Public Health Service Act (42 U.S.C. §§ 265, 268): Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists, 85 Fed. Reg. 17060, 17064 (Mar. 26, 2020).

[158] 2020 Letter from Public Health Experts to HHS & CDC, *supra* note 152, at 2.

[159] *See id.* The Biden Administration suspended and then attempted to terminate MPP. *See* Memorandum from Alejandro N. Mayorkas, Sec'y, U.S. Dep't 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 (Oct. 29, 2021) (on file with author); Memorandum from Alejandro N. Mayorkas, Sec'y, U.S. Dep't Homeland Sec., to Troy A. Miller, Acting Comm'r, U.S. Customs & Border Prot., Tae D. Johnson, Acting Dir., U.S. Immigr. & Customs Enf't & Tracy L. Renaud, Acting Dir., U.S. Citizenship & Immigr. Servs. (June 1, 2021) (on file with author). However, a federal court ordered the Administration to resume implementation of MPP pending the outcome of ongoing litigation, which it did in December 2021. *Court Ordered Reimplementation of the Migrant Protection Protocols*, U.S. DEP'T OF HOMELAND SEC., https://www.dhs.gov/archive/migrant-protection-protocols (last updated Nov. 1, 2022) (reflecting archived content that describes timeline of attempted termination of MPP and related litigation). As of this writing, ongoing litigation has raised questions about the Biden Administration's obligation to continue implementing MPP. *See* Tom Jawetz, *Troubling Signs in Biden Administration's Recent Efforts to Reimplement Migrant Protection Protocols Program*, JUST SEC. (Feb. 21, 2023), https://www.justsecurity.org/85178/troubling-signs-in-biden-administrations-recent-efforts-to-reimplement-migrant-protection-protocols-program/ [https://perma.cc/5TRE-29YN].

[160] *See* 2020 Letter from Public Health Experts to HHS & CDC, *supra* note 152, at 2.

[161] *See* Bandler et al., *supra* note 138.

[162] *See* Ted Hesson, *Biden's Immigration Goals Fade After Setbacks at the U.S.-Mexico Border*, REUTERS (Jan. 20, 2022, 3:09 PM), https://www.reuters.com/world/us/bidens-

period, the Biden administration claimed that "border patrol agents [were] simply following orders from [CDC] that were put in place to keep the country safe from Covid-19," despite the advances the country had made in combating the pandemic and the availability of new disease control measures that could be put in place.[163] Several high-ranking administration officials have resigned in protest of the decision to maintain the policy.[164] DHS Secretary Alejandro Mayorkas has attempted to limit the agency's association with the policy, stating that it "is not an immigration policy that we in this administration would embrace, but we view it as a public health imperative as [CDC] has so ordered."[165] Meanwhile, CDC pointed to the lack of public health mitigation measures in DHS facilities as a reason for its continuation of the policy.[166] Due to ongoing litigation challenging the administration's decision to end Title 42,[167] the policy remains in place and is expected to end when the COVID-19 public health emergency order ends on May 11, 2023. It is now well-understood that the public health rationale for Title 42 was a guise all along, and that both administrations used it as a tool to address immigration concerns.[168]

The next Section describes another issue within the HHS-DHS shared regulatory space—the interpretation of laws governing immigrant eligibility for

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immigration-goals-fade-after-setbacks-us-mexico-border-2022-01-20/ [https://perma.cc/8RVX-G2SA]; *CDC Public Health Determination and Termination of Title 42 Order*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/media/releases/2022/s0401-title-42.html [https://perma.cc/XJ6A-JQ7K] (last updated Apr. 1, 2022).

[163] *It's Time To End the Pandemic Emergency at the Border*, *supra* note 145.

[164] *See* Hesson, *supra* note 162 (describing departures of Tyler Moran, Deputy Assistant to the President and Senior Advisor for Migration, and Esther Olavarria, Deputy Director for Immigration for the Domestic Policy Counsel); Alex Thompson & Alexander Ward, *Top Adviser Leaves Post, Rips Biden's Use of Trump-era Title 42*, POLITICO: IMMIGR. (Oct. 4, 2021, 2:23 PM), https://www.politico.com/news/2021/10/04/top-state-adviser-leaves-post-title-42-515029 [https://perma.cc/PYK9-DJKN] (describing how Harold Koh, senior State Department official, left Biden administration because Title 42 was "illegal," "inhumane," and "not worthy of this Administration that I so strongly support," and Daniel Foote, U.S. Special Envoy to Haiti, left on similar terms).

[165] Jasmine Aguilera, *Biden Is Expelling Migrants on COVID-19 Grounds but Health Experts Say That's All Wrong*, TIME (Oct. 12, 2021, 7:00 AM), https://time.com/6105055/biden-title-42-covid-19/ [https://perma.cc/JZ6R-5P9B] (describing views that Title 42 Order is "immigration policy masquerading as a public health policy").

[166] *See* Public Health Reassessment and Order Suspending the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists, 86 Fed. Reg. 42828, 42830 (Aug. 5, 2021) ("As the ability of DHS facilities to employ mitigation measures to address the COVID-19 public health emergency increases, CDC anticipates additional lifting of restrictions.").

[167] *See, e.g.*, Camilo Montoya-Galvez, *Supreme Court Keeps Title 42 Border Expulsions in Place Indefinitely, Granting GOP-led Petition*, CBS NEWS (Dec. 27, 2022, 6:52 PM), https://www.cbsnews.com/news/supreme-court-keeps-title-42-border-expulsions-indefinitely-grants-gop-led-petition/ [https://perma.cc/YC49-UJRP] (describing "complicated legal fight over Title 42 playing out in federal courts across the U.S.").

[168] *See id.*

public benefits—in which HHS has been delegated sole authority to regulate and yet has been unable to leverage its health policy expertise.

C. *The ACA-DACA Debacle*

The evolving restrictions on noncitizens' eligibility for publicly funded health care over the past five decades present another case study of interagency dynamics in matters of health and immigration. This Section focuses on the regulatory exclusion of DACA beneficiaries from eligibility for publicly funded health insurance, including benefits under the ACA. In 2012, DHS created DACA as a subset of noncitizen beneficiaries of deferred action. Deferred action is a form of prosecutorial discretion in immigration enforcement that permits certain noncitizens to remain in the United States even though they do not have a lawful status. Decisions to grant deferred action are based on larger policy priorities about where to devote immigration enforcement resources. DACA provides temporary protection from removal and employment authorization to undocumented noncitizens who were brought to the United States by their parents when they were children. In general, beneficiaries of deferred action are eligible for certain public benefits, including publicly funded health care programs because they are considered "lawfully present." Advocates informally referred to the exclusion of DACA beneficiaries from the definition of lawfully present—and, therefore, eligibility for health insurance under the ACA—as "the ACA-DACA debacle."[169]

As described in detail below, when Congress first used the term lawfully present in the context of public benefits in 1996, it delegated authority to the Attorney General to define it.[170] The INS—the predecessor agency to DHS and, at the time, an agency within the Department of Justice—promulgated regulations that included beneficiaries of deferred action in the category of lawfully present noncitizens.[171] Pursuant to subsequent health care reforms, HHS adopted the INS regulation to define the category of "lawfully present" and "lawfully residing" noncitizens eligible for publicly funded health care programs.[172] However, HHS departed from this practice by excluding DACA beneficiaries.[173] HHS's reasoning for departing from the prior definition was not

[169] Telephone Interview with Jenny Rejeske, *supra* note 34.

[170] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401(b)(2), 110 Stat. 2105, 2261-62 (codified as amended at 8 U.S.C. § 1611(b)(2)).

[171] Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Public Law 104-193, 61 Fed. Reg. 47039, 47041 (Sept. 6, 1996) (codified at 8 C.F.R. § 103.12).

[172] Letter from Cindy Mann, Dir., Ctr. for Medicare & Medicaid Servs., Dep't Health & Hum. Servs. to State Medicaid Dir. & State Health Off. 1 (July 1, 2010) (on file with author) [hereinafter Mann, July 2010 Letter] (defining "lawful presence" and "lawfully residing" based on immigration regulations and DHS' broad definitions in 8 CFR § 103.12(a)).

[173] Letter from Cindy Mann, Dir., Ctr. for Medicare & Medicaid Servs., Dep't Health & Hum. Servs., to State Health Off. & Medicaid Dir. (Aug. 28, 2012) (on file with author)

based on health policy and did not draw on its health-related expertise, which would have supported a consistent interpretation of the term; rather, it relied on a desire to not interfere with immigration policymaking.[174] Ironically, there is evidence indicating that immigration policy priorities interfered with HHS's health policymaking: The decision to "carve out" DACA beneficiaries from the category of lawfully present noncitizens was made under pressure from an administration that was concerned about appearing too lenient on immigration issues.[175] In this case, a well-understood eligibility criterion in publicly funded health care programs was upended as a concession to immigration policy concerns.

Noncitizen eligibility for subsidized health coverage may be considered a shared regulatory space because, as in this case, it sometimes requires HHS to interpret the impact of developments in immigration law. Specifically, HHS and DHS may have related jurisdictional assignments in this context because Congress has assigned DHS the authority to exercise prosecutorial discretion in the enforcement of immigration laws, including to determine that a class of noncitizens should be allowed to remain in the country under an administrative policy, and it has assigned HHS the authority to determine the eligibility criteria for subsidized health coverage programs.[176]

The current, complex legal framework for noncitizen eligibility for public benefits—including the first use of the term lawfully present in the public benefits context—dates to 1996, when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA").[177] Under this framework, Congress determined that lawfully present noncitizens, as defined by the Attorney General, would be eligible for disability benefits under Title II of the Social Security Act.[178] INS promptly issued an interim rule with request for comments listing seven categories of noncitizens who have not

[hereinafter Mann, August 2012 Letter] (finding DACA beneficiaries to not be eligible for Medicaid and CHIP, contradicting letter issued in 2010, which stated deferred action beneficiaries are "lawfully residing" and are therefore eligible for Medicaid and CHIP).

[174] *Id.*; Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, 52615 (Aug. 30, 2012) (codified at 45 C.F.R. § 152.2(8)) ("HHS is amending its definition of 'lawfully present' in the PCIP program . . . [to] not inadvertently expand the scope of [DHS's] DACA process.").

[175] Telephone Interview with Jenny Rejeske, *supra* note 34.

[176] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401(b)(2), 110 Stat. 2105, 2261-62 (codified as amended at 8 U.S.C. § 1611(b)(2)) (giving DHS authority to determine noncitizens' eligibility for certain public benefits); 42 U.S.C. § 18081(b)(2)(B) (giving HHS authority to clarify eligibility for health coverage benefits).

[177] 8 U.S.C. § 1641(b)-(c) (restricting eligibility for federal public benefits to "qualified aliens").

[178] 8 U.S.C. § 1611(b)(2). The following year, Congress authorized the Attorney General to determine the category of lawfully present noncitizens eligible for Medicare and railroad retirement benefits as well. Balanced Budget Act of 1997, Pub. L. 105-33, § 5561, 111 Stat. 251, 638 (codified at 8 U.S.C. § 1611(b)(3)-(4)).

been deported for humanitarian or other public policy reasons and should be considered lawfully present for purposes of eligibility for Social Security disability benefits.[179] One of these categories was "[a]liens currently in deferred action status."[180] INS's reasoning for including deferred action beneficiaries among those considered lawfully present was that, like noncitizens in the other six categories, these beneficiaries "have been permitted to remain in the United States either by an act of Congress or through some other policy determination affecting that class of aliens."[181] Specifically, deferred action beneficiaries "all remain in the United States under a Presidential or administrative policy that permits them to do so."[182] Later, both the SSA and the U.S. Department of Agriculture adopted the INS's definition of "lawfully present" in interpreting statutes using the term "lawfully residing."[183]

In interpreting two subsequent health reform laws—the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") and the ACA—HHS also adopted the 1996 definition of lawfully present with minor revisions. First, in July 2010, CMS, an entity within HHS, adopted the INS definition to determine noncitizen eligibility for Medicaid and/or Children's Health Insurance Program ("CHIP") coverage under § 214 of CHIPRA, which permitted states to offer such coverage to children and pregnant women who are "lawfully residing in the United States."[184] Later that month, HHS used the definition from the CMS guidance letter in an interim final regulation defining lawfully present for the Pre-Existing Condition Insurance Plan ("PCIP") program, a new health insurance affordability program established by the ACA.[185] Next, in August 2011 and March 2012, HHS issued proposed and final rules regarding noncitizen eligibility for subsidized health insurance from the ACA Affordable Insurance Exchanges that referred to the definition of lawfully present in the PCIP program regulation.[186]

[179] Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Public Law 104-193, 61 Fed. Reg. 47039, 47041 (Sept. 6, 1996) (codified at 8 C.F.R. § 103.12).

[180] *Id.* at 47040.

[181] *Id.*

[182] *Id.*

[183] Mann, July 2010 Letter, *supra* note 172, at 2.

[184] *Id.* at 2-4; Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 214, 123 Stat. 8, 56-57 (codified as amended at 42 U.S.C. § 1396b(v)(4)(A), § 1397gg(e)(1)(O)).

[185] Pre-Existing Condition Insurance Plan Program, 75 Fed. Reg. 45014, 45015-16 (July 30, 2010) (codified at 45 C.F.R. § 152.14(a)(1)-(3)).

[186] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310, 18314 (Mar. 27, 2012) (codified at 45 C.F.R. § 155.20) (considering suggestions to clarify and expand "lawfully present" definition); Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 51202, 51206 (proposed Aug. 17, 2011). Likewise, in May 2012, the Department of the Treasury relied on the same definition to issue regulations implementing the portion of the

In summary, up to this point, various agencies charged with defining the category of lawfully present noncitizens eligible for public benefits reliably adopted the definition that first appeared in the 1996 INS regulation interpreting the Social Security Act. In all these interpretations, beneficiaries of deferred action were considered to be lawfully present. This changed after DHS announced the DACA policy in June 2012.

DHS announced the DACA policy after Congress failed to pass legislation that would have given amnesty to a select group of noncitizens without lawful status who had been living in the United States since they were children.[187] Like other forms of deferred action, DACA provides beneficiaries with employment authorization and with the assurance that they will not be targeted for immigration enforcement.[188] Because DACA is a form of deferred action, it is reasonable to expect that DACA beneficiaries would be treated identically to other beneficiaries of deferred action in the context of public benefits eligibility.[189] However, in August 2012, the Director of CMS issued a guidance letter to state health officials explaining that DACA beneficiaries would be excluded from eligibility for Medicaid and CHIP under the CHIPRA option for lawfully residing pregnant women and children.[190] Two days later, CMS published an amendment to the 2010 interim final rule defining lawfully present

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ACA creating "premium tax credits," a feature of the Exchanges. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30378 (May 23, 2012) (codified at 26 C.F.R. § 1.36B-1(g)).

[187] Memorandum from Janet Napolitano, Sec'y of Homeland Sec., U.S. Dep't of Homeland Sec., to David V. Agular, Acting Comm'r, U.S. Customs & Border Prot., Alejandro Mayorkas, Dir., U.S. Citizenship & Immigr. Servs. & John Morton, Dir., U.S. Immigr. & Customs Enf't (June 15, 2012) (on file with author) (using prosecutorial discretion to grant deferred action for individuals who arrived in the U.S. as children and meet certain criteria).

[188] *Id.*

[189] Some scholars have described how, two years later in 2014, the Administration's acknowledgment of this fact—that deferred action beneficiaries are considered lawfully present, implying their eligibility for certain public benefits—was an important factor in undoing Deferred Action for Parents of Americans ("DAPA"). *See* Chen, *supra* note 26, at 388-89 (stating that DAPA announcement "more strongly supported the award of associated benefits"—one reason why it was more controversial than DACA—and may have motivated more aggressive efforts to challenge policies); Anil Kalhan, *DAPA, "Lawful Presence," and the Illusion of a Problem, by Anil Kalhan*, YALE J. ON REGUL.: NOTICE & COMMENT (Feb. 12, 2016), https://www.yalejreg.com/nc/dapa-lawful-presence-and-the-illusion-of-a-problem-by-anil-kalhan/ [https://perma.cc/QA7Y-6TSQ] (describing how confusion about legal sources of collateral benefits for deferred action beneficiaries among litigants and judges during DACA/DAPA litigation led to determination that DHS had exceeded its mandate in enacting DACA and DAPA policies). DAPA was a policy similar to DACA but applied to the undocumented parents of children who are U.S. citizens or Lawful Permanent Residents. Memorandum from Jen Charles Johnson, Sec'y, U.S. Dep't of Homeland Sec., to León Rodriguez, Dir., U.S. Citizenship & Immigr. Servs., Thomas S. Winkowski, Acting Dir., U.S. Immigr. & Customs Enf't & R. Gil Kerlikowske, Comm'r, U.S. Customs & Border Prot. 4-5 (Nov. 20, 2014) (on file with author).

[190] Mann, August 2012 Letter, *supra* note173, at 1.

for the PCIP program that excluded DACA beneficiaries from the category of lawfully present noncitizens.[191] Since the definition of lawfully present in the PCIP program regulation was adopted by CMS and the Treasury Department in their Exchange regulations, the amendment also excluded DACA beneficiaries from participation in the Exchanges.[192]

HHS's deviation from the otherwise consistent inclusion of deferred action beneficiaries in the category of lawfully present noncitizens eligible for subsidized health insurance programs was not linked to health policy concerns; rather, HHS rationalized it through a constructed understanding of DHS's goals in creating DACA. Specifically, HHS stated that it would be improper to infer that DACA beneficiaries are eligible for health-related benefits because DHS did not explicitly consider eligibility for health-related benefits as a rationale for adopting DACA.[193] Furthermore, HHS claimed that *not* carving out DACA beneficiaries from the definition of lawfully present would "inadvertently expand the scope of the DACA process."[194] This reasoning is faulty, first because it would have been odd for DHS to describe DACA beneficiaries' eligibility for public benefits in its policy announcement since eligibility determinations for public benefits are the domain of HHS, as described in the following paragraph. Second, if DHS were to have interpreted DACA beneficiaries' eligibility for subsidized health coverage in its policy memo, it would have had to recognize that they were considered lawfully present under existing regulations. In no way would this constitute an "expansion" of deferred action processes—it was the status quo. Third, and most crucially, HHS's reasoning conflicts with DHS's overall goal of legitimizing the presence of DACA beneficiaries.[195] Understanding deferred action beneficiaries as noncitizens whose "presence in the United States has been sanctioned by a policy determination . . . implemented by an official act having the force of law" was and continues to be the basis for including them among the lawfully present noncitizens who qualify for certain health-related benefits.[196]

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[191] Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, 52615 (Aug. 30, 2012) (codified at 45 C.F.R. pt. 152) (amending HHS policy to not include DACA recipients in PCIP program).

[192] Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30378 (May 23, 2012).

[193] *See* Medha D. Makhlouf & Patrick J. Glen, *A Pathway to Health Care Citizenship for DACA Beneficiaries*, 12 CALIF. L. REV. ONLINE 29, 35-36 (2021) (citing Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, 52615 (Aug. 30, 2012) (codified at 45 C.F.R. pt. 152)); *see also* Mann, August 2012 Letter, *supra* note 173, at 1.

[194] Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. at 52615.

[195] Makhlouf & Glen, *supra* note 193, at 36-38.

[196] Definition of the Term Lawfully Present in the United States for Purposes of Applying for Title II Benefits Under Section 401(b)(2) of Public Law 104-193, 61 Fed. Reg. 47039, 47040 (Sept. 6, 1996) (codified at 8 C.F.R. § 103.12) (describing, for the first time, "[t]he characteristic common to all the classes of aliens defined as 'lawfully present in the United States'" for purposes of public benefits eligibility).

This decision caught advocates for immigrants by surprise because in all of their communications with HHS up to that point, agency staff indicated that their intent was to make subsidized health coverage under the ACA as expansive as possible and to ensure that all categories of noncitizens eligible for ACA benefits under the statute would have access to subsidized health coverage.[197] When HHS deferred to an immigration-based justification for excluding DACA beneficiaries from eligibility for subsidized health coverage without weighing it against health policy considerations, it essentially surrendered its authority to define the scope of benefits under the ACA to the administration's immigration policy priorities.[198] Among the major goals of the ACA were improving health care equity, health care system efficiency, and public health by expanding access to affordable care.[199] The DACA carve-out weakens each of these efforts.[200] If HHS had leveraged its health policy expertise in determining the scope of benefits for DACA beneficiaries, it would have had to confront these negative health policy consequences. It is precisely because of HHS's health-related expertise that it is responsible for determining the eligibility criteria for subsidized health coverage programs.[201] Jenny Rejeske, an advocate with the National Immigration Law Center stated that, to advocates, it was a "mind-boggling" decision because HHS was not required to interpret DACA beneficiaries' eligibility for ACA benefits; if HHS had not promulgated a rule, DACA beneficiaries would have "quietly gained eligibility," in line with HHS's expressed goals.[202]

Shortly after HHS issued its guidance and regulation creating the DACA carve-out, Congresspeople raised the objections described here and urged the administration to reverse its decision.[203] Although Congress did not explicitly

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[197] Telephone Interview with Jenny Rejeske, *supra* note 169 (noting that she had attended many meetings with HHS staff regarding ACA implementation and accessibility for noncitizens).

[198] *See* Makhlouf & Glen, *supra* note 193, at 37.

[199] *Id.* at 38-40.

[200] *Id.*

[201] *Id.* at 37.

[202] Telephone Interview with Jenny Rejeske, *supra* note 34.

[203] *See, e.g.*, Press Release, Off. of Rep. Barbara Lee, Letter to Obama: Reinstate Healthcare to DREAMers (Dec. 18, 2012), https://lee.house.gov/news/press-releases/letter-to-obama-reinstate-healthcare-to-dreamers [https://perma.cc/QU9Y-NMD2] (arguing HHS rule excludes healthy individuals from risk pool, restricts access to preventative care, and harms public health). HHS noted in its amendment to the 2010 interim final rule that the DACA carve-out "is consistent with the policy" articulated in a recent version of the DREAM Act, perhaps for the purpose of proving alignment between its decision and congressional intent. Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, 52616 (Aug. 30, 2012) (codified at 45 C.F.R. pt. 152). However, the proposed exclusion of "conditional nonimmigrants" from participation in the ACA Exchanges in S. 3992 should not be read to represent congressional intent on inclusion of DACA beneficiaries. *See* DREAM Act, S. 3992, 111th Cong. § 12(a)(2) (2010). This is because DREAM Act beneficiaries, unlike DACA beneficiaries, would have been permitted to apply for adjustment of status to Lawful

define lawfully present in the ACA or CHIPRA, neither did it indicate that new categories of noncitizens that comport with the generally recognized definition of lawfully present should be excluded from or reassessed for eligibility for benefits under these statutes.[204] During the COVID-19 pandemic, there has been a renewed effort among legislators to persuade HHS to delete the DACA carve-out through rulemaking.[205] Legislation has also been introduced that would define lawfully present across subsidized health coverage programs to include DACA beneficiaries.[206]

In September 2021, DHS issued a notice of proposed rulemaking about DACA which, among other things, reiterates its understanding that all beneficiaries of deferred action should be considered lawfully present.[207] That rule went into effect on October 31, 2022.[208] However, the rule's interpretation

Permanent Resident ("LPR") immediately. *Compare id.* at § 6(c) (describing DREAM Act application process), *with* Memorandum from Janet Napolitano, Sec'y of Homeland Sec., *supra* note 187 (authorizing only deferral of removal actions against eligible beneficiaries). Within months of the Act's passage, they would have been eligible for subsidized health coverage from the ACA Exchanges. *See* 42 U.S.C.A. § 18071(e) (West 2022) (clarifying coverage eligibility for noncitizens lawfully present). DACA beneficiaries, by contrast, do not have a pathway to LPR status and any restrictions on their access to public benefits apply for long as they remain in this quasi-status. Some DACA beneficiaries have lacked access to subsidized health coverage for nearly a decade while they lived, studied, and worked in the United States with DHS's permission. *See* Deferred Action for Childhood Arrivals, 86 Fed. Reg. 53736, 53738 (Sept. 28, 2021) (to be codified at 8 C.F.R. pts. 106, 236, 274a) (listing numerous ways DACA beneficiaries have become integrated into their communities).

[204] Deferred Action for Childhood Arrivals, 86 Fed. Reg. at 53762 (citing 8 U.S.C. §§ 1611(b)(3)-(4)) (noting, in a proposed rule reiterating DACA beneficiaries' eligibility for Social Security benefits, that "[i]n the intervening 25 years since the Attorney General issued her rule [defining lawfully present], Congress has not offered any indication to question or countermand that determination that the specified categories of noncitizens are eligible for Social Security benefits, and in fact, Congress only has enacted other similar provisions indicating that the Attorney General's determinations as to lawful presence for certain individuals make those individuals eligible for public benefits").

[205] Letter from Joaquin Castro, Member of Cong., to Joseph R. Biden, U.S. President, and Norris Cochran, Acting Sec'y, U.S. Dep't Health & Hum. Servs. (Jan. 26, 2021), https://castro.house.gov/imo/media/doc/1.27%20Letter%20ACA%20benefits%20for%20DACA%20recipients%20FINAL!.pdf [https://perma.cc/RR9V-W4WQ].

[206] *See, e.g.*, Lifting Immigrant Families Through Benefits Access Restoration Act of 2021, H.R. 5227, 117th Cong. § 2 (amending PRWORA to provide federal public benefit eligibility for lawfully present noncitizens and specifically including DACA beneficiaries); Health Equity & Access Under the Law for Immigrant Families Act of 2021, S. 1660, 117th Cong. §§ 3-5 (restoring eligibility for federal public benefit programs to lawfully present noncitizens, defining lawfully present to mean "all individuals granted federally authorized presence" for subsidized health coverage programs, and eliminating noncitizen restrictions for receiving ACA subsidies to purchase health insurance on Exchanges).

[207] Deferred Action for Childhood Arrivals, 86 Fed. Reg. at 53760-62.

[208] *See* Press Release, U.S. Citizenship and Immigr. Servs., DHS Begins Limited Implementation of DACA Under Final Rule (Nov. 3, 2022), https://www.uscis.gov/newsroom/news-releases/dhs-begins-limited-implementation-of-daca-under-final-rule [https://perma.cc/B7GM-GFFL].

of lawfully present only applies to eligibility for one category of public benefits administered by the Social Security Administration, which Congress had authorized the Attorney General to determine.[209] It remains to be seen if HHS will follow suit and issue regulations reinterpreting the lawfully present category to include DACA beneficiaries, in line with DHS.[210]

The relationship between HHS and DHS on the issue of noncitizen eligibility for public benefits is symmetrical (neither agency has formal authority over the other), which should enable each agency to leverage its expertise to the maximum degree, while potentially generating conflicts based on the agencies' differing perspectives and missions. In the case study of policymaking on DACA beneficiaries' eligibility for subsidized health coverage, however, it appears that HHS deferred entirely to immigration policy priorities on a decision that it had sole authority to make. This is a markedly different situation from when an agency uses coordination tools to seek input from other agencies in joint policymaking because HHS did not draw on health policy goals and constraints in justifying the DACA exclusion.[211] Rather, HHS abdicated its responsibility to do so.

III. ANALYSIS OF HEALTH POLICY MARGINALIZATION IN SHARED REGULATORY SPACE

The case studies of interagency dynamics on issues within the shared regulatory space of HHS and DHS reveal not only that immigration policy and health policy concerns frequently clash, but also that immigration policy concerns are often elevated at the expense of health policy expertise and priorities. The common challenge identified in each of the three case studies is the inability to leverage health-related expertise in support of agency missions.[212] A key factor that affects policymakers' ability to leverage expertise in shared regulatory space is political influence.

Political preferences may dictate what kind of authority is delegated to certain agencies, affecting one agency's ability to co-opt the mission of another, such that only one agency's goals are prioritized.[213] DHS's broad discretion over

[209] Deferred Action for Childhood Arrivals, 87 Fed. Reg. 53152, 53212-13 (Aug. 30, 2022) (codified at 8 C.F.R. pts. 106, 236, 274a); 8 U.S.C. § 1611(b)(2) (authorizing this determination only for Title II of Social Security Act).

[210] *See* Deferred Action for Childhood Arrivals, 86 Fed. Reg. at 53761-62 (addressing whether DHS is authorized to deem DACA beneficiaries lawfully present); Letter from Ctr. for L. & Soc. Pol'y et al., to Xavier Becerra, Sec'y, U.S. Dep't of Health & Hum. Servs. (Oct. 25, 2022), https://www.lwv.org/sites/default/files/2022-11/Immigration%20NILC%20Letter%20to%20HHS%20on%20DACA%20Health%20Coverage.pdf [https://perma.cc/9ZWM-WP2T].

[211] *See infra* Section IV.A.1 (discussing interagency coordination tools generally).

[212] *See supra* Part II (addressing challenges in care of unaccompanied immigrant children, pandemic border expulsions, and ACA coverage).

[213] Robert Knowles & Geoffrey Heeren, *Zealous Administration: The Deportation Bureaucracy*, 72 RUTGERS U. L. REV. 749, 755 (2020) (defining "mission cooptation" in

immigration policy and HHS's lack of autonomy to make decisions on issues relating to UCs in the agencies' shared regulatory space are structural features that enable DHS to coopt HHS's mission in those spaces.[214]

When DHS was established in 2003, the immigration bureaucracy was relocated within a new agency organized around protecting national security and countering terrorism.[215] Scholars have noted that "a national security mandate . . . carries a special vagueness that invites mission creep."[216] Agencies typically focus on tasks that take advantage of or enhance their autonomy, and DHS is no different.[217] Scholars have described how INS/DHS's immigration enforcement mission has co-opted the missions of the Departments of Labor, Justice, and State.[218] This suggests that the tendency to subordinate other policy priorities to immigration enforcement concerns is not limited to issues in the HHS-DHS shared regulatory space. Within DHS itself, immigration enforcement has dominated the bureaucratic culture,[219] co-opting the missions of subagencies focused on providing immigration services and humanitarian protection to noncitizens.[220]

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interagency context to mean "the tendency of an agency . . . to convert to its mission other agencies with different missions sharing the same regulatory space").

[214] *See id.* at 757 (describing DHS's "vast enforcement discretion"). Stephen Lee describes a similar dynamic between the Department of Labor and ICE relating to worksite enforcement, stating, "[I]mmigration enforcement agency officials could have considered the labor consequences of their decisions but chose not to do so, while labor agency officials would have preferred to coordinate enforcement efforts but were powerless to force any such conversation." Lee, *supra* note 26, at 1092.

[215] *Creation of the Department of Homeland Security*, U.S. DEP'T OF HOMELAND SEC., https://www.dhs.gov/creation-department-homeland-security [https://perma.cc/EG8N-GSK2] (last updated June 3, 2022) (detailing DHS creation through Homeland Security Act of 2002); *see* Knowles & Heeren, *supra* note 213, at 752, 788; Nina Rabin, *Victims or Criminals? Discretion, Sorting, and Bureaucratic Culture in the U.S. Immigration System*, 23 REV. L. & SOC. JUST. 195, 216 (2014) ("[T]he War on Terror gave a unifying mission to a pre-existing focus on crime control.").

[216] Knowles & Heeren, *supra* note 213, at 790.

[217] *Id.* at 791 (noting that typically, bureaucrats will not seek greater prestige or authority if it brings less autonomy).

[218] *See* Daval, *supra* note 2, at 1041-42 (citing KITTY CALAVITA, U.S. IMMIGRATION LAW AND THE CONTROL OF LABOR: 1820-1924, at 67-68 (1984)) (detailing how ICE, rather than Department of Labor, now regulates labor of undocumented people); Knowles & Heeren, *supra* note 213, at 757 ("[S]igns abound that immigration agencies in other departments, like Justice and State, have, with White House prodding, also been coopted for ICE's enforcement mission."); Lee, *supra* note 26, at 1093, 1097, 1100 (describing how immigration agencies have "dictate[d] the terms" of worksite enforcement strategy and its interagency relationship with Department of Labor, even though Congress intended to distribute authority symmetrically); Rabin, *supra* note 215, at 242.

[219] *See, e.g.*, Knowles & Heeren, *supra* note 213, at 780 (noting that bureaucrats zealously committed to deportation have been highly empowered within DHS); Rabin, *supra* note 215, at 196.

[220] *See, e.g.*, Jennifer M. Chacón, *Tensions and Trade-Offs: Protecting Trafficking Victims in the Era of Immigration Enforcement*, 158 U. PA. L. REV. 1609, 1614 (2010) (describing

In the context of the first case study, HHS and DHS have formally symmetrical authority to coordinate the release of UCs to safe and appropriate placements; however, DHS has the autonomy to make immigration policy decisions without considering the consequences for the health and wellbeing of UCs, which may be an expression of political preference.[221] These decisions affect HHS's ability to achieve its statutory mission of operating on the best interests of the child in the care and placement of UCs.[222] HHS's ability to leverage its child welfare expertise to improve conditions for UCs in its custody to an acceptable level is limited by its lack of authority to influence immigration policies so that they are oriented toward protecting UCs from harm. Although the formal responsibility of caring for UCs was transferred to HHS/ORR, DHS still plays the dominant role in crafting policy that affects the conditions of their detention.[223] The core of the problem is that HHS has been left out of DHS's decision-making process in matters that will impact the care of UCs, often leaving HHS scrambling to adjust to new DHS policies. Consequently, HHS has not been able to advise DHS during the decision-making process about how proposed actions will impact its mission. The aftermath of the Zero Tolerance policy illustrates the tragic consequences of this dynamic.[224]

Over time, structural choices inform the tasks that dominate an agency's focus and help entrench its bureaucratic culture and mission.[225] Through this process, it becomes harder for the agency to modify or add nuance to its administration of critical tasks.[226] These features have solidified the bureaucratic pattern of deference to immigration enforcement in matters within the HHS-DHS shared regulatory space, allowing DHS to set the agenda.

Section II.A.1 describes HHS's reluctance to intervene in immigration policy on issues in the HHS-DHS shared regulatory space because of the HHS leadership's view that HHS is a "minor participant" on matters in their shared

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how "antitrafficking efforts . . . have been heavily constrained by the politics and policies of rigid immigration enforcement"); Knowles & Heeren, *supra* note 213, at 757, 780, 806 (describing ICE's cooptation of U.S. Citizenship and Immigration Services' service-based mission); Stephen H. Legomsky, *The New Path of Immigration Law: Asymmetric Incorporation of Criminal Justice Norms*, 64 WASH. & LEE L. REV. 469, 505 (2007) (noting "obsession with deterring asylum fraud has blocked out all competing policy objectives"); Rabin, *supra* note 215, at 233 (describing how DHS's culture of viewing immigrants as criminal threats interferes with its humanitarian goals).

[221] *See supra* notes 88-106 and accompanying text (discussing overlap and separation of powers between HHS and DHS for unaccompanied immigrant children).

[222] *See* 6 U.S.C. § 279(b)(1)(B).

[223] *See supra* notes 88, 98 and accompanying text (noting, for example, DHS's responsibility for conditions resulting from Zero Tolerance policy).

[224] *See supra* notes 107-14 and accompanying text (detailing this policy and its effects on unaccompanied children and public trust).

[225] Rabin, *supra* note 215, at 211-12.

[226] *See, e.g.*, *id.* at 233-37 (detailing backlash to prosecutorial discretion initiative by ICE agents, who are entrenched in culture viewing immigrants exclusively as criminal threats).

regulatory space.[227] A 2020 report of the HHS Office of Inspector General quotes a former Acting Assistant Secretary for the Administration of Children and Families ("ACF") within HHS as stating, "Our participation in immigration policy is very limited and well-defined. Our job is to have a bed available for the next child that is brought to us by ICE or CBP. That is what our role is and what we focus on. Our role is limited to that."[228] The report cited this reluctance to intervene as a "key factor" in the agency's failure to ensure adequate care of UCs during the development and implementation of the Zero Tolerance policy.[229] The report also describes findings demonstrating senior HHS officials' beliefs that their "suggestions regarding immigration policy were sometimes interpreted as obstructing law enforcement efforts."[230] Perhaps most indicative of the HHS leadership's subordination of their mission to immigration concerns, "[t]he Acting Assistant Secretary for ACF stated that HHS should not seek to affect immigration policy regardless of its impact on the UAC Program; rather, HHS should adapt to whatever policies are put in place."[231] This culture enabled DHS to further its immigration enforcement mission at the expense of UCs' health and wellbeing. For example, while the Zero Tolerance policy was being developed, DHS prioritized finalizing a Memorandum of Agreement ("MOA") that required HHS to obtain fingerprints from potential sponsors of UCs and share them with ICE, the purpose of which was to enable ICE to identify sponsor applicants for arrest and removal.[232] A foreseeable consequence of this new information-sharing policy was that potential sponsors of UCs would be less likely to come forward based on fears of immigration enforcement, delaying the release of UCs from ORR custody and exacerbating ORR's capacity issues.[233]

Even when Congress has delegated sole authority over an issue to HHS, immigration policy concerns can have outsized influence on health policies, at times outweighing HHS's judgments deriving from its health-related expertise. Over time, patterns of health policy subordination to immigration policy have become entrenched.[234] In the context of the Title 42 policy, there is considerable evidence that the Trump Administration's immigration policy priority of reducing migration flows of asylum seekers at the southern U.S. border displaced public health experts' evaluation of the policy.

It is apparent that CDC Director Robert Redfield understood that he did not have the power to push back against the Trump Administration's immigration policy priorities and capitulated despite the lack of scientific support for the

[227] OIG-HHS Report, *supra* note 107, at 18 (internal quotation marks omitted) (quoting Counselor to Secretary for Human Services Policy).

[228] *Id.*

[229] *Id.* at 17-18.

[230] *Id.* at 18.

[231] *Id.*

[232] *Id.* at 17.

[233] *Id.*

[234] *See, e.g.*, *id.* at 18 (addressing this source of tension between HHS and DHS).

order.[235] As a political appointee, Redfield—like other high-level officials in the executive branch—demonstrated that he felt little pressure to align with lower-level, career administrators with relevant expertise.[236] It is common for political appointees to understand that their job security and future career success depend on their ability to further the goals and interests of the President.[237] This was particularly true about pandemic-related issues during the administration of the mercurial President Trump.[238]

Scholars have introduced concepts such as "pooling" and "structural deregulation" to describe this kind of executive-initiated intervention in the work of agencies. Daphna Renan writes that "[p]ooling blends the legal authorities that different agencies derive from distinct statutory schemes. And it enables the executive to combine one agency's expertise with legal authority allocated to another."[239] In theory, pooling shares in common many of the efficacy benefits of legislatively prescribed interagency coordination. For example, it allows the executive to "bridg[e] silos of expertise in interconnected times," it "enables agencies with greater . . . expertise to help agencies with more muscular legal authorities to make complex [decisions]," and it "can bring detached expertise and the professional norms of one agency to bear on the more pressurized environment of another."[240] In this case, however, the influence appeared to run in one direction only—from the White House's immigration policy priorities to CDC—in order to achieve an outcome that otherwise would have been unobtainable under the authority allocated to DHS.

For this reason, Jody Freeman and Sharon Jacob's concept of "structural deregulation" may be more apt. They define the term as "the systematic undermining of an agency's ability to execute its statutory mandate" by a powerful President.[241] This is accomplished by "erod[ing] an agency's staffing, leadership, resource base, expertise, and reputation."[242] They note that structural deregulation is particularly insidious "when the agency's authorizing statute

[235] *See* Bandler et al., *supra* note 138 (highlighting pressure by Stephen Miller to close border).

[236] *See, e.g.*, *id.* (noting Redfield's limited experience within CDC and frequent contact with White House officials).

[237] *See, e.g.*, Anthony J. Ghiotto, *The Presidential Coup*, 70 BUFF. L. REV. 369, 451 (2022) (noting this dynamic results partly from President's authority to remove appointees).

[238] *See, e.g.*, Sachs, *supra* note 8, at 90-91; Jacqueline Salwa & Christopher Robertson, *The Need for a Strong and Stable Federal Public Health Agency Independent from Politicians*, *in* COVID-19 POLICY PLAYBOOK: LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE 64, 65 (Scott Burris et al. eds., 2021) (describing examples of political interference during Trump Administration, including interference with FDA decision to issue Emergency Use Authorization for Covid-19 vaccine and with CDC's release of public health data in *Morbidity and Mortality Weekly Report*).

[239] Daphna Renan, *Pooling Powers*, 115 COLUM. L. REV. 211, 213 (2015).

[240] *Id.* at 276-77.

[241] Jody Freeman & Sharon Jacobs, *Structural Deregulation*, 135 HARV. L. REV. 585, 586 (2021) (calling structural deregulation dangerous aspect of presidential administration).

[242] *Id.* at 587.

contemplates that the agency will develop and bring to bear scientific and technical expertise."[243] The implementation of Title 42 has marginalized public health expertise and contributed to the damage to CDC's reputation during the COVID-19 pandemic. It has encroached on Congress's purpose of delegating quarantine authority to actors and agencies with public health expertise—to protect against politically motivated discrimination against immigrants. And it has "contravene[d] longstanding administrative law norms of procedural regularity, transparency, rationality, and accountability," by making CDC's rulemaking process into a farce.[244]

In the context of the DACA carve-out, pressure from the President interfered with HHS's ability to leverage its expertise to make a decision that was consistent with existing policies and that would promote health policy priorities. During the discussions leading up to the passage of the ACA in 2010, there were heated debates over whether undocumented immigrants would be eligible for certain ACA benefits.[245] Those who played a central role in negotiating the ACA seemed to believe that including benefits for undocumented immigrants would jeopardize the entire bill.[246] To garner support for his health reform proposal, President Obama promised that undocumented immigrants would be excluded from its new subsidized health insurance program.[247] Two years later, the DACA carve-out helped him fulfill that promise.[248]

[243] *Id.* at 616.

[244] *Id.* at 590.

[245] *See, e.g.*, Opinion, *Immigrants, Health Care and Lies*, N.Y. TIMES (Sept. 10, 2009), https://www.nytimes.com/2009/09/11/opinion/11fri2.html (discussing dynamics of debate after Representative Joe Wilson's interrupted President Obama's joint address to Congress, shouting, "You lie!", after President Obama stated that undocumented immigrants would not benefit from proposed health care reforms); Jim Landers, *Senator Says Health Insurance Plan Won't Cover Illegal Immigrants*, DALLAS MORNING NEWS (May 22, 2009) (reporting on comment by Senator Max Baucus, who played central role in ACA negotiations, that any new subsidized health coverage program would not include undocumented immigrants because such proposals would be "too politically explosive").

[246] *See* Janet L. Dolgin & Katherine R. Dieterich, *When Others Get Too Close: Immigrants, Class, and the Health Care Debate*, 19 CORNELL J.L. & PUB. POL'Y 283, 313 (2010); Interview with Jose Magaña-Salgado, Principal & Founder, Masa Group, LLC (Nov. 5, 2021) (on file with author) (calling including undocumented immigrants in ACA "politically toxic"). Another possible reason why the administration excluded DACA beneficiaries from eligibility for ACA subsidies was to preclude complaints about "expanding" subsidies to new groups at a time when there were widespread complaints about the inadequacy of the subsidies, i.e., that they did not make ACA coverage affordable enough. The decision to exclude may have been a political calculation to avoid highlighting a seeming incongruity in health policy priorities.

[247] *Immigrants, Health Care, and Lies*, *supra* note 245 (discussing President Obama's pitch to congressional joint session).

[248] It is likely that the issue of DACA beneficiaries' eligibility for subsidized health coverage was overlooked entirely by influential immigration policymakers during DACA's development. Telephone Interview with Jenny Rejeske, *supra* note 34 (stating that "people weren't talking about [DACA beneficiaries' eligibility for ACA benefits] in the mainstream

The routine marginalization of health-related expertise in shared regulatory space involving immigration issues reveals a need to extend interagency coordination theory to account for factors beyond institutional design that shape regulatory power in different policy areas. Interagency coordination theory does not currently account for the predictable capitulation by agencies/actors in certain policy areas to agencies/actors in other policy areas. The next Part aims to extend the theory to accommodate evidence from the case studies about immigration enforcement policy dominance.

IV. APPLYING AND EXTENDING ADMINISTRATIVE LAW THEORY

There is a rich scholarly literature on apolitical structural interventions to facilitate interagency coordination and, in some cases, to address imbalances in agency power. To the extent that institutional design is a source of health policy marginalization, it is worthwhile to consider whether interagency coordination and other structural interventions might enable agencies/actors with health policy expertise to leverage that expertise and advocate for their policy priorities. However, structural interventions may not reach entrenched policy dominance, as illustrated in this Article's case studies on issues at the intersection of health and immigration policy. Instead, proponents of balance in this space may look to social movements for strategies to change how political leaders prioritize health issues and value health expertise.

A. *Structural Interventions To Rebalance Authority*

1. Overview of Interagency Coordination Tools

Interagency coordination mechanisms help agencies collaborate effectively and reap the benefits of shared regulatory space described in Part I. This Article adopts Professors Freeman and Rossi's description of three common types of agency interactions that can function as coordination tools: interagency consultation, interagency agreements, and joint policymaking.[249]

Interagency consultation occurs when "an agency with the exclusive authority to regulate or manage a problem cannot proceed without first consulting, or taking comment from, another agency whose mission is implicated in the action agency's decisionmaking."[250] Interagency consultation can occur voluntarily, may be encouraged or required by Congress, or conducted under a directive from the President.[251] This is a flexible tool that can be designed to be more or less

media" and noting that some legislators who focus on immigration policy avoid health policy because of its complexity); Interview with Jose Magaña-Salgado, *supra* note 246.

[249] Freeman & Rossi, *supra* note 1, at 1157-73 (outlining coordination tools of agency interaction).

[250] *Id.* at 1157.

[251] *Id.* at 1161 (noting that interagency consultation may also be prohibited by statute); *see also* Renan, *supra* note 239, at 213 (defining executive-initiated agency coordination as "pooling").

burdensome to the acting agency, depending on the degree of influence that Congress or the President wishes to accord to the interested (non-acting) agency.[252] Mandated interagency consultation is especially useful when an interested agency has expertise—"new information or perspectives"—that could influence policymaking by an acting agency with an insular culture.[253]

Interagency agreements—typically, memoranda of understanding—are contract-like agreements between agencies that "assign responsibility for specific tasks, establish procedures, and bind the agencies to fulfill mutual commitments."[254] Like interagency consultation, agencies can enter into agreements voluntarily or may be required to establish agreements by Congress or directed to do so by the President.[255] They are especially useful for interagency coordination of internal matters, rather than outward-facing policies.[256] For example, in the event that an agency is authorized to delegate certain responsibilities to another agency, interagency agreements may facilitate this process.[257]

The third tool, joint policymaking, includes informal and formal policymaking, from joint administrative guidance to parallel rulemaking.[258] Like the other tools, joint policymaking can be voluntary, encouraged, or required.[259] Freeman and Rossi identify joint policymaking as an especially helpful tool for agencies seeking to leverage expertise for mutual benefit.[260] One way of enabling an interested agency to influence the policies of an acting agency is "leadership intermingling," which is "placing an actor from one agency within the decision-making structure of another."[261]

Professors Freeman and Rossi also describe two interagency coordination tools available to the President as a manager of interagency coordination: the

[252] Freeman & Rossi, *supra* note 1, at 1157-60 (describing interagency consultation arrangements requiring different levels of deference to the interested agency, namely "[d]iscretionary [c]onsultation," "[m]andatory [c]onsultation," "[p]ublic [r]esponse [r]equirements," "[d]efault [p]osition [r]equirements," and "concurrence requirements"). On the more burdensome end of the spectrum, concurrence requirements may be structured as a veto power, enabling an interested agency to prevent another agency from acting. *Id.* at 1160; Jacobs, *supra* note 1, at 400 (describing the interagency veto as "[t]he strongest version of the interagency check").

[253] Freeman & Rossi, *supra* note 1, at 1192 (noting such mechanisms are particularly constructive in situations with high potential for mission conflict).

[254] *Id.* at 1161 (noting that although interagency agreements "resemble contracts, . . . they are generally unenforceable and unreviewable by courts").

[255] *Id.*

[256] *Id.* at 1192.

[257] Jacobs, *supra* note 1, at 403.

[258] Freeman & Rossi, *supra* note 1, at 1165.

[259] *Id.* at 1167.

[260] *Id.* at 1191-92.

[261] Jacobs, *supra* note 1, at 404 (describing leadership intermingling as check on interagency processes).

creation of policy offices and regulatory review.[262] Presidential directives may come in the form of informal requests or executive orders or presidential memoranda.[263] The Office of White House Policy is "the President's primary vehicle for policy coordination," and new offices may be established or special advisors appointed to coordinate agencies in addressing specific problems.[264] The second tool they describe is regulatory review by the Office of Information and Regulatory Affairs (OIRA) within the Office of Management and Budget under Executive Order 12,866.[265] Under this authority, OIRA may "review agency regulatory actions for consistency with presidential priorities, statutory mandates, and, notably, other agencies' rules."[266] This is an ideal opportunity to identify agencies with an interest in the regulation under review and to invite their input on it, in the interest of coherent policymaking.[267]

When mandating or encouraging interagency coordination, Congress and the President can influence interagency relationships by allocating authority symmetrically or asymmetrically between the agencies. Professors Farber and O'Connell describe three types of interagency relationships that Congress might seek to create in different circumstances: hard hierarchical relationships, advising and monitoring relationships, and symmetrical relationships.[268] Although Congress rarely creates hard hierarchical relationships across agencies, such arrangements enable the "agent" agency to contribute expertise while the "principal" agency retains decision-making control.[269] Advising and monitoring relationships may be best suited to leverage agency expertise in policymaking because they allow expert agencies to contribute to decision-making to a greater degree than in hard hierarchical relationships, while still delegating decision-making control to one agency.[270] Since expert agencies have independent authority to advise and monitor principal agencies in this arrangement, it is harder for principal agencies to ignore the advice of expert

[262] Freeman & Rossi, *supra* note 1, at 1173-81 (noting agency officials often coordinate with White House informally, but active management is helpful coordination tool).

[263] *Id.* at 1175.

[264] *Id.* at 1177-78 (giving as examples the Offices of National Drug Control Policy and National AIDS Policy, as well as special advisors appointed "to coordinate 'faith-based' initiatives, to assist with policy in complex regulatory areas such as energy and climate change, or to advise on health care policy").

[265] *Id.* at 1179-80 (describing Executive Order 12,866 requiring submission of annual plans by executive and independent agencies prior to proposing them in *Federal Register*).

[266] *Id.* at 1179.

[267] *Id.* at 1180.

[268] Farber & O'Connell, *supra* note 1, at 1416-28.

[269] *Id.* at 1417. Other benefits of this arrangement are "increase[d] accountability and transparency" and quick and uniform decisions. *Id.* at 1417-19. A drawback is the diminished participation of the expert agency, which "may undermine democratic governance." *Id.* at 1419.

[270] *Id.* at 1419-20.

agencies,[271] particularly in a public process like notice-and-comment rulemaking. Most HHS-DHS interactions seem to fall within the category of symmetrical relationships, in which "entities have no formal authority over another."[272] This arrangement gives agencies the widest berth to leverage their expertise to propose policies in shared regulatory space but is also likely to generate the most conflicts in need of resolution.[273] An interagency agreement would be a helpful tool to manage the relationship.

Congress is not always explicit about whether agency authority should be considered equal or hierarchical.[274] When it is not explicit, other forces—often path-dependent and shaped by the larger historical and cultural contexts—are likely to influence whether one agency becomes the dominant authority.[275]

2. Potential of Interagency Coordination To Rebalance Authority

The case studies reveal that one of the reasons for HHS's inability to leverage its expertise in service of its mission is that it lacks a platform to provide input on immigration policy decisions.[276] Interagency coordination tools are one such platform for rebalancing interagency relationships and could be implemented to give HHS opportunities to contribute to the immigration policymaking process when it implicates HHS's mission. Since interagency coordination tools are premised on a congressional delegation of authority to two or more agencies,[277] this analysis focuses on the first case study in which HHS and DHS each have responsibility for aspects of the treatment of UCs in immigration custody.

If a more symmetrical interagency relationship had existed between HHS and DHS during the development and implementation of the Zero Tolerance policy,[278] it is possible that the family separation crisis may have been averted

[271] *Id.* at 1421.

[272] *See id.* at 1424 n.270 (comparing symmetrical relationships to collective decision-making models such as multiple-player games).

[273] *Id.* at 1424 ("In short, symmetrical arrangements provide wider perspectives, with bite.").

[274] *See, e.g.*, Gersen, *supra* note 1, at 210 (noting that Congress might give rulemaking authority to one agency and enforcement authority to another).

[275] Graham Allison described the role of power among government entities in influencing policy outcomes: "Power . . . is an elusive blend of at least three elements: bargaining advantages (drawn from formal authority and obligations, institutional backing, constituents, expertise, and status), skill and will in using bargaining advantages, and other players' perceptions of the first two ingredients." Allison, *supra* note 3, at 710.

[276] *See* discussion *supra* Section II.A.

[277] Freeman & Rossi, *supra* note 1, at 1157-58 (noting that interagency coordination may be either authorized or mandated by Congress).

[278] Zero Tolerance, originating in the DOJ, was a new policy regarding the prosecution of adult migrants with crimes relating to illegal entry. OIG-HHS Report, *supra* note 107, at 1. In essence, it mandated prosecution in such circumstances, which required parents to be housed in federal custody apart from the children with whom they had arrived. *Id.* at 5. The children were then classified as UCs, dramatically increasing the number of UCs for whom HHS was

or at least had less disastrous consequences. As Freeman and Rossi note, formal interagency coordination mechanisms "can force agencies to consider valuable information they might otherwise overlook, would prefer to overlook, or lack the expertise to produce themselves."[279] They "can also help pierce a closed decisionmaking culture and overcome group polarization effects by introducing viewpoints that do not identify with the dominant agency culture."[280] This is not to say that the Attorney General and top administration officials were unaware that the Zero Tolerance policy would cause children to be separated from their families; indeed, using the threat of family separation to deter migration was a goal of the policy.[281] Rather, it appears that DOJ and DHS officials did not understand the limited capacity of HHS shelters and how long it would take to ramp up capacity, the fact that separations would be long-term, and that reunification would be difficult.[282] Creating a platform for HHS to provide input on immigration policy decisions based on its expertise would enable HHS to counsel against policies that harm children. Such a mechanism would create more balance in the interagency relationship, and potentially improve policies affecting the health and wellbeing of UCs.

Ultimately, Congress can provide the most durable solution for ensuring that the upstream immigration policymaking process includes an evaluation of the downstream health impacts. In its comments responding to the HHS Office of Inspector General's report, "Communication and Management Challenges Impeded HHS's Response to the Zero-Tolerance Policy," ORR committed to advocating for the interests of UCs in interagency discussions of immigration policy; however, it noted that its ability to affect policy "may be constrained by

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responsible. *Id.* at 22 (describing the "unexpected and dramatic increase in young, separated children").

[279] Freeman & Rossi, *supra* note 1, at 1184.

[280] *Id.*

[281] OFF. OF INSPECTOR GEN., U.S. DEP'T OF JUST., REVIEW OF THE DEPARTMENT OF JUSTICE'S PLANNING AND IMPLEMENTATION OF ITS ZERO TOLERANCE POLICY AND ITS COORDINATION WITH THE DEPARTMENTS OF HOMELAND SECURITY AND HEALTH AND HUMAN SERVICES, NO. 21-028, at 2 (2021) (noting that investigation found that AG Sessions, the head of DOJ, "understood at the time the zero tolerance policy was issued that its strict implementation" would "result in family separations").

[282] *See* OIG-HHS Report, *supra* note 107, at 14 (noting that "there was no mention of coordination with HHS or how zero-tolerance would affect the UAC Program" in records of the interagency Policy Coordination Committee, which includes HHS officials); *id.* at 16 (describing an ORR staff member's assessment that DHS had underestimated the number of additional beds that would be required for UCs under Zero Tolerance). Regarding the lack of planning for a reunification process, the agencies did not put in place an interagency recordkeeping or communication system to keep track of separated families. DEP'T OF HOMELAND SEC., INITIAL PROGRESS REPORT: INTERAGENCY TASK FORCE ON THE REUNIFICATION OF FAMILIES 3 (2021). A federal court later found that the policy violated due process and ordered the administration to stop detaining adult migrants apart from their children and to reunify families that had been separated. Ms. L. v. U.S. Immigr. & Customs Enf't, 310 F. Supp. 3d 1133, 1149 (S.D. Cal. 2018) (granting Plaintiffs' motion for classwide preliminary injunction).

the statutory authorities and institutional equities of other departments in decisions that may affect the UAC program."[283] Likewise, HHS noted constraints on its ability to enact formal agreements with DHS regarding issues that impact UCs because of "statutory authorities, agency practices, and institutional prerogatives of other federal departments, as well as the interagency process more broadly."[284] It noted that interagency agreements are not enforceable under law and that "their effectiveness is contingent on the participating departments agreeing and adhering to consensus practices in the first instance"[285]—a subtle recurrence of the interagency "blame game" that arises so often in this Article's case studies. Statutory reforms to expand HHS's authority to influence immigration policymaking when it touches on matters of health would eliminate those barriers.

During the development and implementation of Zero Tolerance, HHS officials were reluctant to intervene in related immigration policy matters in part because of a lack of specific statutory authority to do so. While HHS could coordinate with DHS on discrete issues that would enable it to leverage its relevant expertise in support of its mission, it can be difficult for an agency with less power to persuade an agency with more power to voluntarily coordinate when there are no clear statutory directives to do so.[286] Consequently, HHS was entirely excluded from discussions when Zero Tolerance was formulated and did not receive adequate communication about when and how the policy would be implemented.[287] HHS lacked an opportunity during these critical phases to inform the DOJ and DHS about the impact of the new policy on the health and

[283] OIG-HHS Report, *supra* note 107, at 62 app. G.

[284] *Id.*

[285] *Id.* at 63 app. G.

[286] Daval explores this dynamic in his analysis of the development of the 1999 INS Field Guidance on Deportability and Inadmissibility on Public Charge Grounds. *See* Daval, *supra* note 2, at 1040-41 (describing how HHS's mission to provide benefits to eligible immigrants conflicted with the mission of INS and DOS to exclude from admission immigrants who are primarily dependent on the government for subsistence). In that context, Congress had delegated policymaking authority to the agencies "on parallel tracks, never quite intersecting." *Id.* at 1040. INS had significantly more discretion in its grant of authority, putting HHS in a relatively weak position in negotiations over the interpretation of public charge. *Id.* at 1041. Daval concludes that the asymmetry left HHS "far more eager to reach a compromise" during policy discussions in 1999, and INS and DOS with no "comparable incentive to bargain." *Id.*

[287] OIG-HHS Report, *supra* note 107, at 14 ("OIG found no evidence that HHS was notified in advance by either DOJ or DHS that the zero-tolerance policy would be implemented. In fact, senior HHS officials generally reported that they first learned of the spring 2018 implementation of zero-tolerance when it was reported by the media."). This occurred despite the fact that interagency coordination channels existed and that a 2016 Memorandum of Agreement between HHS and DHS provides that, "Each Party will make all reasonable efforts to notify the other about upcoming changes in UAC policy and procedures that may impact the other agency's policies or operations (absent exigent circumstances)." *Id.* at 14 (quoting Memorandum of Agreement (MOA) Between the Department of Homeland Security and the Department of Health and Human Services Regarding Unaccompanied Alien Children (Feb. 22, 2016)).

wellbeing of migrant children.[288] The result was that there was a routine shortage of ORR beds for UCs while Zero Tolerance was implemented, requiring UCs to stay in DHS facilities for longer than the 72-hour maximum permitted by law.[289]

More effective interagency coordination in the context of the care and placement of UCs could be engineered by establishing a specific mechanism and timeline for DHS to notify HHS of immigration policy decisions that would affect UCs.[290] In the HHS Office of Inspector General report analyzing HHS's failures to ensure adequate care of UCs during Zero Tolerance, a former ORR Director was quoted, stating, "[W]e didn't know what was going on. I just sort of expected lines of communication with DHS that, if there was a formal policy change, we would hear about it from DHS."[291] This did not occur.[292] Strengthening the existing notification requirement through law or policy and requiring congressional monitoring or reporting would improve accountability while still falling in the category of less burdensome interagency collaboration directives.

A requirement for DHS to consult with ORR on immigration policies that affect UCs would acknowledge the importance of leveraging HHS's child welfare expertise in such policies. To increase the likelihood that HHS's recommendations are considered by DHS, Congress could require DHS to provide a justification each time it does not follow an HHS recommendation. An interagency consultation requirement with extreme or total deference to HHS—such as an interagency concurrence requirement or veto—would signal the strongest commitment to ensuring that the interests of UCs are considered. Although such interagency checks may not ultimately prevent the enactment of an immigration policy as harmful to children as Zero Tolerance, it would likely reduce harm by enabling HHS to veto the policy until it had the resources necessary to adequately care for the affected children.

[288] *HHS OIG: Communication and Management Challenges Impeded HHS's Response to Zero-Tolerance Policy*, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS. (Mar. 5, 2020), https://oig.hhs.gov/newsroom/news-releases-articles/hhs-oig-communication-and-management-challenges-impeded-hhss-response-zero-tolerance-policy/ [https://perma.cc/2ENB-FJ8Q] (emphasizing that inadequate communication and poor management decisions left HHS unprepared for Zero Tolerance); OFF. OF INSPECTOR GEN., *supra* note 281, at i ("[T]he OAG's expectations for how the family separation process would work significantly underestimated its complexities and demonstrated a deficient understanding of the legal requirements related to the care and custody of separated children.").

[289] OIG-HHS Report, *supra* note 107, at 21.

[290] *See id.* at 14 (noting a lack of specificity in the requirement for each agency to notify the other of "upcoming changes in UAC policy and procedures that may impact the other agency's policies or operations" in the 2016 HHS-DHS MOA); *id.* at 40-42 (recommending that HHS establish formal agreements to ensure it receives adequate notification of changes in immigration policy that would affect its care of UCs).

[291] *Id.* at 18.

[292] *Id.*

The negotiation of the interagency MOA on sharing information about potential sponsors for UCs[293] is an example in which DHS set the agenda on issues in the HHS-DHS shared regulatory space, and in which it was necessary for Congress to intervene to ensure that HHS's interests were not steamrolled. Tellingly, finalizing this MOA that would enhance DHS's immigration enforcement mission was described as "the core issue for HHS" in Spring 2018.[294] During a critical time for the development of Zero Tolerance, HHS officials felt compelled to devote time and attention to negotiating an MOA that did not promote its mission and was, unsurprisingly, later found to not improve UCs' safety at all.[295] Congress intervened in 2019, legislating to temporarily "prohibit[] DHS from using any data submitted by ORR for immigration enforcement purposes, except in limited circumstances."[296] Congress also created congressional notification requirements and intra-agency concurrence requirements for changes in HHS policy relating to the fingerprint requirement.[297] These mechanisms increase HHS's power relative to DHS on the specific issue of the fingerprint requirement for potential sponsors of UCs, requiring HHS to justify any changes from the status quo in light of its mission.

Interagency coordination can be especially effective when the directives come from the President. Presidential leadership can be critical to help level the playing field between relatively powerless and powerful agencies.[298] For example, the Clinton White House led negotiations among HHS, INS, and other agencies on the interpretation of the public charge law, which was deterring noncitizens from accessing health-promoting public benefits based on

[293] *See id.* at 4 (describing the MOAs which set out expectations and processes for sharing information between DHS and ORR).

[294] *Id.* at 17.

[295] *Id.* at 17-18.

[296] *Id.* at 67 n.10 (citing Consolidated Appropriations Act of 2019, Pub. L. No. 116-6, § 224 and Consolidated Appropriations Act of 2020, Pub. L. No. 116-93, § 216).

[297] *Id.* (first citing Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act of 2019, Pub. L. No. 116-26, § 403; and then citing Further Consolidated Appropriations Act of 2020, Pub. L. No. 116-94, § 231). Specifically, the HHS Secretary was required to "provide[] a written justification to Congress and the HHS Inspector General demonstrating that such changes are necessary to prevent UACs from being placed in danger. The HHS Inspector General must provide an assessment [to] the Secretary and Congress that such changes are necessary." *Id.*; *see* Katyal, *supra* note 4, at 2341 (discussing congressional reporting as a coordination mechanism, noting that "Congress might be able to jump-start internal checks through reporting requirements").

[298] *See* Daval, *supra* note 2, at 1036-37 (describing HHS-INS dynamic in context of negotiations over interpretation of public charge law in 1990s). Presidential leadership is also critical when Congress is deeply divided and swift action is needed to solve a complex problem. *See* Freeman & Rossi, *supra* note 1, at 1173 ("[T]he President is arguably better positioned than Congress to promote coordination . . . it is often easier for him [to act] than for Congress."). Presidents are often moved to direct agencies to coordinate and oversee these efforts when they expect to be held responsible for the outcome of significant government initiatives—a reasonable possibility if family reunification efforts were to fail or stagnate. *Id.* at 1173-74.

immigration concerns.[299] To balance competing agency priorities relating to access to public benefits and immigration enforcement, the Executive Office of the President facilitated a series of meetings that pressured INS and other agencies to interpret the law in a way that was intended to minimize disruption to HHS's public benefits mission.[300] The result: A policy document clarifying the relationship between public charge and public benefits.[301] Very likely, the agencies would not have reached consensus without the intervention of the White House, given "HHS's relative powerlessness to address the deterrent effects of immigration enforcement on benefits participation."[302]

In the aftermath of Zero Tolerance, interagency coordination has proliferated in efforts to reunify separated families[303] and efforts overseen by the President appear to better enable HHS to leverage its expertise. Initial, agency-led efforts

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[299] Daval, *supra* note 2, at 1025 (describing White House's role during Clinton Administration in facilitating interagency negotiations on interpretation of public charge law to balance competing agency priorities relating to access to public benefits and immigration enforcement). Renée M. Landers, who served as Deputy General Counsel for the HHS during the Clinton Administration, has highlighted two other notable instances of HHS involvement with interagency conflict and coordination during that period: policymaking around medical marijuana and the development of the Health Insurance Portability and Accountability Act ("HIPAA") law enforcement exception. Renée M. Landers, Professor of Law, Suffolk University Law School, Association of American Law Schools Virtual Health Law Workshop (Sept. 30, 2022) (notes on file with author). In both cases, health policy priorities—funding research on medical marijuana and HIPAA's law enforcement exception—were initially devalued in favor of law enforcement interests, and interagency coordination mechanisms helped to give health policy experts a voice in policymaking. *Id.* For background on the conflict between the DOJ's Drug Enforcement Administration and HHS and the role of the White House Office of National Drug Control Policy regarding medical marijuana, see Peter A. Clark, *The Ethics of Medical Marijuana: Government Restrictions vs. Medical Necessity*, 21 J. PUB. HEALTH POL'Y 40, 40-41, 45-47, 52-54 (2000) (overviewing marijuana's scheduling under 1970 Uniform Controlled Substance Act, summarizing reports on therapeutic and medical marijuana use, and concluding data supported rescheduling of marijuana to Schedule II), and Sheryl Gay Stolberg, *Government Study of Marijuana Sees Medical Benefits*, N.Y. TIMES (Mar. 18, 1999), https://www.nytimes.com/1999/03/18/us/government-study-of-marijuana-sees-medical-benefits.html (describing differing positions of Director of White House Office of National Drug Control Policy and HHS on funding medical marijuana research). For background on the debate over when law enforcement should have access to personally identifiable health records, see C. STEPHEN REDHEAD, HAROLD C. RELYEA & GINA MARIE, CONG. RSCH. SERV., IB98002, MEDICAL RECORDS CONFIDENTIALITY 12-13 (2000).

[300] Daval, *supra* note 2, at 1037.

[301] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689, 28689 (Mar. 26, 1999) (providing "better guidance as to the types of public benefits that will and will not be considered in public charge determinations").

[302] Daval, *supra* note 2, at 1036.

[303] *See* OIG-HHS Report, *supra* note 107, at 14-15 (finding lack of interagency communication impeded HHS's response to Zero Tolerance).

failed to overcome deep-rooted barriers to effective coordination.[304] The Biden Administration has established an Interagency Task Force on the Reunification of Families chaired by the Secretary of Homeland Security that includes, among others, the Secretary of Health and Human Services and other senior officers of those agencies.[305] Undoubtedly, HHS's expertise in safeguarding health and wellbeing is informing the Task Force's activities.[306] In its initial progress report, issued in June 2021, the Task Force reported that it had established a "multi-Departmental" reunification process and has begun providing services and support to members of separated families.[307] These services include those typically administered by HHS such as "behavioral health screenings and appropriate treatment for behavioral health conditions caused by the family separation."[308] By directing HHS and DHS (among other agencies) to work together to reunify separated families, the President might have prevented or ameliorated the unproductive interagency blame game that has arisen in other issues within their shared regulatory space.[309]

3. Limitations of Structural Intervention To Address Entrenched Policy Dominance

Interagency coordination directives and other structural interventions can support changes in bureaucratic culture toward empowering HHS officials to advocate for their agency's mission in matters at the nexus of health and immigration policy, but may not be adequate to change the underlying power

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[304] For example, HHS and DHS staff encountered significant coordination problems relating to transporting members of separated families to reunification sites. The result was, at times, days-long waits for reunification at DHS sites, causing "significant stress for children and [ORR] caseworkers," and even situations in which HHS transported children to sites where they expected to meet their parent, but the parent had not been brought there by DHS. *Id.* at 30-31. Poor coordination between DOJ, DHS, and HHS also led to some parents being deported while their children remained in ORR custody, lengthening and complicating the reunification process. *Id.* at 32.

[305] *Executive Order on the Establishment of Interagency Task Force on the Reunification of* Families, WHITE HOUSE (Feb. 2, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/02/02/executive-order-the-establishment-of-interagency-task-force-on-the-reunification-of-families/ [https://perma.cc/8Y72-FRDZ]. During the Trump Administration, HHS Secretary Alex Azar was appointed to lead the reunification effort. Cancryn et al., *supra* note 114.

[306] U.S. DEP'T OF HOMELAND SEC., INTERAGENCY TASK FORCE ON THE REUNIFICATION OF FAMILIES: INTERIM PROGRESS REPORT 6 (Nov. 29, 2021) (noting HHS's critical role in advising on provision of behavioral health services for reunited families).

[307] U.S. DEP'T OF HOMELAND SEC., *supra* note 282, at i-ii.

[308] *Id.* at ii (citing J.P. v. Sessions, No. 2:18-cv-06081, 2019 U.S. Dist. LEXIS 217491 (C.D. Cal. Nov. 5, 2019)); *see also* U.S. DEPT. OF HOMELAND SEC., INTERIM PROGRESS REPORT: INTERAGENCY TASK FORCE ON THE REUNIFICATION OF FAMILIES 5 (Aug. 1, 2021) (noting "HHS has extended the contract to provide these services through January 2022").

[309] *See* Cancryn et al., *supra* note 114.

dynamic.[310] The failure of senior HHS officials to respond to information received informally from ORR staff about a potential DHS plan to separate families months before Zero Tolerance was implemented suggests that simply having interagency channels, such as the Policy Coordination Committee, in place without further motivation to coordinate may not change agency officials' behavior.[311]

While it is possible that more coordination between DHS and HHS that drew on the expertise of child welfare experts at HHS would have resulted in more holistic, defensible, and manageable policies,[312] the underlying power imbalance in the formal symmetrical relationship between the agencies prevented HHS from raising its voice. HHS's priority relating to its responsibilities for UCs—incorporating child rights principles into their care and placement—is subsidiary to immigration enforcement policy.

HHS officials' failure to use existing interagency coordination tools to address how Zero Tolerance interfered with its own mission is due, in part, to a reluctance to engage with immigration policy. HHS officials understand ORR's role in this context as "a child welfare agency, not an immigration agency."[313] Some staff have expressed concern about HHS becoming an enabler of immigration policies that contribute to harming immigrant children.[314] They have described how "the pressure put on the O.R.R. to coordinate with [DHS]

[310] The OIG-HHS Report identified a lack of empowerment among HHS leadership as a contributing factor toward the failures in providing adequate care of UCs during the development and implementation of Zero Tolerance. OIG-HHS Report, *supra* note 107, at 39-40 (noting that "[a]s the UAC Program is called to adapt to changes in immigration policy, enforcement, and trends beyond its control, HHS leadership . . . must ensure that HHS centers children's interests in its internal decision-making as well as in its interactions with interagency partners," including by "proactively representing [] children's interests in interagency policy discussions").

[311] *Id.* at 15.

[312] *See* Freeman & Rossi, *supra* note 1, at 1205 ("[T]here is a good chance that the process [of agency coordination] will improve the quality of the resulting decision and thus will be more likely to survive arbitrary and capricious review."); *id.* at 1185 (describing how agency decisions may be more likely to survive judicial review if "coordination improves the analytic basis for decisionmaking by adding data and expertise, and also by diversifying the perspectives an agency takes into account").

[313] Cancryn et al., *supra* note 114 (quoting HHS spokesperson Mark Weber); *see also* Schwartz, *supra* note 109 (quoting Maria Cancian, a former HHS official, who stated, "[O]ur mandate was to act in the best interest of the child. We are not an immigration-enforcement agency."); OIG-HHS Report, *supra* note 107, at 17 (describing as key factor in HHS's failure to adequately prepare for consequences of Zero Tolerance policy "senior HHS officials' reluctance to advocate for the HHS mission in immigration policy discussions").

[314] *See, e.g.*, *An Open Letter from a Counselor at the Office of Refugee Resettlement: Is This Really What the US Stands For?*, LATINO REBELS (June 20, 2018, 6:00 AM), https://www.latinorebels.com/2018/06/20/orropenletter/ [https://perma.cc/L8WH-EG94] (expressing concern that ORR was coordinating with DHS to share personal information about potential sponsors who may then become subject to immigration enforcement).

and ICE [] has begun to force a moral crisis at the agency."[315] Ideally, HHS should be equally empowered to put pressure on DHS to coordinate when immigration policies interfere with HHS's goals and priorities. DHS's reluctance to collaborate with HHS to improve interagency communication in matters affecting UCs should not have deterred HHS from taking the lead to pursue interagency agreements that support its mission of protecting and promoting the interests of children in its custody.[316]

Scholars have written extensively about other structural interventions that aim to balance representation in policymaking. These include encouraging opportunities for conflict rather than demanding consensus among various political perspectives through retrospective review and sunset provisions,[317] reforming notice and comment rulemaking to bring out underrepresented voices,[318] and creating federal advisory committees to advance particular interests that have been historically marginalized in agency deliberations.[319] Health liaison officer programs could help to embed health-related expertise in immigration enforcement agencies, much as intelligence liaison officers have successfully served as the communication link between intelligence and law enforcement.[320] The Office of Management and Budget oversees and coordinates policies across the Executive Branch; its OIRA plays an important role in ensuring that proposed regulations accord with the President's priorities and, in theory, identifying and resolving inconsistent interests among agencies operating in shared regulatory space.[321] OIRA employs cost-benefit analysis to ensure that policy decisions are evidence-based and to limit the influence of political pressure in policymaking.[322]

However, such interventions—like interagency coordination mechanisms—are unlikely to rebalance perspectives in "values-laden domains" such as the

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[315] Schwartz, *supra* note 109.

[316] *See* OIG-HHS Report, *supra* note 107, at 41 ("With regard to DHS, current operational guidance documents support the sharing of certain information between DHS and HHS at the time of referral, but HHS should pursue agreements that require DHS to improve the completeness and accuracy of the information provided to ORR.").

[317] *See* Walters, *supra* note 27, at 69-71.

[318] *See id.* at 77.

[319] *See id.* at 77-78; *see also* Salwa & Robertson, *supra* note 238, at 65-67 (proposing creation of independent public health agency led by expert commission that is politically balanced and protected from being fired and replaced at will).

[320] *See* Jeremy G. Carter & Michael Rip, *Homeland Security and Public Health: A Critical Integration*, 24 CRIM. JUST. POL'Y REV. 573, 593-94 (2012) (emphasizing importance of health liaison officer programs in aiding public health entities).

[321] *See* Freeman & Rossi, *supra* note 1, at 1178-80.

[322] *See* Sunstein, *supra* note 26, at 210 ("Under favorable conditions, the use of cost-benefit analysis can provide safeguards against decisions based on feelings, hopes, presumptions, perceived political pressures, appealing but evidence-free compromises, broad aspirations, guesses, or the wishes of the strongest people in the room.").

intersection of immigration and health policy.[323] In practice, retrospective review and sunset provisions—both of which require political actors to periodically review policies in order to unearth the need for change—exhibit power dynamics that favor deregulation.[324] Combined with increasing judicial reliance on doctrines that limit policymaking by administrative agencies with respect to health policy, it is unlikely that creating more opportunities for contestation among various interests on health policy issues would enable actors or agencies to leverage health-related expertise.[325] Likewise, federal advisory committees and reforms to notice and comment rulemaking designed to put a variety of perspectives before agencies would not change the power dynamics that dictate how the agencies weigh those perspectives.[326] While interagency negotiations facilitated by OIRA during regulatory review provide a platform for agencies to raise concerns about actions contemplated by other agencies, it is not guaranteed that such concerns are taken into account in the final rulemaking.[327] And even the most prominent proponents of cost-benefit analysis acknowledge that the notion of the "common good" that is central to this mode of analysis tends to discount the welfare effects—including the health

[323] *See* Walters, *supra* note 27, at 91-92 (acknowledging that administrative structures and processes embodying norms of agonistic democratic theory may not work as well to achieve incremental progress in such domains).

[324] *See id.* at 71 n.358.

[325] *See* TWINAMATSIKO & KEITH, *supra* note 47, at 5-9 (describing how recent interpretations of nondelegation doctrine, major questions doctrines, and *Chevron* deference have been used to invalidate health policies and forecasting similar decisions on upcoming issues).

[326] *See* Walters, *supra* note 27, at 79 ("Agencies adopting an agonistic standpoint . . . should forthrightly acknowledge that the proposal may not be good for everyone and ensure that all are forced to confront that fact and accept the consequences, knowing that there will be ample opportunities to force revisitation of that temporary settlement."). However, this framework does not address what should happen—if anything—when one perspective is repeatedly favored over all others during these opportunities to reconsider policy decisions. An independent public health agency designed to balance political accountability with expertise would likely suffer from many of the same problems as the short-lived Independent Payment Advisory Board, an entity designed to reduce Medicare spending when it exceeded certain limits set by law. *See* Ian D. Spatz, *IPAB RIP*, HEALTH AFFS. (Feb. 22, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20180221.484846/ [https://perma.cc/825S-LCCB] ("Powerful interests—whether they be providers or beneficiaries—do not want to relinquish their ability to appeal to political actors for relief. Although IPAB . . . sought to find a middle ground that balanced apolitical management with political oversight, it ultimately could not survive the reality of health care politics in the United States.").

[327] *See, e.g.*, Freeman & Rossi, *supra* note 1, at 1180 n.248 ("Because the interagency review process occurs so late in a rule's development, an agency can be fairly entrenched in its views by the time it receives interagency feedback.").

consequences—of regulations, particularly their effects on marginalized groups.[328]

The second case study aptly illustrates how decisions made based on short-sighted political goals can undermine agencies and prevent actors from leveraging public health expertise. The decisions to approve and extend the Title 42 policy discounted public health expertise in favor of politically expedient decisions that support the immigration policy goal of reducing certain types of migration flows at the southern U.S. border. From the outset, CDC Director Redfield ignored the opinions of CDC's top experts on global migration and quarantine, who vigorously opposed the policy.[329] In justifying maintenance of the policy after that, CDC continued to rely on questionable public health evidence. The preexisting pattern of subordination of health-related expertise to immigration policy concerns made it easier for both administrations to justify the Title 42 policy. None of the existing bureaucratic institutions designed to elevate underrepresented interests in policymaking prevented bureaucrats from commandeering the Public Health Service Act to achieve immigration goals. While an expert-led, independent public health agency would likely have been more empowered to rely on the scientific evidence counseling against the Title 42 policy and less pressured to use public health powers in the service of immigration-related goals,[330] they would not have been able to prevent the CDC Director from submitting to the immense political pressure to sign the order.

In the context of the DACA carve-out, HHS lacked the political power to raise health policy-related concerns and, as a result, took on legal risk to adopt a potentially constitutionally unsound interpretation.[331] The DACA carve-out was likely a reaction to the administration's realization that up to 1.2 million formerly undocumented noncitizens would become eligible for ACA benefits through DACA: It allowed the administration to uphold its promise to exclude

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[328] *See* Sunstein, *supra* note 26, at 216 (describing how cost-benefit analysis doesn't typically consider the distributional effects of regulations on human welfare); *id.* at 211 ("If the health benefits of regulation would be enjoyed mostly by members of low-income groups, and particularly by people of color, might that matter? We might think that even if the rule does not have significant net welfare benefits, or even if it has some net welfare costs, it is nonetheless desirable, if and because it increases equality.").

[329] *See supra* notes 152-61 and accompanying text.

[330] *See* 117TH CONG. REPORT ON TRUMP ADMINISTRATION'S COVID-19 RESPONSE, *supra* note 33, at 53 ("To adequately respond to future public health threats . . . [w]e must . . . continue to safeguard the independence of [public health agencies] to ensure that the work of public health officials and experts are protected from individuals more concerned with their political ambition than Americans' wellbeing.").

[331] *See* JOSE MAGAÑA-SALGADO & LORA ADAMS, MASA GRP., PROTECTING ESSENTIAL WORKERS AND FAMILIES: EXPANDING ACA ACCESS TO DACA HOLDERS IN RESPONSE TO COVID-19, at 10-12 (2020), https://static1.squarespace.com/static/6160a38f44d6a328d59c3e3d/t/618a89566c1a1b3075ad1e9e/1636469079226/2020-05%2BProtecting%2BEssential%2BWorkers%2Band%2BFamilies_REPORT.pdf [https://perma.cc/UYT4-JFNX] (arguing DACA carve-out violates Equal Protection Clause and Administrative Procedure Act and urging legal advocates to challenge it).

undocumented immigrants from the ACA[332] and even to get ahead of any criticism from Republicans and moderate Democrats about being soft on immigration issues.[333] After HHS promulgated the 2012 interim final rule, it was criticized for the decision to carve DACA beneficiaries out of the definition of lawfully present.[334] Nevertheless, it appears that HHS considered its hands to be tied: This was a policy that came from the White House, and HHS could not exercise its authority to include DACA beneficiaries in the lawfully present category based on health policy and regulatory consistency rationales.[335]

This is a symptom of the larger pattern of a lack of coordination between policymakers focused on immigration and policymakers focused on health matters. If HHS officials had been consulted during the development of DACA, the Administration would likely have had earlier notice of the implications for beneficiaries' eligibility for health benefits. This information may not have changed their decision to use deferred action as the vehicle for providing temporary protection from deportation and work authorization to this group; but it would have given them more time to weigh the costs and benefits of "quietly" expanding access to health insurance for DACA beneficiaries versus promulgating regulations to exclude them. The latter option, which the Administration chose, brought additional attention to the issue of immigrant

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[332] *See, e.g.*, Marcia Brown, *Biden Can Give DACA Recipients Health Care*, AM. PROSPECT (Jan. 29, 2021), https://prospect.org/health/biden-can-give-daca-recipients-health-care/ [https://perma.cc/7DQ8-H8PC] ("When Obama carved out DACA recipients in 2012, he was fighting for his own political life."); Jacqueline García, *Dreamers in Search of Affordable Health Care (Part 2)*, CTR. FOR HEALTH JOURNALISM (June 16, 2016), https://centerforhealthjournalism.org/fellowships/projects/dreamers-search-affordable-health-care-part-2 [https://perma.cc/9Y9A-WKAH] (quoting Gabrielle Lessard of National Immigration Law Center saying as much and noting "Obama Administration knew it would face a backlash if the undocumented and DACA recipients were allowed to take part in [ACA programs]"); Robert Pear, *Limits Placed on Immigrants in Health Care Law*, N.Y. TIMES (Sept. 17, 2012), https://www.nytimes.com/2012/09/18/health/policy/limits-placed-on-immigrants-in-health-care-law.html ("The move might help Mr. Obama avoid a heated political debate over whether the health law is benefitting illegal immigrants."); Interview with Jose Magaña-Salgado, *supra* note 246. That this interpretation of lawfully present is distinctly tied to the divisive debates over immigration and health care in the early 2010s is evident from HHS's uncontroversial 2015 adoption of the INS definition of lawfully present in a regulation describing noncitizen eligibility for Medicare health maintenance organizations and competitive medical plans. Medicare Program; Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 80 Fed. Reg. 7912, 7895 (Feb. 12, 2015) (codified at 42 C.F.R. § 417.422(h)).

[333] Telephone Interview with Jenny Rejeske, *supra* note 34 (noting this strategy of appeasement was typical of Obama Administration).

[334] *See, e.g.*, Pear, *supra* note 332 (quoting Marielena Hincapié, executive director of the National Immigration Law Center as stating, "We had been working closely with the administration, so we were quite surprised and shocked by the new restrictions on health coverage. This is a shortsighted, reactionary and bad public policy.").

[335] Telephone Interview with Jenny Rejeske, *supra* note 34.

access to publicly funded health insurance—a topic one would think the Administration would seek to avoid after it caused so much controversy during the ACA negotiations. Importantly, giving HHS an opportunity to advise on the health-related implications of the DACA program would have given them a timelier platform to leverage its health policy expertise to influence the Administration's ultimate decision.

B. *Extending the Theory: Policy Dominance in Shared Regulatory Space*

1. Non-Structural Sources of Health Policy Marginalization

This Section describes two factors that shape regulatory power in this Article's three case studies and that are inadequately accounted for in the literature on improving coordination in shared regulatory space, which has mostly focused on how structures allocate power. First, power dynamics among actors and agencies from different policy spheres are shaped by shared understandings of whether or not regulating in a particular policy area is a legitimate role of government. While it is generally understood that government has a legitimate role in protecting security (including at the borders), its role in protecting health is more contested. Second, "expert" actors and agencies may face daunting challenges to leverage their expertise when they share regulatory space with "political" actors and agencies. Although all government actors and agencies rely to a certain extent on expertise and political judgment, certain policy areas may be characterized as more technical or scientific while others are considered purely political.

There is a shared understanding that certain tasks fall within "core presidential function[s]" or, more generally, the legitimate role of government, and national security is perhaps the most prominent of those functions.[336] Executive-initiated action to coordinate agencies and actors in service of political goals is a longstanding feature of the national security policy domain.[337] And Presidents, regardless of their political party, have made national security a top priority.[338] A focus on immigration enforcement policy—under the umbrella of national security dominance—can be tracked across Presidential administrations.

When immigration enforcement policy shares regulatory space with other policy areas or even with other immigration policy goals, expertise that counsels against by-the-book enforcement and suggests taking a more nuanced,

[336] Renan, *supra* note 239, at 241; Kagan, *supra* note 74, at 696 (describing how presidential control of agency action is considered reasonable in certain policy-making contexts as way to hold agencies politically accountable and how immigration enforcement policy is not one in which "Congress has specified that it wants regulatory policy to be set by technical expertise rather than by political considerations").

[337] Renan, *supra* note 239, at 240 ("[P]ooling's longstanding resonance in th[e national security] space combined with the significance of the security domain in contemporary politics elevates pooling's importance for the executive.").

[338] *Id.* at 241 ("[C]apacity-building in the national security domain appears to transcend party politics; it is a prerogative of the modern presidency.").

discretionary approach is often not respected. Immigration enforcement policy's dominance may come from a respect for and basic understanding of what it means to enforce laws. As an example, the DACA policy discussed in the third case study and the related Deferred Action for Parents of Americans ("DAPA") policy attempted to shift resources from ICE and the strict enforcement of immigration laws towards U.S. Citizenship and Immigration Services, the benefits-granting subagency within DHS that would process DACA and DAPA applications.[339] Although ICE had long exercised discretion in enforcing immigration laws against individuals on a case-by-case basis, there was significant backlash from not only President Obama's political opponents but also from ICE officers on the ground who perceived these policies as limiting their ability to do their jobs: enforcing immigration laws.[340]

In contrast, there is not necessarily a shared understanding of the extent to which protecting health is a legitimate role of government. This remains a contested point across the political spectrum, as evidenced by the long, difficult negotiations over the ACA, which aimed to expand access to affordable health insurance among other goals. The numerous attempts to repeal or otherwise challenge provisions of the ACA demonstrate that questions regarding who deserves to receive subsidized health insurance and the health care services to which they are entitled remain divisive.[341] These issues arose in the context of the third case study, regarding whether beneficiaries of a new immigration policy authorizing them to live and work in the United States temporarily should be entitled to receive subsidized health coverage. HHS's decision to exclude DACA beneficiaries from eligibility for subsidized health coverage was undoubtedly linked to debates in the lead-up to the ACA, regarding whether undocumented noncitizens should receive any benefits under that law. The lack of a shared understanding of the government's role in protecting health has also been evident during the COVID-19 pandemic. Since the pandemic began, numerous lawsuits have challenged the authority of states and the federal government to enact public health protection measures.[342] Given that it is

[339] Chen, *supra* note 26, at 386 (describing how resource allocation away from ICE to USCIS in regards to DACA resulted in "inter-departmental conflict").

[340] *See* Kagan, *supra* note 74, at 667.

[341] *See, e.g.*, Katie Keith, *Congress Extends Enhanced ACA Subsidies*, 41 HEALTH AFFS. 1542, 1542-43 (2022) (describing recent federal court decisions holding that ACA provision requiring insurers to cover preventive services without cost sharing is unconstitutional and that ACA provision requiring insurers to cover HIV prevention medication unlawful if it conflicts with insurer's religious beliefs); Matthew Fiedler & Christen Linke Young, *Current Debates in Health Care Policy: A Brief Overview*, BROOKINGS INST. (Oct. 15, 2019), https://www.brookings.edu/policy2020/votervital/current-debates-in-health-care-policy-a-brief-overview/ [https://perma.cc/39CX-2BDP] (summarizing longstanding debates around health coverage policies, such as whether federal health coverage programs should be expanded and provide more generous benefits or whether they are "too generous and inappropriately burden taxpayers").

[342] *See, e.g.*, James G. Hodge, Jr., Jennifer L. Piatt, Leila Barraza & Erica N. White, *Regressive Federalism, Rights Reversals, and the Public's Health*, 50 J.L. MED. & ETHICS

generally understood that the government has a legitimate role in policymaking related to immigration matters, and that the government's role in policymaking relating to health matters is contested, agencies and actors focused on immigration policy may dominate regulatory space shared with agencies and actors with expertise in health policy.

A related factor in shaping regulatory power highlighted by this Article's case studies is the clash between "expert" agencies and actors and "political" agencies and actors.[343] Different approaches to problem-solving between such agencies and actors can contribute to coordination problems making it more difficult for expert agencies and actors to leverage their expertise in shared regulatory space with political agencies and actors.[344]

Although no agency or actor relies entirely on either expertise or political preferences, health policy decisions sometimes require and are justified by expertise in a way that is different from decisions regarding immigration enforcement policy.[345] For example, Congress assigned the quarantine power that was the basis for Title 42 to CDC because Congress presumably intended such decisions to be based on scientific evidence. There is a norm of reliance on scientific evidence in health policy decisions—at least among agency career staff—that clashes with the overtly political nature of immigration enforcement policy.[346] The deprioritization of health policy concerns in shared regulatory

375, 377 (2022) (describing court decisions that limited governments' ability to require social distancing, limit occupancy, and enact residential eviction moratorium); Michelle M. Mello & Wendy E. Parmet, *U.S. Public Health Law—Foundations and Emerging Shifts*, 386 NEW ENG. J. MED. 805, 808 (2022) [hereinafter Mello & Parmet, *U.S. Public Health Law*] (describing "several areas of instability in public health law"); Michelle M. Mello & Wendy E. Parmet, *Public Health Law after Covid-19*, 385 NEW ENG. J. MED. 1153, 1153 (2021) (providing overview of "more than 1000 suits" challenging public health measures during COVID-19 pandemic).

[343] *See* Wendy E. Wagner, *A Place for Agency Expertise: Reconciling Agency Expertise with Presidential Power*, 115 COLUM. L. REV. 2019, 2060 (2015) (discussing balance of "scientific and technical expertise on the one hand and democratic accountability on the other" within administrative state but not discussing this balance in context of shared regulatory space).

[344] *See* Emily Hammond Meazell, *Presidential Control, Expertise, and the Deference Dilemma*, 61 DUKE L.J. 1763, 1782-96 (2012) (illustrating clash by describing how traditional justifications for deference to agency decision-making—expertise and political control—may be split between two agencies in shared regulatory space).

[345] *See, e.g.*, Freeman & Jacobs, *supra* note 241, at 615 ("[S]ome questions assigned by Congress to administrative agencies require expertise and technocratic knowledge, which nonexpert political appointees typically do not possess. . . . Agencies simply cannot . . . approve new drugs to ensure they are 'safe and effective' without evaluating data from clinical trials." (quoting 21 U.S.C. § 393(b)(2)(B))); Kagan, *supra* note 74, at 712 (providing, as contrast with immigration policy, example from health policy which "should be set according to scientific data with minimal or no room for political ideological judgment calls").

[346] *See* David E. Lewis, *Is the Failed Pandemic Response a Symptom of a Diseased Administrative State?*, DAEDALUS, Summer 2021, at 68, 74 (describing how public health

space with immigration enforcement concerns may be aggravated by the general trend of decreasing deference to scientific expertise in health matters.[347]

2. Introducing a Health Security Framework

Changing how political leaders prioritize health issues and value health expertise requires change of a different kind, because reforming institutional design and structure alone may not address national security or immigration policy dominance. A focus on immigration enforcement has long defined the bureaucratic culture of immigration agencies, and DHS's formation in the aftermath of the attacks of September 11 only increased this focus in service of protecting national security.[348] While the most straightforward path to altering the balance of immigration enforcement and health concerns in the DHS-HHS shared regulatory space is to resist immigration enforcement dominance in DHS's bureaucratic culture, the struggles of DHS subagencies to prioritize their goals vis-à-vis ICE's may serve as a cautionary tale about the culture's durability.[349]

Instead, a more pragmatic course may be to accept national security as the organizing principle of the immigration bureaucracy, and to frame health and wellbeing as central to national security.[350] Such framing may broaden political

agency staff may "confuse loyalty to the administration for a lack of competence"); Kagan, *supra* note 74, at 707 ("In the case of immigration enforcement policy, Congress assigned authority explicitly to the DHS Secretary, and there is no daylight between the President's position and the Secretary's."). *But see* Jorge Durand & Douglas S. Massey, *Debacles on the Border: Five Decades of Fact-Free Immigration Policy*, 684 ANNALS AM. ACAD. POL. & SOC. SCI. 6, 6-8 (2019) (describing immigration dataset of 176,696 individuals compiled by Mexican Migration Project that goes unused by administrative agencies).

[347] Mello & Parmet, *U.S. Public Health Law*, *supra* note 342, at 808 ("Traditionally, courts have granted substantial deference to scientific experts and government officials about measures needed to protect health. That deference appears to be waning, in numerous doctrinal areas.").

[348] *See* Renan, *supra* note 239, at 241 (noting "rise of national security priorities in politics since the attacks of September 11 and the expansive notion of security in current times" have increased importance of executive-initiated coordination of agencies and actors in national security domain); Camille J. Mackler, *Immigration Policy Before and After 9/11: From the INS to DHS—Where Did We Go Wrong?*, JUST SEC. (Sept. 9, 2021), https://www.justsecurity.org/78132/immigration-policy-before-and-after-9-11-from-the-ins-to-dhs-where-did-we-go-wrong/ [https://perma.cc/2VNN-VL8M] ("The creation of DHS irrevocably set the country on a path that made immigration enforcement a matter of national security and justified treating migrants as dangers to the homeland.").

[349] *See, e.g.*, Knowles & Heeren, *supra* note 213, at 805. On the other hand, it is worth considering whether the COVID-19 pandemic could be a critical opportunity to shift the dominant narrative in immigration policy from national security to public health. Legal and policy responses to the COVID-19 pandemic will be transformative for decades to come.

[350] Renan describes this not uncommon phenomenon among Presidents as "us[ing] the concept of security strategically to enhance their ability to achieve policy ends." Renan, *supra* note 239, at 241 n.155.

actors' perspective on the ways in which health expertise could be leveraged on issues within the shared regulatory space of HHS and DHS.[351]

In this Article, I will refer to this framing as "health security," a term with contested meanings over place, time, and academic orientation.[352] There is no agreed-upon rationale for determining the types of health issues that fit within the health security paradigm.[353] The first and most common conception of health security is based on the national security framework.[354] Beginning in the late 1990s, health security came to also include the impact of infectious disease on civilians—namely, U.S. citizens traveling abroad and at home.[355] Today, the World Health Organization ("WHO") defines "global public health security" as "the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries."[356] This framing is important for this Article because it shifts the focus away from individual nations' efforts to protect their citizens exclusively and toward recognizing the connections among the health of all people regardless of nationality and geography.

Another conception of health security that may be helpful in this reframing effort is the more expansive notion of "human security," which has traditionally focused on the protection of individuals as constituents of the state.[357] Much of the literature on human security emphasizes "freedom from want" and "freedom from fear" among individuals.[358] This focus on the individual—as opposed to the state—is what distinguishes human security from standard definitions of

[351] *See* Colin McInnes, *The Many Meanings of Health Security*, *in* ROUTLEDGE HANDBOOK OF GLOBAL HEALTH SECURITY 7, 14 (Simon Rushton & Jeremy Youde eds., 2014) ("[T]he broadening of security's horizons . . . has created a space whereby health issues can more easily become a part of the security agenda.").

[352] *See id.* at 7.

[353] *Id.* at 8-9 (noting lack of rationale "as to why some health issues might be considered national security problems but not others"). This may be by design. *See id.* at 13 (describing the benefits of keeping the concept "deliberately vague to ensure maximum support from diverse constituencies" but also noting that this strategy "then makes it ultimately little more than a slogan").

[354] *Id.* at 7-8 (describing focus on how disease affects military performance and capacity).

[355] *Id.* at 8.

[356] *Health Security*, WORLD HEALTH ORG., https://www.who.int/health-topics/health-security#tab=tab_1 [https://perma.cc/G39U-Q4J6] (last visited Apr. 18, 2023).

[357] UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 3-4 (1994). This is the sense in which President Bill Clinton referred to health security in his bid for health care reform, the Health Security Act: "giving every American health security, health care that can never be taken away, health care that is always there." Adam Clymer, *Clinton's Health Plan: The Overview*, N.Y. TIMES (Sept. 23, 1993), https://www.nytimes.com/1993/09/23/us/clinton-s-health-plan-overview-clinton-asks-backing-for-sweeping-change-health.html.

[358] McInnes, *supra* note 352, at 12 (discussing 2003 report of the Commission on Human Security, which argued that "human security was about freedom from want, freedom from fear, and the capacity of individuals to take action on their own behalf").

health security.[359] Guaranteeing freedom from want is strongly associated with anti-poverty initiatives that emphasize the connections between poverty and health.[360] A broader conceptualization of health security that combines this understanding with the inclusiveness of global health security could serve as the basis for a new security agenda that leverages health-related expertise.

Despite the ongoing contestation over the meaning of health security and the issues that fall within its scope, the concept may be helpful to scholars and advocates seeking to raise awareness of underappreciated health policy issues on the national and international levels.[361] Health security—particularly the WHO's definition—is a call to action.[362] Among academics, it has been characterized as "less of an analytical tool and more of a strategic or pragmatic practice."[363] It can be used "to increase awareness and encourage action for change by adding a sense of urgency and importance."[364] As such, the concept of health security has the potential to bridge theory and practice while it is being constructed and contested.

Prior successful social movements that have changed the way political leaders prioritize certain issues should inform this effort. A key strategy has been to create more mechanisms for educating political actors in order to broaden their range of vision when they make decisions about topics in shared regulatory spaces. In the context of the care and placement of UCs, when Congress assigned those responsibilities to ORR, it intended to leverage ORR's expertise in child welfare issues and ensure independence from DHS in decisions about the detention of UCs.[365] However, legislators may have underestimated the degree to which INS/DHS would have to coordinate with ORR, an office of a separate

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[359] *Id.*

[360] *Id.*

[361] *Id.* at 7.

[362] *Id.* at 11 (explaining that WHO's analysis of global health risks "leads to a very clear prescription to develop 'collective international public health action [to] build a safer future for humanity'").

[363] *Id.*

[364] *Id.* ("[G]lobal health security is not an objective condition, but something constructed to promote health, a traditional task of health services nationally but now taken by WHO onto a global stage with added urgency.").

[365] *See, e.g.*, Taverna, *supra* note 77, at 968. When INS was responsible for the care and protection of UCs, the conflict with its overarching goal of immigration enforcement was apparent. *Id.* at 964-65. Many presumed that this internal "mission mismatch," coupled with INS's lack of child welfare expertise, was presumed to have contributed to longstanding problems with the treatment of UCs in INS custody, including with the conditions and length of detention. *Id.* at 952-53 (describing *Reno v. Flores* class action lawsuit and the 1993 Flores Settlement Agreement). Prior to its dissolution, the INS created an Office of Juvenile Affairs ("OJA") to address these concerns. Advocates argued that because the OJA was within INS, this restructuring did not address the inherent conflict of interest: that decisions about the detention of minors would be overly influenced by enforcement concerns. *Id.* at 964. The OJA never got off the ground and Congress eliminated it after responsibility for UCs was transferred to ORR in 2003. *Id.* at 963-66.

executive agency. They may also have overlooked the significance of transforming what many presumed to be an intra-agency conflict into an interagency conflict of interest.

A potential risk of defining health-related events as security issues is that it would justify the expansion of powers and influence of national security actors and agencies like DHS.[366] However, if we are able to understand health-related events as the predictable consequences of laws and policies that should be informed by relevant expertise, then it may encourage administration to include agencies and actors with health-related expertise earlier in policymaking in order to prevent health emergencies from occurring. Agencies like HHS would be included in both policy development and response in order to ensure that health-related consequences of national security policies are considered.[367]

Another potential risk of framing health and wellbeing as central to national security is reviving the old trope of poor, racialized migrants from the Global South as dangerous carriers of disease. For example, the Title 42 policy is ostensibly a public health measure that conceives of SARS-CoV-2 as a threat to national security, barring the entry of a narrow category of noncitizens. As discussed *infra*, however, it is clear that the policy represents a near-total cooptation of CDC's public health mission by immigration enforcement priorities.[368] Prior to the development of the Title 42 policy, DHS was already focused on combating what it considered to be unreasonably high levels of asylum fraud, in line with its bureaucratic culture of viewing immigrants as criminal threats. This perspective likely informed CDC's framing of asylum seekers—but not other types of migrants—as public health threats. Whether framed as criminal threats by DHS or public health threats by HHS, asylum seekers meet the same fate: being barred from entry.

However, a broader conception of health security that recognizes the interconnected nature of health could instead frame the health and wellbeing of noncitizens—even those living outside the United States—as a key concern. The COVID-19 pandemic makes this easy to understand: More than ever, we recognize the importance of cooperative political action for combating the pandemic. Simply expelling migrants to the encampments of northern Mexico—where it is difficult or impossible to comply with social distancing measures, access health care, or even meet basic needs relating to nutrition, shelter, and hygiene—*contributes to* a public health crisis just over the border.

In addition, threats to health security encompass much more than infectious disease and bioterrorism, which have long been recognized as threats that fit squarely within the national security analytical paradigm. Social determinants

[366] *See* Chen, *supra* note 26, at 401 ("The treatment of [Central American migrants fleeing violence into the United States in 2014 and 2016] as a crisis overwhelmed the capacity of the bureaucracy to respond in a measured way.").

[367] Jaya Ramji-Nogales, *Migration Emergencies*, 68 HASTINGS L.J. 609, 650-52 (2017) (discussing challenges to establishing "a viable international law of migration").

[368] *See infra* Section II.B (discussing Title 42 policy).

of health are the broad conditions and forces that shape the health of people and communities, one of which is access to health care. In the United States, the major barrier to health care access is the cost of care, and many noncitizens are legally excluded from public health insurance because of their immigration status. There are several ways in which barriers to health care access for noncitizens may be considered threats to the nation's health security. For example, delayed treatment of chronic conditions can cause disability, reducing the capacity of our workforce, including in the military. Untreated communicable disease due to barriers to care increases the risk of infection to the general public. Lack of access to mainstream medical care may cause some noncitizens to pursue alternative, traditional, or self-administered treatments, contributing to the growth of an unregulated or loosely regulated market of potentially dangerous products. Widespread economic insecurity can contribute to social unrest.[369] In this framing, ensuring health care access for DACA beneficiaries may be considered a national security imperative if they are understood as potential future citizens.

Similarly, ensuring the health and wellbeing of UCs in federal custody, who may ultimately reside in the United States long-term or permanently, can be framed as a health security priority. The Zero Tolerance policy aligned with the DHS bureaucratic culture framing undocumented parents as criminals; negative impacts on children who were to be separated from their parents under the policy were either not considered or were considered collateral damage. By contrast, the health and wellbeing of noncitizen families separated under Zero Tolerance is emerging as a principle of the reunification process. It prioritizes the health and wellbeing of affected families by providing "holistic support and services" that address social determinants of health such as "housing, employment, security, legal status, food insecurity, income, language skills and interpretation, the asylum-seeking process, and discrimination."[370] A goal of these efforts is to "prevent further traumatization of recently reunified children."[371] A broader conception of health security that recognizes the health and wellbeing of children in federal custody as connected with the health of the country as a whole could temper the overwhelming focus on enforcement within DHS. This shift could inform immigration policies that aim higher than "not traumatizing" UCs, some of whom will become U.S. citizens in the future.[372]

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[369] *See* McInnes, *supra* note 352, at 9 (describing how health issues can "affect the internal security of a state").

[370] U.S. DEP'T HOMELAND SEC., *supra* note 282, at 18.

[371] U.S. DEP'T HOMELAND SEC., *supra* note 308, at 7 (discussing Task Force provision of reunification services for reunified families).

[372] Relatedly, Abel Rodriguez has written about the ways in which immigration laws and policies perpetuate harm, focusing on migrant deaths caused by weaponization of the border and as a consequence of encounters with immigration enforcement officers in and outside of detention facilities. *See* Abel Rodriguez, Racialized Migrant Death 1 (Nov. 1, 2022) (unpublished manuscript) (on file with author). He focuses on migrant death in order to highlight the flaws in the rationales for existing immigration enforcement practices. *Id.* at 4.

In the context of the DACA exclusion and more generally, the complexity of laws and policies governing noncitizens' eligibility for publicly funded health care is a barrier for policymakers, advocates, and the general public to understand how changes in immigration law affect access to health care. Given the complexity and importance of each policy area on its own, policymakers typically focus on one without fully understanding the implications for the other. For example, advocates for expanding access to subsidized health insurance have, historically, readily sacrificed access for undocumented noncitizens in health reform negotiations.[373] After the passage of the ACA, there has been growing recognition that in order to achieve health equity and reduce health disparities, the health care needs of undocumented noncitizens must also be addressed.[374] On the other side, policymakers who care about immigration reform typically stay away from the issue of immigrant access to public benefits because it is considered relatively unimportant as a policy priority. Maintaining silos around issues of health policy and immigration policy contributes to misunderstandings and miscalculations on issues in this shared regulatory space.

A social movement that changes the way that health policymakers and immigration policymakers view issues in their shared regulatory space could help to bring about major reforms to make health policies more inclusive, such as simplifying the laws and policies governing noncitizen eligibility for publicly funded health care by eliminating citizenship or immigration status as a criterion for all or most programs. This would both enable policymakers, advocates, and the general public to better understand the implications of changes in both areas and give health policymakers more latitude to leverage their health-related expertise to advise the President, DHS, and other agencies on these issues.

CONCLUSION

This Article analyzes only three of the many topics in the shared regulatory space of HHS and DHS. Issues at the intersection of health law and immigration law are, separately, among the most hotly contested political topics. This Article's case studies reveal that health policy expertise and priorities are often subordinated to an administration's immigration policy preferences, contravening Congress's purpose in establishing related or overlapping jurisdictional assignments to HHS and DHS. When health policy concerns are routinely deprioritized in policymaking in shared regulatory space, the consequences for individual and population health can be devastating.

When feasible, structural reforms to improve health policymakers' ability to leverage their expertise in immigration matters should be considered as a

A new paradigm for enforcement that responds to the concerns surfaced by critical analysis would reduce harm to migrants in many forms, including the kinds of trauma caused by Zero Tolerance.

[373] Telephone Interview with Jenny Rejeske, *supra* note 34 (remarking on health advocates' commitment to providing health care access for undocumented noncitizens).

[374] *Id.*

strategy to improve the consistency, clarity, and defensibility of policies at the intersection of health and immigration. However, such reforms are unlikely to address deeply entrenched political deference to immigration enforcement priorities across administrations. There is a need to extend administrative law theory in order to acknowledge the routine capitulation of health policy priorities to immigration policy priorities. Framing health and wellbeing as central to national security may help to ensure that health policy priorities are expressed in and implemented through the law and legal institutions.