Immigration Policies and Issues on Health-Related Grounds for Exclusion

Chad C. Haddal
Analyst in Immigration Policy

Ruth Ellen Wasem
Specialist in Immigration Policy

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Summary

Under current law, foreign nationals not already legally residing in the United States who wish to come to the United States generally must obtain a visa and submit to an inspection to be admitted. They must first meet a set of criteria specified in the Immigration and Nationality Act (INA) that determine whether they are eligible for admission. Moreover, they must also not be deemed inadmissible according to specified grounds in the INA. One of the reasons why a foreign national might be deemed inadmissible is on health-related grounds. The diseases that trigger inadmissibility in the INA are those communicable diseases of public health significance as determined by the Secretary of Health and Human Services (HHS).

The outbreak of the 2009 H1N1 virus (commonly called "Swine Flu") has generated attention in Congress and the media, particularly with its relationship to foreign travel. With Mexico also suffering high infection rates of this strain of influenza, questions have been raised on travel restrictions to the United States, particularly in regard to foreign nationals. Potential issues for Congress are three-fold: (1) are current health-related grounds for exclusion sufficient to ensure public safety in regards to contagious diseases; (2) would increased restrictions on foreign travel (even temporarily) inflict more economic harm than benefit; and (3) are the resources provided for frontline agencies charged with screening foreign travelers sufficient to identify potentially infected travelers?

From an immigration standpoint, infectious disease outbreaks place the greatest procedural and resource pressures on Customs and Border Protection (CBP), an agency within the Department of Homeland Security (DHS). CBP is charged with screening admissions of all travelers at land, sea, and air ports of entry (POE), and CBP Officers screened approximately 409 million individuals in FY2008 for admissions into the United States. CBP works in conjunction with the Centers for Disease Control and Prevention (CDC) to monitor travelers and attempt to contain any diseases that may be spread by travelers coming from abroad. CDC, in conjunction with CBP, operates 20 quarantine stations and has health officials on call for all ports of entry. DHS has established its role in case of a pandemic outbreak through a memorandum of understanding with other agencies and in The National Strategy for Pandemic Influenza.

Various federal statutes and legal questions may arise should a response to an influenza pandemic require limiting the use of transportation-related infrastructure, which includes, but is not limited to airports, seaports, and land ports of entry. Constitutional concerns, especially those related to the "right to travel" may also be implicated by decisions impacting transportation-related infrastructure.

In recent years health-related grounds for exclusion has also been a congressional concern for other contagious diseases. In addition to the H1N1 outbreak, these diseases have included tuberculosis (TB). This report will be updated as circumstances warrant.

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Introduction

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The outbreak of the 2009 H1N1 virus (commonly called "Swine Flu") has generated attention in Congress and the media, particularly with its relationship to foreign travel. With Mexico also suffering high infection rates of this strain of influenza, questions have been raised on travel restrictions to the United States, particularly in regard to foreign nationals. While grounds for exclusion based on health-related criteria already exist in the Immigration and Nationality Act (INA), some have questioned whether these provisions are sufficient to deal with the current situation, as well as potential future pandemics. Potential issues for Congress are at least three-fold: (1) are current health-related grounds for exclusion sufficient to ensure public safety in regards to contagious diseases; (2) would increased restrictions on foreign travel (even temporarily) inflict more economic harm than benefit; and (3) are the resources provided for frontline agencies charged with screening foreign travelers sufficient to identify potentially infected travelers?

Statutorily, three departments—the Department of State (DOS), the Department of Homeland Security (DHS) and the Department of Justice (DOJ)—each play key roles in administering the law and policies on the admission of aliens.[3] DOS's Bureau of Consular Affairs (Consular Affairs) is the agency responsible for issuing visas, DHS's Citizenship and Immigration Services (USCIS) is charged with approving immigrant petitions, and DHS's Bureau of Customs and Border Protection (CBP) is tasked with inspecting all people who enter the United States. DOJ's Executive Office for Immigration Review (EOIR) has a significant policy role through its adjudicatory decisions on specific immigration cases.

[1] Authorities to except or to waive visa requirements are specified in law, such as the broad parole authority of the Attorney General under § 212(d)(5) of the Immigration and Nationality Act (INA) and the specific authority of the Visa Waiver Program in § 217 of the INA.

[2] Other grounds for exclusion include criminal history; security and terrorist concerns; public charge (e.g., indigence); seeking to work without proper labor certification; illegal entry and immigration law violations; ineligible for citizenship; and aliens previously removed. For more information, see CRS Report RL32256, *Visa Policy: Roles of the Departments of State and Homeland Security*, by Ruth Ellen Wasem.

[3] Other departments, notably the Department of Labor (DOL), and the Department of Agriculture (USDA), play roles in the approval process depending on the category or type of visa sought, and the Department of Health and Human Services (HHS) sets policy on the health-related grounds for inadmissibility discussed below.

Health-Related Grounds for Exclusion

With certain exceptions,[4] aliens seeking admission to the United States must undergo separate reviews performed by DOS consular officers abroad as well as CBP inspectors upon entry to the United States.[5] These reviews are intended to ensure that applicants are not ineligible for visas or admission under the grounds for inadmissibility spelled out in the Immigration and Nationality Act (INA).[6] These criteria are: health-related grounds; criminal history;[7] security and terrorist concerns; public charge (e.g., indigence); seeking to work without proper labor certification; illegal entry and immigration law violations; ineligible for citizenship; and aliens previously removed. The health-related grounds are further broken down into four categories: having a communicable disease, lacking required vaccinations, presenting a physical or mental disorder, and evidencing drug abuse or addiction.[8]

Legislative History

The statutory language permitting the exclusion of aliens on the basis of health or communicable diseases date back to the Immigration Act of 1891. "Persons suffering from a loathsome or a dangerous contagious disease" were added to the grounds of exclusion, and the 1891 Act also required a medical inspection of all aliens arriving at ports of entry.[9] When the various immigration and citizenship laws were unified and codified as the Immigration and Nationality Act of 1952 (INA), the health-related grounds were seven of 31 grounds for exclusion.[10] One of these seven health-related grounds specified that aliens "afflicted with any dangerous contagious disease" would be excluded from the United States.

The Immigration Amendments Act of 1990 streamlined and modernized all of the grounds for inadmissibility into nine broad categories. At that time, Congress recodified the health-related ground for inadmissibility to include any alien "who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance."

In 1996, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) amended the INA to require prospective immigrants to demonstrate that they have been vaccinated against certain "vaccine-preventable" diseases. More specifically, §341 of the IIRIRA

[4] Certain classes of aliens are not required to obtain a visa to enter the United States and are therefore exempt from the consular review process. For example, under the visa waiver program (VWP), nationals from certain countries are permitted to enter the United States as temporary visitors (nonimmigrants) for business or pleasure without first obtaining a visa from a U.S. consulate abroad. See INA § 217; 8 U.S.C. § 1187. For additional background on the VWP, see CRS Report RL32221, *Visa Waiver Program*, by Alison Siskin.

[5] For background and analysis of alien screening and visa issuance policy, see CRS Report RL31512, *Visa Issuances: Policy, Issues, and Legislation*, by Ruth Ellen Wasem.

[6] INA § 212(a); 8 U.S.C. § 1182(a).

[7] For a full discussion of this ground, see CRS Report RL32480, *Immigration Consequences of Criminal Activity*, by Yule Kim and Michael John Garcia.

[8] INA § 212(a)(1)(A).

[9] Act of March 3, 1891; 26 Stat. 1084.

[10] For a complete analysis of the pre-1990 laws and policies, see U.S. Congress, House Committee on the Judiciary, *Grounds for Exclusion of Aliens under the Immigration and Nationality Act: Historical Background and Analysis*, committee print, prepared by the Congressional Research Service, 100th Cong., 2nd sess., September 1988, Ser. No. 7.

created a new basis of inadmissibility in §212(a) for failing to present evidence of vaccination against nine "vaccine-preventable diseases," including mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, influenza type B and hepatitis B.

Much of the policy debate since 1990, however, has centered on HIV/AIDS.[11] In 1993, Congress amended the health-related grounds for inadmissibility by adding the phrase: "which shall include infection with the etiologic agent for acquired immune deficiency syndrome."[12] In 2008, § 305 of P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, eliminated the language in the INA that statutorily barred foreign nationals with HIV/AIDS from entering the United States. This revision does not, however, entitle foreign nationals with HIV/AIDS to receive visas to enter the United States. The HHS reportedly has begun the rulemaking process to remove HIV from this list. On September 29, 2008, the DHS announced the publication of a final rule that grants consular officers the authority to grant nonimmigrant visas to otherwise eligible applicants who are HIV-positive and meet certain requirements. Visas issued under the final rule do not publicly identify any traveler as HIV-positive. The HIV-waiver final rule applies to foreigners who are HIV-positive and seek to enter the United States as visitors for up to 30 days.

Communicable Diseases

The INA renders inadmissible foreign nationals infected with a "communicable disease of public health significance."[13] While the INA does not define "communicable disease of public health significance" directly, it does task the Secretary of Health and Human Services (HHS) to define the term by regulation. The relevant regulation's definition expressly lists eight diseases as a "communicable disease of public health significance": HIV infection; chancroid; gonorrhea; granuloma inguinale; infectious leprosy; lymphogranuloma venereum; active tuberculosis;[14] and

[11] INA § 212(a). The FY1987 Supplemental Appropriations Act included in §518 the following requirement: "On or before August 31, 1987, the President, pursuant to his existing power under section 212(a)(6) of the Immigration and Nationality Act, shall add human immunodeficiency virus infection to the list of dangerous contagious diseases contained in title 42 of the Code of Federal Regulations." Simultaneously with the vote, HHS published a final rule adding AIDS to the list of "dangerous contagious diseases" in Title 42 of the Code of Federal Regulations, and a proposed rule to replace AIDS on this list with HIV infection. Regulations implementing the statutory requirement were published by the HHS, effective August 31, 1987.

[12] P.L. 103-43, the National Institutes of Health Revitalization Act of 1993, § 2007(a). The 1993 legislation was enacted in response to controversy over an announcement by the William Jefferson Clinton Administration that the HHS Public Health Service regulations would be revised to remove HIV infection and six other diseases from a list of diseases for which aliens could be excluded from the United States, leaving only infectious tuberculosis on the list. A similar amendment to the regulations had been proposed in January 1991, by the George H.W. Bush Administration, and had also been controversial. In both cases, the deletion of HIV infection from the list of excludable diseases caused the most concern. (June 10, 1993; 107 Stat. 210).

[13] INA § 212(a)(1), 8 U.S.C. § 1182(a)(1) (Any alien who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance…is inadmissible.).

[14] The prevalence of active tuberculosis among foreign nationals has been a concern for many years. On January 23, 1991, HHS published a proposed rule in which infectious tuberculosis would have been the only communicable disease listed. That rule was suspended May 29, 1991, largely because of the controversies of leaving HIV/AIDS off the list. In addition, processing of Hmong refugees located in Thailand was temporarily halted in 2005 to ensure that the refugees had completed treatment for infectious tuberculosis before they came to the United States. *See* "State Department Halts Travel of Hmong Refugees to U.S.; Institutes Enhanced Medical Screening," *Interpreter Releases*, vol. 82, no. 7 (February 14, 2005).

infectious syphilis.[15] However, this list is neither exclusive nor exhaustive because the regulatory definition also includes other diseases incorporated by reference to a Presidential Executive Order.[16] The relevant executive order lists cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named); severe acute respiratory syndrome (SARS); and "[i]nfluenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic."[17]

Furthermore, the regulatory definition also includes communicable diseases that may pose a "public health emergency of international concern."[18] A disease rises to this level, and thus qualifies as a "communicable disease of public significance," if the CDC Director, after evaluating (1) the seriousness of the disease, (2) whether the emergence of the disease was unusual or unexpected, (3) the risk of the spread of the disease in the United States, and (4) the transmissibility and virulence of the disease,[19] determines that "a threat exists for [the disease's] importation into the United States" and the disease "may potentially affect the health of the American public."[20]

The Centers for Disease Control and Prevention (CDC) in HHS take the lead in protection against communicable diseases among foreign nationals who come to the United States. The CDC are responsible for providing the technical instructions to civil surgeons and panel physicians who conduct medical examinations for immigration purposes. Foreign nationals who are applying for visas at U.S. consulates are tested by in-country physicians who have been designated by the State Department. The physicians enter into written agreements with the consular posts to perform the examinations according to HHS regulations and guidance. Foreign nationals in the United States who are adjusting to legal permanent resident (LPR) status are tested by civil surgeons designated by USCIS.

A medical examination is required of all foreign nationals seeking to come as legal permanent residents and refugees, and may be required of any alien seeking a nonimmigrant visa or admission at the port of entry. Foreign nationals are generally tested at their own expense, though the costs for refugees are covered by the U.S. government. If there is reason to suspect an infection, applicants for temporary admission as nonimmigrants (such as tourists, business travelers, temporary workers, and foreign students) are tested at the discretion of the consular officer or admitting CBP inspector. Children under 15 years of age are required to have a general physical examination and provide proof of immunizations, but they are not required to have the chest x-rays, blood tests, or HIV anti-body test.[21]

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[15] 42 C.F.R. § 34.2(b).

[16] 42 C.F.R. § 34.2(b)(2).

[17] Exec. Order. No. 13295, 68 FR 17255 (April 4, 2003) *as amended by* Exec. Order. No. 13375, 70 FR 17299 (April 1, 2005).

[18] 42 C.F.R. § 34.2(b)(3).

[19] *See* 42 C.F.R. §34.3(d)(2) (factors used to determine whether a communicable disease poses a public health emergency of international concern).

[20] 42 C.F.R. § 34.2(b)(3). *See also* Annex 2 of the revised International Health Regulations http://www.who.int/csr/ihr/en.

[21] U.S. Department of State Bureau of Consular Affairs, *Frequently Asked Questions—Immigrant Visa Interview Medical Examination*, http://travel.state.gov/visa/immigrants/info/info_3745.html#_What_should_the.

Policies and procedures established over the years by the CDC spell out the obligations of the physicians who are designated to conduct the medical examination to meet the statutory requirements of the INA. According to the CDC's technical guidance for the physicians performing the medical examination, they are required to make an assessment of the foreign national that includes a medical history, a review of other available records, a physical examination, and required diagnostic tests (more detailed information on these requirements are available in **Appendix B**).[22] Afterwards, CDC guidance says, the panel physician completes the DS-2053 form if the visa is being processed by consular officers abroad, or the civil surgeon completes I-693 form if the status adjustment is being processed by USCIS adjudicators within the United States. In general, the medical reports are valid for one year.

Mere presence of one of the designated diseases does not always lead to exclusion. After a visa applicant is found to be afflicted with tuberculosis, for example, the consular officer or USCIS adjudicators is to request the medical examiner to determine whether the tuberculosis is Class A (infectious), Class B-1 (clinically active, not infectious) Class B-2 (not clinically active) or Class B-3 (old or healed tuberculosis). A foreign national diagnosed with Class B-1 tuberculosis, is not automatically ineligible for LPR visa purposes; nor is a foreign national diagnosed with Class B-1, B-2, or B-3 tuberculosis automatically ineligible for nonimmigrant (temporary) visa purposes.[23]

Waivers of the Health Grounds

The INA gives the Secretary of Homeland Security[24] the discretionary authority to waive some of the health-related grounds for inadmissibility under certain circumstances.[25] For example, foreign nationals infected with a communicable disease of public health significance can still be issued a waiver and admitted into the country if they are the spouse, unmarried son, unmarried daughter, minor unmarried lawfully adopted child, father, or mother of a U.S. citizen, alien lawfully admitted for permanent residence, or an alien issued an immigrant visa, or is a VAWA self-petitioner.[26] Waivers are also available, under certain circumstances, for those inadmissible for lacking proper vaccination[27] and for those who have a physical or mental disorder.[28] The Secretary may also waive the application of any of the health-related grounds for inadmissibility if she finds it in "the national interest" to do so.[29]

The Department of State Visa Office reports that a total of 832 potential LPRs were initially denied a visa in 2008 on the basis of a communicable disease of public health significance (e.g., cholera, infectious tuberculosis, HIV/AIDS).[30] However, 437 people obtained waivers or

[22] INA § 222(f) provides that if an immigrant visa is not issued, all medical eligibility forms will be treated as confidential.

[23] 9 FAM § 40.11 N.5.2.

[24] The text actually names the Attorney General, but the passage of the Homeland Security Act of 2002 transferred the waiver power to the Secretary of Homeland Security.

[25] INA § 212(g), 8 U.S.C. § 1182(g).

[26] INA § 212(g)(1), 8 U.S.C. § 1182(g)(1).

[27] INA § 212(g)(2), 8 U.S.C. § 1182(g)(2).

[28] INA § 212(g)(3). 8 U.S.C. § 1182(g)(3).

[29] INA, § 212(d)(13)(B)(i).

[30] In FY2008, a total of 291,792 immigration applications were found ineligible under grounds for exclusion in the INA. However, during the same fiscal year 184,457 applications overcame the grounds for exclusion.

overcame an initial denial based upon a communicable disease and were granted LPR visas in 2008.[31] Comparable data from the Department of Homeland Security have not been made available.

When waivers are given to nonimmigrants, it is done on a case-by-case basis for up to 30 days, for such reasons as visiting a family member, short-term treatment, or attending conferences. The Department of State Visa Office reports that a total of 219 potential nonimmigrants were denied a visa in 2008 on the basis of a communicable disease of public health significance.[32] Also in 2008, 187 people obtained waivers or overcame an initial denial based upon a communicable disease and received a nonimmigrant visa.[33] Comparable data from the Department of Homeland Security have not been made available.

Vaccination Requirements

As stated above, the INA renders inadmissible foreign nationals who are not vaccinated against vaccine-preventable diseases.[34] Vaccinations are statutorily required for mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, influenza type B and hepatitis B. Vaccinations against other diseases may also be required if recommended by the Advisory Committee for Immunization Practices (ACIP), an advisory committee to the CDC.[35] Those vaccinations against other diseases the ACIP have added are hepatitis A, human papillomavirus, meningococcal, pneumococcal, rotavirus, varicella, zoster, and the annual influenza vaccine.[36] Most visas denied on this basis are overcome when evidence of the vaccination is presented.[37]

If the panel physician or civil surgeon believes that a vaccination record is fraudulent, the visa applicant is handled in the same way as someone who has failed to present a vaccination record. The vaccination requirement may be waived when the foreign nation receives the vaccination, the civil surgeon or panel physician certifies that the vaccination would not be medically appropriate, or if the vaccination would be contrary to the foreign national's religious or moral beliefs.[38]

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[31] U.S. Department of State Bureau of Consular Affairs, *2008 Report of the Visa Office*, Washington , DC, 2009, Appendix Table XX.

[32] In FY2008, a total of 2,083,726 nonimmigrant applications were found ineligible under grounds for exclusion in the INA. However, during the same fiscal year 538,129 applications overcame the grounds for exclusion.

[33] U.S. Department of State Bureau of Consular Affairs, *2008 Report of the Visa Office*, Washington , DC, 2009, Appendix Table XX.

[34] INA § 212(a)(ii).

[35] *Id.*

[36] *See* CDC Immigration Requirements: Technical Instructions for Vaccination, Table 1 (2007). On April 8, 2009, the CDC issued a notice with comment period that minor modifications would be made to the vaccination requirements under the Immigration and Nationality Act. For more information, see Centers for Disease Control and Prevention, Department of Health and Human Services, "Criteria for Vaccination Requirements for U.S. Immigration Purposes," 74 *Federal Register* 15986-15987, April 8, 2009.

[37] U.S. Department of State Bureau of Consular Affairs, *2008 Report of the Visa Office*, Washington , DC, 2009, Appendix Table XX.

[38] INA § 212(g)(2).

Port of Entry Policies and Procedures

From an immigration standpoint, infectious disease outbreaks place notable procedural and resource pressures on U.S. Customs and Border Protection. The mission of CBP is to protect the borders of the United States by preventing, preempting, and deterring threats against the U.S. through ports of entry and by interdicting illegal crossing between ports of entry. CBP's mission integrates homeland security, safety, and border management in an effort to ensure that goods and persons cross the borders of the U.S. in accordance with applicable laws and regulations, while posing no threat to the country.[39] There are 327 official ports of entry in the United States, including 15 preclearance offices in Canada, Ireland, and the Caribbean. As it performs its official missions, CBP maintains two overarching and sometimes conflicting goals: increasing security while facilitating legitimate trade and travel.[40] Highlighting this challenge, CBP is charged with screening admissions at land, sea, and air ports of entry (POE), and CBP Officers screened approximately 409 million individuals in FY2008 for admissions into the United States, of which 94 million arrived by aircraft.[41] In addition to the large demand for inspections, many ports of entry suffer from staffing shortages, spatial constraints, and a general lack of resources to fully execute the agency's mission.[42]

From CBP's perspective, the most significant challenge in screening for infectious diseases comes at the land border. The vast majority of admissions into the United States occur at the land border, where local and regional economies are dependent upon the movement of goods and people across the border to maintain economic viability. Even without medical screening or other special circumstances, land borders can build up inspection lines that are several hours long due to the high demand for crossings and inadequate infrastructure at most POEs to accommodate such crossings.

General CBP Procedures

At official ports of entry, CBP officers are responsible for conducting immigration, customs, and agricultural inspections on entering aliens.[43] In the case of a foreign national being inspected, the

[39] The priority of CBP is to prevent terrorists and their weapons from entering the United States, and to support related homeland security missions affecting border and airspace security. CBP is also responsible for apprehending individuals attempting to enter the U.S. illegally; stemming the flow of illegal drugs and other contraband; protecting U.S. agricultural and economic interests from harmful pests and diseases; protecting American businesses from theft of their intellectual property; regulating and facilitating international trade; collecting import duties; and enforcing U.S. trade laws. U.S. Congress, House Committee on Appropriations, *Department of Homeland Security Appropriations Bill, 2009*, report to accompany H.R. 6947, 110th Cong., 2nd sess., September 18, 2008, H.Rept. 110-862 (Washington: GPO, 2008), p. 29.

[40] U.S. Customs and Border Protection, *Performance and Accountability Report, Fiscal Year 2008*, Washington, DC, December 2008, p. 6.

[41] *Ibid.*.

[42] For example, see U.S. Government Accountability Office, *Various Issues Led to the Termination of the United States-Canada Shared Border Management Pilot Project*, GAO-08-1038R, September 4, 2008, p. 4.

[43] For more information, see CRS Report RS21899, *Border Security: Key Agencies and Their Missions*, by Chad C. Haddal. Between official ports of entry, the U.S. Border Patrol (USBP)—a component of CBP—enforces U.S. immigration law and other federal laws along the border. As currently comprised, the USBP is the uniformed law enforcement arm of the Department of Homeland Security. Its primary mission is to detect and prevent the entry of terrorists, weapons of mass destruction, and unauthorized aliens into the country, and to interdict drug smugglers and other criminals. In the course of discharging its duties the USBP patrols over 8,000 miles of U.S. international borders (continued...)

officer may ask questions, verify documents and perform various other inspection activities to determine whether any of the grounds for inadmissibility under the INA applies to the foreign national. Violators of any of these grounds may be detained, charged, or offered voluntary removal depending upon the circumstances of a given case.

The CBP Inspector's Field Manual states that CBP officers are responsible for observing all travelers for obvious signs and symptoms of quarantinable and communicable diseases, such as (1) fever, which could be detected by a flushed complexion, shivering, or profuse sweating; (2) jaundice (unusual yellowing of skin and eyes); (3) respiratory problems, such as severe cough or difficulty breathing; (4) bleeding from the eyes, nose, gums, or ears or from wounds; and (5) unexplained weakness or paralysis.[44] Additionally, a person is considered to be ill in terms of foreign quarantine regulations when symptoms meet the following criteria:

1. Temperature of 100 degrees Fahrenheit or greater which is accompanied by one or more of the following: rash, jaundice, glandular swelling, or which has persisted for 2 days or more.
2. Diarrhea severe enough to interfere with normal activity or work.[45]

However, CBP officers are not medically trained or qualified to physically examine or diagnose illness among arriving travelers.

According to a Government Accountability Office (GAO) report,[46] there are three general scenarios in which CBP officers encounter ill persons who are in need of medical attention or who may pose a public health threat:

- In the most common scenario, CBP officers encounter an individual who discloses that he/she needs medical attention for various health reasons.
- CBP officers suspect an individual may need medical attention or may pose a public health risk to others (e.g., individual exhibits obvious signs and symptoms of illness, such as fever, weakness, or both, as observed by officers).
- CBP officers encounter an individual who is an exact match to a public health alert in Treasury Enforcement Communications System (TECS II)[47] and may pose a public health risk to others.

(...continued)

with Mexico and Canada and the coastal waters around Florida and Puerto Rico. For more information on the Border Patrol, see CRS Report RL32562, *Border Security: The Role of the U.S. Border Patrol*, by Chad C. Haddal.

[44] U.S. Department of Homeland Security, *Inspector's Field Manual*, Chapter 17, Section 9, Washington, DC, March 2006.

[45] *Ibid.*

[46] U.S. Government Accountability Office, *Public Health and Border Security: HHS and DHS should Further Strengthen Their Ability to Respond to TB Incidents*, GAO-09-58, October 2008, pp. 49-50.

[47] TECS II is a computerized information system designed to identify suspected violators of federal law, as well as a communications system permitting message transmittal between certain Federal, national, state, and local law enforcement agencies. Immigration inspectors use the Interagency Border Inspections System (IBIS) at ports of entry to verify and obtain information on aliens presenting themselves for entry into the United States. IBIS is a broad system that sits on TECS II and interfaces with other databases as well. Because of the numerous systems and databases that interface with IBIS, the system is able to obtain such information as whether an alien is admissible, an alien's criminal information, and whether an alien is wanted by law enforcement.

The GAO report additionally states that in all three scenarios, CBP protocols require officials, at a minimum, to isolate the person while notifying officials at CDC and, depending on the circumstance, to contact the designated local public health authorities (e.g., hospitals and emergency medical personnel).[48] Each port of entry, according to GAO, is supplied with personal protective equipment, including masks and gloves, and inspecting officers must use this equipment in dealing with travelers suspected of having communicable or quarantinable illnesses, as well as while handling the individuals' documents and belongings. CBP officers are responsible for coordinating with CDC to provide assistance in identifying arriving individuals from areas with known communicable disease outbreaks.

The Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention in HHS take the lead in protection against communicable diseases and is responsible for providing the technical instructions to civil surgeons and panel physicians who conduct medical examinations for immigration. CDC officials are not present at the border on a day-to-day basis, but there are quarantine stations located in a number of international airports and near a few land ports of entry (for a full list, see **Appendix A**). However, these stations constitute a small fraction of the 327 ports of entry operated by CBP. As a result, the CDC, through their Division of Global Migration and Quarantine (DGMQ),[49] is to train CBP inspectors to watch for ill persons and items of public health concern.[50] CDC is to approve the physicians used at the ports of entry, and the tests are to be performed in consultation with and in accordance with CDC guidance. CDC officials are to be stationed at the border during immigration emergencies and other periods when public health may be threatened. But even though steps have been taken to fortify ports of entry with medical staff, even fully staffed quarantine stations are not in a position to perform routine health screening on all passengers crossing the border as a standard operating procedure.[51]

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[48] *Ibid.* If the incident occurs at a port of entry collocated with a quarantine station, CBP officials are instructed to notify the CDC official at the quarantine station on-site. However, all ports of entry have access to on-call medical personnel.

[49] The mission of DGMQ is to reduce morbidity and mortality among immigrants, refugees, travelers, expatriates, and other globally mobile populations, and to prevent the introduction, transmission, and spread of communicable diseases through regulation, science, research, preparedness, and response. DGMQ is comprised of three branches: the Quarantine and Border Health Services Branch, the Geographic Medicine and Health Promotion Branch, and the Immigrant, Refugee, and Migrant Health Branch. Each branch has its own mission that aligns with DGMQ's overarching mission. The Quarantine and Border Health Services Branch's mission is to protect the health of the public from communicable diseases through science, partnerships and response at U.S. ports of entry. The mission of the Geographic Medicine and Health Promotion Branch is to characterize the health risks associated with international travel and develop ways to reduce the associated morbidity and mortality. The mission of the Immigrant, Refugee, and Migrant Health Branch mission is to promote and improve the health of immigrants, refugees, and migrants, and prevent the importation of infectious diseases and other conditions of public health significance into the United States by these groups.

[50] According to ExpectMore.gov: "CDC works closely with CBP to train the CBP officers to incorporate these responsibilities into their daily activities. The quarantine stations rely not only on CBP but also on airline crews and ship masters to identify ill passengers. Officers of CBP and the U.S. Coast Guard (USCG) have statutory responsibility "to aid in the enforcement of quarantine rules and regulations." The CDC Quarantine Stations are technically responsible for inspecting all imports of animals under their authority to ensure that the animals do not display signs of communicable disease. In practice, however, this responsibility usually is carried out by CBP veterinary and animal health inspectors on behalf of the Quarantine Core." (http://www.whitehouse.gov/omb/expectmore/detail/10009087.2008.html)

[51] Through an interagency agreement between the Department of Health and Human Services and the Department of Homeland Security, the Division of Immigration Health Services (DIHS) provides healthcare to undocumented (continued...)

Emergency Procedures

When a health-related emergency occurs that impacts travelers entering and exiting the United States, certain emergency procedures are to be enacted. The National Strategy for Pandemic Influenza (NSPI) clarifies that: "Lead departments have been identified for the medical response (Department of Health and Human Services), veterinary response (Department of Agriculture), international activities (Department of State) and the overall domestic incident management and Federal coordination (Department of Homeland Security). Each department is responsible for coordination of all efforts within its authorized mission, and departments are responsible for developing plans to implement [the NSPI]."[52]

In practice, should emergency actions be required at the border in response to an outbreak of disease, there are several steps that CBP may take. Initially, CBP, in conjunction with other relevant agencies such as CDC, would conduct a risk assessment to determine necessary procedures as well as the best possible distribution of manpower and other resources to effectively manage the emergency. One possible step would be to increase its medical screening at ports of entry. Such a measure would involve working with CDC to bring in medical personnel that would screen individual travelers at the ports of entry inspection areas.[53] Another possible step would be to increase its stockpiles of antiviral drugs and/or redistribute these drugs to targeted CBP field offices. Such a redistribution would generally be based upon the risk assessment conducted by CBP and information provided by the medical community.

Select Contagious Diseases

Although all diseases carry implications for international travel, a few contagious diseases have garnered notable public attention. Two of these diseases are discussed in the sections below. The diseases discussed were selected largely due to the significant congressional attention they received in the context of immigration policy.[54]

(...continued)

migrants in the custody of Immigration and Customs Enforcement (ICE) residing in Service Processing Centers (SPC) and Contract Detention Facilities (CDF). DIHS, however, plays virtually no role in regard to inspection of travelers or screening of legal immigrants and nonimmigrants. For more information on DIHS, see CRS Report RL34556, *Health Care for Noncitizens in Immigration Detention*, by Alison Siskin.

[52] National Strategy for Pandemic Influenza, p. 10.

[53] CBP would only implement such a measure under an emergency procedure due to the large amount of medical resources that would be diverted to ports of entry, the notable slowing of the inspections process that would result, and the additional pressures it would place on already limited inspection spaces at ports of entry (Testimony of Secretary of Homeland Security Janet Napalitano in U.S. Congress, Senate Committee on Homeland Security and Governmental Affairs, *Swine Flu: Coordinating the Federal Response*, 111th Cong., 1st sess., April 29, 2009, Washington: GPO, 2009). For more information on legal issues related to emergency procedures at the border, see CRS Report R40560, *The 2009 Influenza Pandemic: Selected Legal Issues*, coordinated by Kathleen S. Swendiman and Nancy Lee Jones.

[54] Although each disease received notable public attention, Avian Flu and Severe Acute Respiratory Syndrome (SARS) are not included in this discussion. These diseases were not included because their impact on the United States was minimal, the diseases have currently been contained, and each had little or no impact on immigration and port of entry inspection policies and procedures.

H1N1 Virus

On June 11, 2009, in response to the global spread of a new strain of influenza A subtype H1N1 influenza ("flu") virus, the World Health Organization (WHO) declared the outbreak to be a flu pandemic, the first since 1968. The novel flu virus was first identified in two children in Southern California in late April 2009. Health officials quickly confirmed that many of the illnesses in Mexico involved the same new flu strain. Subsequently, a growing number of single or clustered cases of illness were identified across the United States, Canada, and several other countries. CDC estimates that as of October 17, the pandemic had caused between 14 million and 34 million cases of H1N1 infection, between 63,000 and 153,000 H1N1-related hospitalizations, and between 2,500 and 6,000 H1N1-related deaths in the United States.[55]

The global spread of this virus is attributable to transnational travel of individuals infected in a source country and the subsequent infection of other individuals in the arriving country. CBP officers have been instructed to conduct "passive lookouts" for individuals exhibiting symptoms of illness. However, medical questioning or thermal scanning for elevated body temperature of all passengers is not being conducted (as is the case in countries such as Australia).[56] In response to the outbreak, CDC issued a notice on April 27, 2009, recommending that American citizens avoid all nonessential travel to Mexico.[57] This travel notice has since been withdrawn.

The H1N1 outbreak has prompted federal agencies to conduct response and mitigation actions. CDC reported that as of May 1, 2009, supplies from CDC's Division of the Strategic National Stockpile (SNS) were being sent to all 50 states and U.S. territories to help them respond to the outbreak. Secretary of Homeland Security Janet Napalitano stated on April 30, 2009, that the federal government had stockpiled 50 million courses of two types of antiviral drugs—Tamiflu and Relenza. These stockpiles were in addition to the states' stockpiles of 23 million courses and the Department of Defense stockpiles numbering in the millions. The Secretary also stated that antiviral courses from the national stockpiles were being moved to states that have confirmed incidents of the virus.[58] CDC also reported that the federal government and manufacturers have begun the process of developing a vaccine against this new virus.[59] Moreover, gloves and masks and other similar equipment were being provided to employees at ports of entry. In June, the Obama Administration requested $2 billion in FY2009 emergency supplemental appropriations for response to the H1N1 threat, and authority to transfer additional amounts, totaling almost $7 billion, from existing HHS accounts. The Supplemental Appropriations Act of 2009,[60] signed on June 24, 2009, provided $1.9 billion in supplemental appropriations immediately, and an additional $5.8 billion contingent upon a presidential request documenting the need for additional funds.

[55] For additional and updated information, see CRS Report R40554, *The 2009 Influenza Pandemic: An Overview*, by Sarah A. Lister and C. Stephen Redhead.

[56] HSDailyWire.com, *Airport Flu Scanners as Global Health Alert Increases*, May 1, 2009, http://hsdailywire.com/single.php?id=7885.

[57] U.S. Department of State, "Travel Alert: 2009 H1N1 Influenza," press release, April 28, 2009, http://travel.state.gov/travel/cis_pa_tw/pa/pa_3028.html.

[58] U.S. Department of Homeland Security, "Remarks by Secretary Napolitano at Today's Media Briefing on the H1N1 Flu Outbreak," press release, April 30, 2009, http://www.dhs.gov/ynews/releases/pr_1241140344050.shtm.

[59] Centers for Disease Control and Prevention website, available at http://www.cdc.gov/h1n1flu/.

[60] P.L. 111-32.

Border Closing

Some critics of the Administration's current approach to the handling of the H1N1 flu outbreak have called for DHS to consider closing the border between the United States and Mexico in order to prevent the continuing spread from the source country.[61] Both the President and the Secretary of Homeland Security have rejected this proposed course of action, noting that circumstances do not warrant such a response. The Administration generally has contended that a border closure would not achieve its intended purpose since the virus has already spread to the United States. Moreover, when asked what types of conditions related to the H1N1 flu virus would warrant closing the border, the interim Deputy Director for Science and Public Health at the Centers for Disease Control and Prevention, Rear Admiral Anne Schuchat, testified: "I don't think there are any."[62] These general positions were reiterated by the Secretary of Homeland Security at a press conference on April 30, 2009.[63] Thus, it seems unlikely that the Administration would consider closing the border due to the spread of the H1N1 virus.[64] According to the DHS website: "There are no border restrictions in effect. U.S. Customs and Border Protection continues to monitor the health status of incoming visitors at our land, sea and air ports watching out for illness as part of their standard operating procedure."[65]

Closing the United States border with Mexico would be a massive logistical undertaking that most experts believe would cause "economic devastation," particularly in the southwest United States. According to the U.S. Department of Commerce, in 2008 Mexico was the second-largest export market for U.S. goods ($151.5 billion) and the third-largest import market ($215.9 billion).[66] GAO reported that legitimate travel between the United States and Mexico contributes to over $1 billion in bilateral trade on a daily basis.[67] In practical terms, such action would necessitate CBP shifting its non-essential personnel to support law-enforcement functions in the Southwest. The Federal Aviation Administration, the U.S. Coast guard, and numerous other agencies would have to be called upon to coordinate air and sea traffic and prevent any incoming traffic that originated in Mexico. Additionally, national guard troops might be called upon to assist in controlling the 1,933-mile-long land border to prevent surreptitious crossings and maintain law and order. Due to the large number of resources such an effort would require, the manpower and equipment to perform these functions would be partially drawn from other border areas and ports of entry. This shift would likely have a negative effect on the flow of commerce, as well as create increased security risks. Thus, there is a strong probability that closing the border to Mexico would have a detrimental impact on travelers from other countries arriving at ports of entry outside the southwest United States.

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[61] Comments of Sen. John McCain in U.S. Congress, Senate Committee on Homeland Security and Governmental Affairs, *Swine Flu: Coordinating the Federal Response*, 111th Cong., 1st sess., April 29, 2009 (Washington: GPO, 2009).

[62] Kasie Hunt, "Homeland Secretary Sees No Reason to Close Border with Mexico," *CongressDaily*, April 29, 2009.

[63] U.S. Department of Homeland Security, "Remarks by Secretary Napolitano at Today's Media Briefing on the H1N1 Flu Outbreak," press release, April 30, 2009, http://www.dhs.gov/ynews/releases/pr_1241140344050.shtm.

[64] For legal issues related to closing the border, see CRS Report R40560, *The 2009 Influenza Pandemic: Selected Legal Issues*, coordinated by Kathleen S. Swendiman and Nancy Lee Jones.

[65] U.S. Customs and Border Protection, "Department Response to H1N1 (Swine) Flu," January 27, 2010, http://www.dhs.gov/files/programs/h1n1flu.shtm.

[66] U.S. Department of Commerce (2008).

[67] U.S. Government Accountability Office, *Border Security: State Department is Taking Steps to Meet Projected Surge in Demand for Visas and Passports in Mexico*, GAO-08-1006, July 2008, p. 1.

Tuberculosis (TB)

In recent years, tuberculosis (TB) has prompted greater concerns with health and screening officials in the United States, due in part to the development of drug resistant strains of the disease.[68] These developments have caused agencies such as the CDC to implement instructions and preparedness plans for screening and handling travelers to the United States infected with TB. Additional concerns were raised in Spring 2007 when two individuals with drug-resistant TB disease were requested flagged by HHS for CBP interdiction. Despite this call for interdiction, both individuals were able to enter the United States through ports of entry. These incidents resulted in a reassessment of federal coordination and response regarding TB and other contagious diseases.[69] Despite renewed efforts by federal agencies, TB remains an ongoing public health threat from foreign travelers.

The majority (57%) of tuberculosis cases diagnosed in the United States are diagnosed in persons born outside the United States.[70] It is not clear, however, what percentage of this population would have been symptomatic of the disease at the time of their arrival at a port of entry. An estimated 2 billion people—one-third of the world's population—are infected with *Mycobacterium (M.) tuberculosis*, the bacterium that causes TB, approximately 9 million of whom have transmissible TB disease.[71] Medical screening for tuberculosis is legally required of refugees and applicants of U.S. immigration in order to receive a visa and enter the United States. However, CBP does not currently have any special provisions outside of its general procedures for TB screening at ports of entry.

[68] For more information on tuberculosis, see CRS Report RL34144, *Extensively Drug-Resistant Tuberculosis (XDR-TB): Emerging Public Health Threats and Quarantine and Isolation*, by Kathleen S. Swendiman and Nancy Lee Jones.

[69] According to a GAO report: "In the spring of 2007, HHS requested DHS's assistance in attempting to interdict at the border two individuals with drug-resistant TB disease so that they could direct them to treatment. According to HHS documents, in May 2007, one of these individuals, a U.S. citizen, traveled abroad against advice from physicians. When state and local health officials were unable to find this person and serve him with a written order not to travel, they requested help from HHS. While he was traveling abroad, HHS located him and attempted to direct him to treatment. HHS then contacted DHS for assistance. However, while HHS and DHS were determining a course of action to attempt to prevent him from traveling further by airplane, he once again traveled. Furthermore, as the departments were working to intercept him at the U.S. border, he was able to reenter the country because a U.S. Customs and Border Protection (CBP) officer, in violation of CBP policy, ignored a computerized alert in CBP's border screening and inspection system to detain him. In a separate incident, a Mexican citizen with drug-resistant TB who had a prior history of nonadherence to treatment crossed the U.S.-Mexico border approximately 20 times during April and May 2007. HHS and DHS worked together to try to prevent him from crossing the border, but attempts to identify him in DHS databases failed on several occasions. According to HHS officials, both individuals were eventually located and received treatment, and none of the people who might have been in contact with these individuals were reported to have contracted TB."(U.S. Government Accountability Office, Public Health and Border Security: HHS and DHS Should Further Strengthen Their Ability to Respond to TB Incidents, GAO-09-58, October 2008, p. 2-3).

[70] Information available at ExpectMore.gov, http://www.whitehouse.gov/omb/expectmore/detail/10009087.2008.html.

[71] U.S. Government Accountability Office, *Public Health and Border Security: HHS and DHS Should Further Strengthen Their Ability to Respond to TB Incidents*, GAO-09-58, October 2008, p. 1.

Appendix A. CDC Quarantine Stations

Table A-1. CDC Quarantine Stations by City and Location

City	Location
Anchorage, AK	Ted Stevens Anchorage International Airport
Atlanta, GA	Hartsfield-Jackson Atlanta International Airport
Boston, MA	Logan International Airport
Chicago, IL	O'Hare International Airport
Dallas/Ft. Worth, TX	Dallas/Ft. Worth International Airport
Detroit, MI	Detroit Metro Airport
El Paso, TX	CDC El Paso Quarantine Station
Honolulu, HI	Honolulu International Airport
Houston, TX	George Bush Intercontinental Airport
Los Angeles, CA	Los Angeles International Airport
Miami, FL	Miami International Airport
Minneapolis, MN	Minneapolis-St. Paul International Airport
Newark, NJ	Newark Liberty International Airport
New York, NY	John F. Kennedy International Airport
Philadelphia, PA	Philadelphia International Airport
San Diego, CA	CDC San Diego Quarantine Station
San Francisco, CA	San Francisco International Airport
San Juan, PR	Luis Muñoz Marin International Airport
Seattle, WA	Seattle-Tacoma International Airport
Washington, DC	Dulles International Airport

Source: CRS presentation of information posted on CDC website, available at http://www.cdc.gov/ncidod/dq/quarantine_stations.htm.

Notes: Information is current as of January 27, 2010.

Appendix B. CDC Technical Guidance

As previously discussed, policies and procedures established over the years by the CDC spell out the obligations of the physicians who are designated to conduct the medical examination to meet the statutory requirements of the INA. According to the CDC's technical guidance[72] for the physicians performing the medical examination, they are required to make the following assessments of the foreign nationals seeking visas:

- a medical history, obtained by the civil surgeon or a member of the physician's professional staff, from the applicant (preferably) or a family member, which includes (1) a review of all hospitalizations; (2) a review of all institutionalizations for chronic conditions (physical or mental); (3) a review of all illnesses or disabilities resulting in a substantial departure from a normal state of well-being or level of functioning; (4) specific questions about psychoactive drug and alcohol use, history of harmful behavior, and history of psychiatric illness not documented in the medical records reviewed; and (5) a review of chest radiographs and treatment records if the alien has a history suggestive of tuberculosis.
- a review of any other records that are available to the physician (e.g., police, military, school, or employment) that may help to determine a history of harmful behavior related to a physical or mental disorder and to determine whether illnesses or disabilities are present that result in a substantial departure from a normal state of well-being or level of functioning.
- a review of systems sufficient to assist in determining the presence and the severity of Class A or Class B conditions. The physician should ask specifically about symptoms that suggest cardiovascular, pulmonary, musculoskeletal, and neuropsychiatric disorders. Symptoms suggestive of infection with any of the excludable communicable diseases (tuberculosis, HIV infection, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and Hansen's disease) should also be sought.
- a physical examination, including an evaluation of mental status, sufficient to permit a determination of the presence and the severity of Class A and Class B conditions. The physical examination is to include a mental status examination that includes, at a minimum, assessment of intelligence, thought, cognition (comprehension), judgment, affect (and mood), and behavior.
- a physical examination that includes, at a minimum, examination of the eyes, ears, nose and throat, extremities, heart, lungs, abdomen, lymph nodes, skin and external genitalia.
- all diagnostic tests required for the diagnosis of the diseases identified as communicable diseases of public health significance and other tests identified as necessary to confirm a suspected diagnosis of any other Class A or Class B condition.

[72] U.S. Department of Health and Human Services Centers for Disease Control, *Technical Instructions for Medical Examination of Aliens*, June 12, 1991, as revised in July 1992.

Author Contact Information

Chad C. Haddal
Analyst in Immigration Policy
chaddal@crs.loc.gov, 7-3701

Ruth Ellen Wasem
Specialist in Immigration Policy
rwasem@crs.loc.gov, 7-7342