

**THE TELEHEALTH “REVOLUTION” & HOW IT FAILS TO
TRANSFORM CARE FOR UNDOCUMENTED IMMIGRANTS**

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The outbreak of COVID-19 led to the rapid adoption and expansion of telehealth services. Upon understanding telehealth’s potential to reach underserved populations, people began referring to this method of health care delivery as “revolutionary.” This reputation stuck, even though it quickly became obvious that telehealth utilization was more common among White, educated, and relatively wealthier individuals. Meanwhile, advocates of telehealth equity found that the benefits of telehealth did not adequately trickle down to lower-income and rural communities, nor to communities of color. Undocumented immigrants as a group were often ignored during considerations of these disparities.

This Article is among the first, even within interdisciplinary scholarship, to highlight undocumented immigrants and their (in)ability to access telehealth services. It begins with a discussion of federal and state immigration policies that govern health care access for immigrants and proceeds to analyze immigrants’ health care needs and enhanced vulnerability during the pandemic. It then discusses four areas in which an immigrant’s undocumented status makes telehealth services harder to access: (1) insurance and affordability, (2) fears of privacy breaches and surveillance, (3) access to technology and digital skills, and (4) limited English language proficiency. This Article concludes by recommending changes to state and federal immigration policies that may help undocumented immigrants realize the novel and innovative ways to access health care which were promised by the telehealth revolution.

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I. INTRODUCTION

During the COVID-19 pandemic, use of telehealth, where health care providers can see patients virtually, boomed.¹ Telehealth proved a valuable tool during the pandemic, as it enabled patients to visit medical providers from their homes and prevented exposure to COVID-19.² Due to telehealth's increasing popularity, laws and regulations governing it were enacted or changed to facilitate more widespread utilization. Although telehealth has been described as

¹ See *infra* notes 88–93.

² See *infra* notes 72–75.

“revolutionary”³ and “transformative,”⁴ health-equity advocates have recognized that it is not uniformly adopted. People of color, low-income groups, and rural communities disproportionately underutilize telehealth services compared to White, wealthier, and less rural communities.⁵ The most commonly recognized rationale provided for this gap in telehealth use is the “digital divide” and the lack of access to digital technologies and skills.⁶ This awareness led advocates to argue for telehealth equity which focuses on creating access to telehealth for underserved people.⁷

There are approximately 11.04 million undocumented immigrants in the United States.⁸ Due to nativist beliefs and xenophobic policies, undocumented immigrants have been denied access to health care in the United States.⁹ They are unable to obtain health care coverage, are ineligible for public benefits, and are deterred from seeking health services due to immigration enforcement, lack of transportation, and language barriers.¹⁰ For these reasons, data shows that undocumented immigrants utilize health care at much lower rates compared to U.S. citizens, which thereby impacts their health and well-being.¹¹ Undocumented

³ See *The Telehealth Revolution*, AM. TECH. TECHNOLOGISTS (Mar. 30, 2021), <https://americanmedtech.org/Blog/Blog-Post/the-telehealth-revolution> [https://perma.cc/FF26-VQEZ]; *The Telehealth Revolution Has Only Just Begun*, TELADOC HEALTH, <https://intouchhealth.com/the-telehealth-revolution-has-only-just-begun/> [https://perma.cc/X3HT-ANUL] (last visited Sept. 13, 2022).

⁴ See *infra* notes 94–95.

⁵ See *infra* notes 100–04.

⁶ See generally Courtney R. Lyles et al., *Bridging the Digital Health Divide: How Providers and Plans Can Help Communities Better Adopt Digital Health Tools*, THE CAL. HEALTHCARE FOUND. (Feb. 2022), <https://www.chcf.org/wp-content/uploads/2022/02/BridgingDigitalDivideProvidersPlans.pdf> [https://perma.cc/Z34Y-QTNN] (describing how the systematic disparity in access and use of technology amongst adults disproportionately impacts people in poverty, people of color, and the elderly).

⁷ See *infra* notes 102–04.

⁸ *Profile of the Unauthorized Population: United States*, MIGRATION POL’Y INST., <https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US> [https://perma.cc/62RR-JA78] (last visited Oct. 7, 2022).

⁹ See *infra* notes 58–71.

¹⁰ See *infra* notes 14–35.

¹¹ See *infra* notes 32–35.

immigrants served as frontline and essential workers during the pandemic and were disproportionately infected by COVID-19.¹² Despite this disproportionate impact, undocumented immigrants were excluded from meaningful pandemic relief and prohibited from accessing health insurance coverage or care.¹³

This Article, one of the first to examine telehealth access for undocumented immigrants, questions whether this developing health care delivery method is truly transformative for this population. While much has been written about improving telehealth access for the general underserved population, this Article highlights the unique barriers to telehealth access that undocumented immigrants face and discusses the role of federal immigration policy in shaping its utilization and accessibility. It argues that this health care delivery method cannot reach its potential for serving the undocumented immigrant community without meaningful reform to federal immigration policy and how telehealth is administered.

II. HEALTH CARE FOR UNDOCUMENTED IMMIGRANTS

The impact of anti-immigration sentiment on health policy and immigrants' access to health programs has been widely documented by scholars in different fields.¹⁴ This literature has broadly confirmed that punitive anti-immigration policies lead to decreased access and utilization of basic health care services among immigrants. For instance, a recent study showed that about half of all undocumented immigrants do not have a usual source of health care or a place that they frequent when sick or in need of health-related advice; in comparison, only one-fifth of U.S.-born individuals do not have a usual source of health care or place that

¹² See *infra* notes 47–60.

¹³ See *infra* notes 58–71.

¹⁴ See Omar Martinez et al., *Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review*, 17 J. IMMIGR. & MINORITY HEALTH 947 (2015); Nicholas A. Vernice et al., *The Adverse Health Effects of Punitive Immigrant Policies in the United States: A Systematic Review*, PLOS ONE (2020); Wendy E. Parmet, *The Worst of Health: Law and Policy at the Intersection of Health & Immigration*, 16 IND. HEALTH L. REV. 211 (2019).

they frequent when sick or in need of health-related advice.¹⁵ Undocumented immigrants also had significantly lower health care expenditures.¹⁶ While these findings may be explained by research suggesting that immigrants are healthier than non-immigrants,¹⁷ a more accurate explanation is likely immigrants’ lack of access to health care services and coverage due to hostile anti-immigrant policies.¹⁸ Although this Article does not deeply analyze the xenophobia and nativism underlying health policies that apply to immigrants, it does highlight how laws regulating immigrant health care are different from those governing lawfully present immigrants and U.S. citizens.

Part A of this Section provides a brief background on whether (and how) undocumented immigrants can access health care in the United States. Part B discusses the impact of COVID-19 on immigrant health and details the inadequate steps taken by federal and state governments to provide relief to undocumented people and communities.

A. Laws and Policies Regulating Health Care Access for Undocumented People

Undocumented immigrants have very little access to health care in the United States. They are presently ineligible for federal health care coverage because the Patient Protection and Affordable Care Act (“ACA”) excludes undocumented immigrants.¹⁹ They are not eligible for Medicare, non-emergency Medicaid, or the Children’s Health Insurance Program (“CHIP”); cannot purchase private health insurance in state-based insurance marketplaces; and are exempt

¹⁵ Fernando A. Wilson et al., *Comparison of Use of Health Care Services and Spending for Unauthorized Immigrants vs Authorized Immigrants or US Citizens Using a Machine Learning Model*, 3(12) JAMA NETWORK OPEN 4 (2020).

¹⁶ *Id.*

¹⁷ Achintya Dey & Jacqueline Wilson Lucas, *Physical and Mental Health Characteristics of U.S.- and Foreign-Born Adults: United States, 1998–2003*, 369 ADVANCE DATA FROM VITAL HEALTH & STAT. 1 (2006).

¹⁸ Wilson et al., *supra* note 15.

¹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, §§ 1302(b)(1), 2707(a) (2010) (current version at 42 U.S.C. § 18022(b)(1)).

from individual mandates.²⁰ This strategic exclusion can be attributed to the perceived costs of providing health care to immigrants and the belief that providing health care is somehow rewarding those who are in the country without authorization.²¹ Immigrants, who are often employed in low-wage jobs, are also less likely to receive or be able to afford employer-sponsored coverage.²² They can purchase private coverage on the individual market, but it works out to be very costly and, thus, unaffordable. It is no surprise then that in 2019, more than four in ten (46 percent) undocumented immigrants were uninsured compared to less than one in ten (9 percent) U.S. citizens.²³

Although undocumented immigrants are not eligible for state Medicaid, five states and Washington, D.C., use state funds to expand Medicaid to cover immigrant children up to age eighteen.²⁴ As of January 2019, sixteen states had also adopted an option to provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child.²⁵ This coverage is controversial and has garnered criticism from reproductive rights

²⁰ See *id.*; *Immigrants and the Affordable Care Act (ACA)*, NAT'L IMMIGR. L. CTR. (Jan. 2014), <https://www.nilc.org/issues/health-care/immigrants/hr/> [https://perma.cc/FDS6-E79V].

²¹ See Medha D. Makhoul, *Health Justice for Immigrants*, 4 U. PA. J. L. & PUB. AFF. 235, 265 (2019) ("The main rationales for excluding immigrants from most publicly funded health care programs are: (1) it would be too costly to cover immigrants, and (2) it is contrary to immigration policy to reward immigrants with free health care if they enter or remain in the country without authorization.").

²² Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, KAISER FAM. FOUND. (July 15, 2019), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/> [https://perma.cc/5BZM-EB59].

²³ *Id.*

²⁴ Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey*, KAISER FAM. FOUND. (Mar. 27, 2019), <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2019> [https://perma.cc/B8T2-A6K4].

²⁵ *Id.* at 10.

advocates who believe that such coverage furthers ideas of “fetal personhood.”²⁶

Some extreme and life-threatening circumstances may be covered by emergency provisions. While undocumented immigrants are not allowed to seek publicly funded health care, they may be covered in exceptional circumstances under the Emergency Medical Treatment and Active Labor Act (“EMTALA”), which requires hospitals to stabilize all low-income individuals with life-threatening conditions.²⁷ Emergency Medicaid also covers emergency services for immigrants who would qualify for Medicaid, if not for their immigration status.²⁸ Importantly, these provisions apply in very narrow, life-threatening circumstances and are in no way substitutes for holistic health care.²⁹

Even in circumstances where federal, state, or local policies allow undocumented immigrants to use certain public benefits, they are still wary of availing such services due to other xenophobic policies in place. For instance, Public Charge, a component of immigration law in operation for decades, restricts admitting immigrants into the U.S. if they are deemed likely to eventually become dependent on the U.S. government.³⁰ This requirement was heightened during the Trump administration, when the Department

²⁶ See Hailey Cleek, *Borders Across Bodies: Assessing the Balance of Expanding Chip Coverage at the Expense of Advancing Fetal Personhood*, 34 BERKELEY J. GENDER L. & JUST. 1, 20 (2019) https://static1.squarespace.com/static/5ecc003be899466983185381/t/5ed2accd1fbb47d97242814/1590865100849/Borders+Across+Bodies_Cleek.pdf [<https://perma.cc/RL3N-S8X3>].

²⁷ See 42 U.S.C. § 1395dd.

²⁸ See § 1395dd(a) (stating that the obligation applies to “any individual”).

²⁹ *California’s Uneven Safety Net: A Survey of County Health Care*, HEALTH ACCESS FOUND. (2013) https://health-access.org/images/pdfs/CAunevenSafetyNet_countysurvey_Nov2013.pdf [<https://perma.cc/8A7H-34JQ>] (“While many consider hospital emergency rooms as the nation’s safety net, the only requirement is that a hospital must stabilize a patient in an emergent situation. So while an ER will treat the heart attack or gunshot wound, a private hospital has the ability to turn away a patient with cancer or diabetes. Without insurance, a severe asthma attack will be treated, but care to manage asthma is not necessarily provided. Also, in these emergency situations, hospitals bill uninsured patients, and these charges quickly run in the thousands of dollars even if the patient is not admitted to the hospital.”).

³⁰ Immigration and Nationality Act, 8 U.S.C. § 1182(a)(4).

of Homeland Security promulgated regulations that would consider immigrants' mere use of public benefits, such as Medicaid, adequate to qualify them as a public charge, instead of requiring a show of "dependence" on the government.³¹ Medha D. Makhoulf and Jasmine Sandhu, an Associate Professor of Law and a former law student at Penn State Dickinson Law School, respectively, have documented Public Charge's chilling effects on non-citizen enrollment in public benefits even before this rule was introduced: the policy causes non-citizens to disenroll or forego enrollment in public benefits, leading to disastrous impacts on public health.³²

One of the only avenues remaining for affordable health care is through Federally Qualified Health Centers ("FQHCs") and Community Health Centers which offer "comprehensive primary care to vulnerable populations that include Medicaid patients, uninsured patients, and patients in underserved urban, suburban, and rural areas . . . regardless of ability to pay, insurance status[,] or immigration status."³³ While FQHCs provide a source of primary care, they do not provide elective specialty care when patients require specialized care or surgical treatments.³⁴

B. COVID-19 and Its Impact on Immigrant Health

Scholars and researchers have produced some documentation of the disproportionate impact of COVID-19 on racial and ethnic

³¹ Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,354 (Aug. 14, 2019), <https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds> [<https://perma.cc/2L62-4RLX>].

³² Medha D. Makhoulf & Jasmine Sandhu, *Immigrants and Interdependence: How the Covid-19 Pandemic Exposes the Folly of The New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146, 151 (2020), <https://ideas.dickinsonlaw.psu.edu/fac-works/145/> [<https://perma.cc/56TD-WQSG>].

³³ *Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care*, THE HASTINGS CTR., <https://undocumented.thehastingscenter.org/issuebrief/health-policy-and-access-to-care/> [<https://perma.cc/SF2L-CKYG>] (last visited Aug. 19, 2022).

³⁴ Alejandro Portes & Patricia Fernández-Kelly, *Life on the Edge: Immigrants Confront the American Health System*, ETHNIC & RACIAL STUD. (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255/> [<https://perma.cc/9PSX-848E>].

minorities.³⁵ Early in the pandemic, Hispanic, American-Indian and Alaska Natives (“AIAN”), and Black people had higher rates of COVID-19 infection and death rates compared to their White and Asian counterparts, with a particularly high infection rate among Hispanic people.³⁶ Given that the majority of undocumented people are Hispanic, they are understood to have increased vulnerability to COVID-19.³⁷ In the Dallas-Fort Worth area, home to one of the nation’s largest populations of undocumented immigrants, the COVID-19 death rate for middle-aged Latino men was eight times higher than for their non-Latino White counterparts.³⁸ A survey also showed that the likelihood of receiving the vaccine was lower for Hispanic populations in California and Texas, states which host approximately 42 percent of the undocumented population.³⁹ These data points do not capture the complete picture of immigrant health during COVID-19, but in the absence of data and research that

³⁵ See Don Bambino Geno Tai et al., *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States*, 72 CLINICAL INFECTIOUS DISEASES 703 (2021), <https://pubmed.ncbi.nlm.nih.gov/32562416/> [<https://perma.cc/MUK3-QH93>]; Erin K. Stokes et al., *Coronavirus Disease 2019 Case Surveillance—United States, January 22–May 30, 2020*, 69 CDC: MORBIDITY MORTALITY WKLY REP. 759 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm> [<https://perma.cc/9JQ9-T53K>].

³⁶ Latoya Hill & Samantha Artiga, *Covid-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time*, KAISER FAM. FOUND. (2022), <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/> [<https://perm.cc/PDV4-W5CL>].

³⁷ *COVID-19 Vulnerability by Immigration Status—Status-Specific Risk Factors and Demographic Profiles*, DEP’T OF HOMELAND SEC. 18 (May 2021), https://www.dhs.gov/sites/default/files/publications/immigration-statistics/research_reports/research_paper_covid-19_vulnerability_by_immigration_status_may_2021.pdf [<https://perma.cc/6XET-FYDK>].

³⁸ Sarah Varney, *Anti-Immigrant Vitriol Complicates Vaccines Rollout in Southern States*, KAISER HEALTH NEWS (Feb. 16, 2021), <https://khn.org/news/article/anti-immigrant-vitriol-complicates-vaccine-rollout-in-southern-states/> [<https://perma.cc/9FWT-4XFQ>].

³⁹ *COVID-19 Vulnerability by Immigration Status—Status-Specific Risk Factors and Demographic Profiles*, DEP’T OF HOMELAND SEC. 18 (May 2021), https://www.dhs.gov/sites/default/files/publications/immigration-statistics/research_reports/research_paper_covid-19_vulnerability_by_immigration_status_may_2021.pdf [<https://perma.cc/3SZD-UWRC>].

specifically studies undocumented individuals, the available data indicates a disproportionate impact on undocumented Latino immigrants.

There are many factors that help explain this disproportionate impact. It could partially be attributed to a lack of access to health care, which would have allowed early diagnosis, monitoring, and treatment of COVID-19.⁴⁰ Factors unique to undocumented and Latino communities, such as living in densely inhabited, multi-generational homes, can exacerbate the spread of infection. An interview of Latinx people living in Baltimore revealed the following:

Low-income immigrant families and work acquaintances frequently share residences to save money. When we contacted patients to tell them about a positive test result and ask who else could have been exposed, we often found that there were up to 10 workers sharing a two-bedroom apartment or several families living in one house. By the time we reached them, most household contacts were already sick. Maryland issued an emergency order prohibiting many evictions, but it didn't protect immigrants subletting under irregular rental arrangements. Housing instability was so prevalent that we began routinely asking people whether they lived in a basement.⁴¹

Public transportation, which immigrants may frequently rely on, could also contribute to the ease of contracting COVID-19.⁴²

Additionally, research has shown that psychological stress is correlated with falling ill and remaining sick.⁴³ Dr. Sheldon Cohen, the Robert E. Doherty Professor of Psychology at Carnegie Mellon

⁴⁰ See Eva Clark et al., *Disproportionate Impact of the COVID-19 Pandemic on Immigrant Communities in the United States*, 14(7) PLOS: NEGLECTED TROPICAL DISEASES (2020), <https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0008484> [<https://perma.cc/J9E4-X3R4>].

⁴¹ Kathleen R. Page & Alejandra Flores-Miller, *Lessons We've Learned—Covid-19 and the Undocumented Latinx Community*, 384 NEW ENG. J. MED. 5, 5–6 (2021).

⁴² See Madeleine E.G. Parker et al., *Public Transit Use in the United States in the Era Of COVID-19: Transit Riders' Travel Behavior In The COVID-19 Impact And Recovery Period*, 111 TRANSP. POL'Y 53, 60 (2021) (“People with lower incomes or decreased incomes due to the pandemic, people of color, and people living in urban areas and apartments are more likely to be transit riders.”).

⁴³ See S. Cohen et al., *Psychological Stress and Susceptibility to the Common Cold*, NEW ENG. J. MED. 325, 606–12 (1991).

University, published an article arguing that due to the overlapping symptoms between the common cold, influenza, and COVID-19, it may be inferred that psychosocial risk factors, such as stress, play a role in increasing vulnerability to COVID-19.⁴⁴ If true, it is plausible that stress related to immigration status renders immigrants vulnerable to COVID-19.⁴⁵

Finally, the rates at which COVID-19 ravaged immigrant communities can be traced to the economic conditions of poverty and precarity that undocumented communities face, which may compel them to continue working despite stay-at-home orders.⁴⁶ The foregoing characteristics of life as an undocumented immigrant in the U.S. could exacerbate people’s susceptibility to COVID-19.

Moreover, a large part of the undocumented community found themselves at the front lines of the COVID-19 response as health care providers.⁴⁷ 15,000 registered nurses and licensed practical nurses, 19,000 lab and diagnostic technicians, and 139,000 home health aides, nursing assistants, and personal care aides are estimated to be undocumented, in addition to 188,000 others who provide services as custodians, food servers, and administrative workers to keep hospitals, nursing homes, and labs functioning.⁴⁸ These individuals were likely directly exposed to COVID-19 infected patients, significantly increasing their chances of contracting the virus.

⁴⁴ Sheldon Cohen, *Psychosocial Vulnerabilities to Upper Respiratory Infectious Illness: Implications for Susceptibility to Coronavirus Disease 2019 (COVID-19)*, 16(1) PERSPS. ON PSYCH. SCI. 161 (2021), <https://journals.sagepub.com/doi/full/10.1177/1745691620942516> [https://perma.cc/NP7B-SRM8].

⁴⁵ See *Stress & Trauma Toolkit for Treating Undocumented Immigrants in a Changing Political and Social Environment*, AM. PSYCH. ASS’N, <https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/undocumented-immigrants> [https://perma.cc/5JLY-7Y42].

⁴⁶ See *infra* notes 54–57.

⁴⁷ See Nicole Prchal Svajlenka, *Protecting Undocumented Workers on the Pandemic’s Front Lines*, CTR. FOR AM. PROGRESS 11 (Dec. 2, 2020), <https://www.americanprogress.org/wp-content/uploads/2020/12/Making-The-Case-For-Legalization.pdf> [https://perma.cc/QB4G-SUAZ].

⁴⁸ *Id.*

In addition to being frontline workers, undocumented immigrants formed a large part of the “essential” workforce. In the U.S., there are approximately eight million undocumented workers, accounting for about 4 percent of the country’s total workforce.⁴⁹ Based on 2018 U.S. Census data, the Center for Migration Studies estimated that 5.5 million workers in “essential critical infrastructures” categories, meaning people who work to meet the “health, infrastructure, manufacturing, service, food, safety, and other needs of all Americans,” are undocumented immigrants.⁵⁰ In fact, about 74 percent of all undocumented workers are essential workers.⁵¹ Undocumented immigrants form large shares of essential industries: 48 percent of food and agricultural workers are undocumented,⁵² and undocumented immigrants are over-represented in occupations related to construction, building and grounds cleaning, production, and transportation.⁵³ As a significant portion of essential workers, undocumented immigrants face a disproportionate risk of exposure to COVID-19.

Considering this heightened exposure risk in the workplace, it is especially jarring that undocumented immigrants are excluded from unemployment funds and did not have the option to stay home that many Americans had.⁵⁴ It is also worth repeating that jobs in these industries do not commonly provide employer-sponsored health

⁴⁹ Jeffrey S. Passel & D’Vera Cohn, *U.S. Unauthorized Immigrant Total Dips to Lowest Level in a Decade*, PEW RES. CTR. 13 (2018), https://www.pewresearch.org/hispanic/wp-content/uploads/sites/5/2019/03/Pew-Research-Center_2018-11-27_U-S-Unauthorized-Immigrants-Total-Dips_Updated-2019-06-25.pdf [<https://perma.cc/RA8Q-D2BT>].

⁵⁰ Donald Kerwin et al., *U.S. Foreign Born Essential Workers by Status and State, and the Global Pandemic*, CTR. FOR MIGRATION STUD. 1 (May 2020), <https://cmsny.org/wp-content/uploads/2020/05/US-Essential-Workers-Printable.pdf> [<https://perma.cc/C8PJ-GW36>].

⁵¹ *Id.*

⁵² Xavier Roberts & Christian Burks, *Immigrant Essential Workers and Covid-19*, NAT’L CONF. OF STATE LEGISLATURES (July 27, 2021), <https://www.ncsl.org/research/immigration/immigrant-essential-workers-and-covid-19.aspx#:~:text=69%25%20of%20all%20immigrants%20in,delivery%20workers%20are%20unauthorized%20immigrants> [<https://perma.cc/64DX-TN3R>].

⁵³ Svajlenka, *supra* note 47, at 6.

⁵⁴ See Page & Flores-Miller, *supra* note 41, at 5.

care coverage, thus leaving workers to either spend a large sum of their salaries affording private coverage or remain uninsured.⁵⁵ As a final point, these workers often found themselves continuing to work through sickness out of fear of being fired and unable to survive without a paycheck.⁵⁶ A study reported as follows:

Compounding the risks, many of these workers labor in conditions ripe for viral spread, standing shoulder to shoulder along conveyor belts in vegetable-packing houses, washing dishes in restaurant kitchens, stocking grocery shelves[,] and cleaning hotel rooms. At day’s end, many return to bunkhouses or cramped homes housing multiple generations of family. “It’s going through the whole house, and if the whole house doesn’t work, they don’t eat,” Davis said. “We’ve had patients begging us not to test them, because then they can’t go to work.”⁵⁷

Despite the above realities that made undocumented immigrants especially vulnerable to COVID-19, they were left out of meaningful COVID-19 relief. Firstly, undocumented immigrants were barred from receiving stimulus checks.⁵⁸ In addition to restrictions placed on undocumented persons themselves, the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”) passed in March of 2020 also barred those in households with people of mixed immigration status (in which some family members used an Individual Taxpayer Identification Number (“ITIN”)) from receiving stimulus checks despite their own immigration status.⁵⁹ An estimated 5.5 million U.S. citizens or green-card holders live with

⁵⁵ Svajlenka, *supra* note 47, at 16.

⁵⁶ *Id.*

⁵⁷ Sarah Varney, *How Fears Driven by Years of Anti-Immigrant Rhetoric Are Complicating Vaccine Rollout*, PBS (Feb. 17, 2021), <https://www.pbs.org/newshour/health/how-fears-driven-by-years-of-anti-immigrant-rhetoric-are-complicating-vaccine-rollout> [<https://perma.cc/ZNB9-5MWR>].

⁵⁸ Peniel Ibe, *Millions of Immigrants Are Being Left Out of Coronavirus Relief*, AM. FRIENDS SERV. COMM. (July 21, 2020), <https://www.afsc.org/blogs/news-and-commentary/millions-immigrants-are-being-left-out-coronavirus-relief> [<https://perma.cc/S2QQ-9PRK>].

⁵⁹ See *Immigrant Eligibility for Public Programs During Covid-19*, PROTECTING IMMIGRANT FAMS. (Mar. 2021), <https://pifcoalition.org/wp-content/uploads/2021/12/Immigrant-Rights-to-Health-Care-March-2021-English.pdf> [<https://perma.cc/3AJS-LHBT>].

at least one family member filing taxes using an ITIN,⁶⁰ and those millions of people were excluded from pandemic relief simply due to their association with an undocumented family member.

Another significant hole in pandemic assistance for undocumented immigrants was their exclusion from unemployment support. Despite high numbers of workers facing unemployment due to the pandemic, unemployment insurance was only provided to those who had work authorization.⁶¹ Fortunately, some states sought to remedy this situation. For example, one in six undocumented workers lost their jobs in New York City as a result of the pandemic.⁶² Upon recognizing this problem, New York committed \$2.1 billion of the state budget to assist undocumented workers who had been systematically excluded from federal pandemic assistance.⁶³ Under New York's program—the first of its kind—undocumented immigrants who qualified for Tier 1 benefits would receive a flat rate of \$15,600, which is still less than half of what New Yorkers who are U.S. citizens receive in unemployment insurance.⁶⁴ These relief measures are significant, as they directly put money in the pockets of people and can be potentially spent to enhance health—to buy healthier food, improve living situations, alleviate stress, and purchase health insurance. New York's program can also help other states realize what they can do to provide immigrants relief.

⁶⁰ *Fact Sheet: Mixed Status Families and COVID-19 Economic Relief*, NAT'L IMMIGR. F. (Aug. 12, 2020), <https://immigrationforum.org/article/mixed-status-families-and-covid-19-economic-relief/> [<https://perma.cc/H2TC-NQA5>].

⁶¹ *Id.*

⁶² James A. Parrott & Lina Moe, *The New Strain of Inequality: The Economic Impact of Covid-19 in New York City*, CTR. FOR N.Y. AFFS. 3 (Apr. 15, 2020), https://static1.squarespace.com/static/53ee4f0be4b015b9c3690d84/t/5e974be17687ca34b7517c08/1586973668757/NNewStrainofInequality_April152020.pdf [<https://perma.cc/6DBX-699U>].

⁶³ David Dyssegaard Kallick, *Excluded Worker Fund: Aid to Undocumented Workers, Economic Boost Across New York State*, FISCAL POL'Y INST. (Apr. 7, 2021), <https://fiscalpolicy.org/wp-content/uploads/2021/04/Excluded-Worker-Fund-Statewide-Benefits-April-2021.pdf> [<https://perma.cc/NLW6-38U4>].

⁶⁴ *See id.*

Regarding health care services, the Family First Act provided funding for COVID-19 testing for the uninsured.⁶⁵ And, while the CARES Act included treatment of uninsured patients with COVID-19, it did not actually offer insurance to the patients. Even though the treatment was reimbursable, this model caused confusion among undocumented people who did not know that their hospital visits could be covered.⁶⁶ The inadequacy of this option led to several states adopting emergency Medicaid authorizations to cover uninsured patients with COVID-19 and amending their qualifying conditions to include outpatient prevention, testing, and treatment of COVID-19.⁶⁷ Although the CARES Act and the American Rescue Plan increased and extended funding for community health centers that service undocumented immigrants, these facilities too faced difficulty in accessing the aid.⁶⁸

Even where the government made efforts to help undocumented people throughout the pandemic, those efforts were not necessarily fruitful. For instance, when COVID-19 vaccines were developed, there was a push to vaccinate immunocompromised people, elderly people, and front line and essential workers. Similarly, efforts were made for immigrant populations to receive the vaccine.⁶⁹ Despite those efforts, vaccinations were resisted by immigrant populations

⁶⁵ See Jennifer Tolbert et al., *Implications of the Lapse in Federal COVID-19 Funding on Access to COVID-19 Testing, Treatment, and Vaccines*, KAISER FAM. FOUND. (Mar. 28, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/implications-of-the-lapse-in-federal-covid-19-funding-on-access-to-covid-19-testing-treatment-and-vaccines/#endnote_link_550804-1 [<https://perma.cc/FQP3-4E6T>].

⁶⁶ See Rachel Fabi & Lilia Cervantes, *Undocumented Immigrants and COVID-19: A Call for Federally Funded Health Care*, 2(9) JAMA HEALTH F. (Sept. 3, 2021).

⁶⁷ *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19*, KAISER FAM. FOUND. (July 1, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> [<https://perma.cc/3F8Y-QMA7>].

⁶⁸ See *infra* notes 131–35.

⁶⁹ See Samantha Artiga et al., *Immigrant Access to COVID-19 Vaccines: Key Issues to Consider*, KAISER FAM. FOUND. (Jan. 13, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/immigrant-access-to-covid-19-vaccines-key-issues-to-consider/> [<https://perma.cc/J2JP-2H7Y>].

due to the fear of misuse of vaccine administration data—an apprehension that may be justified by looking to the nation’s violent history of immigration surveillance.⁷⁰ There were concerns among communities and immigrant advocates about provisions in the Data Use Agreement between states and the Centers for Disease Control and Prevention (“CDC”) because such agreements mandated the collection of personal identifiable information (“PII”) and permitted such sensitive information to be shared with different federal agencies.⁷¹ The CDC clarified that it would not seek PII such as Social Security numbers, driver’s license numbers, or passport numbers, and assured that vaccine administration data would not be used for immigration enforcement purposes.⁷² Despite this clarification, fear of obtaining the vaccine persisted for many immigrants.⁷³

The significance of the challenges faced and the contributions made by immigrants during the pandemic cannot be overstated. Despite their role in fighting the pandemic, undocumented immigrants found themselves excluded from pandemic relief. In addition to relief, they found themselves unable to access tools, such as telehealth, that were being adapted and expanded to make health care more accessible during the pandemic. The subsequent sections discuss the expansion of telehealth in particular, and describe how it failed to consider the unique needs of undocumented immigrants.

⁷⁰ *Id.*

⁷¹ Medha D. Makhoul, *Health Care Sanctuaries*, 20 YALE J. HEALTH POL’Y, L. & ETHICS 1, 32 (2021), <https://ssrn.com/abstract=3915570> [<https://perma.cc/J8AT-SA2V>].

⁷² See *Data Use and Sharing Agreement to Support the United States Government’s Covid-19 Emergency Response Jurisdiction Immunization and Vaccine Administration Data Agreement*, CTRS. FOR DISEASE CONTROL & PREVENTION 24, <https://www.cdc.gov/vaccines/covid-19/reporting/downloads/vaccine-administration-data-agreement.pdf> [<https://perma.cc/WPH7-ZHPE>] (last visited Sept. 18, 2022) (“CDC has sought minimally necessary data elements for the public health purposes set out in the DUA. Those elements are set out in the appendices. CDC will not seek social security numbers, driver’s license numbers, or passport numbers. As stated here, any changes to the data elements will be in consultation with the jurisdictions.”).

⁷³ *Id.*

III. THE PANDEMIC-INDUCED TELEHEALTH BOOM

As COVID-19 brought the world to a standstill, the prevalence of telehealth as a mode of health care delivery skyrocketed.

The Health Resources and Services Administration (“HRSA”) of the U.S. Department of Health and Human Services (“HHS”) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and landline and wireless communications.⁷⁴

Various types of technologies may be used to provide telehealth, including smartphones, tablets, video-conferencing, and high-resolution cameras.⁷⁵ Telehealth also uses several techniques. For instance, “Remote Patient Monitoring [(‘RPM’)] involves the reporting, collection, transmission, and evaluation of patient health data through electronic devices such as wearables, mobile devices, smartphone apps, and internet-enabled computers.”⁷⁶ RPM also uses store-and-forward methods, which entail capturing, storing, and transmitting health related information including photographs, scans, and data.⁷⁷ Some of the benefits of telehealth include increased access to health care from wherever an individual is located, reduced travel time and associated costs (such as arranging transportation and child care), reduced wait times, and increased access to specialists who may be located at further distances.⁷⁸

While telehealth has been around for a long time, its utilization was minimal due to factors such as the lack of uniform policies that regulated coverage, licensing, and prescription.⁷⁹ However, with the

⁷⁴ *What is Telehealth?*, U.S. DEP’T OF HEALTH & HUM. SERVS. (2020), <https://www.hhs.gov/hipaa/for-professionals/faq/3015/what-is-telehealth/index.html> [<https://perma.cc/M9NB-DTTC>].

⁷⁵ *What is Telehealth?*, NEJM CATALYST (Feb. 1, 2018), <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268> [<https://perma.cc/8HPW-KVDC>].

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ See Abid Haleem et al., *Telemedicine for Healthcare: Capabilities, Features, Barriers, and Applications*, 2 SENSORS INT’L (2021).

⁷⁹ See Gabriela Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KAISER FAM. FOUND. (May 11, 2020), <https://www.kff.org/womens-health-policy/issue-brief/>

spread of COVID-19, this legal landscape was forced to change as telehealth skyrocketed in popularity; its utility during the pandemic was evident as it allowed for limiting physical contact and reduced exposure to the virus.⁸⁰ To meet the needs created by the pandemic and telehealth's rapid expansion, federal and state authorities revisited telehealth regulations and considered the perspectives of different health care stakeholders.

On the coverage and payment front, many changes were made to increase telehealth coverage and reimbursement. Prior to the pandemic, telehealth visits could be reimbursed through Medicaid under a limited set of circumstances, particularly when the patients lived in rural areas.⁸¹ During the pandemic, HHS lifted this requirement for Medicaid as well as the requirement that the patient's home be an originating site of care.⁸² The Centers for Medicare and Medicaid Services ("CMS") also added several telehealth services to its list of covered services.⁸³ Medicare reimbursed all audio-video visits and most audio-only visits at the same rate as in-person visits.⁸⁴ In response to the pandemic, states also issued emergency policies allowing telehealth services to be provided to beneficiaries at home.⁸⁵ Most states also adopted

opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/ [https://perma.cc/U7NB-N5EP].

⁸⁰ See Elham Monaghesh & Alireza Hajizadeh, *The Role of Telehealth During COVID-19 Outbreak: A Systematic Review Based on Current Evidence*, 20 BMC PUB. HEALTH 1193 (2020).

⁸¹ See Seema Verma, *Early Impact of CMS Expansion of Medicare Telehealth During COVID-19*, HEALTH AFFS. (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20200715.454789/full/> [https://perma.cc/7XQT-TFHV].

⁸² Press Release, Ctrs. for Medicare & Medicaid Servs., Trump Admin. Finalizes Permanent Expansion of Medicare Telehealth Servs. & Improved Payment for Time Drs. Spend with Patients (Dec. 1, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment> [https://perma.cc/K6PZ-UJAB].

⁸³ *Id.*

⁸⁴ *Medicare Telemedicine Health Care Provider Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> [https://perma.cc/4JD9-B3NP].

⁸⁵ See Weigel, *supra* note 79.

payment parity for services offered through Medicaid,⁸⁶ as well as for private health plans in some cases.⁸⁷ These federal and state actions expanded telehealth use during the pandemic.

Another area of action in the telehealth context during the pandemic was licensing. While pre-pandemic state licensure laws barred providers from offering services to patients located in states where they were not licensed to practice, during the public health emergency, many states relaxed their licensure requirements and started granting temporary licenses to out-of-state practitioners.⁸⁸ Additionally, rules that governed prescriptions,⁸⁹ warranted the prior existence of doctor-patient relationships,⁹⁰ prohibited the communication of sensitive information over common platforms,⁹¹ and prevented reimbursement for audio-only visits were also relaxed.⁹²

The motivation behind these changes to the regulatory landscape was to encourage the use of telehealth, and the intended effects were achieved. As of July 2021, telehealth utilization had stabilized at levels thirty-eight times higher than pre-pandemic levels, and up to 17 percent of all outpatient/office visit claims with regards to evaluation and management were conducted virtually.⁹³ Telehealth saw differing successes across specialties, with the greatest adoption

⁸⁶ See *States Provide Payment Parity for Telehealth and In-Person Care*, NAT’L ACAD. FOR STATE HEALTH POL’Y (Aug. 25, 2021), <https://www.nashp.org/states-provide-payment-parity-for-telehealth-and-in-person-care/> [<https://perma.cc/V286-YE8M>].

⁸⁷ *Id.*

⁸⁸ Leah D’Aurora Richardson et al., *COVID-19: State Law Telehealth Update: State Licensure Requirements Persist, Permissible Telehealth Modalities Generally Expand, and Insurance Parity Laws Ensure Reimbursement*, NAT’L L. REV. (Feb. 21, 2022), <https://www.natlawreview.com/article/covid-19-state-law-telehealth-update-state-licensure-requirements-persist> [<https://perma.cc/CK5B-NUKK>].

⁸⁹ See Weigel, *supra* note 79.

⁹⁰ *Id.*

⁹¹ See *infra* notes 170–72, 183–85.

⁹² *Medicare Telemedicine Health Care Provider Fact Sheet*, *supra* note 84.

⁹³ Oleg Bestsennyy et al., *Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?*, MCKINSEY & CO. (July 9, 2021), <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality> [<https://perma.cc/8DSX-3BUY>].

of telehealth in psychiatry, substance use treatment, endocrinology, rheumatology, and gastroenterology.⁹⁴ Telehealth's high rates of adoption were underscored by its effectiveness in areas such as telestroke,⁹⁵ telemental health,⁹⁶ and telerehabilitation.⁹⁷ Studies also found that patients' perceptions of telehealth were favorable.⁹⁸

Many in the health care sector have described telehealth as a revolutionary⁹⁹ way of delivering health care. Moreover, many have described the uptick in telehealth use as a radical means that would bridge disparities and improve access to care for underserved populations, including low-income people and those living in rural

⁹⁴ *Id.*; Rina Dhopeswarkar et al., *Changes to Telehealth Policy, Delivery, and Outcomes in Response to COVID-19*, NORC AT THE UNIV. OF CHI. (Dec. 2020), <https://www.pcori.org/sites/default/files/PCORI-Landscape-Review-NORC-Changes-Telehealth-Policy-Delivery-Outcomes-Response-COVID-19-December-2020.pdf> [<https://perma.cc/7N5G-QBUJ>].

⁹⁵ Jake Miller, *Telemedicine for Stroke Patients Improves Outcomes*, HARV. GAZETTE (Mar. 1, 2021), <https://news.harvard.edu/gazette/story/2021/03/telemedicine-for-stroke-improves-patient-outcomes-saves-lives/> [<https://perma.cc/T9FT-MN95>].

⁹⁶ Erin Shigekawa et al., *The Current State of Telehealth Evidence: A Rapid Review*, 27(12) HEALTH AFFS. 1975, 1978 (Dec. 2018).

⁹⁷ *Id.*

⁹⁸ See Bree E. Holtz, *Patients Perceptions of Telemedicine Visits Before and After the Coronavirus Disease 2019 Pandemic*, 27 TELEMEDICINE & E-HEALTH 1 (Jan. 8, 2021); Rachel E. Granberg, *Medical Oncology Patient Perceptions of Telehealth Video Visits*, 17 JCO ONTOLOGY PRAC. (July 21, 2021) ("Patients identified convenience, anxiety, COVID-19, and provider preference as positively influencing the acceptability of video visits.").

⁹⁹ See *The Telehealth Revolution*, AM. MED. TECH. (Mar. 30, 2021), <https://americanmedtech.org/Blog/Blog-Post/the-telehealth-revolution> [<https://perma.cc/GD4W-THSH>]; Chris Kaul, *The Telehealth Revolution*, SIEMENS HEALTHINEERS (June 17, 2021), <https://www.siemens-healthineers.com/perspectives/COVID-19-telehealth> [<https://perma.cc/52ZR-9Y5A>]; Bill Frist, *Today's Virtual Care Revolution: How Policy Has Shaped And Will Continue To Shape Telehealth*, FORBES (Jan. 22, 2021), <https://www.forbes.com/sites/billfrist/2021/01/22/todays-virtual-care-revolution-how-policy-has-shaped-and-will-continue-to-shape-telehealth/?sh=4c4481c9111e> [<https://perma.cc/A6DR-AR8D>]; David Ryan, *Telehealth Revolution Has Only Just Begun*, IN TOUCH HEALTH, <https://intouchhealth.com/the-telehealth-revolution-has-only-just-begun/> [<https://perma.cc/RP5K-FP7Q>] (last visited Sept. 22, 2022).

communities.¹⁰⁰ The federal government invested funds into strengthening telehealth in rural and underserved areas, stressing telemedicine “is a vital tool for improving health equity by providing timely clinical assessment and treatment for our most vulnerable populations.”¹⁰¹ The value of telehealth is demonstrated by studies reporting positive outcomes related to telehealth use in rural communities, including “acceptability and increased satisfaction,” as well as reports that “the technology was considered convenient and efficient.”¹⁰² Decreased time and cost of travel, improved physician recruitment and retention, and increased education of patients were also reported.¹⁰³

As evidenced by the above paragraphs, telehealth was, rightfully, found to be very successful during the pandemic. That said, the advantages of telehealth were not equally distributed. The following section discusses the impact on one sub-section of the population: undocumented immigrants.

IV. TELEHEALTH ACCESSIBILITY FOR UNDOCUMENTED IMMIGRANTS

The Robert Wood Johnson Foundation (“RWJF”) defines health equity as when “everyone has a fair and just opportunity to be as healthy as possible,” and states that this goal cannot be achieved without “removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and

¹⁰⁰ See Ellen B. Franciosi et al., *The Impact of Telehealth Implementation on Underserved Populations and No-Show Rates by Medical Specialty During the COVID-19 Pandemic*, 27 *TELEMEDICINE & E-HEALTH* (2021).

¹⁰¹ *Biden-Harris Administration Invests over \$19 Million to Expand Telehealth Nationwide and Improve Health in Rural, Other Underserved Communities*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Aug. 18, 2021), <https://www.hhs.gov/about/news/2021/08/18/biden-harris-administration-invests-over-19-million-expand-telehealth-nationwide-improve-health-rural.html> [<https://perma.cc/7UDR-7J3Y>].

¹⁰² Michael Butzner & Yendeleda Cuffee, *Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review*, 23 *J. MED. INTERNET RSCH.* (2021).

¹⁰³ *Id.*

housing, safe environments, and health care.”¹⁰⁴ Advocates for telehealth equity have shown that the benefits of telehealth did not reach all populations equally.¹⁰⁵ This inequity is extremely concerning because the benefits of telehealth, as mentioned above, are precluded from reaching populations that already face a myriad of hurdles in obtaining health care.

Elderly, lower-income, and non-White community members are less likely to enjoy the benefits of telehealth. According to a Rock Health study, the most likely telehealth consumers were younger patients with higher incomes and education levels, and patients who had chronic health conditions.¹⁰⁶ Research also found, of “telehealth users, the highest share of visits that utilized video services occurred among young adults ages 18 to 24 (72.5%), those earning at least \$100,000 (68.8%), those with private insurance (65.9%), and White individuals (61.9%).”¹⁰⁷ Furthermore, a study in the Pacific Northwest showed that only 2.6 percent of telemedicine visits were by patients with limited English proficiency.¹⁰⁸ Telehealth usage also differed across races. For instance, data from the Mount Sinai Health System in New York showed that Black patients, Hispanic patients, and non-English speakers were more likely to visit the emergency

¹⁰⁴ *What is Health Equity?*, ROBERT WOOD JOHNSON FOUND. (May 1, 2017), <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html> [<https://perma.cc/5YBL-6KUW>].

¹⁰⁵ *Is Telehealth Transforming Care for Everyone?*, TELEHEALTH EQUITY COAL. (Feb. 2, 2021), <https://www.telehealthequitycoalition.org/is-telehealth-transforming-care-for-everyone.html> [<https://perma.cc/M29Q-JNSL>].

¹⁰⁶ Jasmine DeSilva et al., *Consumer Adoption of Telemedicine in 2021*, ROCK HEALTH (Dec. 13, 2021), <https://rockhealth.com/insights/consumer-adoption-of-telemedicine-in-2021/> [<https://perma.cc/A8P3-PFCA>].

¹⁰⁷ Madjid Karimi et al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services*, ASSISTANT SEC’Y FOR PLAN. & EVALUATION (Feb. 1, 2022), <https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf> [<https://perma.cc/XMG3-JF4V>].

¹⁰⁸ L. Renata Thronson et al., *The Pandemic of Health Care Inequity*, 3 JAMA NETWORK OPEN (Oct. 2, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771185> [<https://perma.cc/ML5A-QRFA>].

room than to use telehealth.¹⁰⁹ The Telehealth Equity Coalition points to these findings as “direct evidence” of the racial and ethnic disparities that exist in the use of telehealth.¹¹⁰

The HHS has a webpage dedicated to health equity in telehealth, where the Department states it can ensure “equal access to telehealth care for everyone . . . through improvements to telehealth workflow, staff training, and community resources.”¹¹¹ The Department goes on to highlight certain measures to improve telehealth access, such as making materials accessible in different languages, and asking if patients need assistive devices to participate in virtual visits.¹¹² None of these measures, however, engage with RWJF’s capacious understanding of health equity that requires tackling structural factors behind inequity, such as the lack of access to jobs with fair pay and powerlessness—both of which can arguably impact telehealth use. That said, measures on increasing accessibility to technology and designing technology with equity in mind have been suggested by many advocates.¹¹³

Being an immigrant often overlaps with being a person of color, being low-income, and living in a rural region. While health equity initiatives will increase immigrants’ access to telehealth, the truth is that this social group has unique needs that have been glossed over by those writing about and advocating for telehealth equity. These issues need to be viewed in light of the above context; undocumented immigrants provided front line services and essential work during the pandemic, whereby they were exposed to COVID-19. The following sections analyze how immigration status impacts telehealth access and identify the unique barriers undocumented immigrants face in using telehealth.

¹⁰⁹ Ellerie Weber et al., *Characteristics of Telehealth Users in NYC for COVID-Related Care During the Coronavirus Pandemic*, 27 J. AM. MED. INFORMATICS ASSOC. 1949, 1951 (2020).

¹¹⁰ See TELEHEALTH EQUITY COAL., *supra* note 105.

¹¹¹ *Health Equity In Telehealth*, U.S. DEP’T OF HEALTH & HUM. SERVS. (June 3, 2022), <https://telehealth.hhs.gov/providers/health-equity-in-telehealth/> [<https://perma.cc/N645-JTF7>].

¹¹² *Id.*

¹¹³ *Id.*

A. *The Impact of Insurance on Telehealth Affordability*

As noted earlier, undocumented immigrants are highly likely to be uninsured,¹¹⁴ meaning their health care expenses are unsubsidized and paid out-of-pocket. Research has shown that the rates of telehealth use were far lower for uninsured individuals compared to individuals with insurance.¹¹⁵ This difference was not marginal by any standard; among respondents who were Medicare or Medicaid users, 27.4 percent and 29.3 percent, respectively, said that they had accessed telehealth services over the last four weeks.¹¹⁶ Of those with private insurance, only 20.7 percent of people reported using telehealth during the last month.¹¹⁷ The lowest use was among the uninsured, with only 9 percent reporting using telehealth services over the last month.¹¹⁸ The uninsured also had higher rates of having audio-only telehealth visits instead of video telehealth visits.¹¹⁹

The above data can be reconciled with other research on medical utilization by uninsured individuals. Studies have demonstrated that the uninsured are less likely than the insured to receive preventive health care or services for chronic diseases and major health conditions.¹²⁰ A study has also found that over 30 percent of nonelderly adults without coverage said that they went without the care they needed in the past year because of costs attached to receiving care. Only 5.3 percent of adults with private coverage and 9.5 percent of adults with public coverage reported going without care for the same reason.¹²¹ The fears of high health care costs are

¹¹⁴ See Artiga & Diaz, *supra* note 22.

¹¹⁵ Karimi, *supra* note 107.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ See Hailun Liang et al., *Health Needs, Utilization of Services and Access to Care Among Medicaid and Uninsured Patients with Chronic Disease in Health Centres*, 24 J. HEALTH SERVS. RSCH. & POL'Y 172 (2019); Megan B. Cole et al., *Health Insurance Coverage and Access to Care for Community Health Center Patients: Evidence Following the Affordable Care Act*, 33 J. OF GEN. INTERNAL MED. 1444, 1444 (2018).

¹²¹ Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/> [<https://perma.cc/C8MG-ZPJT>].

valid in the face of research finding that medical care paid out-of-pocket may cause an uninsured person to become medically bankrupt.¹²²

Telehealth use has often been associated with lower costs for health care.¹²³ A 2017 study found telehealth visits cost patients an average of \$79 per visit, compared to \$146 for an office visit.¹²⁴ As per SaveHealth, a prescription coupon provider, a typical telehealth appointment with a primary care provider costs about \$50, while a traditional in-person office visit generally costs about \$176 per visit.¹²⁵ Both of these studies take into account the use of direct-to-consumer (“DTC”) telehealth.

Aside from telehealth companies, new models of telehealth delivery have arisen among health systems, as can be seen with “JeffConnect,” a telemedicine platform used by Jefferson Health, an integrated academic system in Philadelphia. JeffConnect uses audio and video technology to deliver health care services and charges a \$49 flat fee per consultation.¹²⁶ A study found that providing telehealth reduced costs for both patients and health care providers in emergency situations, with each avoided emergency department visit generating savings from \$309 to over \$1,500.¹²⁷ The study also found “[t]he net cost savings to the patient or payer per telemedicine

¹²² See John W. Scott et al., *Cured into Destitution: Catastrophic Health Expenditure Risk Among Uninsured Trauma Patients in the United States*, 267 ANNALS OF SURGERY 1093 (2018).

¹²³ See generally Asim Kichloo et al., *Telemedicine, The Current COVID-19 Pandemic and The Future: A Narrative Revision And Perspectives Moving Forward In The USA*, 8 FAM. MED. CMTY. HEALTH (Aug. 2020) (contrasting the cost-effective nature of telemedicine to costly in-person visits).

¹²⁴ J. Scott Ashwood et al., *Direct-To-Consumer Telehealth May Increase Access to Care But Does Not Decrease Spending*, 36 HEALTH AFFS. 485, 488 (2017).

¹²⁵ Jamie Greenberger, *Is Telehealth Cheaper Than In-Person Medical Treatment?*, SAVEHEALTH, <https://save.health/telemedicine-3/costs> [<https://perma.cc/U7XN-9NZ7>] (last visited Aug. 14, 2022).

¹²⁶ See Christopher Cheney, *Cost Savings for Telemedicine Estimated At \$19 to \$120 Per Patient Visit*, HEALTH LEADERS (May 7, 2019), <https://www.healthleadersmedia.com/clinical-care/cost-savings-telemedicine-estimated-19-120-patient-visit> [<https://perma.cc/6X9Y-UXGU>].

¹²⁷ Garrison Nord et al., *On-Demand Synchronous Audio Video Telemedicine Visits are Cost Effective*, 37 AM. J. EMERGENCY MED. 890, 892 (2019).

visit of \$19–\$121 represent[ed] a meaningful cost savings when compared with the \$49 cost of an on-demand visit.”¹²⁸

Although saving over \$70 dollars via a telehealth visit is significant for those without insurance, a \$50 visit is still expensive, and may be profoundly more so for immigrants. Undocumented immigrants frequently hold more low-paying jobs than other groups of people, as seen by their over-representation in agricultural, construction, and hospitality industries.¹²⁹ Workers earning the federal minimum wage of \$7.25 per hour would still need to work close to seven hours to afford one telehealth visit. These costs may be more burdensome for undocumented workers, who are extremely susceptible to wage theft¹³⁰ and often support large families.¹³¹

In the conversation about the affordability of health care services, including telehealth, for immigrants, the role of community health centers cannot be ignored. In 2019, about 1,400 community health centers operating in around 13,000 community locations cared for nearly 30 million patients.¹³² Due to their services provided, locations, and experience in serving at-risk populations, community health centers provided not only COVID-19 treatment

¹²⁸ *Id.*

¹²⁹ See Donald Kerwin et al., *U.S. Foreign Born Essential Workers by Status and State, and the Global Pandemic*, CTR. MIGRATION STUD. (May 2020), <https://cmsny.org/publications/us-essential-workers/> [<https://perma.cc/EK3C-WBFM>].

¹³⁰ Annette Bernhardt et al., *Broken Laws, Unprotected Workers: Violations of Employment and Labor Laws in America's Cities*, NAT'L EMP. L. PROGRAM (2009), <https://www.nelp.org/wp-content/uploads/2015/03/BrokenLawsReport2009.pdf> [<https://perma.cc/K5ZQ-WWYB>].

¹³¹ Jeffrey S. Passel & D'Vera Cohn, *Most Unauthorized Immigrants Live with Family Members*, PEW RSCH. CTR. (Nov. 27, 2018), <https://www.pewresearch.org/hispanic/2018/11/27/most-unauthorized-immigrants-live-with-family-members/> [<https://perma.cc/KE62-SYX7>]. See also discussion, *supra* Section II.B.

¹³² Bradley Corallo et al., *Community Health Centers' Role in Delivering Care to the Nation's Underserved Populations During the Coronavirus Pandemic*, KAISER FAM. FOUND. (Dec. 23, 2020), <https://www.kff.org/report-section/community-health-centers-role-in-delivering-care-to-the-nations-underserved-populations-during-the-coronavirus-pandemic-key-findings/> [<https://perma.cc/5MZT-D684>].

and related care, but also tended to other ongoing health concerns.¹³³ Undocumented immigrants rely very heavily on these clinics and providers.¹³⁴

A study of sixteen state and regional Primary Care Associations found that health centers quickly transitioned to providing patients health care services via telehealth when lockdowns were first implemented.¹³⁵ Health care providers were also able to get emergency authorization for telehealth and worked closely with state Medicaid agencies.¹³⁶ While community health centers reportedly ran into many technological issues, such as internet connectivity, they adapted using various techniques like “installing WIFI boosters in their parking lots and providing tablets to patients who participate in telehealth visits from their cars. They [had] also redeployed some staff to walk patients through the process of setting up for telehealth visits.”¹³⁷

One problem created by the pandemic was loss of revenue for community health centers. According to research that studied telehealth use among safety-net organizations in California during the COVID-19 pandemic, visit volumes at Federally Qualified Health Centers (“FQHCs”) modestly declined for primary care visits.¹³⁸ Such visit decreases led to a loss of income.¹³⁹ In response, FQHCs received grants from HRSA, which they did not have to apply for, that were based on the size of the population they served and the number of uninsured patients reported.¹⁴⁰ Health centers were also oftentimes eligible for funding under the Paycheck Protection Program (“PPP”), the Provider Relief Fund, and the

¹³³ *Id.*

¹³⁴ Artiga & Diaz, *supra* note 22.

¹³⁵ Corallo et al., *supra* note 132.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ Lori Uscher-Pines et al., *Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic*, 325 JAMA (2021).

¹³⁹ See Bradley Corallo & Jennifer Tolbert, *Impact of Coronavirus on Community Health Centers*, KAISER FAM. FOUND. (May 20, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/impact-of-coronavirus-on-community-health-centers/> [https://perma.cc/W9YD-9NSA].

¹⁴⁰ *Id.*

Uninsured Claims Fund.¹⁴¹ That said, larger-sized health centers were ineligible for some forms of funding,¹⁴² thereby raising questions of their solvency. In summary, due to the lack of visits to community health centers (which could be explained by COVID-19 and a transition to telehealth), community health centers experienced a lack of revenue and were put at existential risk, threatening loss to undocumented immigrants of what may be their only form of healthcare.

B. Privacy and Surveillance Concerns

An area of concern for undocumented immigrants regarding telehealth is their privacy. “The Health Insurance Portability and Accountability Act of 1996 (‘HIPAA’) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient’s consent or knowledge.”¹⁴³ It oversees aspects of data privacy and security with the aim to protect sensitive medical information that the statute refers to as “protected health information” (“PHI”).¹⁴⁴ Under the HIPAA Privacy Rule, health care providers are generally prohibited from disclosing PHI unless limited circumstances apply.¹⁴⁵ That

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge> [https://perma.cc/Y8TN-HRTK].

¹⁴⁴ 45 C.F.R. § 160.103 (2021) (defining PHI as “individually identifiable health information” either “(i) [t]ransmitted by electronic media; (ii) [m]aintained by electronic; or (iii) [t]ransmitted or maintained in any other form or medium.”). “Individually identifiable health information” includes demographic information collected from an individual by a “health care provider, health plan, employer, or health care clearinghouse” which relates to the “past, present, or future physical or mental health or condition of an individual . . . (i) [t]hat identifies the individual; or (ii) [w]ith respect to which there is a reasonable basis to believe the information can be used to identify the individual.” *Id.*

¹⁴⁵ See § 164.508(a)(1) (2007). See also § 164.502(a) (explaining that a covered entity may not use or disclose protected health information, except either (1) as permitted or required by the Privacy Rule, or (2) as the individual who is the subject of the information authorizes in writing).

said, this rule allows health care providers to share PHI without authorization for certain public health reasons, including preventing or controlling diseases.¹⁴⁶

During the COVID-19 outbreak, the HHS and the Office of Civil Rights (“OCR”) enacted several “Good Faith HIPAA waivers” with the aim to enable data sharing and telehealth provision during the pandemic.¹⁴⁷ Most importantly, HHS stated that covered health care providers would not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that would occur in the good faith provision of telehealth during the COVID-19 emergency.¹⁴⁸ OCR also released guidance regarding how PHI on patients who were infected with COVID-19 could be shared with parties including law enforcement in compliance with HIPAA.¹⁴⁹

This change in landscape has the propensity to cause significant issues for undocumented immigrants who have been found to “live in the shadows,” a phrase used to characterize their persistent state of fear due to the risk of deportation.¹⁵⁰ They are known to exhibit system avoidance by evading record-keeping institutions such as schools, hospitals, banks, and formal employment due to fear of surveillance.¹⁵¹ Low health care utilization among immigrants may

¹⁴⁶ § 164.512(b)(1)(i).

¹⁴⁷ See *Insights into HHS COVID-19 HIPAA Waivers and Lasting Implications*, HEALTH IT SEC. (May 8, 2020), <https://healthitsecurity.com/features/insights-into-hhs-covid-19-hipaa-waivers-and-lasting-implications> [<https://perma.cc/GB2U-6ATH>].

¹⁴⁸ *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, OFF. FOR CIV. RTS., U.S. DEP’T OF HEALTH & HUMAN SERVS., <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> [<https://perma.cc/HP3F-8CH7>] (last visited Oct. 7, 2022).

¹⁴⁹ HEALTH IT SEC., *supra* note 147.

¹⁵⁰ See Adolfo Flores, *Here’s How Undocumented Immigrants Are Living In The Shadow Of Border Patrol Deep Within The US*, BUZZFEED NEWS (Apr. 6, 2017), <https://www.buzzfeednews.com/article/adolfoflores/undocumented-immigrants-border-patrol-checkpoints> [<https://perma.cc/YQB8-PVP7>].

¹⁵¹ See Sarah Brayne, *Surveillance and System Avoidance: Criminal Justice Contact and Institutional Attachment*, 79 AM. SOCIO. REV. 367 (2014); Sarah Desai et al., *Legacies of Marginalization: System Avoidance Among the Adult*

be partially explained by this system avoidance. In health care particularly, these fears are justified by immigration surveillance at health care sites, as detailed by Medha D. Makhoul in her piece “Health Care Sanctuaries.”¹⁵² She narrates an incident where the staff of a medical clinic called law enforcement on a client when they suspected the client had provided a fake driver’s license as her identification, causing her to be arrested and putting her at risk of being deported.¹⁵³

Makhoul points out that health care providers may not have reason to inquire about patients’ citizenship or immigration status, but such information can be clinically relevant.¹⁵⁴ She argues that a patient’s citizenship and immigration status should be considered PHI under HIPAA as long as a connection could be made to the patient’s health condition, the provision of health care to the patient, or the payment for the health care provided to the patient.¹⁵⁵ If immigration status is deemed unprotected as PHI, that in itself is dangerous for immigrants whose information could be shared with law enforcement at any point. However, if immigration status is protected under HIPAA, the relaxation of HIPAA’s enforcement during the pandemic may cause novel issues by allowing this information to be shared with public health authorities and law enforcement.

Public officials in at least two-thirds of states were reported sharing the addresses of people who tested positive with first responders, including police officers, firefighters, and EMTs.¹⁵⁶ Associated Press also found that at least ten states were sharing the names of their patients with these authorities.¹⁵⁷ The Tennessee

Children of Unauthorized Immigrants in the United States, 54 INT’L MIGRATION REV. (2019).

¹⁵² Makhoul, *supra* note 71.

¹⁵³ *Id.* at 13.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 29.

¹⁵⁶ Kimberlee Kruesi, *COVID-19 Data Sharing with Law Enforcement Sparks Concern*, AP NEWS (May 19, 2020), <https://apnews.com/article/nv-state-wire-nd-state-wire-co-state-wire-nh-state-wire-public-health-ab4cbfb5575671c5630c2442bc3ca75e> [<https://perma.cc/VKJ7-ZE9Z>].

¹⁵⁷ *Id.* These states include Colorado, Iowa, Louisiana, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, South Dakota, and Tennessee. *Id.*

Immigrant and Refugee Rights Coalition called sharing the medical information “deeply concerning,” warning that doing so may undermine the trust governments have been trying to build with immigrants and communities of color.¹⁵⁸ The information sharing could undermine efforts to build trust between the government and undocumented immigrants. Such disclosures may inform U.S. Immigration and Customs Enforcement (“ICE”) and law enforcement as to the whereabouts of undocumented immigrants, putting them at risk of arrest, detention, and deportation.

These fears also inform immigrants’ low utilization of telehealth. In a *Health Affairs* article, authors Altaf Saadi and Jorge A. Rodriguez discuss undocumented immigrants’ privacy concerns while using telehealth. As doctors, they noted that their immigrant patients raised questions about what information the app tracked on their phones, who could listen to the telehealth conversations, and whether the conversations were recorded.¹⁵⁹

In addition to the good faith waiver and related relaxations, OCR also stipulated that, in the provision of telehealth, providers must use “non-public facing remote communication,” as well as the need for “end-to-end encryption” when using video, audio, or texting applications, regardless of the waiver.¹⁶⁰ As a result, public-facing products such as TikTok, Facebook Live, and Twitch were not acceptable platforms, but FaceTime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, and Skype were deemed acceptable.¹⁶¹ Prior to the pandemic, such technologies were not used for telehealth; whereas, during the public health emergency, OCR held it would not pursue

¹⁵⁸ *Id.*

¹⁵⁹ Altaf Saadi & Jorge A. Rodriguez, *Addressing Privacy Concerns Central To Success Of Telehealth Use Among Undocumented Immigrants*, HEALTH AFFS. FOREFRONT (Nov. 23, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201118.621497/full/> [<https://perma.cc/7TGP-BWGG>].

¹⁶⁰ *FAQs On Telehealth and HIPAA During The COVID-19 Nationwide Public Health Emergency*, OFF. FOR CIV. RTS., U.S. DEP’T OF HEALTH & HUMAN SERVS. 4, <https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf>. [<https://perma.cc/GLP7-29KY>].

¹⁶¹ *Id.*

otherwise-applicable penalties for interceptions or breaches resulting from the good faith provision of telehealth services.¹⁶²

The broadening of communication methods for telehealth led to a different set of challenges, particularly because a lot of information that was collected through these additional technology and telecommunications companies is not protected under HIPAA. As Sharon Bassan in her article “Data Privacy Considerations for Telehealth Consumers Amid COVID-19” explains:

For example, consider a doctor who uses a company such as Facebook’s online video and chat platform to consult with patients. Notably, care may be delivered by a professional that is ordinarily subject to HIPAA, but the health information provided through Facebook may be regulated under Facebook’s privacy policy, and therefore subject to relaxed standards Effectively, since there is no comprehensive legislation to monitor telehealth technologies that are not covered by HIPAA, telecommunication companies can gather health-related information as they wish.¹⁶³

This example used by Bassan could be devastating for immigrants since Facebook’s privacy policy allows information sharing with law enforcement in certain situations. Similar surveillance of immigrants’ social media has taken place before, such as when ICE agents used Facebook’s backend data to track undocumented suspects by obtaining a log of when their account was accessed and the IP addresses that were used.¹⁶⁴

This problematic lack of privacy is not limited only to Facebook, but also applies to other telehealth and digital health platforms. According to one study, 81 percent of diabetes apps did not have privacy policies.¹⁶⁵ Most of these apps “shared information with third parties, posing privacy risks because there are no federal legal

¹⁶² *See id.* at 5.

¹⁶³ Bassan, *supra* note 83, at 6.

¹⁶⁴ Lee Fang, *ICE Used Private Facebook Data to Find and Track Criminal Suspect, Internal Emails Show*, INTERCEPT (Mar. 26, 2018, 3:39 PM), <https://theintercept.com/2018/03/26/facebook-data-ice-immigration/> [<https://perma.cc/6VGD-GLGA>].

¹⁶⁵ Sarah R. Blenner et al., *Privacy Policies of Android Diabetes Apps and Sharing of Health Information*, 315 JAMA (Mar. 8, 2016).

protections against the sale or disclosure of data from medical apps to third parties.”¹⁶⁶

Recently, a class-action lawsuit was filed against telehealth software vendor MDLIVE alleging that MDLIVE, “without notifying patients, programmed its app to transmit screenshots of consumers’ personal and sensitive health information to an overseas third-party Israel-based tech company, TestFairy, that provides application performance testing on Android and iOS mobile apps.”¹⁶⁷ The complaint alleged that MDLIVE took an average of sixty screenshots of a patient’s screen, including health conditions, medications, and behavioral health history, which was stored and controlled by TestFairy without encrypting the images.¹⁶⁸ Such information, in the wrong hands, could be catastrophic for undocumented immigrants. Not only could their status be learned by people they did not wish to share it with, but this information could also be weaponized for other matters, such as determining who could become a public charge in the future.

In her article, Sharon Bassan found that OCR’s waiver of typical enforcement standards meant that health care consumers became solely responsible for their data privacy protections:

The ball is in the court of patients who use telehealth to take precautions before switching to online consultation. When engaging in telehealth, reading the privacy policy of whichever technology one decides to use can be considered best practice. Given that consumers cannot ex post facto void the terms of service based on their failure to read or understand the policy, it is highly recommended for patients to spend time doing so with respect to any technologies that they consider using during the COVID-19 outbreak.¹⁶⁹

As will be discussed, undocumented immigrants may not possess digital skills and may have limited English proficiency. Considering these realities, it may not be possible for them to engage with highly

¹⁶⁶ *Id.*

¹⁶⁷ Marianne Kolbasuk McGee, *Telehealth App Lawsuit Spotlights Privacy Questions*, GOV’T INFO. SEC. (Apr. 21, 2017), <https://www.govinfosecurity.com/telehealth-app-lawsuit-spotlights-privacy-questions-a-9860> [<https://perma.cc/55WQ-WMT9>].

¹⁶⁸ *Id.*

¹⁶⁹ Sharon Bassan, *Data Privacy Considerations for Telehealth Consumers Amid COVID-19*, 7 J. LAW & BIOSCIENCES 1, 8 (2020).

technical privacy policies of telehealth providers that they might visit. This too should be kept in mind when shifting the onus of privacy protection on health care consumers.

C. Access to Technology and Digital Skills

A person's ability to use telehealth is impacted by a variety of factors, including reliable internet access, availability of devices to access services, and previous experience with the technology. Proponents of telehealth equity have often discussed these issues of digital and language access. The following paragraphs will further these conversations in the context of undocumented immigrants.

The Organisation for Economic Co-operation and Development ("OECD") defines the digital divide as "the gap between individuals, households, businesses and geographic areas at different socio-economic levels with regard to both their opportunities to access information and communication technologies ("ICTs") and to their use of the Internet for a wide variety of activities."¹⁷⁰ Given that telehealth requires access to ICTs and the internet, this framework becomes helpful to assess which side of the divide certain groups fall on regarding access to telehealth. It is crucial to remember that these positions are not static and that the pandemic itself may have caused shifts. For instance, income loss due to COVID-19 may lead to internet access becoming unaffordable for certain families. An April 2021 survey found that "about a quarter of home broadband users (26%) and smartphone owners (24%) said that they worried a lot or some about paying their internet and cellphone bills over the next few months."¹⁷¹ Additionally, the pandemic led to the closure of many public libraries, on which people may be dependent for internet access.¹⁷²

¹⁷⁰ *Digital Divide—Glossary of Statistical Terms*, ORG. FOR ECON. COOP. & DEV., <https://stats.oecd.org/glossary/detail.asp?ID=4719> [<https://perma.cc/F9WQ-M37H>] (last updated Jan. 4, 2006).

¹⁷¹ Colleen McClain et al., *The Internet and the Pandemic*, PEW RSCH. CTR. (Sept. 1, 2021), <https://www.pewresearch.org/internet/2021/09/01/the-internet-and-the-pandemic/> [<https://perma.cc/8HWQ-GEQ4>].

¹⁷² See Lauren Kirchner, *Millions of Americans Depend on Libraries for Internet. Now They're Closed*, MARKUP (June 25, 2020, 10:00 AM),

Broadband internet access has been found, now more than ever, to be a social determinant of health.¹⁷³ Not only has it become impossible to consult a physician without access to telecommunications technology, but during the pandemic, most ambulatory care shifted to telehealth.¹⁷⁴ Broadband intersects with various identified social determinants of health, including education and employment, leading several organizations to recognize internet access as a “super-determinant” of health.¹⁷⁵ Despite its importance, Broadband Now Research estimated that about 42 million Americans lacked access to wired or fixed wireless broadband.¹⁷⁶

Research has shown that some groups of immigrants have lower rates of internet usage. Per 2016 estimates, one-tenth of families headed by Hispanic immigrants had no access to the internet, which was twice the rate of non-Hispanic White residents.¹⁷⁷ This study showed that Black immigrant households, however, had access to digital technology at the same rate as the general U.S. population.¹⁷⁸

In addition to internet usage, there is a separate issue of owning technologies on which the internet can be accessed. According to a Pew Research Center survey conducted from January 25 to February 8, 2021, Black and Hispanic adults in the United States remain less

<https://themarkup.org/coronavirus/2020/06/25/millions-of-americans-depend-on-libraries-for-internet-now-theyre-closed> [<https://perma.cc/Q3ZB-KHJU>].

¹⁷³ See Natalie C. Benda et al., *Broadband Internet Access Is a Social Determinant of Health!*, 110 AM. J. PUB. HEALTH ASSOC. 1123, 1123 (2020).

¹⁷⁴ *Id.*

¹⁷⁵ See Brittney Crock Bauerly et al., *Broadband Access as a Public Health Issue: The Role of Law in Expanding Broadband Access and Connecting Underserved Communities for Better Health Outcomes*, 47 J. L. MED. & ETHICS 39, 40 (2019).

¹⁷⁶ John Busby et al., *FCC Reports Broadband Unavailable to 21.3 Million Americans, BroadbandNow Study Indicates 42 Million Do Not Have Access*, BROADBANDNOW (Feb. 21, 2020), <https://broadbandnow.com/research/fcc-underestimates-unserved-by-50-percent> [<https://perma.cc/42ZN-CEXF>].

¹⁷⁷ Alexis Cherewka, *The Digital Divide Hits U.S. Immigrant Households Disproportionately during the COVID-19 Pandemic*, MIGRATION POL’Y INST. (Sept. 3, 2020), <https://www.migrationpolicy.org/article/digital-divide-hits-us-immigrant-households-during-covid-19#:~:text=One%2Dtenth%20of%20families%20headed,Workshop’s%20Joan%20Ganz%20Cooney%20Center> [<https://perma.cc/JMR2-6VWS>].

¹⁷⁸ *Id.*

likely than White adults to say they own a traditional computer or have high-speed internet at home, but encountered no such differences when it came to other devices, such as smartphones and tablets.¹⁷⁹

While there is limited data on specifically undocumented immigrants' access to data and technology, it could be inferred, due to their membership in certain social groups, they should be treated as though they may face difficulties in accessing these goods. One study on the impact of COVID-19 on Latinx families may support this inference. It found that COVID-19 caused several difficulties for at-home teaching, particularly for members of high-density households where devices may have to be shared, there may be interference from family members, and multiple people using the internet could lead to lower speeds or less data usage availability.¹⁸⁰ In the absence of internet access or electronic devices, telehealth services may become very difficult to use for immigrant families and communities. This understanding was also reflected in a study that explored the provision of social services to Latinx immigrants via telehealth.¹⁸¹

In addition to the problem of accessing digital technology, there is a related problem of whether consumers actually know how to use the technology. The United Nations Educational, Scientific, and Cultural Organization ("UNESCO") defines digital skills as

a range of abilities to use digital devices, communication applications, and networks to access and manage information . . . to create and share digital content, communicate and collaborate, and solve problems for

¹⁷⁹ Sara Atske & Andrew Perrin, *Home Broadband Adoption, Computer Ownership Vary by Race, Ethnicity in the U.S.*, PEW RSCH. CTR. (July 16, 2021), <https://www.pewresearch.org/fact-tank/2021/07/16/home-broadband-adoption-computer-ownership-vary-by-race-ethnicity-in-the-u-s/> [https://perma.cc/FX5F-U6MX].

¹⁸⁰ See *The Impact of COVID-19 on Latino Families Views About Returning to School in the Fall—Results From the 2020 National Latino Family Survey*, LATINO DECISIONS 1, 2–3 (July 2020), <https://latinodecisions.com/wp-content/uploads/2020/07/Report-Parent-Survey-July-2020.pdf> [https://perma.cc/544R-VJVH].

¹⁸¹ See Nalini Junko Negi & Jennifer L. Siegel, *Social Service Providers Navigating the Rapid Transition to Telehealth with Latinx Immigrants during the COVID-19 Pandemic*, 92 AM. J. ORTHOPSYCHIATRY 463 (2022).

effective and creative self-fulfillment in life, learning, work, and social activities at large.¹⁸²

About 33 percent of immigrants do not have digital skills, and 29 percent have limited digital skills.¹⁸³ That said, there is some complexity here, because research from 2012 showed that immigrants with a smartphone or cell phone used its features in greater numbers compared to U.S. cell phone users, particularly when it came to using video-calling services and posting on social media.¹⁸⁴ This could indicate that immigrants may have certain digital skills, for instance video calling, while lacking others, such as sorting one’s emails.

Digital skills and literacy become very important in the provision of telehealth services. The Telehealth Equity Coalition explained that “[t]elehealth may require diverse digital literacy skills, including connecting to the internet, using a specific browser and email, downloading an app, and updating settings for security. It may also require use and calibration of computer hardware components, such as the camera, microphone, and speakers.”¹⁸⁵ Patients may also be expected to operate complex patient portals to schedule meetings and access their health charts, something they might not have the proficiency to do. Given the nature of these tasks, it may be harder for those with limited access to technology and

¹⁸² *Digital Skills Critical for Jobs and Social Inclusion*, UNESCO (Mar. 15, 2018), <https://en.unesco.org/news/digital-skills-critical-jobs-and-social-inclusion> [<https://perma.cc/3D4V-3RVH>].

¹⁸³ *Applying a Racial Equity Lens to Digital Literacy: How Workers of Color are Affected by Digital Skill Gaps*, NAT’L SKILLS COAL. 1, 5 (Mar. 20, 2020), <https://nationalskillscoalition.org/wp-content/uploads/2020/12/Digital-Skills-Racial-Equity-Final.pdf> [<https://perma.cc/8YCX-VB56>] [hereinafter *Applying a Racial Equity Lens to Digital Literacy*]. It would be typical for a person with limited skills to be able to complete basic computer tasks but have hardships while sorting emails. *Id.*

¹⁸⁴ See *Digital Diaspora: How Immigrants are Capitalizing on Today’s Technology*, WELCOMING CTR. FOR NEW PENNSYLVANIANS (Nov. 2012), <https://welcomingcenter.org/wp-content/uploads/2016/08/Digital-Diaspora-FINAL-report-Nov-2012-1.pdf> [<https://perma.cc/8HKA-BSU8>].

¹⁸⁵ *Improving Digital Literacy to Improve Telehealth Equity*, TELEHEALTH EQUITY COAL. (Oct. 18, 2021), <https://www.telehealthequitycoalition.org/improving-digital-literacy-to-improve-telehealth-equity.html> [<https://perma.cc/9FKP-KSUN>].

digital skills to navigate telehealth technologies, and may therefore impact immigrants' access to telehealth.

D. English Proficiency

In 2013, “25.5 million people (8.5% of the U.S. population) reported that they were Limited English Proficient (‘LEP’), or spoke a language other than English at home and spoke English ‘not very well,’ ‘not well,’ or ‘not at all.’”¹⁸⁶ In that same year, a study determined 81 percent of all individuals with LEP were foreign-born.¹⁸⁷ Spanish was the language predominantly spoken by both immigrant and U.S.-born individuals with LEP.¹⁸⁸ “About 64 percent (16.2 million) of the total LEP population spoke Spanish, followed by Chinese (1.6 million, or 6 percent), Vietnamese (847,000, 3 percent), Korean (599,000, 2 percent), and Tagalog (509,000, 2 percent).”¹⁸⁹

In comparison to an English-proficient individual, a person with LEP was more likely to be less educated and to live in poverty.¹⁹⁰ This could be related to the fact that immigrants, particularly those with Limited English Proficiency (“LEP”), are overrepresented in groups with limited or no digital skills.¹⁹¹ The Programme for the International Assessment of Adult Competencies found that the proportion of U.S. adults without computer experience is much higher for immigrants who speak a non-English language in the home at almost 21 percent compared to about 5 percent for English speakers.¹⁹² Employed LEP men in 2013 were more likely to work in construction, natural resources, and maintenance occupations, as

¹⁸⁶ Kimberly Proctor et. al., *The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries*, 2 HEALTH EQUITY 82, 82 (2018).

¹⁸⁷ Jie Zong & Jeanne Batalova, *The Limited English Proficient Population in the United States in 2013*, MIGRATION POL’Y INST. (July 8, 2015), [https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013#:~:text=In%202013%2C%2081%20percent%20of,Dominican%20Republic%20\(3%20percent\)](https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013#:~:text=In%202013%2C%2081%20percent%20of,Dominican%20Republic%20(3%20percent)) [https://perma.cc/WS28-XZS2].

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ See NAT’L SKILLS COAL., *supra* note 183.

¹⁹² Cherewka, *supra* note 177.

compared to men who were proficient in English.¹⁹³ Women with LEP were much more likely to be employed in service and personal-care occupations than English-proficient women.¹⁹⁴ The above data points show the links between LEP and limited digital skills.

One factor that makes telehealth very promising is its enhanced capacity for providing culturally competent care by allowing patients to get in touch with providers who can speak their language and understand their cultural needs and backgrounds.¹⁹⁵ However, this potential has yet to be unlocked. Research shows patients with LEP struggled to set up platforms such as Zoom and relied on clinic personnel, staff, or family members, such as their children.¹⁹⁶ A study among California patients found that only 4.8 percent of patients with LEP utilized telehealth, compared to 12.3 percent of proficient English speakers.¹⁹⁷ Another study in California showed that those with LEP used video visits less frequently than those without.¹⁹⁸ This study found that, once patients with LEP had a video visit, they were not different from patients without LEP in their likelihood to reuse video visits, which led to the hypothesis that

¹⁹³ Jie Zong & Jeanne Batalova, *The Limited English Proficient Population in the United States in 2013*, MIGRATION POL’Y INST. (July 8, 2015), [https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013#:~:text=In%202013%2C%2081%20percent%20of,Dominican%20Republic%20\(3%20percent\)](https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013#:~:text=In%202013%2C%2081%20percent%20of,Dominican%20Republic%20(3%20percent)) [https://perma.cc/TFE9-XYJP].

¹⁹⁴ *Id.*

¹⁹⁵ *Health Equity in Progress*, TELEHEALTH EQUITY COAL. (June 30, 2022) <https://www.telehealthequitycoalition.org/health-equity-in-progress.html> [https://perma.cc/A2UF-CCUF].

¹⁹⁶ Nicole Wetsman, *Telemedicine Leaves Behind Non-English Speakers, Study Shows*, VERGE (Feb. 24, 2022, 4:24 PM), <https://www.theverge.com/2022/2/24/22948959/telemedicine-limited-english-digital-literacy> [https://perma.cc/MX7G-789M].

¹⁹⁷ Jorge A. Rodriguez et al., *Disparities in Telehealth Use Among California Patients with Limited English Proficiency*, 40 HEALTH AFFS. 487, 487 (Mar. 2021).

¹⁹⁸ Loretta Hsueh et al., *Disparities in Use of Video Telemedicine Among Patients With Limited English Proficiency During the COVID-19 Pandemic*, 4 JAMA NETWORK OPEN 1, 3 (Nov. 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2785802> [https://perma.cc/L6DT-STJR].

“helping adults with LEP overcome initial barriers to using video visits will result in more frequent future video visit use.”¹⁹⁹

When providing care to LEP patients, doctors may require interpreters. A study found that “for patients with language service needs, having language concordant providers or a trusted source (i.e., a family member or clinic personnel) interpret was preferable to a third-party service because of the comfort and trust afforded by these existing relationships in addition to fewer technical and communication/interpretation barriers.”²⁰⁰ That said, delays were reported in connecting to interpreter services during virtual visits.²⁰¹ Another barrier is the need for certain pages to be translated for LEP access. However, while translations could be useful, they are often done so inaccurately, losing full relevance and meaning.²⁰²

V. THE PATH TOWARDS TELEHEALTH EQUITY FOR UNDOCUMENTED IMMIGRANTS

While telehealth has been regarded as a radical innovation with the potential of transforming care, the sections above show how the access to telehealth and the effectiveness of this health care delivery method differs from population to population. In particular, the previous sections outlined the ways in which undocumented immigrants are unable to access or benefit from telehealth due to immigration laws and policies in place, and due to their economic, social, and cultural positions.

As seen during the COVID-19 pandemic, immigrants are an indispensable part of the United States and were at the frontlines during the pandemic, ensuring that Americans were kept safe and healthy. This, in itself, should create a moral imperative that their health care needs should be provided for. The following sections

¹⁹⁹ *Id.*

²⁰⁰ Denise D. Payán et al., *Telemedicine Implementation and Use In Community Health Centers During COVID-19: Clinic Personnel and Patient Perspectives*, 2 SSM—QUALITATIVE RSCH. HEALTH 1, 5 (2022).

²⁰¹ Danny W. Linggonegoro et al., *How Telemedicine May Exacerbate Disparities in Patients with Limited English Proficiency*, 84 J. AM. ACAD. DERMATOLOGY 289, 289 (2021).

²⁰² Wetsman, *supra* note 196.

recommend how to substantively unlock telehealth as a mode of health care delivery for immigrants.

A. Ensuring Health Care Coverage and Access for Immigrants

One of the most important steps in achieving health and telehealth equity for undocumented immigrants is to extend health care coverage and make health care affordable. Steps to do so must be taken at both the federal and state levels.

At the federal level, legislators can support the Health Access Under the Law for Immigrant Families Act (“HEAL Act”), which was introduced in the United States Senate during the 117th Congress and would, if passed, remove the exclusion of undocumented immigrants from receiving coverage from the ACA’s Health Insurance Exchanges, thus making undocumented immigrants eligible to purchase qualified health insurance coverage.²⁰³ As of April 2022, six states (California, Illinois, Massachusetts, New York, Oregon, Washington) and the District of Columbia provided state-funded coverage to all income-eligible children, regardless of their immigration status.²⁰⁴ These programs are subsidized through state funds for low-income children and adults who do not qualify for subsidized health insurance under the ACA or through other public programs like Medicaid or CHIP because of their immigration status.²⁰⁵ Actors at the state level should support such measures to ensure undocumented people received state-funded health care. Having such coverage, in turn, can allow immigrants to access the health care being provided on telehealth platforms.

While the above recommendations can make telehealth more accessible for undocumented immigrants, they may not significantly impact “system avoidant” behavior, which stems from fear of

²⁰³ Health Equity and Access under the Law for Immigrant Families Act of 2021, S. 1660, 117th Cong. (2021).

²⁰⁴ Brooks et al., *supra* note 24.

²⁰⁵ See Manatt Health, *Supporting Health Equity and Affordable Health Coverage for Immigrant Populations: State-Funded Affordable Coverage Programs for Immigrants*, STATE HEALTH & VALUE STRATEGIES (Oct. 2021), <https://www.shvs.org/wp-content/uploads/2021/10/State-Funded-Affordable-Coverage-Programs-for-Immigrants.pdf> [<https://perma.cc/T5AJ-VC6M>].

deportation and immigration enforcement.²⁰⁶ To overcome this fear, lawmakers must radically reform immigration enforcement. In fact, various advocates and scholars have implored contemplation of ending deportation and immigration surveillance, but these arguments are outside the scope of this Article.²⁰⁷ In the health care context specifically, “health care sanctuary” policies can help set up safe harbors that shield non-citizens interacting with health care institutions from immigration enforcement.²⁰⁸ Such policies call for actions such as limiting organizational cooperation with law enforcement and providing non-citizens with assistance and community aid.²⁰⁹ In addition, lawmakers should enact robust policies to protect patient data and sensitive information regarding immigration status. These policies would create safer spaces which may encourage seeking health care including via telehealth.

B. Bolstering Community-Based Care

Community health centers and FQHCs play a crucial role in providing health care for immigrants and underserved populations.²¹⁰ These organizations also played a pivotal role in the fight against COVID-19.²¹¹ Despite their importance, FQHCs and local health centers struggle to meet the demands for health care due to a lack of necessary funding.²¹²

At certain times, money is allocated to strengthening community health, but allocations may not trickle down to the grassroots. For

²⁰⁶ See Flores, *supra* note 150; Brayne, *supra* note 151.

²⁰⁷ See Angélica Cházaro, *The End of Deportation*, 68 UCLA L. REV. 1040, 1128 (2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3415707 [<https://perma.cc/ZJB5-49TM>]. See generally *Free Our Future: An Immigration Policy Platform for Beyond the Trump Era*, MIJENTE 1–12 (June 2018), https://mijente.net/wp-content/uploads/2018/06/Mijente-Immigration-Policy-Platform_0628.pdf [<https://perma.cc/RSQ2-J548>].

²⁰⁸ See Makhoul, *supra* note 71, at 57.

²⁰⁹ *Id.*

²¹⁰ See Corallo et al., *supra* note 132; Artiga & Diaz, *supra* note 22.

²¹¹ See Corallo et al., *supra* note 132.

²¹² See Katherine Swartz, *Trying to Survive: Community Responses to Uncertainties About Federal Funding for Medicaid and Public Health Programs*, COMMONWEALTH FUND (Aug. 17, 2018), <https://www.commonwealthfund.org/blog/2018/community-responses-federal-funding> [<https://perma.cc/JX95-ZJCQ>].

example, while the American Rescue Plan set aside funds to build a community health workforce, the money was actually spent on health departments or national initiatives instead of towards funding local, community-based organizations. The funds set aside had also “been going to AmeriCorps workers who may not be from the communities they [even] worked in.”²¹³ This misspending led to demands for sustainable federal and state funding for community health organizations and workers,²¹⁴ which should be considered and granted. HHS and states should also collectively strive to preserve Medicaid’s role in health center financing.²¹⁵ In addition, efforts should be made to improve operations, technology, support systems, human resources, and other business functions in community health centers to facilitate a shift towards a value-based care mindset.²¹⁶

C. *Emphasizing Digital Equity*

Several steps were taken during the pandemic to improve broadband access in the United States. For instance, the Federal Communications Commission launched the Affordable Connectivity Program in 2021, discounting internet services for eligible households.²¹⁷ Eligible households could also receive

²¹³ Lauren Weber, *Pandemic Funding Is Running Out for Community Health Workers*, KAISER HEALTH NEWS (Mar. 31, 2022), <https://khn.org/news/article/community-health-workers-covid-pandemic-funding-running-out-illinois/> [<https://perma.cc/WSQ9-XVAN>].

²¹⁴ Cara Rosner, *With Demand for Community Health Workers Rising, So Does Need for Sustainable Funding*, CT MIRROR (Apr. 3, 2021), <https://ctmirror.org/2021/04/03/with-demand-for-community-health-workers-rising-so-does-need-for-sustainable-funding/> [<https://perma.cc/2RCD-SEA9>].

²¹⁵ Peter Shin et al., *Keeping Community Health Centers Strong During the Coronavirus Pandemic is Essential to Public Health*, HEALTH AFFS. (Apr. 10, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20200409.175784/full/> [<https://perma.cc/V6WE-CZP5>].

²¹⁶ Gabriel Perna, *Community Health Centers Need More Than Just Federal Funding*, HEALTH EVOLUTION (July 27, 2021), <https://www.healthrevolution.com/insider/community-health-centers-need-more-than-just-federal-funding/> [<https://perma.cc/LA87-DWG7>].

²¹⁷ *What is the Affordable Connectivity Program?*, USAC AFFORDABLE CONNECTIVITY PROGRAM, <https://www.affordableconnectivity.gov> [<https://perma.cc/3B2H-7B3F>] (last visited Aug. 26, 2022).

discounts to purchase a laptop, desktop computer, or tablet.²¹⁸ This program also allowed the use of alternate methods to show eligibility, such as using an ITIN instead of requiring a Social Security Number, which only U.S. citizens have.²¹⁹ Any initiatives designed to expand connectivity should include pathways for those who may not have certain types of documentation required for eligibility.

As seen earlier, in addition to digital technology, one may also require digital skills and knowledge to access telehealth platforms. Similarly, law and policy makers should take action to upskill workers through existing legislation, as well as by proposing new legislation. There are many ways that this could be done. The National Skills Coalition recommends that the Biden Administration should take administrative action to convene a task force that prioritizes digital literacy and should allocate more money towards capacity building.²²⁰ It also proposes that Congress should work towards reauthorizing legislation, such as the Workforce Innovation and Opportunity Act, and include additional investment in digital literacy.²²¹ Additionally, it is recommended that policymakers should require outcome data to be disaggregated by race and ethnicity to ensure that workers of color benefit from investments supporting digital skill-building equal to White people.²²²

With regards to telehealth reimbursement policies, state laws should require coverage and payment parity for audio-only telehealth visits. In the absence of broadband or digital skills, immigrants may rely on audio-only care. Before the pandemic, only three states required coverage of audio-only telehealth visits.²²³ This

²¹⁸ *Id.*

²¹⁹ *See id.* (granting eligibility for benefits on criteria such as a household's income being 200% below the Federal Poverty Line and household dependents qualifying for Free or Reduced-Price Lunch).

²²⁰ *Applying a Racial Equity Lens to Digital Literacy*, *supra* note 183.

²²¹ *Id.*

²²² *Id.*

²²³ JoAnn Volk et al., *States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations*, COMMONWEALTH FUND (June 23, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/states-actions-expand-telemedicine-access-covid-19?utm_source=alert&utm_

changed during the pandemic, and multiple states currently require coverage of audio-only telehealth delivery.²²⁴ Such an option should be preserved and expanded, especially keeping in mind underserved populations, such as immigrants.

D. Prioritizing the Needs of LEP Patients

As seen earlier, those who are LEP require assistance and language interpretation services to successfully navigate the health care system. Under Title VI of the Civil Rights Act of 1964, “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”²²⁵ President Clinton issued Executive Order 13,166, entitled “Improving Access to Services for Persons with Limited English Proficiency” which effectively requires each federal agency to devise a system through which persons with LEP could meaningfully access the services it provides.²²⁶

Regulations implementing Title VI have been provided by agencies such as HHS, which requires state agencies and health care entities to provide for interpreters and the translation of written materials.²²⁷ Furthermore, regulations interpreting Section 1557 of the ACA require regulated entities to “take reasonable steps to ensure meaningful access to such programs or activities by limited English proficient individuals.”²²⁸ Following this, HHS and the Department of Justice (“DOJ”) are required to ensure that telehealth is provided in a non-discriminatory manner, and can be accessed by people with LEP. In furtherance of this obligation, the HHS website has some “tips and resources” that recipients of federal funding

medium=email&utm_campaign=Improving%20Health%20Care%20Quality
[<https://perma.cc/Y5VG-RRB6>].

²²⁴ *Id.*

²²⁵ 42 U.S.C. § 2000d.

²²⁶ Exec. Order No. 13,166; 3 C.F.R. § 289 (2000).

²²⁷ See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311 (Aug. 8, 2003).

²²⁸ 42 C.F.R. § 92.10.

could keep in mind while providing telehealth access for LEP patients.²²⁹ It includes identifying the language patients speak, having accessible materials in different languages, including qualified medical interpreters in LEP patient interactions, and matching patients with providers in their preferred language.²³⁰

Each of these recommendations should be actively enforced by the OCR and the DOJ, and providers should be educated on the different ways in which these goals can be met. Complaints about violations by telehealth providers can be filed with HHS²³¹ and should be investigated expeditiously.

The Harris Health System—the safety-net health care system for Harris County, Texas—provides a good example for health care systems to incorporate interpreters when providing telehealth services.²³² In particular, how Harris Health System developed interpretation services can be instructive:

Integration of professional medical interpretation should be easy for the physician and seamless for the patients. This is especially important for areas of the country with large immigrant communities. Given that the majority of our patients speak a language other than English, we made sure that interpreters were readily available for video visits. (Harris Health relies on two sources of interpreters: its own, which it has trained and who have been working from home during the pandemic, and those provided by an outside vendor when demand is high.)

Optimizing this service took several attempts. Initially we relied on the physicians to call the interpreter when needed. However, this created more work for the doctors and sometimes long queues to wait for an interpreter. So we adopted new technology. It allows a member of the clinic's staff (typically a nurse) to initiate a request for an interpreter just prior to the patient's virtual appointment with a physician that first is routed to Harris Health-employed interpreters at home. If one isn't available, it automatically transfers the call to the contracted vendor. The

²²⁹ *Improving Access to Telehealth*, DEP'T OF HEALTH & HUMAN SERVS., <https://telehealth.hhs.gov/providers/health-equity-in-telehealth/improving-access-to-telehealth/#telehealth-for-patients-with-limited-english-proficiency> [<https://perma.cc/EM8J-AV49>] (last visited Sept. 22, 2022).

²³⁰ *Id.*

²³¹ See Lily Lo, *The Right to Understand Your Doctor: Protecting Language Access Rights in Healthcare*, 31 B.C. THIRD WORLD L.J. 377, 385 (2011)

²³² Jonathan Rogg et al., *How to Make Telemedicine More Equitable*, HARV. BUS. REV. (Oct. 7, 2021), <https://hbr.org/2021/10/how-to-make-telemedicine-more-equitable> [<https://perma.cc/MSF7-CMGX>].

interpreter logs into the virtual room assigned to the visit and waits until the physician initiates the visit. This smoother process improved satisfaction among both patients and staff.²³³

This approach demonstrates how Harris Health System established language access as a strategic priority, and put in place a system to provide interpretation services efficiently. Medical providers and health systems should ensure that similar processes are in place while providing telehealth.

In addition to the above recommendations, telehealth providers should ensure that their interfaces are designed with immigrants in mind. This may involve adopting a one-click mobile option, using plain and simple language, or providing a language toggle that can help with accurate translation.²³⁴

E. Conducting Further Research

As seen throughout this Article, there is a significant dearth of data on the rate of telehealth usage by undocumented immigrants. There is also limited data on immigrants’ access to digital technology and the level of the digital skills they possess. Researchers should conduct qualitative and quantitative research that would help us gain a more complete understanding of how telehealth access among immigrants can be encouraged.

VI. CONCLUSION

The telehealth “revolution” has, on the contrary, been quite unrevolutionary for undocumented immigrants, reflecting and even amplifying their existing marginalization in health care systems. While there are undoubtedly barriers for undocumented immigrants to access telehealth services, a first step in tackling these impediments is understanding that they were created by immigration policies and are exacerbated by the fear and system avoidance that accompanies the risk of immigration enforcement and deportation. For immigrants to experience the benefits of telehealth as a new

²³³ *Id.*

²³⁴ Sheila Villalobos, *Designing Telehealth for First-Generation Immigrants*, MEDIUM (Mar. 31, 2021), <https://bootcamp.uxdesign.cc/designing-telehealth-for-first-generation-immigrants-1a93752b1afc> [<https://perma.cc/WZU5-5QCW>].

method of health care delivery, their unique needs and position under immigration law should be confronted, and the recommended changes must be adopted.