Immigration Policies and Issues on Health-Related Grounds for Exclusion

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Summary

News of humans infected with Ebola in West Africa, avian influenza in China, polio in the Middle East, and dengue fever in the Caribbean are examples of reports that heighten concerns about the health screenings of people arriving in the United States. Under current law, foreign nationals who wish to come to the United States generally must obtain a visa and submit to an inspection to be admitted. One of the reasons why a foreign national might be deemed inadmissible is on health-related grounds. The diseases that trigger inadmissibility in the Immigration and Nationality Act (INA) are those communicable diseases of public health significance as determined by the Secretary of Health and Human Services (HHS).

Currently there are seven diseases deemed a communicable disease of public health significance: chancroid, gonorrhea, granuloma inguinale, infectious leprosy, lymphogranuloma venereum, active tuberculosis, and infectious syphilis. Other diseases incorporated by reference are cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named); severe acute respiratory syndrome (SARS); and "[i]nfluenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic." The INA also renders inadmissible foreign nationals who are not vaccinated against vaccine-preventable diseases. Vaccinations are statutorily required for mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, influenza type B and hepatitis B. Vaccinations against other diseases may also be required if recommended by the Advisory Committee for Immunization Practices (ACIP).

The Centers for Disease Control and Prevention (CDC) in HHS take the lead in protection against communicable diseases among foreign nationals who come to the United States. The CDC are responsible for providing the technical instructions to civil surgeons and panel physicians who conduct medical examinations for immigration purposes. Foreign nationals who are applying for visas at U.S. consulates are tested by in-country physicians who have been designated by the State Department. The physicians enter into written agreements with the consular posts to perform the examinations according to HHS regulations and guidance. Foreign nationals in the United States who are adjusting to legal permanent resident status are tested by civil surgeons designated by U.S. Citizenship and Immigration Services, an agency within the Department of Homeland Security (DHS). CDC, in conjunction with Customs and Border Protection (CBP) in DHS, operates 20 quarantine stations and has health officials on call for all ports of entry.

From an immigration standpoint, an outbreak of an infectious disease places substantial procedural and resource pressures on CBP, which is charged with screening admissions of all travelers at land, sea, and air ports of entry (POE). CBP officers screened approximately 362 million individuals in FY2013 for admissions into the United States. CBP works in conjunction with the CDC to monitor travelers and attempt to contain any diseases that may be spread by travelers coming from abroad. In the current context of the Ebola outbreak in West Africa, CDC has emphasized exit-based airport screening from areas with Ebola, and not screening at POEs in the United States. At this point, CDC assures that Ebola poses little risk to the U.S. general population.

Congress has acted legislatively on the health-related grounds for exclusion several times in the recent past. Congress also plays an important oversight role, particularly when concerns arise regarding contagious diseases or potential pandemics.

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Introduction

News of humans infected with Ebola in West Africa,[1] avian influenza in China, polio in the Middle East, and dengue fever in the Caribbean are examples of reports that heighten concerns about the health screenings of people arriving in the United States.[2] Worldwide migration has hit unprecedented levels, now roughly estimated at 214 million international migrants. The United States hosts millions of foreign nationals on a temporary basis and is the prospective home to 1 million lawful permanent residents each year.

Under current law, foreign nationals not already legally residing in the United States who wish to come to the United States generally must obtain a visa and submit to an inspection to be admitted.[3] They must first meet a set of criteria specified in the Immigration and Nationality Act (INA) that determine whether they are eligible for admission. Moreover, they must also not be deemed inadmissible according to specified grounds in the INA. One of the reasons why a foreign national might be deemed inadmissible is on health-related grounds.[4]

While grounds for exclusion based on health-related criteria have long existed in the Immigration and Nationality Act (INA), some have questioned whether these provisions are sufficient to deal with a potential pandemic situation. Potential issues for Congress are at least three-fold: (1) Are the health-related grounds for exclusion updated to ensure public safety in regards to contagious diseases? (2) Would increasing restrictions on foreign travel (even temporarily) during potential pandemics inflict more of an economic harm than a benefit? (3) Are the resources provided for frontline agencies charged with screening foreign travelers adequate to identify potentially infected travelers?

The Department of State (DOS) and the Department of Homeland Security (DHS) each play key roles in administering the law and policies on the admission of aliens.[5] DOS's Bureau of Consular Affairs (Consular Affairs) is the agency responsible for issuing visas, DHS's U.S. Citizenship and Immigration Services (USCIS) is charged with approving immigrant petitions, and DHS's Customs and Border Protection (CBP) is tasked with inspecting all people who enter the United States. The Secretary of Health and Human Services (HHS) determines those communicable diseases of public health significance that trigger inadmissibility in the INA. The Centers for Disease Control and Prevention (CDC) in HHS take the lead in protection against communicable diseases among foreign nationals who come to the United States.

[1] For more information, see CRS Report IF00044, *Ebola: 2014 Outbreak in West Africa (In Focus)*, by Nicolas Cook and Tiaji Salaam-Blyther; and CRS Report IN10126, *Safe at Home? Letting Ebola-Stricken Americans Return*, by Sarah A. Lister.

[2] For the latest reports on epidemics and pandemics , see the Global Alert and Response (GAR) publications of the World Health Organization at http://www.who.int/csr/resources/publications/en/ .

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

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

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

Health-Related Grounds for Exclusion

With certain exceptions,[6] aliens seeking admission to the United States must undergo separate reviews performed by DOS consular officers abroad as well as CBP inspectors upon entry to the United States.[7] These reviews are intended to ensure that applicants are not ineligible for visas or admission under the grounds for inadmissibility spelled out in the INA.[8] These criteria are: health-related grounds; criminal history;[9] security and terrorist concerns; public charge (e.g., indigence); seeking to work without proper labor certification; illegal entry and immigration law violations; ineligible for citizenship; and aliens previously removed. The health-related grounds are further broken down into four categories: having a communicable disease, lacking required vaccinations, presenting a physical or mental disorder, and evidencing drug abuse or addiction.[10]

Legislative History

The statutory language permitting the exclusion of aliens on the basis of health or communicable diseases dates back to the Immigration Act of 1891. "Persons suffering from a loathsome or a dangerous contagious disease" were added to the grounds of exclusion, and the 1891 Act also required a medical inspection of all aliens arriving at ports of entry.[11] When the various immigration and citizenship laws were unified and codified as the Immigration and Nationality Act of 1952 (INA), the health-related grounds were seven of 31 grounds for exclusion.[12] One of these seven health-related grounds specified that aliens "afflicted with any dangerous contagious disease" would be excluded from the United States.

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

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

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

[7] For background and analysis of alien screening and visa issuance policy, see CRS Report R41104, *Immigration Visa Issuances and Grounds for Exclusion: Policy and Trends*, by Ruth Ellen Wasem; and CRS Report R41093, *Visa Security Policy: Roles of the Departments of State and Homeland Security*, by Ruth Ellen Wasem.

[8] INA §212(a); 8 U.S.C. §1182(a).

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

[10] INA §212(a)(1)(A).

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

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

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

HIV/AIDS

Much of the policy debate since 1990 centered on HIV/AIDS.[13] In 1993, Congress amended the health-related grounds for inadmissibility by adding the phrase: "which shall include infection with the etiologic agent for acquired immune deficiency syndrome."[14] In 2008, § 305 of P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, eliminated the language in the INA that statutorily barred foreign nationals with HIV/AIDS from entering the United States. This revision does not, however, entitle foreign nationals with HIV/AIDS to receive visas to enter the United States. On September 29, 2008, the DHS announced the publication of a final rule that grants consular officers the authority to grant nonimmigrant visas to otherwise eligible applicants who are HIV-positive and meet certain requirements. Visas issued under the final rule do not publicly identify any traveler as HIV-positive. The HIV-waiver final rule applies to foreigners who are HIV-positive and seek to enter the United States as visitors for up to 30 days. The CDC issued a final rule amending its regulations to remove HIV infection from the definition of "communicable disease of public health significance" and to remove references to HIV from the scope of medical examinations for aliens on November 2, 2009.

Specified Communicable Diseases

The INA renders inadmissible foreign nationals infected with a "communicable disease of public health significance."[15] While the INA does not define "communicable disease of public health significance" directly, it does task the Secretary of Health and Human Services (HHS) to define the term by regulation. The relevant regulation's definition expressly lists seven diseases as a "communicable disease of public health significance": chancroid, gonorrhea, granuloma inguinale, infectious leprosy, lymphogranuloma venereum, active tuberculosis,[16] and infectious

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

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

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

[16] The prevalence of active tuberculosis among foreign nationals has been a concern for many years. On January 23, 1991, HHS published a proposed rule in which infectious tuberculosis would have been the only communicable disease listed. That rule was suspended May 29, 1991, largely because of the controversies of leaving HIV/AIDS off the list.

syphilis.[17] However, this list is neither exclusive nor exhaustive because the regulatory definition also includes other diseases incorporated by reference to a Presidential Executive Order.[18] The relevant executive order lists cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named); severe acute respiratory syndrome (SARS); and "[i]nfluenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic."[19]

Furthermore, the regulatory definition also includes communicable diseases that may pose a "public health emergency of international concern."[20] A disease rises to this level, and thus qualifies as a "communicable disease of public significance," if the CDC Director, after evaluating (1) the seriousness of the disease, (2) whether the emergence of the disease was unusual or unexpected, (3) the risk of the spread of the disease in the United States, and (4) the transmissibility and virulence of the disease,[21] determines that "a threat exists for [the disease's] importation into the United States" and the disease "may potentially affect the health of the American public."[22]

Tuberculosis (TB)

In recent years, tuberculosis (TB) has prompted greater concerns with health and screening officials in the United States, due in part to the development of drug resistant strains of the disease.[23] These developments have caused agencies such as the CDC to implement instructions and preparedness plans for screening and handling travelers to the United States infected with TB. About one-third of the world's population is infected with *Mycobacterium (M.) tuberculosis*, the bacterium that causes TB. The vast majority have so-called "latent TB" infections and are not contagious. A small percentage (approximately 9 million people) have "TB disease;" more than 1 million of them die from the disease each year. Many but not all persons with TB disease are contagious and can transmit the disease to others. Many persons with latent TB infections never experience TB disease, although latent infections can progress to disease at any time.[24]

The processing of Hmong refugees located in Thailand was temporarily halted in 2005 to ensure that the refugees had completed treatment for infectious tuberculosis before they came to the

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[17] 42 C.F.R. §34.2(b).

[18] 42 C.F.R. §34.2(b)(2).

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

[20] 42 C.F.R. §34.2(b)(3).

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

[22] 42 C.F.R. §34.2(b)(3). *See also* Annex 2 of the revised International Health Regulations http://www.who.int/csr/ihr/en.

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

[24] World Health Organization, "Tuberculosis Fact Sheet," March 2014, http://www.who.int/mediacentre/factsheets/fs104/en/; and Centers for Disease Control and Prevention, "The Difference Between Latent TB Infection and TB Disease," fact sheet, September 2012, http://www.cdc.gov/tb/publications/factsheets/general/LTBIandActiveTB.htm. U.S. Government Accountability Office, *Public Health and Border Security: HHS and DHS Should Further Strengthen Their Ability to Respond to TB Incidents*, GAO-09-58, October 2008, p. 1.

United States.[25] Additional concerns were raised in Spring 2007 when two individuals with drug-resistant TB disease were requested flagged by HHS for CBP interdiction. Despite this call for interdiction, both individuals were able to enter the United States through ports of entry. These incidents resulted in a reassessment of federal coordination and response regarding TB and other contagious diseases.[26]

Almost 10,000 cases of TB disease were reported in the United States in 2013. Almost 65% of these cases were among foreign-born persons; the case rate among foreign-born persons was approximately 13 times higher than among U.S.-born persons. Although the number of cases of TB disease has been on the decline among both U.S.-born and foreign-born persons, the proportion of cases among the foreign-born has risen steadily since 1993.[27]

As discussed below, medical screening for tuberculosis is required of all refugees and foreign nationals seeking LPR visas to live in the United States. However, CBP does not currently have any special provisions outside of its general procedures for TB screening at ports of entry. The majority of TB disease cases reported in the United States among foreign-born persons have been attributed to reactivation of latent TB infection acquired previously, with the rate reflecting TB incidence in their countries of origin.[28] Therefore, most of these persons would not have been ineligible for visas on health-related grounds, and would not have been symptomatic of the disease at the time of their arrival at a port of entry.

Medical Examinations for Visas

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

[25] "State Department Halts Travel of Hmong Refugees to U.S.; Institutes Enhanced Medical Screening," *Interpreter Releases*, vol. 82, no. 7 (February 14, 2005).

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

[27] Centers for Disease Control and Prevention, "Trends in Tuberculosis—United States, 2013," *MMWR*, vol. 63, no. 11, March 21, 2014, pp. 229-233, http://www.cdc.gov/mmwr/pdf/wk/mm6311.pdf.

[28] Ibid.

perform the examinations according to HHS regulations and guidance. Foreign nationals in the United States who are adjusting to legal permanent resident (LPR) status are tested by civil surgeons designated by USCIS.

A medical examination is required of all foreign nationals seeking to come as legal permanent residents and refugees, and may be required of any alien seeking a nonimmigrant visa or admission at the port of entry. Foreign nationals are generally tested at their own expense, though the costs for refugees are covered by the U.S. government. If there is reason to suspect an infection, applicants for temporary admission as nonimmigrants (such as tourists, business travelers, temporary workers, and foreign students) are tested at the discretion of the consular officer or admitting CBP inspector. Children under 15 years of age are required to have a general physical examination and provide proof of immunizations, but they are not required to have the chest x-rays, blood tests, or HIV anti-body test.[29]

Policies and procedures established over the years by the CDC spell out the obligations of the physicians who are designated to conduct the medical examination to meet the statutory requirements of the INA. According to the CDC's technical guidance for the physicians performing the medical examination, they are required to make an assessment of the foreign national that includes a medical history, a review of other available records, a physical examination, and required diagnostic tests (more detailed information on these requirements are available in **Appendix B**).[30] Afterwards, CDC guidance says, the panel physician completes the DS-2053 form if the visa is being processed by consular officers abroad, or the civil surgeon completes I-693 form if the status adjustment is being processed by USCIS adjudicators within the United States. In general, the medical reports are valid for one year.

Mere presence of one of the designated diseases does not always lead to exclusion. After a visa applicant is found to be afflicted with TB disease, for example, the consular officer or USCIS adjudicator is to request the medical examiner to determine whether the tuberculosis is Class A (infectious), Class B-1 (clinically active, not infectious) Class B-2 (not clinically active) or Class B-3 (old or healed tuberculosis). A foreign national diagnosed with Class B-1 tuberculosis, is not automatically ineligible for LPR visa purposes; nor is a foreign national diagnosed with Class B-1, B-2, or B-3 tuberculosis automatically ineligible for nonimmigrant (temporary) visa purposes.[31]

Waivers of the Health Grounds

The INA gives the Secretary of Homeland Security[32] the discretionary authority to waive some of the health-related grounds for inadmissibility under certain circumstances.[33] For example, foreign nationals infected with a communicable disease of public health significance can still be issued a waiver and admitted into the country if they are the spouse, unmarried son, unmarried daughter,

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

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

[31] 9 FAM §40.11 N.5.2.

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

[33] INA §212(g), 8 U.S.C. §1182(g).

minor unmarried lawfully adopted child, father, or mother of a U.S. citizen, alien lawfully admitted for permanent residence, or an alien issued an immigrant visa, or is a VAWA self-petitioner.[34] Waivers are also available, under certain circumstances, for those inadmissible for lacking proper vaccination[35] and for those who have a physical or mental disorder.[36] The Secretary may also waive the application of any of the health-related grounds for inadmissibility if he finds it in "the national interest" to do so.[37]

The Department of State Visa Office reports that a total of 362 potential LPRs were initially denied a visa in FY2013 on the basis of a communicable disease of public health significance (e.g., cholera, infectious tuberculosis, HIV/AIDS). However, 377 people obtained waivers or overcame an initial denial based upon a communicable disease and were granted LPR visas in FY2013.[38] Comparable data from the Department of Homeland Security have not been made available.

When waivers are given to nonimmigrants, it is done on a case-by-case basis for up to 30 days, for such reasons as visiting a family member, short-term treatment, or attending conferences. The Department of State Visa Office reports that a total of 17 potential nonimmigrants were denied a visa in FY2013 on the basis of a communicable disease of public health significance. Also in FY2013, four people obtained waivers or overcame an initial denial based upon a communicable disease and received a nonimmigrant visa.[39] Comparable data from the Department of Homeland Security have not been made available.

Vaccination Requirements

As stated above, the INA renders inadmissible foreign nationals who are not vaccinated against vaccine-preventable diseases.[40] Vaccinations are statutorily required for mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, influenza type B and hepatitis B. Vaccinations against other diseases may also be required if recommended by the Advisory Committee for Immunization Practices (ACIP), an advisory committee to the CDC.[41] Those vaccinations against other diseases the ACIP have added are hepatitis A, human papillomavirus, meningococcal, pneumococcal, rotavirus, varicella, zoster, and the annual influenza vaccine.[42] Most visas denied on this basis are overcome when evidence of the vaccination is presented.[43]

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

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

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

[37] INA, §212(d)(13)(B)(i).

[38] CRS analysis of Table XX, *Report of the Visa Office*, U.S. Department of State, Bureau of Consular Affairs (FY2013), http://travel.state.gov/content/visas/english/law-and-policy/statistics.html.

[39] CRS analysis of Table XX, *Report of the Visa Office*, U.S. Department of State, Bureau of Consular Affairs (FY2013), http://travel.state.gov/content/visas/english/law-and-policy/statistics.html.

[40] INA §212(a)(ii).

[41] Ibid.

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

[43] U.S. Department of State Bureau of Consular Affairs, *2008 Report of the Visa Office*, Washington , DC, 2009, (continued...)

If the panel physician or civil surgeon believes that a vaccination record is fraudulent, the visa applicant is handled in the same way as someone who has failed to present a vaccination record. The vaccination requirement may be waived when the foreign nation receives the vaccination, the civil surgeon or panel physician certifies that the vaccination would not be medically appropriate, or if the vaccination would be contrary to the foreign national's religious or moral beliefs.[44]

Port of Entry Procedures

There are 328 official ports of entry (POE) in the United States, including 16 preclearance offices in Canada, Ireland, the Caribbean, and the United Arab Emirates.[45] CBP officers screened approximately 362 million individuals in FY2013 for admissions into the United States. The vast majority of admissions into the United States occur at the land border, where local and regional economies are dependent upon the movement of goods and people across the border to maintain economic viability.[46] From the perspective of the CBP, the most significant challenge in screening for infectious diseases comes at the land border. Even without medical screening or other special circumstances, land borders can build up inspection lines that are several hours long due to the high demand for crossings and inadequate infrastructure at most POEs to accommodate such crossings.

As noted above, the CDC is the lead agency charged with protection against communicable diseases and is responsible for providing the technical instructions to civil surgeons and panel physicians who conduct medical examinations for immigration. CDC officials are not present at the border on a day-to-day basis, but there are quarantine stations located in a number of international airports and near a few land ports of entry (for a full list, see **Appendix A**). However, these 20 stations constitute a small fraction of the 329 ports of entry operated by CBP. Even fully staffed quarantine stations are not in a position to perform routine health screening on all passengers crossing the border as a standard operating procedure.

Rather than staffing all the POEs, the CDC, through their Division of Global Migration and Quarantine (DGMQ),[47] train CBP inspectors to watch for ill persons and items of public health concern. CDC approves the physicians used at the POEs, and the tests are performed in consultation with and in accordance with CDC guidance. CDC officials are to be stationed at the border during immigration emergencies and other periods when public health may be threatened.[48]

(...continued)

Appendix Table XX.

[44] INA §212(g)(2).

[45] For a complete listing of the ports of entry, see http://www.cbp.gov/contact/ports.

[46] CRS Report R43356, *Border Security: Immigration Inspections at Ports of Entry*, by Lisa Seghetti.

[47] See CDC, Division of Global Migration and Quarantine, http://www.cdc.gov/ncezid/dgmq/. In addition to non-regulatory activities, DGMQ has regulatory authority to prevent the introduction, transmission, and interstate spread of communicable diseases into the United States and its territories.

[48] Through an interagency agreement between the Department of Health and Human Services and the Department of Homeland Security, the Division of Immigration Health Services (DIHS) provides healthcare to undocumented migrants in the custody of Immigration and Customs Enforcement (ICE) residing in Service Processing Centers (SPC) and Contract Detention Facilities (CDF). DIHS, however, plays virtually no role in regard to inspection of travelers or screening of legal immigrants and nonimmigrants. For more information on DIHS, see archived CRS Report RL34556, (continued...)

The CBP Inspector's Field Manual states that CBP officers are responsible for observing all travelers for obvious signs and symptoms of quarantinable and communicable diseases, such as (1) fever, which could be detected by a flushed complexion, shivering, or profuse sweating; (2) jaundice (unusual yellowing of skin and eyes); (3) respiratory problems, such as severe cough or difficulty breathing; (4) bleeding from the eyes, nose, gums, or ears or from wounds; and (5) unexplained weakness or paralysis.[49] Additionally, a person is considered to be ill in terms of foreign quarantine regulations when symptoms meet the following criteria:

1. Temperature of 100 degrees Fahrenheit or greater which is accompanied by one or more of the following: rash, jaundice, glandular swelling, or which has persisted for 2 days or more.
2. Diarrhea severe enough to interfere with normal activity or work.[50]

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

According to a Government Accountability Office (GAO) report,[51] there are three general scenarios in which CBP officers encounter ill persons who are in need of medical attention or who may pose a public health threat:

- In the most common scenario, CBP officers encounter an individual who discloses that he/she needs medical attention for various health reasons.
- CBP officers suspect an individual may need medical attention or may pose a public health risk to others (e.g., individual exhibits obvious signs and symptoms of illness, such as fever, weakness, or both, as observed by officers).
- CBP officers encounter an individual who is an exact match to a public health alert in Treasury Enforcement Communications System (TECS II)[52] and may pose a public health risk to others.

The GAO report additionally states that in all three scenarios, CBP protocols require officials, at a minimum, to isolate the person while notifying officials at CDC and, depending on the circumstance, to contact the designated local public health authorities.[53] Each port of entry,

(...continued)

Health Care for Noncitizens in Immigration Detention, by Alison Siskin.

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

[50] Ibid.

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

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

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

according to GAO, is supplied with personal protective equipment, including masks and gloves, and inspecting officers must use this equipment in dealing with travelers suspected of having communicable or quarantinable illnesses, as well as while handling the individuals' documents and belongings. CBP officers are responsible for coordinating with CDC to provide assistance in identifying arriving individuals from areas with known communicable disease outbreaks.

In the context of the current Ebola outbreak in West Africa, CDC has emphasized exit-based airport screening from areas of the source,[54] not POE screening in the United States. "When this has been evaluated, the yield is much, much greater to try to control the disease at the source, and control the screening and right close to the source. The vast majority of flights from this region to the United States are indirect."[55] At this point, CDC assures that Ebola poses little risk to the U.S. general population.[56]

[54] CDC have issued guidelines for airlines that detail the necessary precautions and infection control procedures the airline personnel should follow. Centers for Disease Control, *Interim Guidance about Ebola Infection for Airline Crews, Cleaning Personnel, and Cargo Personnel*, Ebola Guidance for Airlines, August 11, 2014, http://www.cdc.gov/quarantine/air/managing-sick-travelers/ebola-guidance-airlines.html.

[55] Centers for Disease Control, "Press Briefing Transcript, CDC Telebriefing on Ebola outbreak in West Africa," press release, July 28, 2014, http://www.cdc.gov/media/releases/2014/t0728-ebola.html.

[56] CRS Report IN10126, *Safe at Home? Letting Ebola-Stricken Americans Return*, by Sarah A. Lister.

Appendix A. CDC Quarantine Stations

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

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

Source: CRS presentation of information posted on CDC website, available at http://www.cdc.gov/quarantine/quarantine-stations-us.html.

Notes: Information is current as of April 14, 2014.

Appendix B. CDC Technical Guidance

As previously discussed, policies and procedures established over the years by the CDC spell out the obligations of the physicians who are designated to conduct the medical examination to meet the statutory requirements of the INA. According to the CDC's technical guidance[57] for the physicians performing the medical examination, they are required to make the following assessments of the foreign nationals seeking visas:

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

[57] U.S. Department of Health and Human Services Centers for Disease Control, *Technical Instructions for Medical Examination of Aliens*, June 12, 1991, as revised in July 1992; including the *Addendum to the Technical Instructions for Medical Examination of Alien,* added October 6, 2008.

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