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Submitted via www.regulations.gov

Samantha Deshommes, Chief
Regulatory Coordination Division, Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Re: DHS Docket No. USCIS-2010-0012, RIN 1615-AA22, Comments in Response to Proposed Rulemaking: Inadmissibility on Public Charge Grounds

Dear Ms. Deshommes:

Thank you for the opportunity to submit comments on the Department of Homeland Security's (DHS or the Department) notice of proposed rulemaking (NPRM or proposed rule) on inadmissibility on public charge grounds (public charge). The 15 undersigned organizations oppose the NPRM and urge the Department to withdraw it, as we believe the NPRM would cause major harm to the health and wellbeing of immigrants, their families, and the communities in which they live.

Our organizations represent millions of patients and consumers, including those who have immigrated to the United States, who face serious, acute, and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions including disability. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource in this discussion. We urge the Department to make the best use of the collective insight, experience, and evidence our patients and organizations offer in response to the proposed rule.

In early 2017, our organizations agreed upon three principles that we use to help guide our work on health care to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.¹ These principles state that: (1) health care must be adequate, meaning that health care coverage should cover treatments patients need; (2) health care should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) health care should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. These principles were crafted without regard to socioeconomic standing, origin or immigration status, ethnicity, gender, or orientation - as our organizations firmly believe that all people living within the United States should have access to affordable, adequate, and accessible health care.

In this proposed rule, the Department proposes to broadly expand the public charge evaluation criteria to include critical safety-net programs such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Section 8 housing assistance, and Medicare Part D low-income subsidies for prescription drugs. The Department also requests feedback on if the Children's Health Insurance Program (CHIP) should be included in the public charge determination. Under current guidance, researchers and health care professionals who are prospective immigrants, lawful working immigrants, and their citizen dependents are not penalized for accessing non-cash-based assistance programs; the proposed rule would reverse this. Limiting access to these programs could have broad consequences for the health and wellbeing of immigrants and their U.S. citizen children, spouses, and relatives who use public benefits for which they legally qualify.

We are deeply concerned that the proposed rule would harm immigrants, their families, and the communities where they live. We therefore urge the Department to withdraw the proposed rule and instead focus its efforts on improving our immigration system without negatively impacting the health and wellbeing of individuals and communities throughout the United States.

The Proposed Rule Would Harm Immigrants and their Families

The Proposed Rule Represents a Substantial and Unnecessary Change in Policy

The proposed rule would alter the public charge test dramatically. Under current policy, a public charge is defined as an immigrant who is "likely to become primarily dependent on the government for subsistence".² Guidance in effect since 1999³ only counts cash assistance for income maintenance and government funded long-term institutional care toward the public charge determination – and those benefits only impact the determination when they represent the majority of an immigrant's support.

The proposed rule would expand the public charge definition to any immigrant who "receives one or more public benefits," including those related to health care, nutrition, and housing, among others. This shift to include non-cash-based programs, including programs designed to provide health care services to low-income individuals, drastically increases the scope of who can be considered a public charge to include not just people who receive benefits as the main source of support, but also people who use

¹ Consensus Healthcare Reform Principles, <https://www.heart.org/-/media/files/get-involved/advocacy/access-to-care/101618-healthcare-principles.pdf?la=en&hash=D0D79B3C705FBD48890DC5BD537BC8EFC386C734>

² Department of Homeland Security, *Proposed Rule: Inadmissibility on Public Charge Grounds*. 83 Fed. Reg. 51,114, 51,277. October 10, 2018.

³ 64 Fed. Reg. 28689

basic needs programs, for which they are legally eligible, to supplement their earnings from low-wage work. Thus, if the proposed rule is finalized in its current form, immigration officials could consider a much wider range of government programs in the “public charge” determination. These programs include most Medicaid programs, SNAP, and even assistance for seniors who qualify for Medicare and need help paying for prescription drugs.

The rule also penalizes and discriminates against individuals with serious medical conditions, by including such health issues as a factor in the public charge calculation. As organizations that represent individuals living with cancer, cystic fibrosis, multiple sclerosis, heart, and lung disease, and other life-threatening diseases, we are appalled that the administration has decided to use these conditions as reasons to withhold visas or green cards. Individuals living with these conditions bear an immense burden in terms of the physical, emotional, and financial toll of their disease, and in this proposal, the administration has decided to use their ongoing health conditions as reason to deny immigration requests.

Finally, the rule makes other changes, such as introducing an income test and weighing negatively many factors that have never been relevant during previous determinations. For example, the proposed rule details the manner by which age (i.e. being a child or a senior adult), having a large family, or living with a treatable medical condition could be held against immigrants seeking a permanent legal status.

Chilling Effect and Program Eligibility

The proposed rule could create a chilling effect on lawful immigrants and their families – making lawfully present individuals afraid to access programs and undermining access to critical health, food, and other supports for eligible immigrants and their families for fear that doing so may impact their ability to remain in the United States. Among the most harmed by the proposed rule are children, including U.S. citizen children, whose participation in support programs such as CHIP could decline, despite remaining eligible and unaffected by this rulemaking.

Approximately 25.9 million people could be potentially impacted by the proposed public charge rule, accounting for an estimated 8 percent of the U.S. population. This number represents individuals and family members with at least one non-citizen in the household and who live in households with earned incomes under 250 percent of the federal poverty level. Of these 25.9 million people, approximately 9.2 million are children under 18 years of age who are family members of at least one noncitizen or are noncitizen themselves, representing approximately 13 percent of our nation’s child population.⁴

In the proposed rule, the Department admits that reduced use of the safety net programs by eligible immigrants would lead to negative outcomes, including: “worse health outcomes, including increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children, and reduced prescription adherence; increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment; increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated; increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient; increased

⁴ 2012-2016 5-Year American Community Survey Public Use Microdata Sample (ACS/PUMS); 20122016 5-Year American Community Survey (ACS) estimates accessed via American FactFinder; Missouri Census Data Center (MCDC) MABLE PUMA-County Crosswalk. Custom Tabulation by Manatt health, 9/30/2018. Found online at <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population>.

rates of poverty and housing instability; and reduced productivity and educational attainment.”⁵ States, communities, and individuals would be forced to incur increased costs to meet the needs associated with poorer health, education, and worker productivity outcomes related to the void this proposed rule would create.

We also know that many vulnerable people are dually eligible – meaning they qualify for more than one safety net program. This proposed rule would spur immigrants who are legally authorized to participate in SNAP, Medicaid, Medicare Part D, and housing assistance to not only forgo receiving benefits from these programs or unenroll, but would also discourage them from participating in other programs for which they are eligible and are not covered by the proposed rule, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), CHIP and other programs that help support health and wellbeing. For example, WIC, a program not targeted by the proposed rule, has reported that at least 18 states show enrollment declines of up to 20 percent,⁶ a sign that even the threat of cutting access or jeopardizing immigration status spurs an exodus from safety-net programs among immigrants.

The inclusion of SNAP and Medicaid in the public charge review will also undermine state efforts to streamline enrollment processes and will create a more burdensome screening process. This will inevitably lead to new barriers and decreased participation even for programs not covered under the proposed rule. For example, the Child Nutrition Act specifically authorizes WIC as adjunctively eligible to SNAP and Medicaid, reducing certification requirements and paperwork.⁷ Almost 75 percent of WIC participants meet these eligibility criteria, and service providers at the state and local level rely on streamlined enrollment and certification procedures. This rule would put a detrimental wrench into these systems, and only further generate confusion and create more work for federal, state, local agencies, and service providers as they try to interpret and navigate the new rule, likely resulting in increased costs to do so.

Furthermore, these programs work in tandem with each other to help support families and improve health outcomes. A cut to one can lead to negative consequences for another. Similarly, an investment in one safety net program is an investment for all. For example, WIC has been shown to reduce Medicaid costs: for every dollar spent on WIC, Medicaid cost savings for the first 60 days after birth range from \$1.77 to \$3.13 for newborns and mothers combined, and \$2.84 to \$3.90 for just newborns.⁸ The drop in WIC participation mentioned earlier in these comments – despite not being included in the proposed rule – could therefore increase Medicaid spending. Another example shows that children who receive SNAP have fewer hospitalizations, compared to children who do lack access to SNAP.⁹ We also see that families with access to both housing subsidies and other assistance programs like SNAP were 72 percent more likely to have stable housing.¹⁰

⁵ Ibid.

⁶ Evich HB. Immigrants, fearing Trump crackdown, drop out of nutrition programs. *Politico*. <https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292>. Accessed November 27, 2018.

⁷ 42 U.S.C. § 1786(d)(2)(A)(ii), (iii).

⁸ U.S. Department of Agriculture. *The Savings in Medicaid Costs for Newborns and their Mothers from prenatal Participation in the WIC Program*. 1990. <https://fns-prod.azureedge.net/sites/default/files/SavVol1-Pt1.pdf>. Accessed November 20, 2018.

⁹ Cook JT, et al. Child food insecurity increases risks posed by household food insecurity to young children’s health. *Journal of Nutrition*. 2006.

¹⁰ Sandel M., et al. Co-enrollment for child health: how receipt and loss of food and housing subsidies relate to housing security and statutes for streamlined, multi-subsidy application.

Broad Health Impacts of the Proposed Rule

Proposed Rule Would Harm the Health of Immigrants, their US Citizen Relatives, and the Health Care System

Implementing the proposed rule as drafted would have far reaching impacts on both immigrants and the broader health care system. The proposed rule would deter immigrants and immigrant families from securing and maintaining meaningful health insurance coverage thereby limiting their ability to access routine and emergent care. As a direct result, many immigrants and non-immigrants with an immigrant family member could be left unable to access important health care services that are essential to preventing the onset of a disease, accurately diagnosing a health condition, or treating a debilitating or life-threatening illness. For example, access to preventive screenings such as low dose computer tomography screening (LDCT) for individuals at high risk of lung cancer reduces the death rate from this disease by up to 20 percent.¹¹ If implemented as proposed, many legal immigrants and their dependents will be less likely to access preventive, diagnostic, and critical health care. Multiple studies have indicated that in comparison to insured individuals, uninsured or underinsured individuals are more likely to have poorer health outcomes. For example, uninsured or underinsured patients suffer greater neurological impairment due to a stroke¹²; are more likely to be diagnosed with later stage cancer¹³; to have worse glycemic control when diagnosed with diabetes; to be unable to fully recover following a serious injury; and to have a higher mortality risk due to congestive heart failure.¹⁴

The proposed rule would also penalize lawfully present immigrants for obtaining health insurance through the Medicaid program or the Low-Income Subsidy (LIS) program for Medicare's prescription drug benefit, also known as Medicare Part D. These programs provide access to vital health care services for those who participate in them: ensuring access to health care interventions and serving as an important safety net that promotes both health and financial stability. In fact, evidence suggests that access to affordable health insurance like Medicaid and LIS in Part D promotes the ability of individuals to obtain and maintain employment. Further, the positive effects of access to Medicaid on health outcomes are clear. Medicaid coverage is associated with improved health in adults, improved health and developmental outcomes in children, and declines in infant mortality and morbidity.¹⁵ As compared to children without health insurance, children enrolled in Medicaid in their early years have better health, educational, and employment outcomes not only in childhood but also later as adults. In fact, Medicaid coverage in early childhood (birth to age 5) is associated with improved health in adulthood (ages 25 to 54), including lower likelihood of high blood pressure, heart disease, adult-onset diabetes,

¹¹ De Koning HJ et al. [Benefits and Harms of CT Lung Cancer Screening Strategies. A Comparative Modeling Study for the U.S. Preventive Services Task Force.](#) *Annals of Internal Medicine*, 2014;160(5):311-20. The National Lung Cancer Screening Trial Team. [Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening.](#) *New England Journal of Medicine*, August 2011; 365(5):395-409.

¹² Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Med Care Res Rev* 2005; 62(1): 231-249.

¹³ E Ward et al, Association of Insurance with Cancer Care Utilization and Outcomes. *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), <http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care>.

¹⁴ McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*. 2007; 298:2886–2894.

¹⁵ March of Dimes Issue Brief: Value of Medicaid, <https://www.marchofdimes.org/materials/Value-of-Medicaid-Issue-Brief-April-2015.pdf>.

and obesity.¹⁶ If finalized as drafted, the proposed rule would jeopardize the access to health insurance that is made possible through Medicaid and LIS and the employment made possible by the stability these programs provide to their participants. This would have immediate impacts on legal immigrants in addition to decades-long ramifications for the overall health of our nation and its and economic wellbeing.

Additionally, the exodus of targeted individuals from public health programs could also negatively impact the institutions and providers who serve in affected communities. Health care providers will experience decreased revenue from insurance reimbursements and increased requests for uncompensated care. As a result, citizens and other residents with private, commercial health insurance coverage will see increases in premiums and other health care costs as providers attempt to offset their revenue losses.

Each of these adverse outcomes have a significant impact on the quality of life of the patient and their family, while also increasing costs to the health care system. Given this dynamic, the proposed rule may increase costs to taxpayers, employers, and other health care stakeholders, in addition to harming the health status and financial health of immigrants and immigrant families who are deterred from maintaining insurance coverage.

Specific Health Impacts of the Proposed Rule

Public Health

As the Department states in its own NPRM, the proposed rule could lead to “increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated.”¹⁷ When individuals lose access to coverage through Medicaid or CHIP – both as the result of legal immigrants who are directly impacted by the proposed rule losing access to coverage and as a result of the rule’s broader chilling effects – immunization rates will likely decline, jeopardizing public health.

The impact of reductions in immunization rates goes well beyond the legal immigrant community and impacts all individuals living in the United States. According to the American Academy of Pediatrics, when families without access to care fall behind on their immunization schedule, “gaps in the shield of protection that immunizations provide leave our entire communities more vulnerable, including children who are too young to benefit from vaccines and those who cannot be vaccinated due to medical problems.”¹⁸ The incidence of many vaccine-preventable diseases – including measles, pertussis and influenza – could therefore increase if immunization rates decline.

Chronic Illness

The proposed rule would introduce into existing public charge evaluations a broad range of “heavily weighted negative factors” including an applicant’s “medical condition that requires extensive treatment or institutionalization” and whether the applicant is uninsured and does not have “financial

¹⁶ Boudreaux MH, Golberstein E, McAlpine DD. The long-term impacts of Medicaid exposure in early childhood: Evidence from the program's origin. *J Health Econ.* 2016;45:161-75.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785872/pdf/nihms-761668.pdf>.

¹⁷ Ibid.

¹⁸ <https://www.healthychildren.org/English/safety-prevention/immunizations/Pages/An-Important-Immunization-Message-from-the-President-of-the-American-Academy-of-Pediatrics.aspx>

resources to pay for medical costs associated with a medical condition”.¹⁹ Further, the rule also targets other, non-health care coverage programs that have a direct impact on health outcomes and chronic disease.²⁰ As advocates representing the interests of individuals living with chronic conditions and their families, we are deeply troubled by the discriminatory implications of such a policy and its potential impact on the millions of individuals with chronic illnesses or disabilities we serve.

This aspect of the proposed rule sends the signal that individuals with chronic health conditions or disabilities are “undesirable” and, in doing so, also ignores the reality that the diagnosis of a chronic but treatable illnesses such heart disease, diabetes, cancer, or multiple sclerosis is not an accurate indicator of future self-sufficiency and full-time employment capabilities. Relapsing-remitting conditions such as MS are characterized by wide variations in symptoms and effects, and most lead productive and independent lives throughout most of their adult years. Other diseases such as heart disease and diabetes can be effectively managed, mitigated or even prevented if patients have access to adequate and timely care.

Pregnant Women & Children

The policies articulated in the proposed rule could deter immigrant families, including pregnant women and children, from seeking the help they need to lead healthy and productive lives. One in four children in the U.S. - nearly 18 million children - has at least one immigrant parent.²¹ The vast majority of these children - about 88 percent or 16 million - are U.S. citizens.²² Children born in the United States to immigrant parents are U.S. citizens and therefore eligible for public benefits under the same eligibility standards as all other U.S. citizens. Currently more than eight million citizen children with an immigrant parent have Medicaid/CHIP coverage.²³ However, seven percent of citizen children with an immigrant parent still lack any health insurance coverage.²⁴

Children in immigrant families are more likely to face certain hardships and are already less likely to secure help due in part to complex eligibility rules that create barriers for immigrant families.²⁵ However, like all children, children in immigrant families benefit when they have access to programs and services that promote their development. Parents’ and children’s health are inextricably linked, and children are more likely to thrive when their parents are mentally and physically healthy. Children whose parents are insured are more likely to have insurance themselves.²⁶ Research demonstrates that safety

¹⁹ Ibid.

²⁰ Ibid.

²¹ Migration Policy Institute, *Children in U.S. Immigrant Families 2016*, <https://www.migrationpolicy.org/programs/data-hub/charts/children-immigrant-families>

²² Ibid.

²³ Michael Fix & Ron Haskins, *Welfare Benefits for Non-citizens*, Brookings Institute, (Feb. 2, 2002), <https://www.brookings.edu/research/welfare-benefits-for-non-citizens/>.

²⁴ Ibid.

²⁵ Tanya Broder, Avidah Moussavian, and Jonathan Blazer, *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, 2015, <https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/>; Kinsey Alden Dinan, *Federal Policies Restrict Immigrant Children’s Access to Key Public Benefits*, National Center for Children in Poverty, 2005, http://www.nccp.org/publications/pdf/text_638.pdf.

²⁶ Julie L. Hudon and Asako S. Moriya, “Medicaid Expansion for Adults Had Measurable ‘Welcome Mat’ Effects on Their Children,” *Health Affairs* 36 (2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347>; Joan Alker and Alisa Chester, *Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements*, Georgetown University Health Policy Institute, Center for Children and Families, 2015, <http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf>.

net programs such as Medicaid have short and long-term health benefits and are crucial levers to reducing the intergenerational transmission of poverty.²⁷

The value of access to public benefits has been documented repeatedly. Multiple studies confirm that early childhood or prenatal access to Medicaid and SNAP improves health and reduces reliance on cash assistance. Children in immigrant families with health insurance coverage are more likely to have a usual source of care and receive regular health care visits and are less likely to have unmet care needs. Children with access to Medicaid have fewer absences from school, are more likely to graduate from high school and college and are more likely to have higher paying jobs as adults.²⁸ Children enrolled in Medicaid in their formative years experience improved health throughout their lives. By making health insurance accessible to children and parents, Medicaid keeps families healthy and also protects them from financial hardship. Counting utilization of these services that promote the health and economic stability of children, both citizen and non-citizen, as a negative factor in the public charge assessment is contrary to the purpose of the public charge ground of inadmissibility.

The proposed rule would also create barriers to accessing care for pregnant women that could hasten the rise in maternal mortality and have serious health implications for the next generation. Despite the availability of Medicaid and CHIP, 40 percent of mothers surveyed in 2009-10 across 30 states reported that they delayed prenatal care because they lacked the money or insurance to pay for their care.²⁹ This problem is especially acute for immigrant women of reproductive age, 27 percent whom are uninsured.³⁰ Similarly, the proposed rule may also discourage women from seeking postpartum care, which is crucial to their health and well-being. Forgoing postpartum care could mean that women endure postpartum depression without proper medical, social, and psychological care, skip doctor's visits that address infant feeding, nutrition, physical activity and family planning, or leave other postpartum health issues unaddressed, including the future potential of conditions like heart disease that may have presented during pregnancy.

A lack of prenatal care and nutrition assistance for mothers could have serious implications for their children, affecting their birth and early health outcomes. Negative outcomes would extend decades into the future, diminishing a future generation's opportunity to thrive in tangible and entirely preventable ways. In addition to access to prenatal care, nutrition assistance also helps promote healthy birth outcomes. Researchers comparing the long-term outcomes of individuals in different areas of the country when SNAP expanded nationwide in the 1960s and early 1970s found that mothers with access to SNAP during pregnancy gave birth to fewer low-birth-weight babies.

The preamble to the 1999 Field Guidance on Public Charge clearly acknowledged that the reluctance to access benefits has an adverse impact not just on the potential recipients, but on public health and the

²⁷ Page, Marianne, "Safety Net Programs Have Long-Term Benefits for Children in Poor Households", Policy Brief, University of California, Davis, 2017 https://poverty.ucdavis.edu/sites/main/files/file-attachments/cpr-health_and_nutrition_program_brief-page_0.pdf

²⁸ Karina Wagnerman, Alisa Chester, and Joan Alker, *Medicaid is a Smart Investment in Children*, Georgetown University Center for Children and Families, March 2017, <https://ccf.georgetown.edu/2017/03/13/medicaid-is-a-smart-investment-in-children/>.

²⁹ The Kaiser Family Foundation, *Proposed Changes to "Public Charge" Policies for Immigrants: Implications for Health Coverage*, (Feb. 13, 2018), <https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/>.

³⁰ National Women's Law Center, *If You Care About Immigration, You Should Care About Reproductive Justice*, (Oct. 2016), available at <https://nwlc.org/wp-content/uploads/2016/09/Immigration-Fact-Sheet.pdf>

general welfare of the country as a whole.³¹ Some of the evidence before the agency when writing the field guidance included detailed accounts of pregnant women with gestational diabetes terrified of seeking care, a child with seizures rushed to the hospital whose parents were afraid to enroll in Medicaid at the hospital so he could continue treatment, and female farmworkers afraid to enroll in a state-funded perinatal case management program.

For millions of families, Medicaid is a lifeline that helps keep children and their families living above the poverty threshold. America's future depends on ensuring that all children are healthy and can succeed. We need to invest in children, rather than put their healthy development and education at risk by destabilizing families. Forcing parents to choose between their ability to remain with or reunite their family and accessing critical benefits is short-sighted and will harm the current and future health of our nation.

Individuals with Disabilities

The proposed regulations would create significant hardships for and discriminate against lawful immigrants with disabilities by denying them an opportunity to benefit from an adjustment in their immigration status equal to that available to immigrants without disabilities. Under the proposal, the Department will consider a wide range of medical conditions, many of which constitute disabilities, as well as the existence of disability itself, in determining whether an immigrant is likely to become a public charge. Although DHS states that disability will not be the "sole factor," in that determination, the Department fails to offer any accommodation for individuals with disabilities and instead echoes the types of bias and "archaic attitudes" about disabilities that the Rehabilitation Act was meant to overcome.

Federal law prohibits disability discrimination by its executive agencies, requiring that they provide reasonable accommodation to disabled individuals so they cannot be denied meaningful access to agencies' services and benefits, including immigration benefits, based on their disabilities. However, the proposal would also discriminate against people with disabilities by defining an immigrant as a public charge for using (for the specified periods and amounts) non-cash benefits which individuals with disabilities rely on disproportionately, often due to their disability and the discrimination they experience because of it. For example, about one-third of adults under age 65 enrolled in Medicaid have a disability, compared with about 12 percent of adults in the general population. Many of these individuals are eligible for Medicaid, and unable to obtain private insurance, precisely because of their disability. Likewise, more than one-quarter of people who use SNAP benefits for nutritional support also have disabilities. Many of these individuals rely upon such benefits so that they can continue to work, stay healthy, and remain productive members of the community.

By deeming immigrants who use such programs as a public charge, the regulations will disparately harm individuals with disabilities and impede their ability to maintain the very self-sufficiency the Department purports to promote and which the Rehabilitation Act sought to ensure. Because many critical disability services are only available through Medicaid, the rule will prevent many people with disabilities from getting needed services that allow them to manage their medical conditions, participate in the workforce, and improve their situation over time.

³¹ Ibid.

Seniors

The number of seniors in the United States who are immigrants is growing. Between 1990 and 2010, the number of immigrants age 65 and older grew from 2.7 million to nearly five million. This increase is due to aging of the immigrant population who arrived during the 1980s and 90s, as well as the rise in naturalized citizens who sponsor their parents to immigrate to the U.S. In fact, the number of parents of U.S. citizens who have been admitted as legal permanent residents nearly tripled between 1994 and 2017 and now account for almost 15 percent of all admissions and almost 30 percent of family-based admissions.³²

The proposed rule will undoubtedly impact seniors living in immigrant families in the U.S. who will be afraid to access services they need. More than 1.1 million noncitizens ages 62 and older live in low-income households, meaning they are likely to rely on public assistance programs to meet their basic needs.³³ Having health insurance is especially important for older adults because they have greater health care needs. Medicare is a lifeline for most seniors, providing coverage for hospital, doctors' visits, and prescription drugs, but many immigrant seniors are not eligible for Medicare.

Many low-income seniors also rely on the Medicaid program, which as previously stated would also be considered as part of the public charge determination under the proposed rule. Over 11.7 million seniors in Medicare are dual-eligibles who also qualify for Medicaid, and 68 percent of these individuals have three or more chronic health conditions.³⁴ Medicaid helps low-income seniors access services that Medicare does not cover as well as helps cover cost-sharing for services so that they can afford the care that they need. These seniors should not have to choose between their health care coverage and their immigration status.

The proposed rule would also penalize older, low-income immigrants by considering use of the Medicare Part D Low-Income Subsidy (LIS) program as part of the public charge determination. This program helps low-income seniors with premiums, deductibles and copayments to afford coverage of their prescription drugs. Almost 1 in 3 Medicare beneficiaries enrolled in Part D prescription drug coverage also use the low-income subsidy.³⁵ This coverage is essential for seniors with serious, acute and chronic health conditions. Medications can cure life-threatening illnesses or help manage chronic diseases like cardiovascular disease, diabetes, autoimmune diseases and lung disease, often helping to avoid emergency room visits or hospitalizations. Moreover, reducing out-of-pocket costs has been identified as a key factor in improving medication adherence, and consequently improving health outcomes and reducing health care costs.³⁶ By deterring legal immigrants and non-immigrants with an immigrant family member from using this program, the proposed rule could lead seniors to forgo

³² [Department of Homeland Security. 2016 Yearbook of Immigration Statistics. November 2017. www.dhs.gov/sites/default/files/publications/2016%20Yearbook%20of%20Immigration%20Statistics.pdf](https://www.dhs.gov/sites/default/files/publications/2016%20Yearbook%20of%20Immigration%20Statistics.pdf)

³³ Manatt. *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard*. October 11, 2018. <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population#DataDashboard>. Accessed December 3, 2018.

³⁴ CMS Fact Sheet: People Enrolled in Medicare and Medicaid. February 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

³⁵ Kaiser Family Foundation. Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing. May 2018, www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/

³⁶ Eddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes: a literature review. *Pharmacy and Therapeutics*. 2012; 37: 45-55

medications and ultimately lead to these more expensive outcomes. Our organizations recommend that DHS exclude receipt of LIS subsidies from the final rule.

Providers & Workforce

In the proposed rule, the Department recognizes that the proposed changes would have a detrimental impact on “state and local economies, large and small businesses, and individuals.”³⁷ However, we believe the Department greatly underestimates just how much of a damaging effect the rule would have on the health care workforce, research, and local economies.

Many of the individuals and families our organizations represent rely on a wide variety of health care professionals, including many who are foreign born, and come to the US to pursue careers in medicine and science in addition to serving in the health care workforce. In fact, one in four of America’s doctors is foreign born.³⁸ Many of these doctors are admitted to and stay in the country via temporary work and exchange visa categories that would be subject to public charge under the proposed rule. With the increasing shortage of medical specialists and home care workers, we fear for America’s future patients living with chronic or serious health conditions. The proposed policy may further discourage or prevent those interested in seeking educations and careers in this area from pursuing them, further contributing to this shortage of care. In their 2018 report on physician supply and demand in the US, the Association of American Medical Colleges describes worsening shortages of physicians overall, especially among certain medical specialty areas.³⁹

Further, a full 25 percent of home health aides are foreign-born and a third receive public benefits.⁴⁰ If these workers forego health coverage, they will miss more days of work, burdening their employers and the vulnerable people for whom they provide care. Moreover, it is widely recognized that there will be an increased need for home care workers as the U.S. population ages. If candidates for these critically important but low-wage jobs are denied admission on public charge grounds or are unable to extend or change their nonimmigrant status due to low incomes, vulnerable seniors and others who rely on home health care may be forced to leave their homes to receive more expensive care in nursing homes.

As discussed previously, the Medicaid program is an indispensable funding source for families, but it is also critical to supporting safety-net hospitals and clinics which are financially vulnerable. More than 35 percent of visits to safety-net hospitals are covered by Medicaid. Further, Medicaid is the single largest source of funding for community health centers in both Medicaid expansion and non-expansion states. In California, where one of every two children have an immigrant parent, more than half of all children are enrolled in the state’s Medicaid program.⁴¹ There is a direct relationship between the number of patients covered by Medicaid in a safety-net facility’s service area and the facility’s financial health. Community Health Centers in Medicaid expansion states have more locations, see more

³⁷ Ibid.

³⁸ Migration Policy Institute. *Foreign-Born Health Care Workers in the United States*. June 27, 2012. <https://www.migrationpolicy.org/article/foreign-born-health-care-workers-united-states>. Accessed December 3, 2018.

³⁹ https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

⁴⁰ PHI. U.S. Home Health Care Workers: Key Facts. <https://phinational.org/wp-content/uploads/legacy/phi-home-care-workers-key-facts.pdf>. Accessed December 3, 2018.

⁴¹ California Department of Health Care Services Research and Analytic Studies Division. January 2016. Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group – September 2015. Medi-Cal Statistical Brief.

patients, and have better provider to patient ratios as compared to non-expansion states.⁴² Studies confirm a strong relationship between Medicaid coverage and hospital closures, with hospitals in Medicaid expansion states 84 percent less likely to close than those in non-expansion states.⁴³

The impact of hospital closure on access to care is particularly significant in rural communities, which generally have difficulty attracting health care providers and from which providers often relocate in the wake of a hospital closure. The effects of hospital closures extend beyond reduced access to health care and poorer health outcomes. Hospitals are major employers and purchasers of goods and services. The loss of jobs associated with a hospital closure is especially devastating in rural areas, which have smaller populations and a historic reliance on declining industries. Moreover, some industries and employers will not locate in an area without a hospital, leaving communities without hospitals unable to attract some employers. We have ongoing and serious concerns that the implications of this rule could result in a decrease of immigrant medical providers, particularly in these high needs areas, creating a cascading effect that would result in hospital closures, loss of employment for support industries, and lack of access to care for all people living in the community.

CHIP

The proposed rule requests specific feedback on the inclusion of the Child Health Insurance Program (CHIP) in the determination process. CHIP is a program for working families who earn too much to be eligible for Medicaid. Making the receipt of CHIP a negative factor in the public charge assessment or including it in the “public charge” definition would exacerbate the problems with this rule by extending its reach further to exclude moderate income working families – and applicants likely to earn a moderate income at some point in the future.

Including CHIP in a public charge determination would likely lead to many eligible children foregoing health care benefits, both because of the direct inclusion in the public charge determination as well as the chilling effect detailed earlier. More than 9 million children across the U.S. depend on CHIP for their health care.⁴⁴ Due to the predicted chilling effect, many eligible citizen children likely would forego CHIP—and health care services altogether—if their parents think enrolling them could subject the family to a public charge determination.

In addition to the great harm that would be caused by the inclusion of CHIP, this would be counter to Congress’ explicit intent in expanding coverage to lawfully present children and pregnant women. Section 214 of the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) gave states a new option to cover, with regular federal matching dollars, lawfully residing children and pregnant women under Medicaid and CHIP during their first five years in the U.S.⁴⁵ This was enacted because Congress recognized the public health, economic, and social benefits of ensuring that these populations have access to care.

⁴² Community Health Centers: Recent Growth and the Role of the ACA. Kaiser Family Foundation Issue Brief, 2017. <https://www.kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/>

⁴³ Health Affairs Jan 2018 <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0976>
Understanding The Relationship Between Medicaid Expansions And Hospital Closures

⁴⁴ <https://www.medicaid.gov/chip/index.html>

⁴⁵ 111-3 U.S.C. § 214

Continuous, consistent coverage without disruptions is especially critical for young children, as experts recommend 16 well-child visits before age six, more heavily concentrated in the first two years, to monitor their development and address any concerns or delays as early as possible.⁴⁶ CHIP makes this care possible for millions of children each year. As noted by the Georgetown Center for Children and Families: a child’s experiences and environments early in life have a lasting impact on his or her development and life trajectory. The first months and years of a child’s life are marked by rapid growth and brain development.⁴⁷

We are also concerned that DHS notes that the reason it does not include CHIP in the proposed rule is that CHIP does not involve the same level of expenditures as other programs that it proposes to consider in a public charge determination and that noncitizen participation is relatively low. The question of which programs to include should not consider government expenditures. Whether or not there is a large government expenditure on a particular program is irrelevant to the assessment of whether a particular individual may become a public charge. A public charge determination must be an individualized assessment, as required by the Immigration and Nationality Act, and not a backdoor way to try to reduce government expenditures on programs duly enacted by Congress.

Overall, we believe the benefits of excluding CHIP and Medicaid certainly outweigh their inclusion in a public charge determination. We recommend that DHS continue to exclude CHIP from consideration in a public charge determination in the final rule but also exclude receipt of Medicaid for the same reasons.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable health care regardless of their income, geographic location, or immigration and citizenship statuses. We appreciate the opportunity to provide our recommendations on the proposed rule.

Given the substantial negative impact on the populations we serve, we urge the Department to immediately withdraw this proposed rule and dedicate its efforts to advancing policies that strengthen—rather than undermine—the ability of immigrants to support the health and well-being of themselves and their families, and contribute to this country. Thank you for the opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Heart Association
American Lung Association
Cystic Fibrosis Foundation
Family Voices
Global Healthy Living Foundation
Hemophilia Federation of America

Leukemia & Lymphoma Society
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Multiple Sclerosis Foundation

⁴⁶ Elisabeth Wright Burak, Georgetown Center for Children and Families, *Promoting Young Children’s Healthy Development in Medicaid and the Children’s Health Insurance Program (CHIP)*, Oct. 2018, <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>.

⁴⁷ Ibid.

National Patient Advocate Foundation
WomenHeart: the National Coalition for
Women with Heart Disease
Crohn's & Colitis Foundation