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U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts NW
Washington, DC 20529

**Attn: CIS No. 2499-10; DHS Docket No. USCIS- 2010-0012
Inadmissibility on Public Charge Grounds**

Thank you for the opportunity to comment on the Department of Homeland Security's (DHS) Inadmissibility on Public Charge Grounds proposed rule. The National Health Law Program, founded in 1969, protects and advances health rights of low-income and underserved individuals and families by advocating, educating, and litigating at the federal and state levels.

The National Health Law Program strongly opposes the proposed rule because it would erect insurmountable barriers to the ability of immigrants and citizens to access and use public benefits programs for which they are lawfully eligible. The proposed rule would drastically change the definition of what it means to be a "public charge" by expanding the test to consider immigrants' use of public benefits beyond those used for subsistence. It would improperly penalize immigrants who use supplemental public benefits to augment their standard of living and ultimately achieve self-sufficiency. This would create a broad chilling effect whereby both immigrants and citizens, especially women and citizen-children, disenroll from or forego enrollment in public benefits. The resulting follow-on effects would needlessly harm individuals' and families' health and well-being, the greater public health, the U.S. economy, and the public budget.

The proposed rule would undo decades of policy work that improved benefits administration and eligibility processes for such programs. Access to public benefits, such as Medicaid, have been streamlined, and their use by eligible individuals encouraged, largely due to the positive public health and societal effects they have.¹ No person should have to question whether accessing health care that they need would adversely impact their immigration status or ability to remain in the U.S.

Furthermore, the proposed rule would contradict longstanding law and practice governing public charge determinations, Congressional intent to enable immigrants' access to public benefits, and available evidence regarding the efficacy of DHS' current approach. The justifications DHS gives for its proposed rule are unsupported by its authorizing statute, and DHS largely ignores the overwhelming evidence in opposition to its justifications for the proposed rule. Furthermore, DHS fails to adequately account for the proposed rule's significant adverse social and economic costs in its analysis.

Health care is a human right and society should reduce barriers to accessing it rather than build new ones. The unaffordability of health care services, even with insurance, remains a challenge for individuals across the socioeconomic spectrum. Medicaid provides a crucial source of insurance to many for whom, due to market failures, insurance is not offered through employment or is not affordable on the private marketplace. To promote the general health and well-being of the population, it is essential that the U.S. fosters a culture of access and openness to seeking health care services, no matter an individual's country of origin, income, illness, disability, age, gender, gender identity, sexual orientation, or immigration status. This proposed rule flies in the face of such principles that have been embedded in U.S. public benefits administration practice, law, and regulation.

Given the proposed rule's significant adverse effects on individuals' well-being, the greater public health, and the public budget, its contravention of established law and practice, and its lack of supporting evidence, DHS should immediately withdraw its proposed rule.

We have provided our specific comments below.

¹ See generally CMS, *Medicaid & CHIP: Strengthening Coverage, Improving Health* (2017), <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>; Kaiser Family Found., *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act* (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8445-key-lessons-from-medicaid-and-chip.pdf>.

I. MEDICAID'S IMPORTANCE TO SOCIETY

We strongly oppose the proposed rule's inclusion of Medicaid in the definition of "public benefit" for public charge determinations because Medicaid coverage is not evidence of a lack of self-sufficiency. Instead, Medicaid coverage is an essential source of health insurance, enables enrollees to work and participate in their communities, and supports the greater public health.

- a. *Medicaid is an essential source of health insurance for low-income individuals and families, children, pregnant women, individuals with disabilities, and other underserved population groups.*

Medicaid is the country's most inclusive health care program, providing high quality, affordable health coverage to more than 75 million individuals² – one-fifth of the U.S. population – including 25 million women.³ More than a third of children in the U.S. receive coverage through either Medicaid or CHIP;⁴ among this population, more than 90 percent are insured through Medicaid.⁵ And while children comprise the largest group of Medicaid beneficiaries at over 40 percent, they only account for a fifth of Medicaid expenditures.⁶

The Medicaid program enables states to provide a wide range of federally-specified preventive, acute, and long-term health care services, in addition to various optional services as determined by each state, to individuals who qualify for program eligibility. The program is based on a principle that those eligible for Medicaid are guaranteed coverage through the program.⁷

² Kaiser Family Found., *Medicaid in the United States* (2017), <http://files.kff.org/attachment/fact-sheet-medicaid-state-US>.

³ *Id.*

⁴ Joan Alker & Alisa Chester, *Children's Health Coverage Rate Now at Historic High of 95 Percent*, GEORGETOWN CTR. FOR CHILDREN & FAMILIES (2016), <https://ccf.georgetown.edu/2016/10/26/childrens-health-coverage-rate-now-at-historic-high-of-95-percent/>.

⁵ Medicaid and CHIP Payment and Access Comm'n ("MACPAC"), *MACStats: Medicaid and CHIP Data Book* (2016), <https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-CHIP-Data-Book-December-2017.pdf>.

⁶ HHS, Centers for Medicare and Medicaid Services ("CMS"), Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>.

⁷ Robin Rudowitz & Rachel Garfield, *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAMILY FOUND. (2018), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>.

Medicaid has grown since its inception to cover low-income individuals and numerous underserved populations. Medicaid expansion, in particular, has produced gains in coverage among the low-income population, reducing uninsurance and health disparities by income, age, race, and ethnicity.⁸ These trends hold true for immigrants as much as they do for citizens.⁹ Most recently, 37 states (including D.C.) have expanded Medicaid to low-income adults earning up to 138 percent of the Federal Poverty Level (FPL), providing coverage to millions of additional low-income workers, students, parents, and single adults. Medicaid expansion addressed high uninsurance rates among low-income adults who lacked access to affordable, comprehensive private health insurance through their employers or on the individual marketplace.¹⁰

Numerous studies have shown that sharp declines in rates of uninsurance among the low-income population are due to wider availability of Medicaid coverage.¹¹ Medicaid now covers one in seven adults, two in five children, three in five nursing home residents, almost half of the population of individuals with disabilities, and a fifth of all Medicare beneficiaries.¹²

Coverage gains are especially notable for various vulnerable subpopulations, such as for:

“young adults, prescription drug users, people with HIV, veterans, parents, mothers, women of reproductive age (with and without children), children, lesbian, gay, and bisexual adults, newly diagnosed cancer patients, women diagnosed with a gynecologic malignancy, low-income workers, low-educated adults, early retirees, and childless adults with incomes under 100% FPL.”¹³

Insurance coverage in general, including Medicaid and other sources of insurance coverage indirectly impacted by the proposed rule, is essential to maximizing access to appropriate health care. In particular, Medicaid is important because it fills gaps in private coverage for low-income people, enabling them to save more of their income, access

⁸ Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUND. (2018) <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

⁹ Jim P. Stimpson & Fernando A. Wilson, *Medicaid Expansion Improved Health Insurance Coverage For Immigrants, But Disparities Persist*, HEALTH AFFAIRS (2018), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0181>.

¹⁰ Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAMILY FOUND. (2018), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

¹¹ Antonisse et al., *supra* note 8.

¹² Kaiser Family Found., *supra* note 2.

¹³ Antonisse et al., *supra* note 8.

primary and preventative care (including prenatal care), and manage chronic conditions.¹⁴ As the Kaiser Family Foundation explains, “by enabling families to meet their health care needs, Medicaid supports families’ ability to work and care for their children.”¹⁵

b. *Medicaid improves enrollees’ access to care and medical assistance.*

Medicaid covers a broad range of health care treatment and services for low-income individuals, families, and underserved communities. Federal law requires every state Medicaid program cover a set of “mandatory” services, and states also cover additional “optional” services. By providing coverage to large portions of the low-income and underserved populations, Medicaid enables enrollees to access medical assistance to prevent, treat, and manage health conditions.

Medicaid enables enrollees to seek important preventative care by increasing access to available sites of care, as compared to being uninsured.¹⁶ The vast majority of providers accept new Medicaid patients, and access to care through Medicaid is comparable to private insurance according to key measures of access.¹⁷ Nearly 95 percent of children¹⁸ and 90 percent of non-elderly adults¹⁹ covered by Medicaid have a usual source of care,²⁰ similar rates to those with private insurance.²¹ Children and adults covered by Medicaid also have comparable rates of using preventive services, such as well-child visits and cancer screenings, respectively.²² Particularly important due to the high rate of preventable

¹⁴ Kaiser Family Found., *Proposed Changes to “Public Charge” Policies for Immigrants: Implications for Health Coverage* (2018), <http://files.kff.org/attachment/Issue-Brief-Proposed-Changes-to-Public-Charge-Policies-for-Immigrants-Implications-for-Health-Coverage>.

¹⁵ *Id.*

¹⁶ America’s Health Insurance Plans, *The Value of Medicaid: Access to Care and Preventive Care Services* (2018), https://www.ahip.org/wp-content/uploads/2018/04/Medicaid_onepager.pdf.

¹⁷ Julia Paradise, *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid*, KAISER FAMILY FOUND. (2017), <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>.

¹⁸ Ctrs. for Disease Control (“CDC”), *Table 61 (page 1 of 2). No usual source of health care among children under age 18, by selected characteristics: United States, average annual, selected years 1993–1994 through 2013–2014* (2015), <https://www.cdc.gov/nchs/data/hus/2015/061.pdf>.

¹⁹ CDC, *Table 62 (page 1 of 2). No usual source of health care among adults aged 18–64, by selected characteristics: United States, average annual, selected years 1993–1994 through 2013–2014* (2015), <https://www.cdc.gov/nchs/data/hus/2015/062.pdf>.

²⁰ Leighton Ku et al., *Data Note: Medicaid’s Role in Providing Access to Preventive Care for Adults*, KAISER FAMILY FOUND. (2017), <https://www.kff.org/medicaid/issue-brief/data-note-medicoids-role-in-providing-access-to-preventive-care-for-adults/>; America’s Health Insurance Plans, *supra* note 16; Benjamin D. Sommers et al., *Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance*, 176 JAMA INTERN MED. (2016), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420>.

²¹ Paradise, *supra* note 17.

²² *Id.*

and controllable conditions among the low-income population, Medicaid increases access to preventative care, especially diagnostic screenings.²³ For example, women on Medicaid use primary and preventive health services at rates comparable to women with private insurance, and at higher rates than uninsured women.²⁴

Use of these preventive services translates to earlier detection of disease and illness across age groups, and access to providers through Medicaid improves the likelihood that enrollees will receive proper and timely treatment for their conditions.²⁵ Research shows better access to primary care through Medicaid leads to more utilization of ambulatory sites of care and improved medication adherence.²⁶ It also improves rates of diagnosis, leads to more consistent care for chronic conditions, and enhances the probability of receiving optimal surgical care.²⁷ Systematic reviews of the literature find that Medicaid generally supports these findings, explaining why Medicaid enrollees better manage chronic conditions than do uninsured individuals.²⁸

Medicaid's role is especially important for pregnant women and children, as the program covers nearly half of all births.²⁹ A child's well-being is inseparable from their parents' and families' well-being, so help received by parents is central to children's health and well-being in the short- and long-term. Nearly all states have recognized Medicaid's critical role as a provider of maternal and infant care, and raised the income eligibility threshold for pregnant women and young children well above the limit for non-pregnant adults.³⁰ Indeed, some states have income eligibility rates for pregnant women that are over twice as high as those for non-pregnant adults.³¹

²³ Benjamin D. Sommers et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017), <https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645>; Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*. 368 NEW ENG. J. MED. 1713 (2013), <https://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321>.

²⁴ Kaiser Family Found., *Medicaid's Role for Women* (2017), <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

²⁵ Health.gov, Office of Disease Prevention and Health Promotion, *Healthy People 2020: Access to Health Services* (2018), <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services#7> (last visited December 6, 2018, 10:35 AM); Paradise, *supra* note 17; Baicker et al., *supra* note 23.

²⁶ Sommers et al., *supra* note 23.

²⁷ Antonisse et al., *supra* note 8.

²⁸ Sommers et al., *supra* note 23.

²⁹ Robin Rudowitz & Rachel Garfield, *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAMILY FOUND. (2018), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>; Kaiser Family Found., *supra* note 24

³⁰ See CMS, *Medicaid, CHIP, and BHP Eligibility Levels*, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html> (last visited Dec. 6, 2018, 4:00 PM).

³¹ *See Id.*

Medicaid supports access to appropriate and comprehensive prenatal services, and pregnant women's access to Medicaid is associated with better health outcomes for children through adulthood.³² This includes lower rates of obesity, fewer hospitalizations, and better oral health,³³ while composite measures of health indices show health improvements extend into adulthood.³⁴ Medicaid eligibility earlier in childhood is associated with lower prevalence of high blood pressure, diabetes, heart disease, and obesity,³⁵ in addition to decreased infant, child, and teen mortality.³⁶ Furthermore, research shows that the more years a child is eligible for Medicaid, as compared to being uninsured, the fewer hospitalizations they are likely to have as an adult.³⁷ This is especially true for children of color.³⁸ Such effects are due to Medicaid's nullification of the potential exposure to toxic stress, substandard health care, and other adverse experiences that can affect health later in life as a result of child poverty.³⁹ Medicaid coverage leads to better socioeconomic mobility for children,⁴⁰ allowing them to transition off Medicaid and become fully independent later in life.

Improved access to care through Medicaid provides short- and long-term health benefits to a broader set of enrollees as well. This includes fewer hospitalizations and emergency department visits,⁴¹ reduced rates of disability,⁴² improved oral health,⁴³ lower rates of

³² Karina Wagnerman et al., *Medicaid Is A Smart Investment in Children*, GEORGETOWN CTRS. FOR CHILDREN AND FAMILIES (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf>.

³³ *Id.* See also Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage*, J. HUMAN RESOURCES (2018).

³⁴ Michael H. Boudreaux et al., *The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program's Origin*, 45 J. HEALTH ECON. 161 (2016); Wagnerman et al., *supra* note 32.

³⁵ Wagnerman et al., *supra* note 32; Andrew Goodman-Bacon, *Public Insurance and Mortality: Evidence from Medicaid Implementation*, 126 J. POLITICAL ECON. 216 (2018).

³⁶ Wagnerman et al., *supra* note 32; Goodman-Bacon, *supra* note 35; Bruce D. Meyer & Laura R. Wherry, *Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility*, Working Paper 18309, NAT'L BUREAU OF ECON. RES. (2012), <https://www.nber.org/papers/w18309>.

³⁷ Paradise, *supra* note 17.

³⁸ Wherry et al., *Childhood Medicaid Coverage and Later Life Health Care Utilization*, Working Paper 20929, NAT'L BUREAU OF ECON. RES. (2015), <https://www.nber.org/papers/w20929.pdf>.

³⁹ Wagnerman et al., *supra* note 32.

⁴⁰ Miller & Wherry, *supra* note 33.

⁴¹ Wherry et al., *supra* note 38.

⁴² Andrew Goodman-Bacon, *The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes*, Working Paper 22899, NAT'L BUREAU OF ECON. RES. (2016), <https://www.nber.org/papers/w22899.pdf>.

⁴³ Wagnerman et al., *supra* note 32. See also Miller & Wherry, *supra* note 33.

depression,⁴⁴ and lower rates of obesity,⁴⁵ among other benefits. Even mere eligibility for Medicaid is associated with these improved health outcomes.⁴⁶

c. *Medicaid improves individuals' and families' financial health and bolsters their financial security, thereby enhancing the economy and the public budget in the long term.*

i. **Medicaid coverage improves enrollees' financial health, reducing their use of government supports and contributing to their increased tax contributions over time.**

Medicaid coverage supplements individuals' income and provides a pivotal source of health insurance to enrollees who otherwise would not have affordable, comprehensive coverage. This is true across populations covered by Medicaid, but is particularly visible for low-income workers and their families. Medicaid makes health care more affordable and reduces financial strain on families.⁴⁷ The positive effects Medicaid has on such enrollees' health behaviors, access to care, and health outcomes, and ultimately on population health,⁴⁸ produces compound socioeconomic benefits.

Access to affordable health insurance, such as Medicaid, enables workers to find and retain employment.⁴⁹ Sixty percent of adult Medicaid enrollees work,⁵⁰ and many, if not most, Medicaid beneficiaries are low-wage workers who lack affordable individual marketplace or employer-sponsored coverage options. Most working Medicaid enrollees

⁴⁴ Baicker et al., *supra* note 23.

⁴⁵ Boudreaux et al., *supra* note 34.

⁴⁶ See Wherry et al., *supra* note 38.

⁴⁷ Melissa Majerol et al., *Health Care Spending Among Low-Income Households with and without Medicaid*, KAISER FAMILY FOUND. (2016), <http://files.kff.org/attachment/issue-brief-health-care-spending-among-low-income-households-with-and-without-medicaid>; Aaron Carroll, *Medicaid as a Safeguard for Financial Health*, JAMA FORUM (Nov. 28, 2018), <https://newsatjama.jama.com/2018/11/28/jama-forum-medicaid-as-a-safeguard-for-financial-health/>; Sarah Miller et al., *The ACA Medicaid Expansion in Michigan and Financial Health*, Working Paper 25053, NAT'L BUREAU OF ECON. RES. (2018), <https://www.nber.org/papers/w25053.pdf>.

⁴⁸ Sara R. Collins et al., *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, THE COMMONWEALTH FUND (2016), https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2016_may_1879_collins_americans_experience_aca_marketplace_feb_april_2016_tb.pdf.

⁴⁹ Larisa Antonisse & Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review*, KAISER FAMILY FOUND. (2018), <http://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review>.

⁵⁰ Kaiser Family Found., *supra* note 2.

work, but their income is still low enough to qualify for Medicaid;⁵¹ this is characteristic of insurance coverage in the low-wage job market. The unstable nature of the low-wage job market is also associated with adverse health effects among its workers.⁵² A lack of alternative affordable insurance options leads to increased barriers to accessing care, worse health outcomes, and subsequent increased risk of job loss among this population.⁵³ Similarly, unmet mental and behavior health needs further increase the risk of joblessness.⁵⁴

Medicaid acts as pivotal safeguard against unmet health care needs, enabling low-wage workers to access important preventative, acute, and long-term health care services. Individuals with such health conditions can thereby access and obtain needed care, and successfully seek and maintain employment. Medicaid acts as a support for this entire category of workers as they move between jobs, seek higher-paying employment, or build up savings to improve their economic well-being. Medicaid also protects low-income individuals and families against the prospect of unpredictable and unexpected high medical costs that could otherwise consume a large portion of their finances.⁵⁵

The improved financial security that Medicaid engenders allows enrollees to spend the little money they do have on better quality food and housing.⁵⁶ Out-of-pocket health care expenses no longer crowd out such daily expenses for those with Medicaid coverage.⁵⁷ As evidenced by both pre-expansion research and evaluations of Medicaid expansion versus states that did not expand, Medicaid coverage is associated with spending less out-of-pocket on health care, having fewer medical needs that go unaddressed due to cost, and having less trouble paying for current and future health care bills.⁵⁸ For states that have expanded Medicaid, the percentage of people with medical debt, the average size of medical debt, the probability of new bankruptcy filings, and the number and frequency of

⁵¹ Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work*, KAISER FAMILY FOUND. (2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

⁵² Antonisse & Garfield, *supra* note 49.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Sommers et al., *supra* note 23. See also Margot Sanger-Katz, *1,495 Americans Describe the Financial Reality of Being Really Sick*, N.Y. TIMES (Oct. 17, 2018), <https://www.nytimes.com/2018/10/17/upshot/health-insurance-severely-ill-financial-toxicity-.html>.

⁵⁶ Wagnerman et al., *supra* note 32.

⁵⁷ *Id.*

⁵⁸ Robin Rudowitz & Larisa Antonisse, *Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence*, KAISER FAMILY FOUND. (2018), http://nasuad.org/sites/nasuad/files/KFF_Implications-of-the-ACA-Medicaid-Expansion_May-2018.pdf; Luoia Hu et al., *The effect of the affordable care act Medicaid expansions on financial wellbeing*, 163 J. PUB. ECON. 99 (2018), <https://www.nber.org/papers/w22170.pdf>; Sommers et al., *supra* note 23.

medical bills going to collections have all decreased, while credit scores have improved.⁵⁹ The financial benefits of Medicaid expansion were experienced across age groups.⁶⁰ Such measures indicate that Medicaid coverage improves individual financial health and stability, as has been shown across states.⁶¹ State-specific and national studies have demonstrated that expansion of Medicaid coverage through the ACA also leads to growth in jobs with average pay higher than the poverty level.⁶² Succinctly, Medicaid coverage makes it easier for enrollees to seek employment and to keep working.⁶³ These findings are linked to more stable household finances.⁶⁴ The research consistently shows that Medicaid receipt is associated with improved financial well-being, not a lack of self-sufficiency.

Such beneficial effects from Medicaid are not limited to only newly eligible individuals or to adults who receive Medicaid. Receipt of Medicaid as a child is also demonstrated to produce economic benefits for the entire family, including decreased probability of familial debt and bankruptcy.⁶⁵ Childhood Medicaid also leads to improved educational outcomes at each level of learning, higher rates of finishing high school and college, and increased rates of employment later in life.⁶⁶ Once again, Medicaid coverage is associated with improved financial well-being later in life, and does not evidence a lack of self-sufficiency.

Medicaid's positive effect on enrollees' overall financial health subsequently increases enrollees' tax contributions and decreases their reliance on cash assistance programs, those which have been subject to public charge determinations under the framework currently in place.⁶⁷ Research demonstrates that childhood Medicaid eligibility is associated

⁵⁹ Rudowitz & Antonisse, *supra* note 58. See also Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, MEDICAL CARE RES. & REV. (2017), <https://journals.sagepub.com/doi/pdf/10.1177/1077558717725164>.

⁶⁰ Hu et al., *supra* note 58.

⁶¹ Miller et al., *supra* note 47; Ohio Dept. of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (2016), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

⁶² Antonisse et al., *supra* note 8.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ See Boudreaux et al., *supra* note 34; Tal Gross & Matthew Notowidigdo, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, J. PUB. ECON. 767 (2011); Wagnerman et al., *supra* note 32.

⁶⁶ Wagnerman et al., *supra* note 32. Sarah Cohodes et al., *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, Working Paper 20178, NAT'L BUREAU OF ECON. RES. (2014), <http://www.nber.org/papers/w20178>.

⁶⁷ Aparna Soni et al., *Medicaid Expansion And State Trends In Supplemental Security Income Program Participation*, 36 HEALTH AFFAIRS 1685 (2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1632>; Marguerite Burns & Laura Dague, *The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation*, 149 J. PUB. ECON. 20 (2017).

with higher earnings and increased cumulative tax payments in adulthood.⁶⁸ Each additional year of eligibility from birth to age 18 is associated with almost \$200 more in cumulative tax payments and a near-\$100 reduction in Earned Income Tax Credit (EITC) receipts at age 28.⁶⁹ Medicaid’s positive socioeconomic and fiscal effects are especially pronounced for women. Research shows that receipt of Medicaid in childhood especially improves women’s rates of employment and annual wages, and reduces the need for and use of public assistance later in life.⁷⁰ By age 28, each additional year of Medicaid eligibility for girls increases their cumulative adulthood wage by approximately \$650 and their cumulative tax payment by almost \$250, while decreasing EITC payments by over \$100.⁷¹ Childhood Medicaid eligibility also increases the number of individuals in paid employment and reduces receipt of government funded insurance and disability transfer payments later in life.⁷²

In 2010 alone, Medicaid lifted approximately 2.6 million to 3.4 million individuals above the poverty line and into a more secure financial environment.⁷³ These effects are especially pronounced for communities of color, women, and children – groups comprising a disproportionate share of Medicaid enrollment.⁷⁴

These positive fiscal effects lead to an annual return on the government’s Medicaid investment of between two and seven percent, two-thirds of which are attributable to lower public assistance cash payments in adulthood.⁷⁵ The most recent study of Medicaid’s fiscal effects shows that in raw returns, “the government recoups 57 cents of each dollar it spends on childhood Medicaid by age 28.”⁷⁶ But when accounting for benefits other than raw tax contributions, such as decreased mortality, childhood Medicaid coverage “delivers benefits equal to three times its costs by age 28.”⁷⁷ Viewed together, these studies

⁶⁸ David W. Brown et al., *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?*, Working Paper 20835, NAT’L BUREAU OF ECON. RES. (2015), <https://www.nber.org/papers/w20835.pdf>.

⁶⁹ *Id.* at 16.

⁷⁰ *Id.*; Goodman-Bacon, *supra* note 42.

⁷¹ Leah Zallman et al., *Immigrants Pay More In Private Insurance Premiums Than They Receive In Benefits*, 37 HEALTH AFFAIRS 1663 (2018).

⁷² Goodman-Bacon, *supra* note 42; Wagnerman et al., *supra* note 32.

⁷³ Benjamin D. Sommers & Donald Oellerich, *The Poverty-Reducing Effect of Medicaid*, 35 J. HEALTH ECON. 816 (2013); Dahlia K. Remler et al., *Estimating The Effects Of Health Insurance And Other Social Programs On Poverty Under The Affordable Care Act*, 36 HEALTH AFFAIRS 1828 (2017).

⁷⁴ Sommers & Oellerich, *supra* note 73; Remler et al., *supra* note 73.

⁷⁵ Goodman-Bacon, *supra* note 42; Wagnerman et al., *supra* note 32.

⁷⁶ David W. Brown et al., *Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood*, YALE DEPT. OF ECON. (June 22, 2018), <http://www.econ.yale.edu/~ak669/medicaid.latest.draft.pdf>.

⁷⁷ *Id.*

demonstrate that encouraging both parents' and children's enrollment in Medicaid produces net positives for the public budget over time both by increasing revenue collection and by decreasing government expenditures for incomes supports and costs of delayed and uncompensated care.

ii. **Medicaid produces positive economic effects for surrounding communities and states through its “multiplier effect” which subsequently bolsters the public budget.**

By providing a platform that promotes health and keeps residents from falling into extreme poverty, Medicaid allows residents to contribute more to the local economy and to pay more in taxes than they would have without receiving Medicaid. Substantial research provides clear evidence supporting Medicaid's beneficial economic effects, especially at the state and local levels. This is called Medicaid's “multiplier effect,” the cycle by which receipt of Medicaid frees individuals and families to spend money within their communities at places such as restaurants, grocery stores, and retail stores.⁷⁸ Individuals and families would otherwise spend such funds on health care services.⁷⁹ Long before the ACA was enacted, research showed that Medicaid spending stimulates state-level economic activity in the form of more jobs, income, and tax revenues.⁸⁰

States' experience with Medicaid expansion provides further evidence of the positive economic and fiscal effects that public benefits programs can have on the public budget. Expanding Medicaid boosts states' employment rates, increases states' economic output, and generates state budget savings due to offsets in other state expenditures, such as uncompensated care.⁸¹ States then reap increased tax revenues from individuals' higher incomes and from the economic activity generated in turn by increased levels of spending in the community.⁸² Medicaid expansion states, such as Michigan, have experienced

⁷⁸ Michael E. Chernew, *The Economics of Medicaid Expansion*, HEALTH AFFAIRS BLOG (Mar. 21, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>.

⁷⁹ *Id.*

⁸⁰ See Kaiser Family Found., *The Role of Medicaid in State Economies: A Look at the Research* (2004), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-role-of-medicaid-in-state-economies-a-look-at-the-research-policy-brief.pdf>; Kaiser Family Found., *The Role of Medicaid in State Economies: A Look at the Research* (2009), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7075_02.pdf.

⁸¹ Antonisse et al., *supra* note 8. See also Dee Mahan & Andrea Callow, *Expanding Medicaid: Better Health, Jobs, and Economic Activity for States*, FAMILIES USA (2014), <https://familiesusa.org/product/expanding-medicaid-better-health-jobs-and-economic-activity-states>; Kaiser Family Found., *The Role of Medicaid in State Economies and the ACA* (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf>.

⁸² See Kaiser Family Found., *supra* note 80 (2009); Chernew, *supra* note 78.

increases in economic activity and multiplier effects on various economic sectors.⁸³ However, these effects are especially pronounced within the health care sector, where the indirect effects of Medicaid spending stimulate access to and use of health care. Providers, community hospitals, and other health-related professions subsequently increase demand for other health services, such as home care workers or medical devices, which in turn generate more business for vendors and manufacturers.⁸⁴

Such phenomena have led to expansion states collecting increased tax revenue, decreasing expenditures related to safety net benefits, and realizing net savings in their state budgets.⁸⁵ The Kaiser Family Foundation notes in a comprehensive literature review that “national, multi-state, and single state studies show that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.”⁸⁶ These state savings arise as Medicaid offsets other state costs, such as costs from behavioral health services, criminal justice, and receipt of Supplemental Security Income.⁸⁷ This means that Medicaid not only produces positive economic effects for its enrollees, but also for the communities in which enrollees live. Conversely, reductions in Medicaid spending increases layoffs across the public and private sectors, and is shown to reduce the pace of state-level economic growth.⁸⁸ The proposed rule, both in its direct and chilling effects, will thus negatively impact state budgets.

These findings are especially important given the net positive effect that immigrants have on local economies – “Each immigrant creates 1.2 local jobs for local workers, most of them going to native workers...Overall, it appears that local workers benefit from the arrival of more immigrants.”⁸⁹ Thus, immigration itself has a sort of multiplier effect for local economies. But if immigrants are chilled from using public benefits, such as Medicaid, they are less able to work, save, and spend in the local community. Therefore, reducing Medicaid enrollment of eligible individuals will minimize the positive direct and downstream economic effects naturally provided by both Medicaid and immigration. The degree to

⁸³ John Z. Ayanian et al., *Economic Effects of Medicaid Expansion in Michigan*, 376 NEW ENG. J. MED. 407 (2017), <https://www.nejm.org/doi/pdf/10.1056/NEJMp1613981>.

⁸⁴ Kaiser Family Found., *supra* note 80 (2009).

⁸⁵ Jesse Cross-Call, *Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 9, 2018), <https://www.cbpp.org/sites/default/files/atoms/files/10-9-18health.pdf>.

⁸⁶ Antonisse et al., *supra* note 8.

⁸⁷ *Id.*

⁸⁸ Michael Leachman et al., *Failing to Extend Fiscal Relief to States Will Create New Budget Gaps, Forcing Cuts and Job Loss in at Least 34 States*, CTR. ON BUDGET & POL'Y PRIORITIES (Aug. 13, 2010), <https://www.cbpp.org/sites/default/files/atoms/files/6-8-10sfp2-rev8-13-10.pdf>.

⁸⁹ Gihoon Hong & John McLaren, *Are Immigrants a Shot in the Arm for the Local Economy?*, Working Paper 21123, NAT'L BUREAU OF ECON. RES. (2015), <https://www.nber.org/papers/w21123.pdf>.

which these multiplier effects materialize varies by state because they are partially dependent on state Medicaid spending and a state's federal matching rate for such spending.⁹⁰ However, the presence of a positive economic effect is consistent across economic models.⁹¹

- d. *Medicaid supports hospitals and other community providers that are critical sources of care for low-income people.*

Medicaid payments to hospitals and other providers of care in low-income communities are essential to keeping such sources of care available and accessible. Medicaid payments to these providers compensate them for care provided to their most vulnerable patients, playing an important role in providers' finances. Reimbursement to providers through Medicaid therefore can affect enrollees' access to care by keeping providers' practices open and financially stable.⁹²

Medicaid reimbursements are especially important for hospitals. As hospitals care for a substantial portion of uninsured individuals, hospitals often are confronted with financial shortfalls.⁹³ Medicaid expansion has resulted in improved non-hospital providers' finances; such providers experienced reductions in uninsured visits and uncompensated care costs.⁹⁴ This is especially true for providers of substance use disorder treatment, enabling increased access to such sources of care.⁹⁵ Medicaid expansion also improved hospital financial performance seen in expansion states, as compared to non-expansion states, significantly reducing the likelihood that hospitals in rural areas will close.⁹⁶ Such improved financial performance ensures that low-income, vulnerable, and rural communities continue to have access to essential health care services.

⁹⁰ Kaiser Family Found., *supra* note 80 (2009).

⁹¹ *Id.*

⁹² Peter Cunningham et al., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER FAMILY FOUND. (2016), <http://files.kff.org/attachment/issue-brief-understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes>.

⁹³ *Id.*; Dave A. Chokshi et al., *Health Reform and the Changing Safety Net in the United States*, NEW ENG. J. MED. CATALYST (Oct. 8, 2017), <https://catalyst.nejm.org/health-reform-changing-safety-net/>.

⁹⁴ Antonisse et al., *supra* note 8.

⁹⁵ Johanna Catherine Maclean & Brendan Saloner, *The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act*, Working Paper 23342, NAT'L BUREAU OF ECON. RES. (2017), <http://www.nber.org/papers/w23342.pdf>; Brendan Saloner et al., *Justice-Involved Adults With Substance Use Disorders: Coverage Increased But Rates Of Treatment Did Not In 2014*, 35 HEALTH AFFAIRS (2016).

⁹⁶ Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFAIRS 111 (2018),

As mentioned earlier in this comment, ensuring access to care is critical to improving access to care, as well as bolstering population health. By improving providers' ability to stay in business, accommodate new patients, and deliver care, Medicaid coverage is an essential component in ensuring timely and appropriate access to care. The benefits Medicaid imparts to providers helps support entire sectors of the economy, both locally and nationally – it allows provider systems and their supporting workforces to maintain employment, while also delivering services that enable patients to maintain their own health and return to the workforce.

II. THE PROPOSED RULE'S PRIMARY CHANGES TO PUBLIC CHARGE POLICY

§ 212.20 Applicability of public charge inadmissibility

We strongly oppose the proposed rule's application of new and expansive definitions of "public charge" and of "public benefit." For reasons specifically addressing each of those definitions, respectively found in §§ 212.21(a) and 212.21(b), these new definitions depart from longstanding agency practice, Congressional intent, case law, and generally accepted public understanding of who constitutes a public charge and what constitutes a public benefit under the Immigration and Nationality Act (INA) framework. Such drastic definitional changes upend a system of benefits and supports for which lawfully present immigrants and citizens alike are lawfully eligible.

The proposed rule will cause insurmountable confusion in making benefits eligibility determinations and in properly administering such benefits to recipients. It will also place an incredible administrative burden on states and localities without sufficient federal funding or support.

According to a recent report by the Fiscal Policy Institute (FPI), implementing the proposed rule could cost national, state, and local economies billions of dollars and lead to the loss of hundreds of thousands of jobs. Nationally, FPI estimates the implementing the rule could lead to **\$33.8 billion** in losses to the national economy and **230,000 in job losses**.⁹⁷

Moreover, a new brief from New American Economy estimates that rule implementation could impact over a million workers in key job sectors such as construction, natural resources, mining, hospitality, recreation, food services, manufacturing, professional and business services, trade, transportation, and utilities.⁹⁸

⁹⁷ Fiscal Policy Institute, *Only Wealthy Immigrants Need Apply* (2018), <http://fiscalpolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf>.

⁹⁸ New American Economy Research Fund, *Economic Impact of Proposed Rule Change: Inadmissibility on Public Charge Grounds* (Oct. 31, 2017),

The rule will create new challenges for state and local agencies administering these programs and will result in an increased workload. Issues state and local agencies will face include:

- *Increased “churn” among the caseload.* As consumers learn about the new rule, some families will terminate their participation programs as already experienced in response to draft public charge-related proposed rule changes being leaked to the media. But, because these programs meet vital needs for families, some of these families would likely return to the caseload, resulting in duplicative work for agencies that will experience a new kind of churn in their caseloads. Some families may return if they come to understand that they are not subject to a public charge determination, for example, if they have refugee status. Others may reapply when circumstances become even more dire, for example a child may be withdrawn from Medicaid coverage, but without treatment—such as asthma medication—the child’s condition may worsen, and the family will re-enroll the child even though they are fearful the act may jeopardize a family member’s chance to become a lawful permanent resident. This on again off again approach to benefit enrollment—often referred to as churn—not only yields negative results for families, it also results in duplicative work for state and local agencies.⁹⁹
- *Responding to consumer inquiries related to the new rule.* State agencies will have to prepare to answer consumer questions about the new rule. They will experience increased call volume and traffic from consumers concerned about the new policies. Advising a family on whether they would be subject to a public charge determination and how receipt of various benefits might play out can require technical knowledge of immigration statuses. Yet, state and local agencies will be put in an impossible position when answering questions if they simply tell all consumers that they must speak to an immigration attorney to get their questions answered about the impact of access benefits on their immigration status. And such advice would likely deter eligible people from enrolling in programs, including many who would never be subject to a public charge determination. Moreover, people who seek public benefits

<https://research.newamericaneconomy.org/report/economic-impact-of-proposed-rule-change-inadmissibility-on-public-charge-grounds/>.

⁹⁹ Leighton Ku et al., *Improving Medicaid’s Continuity of Coverage and Quality of Care*, ASS’N FOR COMMUNITY AFFILIATED PLANS 12-16 (2009), <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>; Leighton Ku & Erika Steinmetz, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid*, ASS’N FOR COMMUNITY AFFILIATED PLANS (2013), <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf>.



are also unlikely to be able to afford to seek legal counsel to see if getting services will jeopardize their family's immigration goals.

- *Building new systems to respond to the rule.* If the draft form I-944, included as part of the rule, were finalized as is, (see: <https://www.regulations.gov/document?D=USCIS-2010-0012-0047>), it would require states to build new systems to respond to the rule. Applicants would be required to gather supporting documentation not only about whether they received a public benefits, but the type, amount, agency that granted it, date it was granted and expired and who in the household received it. Recipients will also need to document any Medicaid received that does not count due to the exclusions for IDEA/school-based services and emergency medical conditions. Being able to provide this information in a timely manner will require creating new systems, processes and additional personnel.
- *Modifying existing communications and forms related to public charge.* For almost twenty years, agencies have worked under the consistent and clear rules about when a consumer's use of benefits could result in a negative finding in their public charge determination. Agencies have incorporated these messages on a variety of consumer communications including application, application instructions, website, posters used in lobbies, in notices and in scripts and trainings for staff. All of these consumer communications will have to be identified and taken down. In addition, many states have deliberately created seamless application and client experiences for state/local and federal benefit programs, as well as for Medicaid/CHIP benefits. These would need to be delinked and clients provided with clear information about whether the program they are participating in is subject to the public charge determination.

§ 212.21(a) - Public Charge

- a. *We strongly oppose the new definition of "public charge" contained in the proposed rule. This proposed definition is inconsistent with the term's historical meaning and use.*

The proposed rule's new definition of public charge departs from both the historical understanding and commonplace use of the term. The newly proposed definition would reverse over a century of existing law, policy, and practice concerning the interpretation and application of what it means to be a public charge. Public charge determinations have never considered non-cash benefits, apart from government-funded long-term care. Furthermore, receipt of benefits was never a determinative factor in public charge decisions

as such inquiries were subject to the “totality of circumstances” test that allowed other factors, including showings of employment history or an affidavit of support, to resolve a public charge determination in an applicant’s favor. The proposed rule’s inclusion and heavy negative weighting of public benefits use unjustly skews the test against immigrants without regard for its actual fiscal and societal impacts and without taking into account individualized factors. The use of these negatively weighted factors makes the proposed rule much too broad: if applied to U.S. citizens, one-third of U.S. citizens would fail the test based solely on their use of public benefits.¹⁰⁰ Receiving such benefits makes such immigrants similar to thousands of low-income, hard-working citizens who are not public charges on the state, but who rather are using government services as a means of supplemental supports as they strive towards ultimate self-sufficiency.

A review of the historical legislative and regulatory context concerning what constitutes a public charge illustrates that DHS’ proposed definition wrongly incorporates receipt of “one or more public benefit” as its definitional basis. As noted in the preamble to the proposed rule, Congress’ first law concerning public charges was the Immigration Act of 1882, which authorized state officials to inspect and deny entry to any immigrant aboard ships who was a “convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge.”¹⁰¹ This law conceived of “public charges” as those without capability to function at the most basic societal level – those destined for almshouses – such as people with severe disabilities, abandoned children, drifters, and petty criminals.¹⁰²

The Immigration Act of 1891 expounded on what “public charge” meant, explicitly equating those likely to become a public charge with the term “pauper.”¹⁰³ This indicates that a public charge is someone with **severe** impoverishment, destitution, or insolvency who resorts to begging and charity. Courts later affirmed this meaning: “Congress meant the act to exclude persons who were likely to become occupants of almshouses for want of means with which to support themselves in the future.”¹⁰⁴ Thus, the original understanding of public charge – an understanding that continues to exist to this day, despite the publication of the proposed rule – was an individual so impoverished and incapable of self-care that the government has a moral necessity to give them subsistence supports. In other words,

¹⁰⁰ Danilo Trisi, *One-Third of U.S.-Born Citizens Would Struggle to Meet Standard of Extreme Trump Rule for Immigrants*, CTR. ON BUDGET AND POL’Y PRIORITIES (2018), <https://www.cbpp.org/blog/one-third-of-us-born-citizens-would-struggle-to-meet-standard-of-extreme-trump-rule-for>.

¹⁰¹ 22 Stat. 214, Section 2.

¹⁰² DAVID A. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* (1971), at 198-200, 290-91.

¹⁰³ Immigration Act of 1891, Sess. II ch. 551, 26 Stat. 1084 (1891).

¹⁰⁴ *Howe v. United States*, 247 F. 292, 294 (2d Cir. 1917).

the government must ‘take ‘charge’ of the person to prevent total destitution”¹⁰⁵ and that person must be primarily dependent on the government for subsistence.

The proposed rule correctly notes that this conception of public charge predates the existence of many government benefits programs currently in use.¹⁰⁶ However, as federal and state governments began offering a range of benefits to citizens and immigrants, Congress addressed eligibility for those benefits. When creating these new programs, Congress never indicated that the U.S. Citizenship and Immigration Services (USCIS), formerly called the Immigration and Naturalization Service (INS), and the Department of State (DOS) should consider the use of such benefits in determining whether an individual was likely to become a public charge. The primary dependence model based on benefits received for subsistence, as opposed to a model that considers supplemental benefits, remained long after the decline of almshouses and the advent of modern-day public benefits administration.

Of course, Congress could have added receipt of any new or expanded benefit to a consideration of public charge, but did not. Instead Congress has elected to directly restrict or expand eligibility for public benefits to regulate their use. Further, when Congress was specifically addressing immigration law, it also did not amend the public charge definition, despite several opportunities to do so. Rather, Congress affirmed the existing administrative interpretations of the law. Under the Immigration and Nationality Act (INA) as later amended by the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), public charge determinations are to be made on an individual basis, by considering, at a minimum, an immigrant’s age; health; family status; assets, resources, and financial status; and skills and education.¹⁰⁷ Congress never indicated that receipt of “one or more public benefit” should be considered across the board in a public charge determination. Instead, these factors were applied to expound on the previous framework of who could be considered a public charge by properly evaluating whether an individual’s circumstances are such that they are primarily dependent on the government for subsistence.

This vision of what constitutes “likely to become a public charge” was directly addressed following the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), commonly referred to as “welfare reform,” and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). PRWORA limited eligibility for “federal

¹⁰⁵ Migration Pol’y Institute, Press Release, *Nearly Half of All Noncitizens in U.S. Could Be Affected by Proposed Trump Administration Public Charge Rule, Up from Current 3 Percent* (June 12, 2018), <https://www.migrationpolicy.org/news/mpi-nearly-half-all-noncitizens-us-could-be-affected-proposed-trump-administration-public>.

¹⁰⁶ 83 Fed. Reg. 51163.

¹⁰⁷ See Section 212 of the Immigration and Nationality Act, Public Law 89-236 (codified at 8 U.S.C. 1182(a)(4)).

means-tested public benefits” to “qualified” immigrants and barred many lawful permanent residents from receiving “means-tested public benefits” during their first five years in the U.S. However, Congress did not create a list of public benefits programs under consideration in public charge determinations, nor did it subject those who use public benefits to public charge determinations based on such use. When it passed IIRIRA just a few months later, Congress again declined to include use of public benefits as a factor in public charge determinations. Congress never added language or amended factors to say that receipt of benefits through particular programs, even after five years of residency, would be considered for public charge purposes.

Concerns that INS (Immigration and Nationality Service, now U.S. Customs and Immigration Services or USCIS) was improperly considering government-funded health care and nutrition programs led to mass public confusion about the relation between receipt of public benefits and public charge determinations. In response, INS issued field guidance¹⁰⁸ and a proposed rule¹⁰⁹ in 1999 which clarified public charge inquires as limited to cash assistance for subsistence income maintenance, and government-funded long-term institutional care. The concepts in the 1999 proposed rule, as enshrined in guidance and still in use today, have been consistently applied to specifically assuage concerns that immigrants’ use of various public benefits for which they are eligible, with certain exceptions, would not factor into public charge determinations.

The preamble to the 1999 proposed rule clarifies that it did not change public charge policy from previous practice; rather, the proposed rule responded to the need for a “clear definition” enabling immigrants, providers, and other stakeholders to make informed decisions and take advantage “reliable guidance” on matters that may affect immigrants’ circumstances.¹¹⁰ We believe this guidance represents the correct modern interpretation of what it means to be a public charge, informed by the term’s historical meaning. As DHS notes in the preamble to the proposed rule, “INS consulted with Federal benefit-granting agencies such as the Department of Health and Human Services (HHS), the Social Security Administration (SSA), and the Department of Agriculture (USDA)” in arriving at a definition of “public charge.”¹¹¹ DHS does not note that it undertook such an effort to seek expert opinions in its re-definition of what constitutes dependence on the government.

Importantly, the 1999 guidance unequivocally states, “It has never been [INS] policy that any receipt of services or benefits paid for in whole or in part from public funds renders an

¹⁰⁸ Immigration and Naturalization Service (“INS”), *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689 (Mar. 26, 1999).

¹⁰⁹ INS, *Inadmissibility and Deportability on Public Charge Grounds*, 64 Fed. Reg. 28676 (Mar. 26, 1999).

¹¹⁰ 64 Fed. Reg. 28676.

¹¹¹ 83 Fed. Reg. 51133.

alien a public charge or indicates that the alien is likely to become a public charge.”¹¹² This echoes prior versions of the Department of State’s Foreign Affairs Manual (F.A.M.), which used the supplemental/subsistence framework to evaluate overseas applicants for admission to the U.S. The long history of similar approaches is evident in the 1993 F.A.M.’s explanation that:

“the rule-of-thumb is that a program that is [] supplementary in nature, in the sense of providing training, services, food, etc. to augment the standard of living, rather than to undertake directly the support of the recipients, does not fall within the scope of the INA 212(a)(4).”¹¹³

Following this commonly accepted understanding, the framework described by the 1999 guidance explicitly defines that someone is considered a public charge if they are “primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense.”¹¹⁴ The guidance further clarified that to be considered a public charge, an individual must be “primarily dependent” on public cash assistance, rather than merely receiving such assistance, that noncash benefits other than institutionalization for long-term care are not considered, and that receipt of these specific public benefits is one factor among many that must be considered to make a public charge determination.¹¹⁵ The guidance specifically excluded non-cash programs, such as Medicare, Medicaid, food stamps, WIC, Head Start, childcare, school nutrition, housing and energy assistance, and disaster relief.¹¹⁶ This continued the framework that guides public charge determinations based on primary reliance on government for subsistence, rather than receipt of public benefits to supplement income and improve quality of living. This framework is consistent with historical understandings of public charge, but also comports with subsequent Congressional intent that certain immigrants be eligible for such government benefits programs.

The proposed rule is inconsistent with clear Congressional intent regarding eligibility for means tested programs because it undermines those very rules set by Congress in enacted law. Congress purposefully rejected a number of amendments to public charge provisions that would have excluded, denied status adjustments to, or deported large segments of the U.S. immigrant population.¹¹⁷ Instead, Congress directly addressed

¹¹² 64 Fed. Reg. 28692.

¹¹³ See, 9 F.A.M. 40.41, N 9.1.

¹¹⁴ 63 Fed. Reg. 28689.

¹¹⁵ *Id.*

¹¹⁶ 63 Fed. Reg. 28689.

¹¹⁷ See, e.g. H.R. 2202 §532, Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (referring to deportation); S. 1664, § 202, Immigration Control and Financial Responsibility Act of

concerns it had regarding immigrants receipt of benefits by denying access to a range of benefits for immigrants' first five years in the U.S.,¹¹⁸ and by enacting broader deeming rules.¹¹⁹ Congress also took steps to ensure that the government would not be held responsible for an immigrant's receipt of even a small number of benefits by mandating an affidavit of support for some immigrants. These affidavits obligate an immigrant's sponsor to repay federal or state government for the immigrant's receipt of such benefits. The only notable amendment made to public charge provisions was to codify the widely followed "totality of circumstances" test used by USCIS and DOS.¹²⁰

Congressional intent regarding immigrants' access to benefits was further evidenced following the 1999 guidance, when Congress passed laws that expanded eligibility for such programs to immigrants. Section 4401 of the Farm Security and Rural Investment Act of 2002 granted SNAP (formerly food stamps) benefits eligibility to immigrant children, immigrants receiving disability benefits, and any other qualified immigrant residing in the U.S. for more than five years. Similarly, Section 214 of the 2009 Children's Health Insurance Program Reauthorization Act allowed states the option to cover with federal matching funds, via a new state plan amendment option, lawfully present immigrant children and pregnant women during their first five years in the U.S. Furthermore, the ACA did not include receipt of marketplace tax credits or cost-sharing reductions as part of a public charge determination, even though many lawfully present immigrants can receive such assistance.

These instances are intentional uses of legislative power to extend benefits to lawfully present immigrants and to remove immigrants' barriers to accessing public benefits, such as SNAP, CHIP, and Medicaid. DHS' proposed rule would effectively end immigrants' eligibility for such programs by penalizing immigrants who lawfully use them. The proposed rule goes beyond redefining "public charge" as DHS effectively redefines what it means to be "self-sufficient." Especially with regard to health, complete self-sufficiency is virtually unattainable, a fact that U.S. law recognizes both in the immigration context and also by providing assistance for purchasing health insurance on the marketplaces created by the Affordable Care Act to individuals up to 400 percent of the FPG. DHS correctly states that self-sufficiency is an articulated goal of U.S. immigration law. However, DHS omits that immigration law also recognizes limits and barriers to achieving self-sufficiency, especially with regards to health care, by explicitly making many classes of immigrants eligible for

1996 (referring to deportation); S. 1923, § 501, Immigration Stabilization Act of 1994 (referring to exclusion and adjustment of status).

¹¹⁸ See, e.g., 8 U.S.C. §§ 1611, 1612, 1613.

¹¹⁹ 8 U.S.C. § 1631.

¹²⁰ 8 U.S.C. § 1182(a)(4)(B).

federally-funded benefits.¹²¹ Congress recognized that environmental and social circumstances, some within an individual’s control and others beyond it, make complete self-sufficiency in health a goal to which we can all aspire, but that only very privileged few can fully attain; this “is just as true for non-citizen immigrants as everyone else.”¹²²

As it is contrary to Congressional intent to insert more punitive restrictions into the framework of public charge determinations, the proposed regulation is improper and we urge DHS to withdraw it.

- b. *We strongly oppose the proposed definition of public charge to mean “an [immigrant] who receives one or more public benefit” as it is inconsistent with the term’s meaning as historically used in in practical administration and case law.*

USCIS’ & DOS’ similar historical approach to public charge determinations shows that use not of “one or more” specific public benefits, but rather use of just one of two specific categories of public benefits – cash assistance and government-funded institutionalized long term care – are relevant to public charge determinations. The current restricted scope of public charge inquiries is why USCIS and DOS have infrequently used such a framework as grounds for adverse determinations since 1940.¹²³ The proposed rule departs from decades of practice by the two agencies and over a century of case law upon which individuals and families have relied for assurance of how to navigate the immigration process and access public benefits to maintain healthy lives.

The history of case law regarding public charge determinations supports the “primary dependence” framework of public charge determinations. In such cases, public charge questions were raised primarily with regard to individuals who were either residing in state-funded institutions on a long-term basis, or receiving cash benefits from the government for basic subsistence needs. In non-deportation cases raising public charge concerns, adverse determinations were limited to situations where immigrants were receiving cash-based assistance necessary for daily living, or had no physical capability to earn a living. Both trends of case law indicate applicability to factual circumstances in which immigrants

¹²¹ Wendy E. Parmet & Elisabeth Ryan, *New Dangers For Immigrants And The Health Care System*, HEALTH AFFAIRS BLOG (Apr. 20, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180419.892713/full/>.

¹²² Wendy E. Parmet, *The Health Impact of the Proposed Public Charge Rules*, HEALTH AFFAIRS BLOG (Sept. 27, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180927.100295/full/>.

¹²³ Jeanne Batalova et al., *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use*, MIGRATION POL’Y INST. 3 (2018), https://www.migrationpolicy.org/sites/default/files/publications/ProposedPublicChargeRule_FinalWEB.pdf.

primarily dependent on government benefits for subsistence are those who are subject to public charge inquiries.

DHS' erroneously cites in support of its definition of public charge *Ex parte Kichmiriantz*, which interprets the term as "a money charge upon, or an expense to, the public for support and care."¹²⁴ However, DHS omits important context that this case involved an individual admitted to an "insane asylum" for long-term care at government expense. This squarely comports with the primary dependency framework outlined by INS and DOS and used throughout history. Instead, DHS takes the phrase quoted out of context that, if given proper consideration, shows that the judge was not rigorously examining the meaning of "public charge." Rather the judge was simply stating that the individual at issue did not cause any expense to the public as family members covered the costs for his care and he could therefore not be considered a public charge. DHS cherry picks judicial text to arrive at a definition that is fundamentally in opposition to the meaning of those very statements used.

Two other cases DHS cites as support for its definition, *Ex parte Mitchell*¹²⁵ and *In re Keshishian*,¹²⁶ do not address the degree of support at public expense necessary for a public charge determination because such a question was not at issue in either case. DHS' use of each as support for its new definition of public charge is therefore hollow. Similarly, DHS points to court statements in *Coykendall v. Skrmetta*¹²⁷ and *Iorio v. Day*¹²⁸ to illustrate how courts have not elaborated on the degree of dependence required to sustain a public charge finding. Again, these cases did not pose the question regarding *degree* of dependence. Rather they focused on the *kind* of dependence – whether an individual was considered dependent on government due to imprisonment – therefore, the courts were not in a position to address the degree of dependency necessary for a public charge determination.

In straining the judicial interpretation of "public charge" and discounting past history of legislation, regulation, and agency practice, DHS arrives at a definition of public charge that ignores the reality of how people use public benefits programs to achieve and maintain independence. The preamble lists various dictionary definitions in support of its proposed rule and correctly notes that key elements of such definitions are (i) commitment or entrustment of a person to the government's care, and/or (ii) impoverishment so severe that government assistance is needed to subsist.¹²⁹ Such characterizations are wholly

¹²⁴ 283 F. 697, 698 (N.D. Cal. 1922). See 83 Fed. Reg. 51158.

¹²⁵ 256 F. 230, 234 (N.D. NY 1919).

¹²⁶ 299 F. 804 (S.D. NY 1924).

¹²⁷ 22 F.2d 121 (5th Cir. 1927).

¹²⁸ 34 F.2d 921 (2d Cir. 1929).

¹²⁹ 83 Fed. Reg. 51158.

inconsistent with hard working individuals who occupy jobs in low-wage sectors of the economy and receive supplemental benefits to fill gaps when such work does not pay enough, is not consistent enough, or offers no benefits. Immigrant women in particular are concentrated in low-wage occupations, such as domestic workers and housekeepers, cashiers, personal care aides, and nursing, psychiatric, and home health aides.¹³⁰ Approximately two-fifths of immigrant women workers earn low wages.¹³¹ These populations would be directly affected by this draconian proposed rule, cutting against widely understood and accepted principles of public health and immigration law as enacted and practiced for decades.

§ 212.21(b) – Public benefit

- a. *We do not support the proposed rule’s expansion of the definition of “public benefit” to include Medicaid or other public benefits in the public charge determination process. We also oppose the proposed rule’s consideration of “applications for” public benefits as a negative factor.*

We strongly oppose:

- adding to the definition of “public benefit” consideration of any specific public benefits programs, especially Medicaid;
- any temporal and financial thresholds on benefits use;
- any classification of benefits based on their monetizability; and
- any application for, certification for, and receipt of public benefits, or any other measure related to use of public benefits not described in the 1999 proposed rule and guidance.

The new proposed rule already distorts the totality of circumstances test used in public charge determinations by listing specific public benefits that have never before been factors in public charge determinations. The proposed rule goes further into uncharted and improper territory, though, by subjecting individuals to its scope who have simply applied or been certified for such public benefits. The expansion of the “public benefit” definition in this context is unreasonably broad and will harm millions of immigrant and citizen families, both through its direct impacts and its indirect chilling effects.

¹³⁰ American Immigration Council, *The Impact of Immigrant Women on America’s Labor Force*, March 2017 (2017),

https://www.americanimmigrationcouncil.org/sites/default/files/research/the_impact_of_immigrant_women_on_americas_labor_force.pdf.

¹³¹ *Id.*

As history and practice show, the public charge inquiry into use of public benefits should be limited to whether an individual was primarily dependent on cash benefits or government-funded institutionalization for long-term care. This focus on primary dependence on subsistence benefits appropriately considers the accepted aim of public charge determinations and does not arbitrarily penalize individuals' use of supplemental benefits for which they are lawfully eligible. DHS should rescind its proposed rule because its new, expansive definition of "public benefit" for public charge improperly infringes on this longstanding framework, obscuring the true intent of public charge determinations.

Medicaid coverage is not evidence of a lack of self-sufficiency. In fact, it allows people to work and participate in their communities. Thus, we strongly oppose the inclusion of Medicaid because Medicaid coverage is not evidence of a lack of self-sufficiency. DHS includes Medicaid based on its assertion that "by virtue of their employment, such immigrants should have adequate income and resources to support themselves without resorting to seeking public benefits." But that position is a fallacy.¹³² It demonstrates DHS' fundamental misunderstanding of the reality faced by much of the labor force, the persistent wage and benefits gaps among lower-income workers, and the positive role that public benefits, especially Medicaid, have in society by addressing these gaps.

The proposed rule's inclusion of Medicaid as a "public benefit" under consideration for public charge determinations shows a fundamental misunderstanding of how Medicaid supports low-wage workers' ability to thrive.¹³³ The proposed rule does not acknowledge the substantial overlap among workers and the receipt of benefits. In fact, many workers receive supplemental benefits, such as Medicaid, which, as explained above, improves both their individual economic well-being and their overall economic productivity.

A predominant characteristic of employers of low-wage workers is that they both do not offer employer-sponsored benefits, such as health insurance coverage, and they do not pay enough for workers to buy insurance coverage on their own. In 2016, approximately

¹³² 83 Fed. Reg. 51123.

¹³³ There is wide variation regarding how to define "low-wage work." Each definition considers different contextual factors, data points, and comparison groups, and definitions fluctuate based on job or profession. For instance, low-wage work can be defined in relation to measures of minimum wage, Federal Poverty Guidelines, median wages, or other measures. The definition further depends on what the goals are of those defining low-wage work and the context in which the definition is formulated. See U.S. Dep't of Labor, Bureau of Labor Statistics ("BLS"), *How should we define "low-wage" work? An analysis using the Current Population Survey* (Oct., 2016), <https://www.bls.gov/opub/mlr/2016/article/how-should-we-define-low-wage-work.htm>. For purposes of this comment, low-wage workers are broadly defined as those with low earnings potential such that they are likely experience symptoms of poverty due to their wages.

24% of workers in the United States earned wages at or below the federal poverty level,¹³⁴ less than \$24,300 for a family of four at the time.¹³⁵ Furthermore, low-wage jobs comprise a growing share of the U.S. workforce demands: almost one third of all workers earn under \$12 per hour, and over half of these workers are women.¹³⁶ People of color are also disproportionately concentrated in low-wage jobs.¹³⁷

Even accounting for coverage gains under Medicaid expansion, health insurance coverage rates for low-wage workers lags behind that of relatively higher-wage workers.¹³⁸ This is despite the fact that low-wage workers work comparable hours per week and weeks per year to those of higher-wage workers; the low-wage worker population simply does not regularly receive health insurance through employers, as is commonplace in higher-wage jobs.¹³⁹ Less than one-third of low-income workers have employer-sponsored health insurance, whereas almost two-thirds of higher-income workers receive such benefits. These trends drive higher uninsurance rates among the low-wage worker population.¹⁴⁰ However, the proposed rule assumes that employment is sufficient on its own to ensure access to health insurance. This view disregards the realities of employment faced by the low-wage workforce. It also obfuscates the fact that Medicaid was specifically designed to provide health insurance coverage in such cases.¹⁴¹ Medicaid coverage improves the public health and prevents large-scale impoverishment that would otherwise ensue due to growing wage inequality and the prohibitively high costs of health care.¹⁴²

¹³⁴ Economic Policy Institute, *State of Working America Data Library: "Poverty Level Wages"* (Feb. 13, 2017), <https://www.epi.org/data/#?subject=povwage> (last visited Dec. 6, 2018, 2:56 PM).

¹³⁵ HHS, ASPE, *Prior HHS Poverty Guidelines and Federal Register References*, <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references> (last visited Dec. 6, 2018, 2:56 PM). Today, the federal poverty level is \$25,100 for a family of four. For perspective, individuals earning the federal minimum wage remain in poverty, with total incomes near 50 percent of the Federal Poverty Guidelines. See Shelby Gonzales, *Immigration Officials Given Extremely Broad Authority Under Trump Administration's Proposed Rule*, CTR. ON BUDGET AND POL'Y PRIORITIES (Oct. 10, 2018), <https://www.cbpp.org/blog/immigration-officials-given-extremely-broad-authority-under-trump-administrations-proposed-rule>.

¹³⁶ Economic Policy Institute and Oxfam America, *Few Rewards: An Agenda to Give America's Working Poor a Raise* (2016), https://www.oxfamamerica.org/static/media/files/Few_Rewards_Report_2016_web.pdf.

¹³⁷ *Id.*

¹³⁸ Alanna Williamson et al., *ACA Coverage Expansions and Low-Income Workers*, KAISER FAMILY FOUND. (2016), <http://files.kff.org/attachment/ACA-Coverage-Expansions-and-Low-Income-Workers>.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ See e.g., 42 U.S.C. §§ 1396r-6, 1396e-1.

¹⁴² Williamson et al., *supra* note 138; Samantha Artiga et al., *How do Health Care Costs fit into Family Budgets? Snapshots from Medicaid Enrollees*, KAISER FAMILY FOUND. (2017), <http://files.kff.org/attachment/Issue-Brief-How-do-Health-Care-Costs-fit-into-Family-Budgets-Snapshots-from-Medicaid-Enrollees>.

The proposed rule neglects the benefits Medicaid provides in supporting a large portion of the workforce, immigrant and citizen alike, and their dependent children. Immigrants are more likely to earn lower wages on average and have less access to employer-sponsored insurance, so Medicaid's positive impact on the lives of people in these populations is even more pronounced.¹⁴³ Substantial research supports the efficacy of the Medicaid program in enabling such enrollees to improve their economic and social well-being by providing coverage for and access to health care services. Declines in the rates of uninsurance are directly linked to broader availability of Medicaid coverage, especially among certain vulnerable subpopulations.¹⁴⁴ Access to insurance through Medicaid translates to a better ability to find and retain employment.¹⁴⁵ It also decreases reliance on cash assistance,¹⁴⁶ bolsters individuals' and families financial health,¹⁴⁷ and improves individuals' and families' spending habits to increase savings and direct more spending towards food and housing,¹⁴⁸ rather than health care expenses.¹⁴⁹ These protections that Medicaid provides allows those in low-wage jobs and their families to engage in and contribute to their communities without being saddled with debilitating medical costs.

The Medicaid program fosters a healthier overall population by bolstering recipients' access to care and subsequently improving their health and financial security.¹⁵⁰ The proposed rule neglects to consider any of the aforementioned benefits, instead recasting Medicaid as a public benefit upon which immigrants rely for basic subsistence. This is not only a wrong characterization; it misleadingly disregards the positive effects Medicaid coverage has on promoting health, as well as economic and social well-being. Penalizing use of Medicaid in the way described by the proposed rule is therefore contrary to the goals of the proposed rule and of U.S. immigration law at large. DHS should accordingly extricate Medicaid coverage from its new public charge framework and rescind its proposed rule as the policy erects new barriers to reaching the very goals it purports to promote.

¹⁴³ NAT'L ACAD. OF SCI. ENG'G MED., THE ECONOMIC AND FISCAL CONSEQUENCES OF IMMIGRATION 122 (Francine D. Blau and Christopher Mackie eds.) (2017) (ebook), <https://www.nap.edu/read/23550/chapter/6#122>.

¹⁴⁴ Antonisse et al., *supra* note 8.

¹⁴⁵ *Id.*

¹⁴⁶ Soni et al., *supra* note 67; Burns & Dague, *supra* note 67.

¹⁴⁷ Rudowitz & Antonisse, *supra* note 58; Hu et al., *supra* note 58; Sommers et al., *supra* note 23; Boudreaux et al., *supra* note 34; Miller et al., *supra* note 47.

¹⁴⁸ Wagnerman et al., *supra* note 32.

¹⁴⁹ Sommers et al., *supra* note 23; Sanger-Katz, *supra* note 55.

¹⁵⁰ Collins et al., *supra* note 48.

- b. *We oppose the future inclusion of any “unenumerated benefits” into the proposed rule’s scope, as the proposed rule already improperly considers non-cash benefits.*

We strongly oppose adding any additional programs to the list of counted programs, or in any way considering the use of non-listed programs in the totality of circumstances test. No additional programs should be considered in the public charge determination. The programs enumerated in the proposed rule already go far beyond what is reasonable to consider and will harm millions of immigrant families. The addition of any more programs would increase this harm to individuals, families, and communities. For this reason, we specifically support the exclusion of unenumerated locally- and state-funded benefits from the proposed rule’s scope.

Furthermore, we strongly oppose considering applications for benefits as a negative factor under the proposed rule. The ACA requires Medicaid and CHIP eligibility screens before individuals are enrolled in subsidized marketplace coverage. This mechanism could impact immigrants subject to a public charge determination in two ways. First, if an immigrant is found eligible for Medicaid during their application for marketplace insurance coverage, the state would subsequently automatically enroll immigrant applicants in Medicaid. Such an applicant may not even be aware of their Medicaid enrollment but would still be subject to the proposed rule’s negative consequences. Second, an immigrant applicant found ineligible for Medicaid during the preliminary screen for subsidized marketplace coverage would still fall under the proposed rule’s scope, even if they ultimately received only marketplace coverage. This is because to receive tax credits for marketplace coverage, an applicant must first be denied Medicaid (or CHIP) coverage during their initial screen, and an application for Medicaid, even if it results in a denial, is counted negatively in a public charge determination under the proposed rule.¹⁵¹ This is true even if the immigrant never wanted to apply for or received Medicaid.

- c. *We support the proposed rule’s exclusion of CHIP from the definition of “public benefit” and from determinations of whether someone is likely to become a public charge.*

For many of the same reasons that we oppose the inclusion of Medicaid, we adamantly oppose the inclusion of CHIP. CHIP is a program for working families who earn too much to be eligible for Medicaid without a share of cost. 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.

¹⁵¹ 42 U.S.C. § 1396a.

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 elsewhere in these comments. Nearly 9 million children across the U.S. depend on CHIP for their health care. Due to the chilling effect of the rule, many eligible citizen children likely would forego CHIP—and health care services altogether—if their parents think they will be subject 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. This was enacted because Congress recognized the public health, economic, and social benefits of ensuring that these populations have access to care.

Since its inception in 1997, CHIP has enjoyed broad, bipartisan support based on the recognition that children need access to health care services to ensure their healthy development. Senator Orrin Hatch (R-UT), one of the original co-sponsors of CHIP, said that "Children are being terribly hurt and perhaps scarred for the rest of their lives" and that "as a nation, as a society, we have a moral responsibility" to provide coverage. CHIP has been a significant factor in dramatically reducing the rate of uninsured children across the U.S. According to the Kaiser Family Foundation, between 1997 when CHIP was enacted through 2012, the uninsured rate for children fell by half, from 14 percent to seven percent. Medicaid and CHIP together have helped to reduce disparities in coverage that affect children, particularly children of color. A 2018 survey of the existing research noted that the availability of "CHIP coverage for children has led to improvements in access to health care and to improvements in health over both the short-run and the long-run."¹⁵²

As noted by the Kaiser Family Foundation, CHIP:

- Can have a positive impact on health outcomes, including reductions in avoidable hospitalizations and child mortality.

¹⁵² Lara Shore-Sheppard, *Medicaid and CHIP: Filling in the Gap of Children's Health Insurance Coverage*, ECONOFACT (Jan 22, 2018), <https://econofact.org/filling-in-the-gap-of-childrens-health-insurance-coverage-medicaid-and-chip>.

- Improves health, which translates into educational gains, with potentially positive implications for both individual economic well-being and overall economic productivity.¹⁵³

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.¹⁵⁴ As noted by the 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.¹⁵⁵

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.¹⁵⁶ The question of which programs to include should not at all 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.

¹⁵³ Julia Paradise, *The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?*, KAISER FAMILY FOUND., (2014),

https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8615-the-impact-of-the-children_s-health-insurance-program-chip-what-does-the-research-tell-us.pdf.

¹⁵⁴ Elisabeth Wright Burak, *Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)*, GEORGETOWN CTR. FOR CHILDREN AND FAMILIES (2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>.

¹⁵⁵ *Id.*

¹⁵⁶ 83 Fed. Reg. at 51174.

- d. *We support the proposed rule’s exclusion of assistance for emergency medical conditions; services or benefits funded by Medicaid but provided under the Individuals with Disabilities Education Act (IDEA); and benefits provided to foreign-born children of U.S. citizen parents.*

While we support the above exclusions from the proposed rule’s scope, the chilling effect that will ensue from the proposed rule means that immigrants will forego these services as well as other Medicaid services. As the preamble to the proposed rule notes, this will lead to poor health outcomes, increases in uncompensated care, and higher prevalence of communicable diseases, among other negative effects. These effects are not attributable only to those going through public charge determinations or those who have applied for status adjustments in the past five years – the larger immigrant community will feel them as well.

Immigrants subject to the proposed rule are unlikely to understand the difference in how various services covered under Medicaid are treated by the public charge test. Those who disenroll from Medicaid do so because of fear of poor treatment and adverse immigration effects stemming from use of such benefits.¹⁵⁷ Specifically, Latinx immigrants are more likely to be eligible but unenrolled due to fears of immigration actions.¹⁵⁸

The system imposed by the proposed rule creates a dangerous paradox for immigrants who are ill. Without a health care provider, immigrants will not know if the condition for which they need treatment counts as an “emergency medical condition” subject to the exclusion. However, immigrants will not have access to health care unless they seek care in the first place, which they are less likely to do without Medicaid coverage, applications for and receipt of which immigrants are penalized under the proposed rule.

¹⁵⁷ Jennifer Stuber & Karl Kronebusch, *Stigma and other determinants of participation in TANF and Medicaid*, 23 J. POL’Y ANALYSIS & MGMT. 509 (2004); Claudia Schlosberg & Dinah Wiley, Nat’l Health Law Prog. and NILC, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (1998), https://www.montanaprobono.net/geo/search/download.67362#N_%202; Marilyn R. Ellwood & Leighton Ku, *Welfare And Immigration Reforms: Unintended Side Effects For Medicaid*, 17 HEALTH AFFAIRS 137 (1998), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.17.3.137>.

¹⁵⁸ Jennifer P. Stuber et al., *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?*, THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES (2000), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1052&context=sphhs_policy_briefs.

- e. *We do not support the proposed rule’s inclusion of Medicare Part D Premium and Cost Sharing Subsidies in the definition of “public benefit” and in determinations of whether someone is likely to become a public charge.*

We support the comments submitted by Justice in Aging regarding this topic and incorporate them by reference into these comments.

- f. *We strongly oppose the proposed rule’s reclassification of public benefits from a supplemental / subsistence framework to a monetizable / non-monetizable framework.*

We do not support the proposed rule’s institution of a monetizable / non-monetizable framework for classifying benefits subject to public charge determinations. For reasons discussed elsewhere in this comment, the supplemental / subsistence framework is how public benefits have historically been treated under public charge determinations. The 1999 proposed rule affirmed as much in its text, recognizing that it was not changing past practice but rather clarifying how public charge determinations should be conducted in the wake of public confusion regarding eligibility for benefits and consequences of their use.

DHS correctly notes that the “century-plus” of case law does not comment on the *degree* of benefits use required to be considered a public charge. The proposed rule categorizes certain public benefits as monetizable, without regard to the role each public benefit plays in an individual’s quality of life, health, and well-being. The proposed rule adopts this framework in an attempt to quantify or qualify degrees of reliance or dependence on public benefits for the purposes of determining if someone is self-sufficient.¹⁵⁹ However, plainly underlying this framework, as DHS concedes, is an attempt to expand public charge determinations to reduce “significant public expenditures on non-cash benefits” and to protect the public budget.¹⁶⁰ But that has nothing to do with whether the current framework is effective at prospectively determining on an individualized basis whether an individual is likely to be a public charge.

DHS even concedes, “The current policy’s definition is consistent [] with how other agencies have defined dependence.”¹⁶¹

¹⁵⁹ 83 Fed. Reg. 51163.

¹⁶⁰ 83 Fed. Reg. 51164.

¹⁶¹ 83 Fed. Reg. 51164.

g. *We do not support the proposed rule's use of thresholds for the receipt of monetizable benefits alone, non-monetizable benefits alone, and monetizeable benefits together with non-monetizeable benefits, to determine if someone is likely to become a public charge.*

i. **We strongly oppose DHS' proposed 15 percent of Federal Poverty Guidelines (FPG) standard for receipt of monetizeable benefits.**

The thresholds proposed by DHS for each category of benefits are arbitrary and do not reflect historical understandings of how benefits use is evaluated in public charge determinations. The result is a series of absolute rules that result in absurd outcomes when the threshold standards are applied.

This proposed threshold is arbitrary, with no basis in either legislation or research. DHS acknowledges that in other contexts, such as the determination of whether an individual is a dependent for tax purposes, or HHS's indicators of welfare dependence, the test that is applied is whether the individual or household receives more than half of their total annual income from the designated source. These determinations are based on statute, in the case of the IRS, and the recommendations of a bi-partisan Congressionally mandated Advisory Board comprised of established a 12-member bipartisan Advisory Board, composed of experts in the fields of welfare research and welfare statistical methodology, representatives of State and local welfare agencies, and representatives of other organizations concerned with welfare issues, in the case of the indicators report.¹⁶²

However, DHS rejects this definition simply because it “**believes** that receipt of such benefits even in a relatively small amount or for a relatively short duration would in many cases be sufficient to render a person a public charge.”¹⁶³ (emphasis added). The proposal defines “public charge” to include anyone who uses benefits worth more than 15 percent of the poverty line for a household of one in public benefits—just \$5 a day regardless of family size. DHS asserts that someone who receives public benefits above the 15 percent of FPG threshold is “neither self-sufficient nor on the road to achieving self-sufficiency.”

But a 15 percent standard would arbitrarily deem self-sufficient individuals as public charges, and overlook the extent to which a person is (or is capable of) supporting themselves.

¹⁶² HHS, *Indicators of Welfare Dependence and Well-Being. Interim Report to Congress* (1996), <https://files.eric.ed.gov/fulltext/ED461676.pdf>.

¹⁶³ 83 Fed. Reg. 51164 (emphasis added).

For example, a family of four that earns \$43,925 annually in private income but receives just \$2.50 per day per person in monetizable public benefits would be receiving just 8.6 percent of their income from the government programs, meaning that, even under DHS's understanding of self-sufficiency, they are 91.4 percent self-sufficient.¹⁶⁴ Yet the rule would still consider the receipt of assistance as a heavily weighed negative factor in the public charge determination.

DHS's 15-percent threshold also has no support in research or academic literature of any kind. DHS does not reference any evidence for why this measure is appropriate across programs, much less for any one program. The only justification provided for the lower threshold is that the current policy is "insufficiently protective" of the public budget, which is not a relevant factor for DHS to take into account.

At 83 Fed. Reg. 51165, the Department seeks input on whether to consider the receipt of designated monetizable public benefits at or below the 15 percent threshold. We strongly oppose using any arbitrary threshold, and therefore especially propose lowering the 15 percent threshold. As DHS acknowledges in the preamble, consideration of any lower level of benefits could have significant unintended consequences.

Similarly, at 212.21(b)(3), DHS proposes that any receipt of "monetizable" benefits would be counted when combined with receipt of "non-monetizable" benefits for at least 9 months. This would have a similar effect to having no threshold at all, as people would be afraid to apply for and receive any benefits, no matter how token, for fear of it being held against them.

ii. We strongly oppose DHS' proposed 12-month standard for receipt of non-monetizable benefits.

The proposed rule considers the cumulative receipt of "non-monetizable" benefits for more than 12 months in a 36-month period as indicative of an individual's likelihood of becoming a public charge.¹⁶⁵ DHS justifies its use of a durational threshold by claiming duration of receipt "is specifically accounted for in the guidance's inclusion of long-term institutionalization at government expense."¹⁶⁶ Long-term institutionalized care reflects the long-term receipt of a specific kind of service that provides subsistence for those who use it. Medicaid more generally is a source of insurance coverage for low-income people, which may or may not be associated with utilization of services in any given month. Medicaid

¹⁶⁴ David Bier, *New Rule to Deny Status to Immigrants Up to 95% Self-Sufficient*, CATO INSTITUTE (2018), <https://www.cato.org/blog/new-rule-deny-status-immigrants-95-self-sufficient>.

¹⁶⁵ 83 Fed. Reg. 51165.

¹⁶⁶ 83 Fed. Reg. 51165.

enrollees churn on and off coverage, have a wide array of health conditions. It is inappropriate to extrapolate the durational component of one specific service to maintenance of health insurance writ large.

The proposed rule also cites time limits used in other programs to justify a durational threshold for all “non-monetizeable” benefits, including Medicaid. However, Medicaid is not welfare; it is a source of insurance coverage. The Medicaid statute does not permit any caps to limit the amount of time someone is enrolled because durational caps on insurance are arbitrary; they disregard enrollees’ health circumstances and can inflict substantial harm on enrollees’ well-being by terminating coverage when it is most needed. The same logic applies to the use of a time threshold in the proposed rule. DHS’ 12-month absolute threshold would produce absurd results when applied to a real-world context. Some treatments and services are intensive and span months, if not years. For example, a Medicaid enrollee with cancer could have a debilitating yearlong treatment regimen. The proposed rule would force such an individual into an impossible situation where continued treatment would count against them for immigration purposes.

iii. We strongly oppose DHS’ proposed nine-month standard for receipt of a combination of monetizeable benefits under 15 percent of FPG and one or more non-monetizeable benefits.

For the same reasons we oppose the 12-month standard, we also oppose the nine-month standard for a combination of monetizable benefits. The time limits are arbitrary and have no basis in immigration law. Further, it would have a similar effect to having no threshold at all, as people would be afraid to apply for and receive any benefits, no matter how token, for fear of it being held against them.

§ 212.21(c) – Likely at any time to become a public charge

We oppose the proposed rule’s definition of “likely at any time to become a public charge” because it departs from commonly held conceptions of what it means to be “likely.” In this section, the Department proposes to attempt to estimate the likelihood of future use of any of the public benefits listed. This section therefore incorporates all of the problems with the broad definition of public charge proposed. For example, looking just at SNAP benefits, one study found that more than half of all people in the U.S. would use SNAP benefit at some point in their adult (20-65) life.¹⁶⁷ Therefore, if DHS were to take this definition seriously, it could reject nearly all applicants for permanent status as at risk of at someday receiving one of these benefits. Alternatively, there is a real risk that this definition would be used

¹⁶⁷ Mark R. Rank & Thomas A. Hirsch, *Likelihood of using food stamps during the adulthood years*, 37 J. OF NUTRITION EDUC. & BEHAVIOR 137 (2005), <https://www.ncbi.nlm.nih.gov/pubmed/15904577>.

arbitrarily, creating an excuse for DHS to deny immigration benefits to anyone it deems undesirable.

Additionally, the Administration acknowledges in the preamble language at 83 Fed. Reg. 51174 that “its proposed definition of public charge may suggest that DHS would automatically find an alien who is *currently* receiving public benefits, as defined in this proposed rule, to be inadmissible as likely to become a public charge.” It claims that this is not the case: “DHS does not propose to establish a *per se* policy whereby an alien is likely at any time to become a public charge if the alien is receiving public benefits at the time of the application for a visa, admission, or adjustment of status.” However, this appears to be a distinction without a difference, as given the heavy weight applied to both recent and current receipt of benefits, it is difficult to imagine any circumstances in which a person currently receiving benefits would not be found to be a public charge under DHS’ proposed definitions.

§ 212.21(d) – [Immigrant’s] Household

In this section, DHS proposes a novel definition of a household that includes people to whom an immigrant provides financial support, even if they do not live with the immigrant. This definition is then used in determining whether the household has income sufficient to meet the 125% and 250% of the federal poverty level thresholds that this rule creates. This can lead to several unintended and harmful consequences:

- An immigrant can, in effect, be penalized for providing family support to a sibling or parent to whom they have no legal obligation. This is true even if this support means that the sibling or parent does not need to receive public benefits that they would otherwise qualify for.
- Many immigrants provide financial support to family members who remain in their countries of origin, where the cost of living is often lower. In some countries, as little as \$100 a month could well constitute more than 50 percent of an individual’s financial support. However, this would mean that the person should be counted as part of the immigrant’s household size, which would drive up the earnings they would need to meet the threshold by much higher amounts.

Further, this assessment would have a disproportionately negative impact on immigrant women and children. Immigrant women are more likely than immigrant men to have one or more of their children living in the same household, and are therefore more likely to live in

larger households.¹⁶⁸ Immigrant women are also more likely to be unemployed or working in a low-wage occupation. As such, the combination of a larger household size and lower household income will make it more difficult for many immigrant women to avoid a negative assessment.

§ 212.22(a) – Prospective determination based on the totality of circumstance

We support the proposed rule’s assertion to make a “prospective determination” based on the “totality of circumstances.” However, we strongly oppose DHS’ interpretation of this clause as it does not reflect Congressional intent and DHS’ inclusion of weighted factors exceeds its authority. The listing of factors and additional criteria have the effect of undermining this intent by creating a large number of ways to fail, and very few ways to pass. For example, the discussion of public bonds at 83 Fed. Reg. 51221 suggests that a person with U.S. citizen family members who has a health condition, but has access to employment-based health insurance, received SNAP more than three years ago, but has not used any public benefit more recently, and has household income of 120 percent of the federal poverty line would fail the public charge test and would only qualify for admissibility if able to post a public charge bond. This example highlights the ways in which this rule, while claiming to maintain the totality of circumstances test, actually replaces that test with the weighted factors, which would actually make it nearly impossible for any low-and moderate-income individuals to qualify.

§ 212.22(b) – Minimum factors to consider

We strongly oppose the addition of additional criteria to the statutory list of factors. We support the comments submitted by the Center for Law and Social Policy and incorporate them by reference herein.

With regard to the discussion of the “health” factor, we support the comments submitted by the Consortium for Citizens with Disabilities and incorporate their comments by reference herein.

We provide some additional comments with respect to the proposal regarding English proficiency. In addition to specific education and skills, DHS proposes, for the first time, to add English proficiency as a weighted factor. This poorly justified addition will make it much harder for families to unite in this country. Its inclusion disproportionately harms immigrants and other populations with high levels of limited English proficiency. We believe the

¹⁶⁸ Ariel G. Ruiz et al., *Immigrant Women in the United States*, MIGRATION POL’Y INSTITUTE (Mar. 20, 2015), <https://www.migrationpolicy.org/print/15239#.W-dshZNKjIU>.

presence of any person in this country, regardless of their English skills, is not a burden but rather a contribution to the vibrant and rich landscape that makes up America.

The proposed rule stands in stark contrast to federal civil rights laws prohibiting discrimination on the basis of English proficiency. This is not a country with a national language. No law that allows the federal government to preference those who speak English over those who are limited English proficient (LEP). In contrast to this proposal, numerous federal civil rights laws protecting LEP persons from discrimination on the basis of English proficiency. Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color and national origin in programs and activities receiving federal financial assistance.¹⁶⁹ Title VII of the Civil Rights Act prohibits discrimination in employment on the basis of race, color, national origin, sex, or religion.¹⁷⁰ And the Affordable Care Act's nondiscrimination provision (section 1557) prohibits discrimination on the basis of race, color, national origin as well as sex, disability, and age, in healthcare.¹⁷¹ The Supreme Court has interpreted that discrimination on the basis of language or English proficiency is a form of national origin discrimination. Executive Order 13166 provides that all persons who are Limited English Proficient (LEP) should have meaningful access to federally conducted and federally funded programs and activities and directs federal agencies to ensure they are in compliance.¹⁷²

The public charge statute does not include English proficiency as a factor to be considered in and individual's assessment and instead refers only to "education and skills," among other factors. The agency offers a limited number of justifications for its proposal to add English proficiency to the list of factors that are not justified.

For example, the agency states that those who cannot "speak English may be unable to obtain employment in areas where only English is spoken." There is a significant difference between English proficiency and having no ability to speak the language, which the agency appears to conflate here. Many individuals have limited, but some English proficiency are able to serve many employment roles. Second, the U.S. is a deeply multilingual country, where 63 million people speak a language other than English at home. In fact, there are at least 60 counties in the United States where over 50 percent of the population speaks a

¹⁶⁹ 42 U.S.C. § 2000d.

¹⁷⁰ 42 U.S.C. § 2000e.

¹⁷¹ Patient Protection and Affordable Care Act, Section 1557: Nondiscrimination (codified at 42 U.S.C. 18116).

¹⁷² See *Lau v. Nichols*, 414 U.S. 563 (1974). See also Executive Order No. 13166, 65 Fed. Reg. 50121 (Aug. 15, 2000).

language other than English including some of the most heavily populated.¹⁷³ There are myriad of areas where a person who speaks a non-English language can meaningfully contribute both in employment and civic society.

DHS cites the 2014 Survey of Income and Program Participation data about the use of benefits by populations at various levels of English language ability. Yet DHS fails to provide any causal linkage between the data cited and its conclusions and further, fails to consider alternative reasons that people who are more limited English proficient may be more likely to access benefits. For example, states such as New York and California, which have higher numbers of LEP populations, also have higher income thresholds for Medicaid. In addition, DHS claims that “numerous studies have shown that immigrants’ English language proficiency or ability to acquire English proficiency directly correlate to a newcomer’s economic assimilation into the United States,” yet three out of the four studies cited use data derived from Europe, while the fourth relies on Current Population Survey data nearly 30 years old.¹⁷⁴ This evidence is insufficient to support DHS’ proposed change.

In addition, by proposing to include use of housing assistance, Medicaid and SNAP in public charge determinations, DHS is likely making it more difficult for people who are LEP to improve their skills through the likes of English language classes. Current barriers to education already makes access to these courses difficult, but by preventing people from accessing health care, increasing hunger or creating home instability, this proposed rule could cause affected populations to de-prioritize skills development.¹⁷⁵

Finally, by giving de-facto preference to individuals from English speaking nations, DHS is reworking the careful balancing that Congress created to move us away from the racist quota system.

Among LEP individuals, women with limited English proficiency are much less likely to participate in the labor force than men (49 percent vs. 75 percent).¹⁷⁶ Further, LEP women who have jobs are more than twice as likely to work in low-paying service occupations (45 percent vs. 20 percent) than women with English proficiency.¹⁷⁷ Thus, the rule will also

¹⁷³ U.S. Census Bureau, *2012-2016 American Community Survey Estimates, Table S1601* (2016), <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited Dec. 6, 2018, 4:30 PM).

¹⁷⁴ 83 Fed. Reg. 51196.

¹⁷⁵ Jennifer Ludden, *Barriers Abound for Immigrants Learning English*, NAT’L PUB. RADIO (“NPR”) (Sept. 11, 2007), <https://www.npr.org/templates/story/story.php?storyId=14330106>.

¹⁷⁶ Jie Zong & Jeanne Batalova, *The Limited English Proficient Population in the United States*, MIGRATION POL’Y INSTITUTE (Jul. 8, 2015), <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>.

¹⁷⁷ *Id.*

have a disproportionate impact on women if language proficiency continues to be considered.

§ 212.22(c) – Heavily Weighted Factors

We strongly oppose the proposed use of several heavily weighted factors in making a public charge determination. An analysis of 2014 Survey of Income and Program Participation (SIPP) data from the Kaiser Family Foundation found over four in ten noncitizens who entered the U.S. without a green card have characteristics that would be considered heavily weighed negative factors. The proportion of impacted immigrants nearly doubles for immigrant parents (65 percent vs 34 percent for non-parents) and immigrant women (59 percent vs. 27 percent for immigrant men).¹⁷⁸

Immigrant women are less likely to be employed, enrolled in school full-time, or have private health coverage than immigrant men. While immigrant women participate in the workforce at similar rates as their U.S.-born counterparts (56 percent vs. 59 percent), their participation in the labor market is lower than foreign-born men (67 percent) and U.S.-born men (77 percent).¹⁷⁹ A recent analysis from the Migration Policy Institute found that women made up 72 percent of the population of recent lawful permanent residents who were not employed or in school.¹⁸⁰ In addition, immigrant women are disproportionately concentrated in low-wage occupations that lack employer health coverage or sufficient employee salaries to pay for private coverage. In short, DHS' selection of heavily weighted factors will make it more likely for immigrant women to be excluded from permanent residency than men.

§ 212.23 – Exemptions and waivers for public charge ground of inadmissibility

The proposed rule should still have a narrower scope to avoid subjecting individuals and families who use public benefits to supplement their income to public charge determinations. Further, much more work is needed to ensure that immigrant communities and service providers are aware of these exemptions.

¹⁷⁸ Samantha Artiga et al., *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KAISER FAMILY FOUND. 1 (2018), <http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid>.

¹⁷⁹ American Immigration Council, *The Impact of Immigrant Women in America's Labor Force, March 2017* (2017), *supra* note 130.

¹⁸⁰ Randy Capps et al., *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration*, MIGRATION POL'Y INSTITUTE (Nov., 2018), https://www.migrationpolicy.org/sites/default/files/publications/MPI-PublicChargeImmigrationImpact_FinalWeb.pdf.

§ 213.1– Adjustment of status of aliens on submission of a public charge bond

At Fed. Reg. 21220, the Department invites comments about the public bond process in general. The use of public charge bonds is impractical and would place an impossible burden on immigrant families. There is no evidence demonstrating that public charge bonds will achieve the desired outcome of preventing people from becoming dependent on government assistance. Years of reliance on monetary bonds in the criminal pretrial context has demonstrated the critical importance of empirical study identifying both predictors and effective mitigators of risk.¹⁸¹ Monetary bonds in the criminal pretrial context have been discredited as inefficient and unfair, lacking evidence that money motivates people to appear for court.¹⁸² Moreover, public charge bonds would necessarily have a disparate negative impact on minorities, including U.S. citizens, as financially-based pretrial detention systems have had.¹⁸³

Additionally, studies show that bonds cause long-term hardship and increase the likelihood of financial instability.¹⁸⁴ Public charge bonds are even more likely to cause long-term hardship, given the indefinite life of the bond.¹⁸⁵ Families will face years of annual fees, non-refundable premiums, and liens on the homes and cars put up as collateral charged by for-profit surety companies and their agents.¹⁸⁶ The indefinite term and extremely broad

¹⁸¹ Denise L. Gilman, *To Loose the Bonds: The Deceptive Promise of Freedom from Pretrial Immigration Detention*, 92 IND. L. J. 159 (2016).

¹⁸² *Id.*

¹⁸³ Color of Change, *Selling Off Our Freedom: How insurance companies have taken over our bail system*, AMERICAN CIVIL LIBERTIES UNION (“ACLU”) (2017), https://d11qn0ip9m46ig.cloudfront.net/images/059_Bail_Report.pdf; Arpit Gupta et al., *The High Cost of Bail: How Maryland's Reliance on Money Bail Jails the Poor and Costs the Community Millions*, MARYLAND OFFICE OF THE PUBLIC DEFENDER (2016), <http://www.opd.state.md.us/Portals/0/Downloads/High%20Cost%20of%20Bail.pdf>; Mathilde Laisne et al., *Past Due: Examining the costs and consequences of charging for justice in New Orleans*, VERA INSTITUTE OF JUSTICE (2017), https://storage.googleapis.com/vera-web-assets/downloads/Publications/past-due-costs-consequences-charging-for-justice-new-orleans/legacy_downloads/past-due-costs-consequences-charging-for-justice-new-orleans.pdf.

¹⁸⁴ Color of Change, *supra* note 183; Pretrial Justice Institute, *Pretrial Justice: What Does It Cost? Pretrial Justice: What Does It Cost?* (2017), <https://university.pretrial.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=4c666992-0b1b-632a-13cb-b4ddc66fadcd&forceDialog=0>.

¹⁸⁵ Both leaked drafts of the proposed regulation revise the current regulations to eliminate the automatic cancellation of the public charge bond upon naturalization, death, or permanent departure. See 8 C.F.R. § 103.6(c)(1). Instead, DHS seeks to impose an affirmative obligation on the immigrant or obligor to request the cancellation of the bond upon naturalization, death, or permanent departure. Most LPRs are not eligible to naturalize until at least five years after becoming an LPR, and many more are unable to naturalize for longer than that for a variety of reasons.

¹⁸⁶ Color of Change, *supra* note 183; Gupta et al., *supra* note 183; Laisne et al., *supra* note 183; UCLA School of Law Criminal Justice Reform Clinic, *The Devil in the Details: Bail Bond Contracts in*

and vague conditions governing breach only heightens the risk of exploitation by for-profit companies managing public charge bonds. Impoverishing immigrants and their families will make them more, not less, likely to need assistance. Moreover, at 83 Fed. Reg. 51222, DHS states its intent to require surety bonds, rather than allow for cash or cash equivalent to be placed in escrow. This puts immigrants fully at the mercy of commercial bond companies, who are likely to charge excessive fees, since immigrants will have no alternative to purchasing such a bond. The cost to immigrants of acquiring such a bond (on top of the fees payable to DHS for the posting, substitution, or canceling of a bond) are not included in the cost estimate for this rule.

While DHS creates a new market segment for commercial bond companies, it leaves states and localities, responsible for regulating bond insurers and bond agents--including those issuing immigration detention bonds--holding the bag for consumer protection. Many states already struggle to adequately regulate their current bond industries.¹⁸⁷ By expanding the market without any consideration for the increased burden on states and localities, DHS imposes an unfunded mandate on state and local insurance and financial services regulators.

III. PREAMBLE: CHILLING EFFECTS OF THE PROPOSED RULE

- a. *We strongly oppose the proposed rule because its direct effects would be to reduce enrollment in public benefits, such as Medicaid, creating significant confusion in benefits administration and burdening states with increased costs. DHS' estimate of these direct impacts are flawed, evidence of the insufficiency of its justifications.*

We strongly oppose the proposed rule because it would penalize individuals and families for using public benefits for which they are lawfully eligible. The proposed rule would directly and purposely cause disenrollment from public benefits among individuals applying for status adjustments. It will also create mass confusion in benefits administration,

California (2017), [https://static.prisonpolicy.org/scans/UCLA Devil%20 in the Details.pdf](https://static.prisonpolicy.org/scans/UCLA_Devil%20in%20the_Details.pdf); Brooklyn Community Bail Fund, *License & Registration, Please...An examination of the practices and operations of the commercial bail bond industry in New York City* (2017), https://static1.squarespace.com/static/5824a5aa579fb35e65295211/t/594c39758419c243fdb27cad/1498167672801/NYCBailBondReport_ExecSummary.pdf.

¹⁸⁷ Color of Change, *supra* note 183; Jessica Silver-Greenberg & Shaila Dewan, *When Bail Feels Less Like Freedom, More Like Extortion*, N.Y. TIMES (Mar. 31, 2018), <https://www.nytimes.com/2018/03/31/us/bail-bonds-extortion.html?mabReward=CTM4&recid=12eCxx0XJ509HkP8Jk98Q8kEubA&recp=3&action=click&pgtype=Homepage®ion=CColumn&module=Recommendation&src=rechp&WT.nav=RecEngine>.

saddling states and localities with significantly increased costs without funding from the federal government.

The proposed rule will directly affect approximately 1.1 million individuals seeking to obtain lawful permanent resident (LPR) status, half of whom already reside in the U.S.¹⁸⁸ in 2017, close to 380,000 such individuals sought a status adjustment through a pathway that would be subject to a public charge determination under the proposed rule.¹⁸⁹ But the effects of this proposed rule will not just be confined to immigration status determinations. The proposed rule affects the health and well-being of immigrants and citizens alike by stigmatizing public benefits use, impeding access to supplemental services that raise individual's and families' standard of living and improve overall population health in the U.S., and uprooting a system of benefits administration that supports these functions. Despite recognizing the probability that such negative effects will materialize, DHS wrongly ignores the fact that family members and communities surrounding non-citizens will stop using public benefits, even though they are not directly targeted by the proposed rule.

At highest risk of being negatively impacted by the proposed rule are the 14 million noncitizens and their family members whose household incomes fall below 125 percent of FPG. This starkly contrasts with DHS' estimated effect of the proposed rule, which puts the number of affected persons at 5,685,422.¹⁹⁰ This **total** estimate is better termed a woefully inadequate underestimate – it is closer to the number of children under age 17 who are non-citizens or family members of non-citizens and who reside in households under 125 percent of FPG.¹⁹¹ Furthermore, DHS uses inaccurate figures in its analyses, such as questionable methods to estimate the number of households using Medicaid, what number of those households have a non-citizen, and when number of enrollees live with a non-citizen.¹⁹²

The proposed rule would cause many hard-working and eager immigrants to be turned away from the U.S. altogether, or to be denied status adjustments, merely because they would act like every other person in the U.S. in using public assistance when falling upon hard times. It would replace the current system with an unworkably complex framework for assessing and passing judgment based on individual's use of benefits, placing the financial

¹⁸⁸ Dept. of Homeland Security, 2017 Yearbook of Immigration Statistics, *Table 6. Persons Obtaining Lawful Permanent Resident Status by Type and Major Class of Admission: Fiscal Years 2015 to 2017* (2017), <https://www.dhs.gov/immigration-statistics/yearbook/2017/table6>.

¹⁸⁹ *Id.*

¹⁹⁰ 83 Fed. Reg. 51262.

¹⁹¹ Manatt Health, *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard* (2018), <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population>.

¹⁹² Artiga et al., *supra* note 178.

burden of implementation on agencies, states, and localities that are ill-equipped to handle such a new system. States and localities will also be saddled with the costs of caring for populations who no longer receive public benefits; for example, state and local public health departments may provide vaccination clinic services for children who can no longer access such services through Medicaid. The proposed rule's direct effects on public benefits use necessarily beget indirect effects on health, well-being, and public expenditures at various levels of government.

Furthermore, the proposed rule obfuscates the purpose of public charge determinations. DHS is supposed to make individualized determinations about whether someone is likely to become a public charge in the future. DHS' authority therefore rests in and is contained to making immigration decisions based on an individual's susceptibility to the risk of becoming so destitute that the government will be required to provide for their subsistence. It is not DHS' responsibility to determine the proper level of government spending on public benefits programs, nor is it within DHS' authority to determine eligibility for these programs. DHS' expansive proposed definitions attempt to subvert Congress' intent and authority to determine public benefits budgets, spending levels, eligibility, and administrative processes. DHS, in both its redefinitions of "public charge" and "public benefits," and its justifications in support thereof, extends its reach beyond that intended by Congress. The direct result of the proposed rule, if implemented, will be an untested, burdensome, complex, confusing, and costly system of benefits administration.

b. *We strongly oppose the proposed rule because it would have a devastating chilling effect on the use of public benefits beyond the scope of what DHS considers in its explanation.*

i. DHS erroneously discounts chilling effects in its estimates, giving flawed justifications for the proposed rule's impact.

We dispute the Department of Homeland Security's (DHS) estimates of how the proposed rule, if implemented, would affect individuals' receipt of benefits. The proposed rule would chill immigrants' and citizens' use of public benefits on a large scale, making them afraid to access such programs because of stigma or adverse immigration consequences associated with their use, even if such consequences are not applicable. This undermines access to important social supports that augment individuals' and families' quality of living. The proposed rule's negative chilling effects will especially harm communities of color, women, and children.¹⁹³ Notably, such harm would extend to U.S. citizen-children with immigrant parents because the proposed rule would decrease parents' participation in

¹⁹³ Capps et al., *supra* note 180.

public benefits for which they are eligible. Research shows that as parents' participation in public benefits programs decrease, so do their children's participation in such programs.¹⁹⁴

DHS estimates that the proposed rule's deterrent effect would result in a reduction in transfer payments – funds or expenditures transferred from the federal government either to states or to individuals as a result of the proposed rule – from federal to state governments totaling approximately \$2.27 billion annually.¹⁹⁵ This reduction would be due to immigrants' disenrollment from benefits programs or forgoing benefits for which they are lawfully eligible.¹⁹⁶ DHS estimates that “2.5 percent of the number of foreign-born non-citizens previously estimated” would disenroll from or forego enrollment in public benefits.¹⁹⁷ For Medicaid alone, DHS estimates that 142,136 people would disenroll or forego enrollment, resulting in annual transfer payment reductions of over \$1 billion.¹⁹⁸ However, this estimation is arbitrary and unsupported – DHS gives no rationale for using the 2.5 percent figure to gauge disenrollment. The proposed rule cites no evidence in support thereof. Rather, it explicitly disregards evidence of larger chilling effects – disenrollment rates ranging from 21 to 54 percent – resulting from changes to public benefits programs as seen following the passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA).¹⁹⁹

DHS improperly disregards additional research studying chilling effects resulting from changes to welfare eligibility under PRWORA, stating that such research relied on retrospective analysis of changes in enrollment instead of on prospective estimates of PRWORA's potential effects.²⁰⁰ While this may be true, it does not excuse the lack of appropriate consideration of the effects emanating from PRWORA's eligibility changes. DHS attributes disenrollment from and reductions in the use of benefits after PRWORA to the Act's direct changes to eligibility *requirements*, contrasting it with the proposed rule, which would change enrollment *incentives*. Limiting the analysis to populations whose eligibility for public benefits is affected disregards lawfully present immigrants who would be chilled from applying for or receiving benefits for fear of other government action against them or of adverse status determinations in the future. DHS' estimate ignores such groups of people, a glaring omission considering the substantial research that exists regarding immigrant's confusion and lack of knowledge regarding the details benefits eligibility, their

¹⁹⁴ Georgetown Ctr. for Children and Families, *Health Coverage for Parents and Caregivers Helps Children* (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf>.

¹⁹⁵ 83 Fed. Reg. 51117.

¹⁹⁶ *Id.*

¹⁹⁷ 83 Fed. Reg. 51266.

¹⁹⁸ 83 Fed. Reg. 51268.

¹⁹⁹ 83 Fed. Reg. 51266.

²⁰⁰ *Id.*

deep-rooted fears of government retribution, and their role in fueling past chilling effects from changes to benefits eligibility.²⁰¹

DHS actually contends that it overestimates the number of individuals likely to disenroll from benefits programs. DHS states that its projections assume that disenrollment is most likely among “individuals intending to apply for adjustment of status or individuals who have adjusted status within the past five years” because they will be “sufficiently concerned about potential consequences of the policies proposed [] to disenroll or forgo enrollment in public benefits.”²⁰² DHS’ estimate is both an underestimation and an overestimation of the proposed rule’s effect on enrollment for public benefits. DHS overestimates how many people *directly* affected by the rule will disenroll – less than 100 percent of those applying for status adjustments are likely to disenroll. However, DHS’ analysis is limited to those individuals *directly targeted* by the proposed rule: individuals who imminently will apply or have recently applied for adjustment of status. It subsequently vastly underestimates the total number of people likely to disenroll from public benefits due to the proposed rule’s chilling effects. This includes applicants’ family members and friends, those in immigrant communities, and even those not affected by the proposed rule, such as refugees, as discussed throughout this comment.

²⁰¹ See HHS, ASPE, *How Are Immigrants Faring After Welfare Reform? Preliminary Evidence from Los Angeles and New York City* 16 (2002), <https://aspe.hhs.gov/system/files/pdf/72691/report.pdf> (describing immigrants’ limited understanding of eligibility restrictions and benefits); Danilo Trisi & Guillermo Herrera, *Administration Actions Against Immigrant Families Harming Children Through Increased Fear, Loss of Needed Assistance*, CTR. ON BUDGET & POL’Y PRIORITIES (2018), https://www.cbpp.org/research/poverty-and-inequality/administration-actions-against-immigrant-families-harming-children#_ednref12 (noting how immigrants’ fear of government causes chilling effects); Mark Hugo Lopez et al., *More Latinos Have Serious Concerns About Their Place in America Under Trump*, PEW RES. CTR. (Oct. 25, 2018), <http://www.pewhispanic.org/2018/10/25/more-latinos-have-serious-concerns-about-their-place-in-america-under-trump/> (detailing survey findings of immigrants’ fear of deportation); Samantha Artiga & Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*, KAISER FAMILY FOUND. (2017), <http://files.kff.org/attachment/Issue-Brief-Living-in-an-Immigrant-Family-in-America> (detailing the effect of fear on immigrants’ health); Pew Res. Ctr., *2007 National Survey of Latinos: As Illegal Immigration Issue Heats Up, Hispanics Feel a Chill* (2007), <http://www.pewhispanic.org/2007/12/13/2007-national-survey-of-latinos-as-illegal-immigration-issue-heats-up-hispanics-feel-a-chill/> (describing immigrants’ perceptions of immigration enforcement and resulting chilling effects); HHS, ASPE, *Barriers to Immigrants’ Access to Health and Human Services Programs* 6-8 (2012), https://aspe.hhs.gov/basic-report/barriers-immigrants-access-health-and-human-services-programs#_edn13 (explaining how lack of knowledge and understanding of benefits programs creates barriers to immigrants’ access); Schlosberg & Wiley, *supra* note 157 (describing how fear of public charge determinations manifests in immigrants’ health behaviors).

²⁰² 83 Fed. Reg. 51264-66.

- ii. **The proposed rule’s chilling effect would lead to lawfully present immigrants disenrolling from or foregoing enrollment in public benefits writ large, even if they are not applying for status adjustments, if the specific program is not within the proposed rule’s scope, or if they not targeted by the proposed rule, such as exempt persons and U.S. citizens.**

The proposed rule’s chilling effect will cause a decrease in public benefits use by individuals, families, children, and various population subgroups. As many as 41.1 million non-citizens and family members of non-citizens could be impacted as a result of the proposed rule’s policy changes – almost 13 percent of the entire U.S. population.²⁰³ DHS completely ignores any secondary effects on the immigrant communities targeted, failing to address data attesting to the prevalence of such effects and omitting any original estimations or models of the effects. DHS makes no effort to look at the larger chilling effects emanating from the proposed rule, particularly as they pertain to children, families, and other underserved communities and communities of color. This is despite mounting evidence that chilling effects are already manifesting in the immigrant community.²⁰⁴

History and research shows that the proposed rule will indeed have a substantial chilling effect. The proposed rule does not include estimates of how many *other* individuals, such as those exempt from the proposed rule and U.S. citizens, would be chilled and therefore forego use of or disenroll from the affected benefit programs. As discussed throughout this comment, this chilling effect occurs due to:

- confusion regarding one’s own eligibility for public benefits;
- stigma the proposed rule places on benefits programs writ large;
- erroneous determinations of who should be subject to the proposed rule made by individuals, caseworkers, benefits administrators, and immigration lawyers; and

²⁰³ Manatt Health, *supra* note 191.

²⁰⁴ See Annie Lowrey, *Trump’s Anti-Immigrant Policies Are Scaring Eligible Families Away From the Safety Net*, THE ATLANTIC (Mar. 24, 2017), <https://www.theatlantic.com/business/archive/2017/03/trump-safety-net-latino-families/520779/>; Rebecca Plevin, *Los Angeles Health Clinic ‘A Microcosm’ of the Nation’s Anxieties*, NPR (Mar. 25, 2017), <http://www.npr.org/sections/health-shots/2017/03/25/520813613/los-angeles-health-clinic-a-microcosm-of-the-nations-anxieties>; Pam Fessler, *Deportation Fears Prompt Immigrants to Cancel Food Stamps*, NPR (Mar. 28, 2017), <http://www.npr.org/sections/thesalt/2017/03/28/521823480/deportation-fears-prompt-immigrants-to-cancel-food-stamps>; Caitlin Dewey, *Immigrants are going hungry so Trump won’t deport them*, WASHINGTON POST, (Mar. 16, 2017), <https://www.washingtonpost.com/news/wonk/wp/2017/03/16/immigrants-are-now-canceling-their-food-stamps-for-fear-that-trump-will-deport-them/>. See also Trisi & Herrera, *supra* note 201.

- disenrollment from and foregone enrollment in programs not impacted by the proposed rule stemming from misconceptions over the proposed rule’s scope and details.

By omitting consideration of such factors in its analysis, DHS has significantly underestimated the chilling effect that the proposed rule, if implemented, would have on benefits use by those eligible for such programs.

The effects of this proposed rule would be incredibly far-reaching. Ninety-four percent of non-citizens without lawful permanent resident status have at least one characteristic that DHS could weigh negatively in a public charge determination, 42 percent of which have characteristics that could be considered heavily weighted negative factors.²⁰⁵ Provisional estimates of use of four major public benefits show that the proposed rule would impact approximately 7 million non-citizens who use these benefits and over 10 million individuals living in families in which someone received such benefits.²⁰⁶ Furthermore, the share of non-citizens subject to public charge determinations would increase by more than 15 times the current rate, jumping from three percent of non-citizens to 47 percent.²⁰⁷ Altogether, approximately 27 million individuals, including over 9 million citizen-children, are part of a family in which at least one member receives these public benefits subject to the proposed rule.²⁰⁸ One in four of the non-citizen population receives a benefit that would be subject to the new public charge definition.²⁰⁹ Meanwhile, one in three have incomes below the 125 percent of Federal Poverty Guidelines threshold set by the proposed rule.²¹⁰ Of those immigrants receiving public benefits likely to be affected by the proposed rule, more than half are employed, a rate higher than that of U.S. citizens.²¹¹

Critical evidence of the larger chilling effect on health insurance enrollment is drawn from both experiences following PRWORA and from current research on chilling Medicaid and public benefits use. After welfare reform, both independent research and government studies observed immigrants avoided public benefits use, especially with regard to health care services. For example, one study conducted by the Kaiser Family Foundation for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) detailed that immigrants’ use of Medicaid after 1996 dropped dramatically; for example, Los Angeles

²⁰⁵ Artiga et al., *supra* note 178.

²⁰⁶ Batalova et al., *supra* note 123. The four “major” benefits are Temporary Assistance for Needy Families (“TANF”), Supplemental Security Income (“SSI”), Supplemental Nutrition Assistance Program (“SNAP”), and Medicaid/ Children’s Health Insurance Program (“CHIP”). *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.* at 4.

²⁰⁹ *Id.*

²¹⁰ Artiga et al., *supra* note 178.

²¹¹ Batalova et al., *supra* note 123, at 4.

reported a 50 percent decrease in non-citizen immigrants' Medicaid enrollment.²¹² These reductions were directly linked to prevalent fears in the immigrant community of adverse immigration consequences associated with public benefits use.²¹³ Overall, PRWORA had unintended consequences that led to larger declines in Medicaid enrollment among immigrant populations when compared to native-born populations, even after controlling for socioeconomic factors, state-level policies, and unemployment across states.²¹⁴

Research based on immigrants' behavior and enrollment changes after PRWORA estimate that the proposed rule could cause a decline in immigrants' public benefits enrollment of between 20 and 60 percent.²¹⁵ This would total anywhere from 5.4 million to 16.2 million people disenrolling from or foregoing enrollment in programs for which Congress has made them eligible.²¹⁶ The share of persons who face public charge determinations based on benefits use would subsequently increase from 3 percent of non-citizens to 47 percent.²¹⁷ These estimates do not account for similar effects among U.S. citizens and otherwise eligible immigrants not subject to the proposed rule. Nor do they extend the estimate to populations using other public benefits programs included in the proposed rule. Thus, the overall chilling effect is likely to be even larger,²¹⁸ especially in light of the current political climate which has demonized immigrants, increased arrests and deportations, and shown indifference towards children's health and safety.²¹⁹

Comprehensive reviews of the PRWORA's chilling effects demonstrate that people who were unaffected by the eligibility changes still withdrew from public benefits programs and that low-income immigrants were disparately impacted.²²⁰ PRWORA caused chilling-related disenrollment from public programs among both citizen families and immigrant families, although the latter disenrolled from public benefits at a rate 13 percent more than the

²¹² Leighton Ku & Alyse Freilich, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston*, KAISER FAMILY FOUND. 7 (2001), <https://aspe.hhs.gov/system/files/pdf/72701/report.pdf>.

²¹³ *Id.* at 7-8; HHS, ASPE, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County* (1998), <https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county>.

²¹⁴ Namratha R. Kandula et al., *The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants*, 39 HEALTH SERVS. RES. 1509, 1514 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/pdf/hesr_00301.pdf.

²¹⁵ Batalova et al., *supra* note 123, at 23.

²¹⁶ *Id.*

²¹⁷ *Id.* at 3.

²¹⁸ Artiga et al., *supra* note 178.

²¹⁹ Batalova et al., *supra* note 123.

²²⁰ Michael E. Fix & Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform*, URBAN INSTITUTE 1-2, 5 (1999), <https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf>.

former.²²¹ Particularly concerning was the fact that children with an immigrant mother disenrolled from Medicaid, despite these children being unaffected by eligibility changes and remaining eligible for Medicaid coverage.²²² This effect was particularly pronounced for non-citizen children of lawfully present immigrants.²²³ Other studies note significant reductions in the rate of insurance among citizen-children of immigrants without LPR status, as compared to those with status.²²⁴

Disparities in Medicaid enrollment were seen throughout the larger immigrant community, despite no legal change in immigrants' eligibility for Medicaid and other public benefits in some cases.²²⁵ Research emphasizes the disproportionate impact on qualified immigrants. Refugees withdrew from Medicaid and other public benefits at especially high rates, despite being exempt from eligibility changes.²²⁶ Decreased rates of Medicaid coverage led to avoiding treatment, delaying care, using "underground" sources of care, and seeking uncompensated care at already thinly-stretched safety net providers, such as at clinics and public hospitals that typically rely on Medicaid reimbursements.²²⁷ These trends were even stronger in exempt populations, such as refugees, despite protections included in PRWORA to carve them out of the law's restrictive scope.²²⁸ This is emblematic of the strength of chilling effects in the immigrant community.²²⁹

Generally, immigrants' enrollment in Medicaid fell at much higher rates than did citizens'.²³⁰ Although immigrants accounted for only nine percent of households using welfare before PRWORA, they accounted for 23 percent of the households disenrolling from public benefits programs following PRWORA.²³¹ When adjusting for rising incomes, immigrants' disenrollment from or foregone enrollment in public benefits is affected at even higher rates.²³² Declining use of one program subject to PRWORA's restrictions was associated with declining use of other programs that were unaffected, establishing a link between

²²¹ *Id.* at 2; Ithai Zvi Lurie, *Welfare reform and the decline in the health-insurance coverage of children of non-permanent residents*, 27 J. HEALTH ECON. 786 (2008).

²²² Neeraj Kaushal & Robert Kaestner, *Welfare Reform and health insurance of Immigrants*, 40 HEALTH SERVS. RES. 717 (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/pdf/hesr_00381.pdf.

²²³ Lurie, *supra* note 221.

²²⁴ *Id.*

²²⁵ HHS, *supra* note 213.

²²⁶ Fix & Passel, *supra* note 220, at 4.

²²⁷ Ku & Freilich, *supra* note 212, at 13-15.

²²⁸ Mitchell H. Katz & Dave A. Chokshi, *The "Public Charge" Proposal and Public Health*, JAMA NETWORK (2018), <https://jamanetwork.com/journals/jama/fullarticle/2705813>.

²²⁹ See Kaushal & Kaestner, *supra* note 222, at 713-717; Fix & Passel, *supra* note 220, at 4; Kandula et al., *supra* note 214, at 1519-21.

²³⁰ Fix & Passel, *supra* note 220, at 1-4.

²³¹ *Id.* at 2.

²³² *Id.* at 4.

public benefits use across the spectrum of programs.²³³ Thus, disenrollment and foregone enrollment has broader effects on the public than just those accounted for in the direct estimates of programs targeted.²³⁴ For example, in states that provided substitute Medicaid benefits after PRWORA, its chilling effects were still observed and are associated with a near-10 “percentage point increase in the proportion of uninsured low-educated, foreign-born, single women.”²³⁵ These changes in public benefit use among a swath of lawfully present immigrants are attributable to the chilling effect of welfare reform.²³⁶

Current independent research and modeling estimating the effects of the proposed rule uses disenrollment and foregone enrollment effects following PRWORA as a guide for such projections. Accordingly, assuming a 25 percent disenrollment rate from Medicaid, the number of uninsured Medicaid-eligible immigrants and U.S. citizen-children could rise by well over 1 million.²³⁷ However, broader chilling effects impacting enrollment in other sources of coverage means that the number of uninsured would likely be even more.²³⁸ The proposed rule and the accompanying publicity will spread the chilling effects’ impact to a much larger swath of the immigrant population and those associated or related to immigrants. This will almost certainly produce negative effects that reverberate throughout the U.S. because of the confusion engendered by the proposed rule’s complexity.²³⁹

Chilling effects are likely to be heightened given the enduring antagonism towards immigrant communities that is now taking center stage in the Trump Administration.²⁴⁰ Chilling effects seen in PRWORA were not unique to that law; rather, chilling effects from other government policies have been continually driving immigrants’ use and failure to use public benefits for which they are eligible.²⁴¹ Past studies of heightened federal immigration

²³³ *Id.*

²³⁴ *Id.*

²³⁵ Kaushal & Kaestner, *supra* note 222, at 709.

²³⁶ See IMMIGRANTS AND WELFARE: THE IMPACT OF WELFARE REFORM ON AMERICA’S NEWCOMERS (Michael E. Fix ed.) (2009) (discussing the degree to which varying factors, especially chilling effects, contributed to changes in public benefits use among immigrants following PRWORA).

²³⁷ Krista M. Perreira et al., *A New Threat to Immigrants’ Health — The Public-Charge Rule*, 397 NEW ENG. J. MED. 902 (2018), <https://www.nejm.org/doi/pdf/10.1056/NEJMp1808020>.

²³⁸ *Id.* at 902-903.

²³⁹ Katz & Chokshi, *supra* note 228.

²⁴⁰ Chilling effects are the product not only of specific design, but also of the broader policy choices related to immigration. See Tara Watson, *Inside the Refrigerator: Immigration Enforcement and Chilling Effects in Medicaid Participation*, Working Paper 16278, NAT’L BUREAU OF ECON. RES. (2010), <http://www.nber.org/papers/w16278.pdf> (examining the effect of immigration enforcement on chilling of immigrants’ use of public benefits); Trisi & Herrera, *supra* note 201 (detailing how broader Trump Administration policies contribute to a heightened chilling environment).

²⁴¹ See Kathleen R. Page & Sarah Polk, *Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families*, 376 NEW ENG. J. MED. e20(1) (2017), <https://www.nejm.org/doi/pdf/10.1056/NEJMp1700829> (documenting chilling effects on immigrants

enforcement show reductions in Medicaid participation among children of immigrants by an estimated 9.2 percent, even if those children are citizens.²⁴² Ongoing efforts by the Trump Administration to reduce lawful immigration, increase arrests and deportation, and alter long-standing asylum policies are augmenting existing fears in immigrant communities.²⁴³ This will contribute to even greater chilling effects under the proposed rule.

Contemporaneous evidence has already shown how the chilling effects are playing out in communities. Reports of immigrants, especially women and children, disenrolling from public benefits due to fear of immigration consequences are becoming more prevalent, despite the rule's preliminary nature.²⁴⁴ The fear, confusion, and stigma generated by the proposed rule will propel further disenrollment from and forgone enrollment in public benefits programs, especially among numerous subpopulations that will be disproportionately chilled.

Chilling individuals' use of public benefits will have negative "follow-on" effects – or compound impacts – on individuals' health, finances, well-being, and ability to seek appropriate care from providers. Of particular concern are the proposed rule's follow-on impacts on health insurance coverage, health outcomes, and social determinants of health. The impact of these follow-on effects will reverberate throughout chilled individuals' communities and the states in which they live. Such effects are completely unaccounted for in DHS' analysis of the proposed rule and are discussed more in the following sections of this comment.

health care use resulting from anti-immigrant policies espoused during the 2016 presidential election); Francisco I. Pedraza & Ling Zhu, *The "Chilling Effect" of America's New Immigration Enforcement Regime*, PATHWAYS (2015),

https://inequality.stanford.edu/sites/default/files/Pathways_Spring_2015_Pedraza_Zhu.pdf

(Asserting that where immigration enforcement is most intense, chilling effects are heightened, even among citizens). See also Watson, *supra* note 240; Pew Res. Ctr., *supra* note 201.

²⁴² Watson, *supra* note 240.

²⁴³ Batalova et al., *supra* note 123; Trisi & Herrera, *supra* note 201.

²⁴⁴ See, e.g., Helena Bottemiller Evich, *Immigrants, Fearing Trump Crackdown, Drop Out of Nutrition Programs*, POLITICO (Sept. 3, 2018),

<https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292>;

Jennifer Laird et al., *Foregoing Food Assistance Out of Fear Changes to "Public Charge" Rule May Put 500,000 More U.S. Citizen Children at Risk of Moving into Poverty*, COLUMBIA POPULATION RES. CTR. (Apr. 5, 2018),

https://static1.squarespace.com/static/5743308460b5e922a25a6dc7/t/5af1a2b28a922db742154bbe/1525785266892/Poverty+and+Social+Policy+Brief_2_2.pdf; Samantha Artiga & Barbara Lyons,

Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being, KAISER FAMILY FOUND. (2018), <https://www.kff.org/report-section/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being-issue-brief/>; Trisi & Herrera, *supra* note 201.

See also Fiscal Policy Institute, *supra* note 97.

IV. PREAMBLE: “FOLLOW-ON IMPACTS EMANATING FROM THE PROPOSED RULE’S CHILLING EFFECTS

- a. *Disenrollment caused by the proposed rule will have significant negative “follow-on” impacts on individuals’ and families’ health insurance status, health outcomes, social determinants of health, and financial security and well-being.*
 - i. **The proposed rule will reduce rates of health insurance coverage, especially among immigrant communities.**

The proposed rule will increase the number of uninsured persons in the U.S. much more than DHS predicts, in large part due to the prevalence of the proposed rule’s chilling effects. Over 20 million children nation-wide have at least one immigrant parent; 10.4 million of these children are U.S. citizens.²⁴⁵ This roughly tracks proportions within Medicaid. Over 14 million Medicaid enrollees live in a household with at least one non-citizen; half of these enrollees are citizen-children.²⁴⁶ Despite the fact that over 90 percent of households with children who have at least one immigrant parent contain at least one full-time worker, two-thirds of these households have incomes below 250 percent of FPG.²⁴⁷ Lawfully present immigrant children and adults are twice as likely to be uninsured, reflecting more limited availability of employer-sponsored insurance among industries in which the adults in such households work.²⁴⁸ Disenrollment from and forgone enrollment in Medicaid due to the proposed rule’s chilling effect would further perpetuate this disparity in insurance status, especially harming children of immigrants.

Research demonstrates that the proposed rule’s chilling effect will cause disenrollment from and foregone enrollment in Medicaid among those living in households with at least one non-citizen immigrant. The Kaiser Family Foundation expects the total number of persons disenrolling to be between 2.1 million and 4.9 million, depending on varying rates of disenrollment.²⁴⁹ This is a stark contrast to DHS’ estimate that 142,000 people would disenroll from Medicaid per year, leading to a \$1.1 billion annual decrease in Medicaid expenditures.²⁵⁰ When coupled with recent research showing that immigrants pay more in

²⁴⁵ Artiga et al., *Potential Effects of Public Charge Changes on Health Coverage for Citizen Children*, KAISER FAMILY FOUND. (2018), <http://files.kff.org/attachment/Issue-Brief-Potential-Effects-of-Public-Charge-Changes-on-Health-Coverage-for-Citizen-Children>.

²⁴⁶ Samantha Artiga et al., *Potential Effects of Public Charge Changes on Health Coverage for Citizen Children*, KAISER FAMILY FOUND. (2018), <http://files.kff.org/attachment/Issue-Brief-Potential-Effects-of-Public-Charge-Changes-on-Health-Coverage-for-Citizen-Children>.

²⁴⁷ *Id.*

²⁴⁸ Kaiser Family Found., *Health Coverage of Immigrants* (2017), <http://files.kff.org/attachment/Fact-Sheet-Health-Coverage-for-Immigrants>.

²⁴⁹ Artiga et al., *supra* note 178.

²⁵⁰ *Id.*

health insurance premiums and contribute more in taxes to public sources of insurance than they receive in benefits across such sources of coverage,²⁵¹ DHS' rationale for disenrolling immigrants becomes even more perplexing. Immigrants' total per capital health care expenditures are significantly lower than – between one-half to two-thirds – of that of native-born citizens.²⁵² Such research suggests that policies aimed at curtailing immigration, such as the proposed rule, could negatively impact the risk pools of such sources of insurance coverage, raising costs and further reducing individuals' and families' expendable income.²⁵³ Such policies would also decrease their tax contributions that support public insurance programs, and by extension, the public budget.²⁵⁴

The chilling effect would cause the majority of citizen-children disenrolling from or foregoing enrollment in Medicaid to become uninsured. The current rate of uninsurance for citizen-children of immigrants is eight percent, whereas the uninsured rate for all children is five percent.²⁵⁵ If the proposed rule is implemented, research using the PRWORA-era disenrollment rate of 25 percent would cause 1.5 million children to lose Medicaid coverage, 1.1 million of whom would remain uninsured.²⁵⁶ Assuming a 35 percent disenrollment rate, 2 million children would lose Medicaid coverage, 1.5 million of whom would remain uninsured.²⁵⁷

These scenarios would raise the uninsurance rate among citizen-children of immigrants from eight percent to between 14 and 22 percent; for all children, the rate would be raised from five percent to between six and seven percent.²⁵⁸ Even these projections may underestimate the number of uninsured that the proposed rule would create because, among other reasons, they do not account for confusion that leads enrollees and potential enrollees in other sources of coverage to disenroll from or forego enrollment in such programs.²⁵⁹ Thus, enacting the proposed rule in its current form would subsequently roll

²⁵¹ Zallman et al., *supra* note 71; Lila Flavin et al., *Medical Expenditures on and by Immigrant Populations in the United States: A Systematic Review*, 0 INT'L J. HEALTH SERVICES 0 (2018), http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf.

²⁵² Flavin et al., *supra* note 251.

²⁵³ Zallman et al., *supra* note 71.

²⁵⁴ Lila Flavin et al., *Medical Expenditures on and by Immigrant Populations in the United States*: Flavin et al., *supra* note 251.

²⁵⁵ Artiga et al., *supra* note 246.

²⁵⁶ *Id.*

²⁵⁷ *Id.*

²⁵⁸ *Id.*

²⁵⁹ Kelly Whitener, *Trump Administration Will Drive Up Child Uninsured Rates if Public Charge Guidance is Issued*, GEORGETOWN CTR. FOR CHILDREN AND FAMILIES (May 22, 2018), <https://ccf.georgetown.edu/2018/05/22/trump-administration-will-drive-up-child-uninsured-rates-if-public-charge-guidance-is-issued/>.

back gains made in insuring children and would therefore contradict Congressionally-intended actions to expand coverage to such populations.

As low-income children with immigrant parents are already less likely to receive Medicaid than those with U.S. born parents,²⁶⁰ the proposed rule's chilling effects erect new barriers to immigrant families ability to seek appropriate health care and achieve self-sufficiency. The disenrollment and foregone enrollment caused by the chilling effect will diminish, if not nullify, the "welcome mat" effect, whereby children are more likely to gain insurance coverage when their parents gain coverage. Effectively purging low-income people eligible from Medicaid will "roll up" the welcome mat, taking with it all of the benefits that insurance coverage provides to both children and families.²⁶¹

These benefits of insurance coverage are key to families' financial stability. Enrolling in Medicaid enables low-wage workers to: find and retain employment,²⁶² decrease reliance on cash assistance,²⁶³ save more and contribute more to the local economy,²⁶⁴ address previously unmet medical needs,²⁶⁵ timely pay bills,²⁶⁶ purchase better quality food and housing,²⁶⁷ access credit and reduce debt,²⁶⁸ and achieve financial stability.²⁶⁹

The massive rate of lost insurance coverage, especially of Medicaid coverage, as a result of the proposed rule denies immigrants, their families, and their larger communities such positive effects. Lack of insurance among chilled populations "would reduce the use of prenatal and postnatal care and could therefore lead to higher rates of low birth weight, infant mortality, and maternal morbidity...forgone preventive care such as well-child visits, routine checkups, immunizations, and cancer screenings."²⁷⁰ This is why health insurance coverage is key to promoting health and wellness,²⁷¹ no matter someone's income or immigration status.

²⁶⁰ Wendy Cervantes et al., *Our Children's Fear: Immigration Policy's Effects on Young Children*, CTR. FOR LAW & SOCIAL POL'Y ("CLASP") (2018),

https://www.clasp.org/sites/default/files/publications/2018/03/2018_ourchildrensfears.pdf.

²⁶¹ *Id.*

²⁶² Antonisse & Garfield, *supra* note 49.

²⁶³ Soni et al., *supra* note 67; Burns & Dague, *supra* note 67.

²⁶⁴ Wagnerman et al., *supra* note 32.

²⁶⁵ Rudowitz & Antonisse, *supra* note 58; Hu et al., *supra* note 58; Sommers et al., *supra* note 23.

²⁶⁶ Rudowitz & Antonisse, *supra* note 58; Hu et al., *supra* note 58; Sommers et al., *supra* note 23.

²⁶⁷ Wagnerman et al., *supra* note 32.

²⁶⁸ Rudowitz & Antonisse, *supra* note 58; Caswell & Waidmann, *supra* note 59.

²⁶⁹ Miller et al., *supra* note 47; Ohio Dept. of Medicaid, *supra* note 51.

²⁷⁰ Perreira et al., *supra* note 237.

²⁷¹ Wagnerman et al., *supra* note 32;

DHS' classification of immigrants' pre-existing health conditions as a negative factor in determining whether an applicant for status adjustment is likely to be a public charge further exacerbates these negative effects. It creates a type of "pre-existing condition bar" for status adjustments as low-income immigrants with such conditions will be disincentivized from obtaining insurance needed to access proper care to manage their health.²⁷² As a result, normally manageable conditions and illnesses will fester until they become more costly and more dangerous emergencies.²⁷³ This incentive structure will perpetuate a cycle of poverty among immigrants, handicapping them from maximizing their health, their ability to work, and their contributions to society.

These effects will only worsen as the proposed rule erodes access to other public benefits that affect social determinants of health, such as nutrition programs and housing assistance.²⁷⁴ Instead of promoting these socially valuable programs, the proposed rule's disincentive for immigrants to use them will increase morbidity and mortality among immigrant communities for both children and adults, burdening the health care system with sicker patients and higher costs.

ii. The proposed rule will lead to worse health outcomes among those chilled from public benefits use.

As noted above, lack of insurance, especially for those eligible for Medicaid, reduces access to care and contributes to worse health outcomes.²⁷⁵ This phenomena was seen following PRWORA, when chilling effects on Medicaid use led to worse health outcomes among single mothers, pregnant women, and children,²⁷⁶ especially Latinas.²⁷⁷ Given this history and the outsized chilling effect this proposed rule will have on women and children, it is especially important to note the adverse health effects that will ensue accordingly.

The proposed rule's chilling of Medicaid enrollment would imperil the health of pregnant women and their children. Medicaid enables access to critical prenatal services that

²⁷² Parmet, *supra* note 122.

²⁷³ *Id.*

²⁷⁴ Artiga et al., *supra* note 246; Perreira et al., *supra* note 237.

²⁷⁵ Paradise, *supra* note 17.

²⁷⁶ Paul Wise et al., *Assessing the Effects of Welfare Reform Policies on Reproductive and Infant Health*, 89 AM. J. PUB. HEALTH 1514 (1999),

<https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.89.10.1514>; Kimberly Narain et al., *The impact of welfare reform on the health insurance coverage, utilization and health of low education single mothers*, 180 SOCIAL SCI. & MED. 28 (2017),

<https://escholarship.org/content/qt04s3m0hn/qt04s3m0hn.pdf>.

²⁷⁷ Marianne P. Bitler & Hilary W. Hoynes, *Welfare Reform and Indirect Impacts on Health*, Working Paper 12642, NAT'L BUREAU OF ECON. RES. (2007),

<http://www.socsci.uci.edu/~mbitler/papers/Michigan-Health-3-14-07.pdf>.

support pregnant women’s health and the health of their children. These services provided through Medicaid are associated with better childhood health,²⁷⁸ as well as better health in adulthood.²⁷⁹ The proposed rule would create barriers to accessing care for pregnant women that could increase maternal mortality and have serious health implications for the next generation. Despite the availability of Medicaid and CHIP, from 2009-2010, 40 percent of mothers surveyed across 30 states reported that they delayed prenatal care because they lacked the money or insurance to pay for their care.²⁸⁰ This problem is especially acute for immigrant women of reproductive age, with 34 percent of them being uninsured.²⁸¹ A lack of prenatal care and nutrition assistance for immigrant 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.²⁸²

Similarly, coverage losses due to the proposed rule’s chilling effect would reduce access to care for families writ large, contributing to worse health outcomes among immigrants and in the larger community.²⁸³ The role that Medicaid plays in stabilizing family finances and thereby reducing stress related to health care access translates into better health outcomes. However, disincentivizing Medicaid and insurance coverage, and the resulting reductions in coverage, removes this layer of security for families and introduces unnecessary psychosocial stressors. These stressors affect pregnant mothers by shifting stress hormone balances to trigger premature birth, restricted growth, and lower birth weight.²⁸⁴ These conditions are associated with worse health outcomes and reduced earnings as children grow into adulthood.²⁸⁵ As such, the proposed rule’s effective removal of Medicaid’s protections impedes healthy development for children, as well as overall financial security for the family.²⁸⁶

²⁷⁸ Wagnerman et al., *supra* note 32.

²⁷⁹ *Id.*

²⁸⁰ Kaiser Family Found., *supra* note 14.

²⁸¹ Guttmacher Institute, *Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads* (Dec. 4, 2018), <https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads>.

²⁸² Sharon Parrot, et al., *Trump “Public Charge” Rule Would Prove Particularly Harsh for Pregnant Women and Children*, CTR. ON BUDGET AND POL’Y PRIORITIES, (2018), <https://www.cbpp.org/sites/default/files/atoms/files/5-1-18pov2.pdf>.

²⁸³ Artiga et al., *supra* note 246; Carole Roan Gresenz & Jose J. Escarce, *Spillover effects of community uninsurance on working-age adults and seniors: an instrumental variables analysis*, 49 MED. CARE 14 (2011).

²⁸⁴ Janet Currie, *Inequality at Birth: Some Causes and Consequences*, Working Paper 16798, NAT’L BUREAU OF ECON. RES. (2011). <https://www.nber.org/papers/w16798.pdf>.

²⁸⁵ *Id.*

²⁸⁶ Artiga et al., *supra* note 246.

The climate of fear has deleterious health effects for immigrant families,²⁸⁷ especially for children in those families, and extends across various groups of immigrants.²⁸⁸ Most prevalent of these health effects are behavioral and emotional problems presenting in children who have immigrant parents. Ninety percent of school administrators surveyed across 12 states reported that students are encountering such problems due to concerns about immigration enforcement, regardless of immigration status.²⁸⁹ This is emblematic of toxic stress in children of immigrants, a phenomenon that can seriously harm their development and mental health. Toxic stress occurs when children’s stress management systems are subject to “strong, frequent, or prolonged activation.”²⁹⁰ Chronic exposure to stressors are archetypal of today’s immigration landscape: fears about family members’ separation or deportation, coupled with fear of social stigma, bullying, adverse immigration determinations, and discrimination pervade immigrant communities, especially Latinx and Muslim communities.²⁹¹ Continued exposure to such stressors alters the physical of children’s brains and impairs functioning in adulthood.²⁹²

The negative health effects stemming from the proposed rule are already evident.²⁹³ There are increasingly frequent reports across the country of decreased enrollment in public benefits programs that play a significant role in supporting children’s health due to parents’ worries about the adverse consequences of enrollment.²⁹⁴ Such fears are inducing “behavioral issues, psychosomatic symptoms, and mental health issues.”²⁹⁵ These issues include problems sleeping and eating, headaches, nausea, panic attacks, depression, attention-deficit/hyperactivity disorder, and anxiety, all of which are traced to increased prevalence and intensity of stress.²⁹⁶ Stressors of this nature have also been linked to incidence of inflammatory diseases in adulthood, including early-onset arthritis.²⁹⁷ The

²⁸⁷ Kathleen M. Roche et al., *Impacts of Immigration Actions and News and the Psychological Distress of U.S. Latino Parents Raising Adolescents*, 62 J. ADOLESCENT HEALTH 525 (2018), [https://www.jahonline.org/article/S1054-139X\(18\)30054-5/pdf](https://www.jahonline.org/article/S1054-139X(18)30054-5/pdf).

²⁸⁸ Trisi & Herrera, *supra* note 201; Roche et al., *supra* note 287.

²⁸⁹ Patrici Gándara & Jongyeon Ee, *U.S. Immigration Enforcement Policy and Its Impact on Teaching and Learning in the Nation’s School*, UCLA C.R. PROJECT (2018), <https://escholarship.org/uc/item/3047w6xq>; Cervantes et al., *supra* note 260.

²⁹⁰ Nat’l Sci. Council on Dev. Child, *Excessive Stress Disrupts the Architecture of the Developing Brain*, HARV. U. CTR. ON DEV. CHILD (2014), https://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf.

²⁹¹ Artiga & Ubri, *supra* note 201.

²⁹² Nat’l Sci. Council on Dev. Child, *supra* note 290.

²⁹³ Roche et al., *supra* note 287.

²⁹⁴ Cervantes et al., *supra* note 260.

²⁹⁵ Artiga & Ubri, *supra* note 201.

²⁹⁶ *Id.*

²⁹⁷ Kathleen M. Ziol-Guest et al., *Early childhood poverty, immune-mediated disease processes, and adult productivity*, 109 PROC. NAT’L ACAD. SCI. U S A. 17289 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477379/>.

proposed rule’s chilling effect would subsequently foster “an entire generation of children as second-class citizens – more likely to have adverse childhood experiences that lead to chronic disease, poor mental health, and risk of substance use disorders than their white peers living in homogenous white communities.”²⁹⁸ By contrast, where immigrants feel a greater sense of security, health outcomes improve.²⁹⁹

Lack of insurance and the resulting patterns of decreased utilization and poorer health outcomes will only deepen the disparities in health care access and health outcomes that immigrants already face.³⁰⁰ On almost all relevant measures, Medicaid enrollees have improved access to care when compared to the uninsured population. This includes having a more usual source of care, not delaying medical care,³⁰¹ and being less likely to visit the emergency department.³⁰² These results are core components of Medicaid programs which aim to reduce the costs of otherwise avoidable and unnecessary medical care, in addition to improve health outcomes.³⁰³ By chilling Medicaid enrollment, the proposed rule will slash

²⁹⁸ Cervantes et al., *supra* note 260.

²⁹⁹ Su Yeong Kim et al., *Culture’s Influence on Stressors, Parental Socialization, and Developmental Processes in the Mental Health of Children of Immigrants*, 14 ANN. REV. CLIN. PSYCHOL. 8.1, 8.8 (2018),

https://www.researchgate.net/publication/322946260_Culture%27s_Influence_on_Stressors_Parental_Socialization_and_Developmental_Processes_in_the_Mental_Health_of_Children_of_Immigrants; Atheendar S Venkataramani et al., *Health Consequences of the US Deferred Action for Childhood Arrivals (DACA) Immigration Programme: A Quasi-Experimental Study*, 2 THE LANCET e175, e178-79 (2017), <https://www.sciencedirect.com/science/article/pii/S2468266717300476>.

³⁰⁰ Zhihuan Jennifer Huang et al., *Health Status and Health Service Access and Use Among Children in U.S. Immigrant Families*, 96 AM. J. PUB. HEALTH 634 (2006), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2004.049791>; Susmita Pati & Shooshan Danagoulian, *Immigrant Children’s Reliance on Public Health Insurance in the Wake of Immigration Reform*, 98 AM. J. PUB. HEALTH 2004 (2008),

<https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2007.125773>; Ruth E. Zambrana, & Laura A. Logie, *Latino Child Health: Need for Inclusion in the US National Discourse*, 90 AM. J. PUB. HEALTH 1827 (2000), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446433/pdf/11111250.pdf>.

³⁰¹ MACPAC, *Access and Quality/Key Findings on Access to Care* (2018) <https://www.macpac.gov/subtopic/measuring-and-monitoring-access> (last visited Nov. 7, 2018).

³⁰² Winston Liaw et al., *The Impact of Insurance and a Usual Source of Care on Emergency Department Use in the United States*, 2014 INT. J. FAMILY MED. 1 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3941574/pdf/IJFM2014-842847.pdf>; Tina Hernandez-Boussard et al., *The Affordable Care Act Reduces Emergency Department Use By Young Adults: Evidence From Three States*, 33 HEALTH AFFAIRS 1648 (2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0103>.

³⁰³ See, e.g., Kathleen Gifford et al., *States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019*, KAISER FAMILY FOUND. (2018), <http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019>; Nat’l Ass’n of Medicaid Directors, *State Medicaid Operations Survey: Sixth Annual Survey of Medicaid Directors, FY 2017* (2018), <https://medicaidirectors.org/publications/sixth-annual-medicaid-operations-survey/>.

immigrants' access to preventive services, care management, and primary care.³⁰⁴ These services are essential in reducing health care costs, improving outcomes, and enabling immigrants to live and work in their communities.³⁰⁵ Ultimately, the proposed rule's chilling of public benefits use will detract from the net positive effect on health and the public budget that such public benefits provide to immigrants and to society.³⁰⁶ As with all health effects, these issues will be compounded by the proposed rule's chilling of the use of services that support and improve the social determinants of health.³⁰⁷

iii. By chilling use of non-health public benefits, the proposed rule will worsen immigrants' social determinants of health, further compounding its negative health effects.

Broad consensus among academic researchers,³⁰⁸ practitioners,³⁰⁹ and government entities³¹⁰ of the role that social determinants of health play in shaping health outcomes underscores how devastating this proposed rule would be for immigrants' health. The proposed rule goes beyond cutting access to health care services by disincentivizing immigrants and their families from obtaining insurance and staying insured; it aims to undermine the very supports that bolster their quality of living and thereby their health. Programs like SNAP, public housing assistance, energy assistance, and income tax credits improve health and increase self-sufficiency throughout the course of one's life.³¹¹ The evidence supporting the efficacy of such programs is absolutely incontrovertible. It has

³⁰⁴ Karina Wagnerman, *Medicaid: How Does it Provide Economic Security for Families?*, GEORGETOWN CTR. FOR CHILDREN AND FAMILIES, (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf>; Paradise, *supra* note 17.

³⁰⁵ Wagnerman, *supra* note 304; Paradise, *supra* note 17.

³⁰⁶ Hilary W. Hoynes et al., *Long Run Impacts of Childhood Access to the Safety Net*, 106 AM. ECON. REV. 903 (2016).

³⁰⁷ Artiga et al., *supra* note 246.

³⁰⁸ New Eng. J. Med. Catalyst, *Social Determinants of Health* (Dec. 1, 2018), <https://catalyst.nejm.org/social-determinants-of-health/>; Michael Marmot et al., *Closing the gap in a generation: health equity through action on the social determinants of health*, 372 THE LANCET 1661 (2008); World Health Org., *Social determinants of health and well-being among young people* (2012), <http://www.hbsc.unito.it/it/images/pdf/hbsc/prelims-part1.pdf>; Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. 19 (2014), <https://journals.sagepub.com/doi/pdf/10.1177/00333549141291S206>.

³⁰⁹ Allison Inzerro, *Physicians Call for Action on Social Determinants of Health*, AM. J. MANAGED CARE (Apr. 16, 2018), <https://www.ajmc.com/newsroom/physicians-call-for-action-on-social-determinants-of-health>; Anne Andermann, *Taking action on the social determinants of health in clinical practice: a framework for health professionals*, 188 CANADIAN MED. ASS'N J. e474 (2016), <http://www.cmaj.ca/content/cmaj/188/17-18/E474.full.pdf>.

³¹⁰ Health.gov, Office of Disease Prevention and Health Promotion, *Healthy People 2020: Social Determinants of Health* (2018), <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> (last visited December 6, 2018, 10:35 AM).

³¹¹ Hoynes et al., *supra* note 306.

prompted discussions within the medical community aimed at better addressing social determinants of health, including housing and food insecurity, at the provider and system levels.³¹² But the proposed rule “would hinder uptake of proven housing and nutrition programs in a vulnerable population.”³¹³

The affected programs, especially those supporting housing, income, nutrition, and care coordination, are important not only for the positive impact they have on users’ health, but also because they reduce long-run spending in health care.³¹⁴ Key to maintaining and improving these efficiencies is the continued support of such programs and linking them with traditional medical services to enable holistic, patient-centered care.³¹⁵ The proposed rule does the polar opposite: it disincentives use of both primary care and supportive supplemental benefits. The loss of both realms of public benefits – health and non-health -- will extend to immigrants’ families, meaning the positive effects of such benefits are foregone by an exponentially larger segment of the population.³¹⁶

For example, following trends of benefits use after PRWORA, we can expect to see close to, if not more than a 28 percent reduction in SNAP benefit use, meaning over 1 million people will lose access to healthy, nutritious foods.³¹⁷ Research shows that food insecurity during pregnancy and childhood reduces child test scores and adulthood earnings, and increases the likelihood of disability.³¹⁸ It also is linked with higher incidence of metabolism-related illnesses, such as high blood pressure and diabetes.³¹⁹ When SNAP was introduced, however, birth weight and other measures of newborn health improved, as did childhood and maternal health.³²⁰ Longitudinally, these outcomes were associated with improved economic self-sufficiency, and SNAP was associated with reducing incidence of

³¹² Katz & Chokshi, *supra* note 228.

³¹³ *Id.*

³¹⁴ Lauren A. Taylor et al., *Leveraging the Social Determinants of Health: What Works?*, 11 PLOS ONE (2016), <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0160217&type=printable>.

³¹⁵ *Id.*

³¹⁶ Parmet, *supra* note 122.

³¹⁷ Perreira et al., *supra* note 237.

³¹⁸ Douglas Almond & Bhashkar Mazumder, *Health Capital and the Prenatal Environment: The Effect of Maternal Fasting During Pregnancy*, Working Paper 14428, NAT’L BUREAU OF ECON. RES. (2008), <http://www.nber.org/papers/w14428.pdf>; Trisi & Herrera, *supra* note 201.

³¹⁹ Hoynes et al., *supra* note 306.

³²⁰ Douglas Almond et al., *Inside the War on Poverty: The Impact of Food Stamps on Birth Outcomes*, Discussion Paper 1359-08, INSTITUTE FOR RES. ON POVERTY (2008), <http://www.irp.wisc.edu/publications/dps/pdfs/dp135908.pdf>.

the aforementioned illnesses in early adulthood.³²¹ SNAP now acts as a critical safeguard against poverty and a contributor to better childhood health.³²²

SNAP is but one example of the public benefits addressing social determinants of health considered under the proposed rule. Voluminous research supports the efficacy of other programs in improving health and reducing costs to the public. Housing supports help families move to better neighborhoods and position children in those families to bolster their later earnings by close to 30 percent.³²³ These supports are especially critical for putting children on a path to success; without them, children will experience multiple hardships that compound each other, doing lasting damage to children's long-term development.³²⁴

The net result is that society will be less healthy, its children less able to adapt and succeed, its families less financially secure, and its public budget at more risk in the long-term.

iv. **The chilling effect has a disproportionate impact on people of color.**

The proposed rule will clearly have a disproportionate impact on people of color. While people of color account for approximately 36 percent of the total U.S. population, of the 25.9 million people potentially chilled from seeking services by the proposed rule, approximately 90 percent are people from communities of color (23.2 million). Among people of color potentially chilled by the rule, an estimated 70 percent are Latinx (18.3 million), 12 percent are Asian American and Pacific Islander (3.2 million), and 7 percent are African American (1.8 million).

³²¹ Hoynes et al., *supra* note 306. See also John T. Cook, *Child Food Insecurity Increases Risks Posed by Household Food Insecurity to Young Children's Health*, 136 J. OF NUTRITION 1073 (2006), <https://academic.oup.com/jn/article/136/4/1073/4664203>; Katie A. McLaughlin et al., *Food Insecurity and Mental Disorders in a National Sample of U.S. Adolescents*, 51 J. AM. ACAD. CHILD PSYCHIATRY 1293 (2012).

³²² Chloe N. East, *The Effect of Food Stamps on Children's Health: Evidence from Immigrants' Changing Eligibility*, J. HUMAN RESOURCES (2018), <http://www.sole-jole.org/17153.pdf>.

³²³ Raj Chetty et al., *The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment*, HARV. U. & NAT'L BUREAU OF ECON. RES. (2015), http://scholar.harvard.edu/files/hendren/files/mto_paper.pdf.

³²⁴ Cervantes et al., *supra* note 260; Maya Rossin-Slater, *Promoting Health in Early Childhood*, THE FUTURE OF CHILDREN 25 (2015); Karen Hughes et al., *The Effect of Multiple Adverse Childhood Experiences on Health: A Systematic Review and Meta-Analysis*, THE LANCET 2 (2017); Elizabeth A. Schilling et al., *The Impact of Cumulative Childhood Adversity on Young Adult Mental Health: Measures, Models, and Interpretations*, SOCIAL SCI. & MED. 66 (2008); Natalie Slopen et al., *Cumulative Adversity in Childhood and Emergent Risk Factors for Long-Term Health*, J. PEDIATRICS 164 (2014).

The disproportionate impact on communities of color provides additional evidence of the radical effect this rule would have in reshaping the country’s population. It would both cause disproportionate harm among people of color with unmet health and nutrition needs, and would dramatically reduce the diversity of immigrants entering the U.S. and obtaining green cards, reshaping the demographics of this country for decades to come. According to recent analysis by the Migration Policy Institute, the proposed rule would likely cause a significant shift in the origins of immigrants seeking visas and green cards, away from Mexico and Central America and towards Europe.³²⁵ This trend would not only reduce the diversity of immigration to the United States, it would disproportionately increase family separation among immigrants of color – and U.S. citizens - already residing in the U.S.

b. *Disenrollment caused by the proposed rule will have significant negative “follow-on” effects on individual health care service providers and health systems.*

The chill on Medicaid enrollment and stigmatization of immigrants’ overall use of public benefits will increase the amount and severity of uncompensated care, subsequently harming individual health care providers and health systems. Following PRWORA, safety-net providers that disproportionately care for low-income immigrant populations reported losing Medicaid patients and revenue while the number of uninsured patients rose.³²⁶ This contributed to increases in uncompensated care provided by, uninsured patient load of, and bad debt assumed by hospitals in high-immigrant areas.³²⁷ Similar effects are already manifesting today: safety-net providers are increasingly reporting missed clinic visits,³²⁸ declines in local health programs and Medicaid enrollment,³²⁹ and increases in uncompensated care.³³⁰

The Journal of the American Medical Association calls this “antithetical to the sound practice of medicine” because without Medicaid coverage, immigrants and their families are less likely to seek and receive age-appropriate disease screenings, preventative health

³²⁵ Capps et al., *supra* note 180.

³²⁶ Ku & Freilich, *supra* note 212.

³²⁷ *Id.*

³²⁸ The Children’s Partnership, *California Children in Immigrant Families: The Health Provider Perspective* (2018), <https://www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Infographic-.pdf>; Hannah Matthews et al., *Immigration Policy’s Harmful Impacts on Early Care and Education*, CLASP (2018), https://www.clasp.org/sites/default/files/publications/2018/03/2018_harmfulimpactsece.pdf.

³²⁹ Trisi & Herrera, *supra* note 201; Lowrey, *supra* note 204; Plevin, *supra* note 204.

³³⁰ Dhruv Khullar et al., *Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care?*, HEALTH AFFAIRS BLOG (May 10, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180503.138516/full/>.

counseling, and chronic disease management during emergency department visits.³³¹ Such services are essential to reducing the risk of adverse health events throughout life.

Immigrants' limited understanding of immigration law's complexities, especially of the proposed rule, further complicates providers' roles. Even if outreach efforts to immigrant communities raise the visibility of the proposed rule's implications, providers will still be expected and relied upon to explain the implications of their medical advice.³³² Providers are "trusted sources of information for patients...especially [] for immigrant populations who are unfamiliar with the U.S. medical system."³³³ As providers and patients encounter the types of situations described above, immigrants' faith in providers as a source of information could erode. This could create further confusion in immigrant communities, jeopardizing recent progress made in improving their access to care.³³⁴

V. DHS' INSUFFICIENT ECONOMIC JUSTIFICATIONS FOR THE PROPOSED RULE

DHS' assertions that subjecting a broader array of public non-cash benefits to public charge determinations is more "protective of the public budget" and establishes "a proper nexus between public charge and receipt of public benefit" are flawed.

We oppose DHS' stated rationale for the proposed rule. Its claim that the previous framework established under the 1999 guidance was "insufficiently protective of the public budget"³³⁵ is based off a skewed, one-sided analysis of public benefits. Positive revenue effects emanating from use of public benefits boost states' budgets in the long run, protecting the public budget in a more stable and less disruptive way than disincentivizing the use of public benefits by those who need assistance most. There are a variety of problems with DHS' approach to this analysis, the most pressing of which are discussed below.

- a. *It is not DHS' responsibility to protect the public budget through public charge determinations.*

Public charge determinations are individualized assessments of whether applicants for admission or status change are likely to become so impoverished or incapable of caring for themselves that the government must provide for their subsistence. It is, itself, a justification for inadmissibility or inability to obtain a green card based on each individual

³³¹ Katz & Chokshi, *supra* note 228.

³³² Perreira et al., *supra* note 237.

³³³ Katz & Chokshi, *supra* note 228.

³³⁴ Perreira et al., *supra* note 237.

³³⁵ 83 Fed. Reg. 51164.

applicant's unique circumstances. Instead of continuing this focus, as directed by statute, DHS justifies its changes to public charge doctrine by claiming that the current system's focus on cash benefits is "insufficiently protective of the public budget, particularly in light of significant public expenditures on non-cash benefits."³³⁶ This rationale is inconsistent with the individualized nature of public charge determinations DHS is supposed to conduct.

DHS' goal of reigning in the public budget, as expressed in its proposed rule, is fundamentally different from its statutory mandate to consider whether an immigrant is admissible on account of statutorily enumerated factors. To achieve its goal, DHS carves into consideration a large swath of public benefits that have not been assessed under public charge determinations. DHS explicitly does so because it thinks the federal government spends too much on such programs in the aggregate, and their consideration in public charge determinations will temper such spending levels. However, overall public expenditures are not indicators of an individual's dependency on government. Neither are average per-person expenditures under each program. DHS' attempt to frame raw spending on public benefits as a measure of dependency necessarily devalues the greater public health purposes for which Congress both enacted and expanded eligibility for such programs.

Furthermore, neither section 212(a)(4) of the INA, nor any other part of the statute gives DHS the authority to police the federal budget on a global basis. DHS is not the arbiter of how other agencies spend their money. DHS is also not responsible for determining, influencing, or restricting eligibility for programs on which federal money is spent. These functions are the sole responsibility of Congress. Absent Congressional action specifically giving DHS responsibility to monitor, reduce, and make public charge determinations based on federal spending levels, DHS' rationale for expanding its definitions both of public charge and of public benefit are in excess of its statutory mandate. As this rationale underlies the entirety of DHS' entire proposed, DHS should rescind its proposed rule.

b. *DHS conducted a wholly insufficient review of pertinent literature and resources.*

DHS asserts that there is a lack of literature and research on links between immigration and public benefits.³³⁷ This statement undercuts DHS' position that public benefits are an incentive for immigrants to come to the U.S. and that immigrants' use of such benefits are harmful to the public budget. DHS is seemingly offering a proposed rule to address issues that it wrongly states are not documented, researched, or validated by institutions that primarily study such subject matter. DHS is therefore proposing "solutions" to fix incentives without any concrete understanding of how those incentives operate in reality.

³³⁶ 83 Fed. Reg. 51164.

³³⁷ 83 Fed. Reg. 51236.

DHS offers the proposed rule without adequately considering the comprehensive effects the proposed rule will have on the public budget. DHS states that it is hard to determine if immigrants are “net contributors or net users” of public benefits programs because the inquiry “depends on the data source, how the data are used, and what assumptions are made.” Yet, an accurate and comprehensive review of the research shows that the bulk of the work in identifying and analyzing the impact of these factors is already done.³³⁸ In particular, two reports from the National Academy of Science document the long-term net benefits of immigration to the economy and various levels of government.³³⁹ This body of evidence shows that immigration has net positive effects on the economy and the public budget.³⁴⁰ The “immigration surplus” leaves both immigrants and native-born Americans in better positions to contribute to society.³⁴¹

- c. *DHS’ sparse cost-benefit analysis excludes key data and omits consideration of easily-identified impacts of the proposed rule. Mainly, DHS failed to consider the costs of the proposed rule’s chilling effects and of its follow-on impacts.*

DHS analyzes the impact that current public benefit programs have on the public budget; however, this analysis only considers outputs, i.e. government expenditures for such programs, without accounting for increases in inputs, i.e. relative increases in tax revenue gained later on by virtue of individuals’ prior receipt of public benefits. The preamble to the proposed rule notes the large total federal expenditure for Medicaid.³⁴² It also discusses the costs and benefits of the proposed rule, paying specific attention to the reduction in transfer

³³⁸ David Bier, *The \$1/Day Standard & Other Problems with DHS’s Public Charge Rule*, CATO INSTITUTE (2018), <https://www.cato.org/blog/1-day-standard-other-problems-dhss-public-charge-rule>.

³³⁹ See NAT’L ACAD. OF SCI. ENG’G MED., *THE NEW AMERICANS: ECONOMIC, DEMOGRAPHIC, AND FISCAL EFFECTS OF IMMIGRATION* (James P. Smith and Barry Edmonston eds.) (1997) (ebook), <https://www.nap.edu/catalog/5779/the-new-americans-economic-demographic-and-fiscal-effects-of-immigration>; NAT’L ACAD. OF SCI. ENG’G MED., *THE ECONOMIC AND FISCAL CONSEQUENCES OF IMMIGRATION 122* (Francine D. Blau and Christopher Mackie eds.) (2017) (ebook), http://d279m997dpfwgl.cloudfront.net/wp/2016/09/0922_immigrant-economics-full-report.pdf.

³⁴⁰ See, e.g., Penn Wharton, *The Effects of Immigration on the United States’ Economy*, U. PENN. (2016), <https://static1.squarespace.com/static/55693d60e4b06d83cf793431/t/5bdb6a6540ec9acdd252b311/1541106277851/The+Effects+of+Immigration+on+the+United+States%E2%80%99+Economy.pdf>;

Michael Greenstone & Adam Looney, *Ten Economic Facts About Immigration*, THE HAMILTON PROJECT AT BROOKINGS (2010), https://www.brookings.edu/wp-content/uploads/2016/06/09_immigration.pdf; Nat’l Council of Econ. Advisors, *Immigration’s Economic Impact*, WHITE HOUSE ARCHIVES OF GEORGE W. BUSH (2007), https://georgewbush-whitehouse.archives.gov/cea/cea_immigration_062007.html; NAT’L ACAD. OF SCI. ENG’G MED., *supra* note 339 (1997); NAT’L ACAD. OF SCI. ENG’G MED., *supra* note 339 (2017).

³⁴¹ NAT’L ACAD. OF SCI. ENG’G MED., *supra* note 339, at 122 (2017).

³⁴² 83 Fed. Reg. 51168.

payments from the federal government to both individuals, and states and localities.³⁴³ DHS' focus is thus squarely on the raw costs of public benefits administration – the amount of money the federal government spends or transfers to individuals via public benefits programs. This focus is inherently flawed and wholly insufficient because it ignores the beneficial impact that such programs have not only on individuals' and families' self-sufficiency, but also on the economic contributions to their local and state economies and boosting public budget finances.³⁴⁴

As detailed earlier in this comment, Medicaid spending produces well-documented multiplier effects that boost personal finances, local and state economies, and job growth. By discouraging enrollment in Medicaid, the proposed rule will negate these positive effects, harming both individual financial stability and economic growth.

DHS admits and estimates that the proposed rule will result in some immigrants ceasing the use of public benefits, but such estimates are unconscionably low and do not account for broader chilling effects likely to afflict the larger population. DHS notes that the proposed rule will likely cause great harm to individuals, families, and communities. It further says disenrollment and foregone enrollment in public benefits programs by those chilled by the proposed rule will likely lead to:

- “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 rates of poverty and housing instability; and
- Reduced productivity and educational attainment.”³⁴⁵

The cost of uncompensated care for uninsured individuals comes at great expense to the public budget. Research demonstrates that the federal government is the largest funder of

³⁴³ 83 Fed. Reg. 51267-69.

³⁴⁴ Lynn A. Karoly, *Valuing Benefits in Benefit-Cost Studies of Social Programs*, RAND (2008), https://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR643.pdf.

³⁴⁵ 83 Fed. Reg. 51270.

uncompensated care costs, spending \$32.8 billion in 2013 to offset costs of uncompensated care, whereas states and localities spent \$19.8 billion.³⁴⁶

Instead of encouraging Medicaid enrollment, which helps prevent these effects and boosts revenue collection, the proposed rule will discourage Medicaid enrollment and transfer costs from the federal government to state and local governments. By ignoring the costs associated with disenrollment and chilling, DHS fails ascertain the true costs of the proposed rule.

Furthermore, Immigrants are net contributors to the tax base and discouraging immigration will reduce the number of potential taxpayers, harming the public budget. DHS grossly underestimates the costs of the proposed rule by disregarding the revenue effects following from denying admission to immigrants and reducing the number of eligible taxpayers. Decreases in the number of eligible taxpayers who could add to the public budget will result from the proposed rule.³⁴⁷ DHS' omission of any estimates, analysis, or measurement regarding these effects and their impact on the public budget undermines its conclusory statements regarding the rationale in support of proposed rule.

Concerningly, DHS disregards entirely the work of the National Academy of Sciences, which estimates that, on average, the net fiscal effects of immigration are overwhelming positive.³⁴⁸ It shows that immigrants “contribute to all levels of government, in net present value terms, \$150,000 more in taxes than they receive in benefits over their lifetime.”³⁴⁹ DHS estimates that 324,438 people and 14,532 households annually will forego use of public benefits for which they are eligible, totaling \$1.51 billion in savings to the federal government.³⁵⁰ This population comprises the entire population subject to public charge determinations annually.³⁵¹

When coupled with the research showing that most immigrants have net positive fiscal effects on the public budget over a 75-year span, the proposed rule's penalties for public benefits use defy not only cost-benefit analyses, but logic and common sense as well. This is why researchers have suggested that the proposed rule will cost more than it purports to

³⁴⁶ Teresa A. Coughlin et al., *Uncompensated Care for Uninsured in 2013: A Detailed Examination*, KAISER FAMILY FOUND. (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf>.

³⁴⁷ Bier, *supra* note 164.

³⁴⁸ NAT'L ACAD. OF SCI. ENG'G MED., *supra* note 339, at Table 8-14 (2017).

³⁴⁹ David Bier, *New Rule to Deny Status to Immigrants Up to 95% Self-Sufficient*, CATO INSTITUTE (2018), <https://www.cato.org/blog/new-rule-deny-status-immigrants-95-self-sufficient>.

³⁵⁰ 83 Fed. Reg. 51267.

³⁵¹ 83 Fed. Reg. 51264.

save: for every dollar it saves, the proposed rule imposes approximately \$1.46 in costs.³⁵² This is hardly evidence of protecting the public budget.

The proposed rule changes our system of family-based immigration to an income-based system that grants preference to the wealthy in ways that the Administration has proposed through legislation but that Congress has rejected. It would create a multitude of ways for individuals to fail the public charge test, and very few ways to overcome it.

The public charge test was not meant to erect near-insurmountable barriers to immigration and use of public benefits. It was meant to prevent wholesale reliance on government support by individual members of society. The proposed rule abandons this goal, a change of position that will harm the public health, public budget, and U.S. economy for years to come. For these reasons, DHS must rescind the proposed rule.

VI. CONCLUSION

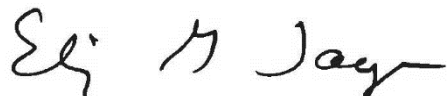
Thank you for the opportunity to provide these comments. As we have concluded throughout our comments, we strongly oppose the rule as ill-advised and detrimental to immigrants, their families and their communities. We urge DHS to rescind the proposed rule and continue using the guidance issued in 1999 to govern public charge determinations.

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act.

³⁵² Alex Nowrasteh, *Denying green cards to legal immigrants won't fix the welfare system — it will cost taxpayers more*, L.A. TIMES (Aug. 17, 2018, 4:05 AM), <https://www.latimes.com/opinion/op-ed/la-oe-nowrasteh-immigrant-use-of-welfare-20180817-story.html>.

If you have any questions about our comments, please contact Mara Youdelman (youdelman@healthlaw.org or 202-289-7661).

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive style with a long horizontal flourish at the end.

Elizabeth G. Taylor
Executive Director