



April 25, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Alejandro Mayorkas
Secretary
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Attention: DHS Docket No. USCIS–2021–0013; Public Charge Ground of Inadmissibility

Dear Secretary Mayorkas:

Thank you for the opportunity to comment on DHS Docket No. USCIS–2021–0013, the notice of proposed rulemaking, “Public Charge Ground of Inadmissibility” (hereinafter referred to as “the NPRM”).

The undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Department of Homeland Security (DHS) to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In March of 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation’s healthcare system.¹ These principles state that: (1) healthcare should be accessible, meaning that patients should be able to enroll in coverage without undue barriers; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need.

In general, we support the proposed regulations issued by DHS. These regulations represent a faithful interpretation of the statute, are consistent with long-established policy on public charge, and most importantly, are responsive to the policy evidence about immigrant access to public benefits, including health care. The patients we represent remain at great risk of not using benefits for which they are eligible under the existing regulations (currently vacated, with litigation pending), and we urge you to finalize these proposed regulations to ensure that immigrant communities retain access to health care and other benefits.

DHS should replace the 2019 final rule with the evidence-based policies in the NPRM.

The vacated 2019 Final Rule, *Inadmissibility on Public Charge Grounds*, made sweeping and radical changes to longstanding public charge law and policy, and the impact was very harmful to patients. Researchers at the Urban Institute (and others) have documented the “chilling effect” of the 2019 Final Rule, including in a June 2020 report which found that 1 in 5 adults in immigrant families with children reported avoiding public benefits in 2019, even before the rule was implemented.² The chilling effect was the worst for low-income families with children (31.5 percent).³ During the same period the number of uninsured children saw the largest increase in recent memory, in part due to avoidance of Medicaid and CHIP by eligible children, underscoring the harm.⁴ The rule was also overly complicated, making it difficult for applicants to understand the implications of benefit use and other decisions. For example, the Well-Being and Basic Needs Survey conducted by the Urban Institute found that while two-thirds of adults in immigrant families were aware of the public charge rule and 65.5 percent were confident in

¹ Healthcare reform principles. Available at: <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf>

²H. Bernstein, et al., “One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018,” (Washington, D.C.: Urban Institute, May 22, 2019), available at <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>; R. Capps, et al., “Anticipated ‘Chilling Effects’ of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families,” (Washington, D.C.: Migration Policy Institute, December 2020), available at <https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real>.

³ J.M. Haley, et al., “One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019,” (Washington, D.C.: Urban Institute, June 18, 2020), available at <https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019>.

⁴ J. Alker and A. Corcoran, “Children’s Uninsured Rate Rises by Largest Annual Jump in More Than a Decade (Washington, D.C.: Georgetown University Center for Children and Families, October 2020) available at https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.

their understanding of the rule, less than a quarter knew it did not apply to citizenship applications and less than 1 in 5 knew children’s enrollment in Medicaid would not be considered in their parents’ public charge determinations.⁵

The 2019 Final Rule would also perpetuate discriminatory practices against people with disabilities by assuming that people with a wide range of medical conditions are more likely to be a public charge, contradicting decades of disability discrimination law.

Ultimately, to protect access to care and other benefits for patients, the NPRM must be finalized to replace the policies of 2019 final rule. Once finalized, it will also be important for DHS to work in partnership with other federal agencies, state and local governments, and trusted community-based partners to inform the public about the rule changes and provide certainty about how public charge will be interpreted.

While this NPRM and the 1999 Interim Field Guidance that is currently in effect both impose a public charge inadmissibility test that, unlike the 2019 Final Rule, is generally consistent with the statutory requirements and policy evidence, we identify several recommendations for improvement outlined below.

DHS should implement the proposed definition of public charge requiring primary dependence on the government for subsistence.

Many low- and moderate-income working families rely on public benefits to supplement their earnings and make ends meet, and use of these benefits is a poor proxy for identifying a public charge. If the 2019 Final Rule were applied to U.S.-born citizens, more than half would potentially be considered a public charge based on benefit receipt.⁶ This is not surprising: the nutrition, health, and other support benefits that families receive cannot be converted into the income needed to pay rent, utilities, childcare, transportation costs, purchase clothing, etc. Use of public benefits such as Medicaid can also help a family achieve greater health, educational, and financial outcomes in the future.⁷ By focusing instead on *primary* reliance for the purpose of *subsistence*, the NPRM is consistent with the statute and prior policy.

⁵ H. Bernstein, et al., “Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019,” (Washington, D.C.: Urban Institute, May 2020), available at https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf.

⁶ *Id.*

⁷ E. Park, et al., “Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm,” (Washington, D.C.: The Commonwealth Fund, December 8, 2020), available at <https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm>.

DHS should only consider the current receipt of TANF and SSI for public charge determinations.

DHS should only consider the current receipt of two federally-funded cash assistance benefits in the public charge inadmissibility determination: TANF and SSI. Furthermore, DHS should only consider *current* use of benefits and should not count past benefit use, which is not predictive of likelihood of becoming a public charge. By focusing on current use of two benefits, DHS will be able to make more consistent determinations that more accurately reflect the applicant's potential to become a public charge. Access to SNAP, health insurance, housing, and other benefits lead to better health that translates to improved educational outcomes and long-term economic security that benefit society as a whole.⁸ We also strongly support the definition of "receipt of benefits" as the actual receipt of benefits where the individual is listed as the beneficiary of the benefit, and not including benefits received on behalf of another person.

DHS should completely exclude Medicaid from consideration in public charge determinations.

The NPRM reinstates the policy of the 1999 field guidance, only considering Medicaid institutional benefits in public charge determinations. This is a critical improvement to the 2019 Rule policy which, despite voluminous evidence against the policy, allowed a wider set of Medicaid benefits to potentially be considered. Non-institutional Medicaid has no connection to income maintenance and is a poor proxy for identifying public charges.⁹ At the same time, considering non-institutional Medicaid for public charge purposes leads to great harms, as many individuals will refuse to seek coverage or care.¹⁰

While we commend that the NPRM corrects the harmful policy of the 2019 rule to count noninstitutional Medicaid, the NPRM continues to count long-term institutional Medicaid for public charge determinations. This ignores the clear practical and public health reasons to fully exclude Medicaid from consideration. Practically, such a policy would be of little relevance or cost. Public charge rarely applies and saves minimal spending.¹¹ Moreover, although an inconsequential number of immigrants subject to the public charge rule actually use Medicaid institutional benefits, countless individuals forgo Medicaid coverage out of fear that they or a

⁸ S. Carlson, et al., "SNAP Works for America's Children," (Washington, D.C.: Center on Budget and Policy Priorities, September 29, 2016), available at <https://www.cbpp.org/research/food-assistance/snap-works-for-americas-children>; D. Murphey, "Health Insurance Coverage Improves Child Well-Being," (Bethesda, MD: Child Trends, May 2017), available at http://www.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf; and A. Sherman and T. Mitchell, "Economic Security Programs Help Low-Income Children Succeed Over Long Term, Many Studies Find," (Washington, D.C.: Center on Budget and Policy Priorities, July 17, 2017), available at <https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-help-low-income-children-succeed-over>.

⁹ Op. cit. 5-6.

¹⁰ Op. cit. 1-2.

¹¹ R. Capps, et al., "The Public-Charge Rule: Broad Impacts, But Few Will Be Denied Green Cards Based on Actual Benefits Use," (Washington, D.C.: Migration Policy Institute, March 2020), available at <https://www.migrationpolicy.org/news/public-charge-denial-green-cards-benefits-use>.

family member will be negatively impacted in their immigration processes.¹² This means they are much less likely to have preventive, chronic, specialty, or acute care, or access to prescriptions drugs and other services, which is associated with worse health outcomes and lower quality of life.¹³ Forgoing Medicaid also results in financial harms.¹⁴

In contrast, if DHS fully excluded Medicaid, DHS, providers, and other public stakeholders could definitively state that, “Medicaid never results in a public charge problem.” Such a message is simple, clear, and would allow people to feel safe accessing Medicaid.

DHS should also exclude Medicaid institutional care from public charge consideration because the need for institutional care is subject to significant variation from state to state based upon the availability of home and community-based support alternatives and requires clinical expertise to evaluate accurately.¹⁵ This makes the NPRM standard difficult to administer and will likely lead to inconsistent application, because an immigration official would not have a meaningful way to evaluate likelihood of long-term institutionalization without knowledge of the specific state in question or clinical expertise. Instead, they may assume incorrectly that any person with an easily identifiable physical or cognitive disability will be institutionalized. We also believe this policy will be discriminatory in practice, as significant numbers of individuals in institutional care are individuals with disabilities that have no alternative to institutional care, often in violation of federal law.¹⁶

If DHS decides to retain the proposal to count institutional Medicaid, then we believe it is particularly important to maintain other features of the proposed rule, including the definition language “long-term institutionalization at government expense”; the specific inclusion of language excepting “short periods for rehabilitation purposes”; and the inclusion of an exception for “institutionalization that violates federal law.” We also support the specific provision that disability alone is not sufficient to determine whether an individual is likely to become a public charge, which should be finalized regardless of how Medicaid is considered.

DHS should only consider federal programs in public charge determinations.

The public charge test should focus on reliance on the *Federal* government, not state or other local governments. This will lead to a more just public charge policy that can be applied uniformly across the country, rather than having different results based on where the applicant

¹² H. Bernstein, Op. Cit. 7.

¹³ B.D. Sommers, et al., “Health Insurance Coverage and Health—What the Recent Evidence Tells Us,” 377 N. Eng. J. Med. 586 (2017), available at <http://www.nejm.org/doi/full/10.1056/NEJMs1706645>.

¹⁴ A. Sojourner and E. Golberstein, “Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction,” Health Affairs Blog (July 24, 2017), available at <https://www.healthaffairs.org/doi/10.1377/hblog20170724.061160/full/>.

¹⁵ M.B. Musumeci, et al., “Key State Policy Choices About Medicaid Home and Community-Based Services,” (Washington, D.C.: Kaiser Family Foundation, February 2020), available at <https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-based-services-issue-brief>.

¹⁶ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

lives and which benefits were available. In addition, including localities in the definition harms many localities that *intentionally* provide benefits to immigrants because they realize it is a valuable investment for the well-being and prosperity of their locality. It is also burdensome for officers to administer a standard that considers state and other local program use. It is nearly impossible for officers to quantify, contextualize, and interpret all of the different public benefits programs administered in every state, county, and local government unit.

DHS should retain the “Totality of the Circumstances” standard, but improve it for children.

We support the NPRM’s proposal that public charge determinations be based on the totality of the circumstances, including consideration of the statutory factors. The NPRM standard is far superior to the approach in the 2019 final rule, which created burdensome documentation requirements for families and social services agencies and which was burdensome for officers and agencies to administer. We support the NPRM’s favorable consideration of the affidavit of support and recommend that a valid affidavit of support be deemed sufficient to overcome a public charge test, unless “significant public charge factors” are present, under the totality of the circumstances.

While we are generally supportive of the totality of the circumstances framework proposed in the NPRM, we recommend that DHS set out an additional criterion for applying this standard to children. DHS should develop a presumption that children cannot be a public charge, barring compelling evidence to the contrary. DHS should implement this policy because children are overrepresented in the TANF program, the use of benefits by children increases their lifetime productivity, and children are not responsible for their presence in the U.S. or enrollment in public benefits.¹⁷

DHS should finalize the proposal to require detailed written denial decisions considering all factors.

We strongly support the NPRM’s requirement for written denial decisions that “reflect consideration of each of the [required] factors” and “specifically articulate the reasons for the officer’s determination.” The similar and long-standing requirement in the 1999 field guidance, which was altered in the 2019 final rule with no reasonable explanation, should be reinstated. This policy will make officers less likely to make erroneous decisions rooted in implicit bias *and* will create written records that allow DHS to investigate patterns of implicit and intentional bias. DHS must take this step to help counteract the legacy of racism, xenophobia, and other forms of discrimination in the U.S. immigration system.

¹⁷ “Characteristics and Financial Circumstances of TANF Recipients Fiscal Year (FY) 2020,” Administration for Children and Families, https://www.acf.hhs.gov/sites/default/files/documents/ofa/fy2020_characteristics_data_final.pdf; Raj Chetty et al., “New Evidence on the Long-Term Impacts of Tax Credits,” Statistics of Income Paper Series, November 2011, <https://www.irs.gov/pub/irs-soi/11rpchettyfriedmanrockoff.pdf>; “A Roadmap to Reducing Child Poverty,” National Academy of Sciences, 2019, <https://nap.nationalacademies.org/catalog/25246/a-roadmap-to-reducing-child-poverty>.

Conclusion

We urge DHS to finalize the NPRM, with the suggested improvements, as soon as possible. The proposed standard is consistent with the long-standing policy and law, easier to administer with consistency, and less discriminatory. It will also reduce the harms associated with chilling effect associated with the 2019 final rule.

If you have questions regarding our comments, you may contact Leslie Powell at lpowell@cff.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Asthma and Allergy Foundation of America
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
The Leukemia & Lymphoma Society
Muscular Dystrophy Association
National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Patient Advocate Foundation
WomenHeart