FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

December 10, 2018

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

Re: DHS Docket No. USCIS-2010-0012, RIN 1615-AA22 – Comments on Inadmissibility on Public Charge Grounds

Submitted electronically via Regulations.gov

Dear Ms. Dehommes:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

We strongly oppose the Notice of Proposed Rulemaking regarding Inadmissibility on Public Charge Grounds. This proposed rule contravenes the will of Congress regarding limits on Medicaid eligibility for immigrants. Furthermore, it would deeply harm immigrants, their families, and other U.S. citizens and would detrimentally affect the U.S. health care system. It would make it more difficult for immigrants to contribute their skills to the health care workforce, and make it more difficult for immigrants to move up the economic ladder. It is antithetical to actions that the United States Congress has taken to improve the health and wellbeing of our nation. Our comments focus on the proposed provisions regarding Medicaid, because that is our area of expertise; however, we believe that the proposed provisions regarding other public benefits are also harmful to health and well-being, unjustified, and should be withdrawn.

212.20 We strongly oppose the proposal to expand the definitions of "public charge" and of "public benefit." As we explain below, this is not in the interest of our nation and would have adverse effects on both immigrants and communities.

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212.21 We strongly oppose the new definition of public charge and its incorporation of public benefits. They are inconsistent with the term's meaning, and legislative and regulatory history. Defining public charge in this way is not in the public's interest.

A. Congress has deliberately expanded Medicaid over many years as a health program distinct from cash benefits, available also to people with work histories who lack health benefits.

The Medicaid statute was first enacted in 1965. In 1967, as part of Social Security Amendments (P.L. 90-248), Congress demonstrated deliberate intent to provide a health benefit, distinctly separate from public cash assistance which has long been the basis for public charge, when it provided for coverage at income levels higher than cash assistance. Since then, Congress, has deliberately expanded public health insurance a number of times, including to immigrant populations, demonstrating a continuing intent to open, not close this program, to beneficiaries in contrast to the effect of this rule. For example:

- In 1988, Congress required states to cover pregnant women and infants up to poverty, and established the Medicare Savings Programs (QMB and SLMB, further expanded to include QI in 1997). The Medicare Savings Programs, which play a critical role in the Medicare program but technically are part of Medicaid, pay Medicare premiums, deductibles and cost-sharing for low income seniors and people with disabilities. These programs assist people with income up to 100, 120 and 135 percent of poverty respectively, and the Qualified Working Disabled Individuals program assists at even higher income levels. The Qualified Medicare Beneficiary program was made permanent in the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).
- In 1996, in the Personal Responsibility and Work Opportunity Act of 1996, Congress was explicit about its intent regarding immigrants, as these comments explain in the next section below. In this same Act, Congress made clear that Medicaid is separate from cash assistance and continues when cash assistance ends. It allowed states to establish Medicaid income guidelines for families that are higher than Temporary Assistance for Needy Families income guidelines.
- The 1999 Ticket to Work and Work Incentives Program (P.L. 106-170) allowed states to cover working disabled individuals with incomes above 250 percent of the federal poverty level who pay income-related premiums.
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) established Medicare Part D and provided for assistance with drug premiums (the Low Income Subsidy, or LIS) for individuals up to 150 percent of the federal poverty guideline, including lawfully present immigrants.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) extended transitional Medicaid assistance for families who would otherwise lose Medicaid coverage because of an increase in work hours or increased income from child or spousal support.

- The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) provides for expanded Medicaid eligibility to individuals under age 65 with incomes up to 133 percent of the poverty level, and streamlines eligibility so that people applying for individual private coverage will learn if they might be eligible for Medicaid instead.

Similarly, Congress has shown its intent regarding the CHIP program – and CHIP should not become a basis for public charge:

- The Balanced Budget Act of 1997 (PL 105-33) created the Children's Health Insurance Program (CHIP), authorizing federal matching funds to states to expand children's coverage beyond Medicaid eligibility levels – and above cash assistance levels. Congress extended the program in 2007 and reauthorized it in 2009 and 2015. (See section below regarding the improvements for immigrant children.)
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) extended the SCHIP program with no public charge requirements.
- The Children's Health Insurance Program Reauthorization Act (CHIPRA) (P.L. 111-3) in 2009, which is discussed in more detail in the next section, expanded access to CHIP and Medicaid to certain immigrants.

B. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and the 2009 Children's Health Insurance Program Reauthorization Act of 2009 Show Congress's Intent Regarding Immigrants

In 1996, PRWORA barred certain immigrants from receiving non-emergency Medicaid for a five-year period (which could end sooner for an immigrant who is naturalized). In passing this bill, Congress clearly chose to not ban immigrants broadly from the program, but rather selectively restricted eligibility, and gave states an option to establish an exclusion period of longer than five years. If Congress did not want these immigrants to use the program, Congress would have taken up a more restrictive version of this bill and would not have made them explicitly eligible for Medicaid after that period. Congress actively considered and then rejected a longer bar on Medicaid benefits for lawful immigrants during Congressional debate on what became PRWORA. Indeed, as several history professors point out, for 400 years, immigration policy has distinguished people who are dependent on the state from low-wage workers that use some government benefits; and since at least 1930, the Immigration Bureau distinguished immigrants who became "victims of the general economic depression" and so eventually received public relief from those who remained public charges from causes existing prior to their entry.[1]

[1] Torrie Hestor, Mary Mendoza, Deirdre Moloney, Mai Ngai (August 9, 2018) Washington Post, "Now the Trump administration is trying to punish legal immigrants from being poor," https://www.washingtonpost.com/news/made-by-history/wp/2018/08/09/now-the-trump-administration-is-trying-to-punish-legal-immigrants-for-being-poor/?utm_term=.df9ec9f36905

The INS followed Congressional intent in its 1999 field guidance, still in effect, which defines public charge as anyone "who has become or who is likely to become *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."[2] In excluding Medicaid from a public charge determination, the INS noted that "reluctance to access" health benefits "has an adverse impact not just on the potential recipients, but on public health and the general welfare." Secondly, INS noted, "non-cash benefits (other than institutionalization for long-term care) are by their nature supplemental and do not, alone or in combination, provide sufficient resources to support an individual or family." Finally, INS noted that "certain federal, state, and local benefits are increasingly being made available to families with incomes far above the poverty level, reflecting broad public policy decisions about improving general public health and nutrition, promoting education, and assisting working-poor families in the process of becoming self-sufficient. Thus, participation in such non-cash programs is not evidence of poverty or dependence." In the years since 1999, when Medicaid has expanded to cover higher income groups, more and more working class families have been able to enroll without fear of immigration consequences. This proposed rule is an abrupt and unprecedented departure from this history.

Congress's only modification to PRWORA's treatment of immigrant Medicaid eligibility has been to liberalize it further. Congress enacted CHIPRA in 2009, and included the Legal Immigrant Child Health Improvement Act to create a state option for lawfully immigrant children and people who are pregnant to enroll in Medicaid and CHIP without needing to wait five years. 40 states and the District of Columbia have adopted this option. CHIPRA explicitly exempted immigrant sponsors from liability if the individuals they sponsored accessed public health insurance under this program. In the proposed public charge rule, by placing these individuals in a position in which they may not be able to receive the public benefits and the immigration status to which they are entitled, the Department exceeds its regulatory authority.

C. Receipt of benefits was never a determinative factor in public charge determinations. The proposed rule's heavy weighting of public benefits and its formula unjustly skews the test against immigrants.

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. Receipt of Medicaid (as well as the other noncash benefits in this proposal) is inconsistent with this concept of "severity." The preamble notes that 21.3 percent of all US residents participate in a major means-tested program each month (p. 51188). Immigrants should not be subjected to a test that more than one-fifth of all US residents would fail!

[2] 64 FR 28689 and 28692, https://www.gpo.gov/fdsys/granule/FR-1999-05-26/99-13202

Medicaid is available to people with incomes well above the poverty line. It is widely used – the preamble states that about 16 percent of US citizens use Medicaid (p. 51192). It fills in gaps for individuals who occupy jobs in low-wage sectors of the economy, providing supplemental benefits to fill gaps when such work does not pay enough, is not consistent enough, or offers no benefits.

In jobs that do offer health care benefits, health insurance is excluded from taxes, which is another form of government subsidy. The Joint Commission on Taxation found that the income tax exclusion of employer contributions for health care totaled $150.6 billion in 2017; and the report did not estimate the cost of the FICA tax exclusion for this insurance.[3] Medicaid should not be treated as a factor in a public charge determination, nor should the receipt of any other form of health insurance be a factor. This proposal would encourage immigrants to forego coverage and also either forego care entirely or amass unreasonable debts when care is needed.

D. **We strongly oppose 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; 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. These tests are not in the public's interest.**

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 to its scope individuals who have simply applied or been certified for such public benefits. Applying for a benefit does not mean that a person is not self-supporting. The expansion of the "public benefit" definition in this context is unreasonably broad and will harm millions of immigrant and citizen families through its direct impacts and its indirect chilling effects.

Medicaid is not a subsistence benefit. It is a core part of our mainstream healthcare system. Together with CHIP it covers approximately 75 million people with preventive, acute and long-term health care services. Studies (cited later in these comments) show that Medicaid improves financial security, enables people to get regular primary care, makes it possible for people to return to work or continue to work by treating their health conditions, and improves people's employment prospects. Health insurance increases the rate of high school and college completion among low-income children, and results in improved earnings when they reach adulthood. The preamble to this proposed regulation cites administrative decisions that say that a determination of public charge is supposed to consider "all the factors bearing on the alien's ability of potential ability to be self- supporting," (p. 51122). The Medicaid program has a positive impact on that ability.

[3] Joint Commission on Taxation, (2018) Estimates of Federal Tax Expenditures for FY 2017-2021, p. 35, online at https://www.jct.gov/publications.html?func=startdown&id=5095;

The provision of job-based coverage varies by industry. Some states have far fewer companies that provide it than others. DHS' contention that "by virtue of their employment, such immigrants should have adequate income and resources to support themselves without resorting to seeking public benefits" is a fallacy.[4] 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 have in society by addressing these gaps.

The proposal also targets core Medicare affordability programs for low and middle-income people. Under the proposal, by explicitly including the Medicare Part D Low Income Subsidy (LIS) as a listed benefit, and by including the Medicare Savings Programs, which are part of Medicaid, DHS could deny visas and adjustment of status for potential lawful permanent residents of older age– including those with work histories but limited incomes – who might not be able to afford prescription drugs nor their Medicare premiums or cost-sharing. These are not marginal programs in Medicare: LIS supports almost 1 in 35 Medicare beneficiaries and MSPs support more 1 in 56. Many of the immigrants placed at risk by the proposal have been in this country for long periods of time, given the work quarters required for Medicare eligibility. They have no other national homes and they contributed to this country during their working careers. Without access to timely medical care, their conditions will worsen until they need expensive emergency treatment. Moreover, forgoing financial assistance with basic necessities like medicine puts a strain on the budget for their entire family.

The Children's Health Insurance Program (CHIP) Should Remain Excluded from the Definition of Public Benefit and from Public Charge Determinations

CHIP is available to children with low and middle income levels. The exact guidelines vary by state. As explained above, making CHIP a factor in public charge determinations would go against Congressional intent and the history of the program: CHIPRA explicitly created a state option for lawful immigrant children to enroll in CHIP without waiting five years, and exempted immigrant sponsors from liability if the individuals they sponsored used the program. Like Medicaid, CHIP pays for services that promote the healthy development of children and enable them to succeed in school.

Emergency Medicaid, IDEA, and Benefits to Foreign Born Children of US Citizens Should Remain Excluded

[4] 83 Fed. Reg. 51123.

5 Kaiser Family Foundation, Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing (May 17, 2018), *available at* www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/

6 Kaiser Family Foundation, Medicaid Enrollment by Age, www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-age/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

We agree that these benefits should remain excluded from the definition of public charge. The Department's justification for excluding them is evidence that other benefits should also be excluded. For example, the preamble explains that not excluding IDEA would discriminate against persons with disabilities – but the whole rule discriminates against persons with disabilities. Children with disabilities need health care services provided both outside and inside the classroom in order to meet their potential. For working adults with disabilities, Medicaid can now wrap around employer-sponsored benefits in order to provide additional services, helping employers make reasonable accommodations as well as helping the employees. The proposed rule is silent about some aspects of Medicaid, such as the specific coverage provided under the Breast and Cervical Cancer Prevention and Treatment program to women up to 250 percent of poverty. Therefore, as drafted, the rule would allow immigrants (including those who were not yet LPRs) to be screened for cancer by CDC programs, but if cancer was found and they were then treated under Medicaid, they would jeopardize their ability to adjust status, even if they had lived and worked in the United States for many years.

The 12 month standard is arbitrary and contrary to federal policy, as is the 9 month standard for a combination of benefits.

Federal policy encourages people to seek insurance and maintain coverage continuously through changes in income, employment, and life circumstances. In the private market and in Medicare, there are restrictive open enrollment periods. Though the tax penalty for being without coverage was zeroed for 2019, the concept remains in law. Medicaid itself, for much of the population, has moved from a fee for service model, that paid for care at the time of service, to a managed care model under which plans receive capitation payments (using federal and state dollars) with rates set based on the expectation that people will stay in the plan for the year. This proposal, by contrast, would encourage people to either remain uninsured entirely or seek insurance episodically. Medicaid was not designed to be a short-term or time-limited program.

212.22 We oppose the public charge inadmissibility standards

We will mention just a few of the problems in this section:

- There is no statutory basis to weight based on an income threshold. The standards are arbitrary. They discriminate against women, who are more likely to have incomes below 125 percent of poverty than men. They discriminate against families with children or other dependents, since wage-earners in these families would have to earn far more to avoid the standards.
- The standards discriminate against people who are not English proficient, even though civil rights law prohibits such discrimination.
- The weight given to education, employment and private coverage are contrary to the effects of this proposed policy that would stand in the way of immigrants receiving health services that may help them succeed in school or move up the economic ladder.
- You propose that an alien must have sufficient income and resources to cover any foreseeable medical costs that might be expensive. However, by deterring immigrants from receiving

Medicaid through this rule, you make it more likely that health conditions will not be treated early but will instead worsen to become expensive, and will then stand in the way when an immigrant seeks adjustment of status.

212. 23 Exemptions and waivers

We support the exemptions contained within § 212.23 of the proposed rule. However, the proposed rule is overly broad and improperly subjects to public charge determinations many hard-working immigrants who are on the road to self-sufficiency. The proposed rule should be more limited in overall scope to avoid penalizing and chilling immigrants who use public benefits for which they are eligible.

In sum, this proposed rule should be withdrawn because it would harm millions and would reach far beyond the population it targets

This proposal will directly affect approximately 1.1 million individuals seeking to obtain lawful permanent resident status, half of whom already reside in the U.S. In 2017, close to 380,000 such individuals sought adjustment through a pathway that would be subject to a public charge determination under the proposed rule.7 Yet the rule would have an even larger impact beyond those populations, for as many as 41.1 million non-citizens and family members of non-citizens – almost 13 percent of the US population – could be impacted as a result of the rule and its chilling effect.8 The chilling effect will occur due to confusion about eligibility for public benefits, stigma that the rule places on benefits programs, erroneous determinations that will be made by individuals, caseworkers, and other professionals serving immigrants due to the complexity of this rule, and disenrollment or foregone enrollment in other health and social programs not impacted by the proposed rule due to misconceptions of the rule's scope. The Kaiser Family Foundation expects the total number of persons disenrolling from Medicaid to be between 2.1 million and 4.9 million, depending on varying rates of disenrollment.[9] For children, an estimated 1.5 million children would lose Medicaid coverage, 1.1 million of whom would remain uninsured.[10]

This rule should be withdrawn because it would harm the public's health

Moreover, the effects of this rule go far beyond immigrants and their families to harm the public health of the nation as a whole. A community's overall health depends on the health of all of its members.

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[7] 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.

[8] 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.

[9] *Id.*

[10] Samantha Artiga, Anthony Damico, and Rachel Garfield, Potential Effects of Public Charge Changes on Health Coverage for Citizen Children, https://www.kff.org/disparities-policy/issue-brief/potential-effects-of-public-charge-changes-on-health-coverage-for-citizen-children/. Estimate uses PRWORA-era disenrollment rate of 25 percent.

Medicaid is a crucial source of insurance for individuals and families who do not receive coverage through their employers. It enables people to get treatment for communicable illnesses, restoring their own health and keeping their communities, workmates, and schoolmates healthy. It helps people get timely care before a health problem worsens. It helps children with diagnosis and treatment of conditions ranging from vision, hearing, and dental problems to major illness and disability, helping them to learn in school and be prepared for life.[11]

Children would be deterred from receiving the many other Medicaid services that help them develop, in addition to programs not listed in this rule but that families may fear to use nonetheless. Besides directly harming the children involved, withholding these services would be detrimental to their schools who would have to find other ways to help them overcome learning challenges.[12]

The proposal will also hurt the health care workforce. About 17 percent of all health care workers and nearly one-fourth of health care support workers, such as nursing aides and home health aides, are immigrants.[13] The agencies employing these workers often do not provide them with health insurance, and so many rely on Medicaid for their coverage. This rule would make it harder for such workers to care for our aging population because to avoid a public charge determination, they would have to forego coverage themselves or change jobs. This could exacerbate shortages of such workers to care for the aging population, affecting us all.

This rule will also cause problems for safety net providers and hospitals when their patients lose access to health insurance. Community clinics will have to stretch their resources to serve more uninsured patients. Hospitals will continue to serve immigrants in emergencies under EMTALA and be reimbursed by Medicaid for the emergency services, but when uninsured immigrants need inpatient or ongoing care hospitals will face a choice of denying care or providing it unreimbursed. As uncompensated care costs rise, the rule could also threaten investments that hospitals make to serve their communities.[14] The

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[11] See Sommers BD, Gawande AA, and Baicker K. Health Insurance Coverage and Health--- What the Recent Evidence Tells Us. N Engl J Med 2017; 377: 586-593.; Ku L, Paradise J, and Thompson V. Data Note: Medicaid's Role in Providing Access to Preventive Care for Adults. The Kaiser Family Foundation, May 2017. www.kff.org; Paradise J. Data Note: Three Findings About Access to Care and Health Outcomes in Medicaid. The Kaiser Family Foundation, March 2017. www.kff.org ; and Gunja MZ, Collins SR, Blumenthal D, et al. How Medicaid Enrollees Fare Compared with Privately Insured and Uninsured Adults. Findings from The Commonwealth Fund Biennial Health Insurance Survey, 2016. April 2017. www.commonwealthfund.org.

[12] D Mahan and S Houshyar, 2018, Health Coverage Matters for Children: The Role of Medicaid in the Healthy Development of America's Children, https://familiesusa.org/sites/default/files/product_documents/MCD_Medicaid-and-Kids_Issue-Brief.pdf; 0 Christine Percheski and Sharon Bzostek,"Public Health Insurance and Health Care Utilization for Children in Immigrant Families,"Maternal and Child Health Journal 21 (2017).

[13] S. Altorjai and J. Batalova (June 2018) Immigrant Health-Care Workers in the United States. Migration Policy Institute, https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states.

[14] Dranove, Garthwaite and Ody (2017), The impact of ACA's Medicaid expansion on hospitals' uncompensated care burden and the potential effects of repeal, Commonwealth Fund, https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care; G. Geiger, L. Ku, et al, (2018) How could the public charge proposed rule affect community health centers? George Washington University and RCHN Community Health Foundation,

American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and the American Psychiatric Association, cumulatively representing 400,000 physicians, have stated their joint opposition to the proposed rule, explaining that it will lead to deferred care, more complex medical and public health challenges, and will significantly increase costs to the health care system; they point out that this puts a new barrier between health care providers and patients, going against their mission.[15]

Thank you for the opportunity to submit these comments. We respectfully request that these comments and the complete articles cited be incorporated into the record.

If you have any questions, please contact Cheryl Fish-Parcham at Families USA, 202-628-3030 or at cparcham@familiesusa.org.

Respectfully submitted,

Cheryl Fish-Parcham
Director of Access Initiatives

https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf; C. Mann, A. Orris, and A. Grady, (2018) Medicaid Payments at Risk for Hospitals Under Public Charge, Mannatt, file:///C:/Users/Parcham/Downloads/Medicaid-Payments-at-Risk-for-Hospitals.pdf.

[15] Joint Statement of America's Frontline Physicians Opposing Public Charge Proposal (Sept. 22, 2018), https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/equality/ST-GroupSix-Public%20Charge-092218.pdf.