December 10, 2018

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

[Name of organization] appreciates the opportunity to comment on DHS' Inadmissibility on Public Charge Grounds proposed rule. [Add 1-2 sentences about your organization's mission].

We strongly oppose the proposed rule because it would erect insurmountable barriers to the ability of immigrants and citizens to access and use Medicaid and other public benefit 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 considering immigrants' use of public benefits beyond those used for subsistence. It would improperly penalize immigrants who use public benefits to augment their standard of living and ultimately achieve self-sufficiency. The proposed rule would also 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 effects would needlessly harm individuals' and families' health and well-being, the greater public health, the U.S. economy, and the public budget.

Further, the proposed rule would undo decades of policy work that improved benefits administration and eligibility processes for such programs. Streamlined enrollment and access to public benefits such as Medicaid have had a positive impact on public health.[1] In particular, Medicaid and health-related public benefits programs improve both individual quality of life and population health of the U.S.[2] No person should have to question whether accessing the health care they need will adversely impact their immigration status or ability to remain in the U.S.

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[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.
[2] See infra.

Given the proposed rule's significant detrimental effects, its contravention of established law and practice, and its lack of supporting evidence, DHS should immediately withdraw its proposed rule.

We provide specific comments below.

§ 212.20 Applicability of public charge inadmissibility.

We strongly oppose the proposal to expand the definitions of "public charge" and of "public benefit." Such drastic definitional changes upend a system of benefits and supports for which lawfully present immigrants and citizens alike are lawfully eligible. These benefits have the express purpose of improving eligible individuals' quality of life and helping them achieve or maintain robust health.

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.[3] 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.[4] But the effects of this proposed rule would 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.

Health care is a human right and society should reduce barriers to accessing it rather than build 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 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, race, ethnicity, gender, gender identity, sexual orientation, language, or immigration status. This proposed rule flies in the face of such principles.

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[3] 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.
[4] *Id.*

Chilling Effect on All Immigrants and Their Families

In addition to those who will be directly impacted by the rule, 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—almost 13 percent of the entire U.S. population—could be impacted as a result of the proposed rule's policy changes.[5] 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. This is despite mounting evidence that chilling effects are already manifesting in the immigrant community.[6] History and research shows that the proposed rule will indeed have a substantial chilling effect.[7] 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
- Disenrollment from and foregone enrollment in programs not impacted by the proposed rule stemming from misconceptions over the proposed rule's scope and details.

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[5] 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.

[6] *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*, NAT'L PUB. RADIO ("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/, Danilo Trisi & Guillermo Herrera, Ctr. on Budget & Pol'y Priorities ("CBPP") *Administration Actions Against Immigrant Families Harming Children Through Increased Fear, Loss of Needed Assistance* (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).

[7] See infra.

Effects on health coverage, insurance, outcomes, and social determinants of health

The proposed rule's chilling effect will have lasting negative impacts on an individual's and family's health and their ability to maintain healthy lifestyles. By stigmatizing and disincentivizing Medicaid enrollment and use of other public benefits that address social determinants of health, the proposed rule will chill the use of vital public benefits that ensures the neediest in society have access to health care services and resources needed to keep them healthy. Foregoing use of Medicaid, as well as use of other services included in the proposed rule, leads to a less healthy and costlier society for all.

The chilling effect after enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in the late 1990's decreased rates of Medicaid coverage and led to immigrants avoiding treatment, delaying care, using "underground" sources of care, and seeking uncompensated care.[8] 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.[9] This is emblematic of the power of chilling effects in the immigrant community.[10]

Disenrollment from and forgone enrollment in Medicaid due to the proposed rule's chilling effect would also perpetuate disparities in insurance status, especially harming children of immigrants. Low-income children with immigrant parents are already less likely to receive Medicaid than those with U.S. born parents.[11] 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.[12] For children, an estimated 1.5 million children to lose Medicaid coverage, 1.1 million of whom would remain uninsured.[13] The

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[8] Leighton Ku & Alyse Freilich, Kaiser Family Found., *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* 7 at 13-15 (2001), https://aspe.hhs.gov/system/files/pdf/72701/report.pdf.1

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

[10] Neeraj Kaushal & Robert Kaestner, Welfare Reform and health insurance of Immigrants, 40 HEALTH SERVS. RES. At 713-71 (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/pdf/hesr_00381.pdf; Fix & Passel, *supra* note 13, at 4; Namratha R. Kandula et al., *The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants,* 39 HEALTH SERVS. RES. 1509 at 1519-1521 (2004).

[11] Wendy Cervantes Rebecca Ullrich & Hannah Matthews, *Our Children's Fear Immigration Policy's Effects on Young Children*, https://www.clasp.org/sites/default/files/publications/2018/03/2018_ourchildrensfears.pdf.

[12] *Id.*

[13] 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.

proposed rule's chilling effects erect new barriers to immigrant families' ability to seek appropriate health care and achieve self-sufficiency. The benefits of insurance coverage are key to a family's financial stability and provide safe environments for their children. Enrolling in Medicaid enables low-wage workers to: find and retain employment,[14] decrease reliance on cash assistance,[15] save more and contribute more to the local economy,[16] address previously unmet medical needs,[17] timely pay bills,[18] purchase better quality food and housing,[19] access credit and reduce debt,[20] and achieve financial stability.[21]

By chilling Medicaid enrollment, the proposed rule will also slash immigrants' access to preventive services, care management, and primary care.[22] These services are essential in reducing health care costs, improving outcomes, and enabling immigrants to live and work in their communities.[23] Medicaid coverage improves access to care, which in turn provides short- and long-term health benefits to enrollees, including fewer hospitalizations, better

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[14] *Larisa Antonisse and Rachel Garfield, The Relationship Between Work and Health: Findings from a Literature Review,* https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

15 Aparna Soni et. al., *Medicaid Expansion And State Trends In Supplemental Security Income Program Participation,* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1632; Marguerite Burns & Laura Dague, *IRP Discussion Paper: The Effect of Expanding Medicaid Eligibility on Supplemental Security Income Program Participation*, https://www.irp.wisc.edu/publications/dps/pdfs/dp143016.pdf;

[16] Karina Wagerman et. al., *Medicaid Is A Smart Investment in Children*, https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

17 Robin Rudowitz and Larisa Antonisse, *Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence*, http://nasuad.org/sites/nasuad/files/KFF_Implications-of-the-ACA-Medicaid-Expansion_May-2018.pdf; Loujia Hu et. al., *The effect of the affordable care act Medicaid expansions on financial wellbeing,* https://www.sciencedirect.com/science/article/abs/pii/S0047272718300707; Benjamin D. Sommers et. al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, https://www.nejm.org/doi/10.1056/NEJMsb1706645.

[18] *Id.*

[19] Karina Wagerman et. al., *Medicaid Is A Smart Investment in Children*, https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

[20] http://nasuad.org/sites/nasuad/files/KFF_Implications-of-the-ACA-Medicaid-Expansion_May-2018.pdf. See also http://journals.sagepub.com/doi/full/10.1177/1077558717725164;

[21] http://www.nber.org/papers/w25053; The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf;

[22] Karina Wagnerman, Georgetown University Center for Children and Families, *Medicaid: How Does it Provide Economic Security for Families?* (Mar. 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf Julia Paradise, Kaiser Family Foundation, *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid* (Mar. 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid.

[23] *Id.*.

oral health, and lower rates of obesity, among other benefits.[24] Even mere eligibility for Medicaid is associated with these improved health outcomes.[25]

Additionally, lack of insurance among chilled populations would reduce the use of prenatal and postnatal care. Pregnant women's access to Medicaid is associated with better health outcomes for children through adulthood including reduced hospitalizations and better oral health.[26] Medicaid access during pregnancy is also associated with better overall health in adulthood, such as lower prevalence of high blood pressure, diabetes, heart disease, and obesity, in addition to decreased mortality.[27] 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.[28]

Moreover, when children are eligible for and receive Medicaid, they are more likely to do better in school,[29] be healthier as adults with fewer emergency department visits and hospitalizations,[30] and pay more in taxes as adults.[31]

Thus, the proposed rule denies immigrants, their families, and their larger communities the positive effects of health insurance coverage, especially of Medicaid coverage. DHS should support policies that recognize the importance of health insurance coverage as key to promoting health and wellness as components of self-sufficiency regardless of income or immigration status.[32]

Effect on health care service providers and health systems

[24] See infra.
[25] See infra. See also Laura R. Wherry et. al., *Childhood Medicaid Coverage and Later Life Health Care Utilization*, http://www-personal.umich.edu/~mille/MillerWherry_Prenatal2015.pdf.
[26] Karina Wagerman et. al., *Medicaid Is A Smart Investment in Children*, https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf,
[27] *Id*.
[28] Sharon Parrot, et al., *Trump "Public Charge" Rule Would Prove Particularly Harsh for Pregnant Women and Children*, Center on Budget and Policy Priorities, (May 1, 2018), *available at* https://www.cbpp.org/research/poverty-and-inequality/trump-public-charge-rule-would-prove-particularly-harsh-for-pregnant.
[29] Sarah Cohoes et. al, *The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions*, http://www.nber.org/papers/w20178.
[30] Laura R. Wherry et. al., *Childhood Medicaid Coverage and Later Life Health Care Utilization,* http://www.nber.org/papers/w20929.
[31]D. Brown, A. Kowalski, and I. Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?,* http://www.nber.org/papers/w20835.
[32] Joan Alker and Karain Wagnerman, *Medicaid & CHIP are Long-Term Investments in Children's Health and Future Success*, https://ccf.georgetown.edu/2017/04/10/medicaid-a-smart-investment-in-children/.

The chill on Medicaid enrollment and stigmatization of immigrants' overall use of public benefits will increase the amount and severity of uncompensated care, and have a financial impact on providers and health systems. Furthermore, the proposed rule will complicate providers' roles in delivering care to those who seek it. From every vantage point, the proposed rule contradicts established principles of the sound practice of medicine, largely because of the increased risk it imposes on individuals seeking care and the providers responsible for treating them. This is why the 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, stated their joint opposition to the proposed rule.[33]

The proposed rule will clearly lead to an increase in the amount of uncompensated care that providers must deliver. Following PRWORA, safety-net providers such as public hospitals, community health centers, nonprofit charitable hospitals, and local health departments reported losing Medicaid patients and revenue while the number of uninsured patients rose.[34] These providers already care for a disproportionately high number of low-income immigrant populations compared to other types of health care providers. The proposed rule will cause further strain on already understaffed and overworked emergency departments. More uninsured patients will likely present at emergency rooms, shifting the cost of providing care onto safety-net health systems, many of which are already struggling financially.[35] This could cost hospitals across the country, especially those that already operate on slim margins, more than $17 billion in Medicaid payments.[36] Similar harms will befall federally qualified health centers and other providers who serve immigrant communities as patients who disenroll from health insurance avoid seeking care until their conditions become higher-cost, higher-risk emergencies. Providers serving such communities will experience a reduction in regular caseload and compensation associated with serving insured patients; some providers could cut back on services vital to the larger community to stay afloat.[37] Such changes in providers' behavior reduces access to health

[33] 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.

[34] Leighton Ku and Alise Freilich, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houson,* Kaiser Family Foundation, https://aspe.hhs.gov/system/files/pdf/72701/report.pdf.

[35] Dhruv Khullar, et. al., *Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care?*, https://www.healthaffairs.org/do/10.1377/hblog20180503.138516/full/.

[36] Cindy Mann et. al,, *Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule,*https://www.manatt.com/Manatt/media/Media/PDF/White%20Papers/Medicaid-Payments-at-Risk-for-Hospitals.pdf.

[37] Wendy E. Parmat, *Health Affairs Blog: The Health Impact of the Proposed Public Charge Rules,* https://www.healthaffairs.org/do/10.1377/hblog20180927.100295/full/.

care services for entire populations, not just for those attempting to avoid adverse public charge determinations.[38]

§ 212.21(a) - Public Charge

We strongly oppose the new definition of "public charge" contained in the proposed rule. This proposed definition is inconsistent with the term's meaning as historically used in legislation and regulation. 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. While the proposed rule keeps the "totality of circumstances" test, its inclusion and heavy negative weighing of public benefits use unjustly skews such a test against immigrants without regard for its actual fiscal and societal impacts. For comparison, if applied to U.S. citizens, one-third of U.S. citizens would fail the test based solely on their use of public benefits – the same benefits for which the targeted class of immigrants are lawfully eligible.[39]

The proposed rule is therefore 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.[40] Instead, Congress directly addressed concerns it had regarding immigrant receipt of benefits by denying access to a range of benefits for an immigrant's first five years in the U.S. and by enacting broader deeming rules.[41] 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.

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[38] Cindy Mann et. al,, *Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule,*https://www.manatt.com/Manatt/media/Media/PDF/White%20Papers/Medicaid-Payments-at-Risk-for-Hospitals.pdf.

[39] Danilo Trisi, *One-Third of U.S.-Born Citizens Would Struggle to Meet Standard of Extreme Trump Rule for Immigrants,* https://www.cbpp.org/blog/one-third-of-us-born-citizens-would-struggle-to-meet-standard-of-extreme-trump-rule-for.

[40] *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 1996 (referring to deportation); S. 1923, § 501, Immigration Stabilization Act of 1994 (referring to exclusion and adjustment of status).

[41] 8 U.S.C. §§ 1611, 1612, 1613, 1631.

DHS' definition of public charge that ignores the reality of how people use public benefits programs to achieve and maintain robust health. 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***.[42] (emphasis added) Such characterizations are wholly 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 and would be disproportionately impacted.[43]

§ 212.21(b) – Public benefit

We oppose the proposed expansion to the definition of "public benefit" in relation to public charge determinations. 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. 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. 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.

As history and practice show, the public charge inquiry into use of public benefits has been 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" within the public charge context improperly infringes on this longstanding framework, obscuring the true intent of public charge determinations.

Medicaid is Not a Subsistence Benefit

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[42] 83 Fed. Reg. 51158.

[43] American Immigration Council, *The Impact of Immigrant Women on America's Labor Force*, March 2017, https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force.

We strongly oppose the proposed rule's classification of Medicaid as a public benefit subject to scrutiny under public charge determinations. To penalize the receipt of Medicaid services that help those lawfully eligible for such services achieve and maintain robust health and self-care is wholly incongruent with the purpose of Medicaid. The Medicaid program provides health insurance to approximately 75 million low-income people in the United States and enables states to provide a range of federally-specified preventive, acute, and long-term health care services to eligible individuals.

The proposed rule aims to penalize one subset of the eligible population, lawfully present immigrants, for receiving Medicaid benefits. If Congress did not want immigrants to use Medicaid, it would not have made them explicitly eligible for the program. While immigrants must typically wait five years after receiving qualified immigration status to access Medicaid and CHIP benefits, Congress authorized states to lift this waiting period for lawfully present immigrant children and pregnant women.[44]

Furthermore, Congress advanced streamlined eligibility in the Affordable Care Act (ACA), requiring 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 found eligible for Medicaid, the state would automatically enroll immigrant applicants in Medicaid and subject them to the proposed rule's negative consequences, which undercuts the ACA's "no wrong door" policy. If the immigrant was found ineligible for Medicaid and received marketplace coverage, the proposed rule still would disincentive applications because the mere application for marketplace coverage would result in an application for Medicaid, and thus, would be counted negatively in a public charge determination, even if the immigrant never wanted to apply for or never received Medicaid. The proposed rule flies in the face of such Congressional proclamations by effectively neutering previously enacted, statutorily-mandated safeguards.[45]

<u>Medicaid Supports Self-Sufficiency of Low-Wage Workers</u>

The proposed rule's inclusion of Medicaid as a "public benefit" under consideration for public charge determinations shows a fundamental misunderstanding of the nature of low-

[44] Coverage for lawfully present immigrants, healthcare.gov, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/; *Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html

[45] 42 U.S.C. § 1396a.

wage work.[46] Many workers receive supplemental benefits, such as Medicaid, which enable them to access vital health care services and supports to bolster their health and well-being. In 2016, approximately 24 percent of workers in the United States earned wages at or below the poverty-level (less than $24,300 for a family of four). [47] Furthermore, low-wage jobs comprise a growing share of the U.S. workforce: almost one-third of all workers earn under $12 per hour, and over half of these workers are women.[48] People of color are also disproportionately concentrated in low-wage jobs.[49] A predominant characteristic of employers of this category of workers is that they 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. 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.[50] 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.

Many, if not most, Medicaid beneficiaries are low-wage workers who lack affordable individual marketplace or employer-sponsored coverage options. Immigrants are more likely to earn lower wages on average,[51] and the unstable nature of the low-wage job

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[46] 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. Bureau of Labor Statistics, *How should we define "low-wage" work? An analysis using the Current Population Survey,* 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.

[47] Economic Policy Institute, *State of Working America Data Library*, "Poverty Level Wages," (updated February 13, 2017) https://www.epi.org/data/#?subject=povwage; CPS ORG | Census Bureau (poverty threshold); *see also* https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references. 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. Shelby Gonzales*, Immigration Officials Given Extremely Broad Authority Under Trump Administration's Proposed Rule,* https://www.cbpp.org/blog/immigration-officials-given-extremely-broad-authority-under-trump-administrations-proposed-rule*.*

[48] 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.

[49] *Id.*

[50] 83 Fed. Reg. 51123.

[51] *The Economic and Fiscal Consequences of Immigration*, National Academies Press, https://www.nap.edu/read/23550/chapter/6#122 p 122.

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, poorer 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 provides a pivotal safeguard against such unmet health care needs, thereby enabling individuals with such health conditions to access and obtain needed care, and successfully seek and maintain their 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. Medicaid also provides financial security to individuals and families, allowing them to spend the little money they do have on better quality food, housing, schooling, and other essential services.

Substantial research supports the efficacy of the Medicaid program in achieving its purpose of enabling beneficiaries to attain and retain self-sufficiency and better health by providing coverage for and access to health care services. Numerous studies have shown that sharp declines in rates of uninsurance among the low-income population are due to wider availability of Medicaid coverage.[55] This is especially true 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."[56]

Thus, Medicaid is a critical supplement to low-wage workers' income that allows them to maintain healthy lives, access important preventive and acute health care services, improve their socioeconomic mobility, and contribute more to society later in life.

Medicaid Promotes Self-Sufficiency of Women and Children

Medicaid's impact is even more pronounced for pregnant women and children. Medicaid covers nearly half of all births in the U.S.[57] Pregnant women on Medicaid receive vital

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[52] Larisa Antonisse and Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review*, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] Kaiser Family Foundation, *Role of Medicaid for Women,* https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.

prenatal care, labor and delivery services, and postnatal support for breastfeeding mothers. 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.[58] Indeed, some states have income eligibility rates for pregnant women that are over twice as high as those for non-pregnant adults.[59]

A child's well-being is inseparable from their parents' and families' well-being. Pregnant women who gained Medicaid coverage generated short- and long-term improvements in their children's health and well-being.[60] Prenatal Medicaid coverage leads to better health and socioeconomic mobility for children, allowing them to reduce their use of public benefits and to better contribute to society later in life. 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.[61] These 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.[62]

Research shows that receipt of Medicaid in childhood also improves women's rates of employment, increases annual wages, and reduces the need for and use of public assistance later in life.[63] Medicaid is the third best poverty-reducing program for the general population,[64] but its effect on reducing child poverty is larger than that of all other non-health benefits combined.[65]

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[58] *See* CMS, *Medicaid, CHIP, and BHP Eligibility Levels*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.
[59] *See id.*
[60] Sarah Miller and Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage,* Aug. 2015) http://www-personal.umich.edu/~mille/MillerWherry_Prenatal2015.pdf.
[61] Julia Paradise, *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid* (Washington, DC: Kaiser Family Foundation, March 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/.
[62] Karina Wagerman et. al., *Medicaid Is A Smart Investment in Children*, https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf;
[63] D. Brown, A. Kowalski, and I. Lurie, *Medicaid as an Investment in Children: What is the Long Term Impact on Tax Receipts?*, National Bureau of Economic Research, (January 2015), https://www.nber.org/papers/w20835; A. Goodman-Bacon, *The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes, National Bureau of Economic Research*, (December 2016), https://www.nber.org/papers/w22899.
[64] Benjamin Sommers and Donald Oellerich, *The poverty-reducing effect of Medicaid,* Journal of Health Economics Vol. 32, Issue 5 (Sept. 2013) 816-832, https://www.sciencedirect.com/science/article/abs/pii/S016762961300091X.
[65] Dahlia Rehmer, et. al., *Estimating The Effects Of Health Insurance And Other Social Programs On Poverty Under The Affordable Care Act,* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0331%20.

Medicaid Protects Against Medical Debt

Medicaid safeguards 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.[66] The money that would be used to pay for such avoidable medical costs are instead used to better provide for basic daily necessities including higher quality food and housing.[67] These are the core components of self-sufficiency and healthy living that have been understood throughout history. As self-sufficiency underpins U.S. immigration law, logic dictates that Medicaid is vital in promoting these features of society among the low-income immigrant population.

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

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 extend the problematic reach of the proposed rule further to exclude moderate income working families and applicants likely to earn a moderate income at some point in the future.

Including CHIP in a public charge determination would likely lead to many eligible children foregoing health care benefits, both because of the direct inclusion in the public charge determination as well as the chilling effects detailed elsewhere in these comments. Nearly 9 million children across the U.S. depend on CHIP for health care.[68] Yet many eligible citizen children likely would forego CHIP – and health care services altogether – if their parents think receipt of CHIP coverage would subject someone in their family to a public charge determination.

In addition, the inclusion of CHIP in a public charge determination 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 under Medicaid and CHIP, with regular federal

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[66] Benjamin Sommers et. al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, https://www.nejm.org/doi/10.1056/NEJMsb1706645; see also Margot Sanger-Katz, *1,495 Americans Describe the Financial Reality of Being Really Sick,* https://www.nytimes.com/2018/10/17/upshot/health-insurance-severely-ill-financial-toxicity-.html.
[67] Karina Wagerman et. al., *Medicaid Is A Smart Investment in Children*, https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.
[68] *See* Medicaid.gov, https://www.medicaid.gov/chip/index.html, based on 2017 Statistical Enrollment Report.

matching dollars, lawfully residing children and pregnant women during their first five years in the U.S. This was enacted because Congress recognized the public health, economic, and social benefits of ensuring access to care. Lawfully present children and pregnant women receiving CHIP pursuant to CHIPRA would not be subject to a public charge determination if CHIP is excluded. However, this also points out to another of the absurd results of the proposed rule – Congress certainly did not intend to subject these individuals to a public charge determination yet the proposed rule would subject some to a public charge determination and others not, determined solely by whether the individual is enrolled in Medicaid or CHIP.

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. 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.[69] 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."[70]

Continuous, consistent coverage without disruptions is especially critical for young children. Child health experts recommend 16 well-child visits (more heavily concentrated in the first two years) before the age of six to monitor their development and address any concerns or delays as early as possible.[71] 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.[72]

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

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[69] Kaiser Family Foundation, *The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?,* https://www.kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-the-research-tell-us/.

[70] *CHIP and Medicaid: Filling in the Gap in Children's Health Insurance Coverage*, Econofact 2018-01-22, https://econofact.org/filling-in-the-gap-of-childrens-health-insurance-coverage-medicaid-and-chip.

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

[72] *Id*.

a public charge determination and that noncitizen participation is relatively low.[73] 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.

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.

Emergency Medicaid, IDEA Services, and Benefits to Foreign-Born Children of U.S. Citizens Should Remain Excluded

While we support these exclusions from the scope of the proposed rule, immigrants will still forego these services due to the rule's chilling effects on all public benefit programs.

The system imposed by the proposed rule creates a dangerous paradox for immigrants who are sick or injured. Without a doctor, 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 may count against them years later. Similar paradoxes exist for the other exclusions as well.

Further, individuals receiving IDEA services in schools are also Medicaid enrollees. Excluding IDEA services is a difference without a distinction because the underlying Medicaid enrollment will still be considered in a public charge determination.

In addition to exempting these services and categories of enrollees, we believe all of Medicaid should be excluded from a public charge determination for the reasons discussed throughout our comment.

DHS' Proposed 12-month Standard for Receipt of Non-Monetizeable Benefits Is Arbitrary.

The proposed rule considers the cumulative receipt of "non-monetizeable" benefits for more than 12 months in a 36-month period or within 12 months of application as indicative of an

[73] 83 Fed. Reg. at 51174.

individual's likelihood of becoming a public charge.[74] 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."[75] This equates institutionalized care with the receipt of public benefits while in the community, such as Medicaid; the two are not interchangeable. Institutionalization connotes an inability to work, care for oneself, and function in the broader community. Long-term institutionalized care is a specific kind of service that provides subsistence for those who use it. Traditional Medicaid, on the other hand, is a source of insurance coverage for low-income people. Medicaid enrollees churn on and off coverage, have a wide array of health conditions, and function in the community to support themselves. It is inappropriate to extrapolate the durational component of one specific service and apply its broader scope to use of a public benefit writ large as if it means the same thing.

The proposed rule similarly equates Medicaid with welfare by citing 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. 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 year-long treatment regimen. The proposed rule would force such an individual into an impossible situation where continued treatment would count against them for immigration purposes.

For the same reasons, we also 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. These are arbitrary limits with significant consequences for those who would be subject to them.

Unenumerated Benefits

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.

In addition to opposing the expansion of the definition of public charge, particularly the consideration of Medicaid, we also 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

[74] 83 Fed. Reg. 51165.
[75] *Id.*

communities. For this reason, we specifically support the exclusion of unenumerated locally- and state-funded benefits from the proposed rule's scope.

§ 212.22(b) – Minimum factors to consider

We oppose consideration of any minimum factors or weighed factors as outlined in the proposed rule. The statute requires consideration of a totality of circumstances and does not authorize weighing any particular factor more than another.

Assets, Resources, and Financial Status

DHS also proposes to treat income below 125 percent of the federal poverty guidelines (FPG, often referred to as the federal poverty level or FPL) for the applicable household size as a negative factor.[76] Conversely, DHS proposes that income above 250 percent of the FPG be counted as a heavily weighed positive factor. We strongly oppose the use of these arbitrary and unreasonable thresholds. No statutory basis exists for either threshold, and the statement that 125 percent of the FPG has long served as a "touchpoint" for public charge inadmissibility determinations is deeply misleading.[77] Even less justification is offered for the 250 percent of FPG threshold. At footnote 583, DHS admits that the differences in receipt of non-cash benefits between noncitizens living below 125 percent of FPG and those living either between 125 and 250 percent of the FPG or between 250 and 400 percent of the FPG was not statistically significant.

A standard of 250 percent of the FPL is nearly $63,000 a year for a family of four – more than the median household income in the U.S.[78] A single individual who works full-time year round – who does not miss a single day of work due to illness or inclement weather – but is paid the federal minimum wage would fail to achieve the 125 percent of FPG threshold. This is clearly not the person that Congress envisioned when they directed DHS to deny permanent status to those at risk of becoming a public charge.

Moreover, these arbitrary income standards will make it more likely that women will receive a negative assessment than men. Among recent lawful permanent residents, 65 percent of women had incomes less than 125 percent of the federal poverty level.[79] Approximately two-fifths of immigrant women are low-wage workers and are overrepresented in low-wage

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[76] 83 Fed. Reg. 51187.
[77] *Id.*
[78] U.S. Census, *Income and Poverty in the United States: 2017,* https://www.census.gov/library/publications/2018/demo/p60-263.html.
[79] Migration Policy Institute, *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration*, Nov. 2018, https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration.

occupations such as domestic work, retail, personal care aides, and nursing, psychiatric, and home health aides.[80]

This assessment would also have a disproportionally 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.[81] 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.

It is worth noting that the combination of the income thresholds, which are based on household size, and the proposed rule's expansive definition of household, will have the perverse effect of discouraging people from supporting family members. For example, if a couple with one child who have income just over the 250 percent of poverty threshold for a family of three, takes in a brother who is temporarily unemployed and does not charge rent, they will become a household of four and no longer qualify for the heavily weighed positive factor.

Education and Skills

DHS' proposal to consider factors such as whether an applicant has completed high school as a positive or negative indicator will make the prospects of lawful permanent residency more difficult for immigrant women. While there is variation in educational attainment among countries of origin, immigrant women from certain countries such as Mexico, El Salvador, and China are less likely to have completed high school, and are therefore less likely to be able to overcome a negative assessment based on this factor.[82] Low-wage immigrant women workers are even more likely to receive a negative assessment; approximately 40 percent lack a high school diploma.[83]

In addition to specific education and skills, DHS proposes, for the first time, to add English proficiency as a weighed factor. This poorly justified addition disproportionately harms immigrants and other populations with limited English proficiency. We believe the 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 this nation.

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[80] American Immigration Council, *The Impact of Immigrant Women on America's Labor Force*, March 2017, https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force.
[81] Migration Policy Institute, *Immigrant Women in the United States*, March 20, 2015, https://www.migrationpolicy.org/print/15239#.W-dshZNKjIU.
[82] *Id*.
[83] *Supra note 119*.

The proposed rule stands in stark contrast to federal civil rights laws prohibiting discrimination on the basis of English proficiency. Our country does not have a national language, and there is no law that allows the federal government to prefer those who speak English over those who are limited English proficient (LEP). In contrast to this proposal, numerous federal civil rights laws protect 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.[84] Title VII of the Civil Rights Act prohibits discrimination in employment on the basis of race, color, national origin, sex, or religion.[85] In addition, the Affordable Care Act's nondiscrimination provision (section 1557) prohibits discrimination on the basis of race, color, national origin, sex, disability, and age, in health care.[86] The Supreme Court has interpreted that discrimination on the basis of language or English proficiency is a form of national origin discrimination.[87] These protections are also embedded in Executive Order 13166, which provides that all LEP persons should have meaningful access to federally conducted and federally funded programs and activities and directs federal agencies to ensure they are in compliance.[88]

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

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, and are able to fulfill 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 language other than English, which includes some of the most heavily populated.[89] Thus, a person who speaks a non-English language can meaningfully contribute both in employment and civic society.

[84] 42 U.S.C. § 2000d.
[85] 42 U.S.C. § 2000e.
[86] 42 U.S.C. § 18116.
[87] *Lau v. Nichols*, 414 U.S. 563 (1974).
[88] Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency* (Aug. 11, 2000), https://www.gpo.gov/fdsys/pkg/FR-2000-08-16/pdf/00-20938.pdf.
[89] 2012-2016 American Community Survey Estimates, Table S1601.

DHS also 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 draws improper conclusions about the data. For example, states such as New York and California, which have higher numbers of LEP populations, also have higher income thresholds for Medicaid. Higher Medicaid eligibility thresholds means higher usage rates, and does not support a conclusion that limited English proficiency leads to higher benefit usage. 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, and the fourth relies on Current Population Survey data that is nearly 30 years old. 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 English language classes. The prospect of decreased health care access, increased hunger, and home instability may cause affected populations to de-prioritize skills development.[90]

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 pre-1965 racist quota system. Incorporating English proficiency in a public charge assessment would also have a greater negative impact on women. 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).[91] Further, LEP women who have jobs are more than twice as likely to work in low-wage service occupations (45 percent vs. 20 percent) than are women with English proficiency.[92] Thus, the rule will also have a disproportionate impact on women if language proficiency continues to be considered.

Health

We oppose consideration of an individual’s disability or chronic condition in a public charge determination. We support and incorporate by reference the comments submitted by the Consortium for Citizens with Disabilities related to this factor as addressed by the proposed rule.

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[90] Ludden, Jennifer, "Barriers Abound for Immigrants Learning English," National Public Radio. (September 11, 2007). Available at: https://www.npr.org/templates/story/story.php?storyId=14330106.

[91] Migration Policy Institute, *The Limited English Proficient Population in the United States*, July 8, 2015, https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

[92] *Id.*

§ 212.22(c) – Heavily Weighed Factors

We strongly oppose the proposed use of several heavily weighed 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).[93]

Immigrant women are less likely to be employed, to be enrolled in school full-time, or to 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).[94] 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.[95] In addition, immigrant women are disproportionately concentrated in low-wage occupations that lack either employer-sponsored 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

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.

Conclusion

Thank you for the opportunity to provide these comments. If you have any questions, please contact us.

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[93] Kaiser Family Foundation, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/.

[94] American Immigration Council, *The Impact of Immigrant Women in America's Labor Force*, March 2017, https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force.

[95] Migration Policy Institute, *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration*, Nov. 2018, https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration.

Sincerely,