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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

LA CLINICA DE LA RAZA; ET AL., Plaintiffs, v. DONALD J. TRUMP, ET AL. Defendants.	Case No. 4:19-cv-4980-HSG **DECLARATION OF LEIGHTON KU, PH.D., MPH**

DECLARATION OF LEIGHTON KU, PH.D., MPH

I, Leighton Ku, pursuant to 28 U.S.C. § 1746, declare as follows:

1. My name is Leighton Ku. I have personal knowledge of and could testify in Court concerning the following statements of fact.

2. I am a Professor of Health Policy and Management and Director of the Center for Health Policy Research at the Milken Institute School of Public Health, George Washington University in Washington, DC. I have attached my Curriculum Vitae as Exhibit A to this Declaration.

3. I am a nationally-known health policy researcher with over 25 years of experience. I have conducted substantial research about immigrant health, and health care and costs. I have authored or co-authored more than a dozen articles and reports about immigrant health issues, including articles in peer-reviewed journals such as *Health Affairs* and *American Journal of Public Health*, as well as scholarly reports published by diverse non-profit organizations including the Social Science Research Network, Migration Policy Institute, the Cato Institute and the Commonwealth Fund, as well as many more articles and reports on other subjects. I have testified before the U.S. Senate Finance Committee about immigrant health issues and provided analyses and advice to state governments and non-governmental organizations in many states about immigrant health.

4. I have expertise in quantitative data analysis and have conducted quantitative analyses for most of my career, including analyses for a federal agency, two think tanks and now at a university. I have taught statistical analysis and research methods at the graduate school level for over 25 years, training hundreds of graduate students, as well as dozens of federal and state budget and policy analysts. I have authored or co-authored more than 90 papers in peer-reviewed journals and hundreds of other reports, most of which were quantitative analyses. As a quantitative health data analyst I have consulted with the Congressional Budget Office and numerous federal and state agencies.

5. I provided expert declarations about the effects of terminating DACA on health insurance coverage and states in *State of New York, et al. v Trump, et al.*[1] in November 2017 and in *State of Texas v. United States, et al*. *and Karla Perez, et al.*[2] in June 2018. I have not provided testimony in any other court cases in the past four years.

6. I also have knowledge of health insurance and employment through my role as a voluntary (unpaid, appointed) Executive Board member for the District of Columbia's Health Benefits Exchange Authority, which governs the District's health insurance marketplace, formed under the federal ACA. This includes oversight of health insurance for small businesses as well as individual health insurance in the District of Columbia.

7. I have a PhD. in Health Policy from Boston University (1990) and Master of Public Health and Master of Science degrees from the University of California at Berkeley (1979). Prior to becoming a faculty member at George Washington University, I was on the staff of the Urban Institute and the Center on Budget and Policy Priorities.

8. I have been engaged by counsel for the Plaintiffs in this case to evaluate the effect of the new public charge rule on Medicaid enrollment, public health, and health systems.

OVERVIEW

9. This declaration examines the potential effects of the final regulation issued by the U.S. Department of Homeland Security (DHS) regarding inadmissibility on public charge grounds on August 14, 2019 ("the public charge rule" or "the rule"),[3] specifically the health consequences and effects of the rule related to the receipt of health insurance benefits under the Medicaid program. In this declaration I:

(a) summarize key aspects of public charge rule,

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[1] Declaration of Leighton Ku in *State of New York, et al. v Donald Trump, et al.* in U.S. District Court for the Eastern District of New York. Nov. 22, 2017.

[2] Declaration of Leighton Ku in *State of Texas v. United States of America, et al. and Karla Perez,,et al., Defendant-Intervenor* in U.S. District Court for the Southern District of Texas, Brownsville Division, June 14, 2018.

[3] Department of Homeland Security. Final Regulations: Inadmissibility on Public Charge Grounds. Federal Register. *Federal Register.* Vol. 84, No. 157, pg: 41290-508. Aug. 14, 2019.

(b) describe the Medicaid program, and provisions related to lawful immigrants,

(c) demonstrate how the public charge rule will have severe repercussions and create "chilling effects" that cause substantial numbers of members of immigrant families, including citizens in those families, to disenroll or forego Medicaid or other public benefits, even if they are not applying for adjustment in immigration status,

(d) describe serious flaws in estimates by the Department of Homeland Security about the number of members of immigrant families who may forego or drop Medicaid coverage due to the public charge regulation,

(e) produce independent, evidence-based analyses and estimate that between 1.0 million and 3.1 million members of immigrant families would drop or forego Medicaid coverage or disenroll due to the public charge regulation,

(f) explain the documented benefits of Medicaid coverage and discuss the serious health harms that are likely to befall members of immigrant families, including premature death, due to dropping Medicaid coverage in response to the public charge regulation,

(g) analyze other consequences of the public charge regulation including financial harm to state and local governments, including New York and California, and to health care providers, such as community health centers and safety net hospitals, and to the patients they serve,

(h) discuss other health-care-related harms from other provisions of the rule, such as provisions related to private health insurance or savings for medical care and

(i) explain why public charge policies, which rely on current or past characteristics of immigrants, specifically receipt of Medicaid, do not accurately predict immigrants' future economic status.

I conclude that the public charge rule will lead between 1.0 to 3.1 million members of immigrant families, many of whom are United States citizens, to disenroll from or forego Medicaid benefits each year, even though they are eligible. Those harmed are disproportionately low-income

members of racial and ethnic minority groups, especially Latino and Asian families, and many have serious chronic health problems. The loss of Medicaid will substantially reduce their ability to access affordable health care and will lead to serious health problems for many, such as diabetics who will no longer be able to afford insulin or other medications or medical services. As a result, there could be as many as 1,300 to 4,000 excess premature deaths per year. The reduction in Medicaid revenue and subsequent increase in the number of low-income uninsured people will also create financial harm for health care providers, especially safety net facilities like community health centers and safety net hospitals, as well as to local and state governments.

A. Summary of the Revised Public Charge Rules

10. Section 531 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) included five criteria that could be considered when making public charge determinations for admissibility to the United States, approval of lawful permanent residency (LPR) or other adjustments of immigration status: age; health; family status; assets, resources and financial status; and education and skills.[4] In 1999, the Immigration and Naturalization Service (INS), which oversaw the immigration system at the time, specified that being primarily dependent on cash assistance income maintenance (e.g., Supplemental Security Income (SSI) or Temporary Assistance for Needy Family (TANF) benefits) or institutionalized for long-term care at government expense (e.g., nursing home expenses paid by Medicaid) could result in public charge determinations.[5] The INS explained that this was consistent with a historical approach to the concept of public charge, that it would apply to those who were "primarily dependent" on the government for income or for institutionalization. Non-cash benefits, such as Medicaid (other than the long-term care benefits mentioned above), the Children's Health Insurance Program (CHIP), or the Supplemental Nutrition Assistance Program (SNAP), were not be considered in determining public charge status under the 1999 guidance.

[4] Public Law 104-208, Div C. Section 531, 8 USC 1182(1)(4).

[5] Immigration and Naturalization Service. Notice: Field Guidance on Deportability and Inadmissibility on Public Charge Grounds. (Federal Register. Mar. 26, 1999. Pg. 28689-92).

11. Under the new public charge rule, DHS will now include the receipt of non-cash benefits such as Medicaid, SNAP, and public housing as grounds to make a public charge determination to deny status adjustments, including approval for lawful permanent residency.

12. Under § 212.22(c)(1)(ii) of the final regulation, the following will be considered a "heavily weighted negative factor" in consideration of a determination of public charge inadmissibility: "The alien has received or has been certified or approved to receive one or more of the public benefits, as defined in §212.21(b) for more than 12 months in the aggregate within any 36-month period, beginning no later than 36 months prior to the alien's application for admission for admission or adjustment of status on or after October 15, 2019." The public benefits in § 212.21(b) include non-cash benefits like Medicaid, SNAP, and public housing, and cash benefits like Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). Section 212.21(b) indicates that receipt of Medicaid counts as a highly weighted negative factor, except for certain circumstances, such as the receipt of Medicaid due to emergency medical conditions, Medicaid services received under the Individuals with Disabilities Education Act, school-based Medicaid services and services provided to immigrants under the age of 21 or a woman who is pregnant (up to 60 days postpartum).

13. If the immigrant receives two or more benefits, the receipt of each benefit will be summed in reaching the 12-month limit; *i.e.*, an immigrant who receives Medicaid, SNAP *and* public housing benefits for more than four months each would exceed the 12-month criterion. An immigrant may be considered "likely to become a public charge" if the immigration officer believes he or she will receive one or more of these benefits. Applying for Medicaid (or related benefits) after October 15, 2019 will not be considered "receipt" of benefits, but can be considered in determining public charge status (§ 212.22(b)(4)(E)).

14. Other factors which will be considered negative factors include: having an income below 125% of poverty, being a child or elderly, low education, poor health, being uninsured and having been denied entry or adjustment in the past.

15. Although certain exclusions apply with respect to receipt of Medicaid benefits, many Medicaid enrollees with such exclusions are still at risk of being determined public charges

for other reasons. For example, children or pregnant women enrolled in Medicaid could still be determined public charges because they are: under 18 (§ 212.22(b)(1)), have serious health problems (§212.22(b)(2) and §212.22(c)(1)(iii)(A)), are members of large families (§212.22(b)(3)), have incomes below 125 percent of federal poverty guidelines (§212.22(b)(4)), or for other related reasons. For example, an immigration officer could interpret that pregnancy (and subsequent labor and delivery) constitutes a "medical condition that is likely to require extensive medical treatment or institutionalization" (§212.22(b)(2) and §212.22(c)(1)(iii)(A)) which therefore authorizes a public charge determination, even though the child born would be a native-born U.S. citizen. In fact, a pregnant woman be considered a public charge even if she has not been enrolled in Medicaid, simply because of her health condition.

B. Brief Description of Medicaid

16. Medicaid, authorized under Title XIX of the Social Security Act, provides health insurance coverage to low-income populations. As of May 2019, 65.7 million individuals were enrolled in federally-funded Medicaid, about 20% of the U.S. population. (An additional 6.6 million children were enrolled in CHIP; as noted below some of these children could be considered Medicaid recipients as well, depending on how states have decided to structure their programs.)[6] Medicaid is the nation's largest health insurance program. Medicaid is an entitlement program whose eligibility rules and benefit levels are established by federal and state laws and regulations; total spending is not limited by appropriations limits. The Centers for Medicare and Medicaid Services, which administers Medicaid, does not provide detailed information about the immigration status of Medicaid participants.

17. Medicaid serves a wide range of low-income beneficiaries including children, the elderly, persons with disabilities, non-elderly adults and pregnant women. Eligibility is based on

[6] Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed Aug. 19, 2019. This is the number reported by the federal agency, there may be many others, as described below, who are enrolled in state-funded Medicaid plans, who might also disenroll or forego coverage due to the public charge rule.

multiple criteria including age, income, category (e.g., child, adult, elderly, pregnant woman), disability status, state residency and immigration status. Medicaid offers a broad health benefit, including preventive and primary health care, acute medical care, emergency and inpatient hospital care, and long-term care services. Children on Medicaid receive other important services, including dental care and therapies that address developmental problems. For the elderly or disabled who also participate in Medicare, Medicaid can provide "wrap around" insurance that covers fees not covered by Medicare, such as Medicare deductibles or copayments, or for certain services like long-term care or hearing aids not covered by Medicare.

18. Medicaid is a joint federal-state program. Within the federal regulatory framework, states have great flexibility to establish policies. The federal government funds the majority of Medicaid expenditures based on a federal medical assistance percentage (FMAP), which annually establishes the percent of total Medicaid expenditures that will be paid by the federal government, while state or local governments fund the remaining costs. Under Medicaid, 36 states (plus the District of Columbia) cover non-elderly adults with family incomes up to 138 percent of the federal poverty level (about $29,435 per year for a family of three), but 14 states have not expanded Medicaid, as permitted by the Patient Protection and Affordable Care Act and many do not provide any coverage to non-elderly adults without dependent children.[7] The range of income eligibility criteria in Medicaid is very broad. At the high end, in the District of Columbia, adults with incomes up to 221 percent of the poverty level are eligible for Medicaid. Thirty-six states use 138 percent of the poverty level as the income cutoff. At the low end, twelve states use a threshold below 50 percent of the federal poverty level.[8] The lowest threshold is in Texas where Medicaid eligibility for parents ends at 17 percent of poverty ($3,600 per year for a family of three) and non-disabled, non-elderly adults without dependent children are not eligible at all,

[7] Kaiser Family Foundation. Medicaid Income Eligibility Limits as a Percent of the Federal Poverty Level. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed July 26, 2019.

[8] *Id.*

regardless of income. Thus, eligibility criteria related to use of Medicaid would only affect very poor parents in Texas, but may affect low-income working class adults in 36 states and the District of Columbia. Moreover, predicting future Medicaid use would depend heavily on predicting where an individual will live in the future.

19. Medicaid Eligibility for Legal Immigrants. Special policies exist for Medicaid eligibility for legal immigrants. Citizens, including naturalized citizens and citizen children with noncitizen parents, are eligible for Medicaid and CHIP on the same terms as US-born citizens. Undocumented immigrants are not eligible for Medicaid or CHIP benefits (except emergency care). The Personal Responsibility and Work Opportunities Reauthorization Act of 1996 (PRWORA)[9] restricted legal immigrants' eligibility for certain means-tested programs, including Medicaid. In 2009, Congress modified the rules under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and gave states the option to expand eligibility for lawfully residing children and pregnant women. This section is sometimes called the "ICHIA" provision, named after a legislative proposal, Immigrant Children's Health Improvement Act, that evolved into Section 214.[10] Federal policies as of July 23, 2019 (prior to issuance of the final regulation) are summarized by the Department of Health and Human Services' HealthCare.gov website[11]:

> *"Immigrants and Medicaid and CHIP*
>
> *Immigrants who are "qualified non-citizens" are generally eligible for coverage through Medicaid and the Children's Health Insurance Program (CHIP), if they meet their state's income and residency rules.*
>
> *In order to get Medicaid and CHIP coverage, many qualified non-citizens (such as many LPRs or green card holders) have a 5-year waiting period. This means they must wait 5 years after receiving "qualified" immigration status before they can get Medicaid and CHIP coverage. There are exceptions. For example, refugees, asylees, or LPRs who used to be refugees or asylees don't have to wait 5 years.*
>
> *The term "qualified non-citizen" includes:*

[9] *See* 8 USC §§ 1601-1646.

[10] Public Law No: 111-3 (02/04/2009).

[11] Department of Health and Human Services. Coverage for lawfully present immigrants. https://www.healthcare.gov/immigrants/lawfully-present-immigrants/. Accessed July 23, 2019.

- *Lawful Permanent Residents (LPR/Green Card Holder)*
- *Asylees*
- *Refugees*
- *Cuban/Haitian entrants*
- *Paroled into the U.S. for at least one year*
- *Conditional entrant granted before 1980*
- *Battered non-citizens, spouses, children, or parents*
- *Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa*
- *Granted withholding of deportation*
- *Member of a federally recognized Indian tribe or American Indian born in Canada*

Medicaid & CHIP Coverage for Lawfully Residing Children and Pregnant Women.

States have the option to remove the 5-year waiting period and cover lawfully residing children and/or pregnant women in Medicaid or CHIP. A child or pregnant woman is "lawfully residing" if they're "lawfully present" and otherwise eligible for Medicaid or CHIP in the state….

Getting emergency care

Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but don't have an eligible immigration status.

Medicaid, CHIP, and "public charge" status

Applying for Medicaid or CHIP, or getting savings for health insurance costs in the Marketplace, doesn't make someone a "public charge." This means it won't affect their chances of becoming a Lawful Permanent Resident or U.S. citizen.

There's one exception. People receiving long-term care in an institution at government expense may face barriers getting a green card."

20. The provisions above concern eligibility for immigrants under *federal* Medicaid policies that govern the availability of federal funds (i.e. FMAP). But many states extend Medicaid or similar health insurance coverage to additional immigrants, including legal immigrants who do not meet federal criteria as well as undocumented immigrants, using state funds. In July 2019, California enacted Senate Bill 104 which will extend "eligibility for full-scope Medi-Cal benefits to individuals 19 to 25 years of age, inclusive, and who are otherwise

eligible for those benefits but for their immigration status."[12] (Medi-Cal is California's name for Medicaid.) This expands upon a 2015 California law (SB 75) that expanded Medi-Cal eligibility for children 0 to 18 regardless of immigration status.[13] The District of Columbia, Illinois, Maryland (in some counties), Massachusetts, New York and Oregon provide state-funded health insurance coverage to income-eligible children regardless of immigration status.[14] Sixteen states provide prenatal care coverage to income-eligible women regardless of immigration status (Arkansas, California, Illinois, Louisiana, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas and Washington).[15]

21. The rule only applies to federally-funded Medicaid and does not count state-funded assistance in public charge determinations.[16] However, it is important to note that numerous state programs are called or considered Medicaid (often under a state-specific name, like Medi-Cal in California, Arizona Health Care Cost Containment System (AHCCCS) in Arizona or MassHealth in Massachusetts) although the source of funds may not include federal Medicaid funds. As a result, many participants may not know whether the "Medicaid" in which they are enrolled is Medicaid that counts under the regulations or another form of government subsidized health insurance.

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[12] California Senate Bill 104. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB104. Accessed July 23, 2019.

[13] California Senate Bill 75. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB75. Accessed July 23, 2019.

[14] National Immigration Law Center. Medical Assistance Programs for Immigrants in Various States. Jan. 2018 update. https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf

[15] *Id.*

[16] For example, the preamble (Federal Register, Aug. 14, 2019, page 41313) says: "Notwithstanding the inclusion of SNAP as a designated public benefit, DHS will not consider for purposes of a public charge inadmissibility determination whether applicants for admission or adjustment of status are receiving food assistance through other programs, such as exclusively state-funded programs, food banks, and emergency services, nor will DHS discourage individuals from seeking such assistance."

22. The draft form USCIS I-944, titled "Declaration of Self-Sufficiency,"[17] must be completed by those applying for adjustment of status and will be used by DHS officials to determine public charge status. It is long and extremely complicated; its complexity (and lack of clarity) could lead to many erroneous determinations of public charge status by DHS officials. The form is 19 pages long and asks for detailed information and documentation related to income, prior year tax filings, assets (including bank accounts, the value of homes and cars), appraisals of the value of your home, mortgages, a credit score from within the past year, proof of education (such as degrees or transcripts), and occupational licenses, in addition to information about public benefit use. More pertinent to Medicaid, Form I-944 asks "Have you EVER received or are currently certified to receive in the future any of the following benefits," one of which is "federal-funded Medicaid." If the answer is yes, it asks for the beginning and ending dates of receiving Medicaid and the total value of benefits received.

23. There are at least three flaws that could lead to erroneous reporting using Form I-944. First, it is not clear whether "you" in the sentence above applies to the individual or to his or her whole household. Because this question is in a section titled "You and Your Household Members' Assets, Resources and Financial Status," the implication is that "you" means the entire household. This can produce errors since an immigrant applicant might not receive Medicaid him or herself, while another family member, such as a US-born citizen child, spouse or other household member is the recipient. But the public charge regulation is supposed to apply only to the applicant's use of benefits, not the use of benefits by other family members. The form, however, could lead to the determination that the immigrant applicant used Medicaid and is therefore a public charge, even though the immigrant him or herself did not actually receive Medicaid, only another household member. Second, many, perhaps most, applicants will not know if the Medicaid they received is "federal-funded Medicaid" or not. Presumably, DHS used this phrase to differentiate the benefit from state-funded medical assistance programs, such as those

[17] US Citizenship and Immigration Service. Declaration of Self Sufficiency. USCIS I-944. OMB No. 1615-0142. https://www.regulations.gov/document?D=USCIS-2010-0012-63772

described above. But the definitions and names may not be clear to enrollees. All Medicaid programs are state-administered, they sometimes have names other than Medicaid (e.g., Medi-Cal in California, Arizona Health Care Cost Containment System (AHCCCS) in Arizona or MassHealth in Massachusetts) and the insurance card many enrollees receive may only have the name of a private managed care plan (e.g., Aetna or United) that is contracted to provide Medicaid benefits; thus many applicants will be unable to report if they used "federal-funded Medicaid." Finally, Form I-944 asks for the dollar amount received. Almost no Medicaid recipient knows the dollar value of benefits received; it is not reported to them, and it is unclear whether such information could be obtained on demand, so how could they know? DHS provides no guidance on this point. The net effect is that it will be extremely difficult for an immigrant applying for adjustment of status to complete these parts of the I-944 correctly, leading to a substantial risk of erroneous public charge determinations. There is the further risk that many applicants may simply give up due to confusion and will therefore not apply for permanent residency or other status adjustments—even if they are individuals who are unlikely to be deemed public charges based on their receipt of public benefits.

C. The Public Charge Regulation Will Have Substantial and Broad Effects in Reducing Immigrants' Participation: the "Chilling Effect"

24. The public charge rule is ostensibly targeted at certain federal public benefits, including Medicaid. In reality, a substantial share of candidates for adjustment of status do not receive these benefits because they are already ineligible to receive them under existing law. Thus, the rule is not only disconnected from the reality of immigrants' actual federal benefits usage, it also poses a significant threat to lawful use of benefits by members of immigrant families who are *not* covered by the rule. In both the preamble to the regulation and the regulatory impact analysis that accompanies the regulation,[18] DHS acknowledges that a large number of immigrants and members of their families who are eligible for Medicaid will lose benefits but declares that these are "indirect effects" of the rule, as the rule itself does not change the eligibility criteria for

[18] Dept of Homeland Security. "Regulatory Impact Analysis: Inadmissibility on Public Charge Grounds." Aug. 2019. https://www.regulations.gov/document?D=USCIS-2010-0012-63741

Medicaid or other programs. DHS concedes, however, that many members of immigrant families who are lawfully eligible for these programs will disenroll or forego enrollment in order to avoid a public charge determination, though as explained below its estimates of the number of people who will drop coverage is seriously flawed.

25. While the specifics of who is subject to the public charge rule are detailed in the more than 200-page regulation and preamble, experience and research indicates there will be much broader "chilling effects" for those in immigrant families, including U.S.-born citizen children, naturalized citizens, lawful permanent residents and others who are not specifically described by the regulation. In this context, "chilling effect" refers to the likelihood that many members of immigrant families will disenroll or forego participation in public benefit programs, even if they are lawfully eligible, because they are fearful of harmful repercussions for themselves or members of their family. As described below, these fears extend beyond the directly affected immigrants, but creep out to other family members, who may be citizens, already have green cards, or whose benefit use is excluded from consideration. Stated differently, the chilling effect extends far beyond the specific individuals eligible for an adjustment of status who, in DHS's view, rationally choose to forego public benefits in order to reduce the odds of a public charge determination. Many who are supposed to be exempt from the rule, such as pregnant women or refugees fleeing persecution in their homelands, will be understandably confused about the rule and will avoid Medicaid too.

26. While the details of the public charge regulations matter, the effects can be much larger and broader because of the ways that immigrant families perceive these rules. DHS references the existence of chilling effect in its regulatory impact analysis.[19] On pages 90 and 91, DHS cites one study from the US Department of Agriculture which estimated that legal immigrants' food stamp participation fell by 54 percent after the immigrant restrictions in the

[19] *Id.*

1996 PRWORA went into effect[20] and another Urban Institute report which found that welfare enrollment by foreign-born individuals, including both citizen and non-citizens, fell by 21 percent in the years after PRWORA's immigrant restrictions.[21] DHS, moreover, was well aware of potential chilling effects because various comments on the proposed rule raised concerns about them.

27. The most direct, recent evidence of the magnitude of the chilling effects comes from a study conducted by the non-partisan Urban Institute,[22] which was based on a nationally representative survey conducted in December 2018, after the proposed rule was released in October 2018 and included a sample of 2,950 adults in immigrant families (i.e., at least one person in the family was an immigrant).[23] The survey, called the Well-Being and Basic Needs Survey, was a nationally representative sample of adults 18 to 64. It is based on a stratified random sample drawn from Ipsos' Knowledge Panel, a probability-based online basis; it included an oversample of noncitizen respondents. The survey was conducted in English and Spanish. To ensure that the findings corresponded to nationally accepted representativeness, the data were weighted based on benchmarks drawn from the Census Bureau's American Community Survey. The researchers found that:

- Overall, about one-seventh (13.7%) of all adults in immigrant families reported that they avoided noncash public benefits in the past year because

[20] Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997.

[21] Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform

[22] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. May 2019. https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_2.pdf

[23]

of concerns that they or a family member could be disqualified from obtaining a green card (lawful permanent resident status). Hispanics, low-income members of immigrant families, and immigrant families with children were more likely than other groups to avoid such benefits.

- The rate of avoidance was higher (20.7%) among low-income members of immigrant families whose incomes were below 200% of the federal poverty line ($25,100 for a family of four in 2018); this subpopulation is more likely to need public benefits and more prone to suffer long-term consequences from their avoidance.
- Of those who said they avoided noncash benefits, 46% said they avoided receiving Supplemental Nutrition Assistance Program (SNAP) benefits, 42% said they avoided Medicaid or CHIP and 33.4% said they avoided public housing subsidies.
- These concerns were greatest among Hispanics (20.6%), more than double the levels expressed by non-Hispanic whites (8.5%).
- The share avoiding benefits was higher (17.4%) among immigrant families with children, but was still substantial in families without children (8.9%).
- Avoidance of public benefits occurred even in families where all the foreign-born members were naturalized citizens (9.3%) and where all the noncitizen family members were already permanent residents (14.7%). In other words, avoidance occurred even in families in which no one was subject to denial of an adjustment of status due to a public charge determination.
- Awareness of the public charge rule was related to avoidance: Most adults in immigrant families reported awareness of the public charge rule (62.9 %). Adults who had heard “a lot” about the proposed rule were the most likely to report chilling effects in their families (31.1%).

These data form a credible lower bound of the impact of the public charge regulation; it is reasonable to believe that the effects will be even larger once the public charge rule is implemented and enforced. Implementation, denials of adjustment applications, and word of mouth in the immigrant community will cause far more members of immigrant families to avoid Medicaid and related programs.

28. An example of the dramatic effect of the implementation of public charge rules can be seen from statistics from the State Department reporting on visa denials following the January 2018 issuance of a revised public charge policy in its Foreign Affairs Manual, which is used by consular offices across the globe in determining who can receive visas to enter the United States.[24] The revised State Department policy was a precursor to DHS's public charge rule. It revises how sponsor affidavits of support and the use of noncash benefits by applicants, family members, and sponsors are evaluated prior to entry to the United States. The number of visa applications denied on the basis of public charge determinations rose from 1,076 in 2016, using earlier public charge guidance, to 3,237 in 2017, at which time public charge restrictions first came under discussion. The number of public-charge visa denials jumped to 13,450 in 2018 after more restrictive guidance was issued.[25] By comparison, the number of visa applications determined ineligible due to drug abuse, criminal activity or terrorism remained relatively stable: 4,991 denied in 2016, 4,652 in 2017 and 4,916 in 2018.[26] In other words, in 2018, after the public charge changes were implemented, the State Department denied about 12 times as many visa applicants due to public

[24] National Immigration Law Center. Changes to "Public Charge" Instructions in the U.S. State Department's Manual. Aug. 7, 2018. https://www.nilc.org/issues/economic-support/public-charge-changes-to-fam/ https://www.nilc.org/wp-content/uploads/2018/02/PIF-FAM-Summary-2018.pdf.

[25] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html. These statistics do not include counts of cases subsequently overturned. Since then, the State Department issued slightly lower numbers, as cited by Hesson T, Exclusive: Visa denials to poor Mexicans skyrocket under Trump's State Department. Politico, Aug. 7, 2019. https://www.politico.com/story/2019/08/06/visa-denials-poor-mexicans-trump-1637094

[26] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html.

charge than in 2016 before the rule was modified, whereas the number of denials based on these other categories remained relatively constant. The level of denials rose even in 2017, when the issue was being discussed and then surged after formal adoption. These data collectively suggest that the rise in public charge denials was not due to a fundamental change in the composition of applicants but instead due to increasingly stringent criteria in public charge determinations. As rates of denials increase under the new rule, the corresponding chilling effect will also increase. Similarly, after the DHS public charge rule is implemented, the number of denials of adjustment applications on the basis of public charge can also be expected to surge. As the rate of denial increases under the rule, the corresponding chilling effect will also increase.

29. Other research on the chilling effect has also shown that policies designed to limit participation by noncitizen immigrants have repercussions on others, including citizen children in immigrant families. Soon after the 1996 PRWORA immigrant restrictions were enacted, data showed that there were significant reductions in use of Medicaid and similar benefits among citizen children in immigrant families, despite the fact that these citizen children remained eligible. Participation also fell sharply among refugees, who were exempt from PRWORA eligibility changes.[27] A rigorous analysis by researchers at Columbia University and the University of Illinois at Chicago found that the reduction in participation by US-born citizen children in immigrant families was slightly higher than for children in immigrant families born outside the U.S. (18% reduction for US born citizen children vs 14% reduction for foreign-born children).[28]

[27] Zimmerman W, Fix M. Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County. Urban Institute. July 1998. https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county. Fix M, Passel J. Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97. Urban Institute. March 1999. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[28] Kaushal N, Kaestner R. Welfare Reform and Health Insurance of Immigrant. *Health Services Researc*h. 2005; 40(3): 697-721.

30. It is clear from its regulatory impact analysis that DHS was aware of at least two research reports[29] about chilling effects and, given the numerous comments in response to the proposed regulation received, ought to have been aware of other related evidence, such as the reports cited above, but disregarded them in its final analysis. All of the available analyses, including those two studies cited by DHS and other reports cited in the paragraph above, find that changes in policies aimed at noncitizen immigrants have substantial and broad repercussions and lead to reductions in participation by others, including citizen members in immigrant families.

31. There could be multiple reasons for the chilling effect. First of all, the policies are very complicated and difficult to understand. For example, the final public charge regulation is 217 pages long in the Federal Register (three columns with a small font size) and is highly technical. Even the DHS website[30] which tries to summarize the rule in plain language is 15,572 words long, or about 60 double-spaced, typed pages. According to a readability scoring system called the Gunning Fog index, a person would need over 14 years of formal education (completed sophomore year of college) in order to read the information in the website easily.[31] Many, whether immigrant or US born, lack the literacy or time to comprehend such policies. (About half of Americans 18 to 64 have less than this level of education.[32]) Moreover, there are many

[29] The DHS regulatory impact analysis cites Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997 and Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform

[30] US Citizenship and Immigration Services, DHS. Final Rule on Public Charge Grounds of Inadmissibility. Aug. 2019. https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility. Accessed Aug 15, 2019.

[31] To get this assessment, I copied the entire text of the DHS website notice into an online Tests Document Readability Calculator found at https://www.online-utility.org/english/readability_test_and_improve.jsp on Aug. 15, 2019.

[32] Author's analysis of the Census Bureau's 2018 Current Population Survey. https://www.census.gov/cps/data/cpstablecreator.html

technical immigration and public assistance issues embedded in the regulation that require sophisticated understanding of policies to comprehend.

32. The extent to which immigrants take actions to avoid Medicaid or similar benefits after implementation of the rule is intensified by the climate of fear that already exists in immigrant communities. Since the rule was released, there has been substantial publicity pointing out that immigrants may face negative consequences for using these benefits, turning speculative suspicions into concrete hazards. As described earlier, the implementation of public charge policies in the State Department led to a massive increase in public charge denials.

D. Serious Flaws in the Department of Homeland Security's Regulatory Impact Analysis

33. The DHS analysis of the impact of the rule is flawed because it relies on faulty assumptions to determine that only 2.5% of Medicaid recipients will be affected, fails to account for the three-year lookback of benefit use as provided by the DHS rule, and uses a severe undercount of the total number of Medicaid recipients in its calculations.

34. DHS presented its analysis of the potential effects of the public charge regulation in a Regulatory Impact Analysis.[33] Evidence cited by DHS in its regulatory impact statement indicates that participation reductions among members of immigrant households have been as high as 21 percent[34] or 54 percent[35] following prior changes to laws affecting immigrants' access to public benefits. The preamble to the final regulation itself, however, relies on the lowest of the

[33] Dept of Homeland Security. "Regulatory Impact Analysis: Inadmissibility on Public Charge Grounds." Aug. 2019. https://www.regulations.gov/document?D=USCIS-2010-0012-63741. Department of Homeland Security. Economic Analysis Supplemental Information for Analysis of Public Benefits Programs. Undated. https://www.regulations.gov/document?D=USCIS-2010-0012-63742

[34] Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997.

[35] Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform

agency's estimates of the potential impact. DHS's analyses of the chilling effect included critical omissions and was seriously flawed.

35. In Table 14 of the impact analysis, DHS begins by reporting that 34,706,865 people are Medicaid recipients and, based on 2012-2016 Census data, proceeds to estimate that 3,069,651 Medicaid recipients are members of households including foreign-born non-citizens. In Table 16, it estimates that 2.5 percent of the estimated Medicaid recipients (76,741 people) are "members of households that include foreign-born non-citizens expected to disenroll or forego enrollment based on a 2.5% rate of disenrollment or foregone enrollment." The 2.5 percent avoidance rate is based on DHS' estimate of the share of non-citizens who seek to adjust their immigration status each year, such as applying for lawful permanent resident status. DHS presumes that all immigrants who are adjusting status that year drop Medicaid, but that no others do so. (Using a similar logic, DHS estimates that 129,563 will disenroll or forego SNAP benefits and 8,801 will avoid federal rental assistance.) In Table 17, DHS estimates that this would lead to a $1.06 billion reduction in federal spending for Medicaid benefits per year, which is about two-thirds of the $1.46 billion in federal public benefit payments foregone annually; the remainder is other lost benefits, including SNAP, TANF, Supplemental Security Income and federal rental assistance.

36. In Table 18, DHS provides alternative budget estimates that acknowledge that it might be more appropriate to consider a three-year lookback period given that public charge determinations focus on receipt of public benefits during the prior 36-month period. Assuming people avoid benefits for three years, not just one, the total projected annual foregone benefits (from all public benefit programs including Medicaid) would total $4.4 billion, or three times the $1.46 billion cited in the final regulation as the official estimate. It also notes that "the number of people who may disenroll from or forego enrollment in public benefit programs in one year could be as many as the combined three-year total," i.e., it could be three times higher based on the three-year lookback period in the rule. In Table 19, DHS provides alternative evidence-based participation loss estimates much higher than 2.5 percent of the immigrant population that could

reach as high as 21 percent or 54 percent, based on prior research about chilling effects; these lead DHS to estimate Medicaid enrollment losses between 644,627 and 1,657,612 individuals.[36]

37. Despite these alternative estimates, the official estimate used by DHS in the final rule is based on the lowest of these estimates, shown in Table 8 of the preamble for the regulation, based on the reduction in federal benefit payments that would otherwise have been made on behalf of members of immigrant families who avoided Medicaid and other benefits.[37] Table 8 also notes that there could be other costs, including "Potential lost productivity, Adverse health effects, Additional medical expenses due to delayed health care treatment," but makes no effort to quantify them.

38. Although the regulatory impact analysis included alternative estimates of effects that could be over twenty times larger -- up to 1.66 million losing Medicaid (Table 19, page 100 of the impact analysis) rather than 76,741 – DHS chose to use the lowest estimates as the basis of impact for the final rule. DHS says: "While previous studies examining the effect of PRWORA in 1996 showed a reduction in enrollment from 21 to 54 percent, it is unclear how many individuals would actually disenroll from or forego enrollment in public benefits programs due to the final rule. The previous studies had the benefit of retrospectively analyzing the chilling effect characterized by disenrollment or forgone enrollment after passage of PRWORA using actual enrollment data, instead of being limited to prospectively estimating the number of individuals who may disenroll or forego enrollment in the affected public benefits programs. This economic analysis must rely on the latter."[38] In essence, DHS says that although there is historical evidence that there could be a large chilling effect, it cannot use that evidence because it is about a

[36] For 21 percent, DHS cites: Genser J. Who is leaving the Food Stamp Program: An analysis of Caseload Changes from 1994 to 1997. Food and Nutrition Service, USDA. 1999. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997. For 54 percent, it cites Fix M, Passel J. Trends in Noncitizens' and Citizen' Use of Public Benefits Following Welfare Reform: 1994-1997. 1999. The Urban Institute. https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform

[37] Dept of Homeland Security. *Federal Register*, Vol. 84, Issue 157, Aug. 14, 2019, pg. 41489.

[38] DHS, Regulatory Impact Analysis, pages 91-92, just before Table 16.

somewhat different policy while it must assess changes prospectively before the policy goes into effect. DHS furthermore says that its estimate should be related to the number who have to adjust status each year, but it presents no evidence that effects would occur only in that year (and in fact it also indicates that a three-year timeframe might be more appropriate).

39. DHS's estimate flouts substantial evidence, including the recent Urban Institute report, that chilling effects are often far broader than the targeted individuals. I note that the Urban Institute report was released in May 2019; those data were available before DHS completed its August 2019 impact analysis. DHS disregards standard methods for sound policy analysis and research by rejecting actual evidence-based research findings and substituting a flawed metric that yields disenrollment estimates far below the range of other estimates. (The alternative estimates that I produce in the next section are more strongly based on recent and directly relevant evidence.)

40. It is noteworthy that DHS only discusses its estimate of 2.5 percent of immigrants adjusting status annually, rather than its own alternative estimate that the rate could be three times higher, based on the three-year lookback period actually included in the regulation. DHS disregards the research evidence of the scope of effects caused by prior immigration policy changes to select a much lower number and also disregards a three-times higher rate that better corresponds with the regulation.

41. The only estimate in the preamble of the number who are expected to disenroll from or forego Medicaid, SNAP or public housing benefits is the reference to 2.5 percent of members of non-citizen households receiving benefits on page 41313 of the regulation. It is only in the regulatory impact analysis that DHS converts this to actual human terms – reporting that 76,741 people would lose Medicaid. But this estimate is far too low.

42. As noted before DHS primarily assumes that 2.5 percent of members of non-citizen households will avoid Medicaid participation because 2.5 percent of immigrants seek to adjust immigration status each year. But since the public charge regulation uses a three-year lookback period – receipt of benefits of at least 12 months out of the last 36 months – a more appropriate

factor, even accepting DHS's baseline estimate, would be three times higher, or 7.5 percent.[39] In addition, as the Urban Institute analyses and other prior studies of chilling effects described earlier indicate, chilling effects are much broader and affect many who are in naturalized citizen households, mixed status households and are likely to deter participation regardless of when the immigrant is considering applying for adjustment.

43. There are additional serious flaws with the DHS analysis. First of all, DHS begins with an estimate that there are 34.7 million Medicaid recipients, based on a five-year average of data from 2012 to 2016.[40] However, more recent reports show that 65.7 million individuals were enrolled in Medicaid in May 2019.[41] DHS begins by underestimating the total number of people on Medicaid by about half, which affects all subsequent calculations. Because the Affordable Care Act's Medicaid expansion was largely implemented in 2014, inclusion of data from earlier years vastly reduces the average number of Medicaid participants per year. Further, several states, including Virginia, Pennsylvania, and Indiana expanded Medicaid after 2014, making the use of this five-year average even more flawed. Even if one accepted other parts of the DHS methodology, this flaw alone leads to a serious underestimate, even if the 2.5 percent assumption was correct.

44. Moreover, because DHS uses this flawed participation estimate to compute the average Medicaid expenditure per person, this leads to an absurdly high estimate of the cost of federal Medicaid benefits per person, $13,755 per person (Table 17.) In contrast, an official

[39] This is because each year there would be a new group of individuals looking ahead to an adjustment of status in 36 months, so the dollar value associated with their Medicaid avoidance must be added to the group that already began avoiding Medicaid. In any given year, three years' worth of expected adjusters—those applying in one year, those applying in two years, and those applying in three years—would be avoiding Medicaid.

[40] Department of Homeland Security. Economic Analysis Supplemental Information for Analysis of Public Benefits Programs. Undated. https://www.regulations.gov/document?D=USCIS-2010-0012-63742

[41] Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed Aug. 20, 2019.

estimate by the Department of Health and Human Services of federal Medicaid expenditures per person was $5,522 per person for 2019.[42]

E. Evidence-Based Estimates of the Effect of the Public Charge Regulation in Reducing Medicaid Participation by Members of Immigrant Families

45. In this section, I provide an evidence-based analysis of the potential effects of the public charge rule on Medicaid participation by members of immigrant families, based on research and experience regarding the chilling effects. The summary of these calculations are shown in Table 1 below. Overall, these estimates indicate that between 1.0 million and 3.1 million members of immigrant families will forego Medicaid or disenroll due to the final public charge regulations, each year after full implementation. This includes between 0.6 and 1.8 million adults 21 or older who will not receive Medicaid and between 0.4 and 1.2 million children 21 or younger who will not receive Medicaid because they are members of immigrant families, even if they remain eligible for benefits.

[42] US Department of Health and Human Services. 2017 Actuarial Report on the Financial Outlook for Medicaid. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf

Table 1.
Estimates of Medicaid Enrollment Losses Due to the Final Public Charge Regulation

Number of People Potentially at Risk	**Number or % Affected**
1. Number of Medicaid Enrollees, May 2019 (1)	65,663,268
2. Percent of Medicaid Enrollees Who Are Members of Low-income Immigrant Families (b)	25.17%
3. Estimated Number of Members of Low-Income Immigrant Families Enrolled in Medicaid (#1 times #2)	16,526,558
4. Adults 21 or Older Who Are Members of Low-Income Immigrant Families Enrolled In Medicaid (b)	6,946,405
5. Children Under 21 Who Are Members of Low-Income Immigrant Families Enrolled in Medicaid (b)	9,580,153
Low and High Estimates of Number of Members of Immigrant Families Who Disenroll or Forego Medicaid Benefits Due to Public Charge Regulation	
6. Low Estimate Adult Medicaid Reduction (c)	603,920
7. High Estimate Adult Medicaid Reduction(d)	1,813,012
8. Low Estimate of Child Medicaid Reduction(e)	416,258
9. High Estimate of Child Medicaid Reduction (f)	1,248,773
10. Low Estimate of Total Medicaid Reduction (#6 + #8)	**1,020,178**
11. Low Percent Reduction in Total Medicaid Enrollment (#10/#3)	**6.2%**
12. High Estimate of Total Medicaid Reduction (#7 + #9)	**3,061,785**
13. High Percent of Total Medicaid Reduction (#12/#3)	**18.5%**

a. Centers for Medicare and Medicaid Services. May 2019 Medicaid & CHIP Enrollment Data Highlights.
b. Author's analysis of CDC's 2017 National Health Interview Survey. Low-income means family income below 200% of the poverty line. Immigrant family means the head of household and/or spouse is a foreign-born immigrant. Line 3 = lines 4 plus 5.
c. Based on estimates from Bernstein, et al. (2019): 20.7% of members of immigrant families avoiding public benefits times 42.0% = 8.69% of adults in immigrant households.
d. Assumes that after implementation and enforcement begin, the impact is three times higher = 26.1%.
e. Assumes half the level of adult loss because receipt of Medicaid by children under 21 is not counted as a heavily weighted factor. 8.69%* times 50% = 4.35%.
f. Assumes that after implementation and enforcement, the impact is three times higher = 13.0%.
Note: Numbers may not sum due to rounding.

46. My estimates are conservative and evidence-based, using the most recent data and evidence available, and present a range of effects due to the uncertainty surrounding implementation and application of the rule, public awareness and behavioral responses. Although

there is ample evidence, cited earlier, that a chilling effect will reduce immigrants' use of public benefits, some uncertainty exists because it is not completely clear how these rules will be implemented, publicized, or perceived by the immigrant community. Thus, I provide low and high estimates, expecting that the "true" impact would fall in between those limits. Although my estimates of those who lose coverage are higher than the 76,741 estimate used by DHS, they are more conservative than other independent estimates. For example, in October 2018, the Kaiser Family Foundation estimated that between 2.1 and 4.9 million members of immigrant families could lose Medicaid due to the proposed public charge rule.[43] The Migration Policy Institute estimated, based on earlier estimates of chilling effect losses under PRWORA, that 5.4 million to 16.2 million immigrants and members of their families could disenroll from public benefit programs.[44]

47. My calculations begin with the number of people receiving Medicaid as of May 2019, as reported by the Centers for Medicare and Medicaid Services, 65.7 million.[45] Note that because this data represents only federally-funded Medicaid, it is a conservative starting point because it does not include individuals enrolled in state-funded programs who may drop coverage. The federal agency does not have administrative data showing the immigration status of Medicaid participants, so I analyzed data from the 2017 National Health Interview Survey,[46] which is a nationally representative survey conducted by the Centers for Disease Control and Prevention of

[43] Artiga S, Garfield R, Damico A. Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid. Kaiser Family Foundation. Oct. 2018. https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/

[44] Batalova J, Fix M, Greenberg M. Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefit Use. Migration Policy Institute. June 2018. https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families

[45] *Id.*

[46] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm. I downloaded the 2017 data and conducted statistical analyses using standard statistical methods; 2017 is the last year for which population characteristics and income were available as of August 2019.

demographic and health characteristics of the non-institutionalized American population, often used for research like this that includes immigration, socioeconomic and health characteristics. I identify immigrant-headed families, i.e., where the respondent or spouse is a foreign-born immigrant.[47] Because Medicaid is a program for low-income people, I limit the analyses to those who report having incomes below 200 percent of the federal poverty line. As seen in Table 1, about one-quarter of Medicaid enrollees, 16.5 million, are members of a low-income immigrant family. Of the 16.5 million members of immigrant families, 6.9 million are adults 21 or older and 9.6 are children under 21. A large share of the members of immigrant families, especially children, are U.S. citizens. As described above, there is ample evidence that policies aimed at non-citizen immigrants also have harmful effects on their citizen children, because of the chilling effect.

48. To estimate the effects of the public charge regulation in causing people to forego or disenroll from Medicaid, I use estimates from the Urban Institute's May 2019 study,[48] described earlier, which is the only study that provides direct evidence about the extent to which the public charge rules and fears about permanent resident (green card) status influence use of noncash benefits, including Medicaid. The public charge rule had been proposed (October 2018) when the survey was fielded in December 2018. Its findings are comparable to prior studies about the effects of PRWORA immigrant benefit restrictions, but more specific about the reaction to the public charge rule and based on data from late 2018. The study found that 20.7% of members of

[47] I use the population of immigrant families, which includes some naturalized citizens, rather than of families containing one or more non-citizens, as DHS used. I use this population to align with the estimates of the Urban Institute report by Bernstein, et al. (2019), which found that 20.7% of adults in immigrant households avoided noncash benefits due to the chilling effect. While DHS used a base of non-citizen households, in that case the percentage of people avoiding benefits would be higher. That would produce a smaller population base, but a higher percentage of people affected, which ought to produce a similar level of estimates. Moreover, as the Urban Institute report found, and other studies corroborate, even citizens are affected by the chilling effect.

[48] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018. Urban Institute. May 2019. Adults in Immigrant Families Report Avoiding Routine Activities Because of Immigration Concerns. Urban Institute. July 24, 2019. https://www.urban.org/research/publication/adults-immigrant-families-report-avoiding-routine-activities-because-immigration-concerns

low-income immigrant families avoided non-cash benefits due to green card concerns and that 42 percent of those who avoided noncash benefits specifically avoided Medicaid or CHIP; this leads to an estimate that 8.7 percent of low-income adults in immigrant families (20.7 percent times 42 percent) will forego or disenroll from Medicaid as the low estimate. This is the low estimate because those levels of avoidance were occurring before there was any implementation or enforcement of the policy and before there was even much publicity about impending changes in the public charge rules.

49. Because of evidence that effects increase after policies are adopted (including data about public charge denials at the State Department and about the consequences of implementation of PRWORA immigrant restrictions), I set a high estimate at three times that level (26.1 percent reduction), assuming that additional awareness increases avoidance. A few factors led me to conservatively determine that a three-fold increase is reasonable. First, the Urban Institute found that one third (31 percent) of immigrants who avoided benefits said they had heard a lot about the proposed rule; it is reasonable to assume that awareness and avoidance will rise sharply after implementation and enforcement.[49] Second, visa denials rose from 1,076 in 2016, prior to the implementation of recent State Department public charge policies, to roughly three times more (3,237) in 2017 when the changes were under consideration, to an additional four-fold increase (to 13,450) in 2018 after the change was implemented.[50] Large reductions in applications occurred in the wake of implementation of PRWORA immigrant restrictions; for example, in Los Angeles County the number of enrolled citizen children with immigrant parents fell by 48 percent

[49] *Id.*

[50] Based on statistics from Table XX of the State Department's Annual Reports of the Visa Office for 2016, 2017 and 2018. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics.html. These statistics do not include counts of cases subsequently overturned. Since then, the State Department issued slightly lower numbers, as cited by Hesson T, Exclusive: Visa denials to poor Mexicans skyrocket under Trump's State Department. Politico, Aug. 7, 2019. https://www.politico.com/story/2019/08/06/visa-denials-poor-mexicans-trump-1637094

from 1996-98, despite the fact that citizen children remained eligible for coverage.[51] It is reasonable to assume that awareness of risks associated with public charge and avoidance will increase substantially after implementation, based on prior experiences.

50. For children, I use a similar approach, but reduce the estimated effects for children by 50 percent, compared to the level for adults. The final regulation excludes Medicaid benefits received by children under 21 from being considered as a heavily weighted factor. Despite this shift from the proposed rules, there is still strong evidence that children in immigrant families will be harmed, including citizen children, as found in the research on the impact of PRWORA immigrant restrictions, cited earlier. Moreover, as explained before, the confusing directions for Form I-944 about how to report use of Medicaid family suggest that erroneous determinations of public charge status could be common because immigrants might report other family members' use of Medicaid not their own, so that families could be penalized for their children's use of Medicaid benefits.

51. Finally, there is ample evidence indicating that parental participation in Medicaid affects children's participation: when parents gain Medicaid coverage, their children are more likely to enroll, even if the eligibility criteria for children do not change. My research demonstrated this relationship about twenty years ago[52] and the effect has been confirmed in multiple studies since.[53] Evidence indicates that the reverse holds true too; when parents lose

[51] Zimmerman W, Fix M. Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County. Urban Institute. July 1998. https://aspe.hhs.gov/basic-report/declining-immigrant-applications-medi-cal-and-welfare-benefits-los-angeles-county.

[52] Ku L, Broaddus M. The Importance of Family-Based Insurance Expansions: New Research on the Effects of State Health Reforms, Center on Budget and Policy Priorities, September 5, 2000.

[53] For example, Georgetown University Health Policy Institute. Health Coverage for Parents and Caregivers Helps Children. Mar. 2017. https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf. Hudson J, Moriya A. Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children. *Health Affairs.* 36(9): 1643-51. Haley J, et al. Uninsurance and Medicaid/CHIP Participation among Children and Parents. Urban Institute. Sept. 2018. https://www.urban.org/sites/default/files/publication/99058/uninsurance_and_medicaidchip_participation_among_children_and_parents_updated_1.pdf. Hamersma S. Kim M, Timpe B. The

Medicaid coverage, many of their children disenroll too, even though the children remain eligible. For example, in 2012 the state of Maine cut Medicaid eligibility for parents. Although eligibility levels for children did not change, about 6,000 Maine children lost Medicaid benefits.[54] Insurance coverage is often considered as a family matter, so policies that force parents off trigger the loss of children's insurance coverage too. Since DHS only announced the change in policy that exempts consideration of Medicaid benefits received by children under 21 as a heavily weighted negative factor in early August, I am not aware of any direct evidence showing how this might reduce effects for children, so I determined that a 50 percent reduction was a conservative estimate, splitting the difference between no effect and the full adult effect. Thus, in Table 1, I estimate that the number of children in immigrant families who lose Medicaid will range from 0.4 million to 1.25 million.

52. Taken together, these analyses indicate that between 1.02 million and 3.06 million members of low-income immigrant families will lose Medicaid coverage after the public charge rule is fully implemented and enforced. This corresponds to a 6.2 percent to 18.5 percent loss of Medicaid among those who are members of low-income immigrant families.

53. Using additional data from the 2017 National Health Interview Survey, we can also describe some characteristics of those who could be harmed by the public change rule.

- The low-income adults on Medicaid in immigrant families are about twice as likely to have serious health problems as adults who are not in immigrant families and not on Medicaid. Almost one-third (29 percent) of the low-income immigrant group report being in fair or poor health, compared with 11 percent of non-immigrant non-Medicaid adults. About one-quarter (27 percent) of the immigrant group report having a functional limitation, such as difficulty walking, vision problems or having a health problem that

Effect of Parental Medicaid Expansions on Children's Health Insurance Coverage. *Contemporary Economic Policy*. 37(2):297-311.

[54] Maine Children's Alliance. Ensuring Health Coverage for Maine Families with Children in 2014. 2014. http://www.mekids.org/assets/files/issue_papers/healthcoverage_children_2014.pdf.

impairs work versus 15 percent of the non-immigrant, non-Medicaid adults. The burdens of the public charge rule will fall disproportionately on those with poorer health. Because the low-income adults on Medicaid in immigrant families are less healthy, they are more likely to need medical care and are more likely to experience harm to their health if they must forego Medicaid. In addition, the public charge rule also penalizes applicants in general if they are in poor health.

- Those affected by the public charge regulation are far more likely to be members of racial/ethnic minorities. The low-income members of immigrant families receiving Medicaid group are 56 percent Hispanic, 13 percent non-Hispanic white, 9 percent non-Hispanic black and 21 percent Asian. In comparison, those who are not in immigrant families and not on Medicaid are 80 percent white, 7 percent Hispanic, 11 percent non-Hispanic black, 2 percent Asian and 1 percent other/mixed race. Those who are harmed by the public charge rule are far more likely to be Hispanic or Asian and much less likely to be non-Hispanic whites.

F. Harm to Members of Immigrant Families Due to the Loss of Medicaid Benefits Due to the Public Charge Rule

54. A substantial body of research has demonstrated how Medicaid helps improve access to health care, helps people recover from illness or stay healthy, reduces mortality and has other important socially beneficial effects. Much of this literature has developed because of the Medicaid expansions that occurred under the Affordable Care Act or other high quality research studies. In turn, this means that the loss of Medicaid benefits, as caused by the public charge rule, will create serious harm for those who lose Medicaid benefits due to the public charge regulation.

55. A March 2018 review of the literature by the Kaiser Family Foundation identified over 200 studies about the effects of Medicaid expansions across a variety of areas.[55] The review

[55] Antonisse L, Garfield R, Rudowitz R, Artiga S. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Kaiser Family Foundation. Mar. 2018.

found that Medicaid expansions (a) increased insurance coverage and reduced the number of uninsured, benefiting both rural and urban residents and those who are African-American, white and Latino, (b) strengthened access to health care services, increasing the ability of people to obtain preventive, primary and acute care services, medication and mental health care, (c) increased low-income families' financial security, (d) improved a variety of health outcomes, and (e) reduced uncompensated care costs and stabilized safety net health care providers. A more focused review on health benefits conducted by faculty at Harvard University and published in the *New England Journal of Medicine* found consistent evidence that expanding health insurance coverage, especially Medicaid, improves access to and utilization of appropriate health care such as cancer screening, improves assessments of health, eases depression and increases financial security.[56] A recent study demonstrated that receiving Medicaid during pregnancy or early childhood can lead to demonstrable long-term benefits, including reductions in chronic disease hospitalizations for problems like diabetes or obesity as well as higher high school graduation rates.[57]

56. A new analysis by researchers at the University of Michigan, the National Institutes of Health, the Census Bureau and the University of California at Los Angeles found that expanding Medicaid eligibility was associated with significantly lower mortality, particularly disease-related deaths (e.g., as opposed to accidents) and the effect increases over time.[58] Specifically, it estimated that Medicaid expansions were associated with 0.13 percent reduction in the mortality rate. If we assume that this estimated change in mortality rates can be applied to the

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https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

[56] Sommers B Gawande A, Baicker K. Health Insurance Coverage and Health — What the Recent Evidence Tells Us. *New England Journal of Medicine.* 2017 Aug 10; 377(6): 586-93.

[57] Miller S, Wherry L. The Long-Term Effects of Early Life Medicaid Coverage. *J Human Resources*. 2019; 54(3): 786-821.

[58] Miller S, Altekruse S, Johnson N, Wherry L. Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data. NBER Working Paper No. 26081. July 2019. www.nber.org/papers/w26081

number of persons that I have projected to lose Medicaid coverage, the public charge rule could eventually increase the number of premature deaths by between 1,300 and 4,000 (0.13 percent times 1.02 million to 3.06 million losing Medicaid coverage). This corroborates an earlier study that examined the reduction in mortality after Massachusetts increased insurance coverage under its state health reform, which found that every increase in insurance coverage by 830 people prevented one death per year, (0.12 percent),[59] almost the same as the rate cited above. I note that mortality rates might be slightly lower among those in immigrant families. Other research indicates that immigrants have slightly lower mortality rates than those who are native-born, so the effect might be less pronounced.[60] On the other hand, evidence indicates that the loss of health services for low-income people, many with poor health, would lead to more serious health problems, including higher mortality.

57. As noted earlier, a significant share of the immigrants who could be affected by the public charge regulation have fair or poor health or have limitations because of health problems. This is because the final rule assigns negative weight to individuals who have a serious medical condition. Analyses of the 2018 Medical Expenditure Panel Survey reveal more detail about disease prevalence among immigrant adults now covered by Medicaid.[61] About 14 percent of low-income immigrant adults enrolled in Medicaid report having diabetes, 27 percent have high blood pressure, 29 percent have high cholesterol, 3.4 percent have a history of cancer, and 5 percent have a history of coronary heart disease. These are all serious chronic diseases, which generally require ongoing medical care and/or medication.

[59] Sommers B, Long S, Baicker K, Changes in Mortality after Massachusetts Health Care Reform: A Quasi-Experimental Study, *Ann. Intern. Med*. 2014; 160(9): 585-93.

[60] Singh G, Miller B. Health, Life Expectancy, and Mortality Patterns Among Immigrant Populations in the United States. *Can J Public Health.* 2004; 95(3): I14-21. Singh G, et al. Immigrant Health Inequalities in the United States: Use of Eight Major National Data Systems. *Scientific World Journal*. 2013; Article ID 512313, 21 pages http://dx.doi.org/10.1155/2013/512313

[61] Author's analysis of the 2017 Medical Expenditure Panel Survey, conducted by the federal Agency for Healthcare Research and Quality. https://meps.ahrq.gov/mepsweb/index.jsp

58. To illustrate the consequences of the loss of Medicaid insurance coverage, I present a hypothetical example about problems for a person with diabetes. Loss of Medicaid would make it much harder for a diabetic to continue to afford insulin or other diabetes-related medications or other medical care. The average cost of insulin (without insurance) was $450 per month in 2016, compared to $234 in 2012.[62] When diabetes is adequately controlled, diabetics can function well in work and other normal activities of life, but the loss of medical care could lead to severe medical problems, including death and impairments such as heart disease, loss of vision or amputation.[63] With adequate medical care, an immigrant could hold a job, go to school, support a family and pay taxes, but the loss of Medicaid could put all of that at risk and lead to serious, long-term health problems.

59. A recent study examined some of the medical needs of children who could be affected by the public charge regulation, looking at children who lived with at least one noncitizen adult, based on analyses of the 2015 Medical Expenditure Panel Survey. Of these children: 11 percent had asthma, 18 percent had experienced gastrointestinal problems, 14 percent had the flu, and 9 percent had neuromuscular problems. Forty percent needed care for an illness or injury and 18 percent needed medication.[64] Forgoing Medicaid could have serious medical consequences for these children that could not only impair their health, but reduce their opportunities to function well in school.

60. The public charge rule creates other harms for immigrants. As noted earlier, many in immigrant families are already under serious psychological stress due to the public charge rule and perceptions of other Trump Administration policies. The loss of Medicaid would compound

[62] Thomas K. Express Scripts Offers Diabetes Patients a $25 Cap for Monthly Insulin. *New York Times.* Apr. 3, 2019.

[63] American Diabetes Association. Standards of Medical Care in Diabetes—2019. *Diabetes Care*. 2019 Jan. (supplement)

[64] Zallman L, et al. Implications of Changing Public Charge Immigration Rules for Children Who Need Medical Care. *JAMA Pediatr*. Published online July 1,m 2019. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2737098

these problems. Research has shown that receiving Medicaid helps reduce depression and increases the ability to get access to mental health care services.[65] It also increases financial security, since beneficiaries know that their medical expenses will be covered.

61. Another harm of the public charge rule is the risk of family separation. As noted by the Cato Institute, about 40 percent of those subject to the public charge rule are spouses or minor children.[66] If they do not meet the public charge rule's requirements, their ability to remain in the United States – and their ability to remain with their citizen or permanent resident spouses or children – is jeopardized, increasing the risk of family separation. This risk increases the pressure for immigrant families to avoid public benefits, while also adding to their psychological distress.

G. Harm to State and Local Governments and Health Care Facilities Due to the Public Charge Rule

62. The harm caused by the public charge rule extends beyond the harm caused to members of immigrant families; there are broader repercussions that would create serious harm to state and local governments, health care providers and other members of these communities who are not in immigrant families. Safety net health care providers will lose Medicaid revenue, which will threaten their ability to serve their communities, including patients who are not members of immigrant families. Many state or local governments will be forced to spend more to provide health care to indigent patients, increasing their state and local budget pressures. Finally, the loss of federal Medicaid revenue (as well as the loss of federal SNAP benefits) would have broader effects on state and local economies and employment.

63. The problem can be clearly understood in the case of health care. If fewer people have Medicaid coverage, then health care providers, such as hospitals or community health centers, will collect less insurance revenue; this is particularly a problem for safety net health care

[65] Baicker K, et al. The Effect of Medicaid on Management of Depression: Evidence from the Oregon Health Insurance Experiment. *Milbank Q.* 2018 Mar; 96(1): 29–56.

[66] Bier D. An Explanation of the Public Charge Rule: Frequently Asked Questions. Cato Institute. Aug. 12, 2019. https://www.cato.org/blog/explanation-public-charge-rule-frequently-asked-questions

providers that care for a large number of Medicaid patients. But uninsured patients still need medical care and often seek care at these facilities as uninsured patients. Safety net facilities often continue to care for uninsured patients, whether because of legal mandates or because of their mission to serve needy patients. For example, as a condition of receiving federal funds under Section 330 of the Public Health Service Act, community health centers must serve all patients, regardless of their ability to pay for care.[67] Thus, the health center must continue to provide care, even if patients are uninsured and cannot pay.

64. In this section, I summarize data from several reports that were released in late 2018 that examine the effects of the public charge rule, as it was proposed in October 2018. If these analyses were conducted now the results might be slightly different because of changes in the final regulation, such as the exclusion of consideration of Medicaid benefits used by children and pregnant women or the availability of more recent information. But the general methods used in these reports appear technically reasonable and the direction of findings should be approximately valid, even if they were revised in light of the final regulation or more recent data.

65. In a November 2018 report, I and colleagues at George Washington University examined the financial impact of the then-proposed public charge rule for community health centers.[68] The key results from that report are reproduced in Table 2 below. Nationwide, we estimated that health centers would sustain between $345 and $623 million in lost Medicaid revenue. In order to make up for that loss in revenue, we considered scenarios in which they would either reduce the number of patients served or reduce their staffing. We estimated that this would cause health centers to serve between 295,000 and 538,000 fewer patients or reduce staffing by around 3,400 to 6,100 staff. Because health centers cannot discriminate and must serve all patients regardless of their ability to pay (or their immigration status), they must lower their

[67] 42 U.S.C. 254b(k)(3)(G)

[68] Ku L, Sharac J, Gunsalus R, Shin P, Rosenbaum S. How Could the Public Charge Proposed Rule Affect Community Health Centers? Policy Brief # 55. Geiger Gibson RCHN Community Health Research Collaborative. Nov 2018. https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf

overall patient caseloads, which would result in losses in the broader patient community and most of those patients would not be immigrants or members of immigrant families, or reduce staff, most of whom are not immigrants. The public charge rule would have broader repercussions that reduce services for broader communities, not just members of immigrant families.

66. The report estimated that community health center losses in New York state could be between $55 and $102 million, in California from $126 to $240 million, in Connecticut from $4.4 to 11.4 million and in Vermont from $166,000 to $293,000.

Table 2.
Potential Effect of Proposed Public Charge Rule on Community Health Center Revenue and the Potential Reduction in the Number of Patients Served or the Number of Health Center Staff Needed to Compensate for the Loss of Medicaid Revenue

	Loss of Health Center Medicaid Revenue Due to Public Charge Rule		Potential Compensatory Actions Due to the Loss of Medicaid Revenue			
			Reduce Number of Patients Served		Reduce Number of Health Center Staff	
	Low Estimate	High Estimate	Low Estimate	High Estimate	Low Estimate	High Estimate
Total, U.S.	**-$345,673,184**	**-$623,753,853**	**-294,642**	**-537,683**	**-3,373**	**-6,075**
Alabama	-$225,564	-$526,557	-365	-851	-2	-6
Alaska	-$471,897	-$996,953	-149	-315	-3	-7
Arizona	-$10,595,610	-$12,817,305	-9,900	-11,976	-116	-141
Arkansas	-$394,544	-$771,900	-425	-832	-5	-9
California	-$126,143,256	-$240,183,200	-102,201	-194,595	-1,139	-2,169
Colorado	-$5,696,253	-$11,848,222	-5,143	-10,697	-63	-131
Connecticut	-$4,408,901	-$11,391,917	-4,208	-10,873	-44	-113
Delaware	-$553,818	-$852,250	-696	-1,071	-6	-9
Dist. of Columbia	-$9,953,898	-$14,464,689	-4,258	-6,188	-106	-154
Florida	-$7,813,025	-$15,909,023	-9,334	-19,006	-94	-192
Georgia	-$254,034	-$820,574	-310	-1,003	-3	-10
Hawaii	-$1,008,457	-$1,650,632	-736	-1,205	-10	-16
Idaho	-$225,677	-$900,226	-202	-805	-2	-9
Illinois	-$5,948,171	-$13,574,467	-7,417	-16,927	-64	-147
Indiana	-$1,817,859	-$2,930,27 4	-2,312	-3,727	-20	-32
Iowa	-$1,963,423	-$2,414,045	-2,249	-2,765	-19	-24
Kansas	-$471,669	-$789,340	-623	-1,042	-6	-10
Kentucky	-$1,951,046	-$2,143,024	-2,062	-2,265	-22	-24
Louisiana	-$155,599	-$563,779	-164	-595	-2	-6
Maine	-$233,447	-$457,375	-224	-438	-2	-5
Maryland	-$1,782,988	-$3,300,834	-1,628	-3,013	-20	-37
Massachusetts	-$32,471,101	-$44,392,363	-23,251	-31,787	-335	-458
Michigan	-$3,839,013	-$6,084,838	-3,899	-6,180	-40	-64
Minnesota	-$2,658,967	-$5,351,271	-2,530	-5,093	-25	-49
Mississippi	-$9,842	-$210,900	-15	-312	0	-2
Missouri	-$345,504	-$1,286,065	-417	-1,552	-4	-15
Montana	-$137,605	-$197,994	-124	-179	-1	-2
Nebraska	-$623,129	-$849,313	-742	-1,012	-8	-11
Nevada	-$581,865	-$1,463,941	-390	-981	-8	-20
New Hampshire	-$366,666	-$666,839	-290	-528	-4	-7
New Jersey	-$2,799,363	-$7,001,699	-3,406	-8,520	-27	-66
New Mexico	-$3,349,127	-$5,363,475	-2,693	-4,313	-35	-56
New York	-$55,237,669	-$101,597,422	-41,733	-76,758	-495	-911
North Carolina	-$1,070,195	-$3,276,186	-1,376	-4,211	-12	-38
North Dakota	-$273,951	-$370,515	-300	-405	-3	-5
Ohio	-$1,401,176	-$2,540,892	-1,799	-3,262	-16	-29
Oklahoma	-$312,067	-$1,079,861	-373	-1,291	-4	-12
Oregon	-$8,251,838	-$15,300,182	-4,890	-9,066	-80	-148
Pennsylvania	-$7,616,148	-$12,335,111	-7,967	-12,903	-83	-135
Rhode Island	-$3,003,273	-$4,439,375	-3,036	-4,488	-33	-49
South Carolina	-$209,046	-$1,263,821	-203	-1,227	-2	-15
South Dakota	-$485,598	-$597,119	-614	-755	-6	-7
Tennessee	-$347,224	-$938,841	-533	-1,440	-5	-12
Texas	-$13,410,285	-$26,466,577	-17,137	-33,822	-156	-308
Utah	-$1,369,508	-$2,516,979	-1,426	-2,622	-16	-29
Vermont	-$166,063	-$293,264	-167	-295	-2	-3
Virginia	-$458,375	-$1,173,334	-577	-1,477	-5	-13
Washington	-$19,832,337	-$32,646,223	-17,036	-28,043	-190	-312
West Virginia	-$172,518	-$330,056	-214	-409	-2	-4
Wisconsin	-$2,708,512	-$4,285,574	-2,806	-4,439	-28	-44

Source: Ku, Sharac, Gunsalus, Shin & Rosenbaum. 2018.

67. Similar analyses were conducted about the impact of the proposed public charge rule on the Medicaid revenues of hospitals across the country by Manatt Health, on behalf of America's Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children's Hospital Association, and the Federation of American Hospitals.[69] Like the community health center report, this November 2018 report was issued before the final regulation was issued. Results today might differ somewhat, although the general nature and magnitude of results ought to remain similar. This report analyzed the potential effect of the loss of Medicaid revenues in every state and in many metropolitan areas across the nation. Like health centers, hospitals would need to compensate for the loss of revenue by reducing the number of patients served, including many who are not in immigrant families, reducing services and/or reducing staffing. Overall, the report concluded that American hospitals could lose an estimated $17 billion, harming them and the communities they serve. Because hospitals are so much larger and provide much costlier care, the size of the losses is far higher for hospitals than community health centers. The losses reported in this report include all types of hospitals, but the losses will be higher in hospitals that serve more Medicaid patients or in areas with higher immigrant populations, many of which are public hospitals or hospitals that receive substantial state or local subsidies. Table 3 provides the estimates of hospital losses by state; Table 4 shows them instead arrayed by metropolitan areas.

[69] Mann C, Grady A, Orris A. Medicaid Payments to Hospitals at Risk Under the Proposed Public Charge Rule. Nov. 2018. https://www.manatt.com/Manatt/media/Documents/Articles/Medicaid-Payments-at-Risk-for-Hospitals-Under-the-Public-Charge-Proposed-Rule_Manatt-Health_Nov-2018.PDF

Table 3.
Potential Medicaid/CHIP Hospital Payment Losses Due to Proposed Public Charge Rule by State (2016, $ in millions)

State	$ millions	State	$ millions
Alabama	$48	Montana	$6
Alaska	$23	Nebraska	$32
Arizona	$383	Nevada	$223
Arkansas	$24	New Hampshire	$25
California	$5,168	New Jersey	$608
Colorado	$234	New Mexico	$126
Connecticut	$163	New York	$2,710
Delaware	$31	North Carolina	$216
District of Columbia	$117	North Dakota	$7
Florida	$785	Ohio	$170
Georgia	$243	Oklahoma	$98
Hawaii	$51	Oregon	$186
Idaho	$27	Pennsylvania	$216
Illinois	$554	Rhode Island	$51
Indiana	$117	South Carolina	$54
Iowa	$57	South Dakota	$5
Kansas	$40	Tennessee	$96
Kentucky	$85	Texas	$1,923
Louisiana	$52	Utah	$70
Maine	$7	Vermont	$3
Maryland	$254	Virginia	$112
Massachusetts	$457	Washington	$329
Michigan	$246	West Virginia	$8
Minnesota	$157	Wisconsin	$68
Mississippi	$17	Wyoming	$1
Missouri	$93	**Total, U.S.**	**$16,771**

Source: Mann, Grady & Orris, 2018.

Table 4.
Potential Medicaid/CHIP Hospital Payment Losses Due to Proposed Public Charge Rule by Metropolitan Area (2016, $ in millions)

Metropolitan Area	$ millions
Atlanta-Sandy Springs-Roswell, GA	$183
Baltimore-Columbia-Towson, MD	$136
Boston-Cambridge-Newton, MA-NH	$365
Chicago-Naperville-Elgin, IL-IN-WI	$548
Dallas-Fort Worth-Arlington, TX	$421
Denver-Aurora-Lakewood, CO	$169
Detroit-Warren-Dearborn, MI	$136
El Paso, TX	$156
Fresno, CA	$214
Houston-The Woodlands-Sugar Land, TX	$634
Las Vegas-Henderson-Paradise, NV	$132
Los Angeles-Long Beach-Anaheim, CA	$1,978
McAllen-Edinburg-Mission, TX	$124
Miami-Fort Lauderdale-West Palm Beach, FL	$529
Minneapolis-St. Paul-Bloomington, MN-WI	$136
New York-Newark-Jersey City, NY-NJ-PA	$3,113
Philadelphia-Camden-Wilmington, PA- NJ-DE-MD	$232
Phoenix-Mesa-Scottsdale, AZ	$301
Portland-Vancouver-Hillsboro, OR-WA	$137
Riverside-San Bernardino-Ontario, CA	$572
Sacramento–Roseville–Arden-Arcade, CA	$198
San Antonio-New Braunfels, TX	$181
San Diego-Carlsbad, CA	$387
San Francisco-Oakland-Hayward, CA	$506
San Jose-Sunnyvale-Santa Clara, CA	$365
Seattle-Tacoma-Bellevue, WA	$178
Washington-Arlington-Alexandria, DC- VA-MD-WV	$256
Yuba City, CA	$115
All other	$4,365
Total, U.S.	**$16,771**

Source: Mann, Grady & Orris, 2018.

68. The Manatt report estimated that hospital losses due to the proposed public charge rule in New York State could total $2.7 billion, in California $5.2 billion, in Connecticut $163 million and in Vermont $3 million. In the New York City-Newark metropolitan area the losses could be $3.1 billion and losses could reach $2.0 billion in the Los Angeles area.

69. Public health directors have commented on the major damage engendered by the public charge policies. In November 2018, Mitchell Katz, MD, MPH, who directs New York City's Health and Hospitals system and previously led the health departments of Los Angeles County and San Francisco and is one of the nation's foremost authorities on public health and health care systems stated: "If enacted as proposed, this public charge provision could decrease access to medical care and worsen the health of individuals, threaten public health, and undercut the viability of the health care system."[70]

70. The results of the loss of Medicaid benefits would spill over into harm for hospitals, clinics and related facilities, both because of their underlying commitments to serve disadvantaged patients, but in many cases because of state laws that require them to provide care to the indigent who are otherwise uninsured. For example, under Section 2807-k(9-a) of the New York State Public Health Law, the state requires that hospitals must limit what they can charge low-income uninsured patients, effectively requiring them to accept losses to care for such patients.[71] Section 17000 of the California Welfare and Institutions Code requires cities and counties to assume responsibilities for care: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions." Similar laws at state and local levels across the country that require efforts to provide indigent care and the loss of Medicaid coverage by millions of members of immigrant families would shift costs and burdens onto states, local governments and health care providers, as well as reducing access to care by those who lose their insurance.

[70] Katz M, Chokshi D. The "Public Charge" Proposal and Public Health: Implications for Patients and Clinicians. *Journal of the American Medical Association*. 2018;320(20):2075-2076. Nov. 27, 2018.

[71] New York State Department of Health. Understanding Your Financial Aid Rights. https://profiles.health.ny.gov/hospital/pages/financial_aid_info. Accessed Aug. 22, 2019.

71. Other researchers have analyzed broader economic consequences of the public charge rule. For example, a report by researchers at the University of California[72] estimated the impact of the proposed public charge rule on California. The researchers began by estimating the potential loss of Medicaid and SNAP (called Medi-Cal and CalFresh in California) benefits by members of immigrant families in California, then estimated the level of federal revenue (Medicaid matching funds and federal SNAP payments) would be lost, a combined loss of $1.7 billion in federal benefits received in California. Because these benefits pay for health care services and food, the lost federal revenue decreases money going to pay hospitals, doctors' offices, grocery stores, etc., and this in turn lower payments made to staff and to vendors, such as food producers, which have effects that multiply through the economy. The researchers then used economic models to estimate the number of jobs that would be lost due to the reduction in federal revenue. It estimated that this could cost California 17,700 jobs, about half of which are in health care, 10 percent in the food sector and the rest in other areas of the state's economy.

72. The reports cited above are just a portion of the analyses, mostly conducted soon after the proposed public charge regulation was released, that attempt to demonstrate the economic harm that would occur among community health centers, hospitals, states and local areas. Despite the diversity in data, methods and issues examined, they are consistent in indicating that the public charge rule would have broad and harmful effects on state and local governments, health care providers and the communities they serve.

H. Other Harmful Health Care Aspects of the Public Charge Regulation

73. The public charge regulation includes other provisions that relate to health insurance coverage or health status. Not only is the receipt of Medicaid a heavily weighted negative factor, so are: (a) having a serious medical condition that could result in hospitalization or extensive medical care or interfere with the ability to work or (b) being uninsured with no prospect

[72] Ponce N, Lucia L, Shimada T. Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health. UCLA Center for Health Policy Research. Dec. 2018. https://healthpolicy.ucla.edu/publications/Documents/PDF/2018/publiccharge-factsheet-dec2018.pdf

of obtaining private insurance, nor having the ability to pay for care (§212.22(c)(1)(iii)). In contrast, heavily weighted positive factors include having an income greater than 250 percent of the federal poverty line or having private insurance, not including private coverage obtained through the Health Insurance Marketplace (also known as "Obamacare") subsidized with premium tax credits (§212.22(c)(2)).

74. Table 5 presents data on the health insurance coverage of adults who are low-income (with incomes below 200 percent of poverty) members of immigrant families and of low-income and upper-income families without immigrants, based on further analyses of the 2017 National Health Interview Survey.[73] Low-income members of immigrant families are much more likely to be uninsured (38 percent) than low-income adults not in immigrant families (19 percent) and higher-income adults not in immigrant families (7 percent). Moreover, members of low-income immigrant families are less likely to be covered by private insurance, Medicaid or other insurance than low-income adults who are not in immigrant families.

75. Medicaid eligibility for non-citizen immigrants was sharply restricted by PRWORA; analyses show that non-citizen immigrants are much less likely to get Medicaid than low-income citizens.[74] But the largest reason that immigrants are less insured is that, although they have high labor participation rates, immigrants often work in jobs, such as construction, agriculture, hospitality or food processing jobs, that do not offer insurance to their employees.[75] Immigrants are simply less likely to be offered insurance, whether by the government or by their employers. The public charge sanctions associated with being uninsured create a further disadvantage that disproportionately harms low-income members of immigrant families, particularly Latinos.

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[73] Author's analysis of the 2017 National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm

[74] Ku L, Bruen B. Poor Immigrants Use Public Benefits at a Lower Rate than Poor Native-Born Citizens, *Economic Development Bulletin* No. 17, Washington, DC: Cato Institute. March 4, 2013, http://www.cato.org/sites/cato.org/files/pubs/pdf/edb17.pdf

[75] Buechmuller T, LoSasso T, Lurie I, Dolfin S. Immigrants and Employer-Sponsored Health Insurance. *Health Services Research* 2007; 42(1): 286-310.

Table 5.
Health Insurance Coverage of Adult (21-64) Members of Immigrant Families and Those Who are Not Members of Immigrant Families, 2017

	Low-income Member of Immigrant Family	Low-income Not Member of Immigrant Family	Not Low-income Not Member of Immigrant Family
Private Insurance	28.5%	35.4%	83.4%
Health Insurance Marketplace	1.5%	1.2%	1.3%
Medicaid /CHIP	29.0%	35.7%	4.2%
Other (e.g., Medicare, military)	3.0%	8.6%	3.8%
Uninsured	38.0%	19.1%	7.3%
Total	100.0%	100.0%	100.0%

Source: Author's analysis of 2017 National Health Interview Survey

76. Having private insurance is a heavily weighted positive factor in public charge determinations, but immigrants have lower opportunities to get private insurance than those who are not in immigrant families. Data from the 2017 National Health Interview Survey indicate that 21 percent of immigrants who lack coverage report that it was because it was not offered in their jobs, because they were rejected by an insurance company, lost their job or changed companies, changed family status (e.g., divorced), or because the cost was too high), compared to 10 percent of low-income adults not in immigrant families and 4 percent of higher income adults not in immigrant families. In addition, since those who get insurance through the Health Insurance Marketplaces with federal tax subsidies cannot count that insurance as a heavily weighted positive factor, about 1.5 percent of the low-income members of immigrant families will not receive this positive factor either.

77. Under the public charge regulation, members of immigrant families can be sanctioned if they use Medicaid or are uninsured. Any expectation that they may make up this gap by gaining private insurance is utterly unrealistic. For example, in 2018, the average total cost of health insurance in an employer-sponsored plan was $6,715 for single person and was $19,565 for a family; these levels would be out of reach for almost all low-income immigrants if they are not offered insurance by their employers or get federal tax premiums to help them buy coverage through Health Insurance Marketplaces. Less than a third of the adults in low-income immigrant

families (28.5 percent) have the private insurance that could count as a highly weighted positive factor; most of the rest would be sanctioned under the Administration's new regulation.

I. Current or Past Status of Immigrants Does Not Predict Their Future Economic Success

78. According to DHS, the overarching goal of its revised public charge policies is to "better ensure that applicants for admission to the United States and applicants for adjustment of status to lawful permanent residency…are self-sufficient."[76] To accomplish this DHS will use current or past characteristics of immigrant applicants, such as use of public benefits, being uninsured or having a low income, to effectively predict the future economic status of immigrants.

79. A fundamental question is whether receiving Medicaid interferes with a recipient's economic status or employment. The strongest evidence comes from a rigorous study conducted in Oregon by Harvard University researchers that found that receiving Medicaid did not significantly discourage employment or lower earnings by low-income adults.[77] Medicaid did not harm their chances of employment or earnings; it just gave them health insurance coverage to address their medical needs. This study used a randomized experiment, the strongest possible evaluation design, to compare those who received Medicaid and those who did not and found that those who gained Medicaid coverage had equivalent employment rates and earnings levels as those who did not. Receiving Medicaid does not make recipients less likely to work or able to meet their economic needs. Instead it provides health insurance coverage that helps them meet their health care needs that can help them maintain employment and well-being.

80. Research and experience also indicates the hazard of predicting future economic status based on past performance. Immigrants are often initially disadvantaged when they first arrive in the United States; they have limited American job experience and have not developed the social and business networks that enable people to find better work, but their status improves

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[77] Baicker K, Finkelstein A, Song J, Taubman A. The Impact of Medicaid on Labor Market Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment. *American Economic Review*. 2014, 104(5): 322–328.

rapidly. Research consistently shows that when immigrants first enter, they tend to have lower incomes than similar US born adults, but their earnings grow rapidly as they remain in the US and gain experience, skills and opportunities, enabling them to integrate into the economic mainstream.[78] The prototypical immigrant success story is one of a person who comes to the U.S. with nothing in his or her pocket, but, through hard work and persistence, eventually becomes a success. For example, analyses of Census data reveal that immigrants without a high school education, such as those targeted by the public charge rule, initially have lower average incomes than similar US born citizens (with the same gender, age, and education), but the immigrants' incomes catch up and then surpass their US-born peers within six or seven years.[79] Public charge policies make it harder for the immigrant to remain in the U.S. could jeopardize their ability to improve their economic status. There is even stronger evidence of the economic and educational success of "second generation" immigrants, the U.S.-born children of immigrants.[80] Public charge policies that reduce the ability of immigrants or their children to remain in the United States could short-circuit their subsequent economic well-being.

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[78] See, for example, Chiswick B. The effect of Americanization on the earnings of foreign-born men. *Journal of Political Economy* October 1978: 897–922; Duleep H, Dowhan D. Research on immigrant earnings. *Social Security Bulletin*. 2008; 68(1): 31-50; Kaushal N, et al. Immigrant employment and earnings growth in Canada and the USA: evidence from longitudinal data. *Journal of Population Economics*. 2016; 29(4): 1249–1277; Borjas G, Friedberg R. Recent trends in the earnings of new immigrants to the United States. National Bureau of Economic Research Working Paper 15406. Oct.2009.

[79] Ku L, Pillai D. The Economic Mobility of Immigrants: Public Charge Rules Could Foreclose Future Opportunities. Nov. 15, 2018. Social Science Research Network. http://ssrn.com/abstract=3285546

[80] Pew Research Center. Second-Generation Americans: A Portrait of the Adult Children of Immigrants. Feb. 2013. https://www.pewresearch.org/wp-content/uploads/sites/3/2013/02/FINAL_immigrant_generations_report_2-7-13.pdf; Doung M, et al. Generational Differences in Academic Achievement Among Immigrant Youths: A Meta-Analytic Review. *Review of Education Research*. 2016; 86(1): 3-41.

I hereby declare under penalty of perjury under the laws of Washington D.C. and the United States that the foregoing is true and correct.

DATE: September 1, 2019

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