October 22, 2021

U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Submitted via www.regulations.gov

Re: DHS- Docket No. USCIS-2021-0013; Comments on Public Charge Ground of Inadmissibility

Thank you for the opportunity to comment on the Department of Homeland Security's (DHS) Advance Notice of Proposed Rulemaking (ANPRM) on the public charge ground of inadmissibility. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals by advocating, educating, and litigating at the federal and state level.

We support the comments submitted by the Protecting Immigrant Families (PIF) campaign, and submit additional comments in response to the questions posed in the ANPRM. We share PIF's view that the nation is stronger when we welcome people who are willing to contribute to the country and recognize their potential. NHeLP opposes the consideration of health, nutrition, housing, and cash assistance programs in public charge determinations. We believe U.S. immigration laws should not discourage immigrants and their family members from seeking health care, nutrition, housing, or other benefits for which they are eligible. We also urge DHS to adopt a narrow definition of public charge, and to ensure the regulations include clear guardrails to prevent a public charge determination from being used as a tool to discriminate against people of color, women, people with disabilities, older adults, or anyone else.

For these reasons, we recommend DHS incorporate the following:

I. Purpose and Definition of Public Charge

Ambiguity in and expansion of the definition of public charge dissuades immigrants from applying for life-saving public benefits. We propose that DHS define someone likely to become a public charge for inadmissibility purposes as a person who is "likely to become primarily and permanently reliant on the federal government to avoid destitution." We believe this is the narrowest definition of public charge possible and that it will support increased access to public benefits, in turn strengthening the Administration's commitment to racial justice and health equity. Codifying a clear and defined definition of public charge will also reduce the chilling effects on immigrant families.

a. Destitution has historically been used to define individuals considered "public charges."

Section 1182 of Title 8 of the U.S. Code renders inadmissible a noncitizen who is "likely at any time to become a public charge."[1] Since Congress first introduced the term in the immigration context in 1882, "public charge" has been interpreted narrowly to mean a person who is primarily dependent on public assistance to avoid destitution, *i.e.*, extreme poverty. Congress based this definition on the concept of "public charge" already used in several state and local laws, which described people "incompetent to maintain themselves" and who "have *no* visible means of support", such that they "might become a *heavy and long* continued charge to" the public.[2] Thus public charge has generally been understood to apply to someone with severe impoverishment and destitution who is permanently and primarily reliant on the government for survival.

The Board of Immigration Appeals has also recognized that the term "public charge" means a person who is "destitute," holding that"[t]he words 'public charge' had their ordinary meaning: that is to say, a money charge upon or an expense to the public for support and care, the [immigrant] being destitute."[3]

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[1] 8 U.S.C. § 1182(a)(4)(A).
[2] *City of Boston v. Capen*, 61 Mass. 116, 121–22 (1851) (emphasis added); *see also* Gerald L. Neuman, *The Lost Century of American Immigration Law* (1776-1875), 93 COLUM. L. REV. 1833, 1848–59 (1993).
[3] *Matter of Harutunian*, 14 I. & N. Dec. 583, 586 (BIA 1974). The BIA opinion uses the term "alien," which is a dehumanizing term. NHeLP has replaced that term with "immigrant."

Outside of the immigration context, the term "public charge" also has been consistently interpreted to require destitution, that is, permanent and primary dependence on public support. For example, many state *in forma pauperis* cases distinguish between those who are poor and need limited assistance with court costs (who are not public charges), and those who are so destitute as to be public charges.[4] Federal bankruptcy exemption rules likewise equate being a public charge with being destitute.[5]

Historically, though there have been several changes to the public charge definition in the immigration statutes, all changes support the core concept that a public charge determination should be based upon permanent and primary dependence on the government, not just mere receipt of temporary benefits.[6] The Trump Administration's Final Rule was the first to drastically expand the meaning of public charge, and to broaden the public benefits immigration officers may consider. It disrupted the longstanding principle of a public charge as an individual permanently and wholly or primarily dependent on the government for support, as well as the 1999 Field Guidance interpretation which only considered income maintenance programs and long-term institutionalization when determining if someone was a public charge.[7]

b. Temporary use of public benefits does not correlate with permanent or primary reliance.

A definition of public charge that considers only those who are permanently and primarily reliant on the government to avoid destitution is consistent with the long-standing interpretation of public charge. Notably, provisions of the 1882 Act, which first introduced the term public charge in the immigration context, confirm that Congress used the term public charge to mean individuals who rely primarily and permanently on the government and that

[4] *See, e.g., Martinez v. Kristi Kleaners, Inc.*, 364 F.3d 1305, 1307–08 (11th Cir. 2004); *Harris v. Harris*, 424 F.2d 806, 810 (D.C. Cir. 1970); *Brown v. Upfold*, 123 N.Y.S.2d 342, 345 (Sup. Ct. 1953).
[5] *See, e.g., Clark v. Rameker*, 573 U.S. 122, 129 n.3 (2014) (explaining that purpose of bankruptcy exemptions is to provide debtor "'with the basic necessities of life' so that she 'will not be left destitute and a public charge'" (quoting H.R. Rep. No. 95–595, at 126 (1977)); *In re Krebs*, 527 F.3d 82, 85 (3d Cir. 2008) (same); *In re Collins*, 281 B.R. 580, 583 (Bankr. M.D. Pa. 2002) (explaining that to fulfill statute's purpose of preventing debtor from becoming public charge, court must "set aside an amount sufficient to sustain the basic needs," or "subsistence needs," of debtor).
[6] Ashley M. Slater, *A Public Charge: Can Temporary Benefits Mean Primary Dependence?* 19 DARTMOUTH L.J. 134 (2021).
[7] Anna Shifrin Faber, *A Vessel for Discrimination: The Public Charge Standard of Inadmissibility and Deportation*, 108 GEORGETOWN L. J. 1363 (2018).

the term did not encompass temporary use of public aid.[8] The 1882 Act established a fund to provide "for the care of immigrants arriving in the United States [and] for the relief of such as are in distress," and empowered federal immigration officials "to provide for the support and relief of such immigrants therein landing as may fall into distress or need public aid."[9] Thus, Congress anticipated that some immigrants would be in need of "support," "relief," or "public aid" after their arrival, and that these immigrants would not be excluded as people "unable to take care of [themselves] without becoming a public charge."[10]

Courts have confirmed this long-standing interpretation. For instance, the Ninth Circuit has found that public charge has never encompassed persons likely to make short-term use of public benefits, concluding that "[u]p until the promulgation of," the 2019 "Rule, the concept has never encompassed persons likely to make short-term use of in-kind benefits that are neither intended nor sufficient to provide basic sustenance."[11] Assuming that individuals who need temporary assistance from public benefits will rely on such benefits permanently ignores the role of public benefits in supporting individuals' ability to contribute to the workforce and generate economic mobility for themselves and their families.[12]

c. Quickly codifying a clear definition of public charge will limit the chilling effect for immigrant families.

When the Trump Administration proposed sweeping changes to the public charge rule, nearly 1 in 7 adults in immigrant families (15.6 percent) reported that they or a family member avoided a noncash government benefit program such as SNAP, Medicaid, or housing subsidies in 2019.[13] Constant changes (and proposed changes) to the public charge rule drove confusion and fear among immigrant communities leading to avoidance of important public benefits that promote health and well-being. Quickly codifying a clear and narrow definition of public charge that only applies to individuals who are likely to be primarily and permanently reliant on the federal government to avoid destitution can limit

[8] An Act to Regulate Immigration, Pub. L. No. 47-***, ch. 376, 22 Stat. 214 (1882) (hereinafter "1882 Act").
[9] 1882 Act at §§ 1, 2.
[10] *Id.*
[11] *City & Cty. of San Francisco v. United States Citizenship & Immigr. Servs.*, 981 F.3d 742, 756 (9th Cir. 2020).
[12] Arloc Sherman and Tazra Mitchell, Center on Budget and Policy Priorities, *Economic Security Programs Help Low-Income Children Succeed Over Long Term, Many Studies Find*, (July 2017), https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-help-low-income-children-succeed-over.
[13] Jennifer M. Haley, Genevieve M. Kenney, Hamutal Bernstein, and Dulce Gonzalez, Urban Institute, *One In Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, 1 (June 2020) https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.

immigrant families' confusion and fear when considering applying for public benefits programs, and thus improve access to life-affirming resources.

d. Ultimately, public charge should be eliminated to advance racial and health equity.

While we recognize the need for a final rule that adopts a narrow definition of public charge that only applies to those who are primarily and permanently reliant on the federal government to avoid destitution, we ultimately advocate for the complete removal of the public charge test from the statute. President Biden outlined the goals of his Administration with regards to equity, stating it is "the policy of my Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality."[14] The history of the public charge is mired in racism and, simply put, there is no way to salvage the public charge test without continuing its racist legacy.[15] Eliminating public charge is an important step towards justice for low-income immigrant communities. Public charge's legacy of xenophobia, racism, ableism, and classism imposes life endangering structural violence on immigrant communities. It limits access to life-affirming and life-saving resources and thereby contributes to health, economic, and racial inequities. We urge DHS to limit the definition of public charge as narrowly as possible and urge the administration to work towards ultimately removing the rule to promote health justice for all communities.

II. Public Benefits Considered

When the administration is deciding what level of federal government assistance constitutes a public charge, we recommend consideration of previous or current use of benefits should be limited to a two or three year look-back period and should exclude all public benefits, except for, possibly, SSI. Very few people subject to the public charge ground of inadmissibility are even eligible for public benefits, and thus the risk of a chilling effect for individuals who are eligible vastly outweighs any utility from including such benefits in the public charge determination. Moreover, among those who are eligible, receipt of public benefits that provide supplemental food, nutrition, health, housing and income assistance

[14] The White House, Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Jan. 2021) https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

[15] *See generally* Faber, *A Vessel for Discrimination, supra* n.7.

does not show primary or permanent reliance on the federal government. In fact, the Center on Budget and Policy Priorities estimated that nearly half of U.S.-born citizens received one of the benefits included in the 2019 rule in their lifetime.[16] As described above, courts have found that public charge has a historically narrow meaning, and any interpretation that would sweep in such broad swaths of the population must be rejected. Accordingly, we believe that the only public benefit that possibly evinces primary and permanent reliance on the federal government to avoid destitution is SSI. Thus, the test should be clearly limited to only consider SSI, and only for a clear, time-limited look-back period.

a. Exclude Medicaid from consideration.

The 2019 rule targeted reliance on Medicaid benefits as grounds for exclusion under public charge. We urge the administration not to consider reliance on Medicaid writ large because it is not indicative of becoming destitute for numerous reasons.

First, eligibility for Medicaid in some states extends up to 400 percent FPL for certain eligibility groups.[17] There are over 13 million people that work part-time and full-time jobs while enrolled in Medicaid, representing 63 percent of non-dual eligible, non-SSI, non-elderly Medicaid adults.[18] In fact, the high eligibility limits were one important reason that the 1999 Field Guidance excluded most Medicaid (and many other) benefits. At that time, INS explained that "[c]ertain Federal, State, and local benefits are increasingly being made available to families with incomes far above the poverty level, reflecting broad public policy decisions about improving general health and nutrition, promoting education, and assisting working-poor families."[19] Thus, INS previously recognized that mere receipt of these benefits is not an indication of permanent and primary reliance, but was instead a consequence of decisions by legislatures across the country—including Congress—to provide various benefits to those who are not in fact destitute. Courts have similarly embraced this reasoning, concluding that the public charge determination cannot count

[16] Danilo Trisi, Center on Budget and Policy Priorities, *Administration's Public Charge Rules Would Close the Door to U.S. to Immigrants Without Substantial Means*, 1-2 (Nov. 2019) https://www.cbpp.org/research/immigration/administrations-public-charge-rules-would-close-the-door-to-us-to-immigrants.

[17] *See generally*, Kaiser Family Found., *Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements* (Feb. 2021), https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/.

[18] *Id.*

[19] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,678 (May 26, 1999). Immigration and Naturalization Services (INS), was the agency that preceded the Department of Homeland Security.

benefits with such high eligibility thresholds.[20] The new public charge rule should follow that same reasoning.

Second, past use of Medicaid coverage is not indicative of future destitution or primary and permanent reliance on the federal government. Medicaid has been shown to be a successful benefit program that reduces poverty rates among enrollees.[21] One study estimated that Medicaid kept 2.1 million people out of poverty, and 1.4 million people out of extreme poverty by substantially reducing out-of-pocket medical expenses.[22] This research also showed that without Medicaid, were health-care costs paid out of pocket, an additional 500,000 institutionalized Americans would have lived under the federal poverty level and an additional 850,000 would have lived under extreme poverty.[23] Moreover, access to Medicaid promotes health and economic status.[24] Medicaid allows residents to contribute more to the local economy and to pay more in taxes than they would have without receiving Medicaid. Substantial research provides clear evidence that access to Medicaid has beneficial economic effects, especially at the state and local levels. This is called Medicaid's "multiplier effect," the cycle by which receipt of Medicaid frees individuals and families to spend money within their communities at places such as restaurants, grocery stores, and retail stores.[25] Individuals and families would otherwise spend such funds on health care services.[26]

Finally, excluding Medicaid from a public charge determination is necessary because it will reduce the chilling effects on enrollment in all Medicaid, CHIP, and state-funded health programs. Although the 1999 rule counted only Medicaid for long-term institutionalization, evidence shows that immigrants were nonetheless deterred from enrolling in and using other Medicaid services.[27] From 2016 to 2019, noncitizen participation in TANF, SNAP, and

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[20] *New York v. United States Dep't of Homeland Sec.*, 969 F.3d 42, 75 (2d Cir. 2020) (finding 2019 rule arbitrary and capricious because "many of the benefits newly considered by the Rule have relatively generous eligibility criteria and are designed to provide supplemental assistance to those living well above the poverty level.").
[21] Benjamin D. Sommers, Donald Oellerich, *The poverty-reducing effect of Medicaid*, Journal of Health Economics, 824 (2013) https://www.sciencedirect.com/science/article/pii/S016762961300091X.
[22] *Id.* at 817.
[23] *Id.* at 818.
[24] Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes.* 368 New Eng. J Med. 1713 (2013), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321.
[25] Michael E. Chernew, *The Economics of Medicaid Expansion*, Health Affairs Blog (Mar. 21, 2016), *https*://www.healthaffairs.org/do/10.1377/hblog20160321.054035/full/.
[26] *Id.*
[27] Jennifer Stuber & Karl Kronebusch, *Stigma and other determinants of participation in TANF and Medicaid*, 23 J. POL'Y ANALYSIS & MGMT. 509 (2004); Claudia Schlosberg & Dinah Wiley, Nat'l Health Law Prog. and NILC, The Impact of INS Public Charge Determinations on Immigrant Access to Health Care (1998), https://www.montanaprobono.net/geo/search/download.67362#N_%202; Marilyn R. Ellwood & Leighton Ku,

Medicaid declined faster than for citizens.[28] Similarly, although the 2019 rule excluded Medicaid received by children, studies showed that parents were still hesitant to enroll their children in Medicaid. Citizen children living in households with at least one noncitizen saw an 18 percent drop in Medicaid participation as compared to only an 8 percent drop in participation by citizen children living in households with only U.S. citizens.[29] And although DHS issued guidance that excluded Medicaid coverage of COVID-19 testing and treatment from a public charge determination, the chilling effect of the public charge rule has nonetheless deterred families from accessing critical services. A survey of immigrants with undocumented members in their households that got sick with COVID-19 revealed that 18 percent of respondents cited being labeled a public charge and 13 percent said they feared their information would be shared with immigration agents as reasons why they did not seek treatment for the virus.[30] The Urban Institute surveyed immigrant-serving community-based organizations and found that 70 percent reported that public charge and other anti-immigrant policies deterred immigrants from seeking COVID-19 testing and treatment.[31]

This substantial body of evidence confirms that despite efforts to exclude certain parts of Medicaid coverage, the chilling effect will inevitably sweep broader than the particulars of the public charge definition. This reaction is understandable: there are many types of Medicaid coverage programs, many with different names in different states, and each program provides a wide range of varying services. Thus, it is difficult for most Medicaid beneficiaries to distinguish between the differences in coverage, and as a result they are fearful that utilizing Medicaid coverage of any kind will trigger a negative immigration action.

Welfare And Immigration Reforms: Unintended Side Effects For Medicaid, 17 HEALTH AFFAIRS 137 (1998), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.17.3.137; HHS, ASPE, How Are Immigrants Faring After Welfare Reform? Preliminary Evidence from Los Angeles and New York City 16 (2002), https://aspe.hhs.gov/system/files/pdf/72691/report.pdf (describing immigrants' limited understanding of eligibility restrictions and benefits); Danilo Trisi & Guillermo Herrera, Administration Actions Against Immigrant Families Harming Children Through Increased Fear, Loss of Needed Assistance, CTR. ON BUDGET & POL'Y PRIORITIES (2018), https://www.cbpp.org/research/poverty-and-inequality/administration-actions-against-immigrantfamilies-harming-children#_ednref12 (noting how immigrants' fear of government causes chilling effects); Leighton Ku & Alyse Freilich, Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston, KAISER FAMILY FOUND. 7 (2001), https://aspe.hhs.gov/system/files/pdf/72701/report.pdf.

[28] Randy Capps, Michael Fix and Jeanne Batalova, Migration Policy Institute, *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families* (Dec. 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

[29] *Id.*

[30] Marion Davis, Massachusetts Immigrant and Refugee Advocacy Coalition, *The Impact of COVID-19 on Immigrants in Massachusetts: Insights from our Community Survey* (2020), http://www.miracoalition.org/cvsurvey.

[31] Hamutal Bernstein, Jorge Gonzale, Dulce Gonazalez, Jahnavi Jagannath, Urban Institute, *Immigrant-Serving Organizations' Perspectives on the COVID-19 Crisis* (August 2020), https://www.urban.org/research/publication/immigrant-serving-organizations-perspectives-covid-19-crisis.

Thus, while most immigrants who are subject to a public charge assessment are ineligible for Medicaid benefits, the chilling effects of the 2019 policy has deterred a broader group of eligible immigrants from enrolling in Medicaid.[32] Moreover, even public benefit programs that were not part of the 2019 rule's definition of "public benefits" (such as the Special Supplemental Nutrition Program for Women, Infants and Children) experienced decreased enrollment because unclear descriptions of which benefits were considered led individuals to assume they would be subject to a public charge determination.[33]

b. Long-term institutionalization at government expense should not be considered.

As explained above, the definition of public charge should be narrow and should not count factors that if applied to the whole U.S. population, would sweep in large swaths of people. Yet, the 1999 field guidance includes long-term institutionalization at the government's expense as a benefit that will be evaluated in the public charge determination. We believe this is a fundamental misunderstanding of the realities of Medicaid-funded long term care, and contrary to the principle of keeping the public charge definition narrow.

First, the need for long-term institutionalization today is not like the almshouses of our past, which were used by an exceptionally small portion of the population. In 1910, for instance, the Commerce Department counted 88,313 "paupers" in almshouses across the country.[34] The population at the time was 92,228,496.[35] Thus, almshouses were used by less than one-tenth of one percent of the population. By contrast, substantial portions of the U.S. population will need long-term institutionalization, such as in a nursing home, at some point in their lifetime if they live long enough. According to the Kaiser Family Foundation, in the U.S., one in three people turning 65 will require nursing home care in their lives.[36] Moreover, most of this long-term institutional care will be paid for by Medicaid, because private insurance is extremely limited. In 2018, just 276,000 people received benefits from long-term care insurance and less than 6 percent of the U.S. population over 50 have private

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[32] *See* Jeremy Barofsky, Ariadna Vargas, Dinardo Rodriguez, and Anthony Barrows, *Spreading Fear: The Announcement of the Public Charge Rule Reduced Enrollment in Child Safety-Net Programs*, 39 Health Affairs 1752 (Oct. 2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00763.
[33] *Id.*
[34] Department of Commerce and Labor, Bureau of the Census, *Bulletin 120, Paupers In Almshouses, 1910.*, 46. (1914), https://www2.census.gov/prod2/decennial/documents/03322287no111-121ch7.pdf.
[35] United States Census Bureau, *History Through The Decades: 1910 Fast Facts*, https://www.census.gov/history/www/through_the_decades/fast_facts/1910_fast_facts.html.
[36] Kaiser Family Found., *Medicaid's Role in Nursing Home Care* (June 2017), https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.

insurance coverage for long-term institutionalization.[37] This leaves Medicaid as the primary payer for long-term care in the U.S., covering six in ten nursing home residents.[38] Thus, long-term institutionalization at government expense should be excluded from consideration because including this benefit renders the public charge test far too broad.

Moreover, many individuals will require some form of long-term care, either in an institution or through home and community based services (HCBS). For instance, within the population of 65 year old individuals residing in the U.S., 56 percent will develop a disability requiring a need for long-term care for at least some period of time, and 20 percent of those will need that long-term care for 5 years or more.[39] More women than men will need some form of long-term care and they will need those services longer due to their longer life expectancy. These numbers are based on a definition that assumes the person with the disability needs help with at least two activities of daily living (ADLs).[40] If the definition were expanded to include people who only need help with one ADL, the numbers of people with disabilities cited above would be much higher. Data from the CDC reinforces the prevalence of conditions that may require some form of long-term care: over one-quarter of adults, 61 million people, have some form of disability.[41] From 2020 to 2065 the number of people in the U.S. with a significant disability is expected to grow from 7.2 million to 14.3 million people, which accounts for 13 to 15 percent of the total aged population.[42]

But whether someone who requires long-term care will be institutionalized versus using HCBS is nearly impossible to predict. It largely depends on state policy and varies

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[37] National Association of Insurance Commissioners. *Long-Term Care Insurance Experience Reports for 2018* (2019), https://www.nh.gov/insurance/consumers/documents/2019-ltc-experience-report.pdf.
[38] Kaiser Family Found., *Medicaid's Role in Nursing Home Care* (June 2017), https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.
[39] Melissa Favreault, Judith Dey, Assistant Secretary for Planning and Evaluation, *Long-Term Services and Supports for Older Americans: Risks and Financing, 2020 Research Brief,* Jan. 2021, https://aspe.hhs.gov/reports/long-term-services-supports-older-americans-risks-financing-2020-research-brief-0.
[40] Definition of disability in this context is the threshold for benefits under a tax-qualified LTCI policy, set in the Health Insurance Portability and Accountability Act (HIPAA): a need for assistance with at least two ADLs that is expected to last at least 90 days or need for substantial supervision for health and safety threats due to severe cognitive impairment.
[41] National Center on Birth Defects and Developmental Disabilities.Centers for Disease Control and Prevention, *Disability Impacts All Of Us*, Sep. 2020, https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html.
[42] Melissa Favreault, Judith Dey, Office of the Assistant Secretary for Planning and Evaluation, *Long-Term Care Services and Supports for Older Americans: Risks and Financing, 2020* (Jan. 2021), https://aspe.hhs.gov/reports/long-term-services-supports-older-americans-risks-financing-2020-research-brief-0.

significantly across the country.[43] Shortly after the 1999 Field Guidance was issued, the Supreme Court issued its decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999). That decision held that the Americans with Disabilities Act's "integration mandate" requires public entities to administer services to people with disabilities in the most integrated setting appropriate to their needs. In states that have invested significantly in home and community based services since that decision, more individuals will be able to remain at home and in their communities. Other states, however, have not developed robust HCBS programs, causing more individuals to seek care in institutional settings.[44] For example, many states cover HCBS under Medicaid Section 1915(c) waivers, but the types of disabilities the states cover under these waivers vary widely: 48 states cover people with intellectual and developmental disabilities, 21 cover people with spinal cord injury and traumatic brain injury, 18 cover medically fragile children, but only 5 states cover HCBS for people with HIV/AIDS.[45] As a result, individuals with the same medical conditions and the same need for long-term care may be institutionalized in one state, but be able to receive services at home in another. Individuals who require long-term care should not be penalized for the failure of certain states to offer robust community-based services in accordance with federal law. Moreover, immigration officials do not have the expertise to predict future institutionalization, understand what conditions may effectively be treated and supported at home with robust HCBS, or evaluate the strength and scope of various state HCBS programs. Ultimately, including such an unpredictable analysis as part of the public charge analysis opens up huge opportunities for implicit bias to create disparate results.[46]

Furthermore, the fact that long-term institutionalization may be more expensive than other forms of care, including home and community based services, should not justify its inclusion

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[43] MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, Kaiser Family Foundation, *Key State Policy Choices About Medicaid Home and Community-Based Services* (Feb. 2020) https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/.

[44] Andrea Avila, William D. Spaulding, and Eric A. Evans. *Olmstead's Implementation: Differences in Enforcement Approaches.* Psychological Services (June 2021), https://psycnet.apa.org/record/2021-52584-001; Amber Knight. *Unfinished business: deinstitutionalization and Medicaid policy*. Politics, groups & identities. (Dec 2020), https://www.tandfonline.com/doi/abs/10.1080/21565503.2020.1854324?journalCode=rpgi20.

[45] Molly O'Malley Watts, MaryBeth Musumeci, and Priya Chidambaram, Kaiser Family Foundation. *Medicaid Home and Community-Based Services Enrollment and Spending* (Feb. 2020), https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/.

[46] *See generally* Ladonna Pavetti, Center on Budget and Policy Priorities, *TANF Studies Show Work Requirement Proposals for Other Programs Would Harm Millions, Do Little to Increase Work*, 6-7 (Nov 2018), https://www.cbpp.org/research/family-income-support/tanf-studies-show-work-requirement-proposals-for-other-programs (documenting implicit bias and disparate outcomes when case workers determine good cause exemptions).

in the public charge test. The Second Circuit noted, in its consideration of the 2019 rule, that it was:

> not persuaded that the difference in dollars expended is an appropriate indicator of a non-citizen's level of self-sufficiency; rather, it seems plain to us that the difference is due to the high cost of providing healthcare in the United States. The size of the government expenditure on Medicaid may be relevant to a policy debate about the costs and benefits of the program, but it has little bearing on whether Medicaid recipients should be considered 'public charges.'"[47]

The same logic should apply to long-term institutionalization specifically.

In sum, our immigration system should not make intending immigrants at fault for the inequities in our healthcare system. If HCBS was more widely available, many individuals using these services would be in the community and would not need institutionalization. It is unfair and discriminatory to penalize immigrants for the limited and uneven HCBS options available in the U.S. The administration should not import access flaws in our current healthcare system into the public charge determination by keeping long-term institutionalization at government expense in the public charge definition.

c. Provide clear guidance on how to predict the likelihood of becoming a public charge based on past or current benefit use.

The administration should provide clear guidance on how to predict the likelihood of becoming a public charge based on past or current benefits use. Without such guidance, predicting who is likely to become a public charge "at any time in the future" is an act of speculation that could easily allow immigration officers to discriminate. The best way to ensure fairness, consistency, and predictability is to instruct adjudicators to look back at the applicant's use of SSI for a finite look back period—such as two or three years—as a way to gauge future likelihood. In addition, the I-485 form and its instructions should make clear that applicants only need to provide information about the use of SSI during the look-back period.

[47] *New York v. United States Dep't of Homeland Sec.*, 969 F.3d 42, 85 n.37 (2d Cir. 2020).

d. Identify and update a list of programs that do not count in order to minimize the chilling effect on eligible public benefit programs.

The administration should include in the regulatory text a clear statement that any benefits not specifically identified in the regulation "shall not be counted" in a public charge determination. Such language is critical to avoid confusion about whether the public charge test applies to other benefit programs, and will prevent confusion if and when new public benefit programs are developed in the future.

In addition to the regulatory text, the administration should identify and update a list of public benefit programs that do not count in a public charge determination to minimize chilling effects. The preamble to the expected NPRM and final rule should name as many excluded benefits as possible - including the types of cash, tax, food, health, housing, employment, nutrition, education, immigration fee waivers, and other benefits - that are *not* included as factors in a public charge test and create guidance that is updated when additional or new programs are created. The guidance should also address COVID and other disaster-related benefits such as FEMA, as well as unemployment insurance benefits and programs that provide universal basic or guaranteed income to all. The preamble, like the regulatory text, should make clear that "any benefit not listed" in the regulation "shall not count in the public charge determination."

e. Exclude programs funded completely by state, local, tribal and territorial governments.

The administration should also exclude programs funded completely by state, local, tribal and territorial governments. The new rule must clarify that state or local government funded programs—including those that provide cash assistance—are exercises of the powers traditionally reserved to the states and are not considered in a public charge test.

We recommend this approach for several reasons. First, excluding all state and local programs will make the public charge rule easier for both immigrants and DHS adjudicators to understand, and will avoid needing to evaluate the particulars of a wide range of different programs. State and local benefits vary significantly by state, with different eligibility requirements, benefit amounts, etc. Providing this clarity will greatly reduce confusion among immigrants and lower the risk of erroneous determinations by adjudicators.

Second, this clarity will help reduce chilling effects. Coupled with an exclusion of Medicaid, excluding state and local benefits, will enable state and local benefit offices to provide clear information and reassurance about receipt of state and local benefits, because there will be no ambiguity. Medicaid applicants—both U.S. citizens and eligible immigrants—should not be expected to understand whether the source of their Medicaid coverage is federally or state funded. Excluding all state, local, tribal and territorial benefit programs in addition to Medicaid will help assure eligible immigrants that it is safe to enroll in these programs.

Third, states and localities have a compelling interest in promoting health and safety that includes providing benefits at their own expense without barriers caused by federal policies. The public charge rule should not interfere with state efforts to promote the health and wellbeing of their citizens. For example, the state of Washington's Apple Health provides long-term care for noncitizens and is an example of a state-funded program that should not be included in the public charge determination. It also serves as a model for other states that may wish to extend long-term care coverage to noncitizens.[48] Massachusetts is another state that is expanding a state-funded program to cover the long-term care of immigrants who were ineligible for Medicaid benefits due to their immigrations status. Beginning in November of this year, MassHealth Family Assistance will cover six months of care in a skilled nursing facility or other setting, as needed.[49] Incorporating state-funded long-term institutionalization into the public charge determination would directly undermine state efforts like these to promote and maintain the health of their residents.

f. Exclude family members and sponsors' use of benefits.

The administration should make clear that benefits used by an applicant's family members or sponsors do not count as factors in the applicant's public charge test. This is critical in minimizing the chilling effect of the public charge rule on access to benefits by people, including U.S. citizen children, who are not subject to a public charge determination but whose family members may seek lawful permanent resident (LPR) status in the future.

[48] Washington Health Care Authority, WAC 182-503-0535 Washington Apple Health -- Citizenship and immigration status (Oct. 2021), https://www.hca.wa.gov/health-care-services-and-supports/program-administration/wac-182-503-0535-washington-apple-health.
[49] Lynn Jolicoeur, Lisa Mullins, WBUR News, *MassHealth expands long-term care to thousands of immigrants* (Oct. 15, 2021), https://amp.wbur.org/news/2021/10/15/masshealth-massachusetts-immigrants-long-term-care-hospitals.

g. Exclude any use of benefits by survivors of domestic violence and other survivors of crimes and by anyone during public emergencies.

Benefits used by survivors of domestic violence or other serious crimes, or used by anyone during natural disasters or other extraordinary circumstances, such as the COVID-19 pandemic or in the aftermath of hurricanes and wildfires, should not be included as factors in a public charge determination. Use of these benefits is due entirely to external events and does not provide any information on the recipient's likelihood of becoming primarily and permanently reliant on government assistance to avoid destitution at a future date.

h. Specify that use of benefits as a child or when in an exempt status will not be included in a public charge determination, nor will benefits used when applying for an exempt status, regardless of a person's pathway to legal status.

DHS should propose that benefits received by children—whose long-term economic contributions are generally bolstered by childhood receipt of benefits—be excluded from consideration.[50] In addition, benefits received when in an exempt status, such as cash assistance provided to a refugee, should be excluded regardless of a refugee's pathway to legal status. Finally, benefits should be excluded if an individual is applying for an exempt status, for example, if an individual has applied for asylum.

i. Specify that use of benefits by individuals who are already in an adjusted status, including LPRs who leave the country for 180 days or more and seek re-entry, will not be included in a public charge determination.

The administration should not count benefits used by individuals who have already adjusted status, even those who leave the country for 180 days and re-enter. Failing to create this exemption will exacerbate chilling effects because it will deter LPRs from using benefits for which they are eligible, since many immigrants will want to maintain the option to leave the country for extended time to visit family or care for an aging relative. Counting benefits used by LPRs who seek to re-enter will also make clear messaging and communication substantially more difficult, as there will not be a clear bright line rule that LPRs do not have to worry about benefit use, and thus could exacerbate the chilling effect among LPRs who are eligible for various public benefits.

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

The 1999 Field Guidance noted that, pursuant to the Immigration and Nationality Act (INA) §101(a)(13)(C), the public charge test would apply to LPRs who left the country for more than 180 days.[51] While this is consistent with the statute, the administration should exercise prosecutorial discretion to disregard receipt of benefits by these individuals when making a public charge determination upon re-entry. LPRs are not subject to the public charge test when applying for U.S. citizenship and receipt of public benefits as an LPR is not considered in their citizenship application. Therefore, it would be more consistent to ignore receipt of public benefits while an LPR even though the immigrant is re-subjected to the public charge test overall due to a longer stay out of the country. Immigrants who have achieved LPR status frequently have long and deep ties to the United States and are therefore unlikely to be permanently and primarily reliant on the federal government to avoid destitution.

III. Statutory Factors

The Department of Homeland Security should not repeat the mistakes of the 2019 public charge rule by defining the statutory factors in a manner that disproportionately burdens people of color, women, LGBTQ+ individuals, and people with disabilities or that creates the opportunity for conscious or implicit bias to affect an individual adjudicators' determinations.

a. DHS should propose that adjudicators look at all the factors together to see if they would make an applicant likely to become a public charge and clarify that receipt of SSI alone does not automatically make someone a public charge.

If adjudicators identify a circumstance that might make an applicant likely to meet the definition of a public charge, DHS regulations should direct adjudicators to look to the totality of circumstances to see if other evidence exists to overcome the circumstance. The judicial and administrative decisions that were used to inform adding the five "totality of circumstances" factors to the statute in 1996 overwhelmingly found immigrants not excludable based on one or more of the factors when considering the totality of circumstances. In other words, the five statutory factors and totality of circumstances test were ways to demonstrate that an applicant would not be excludable as a public charge and were never intended to be a list of negative and positive factors to be weighed individually in every case.

[51] 8 U.S.C. §1101(a)(13)(C).

Moreover, even if an individual has used SSI in the two or three years before a person is subject to a public charge test, that should not be determinative. Use of SSI remains only one small part of the totality of the circumstances test. Other factors and circumstances can be used to overcome any negative inference. For instance, people with disabilities who receive SSI are also part of our nation's workforce and should not be excluded based on SSI use alone. In fact, there are multiple federal work incentives programs that help people receiving SSI go to work by minimizing the risk of losing their SSI or Medicaid benefits.[52] Accordingly, adjudicators must be instructed not to rely solely on past SSI use, and instead to look to the remaining factors before finding someone a public charge.

This is consistent with how courts have interpreted the public charge statute in the past. For instance, the Second Circuit held that the

> 'determination of whether an [immigrant]is likely to become a public charge . . . is a prediction based upon the totality of the [immigrant]'s circumstances . . . The fact that an [immigrant] has been on welfare does not, by itself, establish that he or she is likely to become a public charge.'[53]

b. Adjudicators should not import structural and institutional discrimination into their analysis of the statutory factors.

We urge DHS to develop an equitable public charge policy that does not exclude immigrants simply because conditions in their countries of origin, discrimination they may have faced in the U.S., and other circumstances have made it difficult for them to complete an education, secure professional credentials, or earn a high income. Adjudicators should assume an applicant will have access to supports—like reasonable accommodations at work and access to health care—and be treated fairly regardless of their race, ethnicity, language, sex, sexual orientation, gender identity, disability, age or other status when evaluating the factors.

When evaluating the health factor in particular, DHS should assume individuals have health care coverage. Although Medicaid has restrictive eligibility rules for immigrants, adjudicators should not import these conditions into their analysis of an individual's health status. Again,

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[52] Social Security Administration, Understanding Supplemental Security Income Work Incentives, https://www.ssa.gov/ssi/text-work-ussi.htm.

[53] *New York v. United States Dep't of Homeland Sec.*, 969 F.3d 42, 75 (2d Cir. 2020) (quoting *Matter of Perez*, 15 I. & N. Dec. 136, 137 (BIA 1974)); *id*. at 78 (noting that 1999 Field Guidance also did not find benefit use determinative). NHeLP has replaced the term "alien" with "immigrant" in the quote.

we reiterate the need for DHS to adopt an equitable view of an individual applicant's ability to access health care and receive an accommodation.

IV. Conclusion

Thank you for the opportunity to provide comments. We urge DHS to move as expeditiously as possible to issue a NPRM and a Final Rule on this topic. Please contact me at grusin@healthlaw.org with any questions.

Sincerely,

Sarah Grusin
Senior Attorney