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U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
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Submitted via www.regulations.gov

**Re: DHS-Docket No. 2021-0013; Comments In Response
to Proposed Rulemaking: Public Charge Ground of
Inadmissibility**

Thank you for the opportunity to comment on the Department of Homeland Security's (DHS) [Notice of Proposed Rulemaking](#) (NPRM) on the public charge grounds 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 levels.

We support the comments submitted by the Protecting Immigrant Families (PIF) campaign and submit additional comments in response to the questions posed in the NPRM. We share PIF's view that the nation is stronger when we welcome people who are willing to contribute to the country. 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. NHeLP urges DHS to quickly improve and finalize the proposed rule. 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, and individuals with limited English proficiency, or anyone else.

We also request that our comments on DHS' Advanced Notice of Proposed Rulemaking be incorporated into these comments. Our comments on the ANPRM may be found [here](#).

For these reasons, we generally support the NPRM as a whole because it is crucial to address current ambiguity and provide the clarity many immigrants need to access benefits. We offer the following additional comments on the NPRM:

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. While we generally support DHS' proposal that only those primarily dependent on the federal government for subsistence should be determined a public charge, we also recommend refining the definition. Given both policy and health care developments over the past decades, particularly with regard to the expansion of eligibility for public benefits as well as the lack of community-based services for people with disabilities, this clarification supports Congress' recognized support for increased access to public benefits and in turn strengthens the Administration's commitment to racial justice and health equity. Thus 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 an appropriate definition of public charge. Codifying a clear and defined definition of public charge will also reduce the chilling effects on immigrant families.

It is important to recognize that the concept of public charge is fundamentally rooted in racist ideologies, initially aimed to exclude immigrants who were viewed as racially or ethnically different.¹ The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)² transformed our system of social support by accentuating economic and racial inequities that have harmed children and families for the last quarter of a century. Like the public charge ground of inadmissibility, PRWORA codified "artificial divisions between families deemed

¹ Cori Alonso-Yoder, *Publicly Charged: A Critical Examination of Immigrant Public Benefit Restrictions*, DENV. L. REV. 97 (2020) <http://works.bepress.com/cori-alonso-yoder/3/>.

² Public Law 104-193 (Aug. 22, 1996), <https://www.congress.gov/104/plaws/publ193/PLAW-104publ193.pdf>.



‘deserving’ and ‘undeserving,’” the result of which left a critical segment of the population without access to vital support and services.³ While we continue to push for Congress to reverse these harmful laws, it is critical that DHS move quickly to finalize a more fair and equitable public charge rule that minimizes the harm to children and families, while recognizing the need to create an inclusive and anti-racist system.

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 modeled public charge on the concept 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.⁴ 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.

Clarifying that a definition of public charge that considers only those who are primarily and permanently 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 the term did not encompass temporary use of public aid.⁵ 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.”⁶ 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

³ E. Minoff et. al., *how the Law that Brought us Temporary Assistance for Needy Families Excluded Immigrant Families & Institutionalized Racism in Our Social Support System*, Center for the Study of Social Policy, Georgetown Center on Poverty and Inequality, <https://cssp.org/wp-content/uploads/2021/08/Lasting-Legacy-of-Exclusion-FINAL-ACCESSIBLE.pdf>.

⁴ *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).

⁵ An Act to Regulate Immigration, Pub. L. No. 47-***, ch. 376, 22 Stat. 214 (1882) (hereinafter “1882 Act”).

⁶ 1882 Act at §§ 1, 2.



take care of [themselves] without becoming a public charge.”⁷ 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.”⁸ 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.⁹

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.¹⁰ Federal bankruptcy exemption rules likewise equate being a public charge with being destitute.¹¹

⁷ *Id.*

⁸ *City & Cty. of San Francisco v. United States Citizenship & Immigr. Servs.*, 981 F.3d 742, 756 (9th Cir. 2020).

⁹ 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>.

¹⁰ 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).

¹¹ Ashley M. Slater, *A Public Charge: Can Temporary Benefits Mean Primary Dependence?* 19 DARTMOUTH L.J. 134 (2021).



Historically, though there have been several changes to the provision addressing public charge 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.¹²

As the 2022 proposed rule recognizes, Congress did not design the public charge test to prevent immigration of low- and moderate-income families who may at some point need access to public programs to overcome temporary setbacks. Codifying a clear definition of public charge will also reduce the chilling effects on immigrant families, both those directly subject to the rule and those who erroneously adjust their behavior thinking the rule does apply to them.

II. Chilling Effect and Harm

We support the finalization of the proposed rule – preferably with our suggested changes -- not only to provide clarity but also to reduce the chilling effect of the 2019 rule (and its aftermath). The following section describes the detrimental impact of the chilling effect and thus supports DHS' efforts to codify a final regulation.

A. The Chilling Effect of the Trump Administration and their 2019 Rule

In February 2017, a draft Executive Order was leaked that, among other factors, would redefine public charge to apply to a wider array of benefits than had been considered under the pre-existing 1999 Field Guidance and deport legal permanent residents who received public benefits. When the Administration finally released its proposed public charge rule in December 2018, commenters warned about the chilling effect it would bring, based on decades of prior research.¹³ These predictions were realized even prior to the enactment of the

¹² 6 Ashley M. Slater, *A Public Charge: Can Temporary Benefits Mean Primary Dependence?* 19 DARTMOUTH L.J. 134 (2021), <https://dartmouthlawjournal.org/article/28218-a-public-charge-can-temporary-benefits-mean-primary-dependence>.

¹³ Samantha Artiga, Rachel Garfield, Anthony Damico, *Estimated Impacts of Final Public Charge Inadmissibility Rule on Immigrants and Medicaid Coverage*, KAISER FAM. FOUND. (September 2019), <https://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-Final-Public-Charge-Inadmissibility-Rule-on-Immigrants-and-Medicaid-Coverage>; Randy Capps, Mark Greenberg, Michael Fix, Jie Zong, *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration*, MIGRATION POL'Y INST. (November 2018), <https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration>.



rule, stemming from the leaked EO and the release of a proposed rule. While the Trump Administration did not finalize its sweeping changes to the public charge rule until 2019, 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 that same year.¹⁴ Immigrant families also avoided WIC, free and reduced price school lunches, and health insurance purchased through the Marketplace; most families who reported chilling effects indicated avoiding more than one public benefit program.¹⁵ From 2016 to 2019 (when the Trump Administration’s public charge rule was finalized), participation in TANF, SNAP, and Medicaid declined far more rapidly for non-citizens than U.S. citizens.¹⁶ Medicaid participation by low-income noncitizens fell by 20 percent between 2016 and 2019.¹⁷

And although the finalized 2019 rule excluded Medicaid received by children, U.S. Census Bureau data indicates that immigrant parents were still hesitant to enroll their children in Medicaid.¹⁸ Citizen children living in households with at least one noncitizen saw an 18 percent drop in Medicaid participation as compared to only 8 percent drop in participation by citizen children living in households with only U.S. citizens.¹⁹

Low-income immigrant families were especially impacted by the Rule’s chilling effect; about 32 percent of low-income immigrant families avoided a public benefit program in 2019.²⁰ Families without low incomes were also negatively impacted, with 10 percent avoiding public benefits because of immigration concerns.²¹ The Rule drastically affected immigrant families with children: these families were twice as likely to report avoiding public benefits because of fear of the impact on their immigration status compared to immigrant families without children.²² The

¹⁴ 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> [hereinafter “Haley et al.”].

¹⁵ *Id.*

¹⁶ Randy Capps, Michael Fix & Jeanne Batalova, *Anticipated “Chilling Effects” of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families*, MIGRATION POL’Y INST. (Dec. 2020), <https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real> [hereinafter “Capps et al.”]

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Haley et al.

²¹ *Id.*

²² *Id.*

Rule was linked to a decrease in 260,000 child Medicaid enrollments from 2017-2020.²³ Adults in immigrant families with children most frequently avoided applying for SNAP, Medicaid and CHIP, and housing subsidies.²⁴

B. The Scope of the Chilling Effect is Broader than the Rule Itself

Decades of evidence shows that the chilling effect of restrictive policies inevitably sweep broader than the actual application of the restrictions. First, evidence shows that the chilling effect often extends to people who are not actually subject to the particular restrictions. For example, scholars have documented that following passage of the Personal Responsibility and Work Opportunity Act (PRWORA) in 1996, many immigrants entitled to public benefits and services were deterred from using them due to confusion about eligibility criteria and concerns about future immigration consequences.²⁵ This includes a reduction in benefit use by refugees and asylees who remained eligible for benefits under the new rules.²⁶

Second, historical evidence shows that the chilling effect often extends to benefits and programs which are not considered by the relevant law or regulations. For instance, although the public charge guidance of 1999 only counted Medicaid for long-term institutionalization, studies indicate that immigrants were nonetheless deterred from enrolling in and using other

²³ Jeremy Barofsky, et al., *Spreading Fear: The Announcement of the Public Charge rule Reduced Enrollment in Child Safety-Net Programs* HEALTH AFFAIRS (October 2020), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00763> [hereinafter “Barofsky et al.”].

²⁴ *Id.*

²⁵ Jeanne Batalova, Michael Fix, & Mark Greenberg, *Chilling Effects: The Expected Public Charge Rule and its Impact on Legal Immigrant Families’ Public Benefit Use*, MIGRATION POL’Y INST. (June 2018), https://www.migrationpolicy.org/sites/default/files/publications/ProposedPublicChargeRule_FinalWEB.pdf.

²⁶ *Id.* citing (Jenny Genser, *Who Is Leaving the Food Stamp Program: An Analysis of Caseload Changes from 1994 to 1997*, U.S. DEP’T OF AG., FOOD & NUTRITION SERV., OFFICE OF ANALYSIS, NUTRITION, & EVAL. (Mar. 1999), <https://fns-prod.azureedge.net/sites/default/files/cdr.pdf>; Michael E. Fix & Jeffrey S. Passel, *Trends in Noncitizens’ and Citizens’ Use of Public Benefits Following Welfare Reform: 1994-1997*, URBAN INST. (Mar. 1, 1999), <https://www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform>).



Medicaid services.²⁷ Evidence also shows that immigrants disenrolled from local and state health programs not subject to public charge.²⁸

This reaction is understandable: there are many types of programs, with different eligibility determinations and a wide range of services. In particular, navigating the Medicaid program is difficult because the programs have different names in different states, and it is hard for individuals to know if their particular benefits are state- or federally-funded. Thus, it is difficult for most individuals to distinguish between the differences in programs, and as a result they are fearful that utilizing public health care coverage or even stand-alone services (e.g. COVID vaccinations) of any kind will trigger a negative immigration action.

C. The Chilling Effect Harms Health During a Pandemic

Given the context of the current COVID-19 pandemic, it is especially important to note the adverse health effects that result from the Trump Administration's efforts and the 2019 Rule's chilling effect. Lack of insurance, especially for those eligible for Medicaid, reduces access to

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, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care*, NAT'L HEALTH LAW PROG. & NILC (1998), https://www.montanaprobono.net/geo/search/download.67362#N_%202; Marilyn R. Ellwood & Leighton Ku, *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, 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 Matthew Yu et al., *Challenges for Adult Undocumented Immigrants in Accessing Primary Care: A Qualitative Study of Health Care Workers in Los Angeles County*, HEALTH EQUITY (September 2020), <https://www.liebertpub.com/doi/10.1089/heq.2020.0036>; Grace Kim et al., *Public Charge: Reducing the Chilling Effects on Medi-Cal Participation Due to the 2018 Proposed Public Charge Rule*, CAL. IMMIGRANT POL'Y CTR. (September 2019), <https://caimmigrant.org/updates/https-caimmigrant-org-wp-content-uploads-2019-09-public-charge-long-r4-1-pdf/>.



care and contributes to worse health outcomes.²⁹ On almost all relevant measures, Medicaid enrollees have improved access to care when compared to the uninsured population. This includes having a more usual source of care, not delaying medical care,³⁰ and being less likely to visit the emergency department.³¹ The chilling of Medicaid enrollment reduces immigrants' access to preventive services, care management, and primary care.³² Lack of insurance and the resulting patterns of decreased utilization and poorer health outcomes will only deepen the disparities in health care access and health outcomes that immigrants already face.³³

While all of these effects would be harmful absent the existence of a public health emergency, they are dire and deadly in the context of COVID-19, when individuals—immigrant and native-born, insured and uninsured—are having difficulty accessing health care while hospitals, health care workers, and emergency departments in particular are severely overloaded. Large-scale disenrollment from health coverage is particularly concerning in the context of a global pandemic, where lack of coverage threatens individual, family, and public health. The impact of the pandemic on immigrant communities is largely pronounced given that twenty million immigrants hold essential jobs that place them at the front lines of the pandemic and at

²⁹ Julia Paradise, *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid*, KAISER FAMILY FOUND. (2017), <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>.

³⁰ MACPAC, *Access and Quality/Key Findings on Access to Care* (2018) <https://www.macpac.gov/subtopic/measuring-and-monitoring-access> (last visited Nov. 7, 2018).

³¹ Winston Liaw et al., *The Impact of Insurance and a Usual Source of Care on Emergency Department Use in the United States*, 2014 INT. J. FAMILY MED. 1 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3941574/pdf/IJFM2014-842847.pdf>; Tina Hernandez-Boussard et al., *The Affordable Care Act Reduces Emergency Department Use By Young Adults: Evidence From Three States*, 33 HEALTH AFFAIRS 1648 (2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0103>.

³² Karina Wagnerman, *Medicaid: How Does it Provide Economic Security for Families?*, GEORGETOWN CTR. FOR CHILDREN & FAMILIES, (2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf>; Paradise, *supra* note 29.

³³ Zhihuan Jennifer Huang et al., *Health Status and Health Service Access and Use Among Children in U.S. Immigrant Families*, 96 AM. J. PUB. HEALTH 634 (2006), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2004.049791>; Susmita Pati & Shooshan Danagoulian, *Immigrant Children's Reliance on Public Health Insurance in the Wake of Immigration Reform*, 98 AM. J. PUB. HEALTH 2004 (2008), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2007.125773>; Ruth E. Zambrana, & Laura A. Logie, *Latino Child Health: Need for Inclusion in the US National Discourse*, 90 AM. J. PUB. HEALTH 1827 (2000), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446433/pdf/11111250.pdf>.



greatest risk for COVID-19.³⁴ Generally, noncitizen immigrant workers are concentrated in jobs that cannot be done virtually, including high percentages who are employed in construction and restaurant/food service.³⁵ In addition, researchers have concluded that noncitizen immigrants face increased risk of contracting COVID-19 as they are more likely to live in larger households and urban areas and to rely on public transit or carpools to commute, increasing exposure to the virus.³⁶

A 2021 Kaiser Family Foundation analysis found that 35 percent of immigrants noted concern that getting the COVID-19 vaccine might negatively affect their own or a family member's immigration status.³⁷ Additionally, one study found that immigrants avoided COVID-19 testing services due to concerns that a COVID-19 diagnosis will label them as undesirable citizens and negatively affect their immigration applications.³⁸ A survey of immigrants with undocumented members in their households who got sick with COVID-19 revealed that 18 percent of respondents cited being labeled as a public charge and 13 percent cited fear of their information being shared with immigration agents as reasons why they did not seek treatment for the virus.³⁹ The Urban Institute surveyed immigrant-serving community-based organizations

³⁴ Donald Kerwin et al., *US Foreign-Born Essential Workers by Status and State, and the Global Pandemic* CTR. FOR MIGRATION STUDIES (May 2020), <https://cmsny.org/publications/us-essential-workers/>.

³⁵ Samantha Artiga & Matthew Raw, *Health and Financial Risks for Noncitizen Immigrants due to the COVID-19 Pandemic*, KAISER FAM. FOUND. (Aug. 18, 2020), <https://www.kff.org/report-section/health-and-financial-risks-for-noncitizen-immigrants-due-to-the-covid-19-pandemic-issue-brief/>.

³⁶ *Id.*

³⁷ Liz Hamel et al., *KFF COVID-19 Vaccine Monitor: COVID-19 Vaccine Access, Information, and Experiences Among Hispanic Adults in the U.S.*, KAISER FAM. FOUND. (May 2021), <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/>.

³⁸ Carol Galletly, Julia Lechuga, Julia Dickson-Gomez, *Assessment of COVID-19 Related Immigration Concerns Among Latinx Immigrants in the US*, JAMA, (July 2021), <https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2782051>.

³⁹ Marion Davis, *The Impact of COVID-19 on Immigrants in Massachusetts: Insights from our Community Survey*, MASS. IMMIGRANT & REFUGEE ADVOCACY COALITION (2020), <http://www.miracoalition.org/cvsurvey>; see also US DEP'T OF HOMELAND SECURITY, *COVID-19 Vulnerability by Immigration Status: Status-Specific Risk Factors and Demographic Profiles* (May 2021), https://www.dhs.gov/sites/default/files/publications/immigration-statistics/research-reports/research_paper_covid-19_vulnerability_by_immigration_status_may_2021.pdf.



and found that 70 percent reported that public charge and other anti-immigrant policies deterred immigrants from seeking COVID-19 testing and treatment.⁴⁰

This chilling effect continues despite the fact that DHS has issued guidance excluding Medicaid coverage of COVID-19 testing and treatment from its public charge determination. We expect that having a new final rule that explicitly clarifies who is subject to a public charge determination and what benefits are included (as well as excluded) will greatly assist in fixing the chilling effect, particularly when finalized alongside strong public education efforts to explain the new rule.

III. Exclusion of Medicaid

As explained below, we recommend that DHS exclude all receipt of Medicaid – including Medicaid-funded long-term institutionalization – from a public charge test. In the alternative, we recommend excluding receipt of long-term institutionalization by pregnant people and children.

A. RECOMMENDATION: Continue to Exclude General Receipt of Medicaid from Consideration

The 2019 rule targeted reliance on Medicaid benefits as grounds for exclusion under public charge. We support the administration’s decision not to consider reliance on Medicaid writ large because it is not indicative of becoming destitute for numerous reasons. Thus we support the proposed rule’s exclusion of most of Medicaid from a public charge determination.

First, eligibility for Medicaid in some states extends up to 400 percent FPL for certain eligibility groups.⁴¹ 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.⁴² 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

⁴⁰ Hamutal Bernstein et al., *Immigrant-Serving Organizations’ Perspectives on the COVID-19 Crisis*, URBAN INST. (Aug. 2020), <https://www.urban.org/research/publication/immigrant-serving-organizations-perspectives-covid-19-crisis>.

⁴¹ 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/>.

⁴² *Id.*



“[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.”⁴³ 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 benefits with such high eligibility thresholds.⁴⁴ 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.⁴⁵ 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.⁴⁶ 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.⁴⁷ Moreover, access to Medicaid promotes health and economic status.⁴⁸ 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

⁴³ 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.

⁴⁴ *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.”).

⁴⁵ 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>.

⁴⁶ *Id.* at 817.

⁴⁷ *Id.* at 818.

⁴⁸ 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>.



communities at places such as restaurants, grocery stores, and retail stores.⁴⁹ Individuals and families would otherwise spend such funds on health care services.⁵⁰

B. RECOMMENDATION: Exclude Medicaid Institutionalization at Government Expense from Consideration

We also recommend DHS exclude Medicaid institutionalization at government expense from a public charge determination. DHS proposes to define “likely at any time to become a public charge” as “likely at any time to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or long-term institutionalization at government expense.” Thus, it proposes to consider past or present long-term institutionalization at government expense in the public charge determination. In the final rule, DHS should remove long-term institutionalization from the definition the list of considerations for several reasons. First, it makes the public charge definition overbroad and also impossible to predict. Second, it reflects a fundamental misunderstanding of the realities of Medicaid-funded long-term care and the over institutionalization of people with disabilities in violation of their rights. In addition, the proposed policy to rely on evidence submitted by the applicant that a long-term institutionalization violated Federal law puts the burden impermissibly on the applicant and is contrary to established law regarding improper institutionalization.

Who becomes institutionalized and for how long has dramatically changed over the years and has both grown and is far more unpredictable. In 1900, 4 per cent of the population was aged 65 and over, but by 1990, this population accounted for 12 percent of the population and is expected to be 20 percent of the population by 2030.⁵¹ There has also been an accelerated growth of the oldest age group, those 85 and over. Although there has been medical progress on many conditions like acute and infectious diseases that used to be fatal, there is a growing number of older adults with conditions that require some level of care, including cognitive conditions like Alzheimer’s and dementia, which have become more prevalent.⁵² In addition 1

⁴⁹ Michael E. Chernew, *The Economics of Medicaid Expansion*, Health Affairs Blog (Mar. 21, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>.

⁵⁰ *Id.*

⁵¹ See, e.g., Pamela Doty, APSE, US HHS, *Caring for the Frail Elderly People: Policies in the Evolution* (1995), <https://aspe.hhs.gov/reports/caring-frail-elderly-people-policies-evolution-0> (note this listing is not inclusive of the changes to disability policy);

⁵² *Id.*



in 4 U.S. adults have a disability that impacts major life activities.⁵³ As a result, substantial portions of the U.S. population will likely end up in an institution long-term, such as in a nursing facility, at some point in their lifetime, and particularly if they live long enough. According to the Kaiser Family Foundation, in the U.S., one in three people turning 65 will require nursing facility care in their lives.⁵⁴ 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 six percent of the U.S. population over 50 has private insurance coverage for long-term institutionalization.⁵⁵ Therefore, significantly more people in the U.S. will need institutional care, and who will need that care is rather unpredictable, especially far into the future.⁵⁶ Age and disability are not accurate predictors.⁵⁷ Nor is not having either of those factors as institutionalization could occur due to unforeseen circumstances, such as injury or onset of health conditions. In fact, it will be virtually impossible for adjudicators to accurately predict long-term institutionalization based on a person's characteristics at time of their public charge evaluation.

Additionally, as the NPRM recognizes, there have been significant changes in federal law and policy regarding older adults and people with disabilities.⁵⁸ Congress passed significant

⁵³ CDC.gov, CDC: 1 in 4 US adults live with a disability, <https://www.cdc.gov/media/releases/2018/p0816-disability.html>. That number is likely to have increased due to the impact of COVID-19 and the estimates that 1.2 million more people will have a disability by the end of 2021. CAP, *COVID-19 Likely Resulted in 1.2 Million More Disabled People by the End of 2021—Workplaces and Policy Will Need to Adapt* (Feb. 9, 2022), <https://www.americanprogress.org/article/covid-19-likely-resulted-in-1-2-million-more-disabled-people-by-the-end-of-2021-workplaces-and-policy-will-need-to-adapt/>.

⁵⁴ Kaiser Family Found., *Medicaid's Role in Nursing Home Care* (June 2017), <https://files.kff.org/attachment/Infographic-Medicoids-Role-in-Nursing-Home-Care>.

⁵⁵ 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>.

⁵⁶ See, e.g., Joseph E Gaugler et al, *Predicting Nursing Home Admission in the U.S.: a meta-analysis*, BMC GERIATRICS 13 (2007), <https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-7-13> (while there is some consensus regarding identifying factors for nursing facility admission for older adults 1 year or more into the future, there are significant limitations).

⁵⁷ *Id.* While certain conditions may be helpful in predicting nursing facility admission, there are significant limitations. And this study does not take into consideration whether community-based services should be move available to prevent nursing facility admission.

⁵⁸ Public Charge Proposed Rule at n. 422 (noting Congressional action to expand HCBS as an alternative to long-term institutionalization); see, e.g., Doty, *supra* note 51 (describing policy changes regarding older adults); Mary Jean Duckett & Mary R. Guy, *Home and Community-Based Services Waivers*, 22 HEALTH CARE FIN. REV. 123 (2000), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg123.pdf> (discussing history of



policies to support older adults and people with disabilities and moved away from long-term institutionalization with protections for people with disabilities, and increased focus on offering community-based services. The term “long-term institutionalization” is so broad that it encompasses those who are institutionalized in violation of their rights.

One of the most significant changes was the Supreme Court’s ruling in *Olmstead v. L.C.*, finding that institutionalization can violate Federal Law, including the Americans with Disabilities Act and the Rehabilitation Act.⁵⁹ Nearly two decades before the ruling, states were using Medicaid, including waivers, to provide services to people with disabilities in the community rather than in institutions.⁶⁰ Around the time of the *Olmstead* decision, study after study found that significant percentages of people receiving institutional services could live in the community, but that long-standing institutional bias in policies and eligibility structures prevented community living.⁶¹ In the *Olmstead* decision, the Court recognized that unjustified institutionalization is a form of discrimination and perpetuates unwarranted assumptions about the capability of people with disabilities to participate in community life. Further, providing dissimilar treatment requires people with disabilities to sacrifice community living to receive needed medical services; sacrifices that people without disabilities need not make to access medical care.⁶² Following the Supreme Court’s elucidation of assumptions, rights, and unwarranted sacrifices of people with disabilities, long-term institutionalization for purposes of public charge should not include institutionalization of people with disabilities. Given the history, reports of over-institutionalization, and ongoing enforcement activities, the presumption

Medicaid home and community-based services and the studies supporting community-based services and over-institutionalization of people with disabilities).

⁵⁹ Although there were numerous cases before *Olmstead* finding institutionalization improper and in violation of people’s rights, those cases were largely under due process and improper treatment theories. The *Olmstead* decision was a significant turning point in recognizing the right of people with disabilities to community-based care. Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1 (2012-2013), available at https://repository.law.umich.edu/cqi/viewcontent.cqi?article=1156&context=law_econ_current (describing early deinstitutionalization litigation in the 1970s and 1980s grounded in due process theories to antidiscrimination theories grounded in the ADA and *Olmstead*).

⁶⁰ 527 U.S. 581 (1999); Bagenstos, *supra* note 59; Duckett & Guy, *supra* note 58.

⁶¹ See *supra* note 58 regarding community-based services; Molly O’Malley Watts et al., Kaiser Family Found., *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19* (2022), <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/> (describing current payers of long-term care, distribution of spending in institutions v. community, and emerging issues in community based care, including the impact of COVID-19); see also *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003) (“where the issue is the *location* of the services, not *whether* services will be provided, *Olmstead* controls”);

⁶² *Olmstead*, 527 U.S. at 600-01.



should be that institutionalization of people with disabilities is improper unless the government can show otherwise.

In addition, long-term institutionalization is not an indicator that a person is primarily dependent on the government for subsistence. As testimony highlighted in the 2013 “Harkin Report” illustrates, long-term institutionalization because of disability does not define future community participation or governmental reliance. For example, the report cites testimony from Ricardo Thornton, Sr. from the District of Columbia who spent his childhood in various D.C. institutions where he had limited if any opportunity to make life decisions, but in subsequent years he moved to the community, had a good job for over 35 years, a driver’s license and car, and family, including a wife, son and granddaughter.⁶³

Even if the final rule includes consideration of past or current long-term institutionalization as part of the public charge determination, there should be a presumption that the institutionalization was improper. For it to count against an individual in the public charge determination, DHS officials would have to prove otherwise. This is for two main reasons (1) community-based services are not as available as *Olmstead* requires; and (2) the *Olmstead* analysis puts the burden on the government rather than an individual to show that community placement is improper and thus the public charge analysis should do the same.⁶⁴

Despite policy advancements, litigation to enforce the rights of people with disabilities, and state efforts, thousands upon thousands of people with disabilities remain unnecessarily institutionalized or at risk of institutionalization due to a lack of community-based services.⁶⁵

Medicaid spending on community-based services only became a majority of Medicaid long-term care spending in 2015 and still hovers at less than 60% of spending. However, this is not an indicator of whether those services could be provided in the community. As courts have

⁶³ See, e.g., Sen. Tom Harkin, Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act (July 18, 2013), <https://www.help.senate.gov/imo/media/doc/Olmstead%20Report%20July%2020131.pdf> (documenting the ongoing failure to provide services in the community rather than in an institution).

⁶⁴ See generally *Olmstead*, 527 U.S. 581 (explaining that the 3 prong test under *Olmstead* is that community placement is appropriate; the individual does not oppose such placement; and that the placement can be reasonably accommodated and that it is up to the state defendant to show that it would be a fundamental alteration of the program to accommodate the person or other defenses related to showing the state is making progress on providing services in the community rather than an institution); see, e.g., *Steimel v. Wernert*, 823 F.3d 902, 916 (7th Cir. 2016); *Townsend*, 328 F.3d at 517 (holding plaintiff can state violated Title II of the ADA, unless state can demonstrate that provision of community-based services would be a fundamental alteration); *Hampe v. Hamos*, 917 F.Supp.2d 805, 822 (N.D. Ill. 2013) (a fundamental alteration defense cannot be based solely on costs).

⁶⁵ *Id.* at 6-7.



said, if a state is providing the services in the community and in an institution, a person who wants to receive the services in the community should be able to and *Olmstead* controls.⁶⁶ However, the reality is different from this promise under *Olmstead*. Medicaid funded community-based services remain largely insufficient to meet the needs of people with disabilities in America, leaving people in institutions and at risk of institutionalization as they remain on waitlists for community-based services.⁶⁷ In addition, many people remain in institutions who may be more costly to serve in the community, in violation of their rights.⁶⁸ Congress recently recognized the vulnerability of many state HCBS programs to even exist at their current levels and authorized significant increased funding to stabilize and enhance HCBS programs.⁶⁹ Current HCBS programs remain an insufficient, readily accessible feasible alternative to institutional, congregate services and thus individuals with disabilities who have been institutionalized should not bear the burden of showing they were wrongfully institutionalized.

As courts have recognized, when people with disabilities have expressed a desire to live in the community, it falls to the governmental entity to show that providing community-based services instead of institutional services would be a fundamental alteration of the program.⁷⁰ Yet as litigation and policy choices have shown, it can be incredibly difficult for an individual in an

⁶⁶ See, e.g., *Townsend*, 328 F.3d 511.

⁶⁷ See, e.g., MaryBeth Musumeci et al., *Key State Policy Choices About Medicaid Home and Community-Based Services* 1, 17 (2020), <https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services> (citing that over three-quarters of states report an HCBS waiver waiting list, with not all states reporting, and that waiting lists have grown significantly since 2002).

⁶⁸ See, e.g., Statement of the National Disability Rights Network, *The Meaning of Olmstead* (2016), https://www.tascnow.com/wp-content/uploads/2019/03/The_meaning_of_Olmstead_2016_NDRN.pdf (summarizing *Olmstead* principles and collecting resources).

⁶⁹ American Rescue Plan Act, Pub. L. No. 117-2 § 9817 (2021); see also Medicaid.gov, *Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817 Spending Plans and Narratives* (describing the HCBS ARPA funding, related CMS guidance, and state narratives that highlight issues in HCBS programs and how they plan to use the funding to strengthen and expand current programs).

⁷⁰ *Steimel*, 823 F.3d at 916; *Townsend*, 328 F.3d at 517; see also *Radaszewski v. Maram*, 383 F.3d 599, 613-14 (7th Cir. 2004) (noting that even if a state would have to increase expenditures to cover plaintiff's 24-hour care, by three to four times the approved amount, that alone would not defeat the ADA claim because to provide rule otherwise would make the ADA "hollow indeed."); see also *Pa. Prot. & Advocacy, Inc. v. Dep't of Pub. Welfare*, 402 F.3d 374, 380 (3d Cir. 2005) (collecting cases).



institution to enforce their right to community living.⁷¹ The Money Follows the Person (MFP) program, which has been lauded for its successes in moving people from institutions to community settings, has found that about a quarter of the program participants would have remained institutionalized without the MFP program, which provides case management and other services to help transition people into community settings.⁷² The MFP program is certainly not the only avenue for individuals to move from institutions to the community, but it is a significant component. However, states have identified other major barriers to community integration, including lack of affordable, accessible housing; employment opportunities; resources for services; state leadership; and other issues.⁷³ While federal policies have pushed towards greater community integration and away from institutionalization, the promise remains unfulfilled.⁷⁴ Therefore, institutionalization for medical purposes should not be counted against an individual as it is often a violation of their rights and never determinative of their

⁷¹ See, e.g., Bagnestos, *supra* note 59; U.S. Dept. of Justice, *Olmstead: Community Integration for Everyone*, <https://www.ada.gov/olmstead/> (listing and providing additional access to information regarding the enforcement of *Olmstead* including the Faces of *Olmstead* page which highlights personal stories);

⁷² See MaryBeth Musumeci et al., Kaiser Family Found., *Medicaid's Money Follows the Person Program: State Progress and Uncertainty Pending Federal Funding Reauthorization* (2019), <https://www.kff.org/medicaid/issue-brief/medicaids-money-follows-the-person-program-state-progress-and-uncertainty-pending-federal-funding-reauthorization/>; generally Mathematica, *Projects: Research and Evaluation of the Money Follows the Person (MFP) Demonstration Grants*, <https://www.mathematica.org/projects/research-and-evaluation-of-the-money-follows-the-person-mfp-demonstration-grants> (for a variety of reports that highlight the successes and challenges of the MFP program). In recognition of the need for this critical component of deinstitutionalization, CMS recently released \$110 million in funding for MFP to expand access to HCBS for people currently institutionalized. CMS.gov, HHS to Provide \$110 Million to Strengthen Safety Net for Seniors with Disabilities (Mar. 31, 2022), https://www.cms.gov/newsroom/press-releases/hhs-provide-110-million-strengthen-safety-net-seniors-and-people-disabilities?j=1449174&sfmc_sub=6954352&l=6707_HTML&u=32314038&mid=515008575&jb=0.

⁷³ See, e.g., Harkin, *supra* note 63; SAMHSA, *Restoring Lives: Building Integrated Communities and Strengthening Support: A Report of the 2012 Olmstead Implementation Best Strategies and Practices Policy Academy* (2012), <https://www.samhsa.gov/sites/default/files/olmstead-policy-academy.pdf>; MaryBeth Musumeci & Henry Claypool, Kaiser Family Found., *Olmstead's Role in Community Integration for People with Disabilities Under Medicaid* (2014), <https://www.kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicare-issue-brief/>.

⁷⁴ See, e.g., Harkin, *supra* note 63; Musumeci, *supra* note 67; Bagnestos, *supra* note 59; National Council on Disability, *Home and Community-Based Services: Creating Systems for Success at Home, at Work and in the Community* (2015), <https://ncd.gov/publications/2015/02242015> (highlight the changes to Medicaid HCBS requirements and the barriers to community integration).



future community participation. At the very least, the presumption should be on DHS to show that the long-term institutionalization was required.

C. ALTERNATIVE RECOMMENDATION: Exclude Pregnant People and Children from Public Charge Determination Based on Long-term Institutionalization

If DHS does not follow our above recommendation regarding exclusion of all long-term institutionalization, we alternatively recommend that DHS exclude receipt of Medicaid by all pregnant people and children from a public charge determination.

As part of the 2019 Trump Final Rule, the administration exempted receipt of Medicaid by pregnant people and children under 21 from the public charge determination. Specifically, the administration exempted Medicaid received by pregnant people “during pregnancy and the 60-day period beginning on the last day of pregnancy.” As part of the rule, the administration noted, “DHS believes that Medicaid received by pregnant aliens, while providing a short-term benefit for the alien herself, in many cases ultimately benefits the U.S. citizen child(ren) who is born to such alien.” We support the Biden Administration’s removal of general receipt of Medicaid as part of a public charge determination. However, as noted elsewhere in our comments, we strongly oppose the 2022 proposed rule’s inclusion of long-term institutionalization at government expense in a public charge test.

We recommend eliminating all receipt of Medicaid long-term institutionalization as part of a public charge determination. Should the Administration not accept this recommendation, we urge the administration to specifically exempt pregnant people and children under 21 who receive Medicaid long-term institutionalization. Commentators to the 2019 rule noted that pregnant people and children are disproportionately impacted by the chilling effect caused by the Public Charge rule. The chilling effect specifically impacted people who qualify for Medicaid that covers prenatal care and labor and delivery who may feel that they face the impossible choice of risking a public charge determination by signing up for this coverage, finding a way to pay thousands of dollars for labor and delivery as well as prenatal and postpartum care, or going without needed care.⁷⁵ About ten percent of foreign-born pregnant women reported

⁷⁵ Sharon Parrot, Shelby Gonzales, and Liz Schott, Center on Budget and Policy Priorities. *Trump “Public Charge” Rule Would Prove Particularly Harsh for Pregnant Women and Children*, (May 2018) <https://www.cbpp.org/research/poverty-and-inequality/trump-public-charge-rule-would-prove-particularly-harsh-for>.



forgoing applying for Medicaid because of a range of fears associated with public charge ranging from deportation to impact on future residency and citizenship applications.⁷⁶

Several commentators to the 2019 Trump Rule note the importance of robust health care services for pregnant people. Excluding pregnant people from long-term institutionalization public charge determinations affords necessary health care services to this high risk population. This is especially important for low-income immigrant women who are enrolled in Medicaid who may suffer complications during pregnancy, hospitalization with COVID-19, and complications after birth that could result in long-term hospitalization depending on the parameters of what “long-term” may mean. Further, it is important to safeguard the delivery of key health care services for pregnant people and new mothers who may be institutionalized now that states are afforded the option to provide 12 months postpartum coverage through Medicaid. These services are key to ensuring the continued health of mothers and their newborns.

Due to historical and ongoing racism and xenophobia in our health care system and health policies, low-income immigrant women face high rates of maternal morbidity. Structural violence ranging from ICE surveillance to public charge significantly impacts the health of immigrant women leading to long-term health complications that are exacerbated during pregnancy.⁷⁷ Moreover, pregnant individuals have significantly higher instances of COVID-19 hospitalization and case fatality than similarly aged adults. As such, pregnant individuals are at risk of severe or critical disease and mortality compared to nonpregnant adults, and are also at risk for preterm birth.⁷⁸ These complications are heightened for low-income immigrant women

⁷⁶ Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, Urban Institute. *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, (May 2019) <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.

⁷⁷ Kaitlyn Stanhope, Shakira Suglia, Carol Hougue, Juan Leon, Dawn Comeau, Michael Kramer, *Spatial Variation in Very Preterm Birth to Hispanic Women Across the United States: The Role of Intensified Immigration Enforcement, Ethnicity and Disease*, (2021) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8143852/>.

⁷⁸ Erica Lokken, et al., *Disease severity, pregnancy outcomes, and maternal deaths among pregnant patients with severe acute respiratory syndrome coronavirus 2 infection in Washington State*, *Obstetrics* (2021), <https://www.binasss.sa.cr/qine/5.pdf>.



who have lower rates of vaccinations due to systemic barriers and have higher rates of preexisting conditions that lead to severe cases of COVID-19.⁷⁹

In addition to excluding pregnant people, we recommend that DHS exclude consideration of children's receipt of long-term institutionalization from a public charge test. In the preamble to the NPRM, DHS notes that it "remains particularly concerned about the potential effects of public charge policy on children." Yet the Trump administration categorically excluded children's receipt of Medicaid from the public charge determination. We recommend DHS do the same for the following reasons. One, childhood institutionalization is not an indicator of long-term institutionalization and reliance on the government. Two, children under 21 often do not have autonomy over the care that they receive (or even their immigration to the United States) as this is governed by a parent or caregiver. Further, children need health care during their critical, formative years or could face lifelong issues which could then lead to an adverse public charge test.

Though a growing number of children are eligible to receive home-based care for medical complexities, there is still a dearth of available home health care providers with pediatric training to serve children and youth with medical complexity. Additionally, many states have yet to fully invest in home and community-based Medicaid services particularly for children.⁸⁰ Investments in home and community-based services as well as workforce development are key to lessening the number of children who rely on long-term institutionalization. Children who are in long-term institutionalization should not be penalized for receiving this care through the public charge rule. Instead, the Administration should bolster investments in home and community-based services and address the historical and ongoing challenges that families face as they navigate care for their children with disabilities. Investment in robust health care services for children with disabilities improves health outcomes and leads to healthy and productive adults.⁸¹

⁷⁹ Centers for Disease Control and Prevention. COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy – Eight Integrated Health Care Organizations, United States, December 14, 2020-May 8, 2021. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e2.htm>.

⁸⁰ Carolyn Foster, Rishi Agrawal, Mathew Davis, Health Affairs, *Home Health Care for Children With Medical Complexity: Workforce Gaps, Policy, and Future Directions*, (June 2019) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05531>.

⁸¹ Dennis Kuo, Meg Comeau, James Perrin, Cara Coleman, Patience White, Carlos Lerner, Christopher Stille, *Moving from Spending to Investment: A Research Agenda for Improving Health Care Financing for Children and Youth with Special Health Care Needs*, Academic Pediatrics (2022), <https://pubmed.ncbi.nlm.nih.gov/34808384/>.



Further, the COVID-19 pandemic has also disproportionately impacted children. Hospitalization rates are especially high for children under 5 who are not yet eligible for vaccinations.⁸² Unvaccinated children 5-11 years old also face higher rates of COVID-19; hospitalization rates among this population are twice as high compared to vaccinated children.⁸³ In addition to hospitalization, COVID-19 has resulted in high rates of long COVID among children as well as serious mental health impacts which could lead to institutionalization, particularly in states without sufficient home and community-based services.

The continued expansion of Medicaid eligibility for pregnant people and children over the last decades demonstrates Congress' intent to ensure they have access to the often life-saving health care they need without fear of repercussions. We thus urge the administration to exclude Medicaid long-term institutionalization from the public charge determination completely; if this will not be the case, we urge specific protection of pregnant people and children given their vulnerable status to COVID-19 complications as well as the unique health inequities that these groups face leading to their increased risk of institutionalization.

IV. Statutory Factors to Consider

We support DHS's proposed language that simply acknowledges the statutory language and elects not to define the five factors. In addition to their relatively low importance compared with the affidavit of support, defining them would invite potential abuse by adjudicators. The previous administration's attempt to define them resulted in a mosh pit of competing factors—ranging from weighted to heavily weighted—that took into account, among other factors, the applicant's current and estimated income, job history, job skills, liabilities and debts, health status, health insurance enrollment, assets, credit reports, prior income tax filings, educational level (lack of high school degree was a negative factor), foreign education degree equivalency reports, and proficiency in English. Many of these factors are not listed in or contemplated by the statute.

⁸² Centers for Disease Control and Prevention. Hospitalization of Infants and Children Aged 0-4 Years with Laboratory-Confirmed COVID-19, 14 States, March 2020-February 2022, <https://www.cdc.gov/mmwr/volumes/71/wr/mm7111e2.htm>.

⁸³ Centers for Disease Control and Prevention. Hospitalizations of Children Aged 5-11 Years with Laboratory-Confirmed COVID-19, 14 States, March 2020-February 2022, https://www.cdc.gov/mmwr/volumes/71/wr/mm7116e1.htm?s_cid=mm7116e1_w.



The USCIS admitted at the time that the new standard for determining public charge inadmissibility would necessarily now be “subjective and discretionary in nature,” and “to the extent that each applicant’s facts and circumstances are unique, officers’ public charge inadmissibility determinations will vary.” USCIS Policy Manual, Vol. 8, Part G, ch. 4(A). It also acknowledged that there would no longer be any “‘bright-line’ test in making a public charge inadmissibility determination.” USCIS Policy Manual, Vol. 8, Part G, ch. 4(C).

Any effort to define the five statutory public charge factors would necessarily result in a far more complicated and discretionary determination and one that is both unnecessary and potentially harmful. Rather than applying a discrete analysis based on the sponsor’s financial status and current income, it would redirect the focus onto the applicant. Consular and USCIS officials would be required to juggle a variety of factors that have little relationship to the applicant’s qualifying for specific federal cash assistance programs at a time well into the future when they might theoretically become eligible to receive them. Applicants and the practitioners who represent them—as well as those who are adjudicating these applications—need to maintain the less burdensome test that is currently being applied.

- 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.

DHS should only consider current receipt of SSI and TANF in a public charge determination. To the extent that an individual is currently receiving benefits, the applicant’s receipt should be weighed against other factors, including eligibility restrictions on further receipt upon being granted LPR status. In addition to limiting the inquiry to focus on current receipt of relevant benefit programs, DHS should make clear that any past benefits used by an applicant’s family members or sponsors would not be considered in the applicant’s public charge test.

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.⁸⁴ Accordingly,

⁸⁴ Social Security Administration, Understanding Supplemental Security Income Work Incentives, <https://www.ssa.gov/ssi/text-work-ussi.htm>.



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.⁸⁵

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. Although Medicaid has restrictive eligibility rules for immigrants, adjudicators should not import these conditions into their analysis of an individual’s health status. Again, 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

V. 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

⁸⁵ *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)); 969 F. 3d 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.



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.⁸⁶

The history of public charge is mired in racism and, simply put, there is no way to salvage the public charge test without continuing its racist legacy.⁸⁷ 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 quickly move to finalize the proposed rule and urge the administration to simultaneously work towards ultimately removing the statutory requirement to promote health justice for all communities.

VI. Conclusion

Thank you for the opportunity to provide comments. We urge DHS to move as expeditiously as possible to quickly improve and finalize the proposed rule.

Our comments include citations to supporting research and documents for the benefit of HHS in reviewing our comments. We direct HHS to each of the items cited and made available to the agency through citations and active hyperlinks, and we request that HHS consider these, along with the full text of our comments, part of the formal administrative record on this proposed rule.

⁸⁶ 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/>.

⁸⁷ See generally Anna Shifrin Faber, *A Vessel for Discrimination: The Public Charge Standard of Inadmissibility and Deportation*, 108 GEORGETOWN L. J. 1363 (2018).



If you have any questions about our comments, please contact Eskedar Girmash (girmash@healthlaw.org) or Mara Youdelman (youdelman@healthlaw.org).

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor
Executive Director

