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Robert Wood Johnson Foundation

Office of the President and CEO

December 3, 2018

The Honorable Kirstjen M. Nielsen
Secretary of Homeland Security
Washington, D.C. 20528

RE: RIN 1615-AA22 "Inadmissibility on Public Charge Grounds"

Dear Secretary Nielsen;

The Robert Wood Johnson Foundation (RWJF) appreciates the opportunity to comment on the proposed rule, issued by the Department of Homeland Security (DHS). This rule would prescribe how DHS determines whether an individual (known as an alien under federal law) who seeks admission into the United States or adjustment of status is likely at any time to become a public charge under Section 212(a)(4) of the Immigration and Nationality Act (INA). Such a determination represents grounds for inadmissibility or adjustment of status.

RWJF is the nation's largest philanthropy dedicated to improving health and well-being in the United States. Since 1972, we have worked with public and private sector partners to advance the science of disease prevention and health promotion, train the next generation of health leaders, and support the development and implementation of policies and programs to foster better health across the country, including high-quality health care coverage for all. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being.

We are commenting on the proposed rule because it threatens immediate access to vital services and programs for individuals, families, and communities and could have a negative impact on health and well-being. The rule would penalize people and families for using the very supports that U.S. law affords them: health insurance; food assistance; housing assistance; and a limited amount of help with basic financial needs.

Denying such basic services could create near-term health and social well-being risks, including risks associated with social stigma,[1] for families confronting denial or loss of basic services. Furthermore, the agency's proposal is likely to have far-reaching health consequences: for immigrants and their families; for thousands of urban and rural communities that are home to immigrants; and ultimately, for the nation as a whole. The implications of the rule are substantial for communities with sizable immigrant populations, which tend to be lower income and

interdependent on a fragile ecosystem of hospitals, clinics, local food markets, and social service programs that derive important operating revenue from government programs. By threatening access to basic health and health care services, the proposal could create broader population health risks from untreated but preventable conditions.

For these reasons, RWJF respectfully recommends that the proposed rule be withdrawn.

The Proposed Rule Represents a Fundamental and Deeply Harmful Departure from Current Policy

The proposed rule would fundamentally alter current regulatory policy. DHS has not fully accounted for the consequence of these changes, not only for those directly affected but also for their family members, especially their children, and for communities in which large numbers of immigrant families reside. Moreover, DHS is underestimating how dramatic the effect of the proposed policy would be by not accounting for the evidence of people avoiding benefits and programs out of fear or misunderstanding of the new policy (a chilling effect) and cumulative effect on communities. The proposed rule is a fundamental change in policy that poses risks to health and well-being, without fully considering the full scope of evidence available for such a significant change.

In two respects, the proposed rule would broadly expand the definition of who is a public charge. First, the rule would treat as generally negative factors certain family characteristics common to immigrants, particularly those who are newly-arrived. Second, the proposal would expressly treat use of a dramatically expanded list of public benefits by individuals and families as a heavily weighted negative factor, despite the fact that they are eligible to receive these benefits under law.

Reflecting the 1996 Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA),[2] current public charge determination policy uses a "totality of circumstances" test that considers age, health status, family status, financial status, and education and skills. In making public charge determinations, IIRIRA does not identify receipt of public benefits as a specific criterion. This is not surprising, since IRRIRA was enacted contemporaneously with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).[3] PRWORA specifically identified multiple classes of immigrants whose eligibility for public benefits such as Medicaid, food stamps, and cash welfare assistance is recognized under law, typically after a waiting period.

Subsequent legislation has enabled states to set aside PRWORA's waiting period rules in the case of Medicaid and Children's Health Insurance Program (CHIP) benefits for immigrant pregnant women and children; as of 2017, 31 states did so.[4] Furthermore, the federal government has encouraged immigrants to enroll in programs for which they are eligible, especially Medicaid and CHIP,[5] and has encouraged states to use their own funds to provide food, cash assistance, and health coverage in situations in which PRWORA restrictions apply.[6]

In sum, IRRIRA, which governs public charge determinations generally, exists alongside PRWORA, which was enacted simultaneously and which explicitly grants public benefits to multiple classes of legal immigrants. The reasonable interpretation of this dual policy is that

qualified immigrants can use public benefits for which they are eligible without fear that doing so will trigger a public charge determination. As a result, over decades, the federal government and many states have made extensive efforts to find and enroll eligible individuals and families.

Active efforts by both the federal and state governments to find and enroll eligible immigrants has had a substantial positive effect. Data from the Migration Policy Institute show that over the 2014 –2016 time period, among 21.9 million noncitizens, nearly 4.5 million (20 %) received benefits from the Supplemental Nutrition Assistance Program (SNAP) and 4 million (18.3 %) received Medicaid. Slightly more than 1 percent received cash welfare assistance under Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI).[7] Over 43 percent of noncitizens lived in families in which a family member received Medicaid (typically a child).[8]

In order to ensure that use of public benefits by eligible immigrants does not trigger a public charge determination, current policy identifies two very limited circumstances in which receipt of a public benefit can serve as evidence of public charge: (1) situations in which individuals or families are "primarily dependent" on government cash welfare; and (2) cases in which government health programs are paying for long-term institutional care. Otherwise, eligible immigrants can enroll, without concern, in all forms of Medicaid that are available, as is the case with SNAP and public housing assistance. They also can receive modest levels of cash welfare assistance. Eligible immigrants also can qualify for non-cash forms of help under TANF such as job support funding or child care. All of these benefits are considered "supplementary" in nature, not evidence of primary dependence on the government.[9]

The proposed rule would fundamentally depart from current policy. Under the guise of "self-sufficiency", the rule would adopt specific criteria to be used in the "totality of circumstances" test to tip it decisively against lower income families with children. DHS is unequivocal in its intent: despite federal laws making immigrants eligible for assistance, officials "may take into consideration for purposes of a public charge determination receipt of public benefits even if an alien may receive such benefits." Furthermore, "although an alien may obtain public benefits for which he or she is eligible, the receipt of those benefits may be considered for future public charge inadmissibility determination purposes."[10]

Beyond dramatically expanding the list of which public benefits count in a public charge determination, the agency also identifies certain personal characteristics that will be weighed negatively as predictors of use of public benefits. Thus, children become a negative factor because they tend to be eligible for public benefits.[11] Larger families become a negative factor because larger families use benefits.[12] Low income (including both low family income and the "means to pay for medical support") and limited English become negative factors as public benefit predictors. In short, DHS would identify as negative factors personal characteristics that are associated with use of benefits for which people are eligible and that are considered unrelated to public charge status.

Health conditions requiring medical care—far beyond those that under current law trigger inadmissibility on health-related grounds—become a negative factor because they could "interfere" with school or work and the ability to earn.[13] Given such latitude, officials could classify as likely to become public charges people with medical conditions as simple as a need for

vision or oral health care or reliance on primary care management for common conditions such as hypertension or diabetes, particularly when coupled with a lack of private health insurance coverage. [14] Any of these conditions could be considered ones that could "interfere" with work or school.

The proposed rule would treat as a "heavily weighted" negative factor the current receipt of public benefits (as defined in the rules),[15] or receipt of benefits within 36 months of filing an application[16] for admission or adjustment of status. This test sweeps in programs and services now considered merely supplementary in nature. The list of affected programs would expand to include SNAP, SSI, TANF (both cash and non-cash), and public housing assistance. The proposal would also classify Medicare Part D premium and cost sharing assistance as public benefits, presumably in response to the greater reliance on Medicare and Medicaid by older immigrants.[17]

The proposal would allow Medicaid to continue to be available as a source of health care financing only in the case of medical emergencies or for services furnished in schools. Even this narrow school exception is essentially unworkable, since the agency does not explain how such financing actually would be available to either children or schools since, in order to qualify, children would first have to be enrolled in Medicaid generally. Doing so could, under the proposed rule, raise both direct and indirect (chilling effect) problems since Medicaid is now on the expanded list of prohibited public benefits. The proposal seeks public input on whether CHIP should remain an exempt form of assistance. DHS overlooks the fact that in 48 states, the District of Columbia and 5 territories, CHIP is administered as a Medicaid expansion either in whole or in part.[18]

The Proposed Rule Would Affect the Health and Well-Being of Millions of Children and Adults

The proposed policy has a vast reach. Studies estimate that 42 percent of noncitizens entering the United States without legal permanent residency status have characteristics that DHS would consider a heavily-weighted negative factor; 26 percent are currently enrolled in one or more public benefit programs for which they are eligible.[19]

The proposed standard would reach all aspects of daily life, implicating millions of immigrants and their families —either directly or as a result of the rule's chilling effect —potentially leading to a wholesale withdrawal from public programs. A few examples illustrate the rule's fullest potential direct and indirect reach:

- Immigrant families that enroll their children in Medicaid in order to receive comprehensive primary and preventive health care, both through their school clinic and in the community.

- Low-income women working at jobs without employer insurance who use Medicaid to help them afford routine care or pregnancy care.

- Young families working at lower-wage jobs who supplement earnings with SNAP benefits for their children or older parents.

- Low-wage workers who lack job-based insurance[20] who enroll in Medicaid to pay for routine health care needed to remain healthy and hold jobs.

The vast expansion of the public benefits list, coupled with public charge risk factors that explicitly focus on the likelihood of public benefit use, can be expected to have an enormous impact, especially since immigration policies are so complex. Since eligibility for services is no shield against a public charge determination, the natural effect will be to deter enrollment.

Research Shows That the Proposed Rule Could Cause Significant Harm, Including Widespread Disenrollment from Essential Programs, With Traumatic Effect

Previous research focusing on the effects of prior eligibility changes in public programs for non-citizens points to the rule's consequences for program participation. Here, the proposal goes a step further, creating a risk of severe sanctions against people who use benefits for which they are eligible.

DHS readily acknowledges chilling effect research,[21] noting the evidence of its existence.[22] Specifically the proposal cites a governmental study by the United States Department of Agriculture (USDA) showing a 5.9 million-person decline in food stamp enrollment between 1994 and 1997 following PRWORA, with the "steepest" declines —a 54 percent reduction —occurring among legal immigrants.[23] According to your agency, this study parallels the findings in a separate study showing similar, disproportionately steep declines in the receipt of public benefits among legal immigrants following enactment of PRWORA.[24]

These estimates do not stop at immigrants themselves. The complexity of the rule and its potential sweep may cause immigrants to avoid community-wide programs such as food banks, women's health clinics, and community health centers. DHS recognizes that these programs are not affected, [25] and yet the agency does not acknowledge any potential spillover effect from expanding the list of public benefits. The rule's most serious repercussions may be for mixed-status families, where past research also suggests a significant spillover effect. In 2016, 10.4 million citizen children had at least one noncitizen parent.[26] Although the proposed rule eliminates a provision in an earlier draft that would have sanctioned parents for using benefits for their citizen children, anecdotal evidence suggests confusion[27] over the implications of using any benefit on the public benefit list. The rule's apportionment formula[28] suggests severe sanctions even if eligible family members receive help.

Numerous studies all point to a broad chilling effect, with varying impact. One recent analysis of multiple chilling effect studies found an impact of between 17 percent and 78 percent, depending on the specific program and the specific study.[29] Other research included in the multi-study analysis, which focused on Medicaid and chilling effects, found a chilling effect ranging from 15 percent to 35 percent.[30] From these multiple chilling effect studies, researchers estimated overall Medicaid disenrollment rates ranging from 2.1 million to 4.9 million beneficiaries and disenrollment rates for citizen children ranging between 875,000 and 2 million.[31] A separate study examining the health implications for children living in households with at least one non-citizen and enrolled in Medicaid or CHIP because of a need for medical attention (estimated at some 4.8 million children) calculated disenrollment numbers between 700,000 to 1.7 million. These children

include newborns and children with serious conditions such as asthma, influenza, diabetes, epilepsy, cancer, and musculoskeletal, rheumatologic or other conditions that create a need for continuous health care.[32]

Despite this evidence, DHS suggests that the proper chilling effect measure for regulatory cost impact purposes is 2.5 percent. The agency's rationale is that only those immediately affected by the rule will be deterred from enrolling, and that deterrence will occur only among those immediately applying for adjustment of status. DHS says that even this impact may be an over-estimate since it does not know how many people actually will seek status adjustment. Nor does DHS acknowledge the potential spillover effect on family members of those who do seek status adjustment and fear the impact of other members' receipt of public benefits on their ability to qualify.

Accordingly, DHS estimates a Medicaid impact of only 142,000 people.[33] Similarly, the agency concludes that fewer than 27,000 people will disenroll from Medicare low income subsidy assistance and places SNAP disenrollment at slightly less than 130,000. The federal rental assistance decline is placed at slightly more than 324,000, and SSI disenrollment at just over 18,000. The evidence strongly suggests that DHS is underestimating the chilling effect of this regulation.

As immigrants and their families lose access to housing and food supports and affordable medical care, this loss could in turn intensify the trauma that immigrants already experience as a result of the immigration experience itself.[34] With rising trauma, research shows, health further declines.[35]

The Proposal Can Be Expected to Chill Entire Communities

Beyond the immediate impact of the rule on the use of services for which immigrants and other non-citizens are eligible, the rule may have a broader, community-wide chilling effect on citizens and non-citizens alike, something that the proposal does not appear to consider at all. The potential for community-wide chilling effects of population-level public policy shifts may be especially great under this rule, because as with lower-income Americans generally, immigrant families tend to live in communities with more concentrated poverty, creating greater dependence on public programs among community-wide institutions. Indeed, in more than 11 states, noncitizens represent 12 percent or more of the entire low-income resident population (income level < 125 percent of the federal poverty level).[36]

The impact of large-scale insurance policy on community health systems has been documented in the research literature;[37] as insurance declines, so does provider revenue. One recent study estimates that $68 billion in Medicaid/CHIP spending would be potentially subject to the chilling effect; of this total amount, $17 billion in hospital payments are potentially at risk, and hospitals and safety net providers would likely see a significant increase in uncompensated care.[38]

Another recent study estimates that the impact on immigrants and their children as a result of the chilling effect could translate into community-wide resource losses reaching $17.5 billion in health care and food supports, leading to $33.8 billion in broader economic consequences including a loss of 230,000 jobs.[39] Yet another study examining the community-wide effects of the proposed

public charge rule on community health centers (the single largest source of comprehensive primary care in medically underserved urban and rural communities) estimates that over a year, patient care capacity at health centers would fall by between 295,000 and 538,000 patients nationwide, with particularly steep reductions in certain states. Service capacity reductions would affect the entire population. As an estimated 354,000 to 646,000 noncitizen patients lose Medicaid, health centers would experience revenue reductions of between $346 million and $624 million, losses that translate into staffing reductions of between 3,400 and 6,100 clinical staff.[40]

The Impact of the Rule on Children Likely Will Be Particularly Acute

A number of studies focus on the proposed rule's potential effects on children, an especially vulnerable part of the population given their dependence on adults, their poverty, and the extent to which lower income children live in mixed-status households with both citizen and noncitizen family members. An estimated 10.4 million citizen children live in households with at least one non-citizen parent,[41] while a separate study reports that another 1.2 million noncitizen children, also eligible for public insurance, live in mixed status families.[42]

Children disproportionately rely on public benefit programs. While 12.1 percent of all immigrant adults receive SNAP, 25.4 percent of citizen children of non-citizen parents do so, as do 19.5 percent of immigrant children.[43] Medicaid use among immigrants or citizens living in mixed households is far higher for children. Among adult immigrants, 30.1 percent received Medicaid in 2016; by contrast, among children, 52.3 percent of immigrant children and 74.0 percent of citizen children living with noncitizen adults received Medicaid that year.[44]

In short, regardless of whether they are U.S. citizens or immigrants, children, by virtue of their poverty and eligibility for need-based assistance, disproportionately depend on public benefits that now appear on the expanded list of programs and services that carry public charge implications. As a result, children can be expected to bear the disproportionate impact of policies that flag poor families as a result of their poverty and the presence of children, both of which are predictors of public benefit use and that couple this new weighting system with an expanded list of public benefit programs that carry sanction implications. DHS fails to take this into account in either formulating its policies or gauging their impact, despite extensive evidence regarding the impact of unmitigated childhood poverty on both near-term and long-term health. [45]

The Proposed Rule Will Produce a Negative Impact on Health and Well-Being

Just as the rule fails to consider its potential health impact on children, the proposal avoids health impact more generally, despite extensive evidence regarding the effects of poverty on health [46] as well as evidence regarding the role played by programs such as SNAP in mitigating poverty's impact. For example, SNAP benefits have a powerful antipoverty effect, lifting 10 percent of SNAP households above the federal poverty line when assistance is factored in.[47] Similarly, housing supports reduce impoverishment and are associated with safer residential housing.[48]

The loss of SNAP carries particularly serious implications for the health of children and their families. According to research complied by the Food Research and Action Center (FRAC),[49] for example, young children in families losing SNAP as a result of changes in income are more likely

to experience fair or poor health and developmental delays.[50] Families losing SNAP are at increased risk of forgoing medical care for their children or other family members because of cost[51,52] and mothers losing SNAP are at greater risk for depression,[53] which in turn heightens the risk for trauma among children. As SNAP benefits decline, households with young children are more likely to experience food insecurity.[54,55,56] The end of SNAP eligibility also has been associated with increased inpatient hospital admissions and growing medical costs.[57] The loss of SNAP also is associated with lower math and reading achievement test scores among school children[58,59] and increased rates of hospital admissions for hypoglycemia and diabetes[60] as SNAP benefits are lost.

Multiple studies associate Medicaid with improved access to health care for a range of conditions as well as with positive health outcomes.[61] Loss of Medicaid is associated with reduced access,[62] declining health status,[63] increased uncompensated care,[64] and higher rates of health spending for preventable conditions. Yet DHS does not take these consequences into account.

Similarly, reduced access to affordable housing can be expected to produce health risks as a result of substandard living conditions.[65] These health risks in turn carry economic costs of their own, even as public revenue decline strains the resources of community programs and institutions that are expected to address these risks.

Again, we thank you for the opportunity to comment on the proposed rule, "Inadmissibility on Public Charge Grounds." We respectfully recommend that DHS withdraw the proposed rule in order to protect the health and well-being of immigrants and families, especially children.

Sincerely,

Richard E. Besser, MD
President and CEO

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[11] 83 Fed. Reg. 51114, 51180 (October 10, 2018).
[12] Id. at 51185-51186.
[13] Id. at 51182.
[14] Id. at 51200-51202.
[15] Id. at 51198-51199.
[16] Id. at 51199-51200.
[17] See Table 15, 83 Fed. Reg. at 51181.
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[19] Artiga, S., Garfield, R., & Damico, A. (2018, October 11). Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid. *Kaiser Family Foundation*. Available at *www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/.*
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[21] 83 Fed. Reg. 51114, 51266-51267.
[22] 83 Fed. Reg. at 51266
[23] Id.
[24] Id, citing Fix, M.E. & Passel, J.S. (1999, March 1). Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform. *Urban Institute*. Available at *www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform*, finding far greater declines in Medi-Cal and TANF enrollment among legal immigrants compared to citizens despite the fact that PRWORA did not change eligibility criteria for current beneficiaries. (Overall drop in welfare enrollment of 21 percent).
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