Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

October 22, 2021

VIA ELECTRONIC SUBMISSION

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

Attention: DHS Docket No. USCIS-2021-0013; Public Charge Ground of Inadmissibility

To Whom it May Concern:

Thank you for the opportunity to comment on DHS Docket No. USCIS-2021-0013, the advance notice of proposed rulemaking, "Public Charge Ground of Inadmissibility" (hereinafter referred to as "the ANPRM").

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for children and families. As part of the McCourt School of Public Policy, CCF provides research, develops strategies, and offers solutions to improve the health of children and families, particularly those with low and moderate incomes. In particular, CCF examines policy development and implementation efforts related to Medicaid, the Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA).

I. Summary

The vacated 2019 Final Rule, *Inadmissibility on Public Charge Grounds*, made sweeping and radical changes to longstanding public charge law and policy, and the impact is still being felt today. Though the rule only directly targeted lawfully residing immigrants wishing to adjust their immigration status and individuals living abroad wishing to legally immigrate to the U.S., the ripple effects of the 2019 Final Rule extended much further. Researchers at the Urban Institute have documented the "chilling effect" of the 2019 Final Rule, including in a June 2020 report which found that 1 in 5 adults in immigrant families with children

reported avoiding public benefits in 2019, even before the rule was implemented.[1] The chilling effect was the worst for low-income families with children (31.5%).[2] During the same period the number of uninsured children saw the largest increase in recent memory; in part due to avoidance of Medicaid and CHIP by eligible children, underscoring the harm.[3]

Given the harmful and widespread impact of the 2019 Final Rule, we believe that it is imperative that the Department of Homeland Security (DHS) issue a notice of proposed rulemaking outlining a fair and just public charge inadmissibility test soon. Doing so will allow the public to make meaningful comments on the rule that can inform a final rulemaking, which would give the public much needed certainty about the interpretation of these rules going forward. Once finalized, it will also be important for DHS to work in partnership with other federal agencies, state and local governments, and trusted community-based partners to inform the public about the rule changes.

While the 1999 Interim Field Guidance (Field Guidance) that is currently in effect imposes a public charge inadmissibility test that is more consistent with the statutory requirements and case law than the 2019 Final Rule, we believe it could be improved upon in two key ways:

- Creating a new definition: The Field Guidance defines a public charge as someone who is likely to become "primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense." We propose that DHS define a public charge as someone who is *"likely to become primarily and permanently reliant on the federal government to avoid destitution."* We believe that this new definition is more consistent with the statute and longstanding understanding of the purpose of the public charge inadmissibility test and that it would help DHS achieve its stated goal of making public charge determinations more predictable and less subject to variation in different cases presenting similar facts.

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[1] H. Bernstein, et al., "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018," (Washington, D.C.: Urban Institute, May 22, 2019), available at https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018.

[2] J.M. Haley, et al., "One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019," (Washington, D.C.: Urban Institute, June 18, 2020), available at https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019.

[3] J. Alker and A. Corcoran, "Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade (Washington, D.C.: Georgetown University Center for Children and Families, October 2020) available at https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.

- Excluding all Medicaid benefits: We believe that very few individuals who are subject to the public charge inadmissibility test are also eligible for and likely to use Medicaid (and other publicly funded) institutional care, which is included in the public charge inadmissibility test under the 1999 Field Guidance. Despite the institutional care policy directly impacting only a small portion of applicants, many families have avoided enrolling in Medicaid completely out of fear and confusion about how doing so may impact a future application for lawful permanent residency. Therefore, *excluding all Medicaid benefits from consideration in a public charge inadmissibility test would significantly advance DHS' stated goal to minimize confusion and uncertainty that could lead otherwise eligible individuals to forgo the receipt of public benefits without having a material impact on the public charge policy or federal Medicaid spending*.

These issues, along with responses to some of the specific questions posed by the ANPRM are addressed in more detail below. Please note that we are also signatories to the Protecting Immigrant Families and child-focused sign-on letters, which address other issues not addressed in this letter, such as the prospective nature of the test, the application of the statutory factors, and the relative weight of the affidavit of support.[4]

II. Detailed Comments

Purpose and Definition of Public Charge

- *How should DHS define the term "public charge"?*

DHS should define public charge as someone who is, "likely to become *primarily* and *permanently reliant* on the *federal government* to *avoid destitution*."

Many low- and moderate-income families rely on public benefits to supplement their earnings and make ends meet. If the 2019 Final Rule were applied to U.S.-born citizens, more than half would be considered a public charge based on benefit receipt.[5] By focusing instead on *primary* and *permanent* reliance, this definition is consistent with the statute, prior policy, and the historical understanding of public charge as applying to a narrow group of immigrants living in almshouses.

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[4] The Protecting Immigrant Families letter is available at https://protectingimmigrantfamilies.org/anprm-full-text/ and the child-focused letter is available at https://childrenthriveaction.org/2021/10/child-focused-comment-in-response-to-dhs-public-charge-anprm/.

[5] D. Trisi, "Trump Administration's Overbroad Public Charge Definition Could Deny Those Without Substantial Means a Chance to Come to or Stay in the U.S." (Washington, D.C.: Center on Budget and Policy Priorities, May 30, 2019), available at https://www.cbpp.org/research/poverty-and-inequality/trump-administrations-overbroad-public-charge-definition-could-deny.

Using supplemental benefits to improve access to nutrition, health care, and other services does not indicate someone is or is likely to become a public charge. In fact, benefit use such as Medicaid can help a family achieve greater health, educational, and financial outcomes in the future.[6] Moreover, most people who use public benefits do so only temporarily, for three years or less.[7] For many such families, benefit use indicates a transitional period (e.g., between jobs or between education/training and work), not a likelihood of becoming a public charge.

Additionally, the definition should focus on reliance on the *Federal government*, not state or local governments. This will lead to a more just public charge policy that can be applied uniformly across the country, rather than having different results based on where the applicant lives and which benefits were available. State and local governments have a compelling interest in promoting health and safety that includes providing benefits at their own expense without barriers caused by federal policies.

Finally, the definition should include only those applicants who primarily and permanently rely on the federal government to *avoid destitution*. Government programs form a "safety net," offering families needed support during difficult personal circumstances and situations outside of an individual's control such as economic downturns, natural disasters, or during a global pandemic. This safety net is an important part of our social compact, and relying on it does not indicate a person is or is likely to become a public charge.

- *How might DHS define the term "public charge", or otherwise draft its rule, so as to minimize confusion and uncertainty that could lead otherwise eligible individuals to forgo the receipt of public benefits?*

The chilling effect of the 2019 Final Rule is well-documented.[8] This has been attributed not only to the policies outlined in the rule itself, but the fact that the rule was overly complicated, making it difficult for applicants to understand the implications of benefit use and other decisions. For example, the Well-Being and Basic Needs Survey conducted by the

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[6] E. Park, et al., "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," (Washington, D.C.: The Commonwealth Fund, December 8, 2020), available at https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm.

[7] S.K. Irving, "How Long Do People Receive Assistance?", (Washington, D.C.: United States Census Bureau, May 28, 2015), available at https://www.census.gov/newsroom/blogs/random-samplings/2015/05/how-long-do-people-receive-assistance.html.

[8] R. Capps, et al., "Anticipated 'Chilling Effects' of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families," (Washington, D.C.: Migration Policy Institute, December 2020), available at https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

Urban Institute found that while two-thirds of adults in immigrant families were aware of the public charge rule and 65.5 percent were confident in their understanding of the rule, less than a quarter knew it did not apply to citizenship applications and less than 1 in 5 knew children's enrollment in Medicaid would not be considered in their parents' public charge determinations.[9] In fact, low-income U.S. citizen children with noncitizens in the household stopped participating in SNAP, Temporary Assistance for Needy Families (TANF), and Medicaid/CHIP at almost the same rate as noncitizens themselves over the 2016 to 2019 period.[10]

This mass confusion and uncertainty that led otherwise eligible individuals to forgo the receipt of public benefits can be avoided by: (1) outlining a clear definition of public charge that is consistent with longstanding public charge principles (such as the definition proposed above); (2) limiting any consideration of benefit use to recent use of TANF and Supplemental Security Income (SSI); and (3) clearly excluding use of state and local benefits, benefits used by family members, and benefits used by children. At the same time, to ensure public confidence using other programs and minimize the chilling effect, we recommend that DHS specifically identify and update a list of the programs that are <u>not</u> counted.

In addition to establishing a clear and consistent rule, DHS will also need to actively explain the rule to impacted communities in multiple languages. Adults in immigrant families are most likely to trust government agencies and legal professionals for information about how using public benefits will affect their or a family member's immigration status, so while this education component should be done in partnership with trusted community partners, it is important that DHS play an active role.[11]

- *What potentially disproportionate negative impacts on underserved communities (e.g., people of color, persons with disabilities) could arise from the definition of "public charge" and how could DHS avoid or mitigate them?*

The 2019 Final Rule effectively created an income test that would have excluded many applicants even if they did not use any public benefits. It also would have made it extremely difficult for applicants from poor countries to qualify, effectively preventing primarily non-White immigrants from South Asia, Sub-Saharan Africa, Latin America and the Caribbean

[9] H. Bernstein, et al., "Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019," (Washington, D.C.: Urban Institute, May 2020), available at https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf.
[10] R. Capps, Op. Cit. 8.
[11] H. Bernstein, Op. Cit. 9.

from gaining lawful permanent status. Meanwhile, applicants from predominantly White regions such as Western Europe and Australia would have had a much easier time passing the test.[12] Additionally, the 2019 Final Rule perpetuated discriminatory practices against people with disabilities by assuming that people with a wide range of medical conditions are more likely to be a public charge, contradicting decades of disability discrimination law.

DHS can avoid this racially disparate and discriminatory impact by advancing a policy that fully values the contributions made by immigrants and low wage workers to our society and economy, and allows individuals to overcome any factor indicating a possible future reliance on the government by the balance of the other factors, such as an affidavit of support.

Public Benefits Considered

- *Should DHS consider the receipt of public benefits (past and/or current) in the public charge inadmissibility determination? If yes, how should DHS consider the receipt of public benefits and why?*

DHS should only consider the receipt of two, federally-funded cash assistance benefits in the public charge inadmissibility determination: TANF and SSI. Importantly, such consideration should be limited to a recent lookback period, such as in the two or three years prior to adjudication. We believe that by focusing on two benefits over a short time period, DHS will be able to make more consistent public charge determinations that more accurately reflect the applicant's ability to contribute to U.S. society. Additionally, even if an applicant has used TANF or SSI in the past two or three years, use of these benefits does not automatically make them a public charge as DHS must still consider the totality of the circumstances. For example, use of TANF while completing a training program to gain more lucrative employment down the road does not indicate a likelihood of primary and permanent dependence on the federal government. Instead, it indicates a high likelihood to be a productive member of society long-term.

Unlike the five factors at section 212(a)(4) of the INA, there is no statutory directive for DHS to consider benefit use at all. In addition, there is ample evidence for DHS to reasonably conclude that Medicaid (and other publicly funded) institutional care should not be considered.

- *Which public benefits should be considered as part of a public charge inadmissibility determination?*

[12] D. Trisi, Op. Cit. 5.

Receipt of health care, nutrition or housing assistance is not an indication that a person is primarily or permanently reliant on the federal government. In fact, access to SNAP, health insurance, housing, and other benefits lead to better health that translates to improved educational outcomes and long-term economic security that benefit society as a whole.[13] Therefore, as mentioned above the consideration of past benefit use should be limited to two federal cash assistance programs: TANF and SSI. Limiting the past or current benefit use inquiry to TANF and SSI would help reduce the chilling effect of the public charge test on participation in other public benefit programs while still allowing DHS to consider benefit use as one part of the public charge inadmissibility determination.

DHS should make clear that past receipt of TANF and SSI is only one small part of the totality of circumstances test and that other factors and circumstances can be used to overcome any issue. For example, people with disabilities who receive SSI may also be part of the workforce and cannot be excluded based on SSI use alone.

- *Which public benefits, if any, should not be considered as part of a public charge inadmissibility determination?*

DHS should exclude all Medicaid and institutional benefits from the public charge policy. Under the Field Guidance, DHS currently excludes all health care programs except "[p]rograms (including Medicaid) supporting aliens who are institutionalized for long-term care." This policy leads to confusion and serious harms for children and families that forgo health care. At the same time, the policy has negligible value – it applies rarely and saves minimal spending.[14] *Cost-benefit analysis of the evidence strongly favors eliminating the application of public charge to all Medicaid and institutional care, and there is no statutory barrier to doing so.*

Although an inconsequential number of immigrants subject to the public charge rule actually use Medicaid institutional benefits, countless individuals forgo Medicaid coverage out of fear that they or a family member will be negatively impacted in their immigration

[13] S. Carlson, et al., "SNAP Works for America's Children," (Washington, D.C.: Center on Budget and Policy Priorities, September 29, 2016), available at https://www.cbpp.org/research/food-assistance/snap-works-for-americas-children; D. Murphey, "Health Insurance Coverage Improves Child Well-Being," (Bethesda, MD: Child Trends, May 2017), available at http://www.childtrends.org/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf; and A. Sherman and T. Mitchell, "Economic Security Programs Help Low-Income Children Succeed Over Long Term, Many Studies Find," (Washington, D.C.: Center on Budget and Policy Priorities, July 17, 2017), available at https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-help-low-income-children-succeed-over.

[14] R. Capps, et al., "The Public-Charge Rule: Broad Impacts, But Few Will Be Denied Green Cards Based on Actual Benefits Use," (Washington, D.C.: Migration Policy Institute, March 2020), available at https://www.migrationpolicy.org/news/public-charge-denial-green-cards-benefits-use.

processes.[15] Some individuals may avoid a wide range of specific services, but even more individuals and families will avoid enrolling in Medicaid completely. This means they are much less likely to have preventive, chronic, specialty, or acute care, or access to prescriptions drugs and other services, which is associated with worse health outcomes and lower quality of life.[16] Forgoing Medicaid also results in financial harms.[17] Individuals may also avoid state-funded health care programs due to the same fears about the institutional services policy, and as a result, experience the same health and financial harms.

This is particularly true because "institutional long-term care" services is a complicated term that consumers do not understand. This is likely especially true when they have limited English proficiency. Moreover, the term "long-term care" itself, even properly understood, is "hard to define precisely."[18] It is often difficult to draw the line between a short-term rehabilitation service and "long-term care." This makes it difficult to characterize services received, and even more difficult for consumers to label *prior* to services, when treating clinicians may be unsure of what the recovery process and period may look like. Considering how many simple health conditions have "rehabilitative" recovery treatments that could be confused by laypeople as long-term care "rehabilitation" (for example, a simple sprained ankle may involve "rehabilitation" treatments), and how technical and blurry the actual definitions are, it is nearly impossible for consumers to navigate this policy. In the face of uncertainty, many consumers understandably avoid the risk of seeking care.

In contrast, if DHS excluded Medicaid, DHS and other public stakeholders could definitively state that, "Medicaid never results in a public charge problem." Such a message is simple, clear, and would allow people to feel safe accessing Medicaid. If DHS excluded Medicaid *and* other institutional care, the messaging would be even simpler: "All health care programs are safe for public charge purposes." This would include at least Medicaid; CHIP; the Affordable Care Act's marketplace health coverage and related premium tax credits and cost-sharing reductions; public assistance for immunizations and for testing and treatment of symptoms of communicable diseases; use of health clinics; home and community-based care; and emergency medical services. Such a message could result in the minimum

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[15] H. Bernstein, Op. Cit. 9.
[16] B.D. Sommers, et al., "Health Insurance Coverage and Health—What the Recent Evidence Tells Us," 377 N. Eng. J. Med. 586 (2017), available at http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.
[17] A. Sojourner and E. Golberstein, "Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction," Health Affairs Blog (July 24, 2017), available at https://www.healthaffairs.org/do/10.1377/hblog20170724.061160/full/.
[18] P.H. Feldman and R.L. Kane, "Strengthening Research to Improve the Practice and Management of Long-Term Care," Milbank Quarterly 81(2): 179–220 (June 2003), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690214.

possible number of individuals forgoing care. As such, we recommend that DHS exclude Medicaid and institutional care from the public charge definition.

DHS should also exclude Medicaid institutional care from public charge consideration because the need for institutional care is subject to significant variation from state to state based upon the availability of home and community-based support alternatives. Medicaid is administered by states, and states have developed very different supports that prevent or obviate institutional care.[19] State-funded programming also varies wildly. As a result, the institutional public charge standard applies to individuals arbitrarily based on the state they happen to live in.

The standard is also difficult to administer, because an immigration official would not have a meaningful way to evaluate likelihood of institutionalization without knowledge of the specific state in question. This will likely lead to inconsistent application of the policy. It is also tough to administer because it is an overbroad criterion. As life expectancy in the U.S. increases, a growing proportion (and number) of individuals will need to access institutional care. Estimates are that "70% of adults who survive to age 65 develop severe [long-term services and supports] needs before they die."[20] The National Institute on Aging has noted that "[i]t is difficult to predict how much or what type of long-term care a person might need."[21] For these reasons, the inclusion of an institutionalization test could sweep in almost anyone. Considering the high rate of institutionalization for the full U.S. population, and that Medicaid pays for about six in ten nursing home residents, DHS should eliminate the institutionalization policy.[22] These individuals are not public charges – they are going through extremely common stages of life and health.

We also believe this policy is discriminatory in concept and in practice. Only a few months after the release of the Field Guidance, the U.S. Supreme Court ruled that the segregation of people with disabilities in institutional care is discriminatory and violates the Americans with Disabilities Act.[23] The reality is that a significant number of individuals in institutional care – if not a majority – are individuals with disabilities that are discriminatorily only offered institutional care. Codifying the public charge institutional standard would be compounding that health care discrimination by adding a layer of immigration

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[19] M.B. Musumeci, et al., "Key State Policy Choices About Medicaid Home and Community-Based Services," (Washington, D.C.: Kaiser Family Foundation, February 2020), available at https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-based-services-issue-brief.
[20] R.W. Johnson, Office of the Assistant Secretary for Planning and Evaluation (April 2019), available at https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0.
[21] National Institute on Aging, "What Is Long-Term Care?" (May 2017), available at https://www.nia.nih.gov/health/what-long-term-care.
[22] Kaiser Family Foundation, Medicaid's Role in Nursing Home Care, June 2017, available at: https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.
[23] Olmstead v. L.C., 527 U.S. 581 (1999).

discrimination. That is, if individuals have a disability, they are more likely to only be offered health care in an institution, and that in turn, means they are less likely to be allowed to adjust their status. We also believe that, in practice, an institutionalization policy leads to immigration officials making assumptions about the likelihood of institutionalization simply based on the existence of a disability.

Finally, there is no statutory mandate to include use of Medicaid or institutional care in the public charge determination. Based on all of the evidence that considering Medicaid or institutional care is very harmful to health coverage and health equity, and leads to negligible benefits or savings, the most reasonable interpretation of the statute is to fully exclude Medicaid and institutional care.

For clarity, we recommend that for the purpose of the public charge determination, HHS only consider two specific, *federal* programs (SSI and TANF) that provide cash assistance for income maintenance.

- *How should DHS address the possibility that individuals who are eligible for public benefits, including U.S. citizen relatives of noncitizens, would forgo the receipt of those benefits as a result of DHS's consideration of certain public benefits in the public charge inadmissibility determination? What data or information should DHS consider about the direct and indirect effects of past public charge policies in this regard?*

Limiting consideration of public benefits to only TANF and SSI in the most recent two- to three-year period, and making clear that such benefit use may be overcome by other factors, will help reduce the confusion surrounding the public charge inadmissibility test and the related chilling effects. Additionally, DHS should clearly explain in plain language what will <u>not</u> be considered, including every other federal benefit and all state/local benefits, plus benefits used by: the applicant's family members, children and youth under age 21, survivors of domestic violence and other serious crimes, individuals with an exempt status, and anyone during a natural disaster or public health emergency. These public-facing educational materials should be developed in consultation with community-based organizations who can test the messages for readability and provide feedback prior to final publication.

With respect to benefits used by children and youth under age 21, DHS should bear in mind that children do not make decisions about whether they receive public benefits, and they should not be penalized for being enrolled in benefits for which they are eligible. Moreover, as articulated earlier, benefit use during childhood and adolescence is not predictive of future likelihood of becoming a public charge. In fact, benefit use during childhood leads to better health, educational, and economic outcomes in adulthood.

III. Conclusion

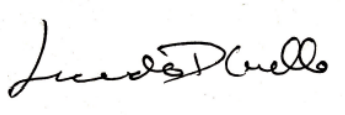
DHS should define a public charge as someone who is "*likely to become primarily and permanently reliant on the federal government to avoid destitution.*" This definition will be easier to administer and produce more consistent results. DHS may consider past use of benefits when making a public charge inadmissibility decision, but such consideration should be limited to TANF and SSI in the two- to three-year period prior to adjudication. Even if an applicant has used TANF or SSI in the recent past, such use should not be dispositive – other factors in the totality of circumstances test can overcome benefit use.

Importantly, DHS should exclude Medicaid (and other publicly funded) institutionalization. By including institutionalization for long-term care, the current definition creates mass confusion about how use of Medicaid benefits will be considered, despite the fact that very few immigrants subject to public charge are eligible for such services. It also has a discriminatory impact on older people and people with disabilities. Having a simple rule that excludes all Medicaid benefits and institutionalization will make it much easier for applicants to understand the rule without materially impacting the number of people excluded based on public charge grounds or federal spending.

Finally, it is critical that DHS issue a notice of proposed rulemaking outlining parameters for the public charge inadmissibility test that is consistent with the statute and longstanding policy soon. After such issuance and consideration of public comments received, DHS should move forward with a final rule as quickly as possible. The past several years of debate about public charge rules – from a leaked draft to a proposed rule to a final rule eventually vacated by the courts – have left immigrant families confused and afraid. Rebuilding that trust will take years, but it must begin with a new, final rule that is easily understood and consistently and justly applied.

If you have questions regarding our comments, you may contact Leo Cuello at leo.cuello@georgetown.edu or Kelly Whitener at kelly.whitener@georgetown.edu.

Sincerely,



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