Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

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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 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) promptly issue regulations implementing a rational and just public charge inadmissibility standard. The 2019 Final Rule was unlawful, unreasonable, and ignored voluminous evidence that the proposed policy would be harmful, and DHS should return to a regulatory framework grounded in the statutory framework and sound health policy. 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 and provide certainty about how public charge will be interpreted.

Specifically, we believe numerous provisions of the NPRM are faithful to the statute and supported by extensive policy evidence. The proposed definition of public charge is consistent with long established public charge policy and law, and is supported by policy evidence regarding immigrant communities. Likewise, applying the standard only to the beneficiaries of a limited set of income maintenance programs matches the legislative intent of the policy and is consistent with evidence about public policy and immigrant and mixed-status families.

While the 1999 Interim Field Guidance (Field Guidance) that is currently in effect and this NPRM both adopt a public charge inadmissibility test that, unlike the 2019 Final Rule, is generally consistent with the statutory requirements and policy evidence, we believe the policy could be improved in full consideration of the policy evidence in several key ways, *most notably by completely excluding Medicaid from consideration*. As discussed below, excluding all Medicaid benefits 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

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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.

Medicaid spending. This and other recommendations to improve the NPRM are discussed 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.

II. Detailed Comments

DHS should finalize the NPRM (with some improvements), as it is a significant improvement over the 2019 final rule.

The chilling effect of the 2019 Final Rule is well-documented. From 2016 to 2019, while the 2019 final rule policy was debated, proposed, and implemented, participation in TANF, SNAP, and Medicaid "fell about twice as fast among U.S.-citizen children with noncitizen household members as it did among children with only citizens in their households."[4] 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 from 2016 to 2019.[5] 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 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.[6]

Furthermore, 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 from gaining lawful permanent status. Meanwhile, applicants

[4] 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.

[5] *Id.*

[6] 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.

from predominantly White regions such as Western Europe and Australia would have had a much easier time passing the test.[7] 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.

Ultimately, the policies implemented in the 2019 final rule were inconsistent with policy evidence about public benefits use by immigrants, including the bulk of the extensive data that was shared with DHS in the rulemaking process. In addition, the 2019 rule was a radical departure from the established public charge doctrine developed by agencies, courts, and the legislature over the past century. In contrast, the new NPRM is broadly consistent with policy evidence about immigrant use of public benefits and the historical legal framework for public charge. While the NPRM policies could be improved, per some of our recommendations below, we recommend DHS finalize the NPRM in replacement of the 2019 rule.

DHS should implement the proposed definition of public charge requiring primary dependence on the government for subsistence.

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 at some point based on benefit receipt.[8] By focusing instead on *primary* reliance for the purpose of *subsistence*, the NPRM 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.

Even among nondisabled adult enrollees in Medicaid – who tend to have the lowest income eligibility thresholds – the vast majority of enrollees (79%) are in working households.[9] This is not surprising: the health care services that families receive cannot be converted into the income needed to pay rent, utilities, childcare, transportation costs, purchase clothing, etc. The large numbers of working Medicaid enrollees use public insurance because they disproportionately work in low-wage industries with low employer

[7] 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.
[8] *Id*.
[9] Rachel Garfield, et al., "Understanding the Intersection of Medicaid and Work," (Washington, DC: Kaiser Family Foundation, January 2018), https://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

sponsored coverage rates.[10] Therefore, such "supplemental benefits" are a poor proxy for identifying a public charge. Furthermore, even benefits that *do* provide income maintenance, should carefully be evaluated – many individuals receive only nominal amounts that supplement work earnings. Receipt of benefits alone is not dispositive; only support that shows primary dependence for subsistence might identify a public charge.

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 for another reason as well: Benefit use such as Medicaid can help a family achieve greater health, educational, and financial outcomes in the future.[11] Moreover, most people who use public benefits do so only temporarily, for three years or less.[12] For many such families, benefit use indicates a transitional period (e.g., between jobs or between education/training and work) that may in fact *increase* government tax revenues in the near term, not a likelihood of being or becoming a public charge.

In punishing low income or any use of supplemental benefits, the 2019 final rule was discriminatory and disproportionately impacted low wage workers and their families. The NPRM reduces 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. It is critical that DHS finalize a public charge policy that supports the working families that are the backbone of U.S. communities, business, and the economy.

Finally, DHS should clearly explain and publicize in plain language the public charge policy, including what will not be considered in public charge determinations. 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.

DHS should only consider the current receipt of TANF and SSI for public charge determinations.

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[10] *Id*.

[11] 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.

[12] 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.

DHS should only consider the current receipt of two, federally-funded cash assistance benefits in the public charge inadmissibility determination: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). DHS should only consider current use of benefits and should not count past benefit use, which is not predictive of the likelihood of becoming a public charge. This is particularly true for past benefit use as a child, which should never be counted. Counting past benefit use as a child is of no value to identifying public charges and would put parents in the distressing position of choosing between the health and immigration status of their child.

We believe that by focusing on current use of two benefits, 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 is currently using TANF or SSI, use of these benefits does not automatically make them a public charge as DHS should 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.

Receipt of health care, nutrition, or housing assistance is not an indication that a person is primarily reliant on the federal government for subsistence. 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 benefit use should be limited to two federal cash assistance programs: TANF and SSI. Limiting the 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 completely exclude Medicaid (and other institutional care) from consideration in public charge determinations

The NPRM reinstates the policy of the 1999 field guidance, only considering Medicaid institutional benefits for public charge determinations. This is a critical improvement to the

[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.

2019 Rule policy which, despite voluminous evidence against the policy, allowed a wider set of Medicaid benefits to be considered. This policy had immediate and devastating impacts on health care, harming a large population of immigrants going well beyond the individuals and services that should even have been subject to the rule.

As noted above, non-institutional Medicaid has no connection to income maintenance and is a poor proxy for identifying public charges.[14] Such a supplemental benefit, which (together with CHIP) covers about 50% of all U.S. children, would also be incredibly overbroad for determining which children are a public charge.[15] In fact, there is evidence that enrolling Medicaid for children has many long-term benefits including improved education outcomes and benefits to the economy.[16] At the same time, considering non-institutional Medicaid for public charge purposes leads to great harms, as many individuals will refuse to seek coverage or care.[17] It is therefore critical that DHS preserve the policy that non-institutional Medicaid is not considered for public charge determinations.

While we commend that the NPRM corrects the harmful policy of the 2019 rule to count noninstitutional Medicaid, the NPRM continues to count long-term institutional Medicaid for public charge determinations. *This ignores the clear practical and public health reasons to fully exclude Medicaid from consideration*. Practically, the policy is of little relevance or cost. The number of immigrants eligible for Medicaid institutional benefits, *and* subject to public charge exclusion, *and* opting to choose institutional as opposed to community-based care is very, very low. Public charge rarely applies and saves minimal spending.[18]

Meanwhile, the public confusion created because "sometimes Medicaid counts" leads to great harms. Although an inconsequential number of immigrants subject to the public charge rule actually use Medicaid institutional benefits, countless individuals forgo *any*

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[14] R. Garfield, Op. Cit. 9.
[15] Joan Aker, et al., "Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured," (Washington D.C.: Georgetown University Center for Children and Families, February 2022), available at https://ccf.georgetown.edu/wp-content/uploads/2022/02/Kids-PHE-FINAL-2-17.pdf.
[16] Edwin Park, et al., "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," (New York, N.Y.: Commonwealth Fund, December 2020), available at https://www.commonwealthfund.org/sites/default/files/2020-12/Park_Medicaid_short_term_cuts_long-term-effects_ib_v2.pdf; "Julia Paradise, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," (Washington, D.C.: Kaiser Family Foundation, March 23, 2017), available at https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/; Raj Chetty, et al., "New Evidence on the Long-Term Impacts of Tax Credits," (Internal Revenue Service Statistics of Income, November 2011), available at https://www.irs.gov/pub/irs-soi/11rpchettyfriedmanrockoff.pdf
[17] R. Capps, Op. Cit. 4.
[18] 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.

Medicaid coverage out of fear that they or a family member will be negatively impacted in their immigration processes.[19] Some individuals may avoid a wide range of specific services, but even more individuals and families will avoid enrolling in Medicaid entirely. 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.[20] Forgoing Medicaid also results in financial harms.[21] 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.

Additionally, most consumers do not understand exactly what "institutional" care means, much less the nuances of institutional care versus short-term rehabilitative care versus community-based care, etc. This is all the more challenging for many immigrants who are limited English proficient. The term "long-term care" itself, even properly understood, is "hard to define precisely."[22] 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. Even if an exception for short-term rehabilitative care exists, 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, then DHS, providers, 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 improve immigrant access to Medicaid; CHIP; the Affordable Care Act's marketplace health coverage and related premium tax credits and cost-sharing reductions; public assistance for

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[19] H. Bernstein, Op. Cit. 6.
[20] 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.
[21] 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/.
[22] 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.

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 possible number of individuals forgoing care.

This is especially important for children who reside in mixed-status families. The uninsurance rate for Latino children grew more than twice as fast as the rate for non-Latino children from 2016 to 2019.[23] This was true despite the fact that 95% of Latino children are citizens and not subject to public charge exclusion.[24] Public charge policy, if connected in any way with Medicaid and other health care programs, leads to concrete and measurable chilling effects.[25] As such, we recommend that DHS exclude Medicaid and other 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. Medicaid is administered by states, and states have developed very different supports that prevent or obviate institutional care.[26] 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 long-term institutionalization without knowledge of the specific state in question. This will likely lead to inconsistent application of the policy. It is also 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."[27] 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."[28] 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

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[23] K. Whitener, "Getting Back on Track: A Detailed Look at Health Coverage Trends for Latino Children," (Washington, D.C.: Georgetown University Center for Children and Families, June 8, 2021), available at https://ccf.georgetown.edu/2021/06/08/health-coverage-trends-for-latino-children.
[24] *Id*.
[25] R. Capps, Op. Cit. 4.
[26] 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.
[27] 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.
[28] National Institute on Aging, "What Is Long-Term Care?" (May 2017), available at https://www.nia.nih.gov/health/what-long-term-care.

institutionalization policy.[29] These individuals are not public charges – they are going through extremely common stages of life and health and function.

We also believe this policy will be discriminatory 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.[30] A significant number of individuals in institutional care are individuals with disabilities that have no alternative to institutional care. Codifying the public charge institutional standard would be compounding that health care discrimination by adding a layer of immigration discrimination. That is, if individuals have a disabling condition, 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. While we commend and support the creation of an exception in the NPRM for individuals institutionalized in violation of federal law, only a miniscule fraction of the individuals wrongly institutionalized would be able to prove a violation of federal law and it is not clear what evidence they could produce nor how officers could asses it.

Ultimately, 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 and 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.

If, against our recommendation, DHS decides to retain the proposal to count institutional Medicaid, then we believe it is particularly important to maintain other features of the proposed rule:

- **We support the change of the definition language to "long-term institutionalization at government expense."** This should help reduce confusion about when accessing long-term services and supports (LTSS) impacts public charge determinations.
- **We support the specific inclusion of language excepting "short periods for rehabilitation purposes."** This too will help avoid overbroad public charge exclusions. We also support specifying that imprisonment is excepted.
- **We support the inclusion of an exception for "institutionalization that violates federal law."**

[29] 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.
[30] Olmstead v. L.C., 527 U.S. 581 (1999).

We also support the specific provision that disability alone is not sufficient to determine whether an individual is likely to become a public charge. This provision should be included in the final regulation regardless of whether or not the final rules allow institutional Medicaid to be considered in public charge determinations.

DHS should only consider federal programs in public charge determinations.

The public charge test should focus only on reliance on the *Federal* government, not state or other 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. In the preamble to the NPRM, DHS suggests that public charge policy may protect states and other units of government from unwanted costs. In fact, however, states and other localities are harmed by a broad public charge policy. Local governments can easily control their own programmatic eligibility requirements to determine who should be eligible and how they spend money, but they face great difficulty administering public benefits to immigrants and mixed-status families fearful of the immigration consequences to accessing state benefits. Many localities *intentionally* provide benefits to immigrants, particularly immigrant children, because they realize it is a valuable investment for the well-being and prosperity of their locality. A public charge policy that includes local programs does not help these localities – it subverts their ability to advance their own interests.

In addition, it is burdensome for officers to administer a standard that considers state and other local program use. There is no way that officers can quantify, contextualize, and interpret all of the different public benefits programs administered in every state, county, and local government unit. Officers will simply have to guess as to the significance of an individual's particular benefit use. This too will lead to inconsistent outcomes. Two individuals using the same county program may get very different outcomes if assessed by different officers. In contrast, all officers can reasonably be expected (or if necessary, trained) to properly evaluate use of TANF and SSI, the two largest and most well-known income maintenance programs, both of which are uniformly available in all parts of the United States. Finally, as DHS itself notes in the preamble to the NPRM, over the course of history these federal programs have been implemented and grown to now have an outsized role in providing income maintenance in the United States; state and local programs are now smaller in size and scope.

DHS should retain the "Totality of the Circumstances" standard, but improve it for children.

We support the NPRM's proposal that public charge determinations be based on the totality of the circumstances, including consideration of the statutory factors. The NPRM standard is far superior to the approach in the 2019 final rule, which created burdensome documentation requirements for families and social services agencies and which was burdensome for officers and agencies to administer. DHS should retain the proposed standard.

While we are generally supportive of the "totality of the circumstances" framework proposed in the NPRM, we recommend that DHS set out an additional criterion for applying this standard to children. In the preamble to the NPRM, DHS notes that it "remains particularly concerned about the potential effects of public charge policy on children," but cannot apply an "exemption" or "exclude from consideration any of the congressionally established statutory minimum factors." To be clear, our recommendation is not that DHS *ignore* the statutory factor of age; we recommend that DHS *interpret* the statutory factor of age. DHS should develop a presumption that children cannot be a public charge, barring compelling evidence to the contrary. (DHS should also require this to be documented in § 212.22(c), as per our recommendation below.) DHS should implement this policy in light of the following considerations, among others:

- **Children are far more likely than adults to be enrolled in TANF.** More than half of TANF households (52%) include *only* children and 77% of total enrollees are children.[31] There is dangerous potential for immigrant children to be disproportionately impacted by a public charge policy that does not compensate for the fact that children are simply more likely to be eligible for some benefits. In particular, the policy would primarily target Latino and black children, who make up more than 65% of the TANF child population.[32]

- **Use of benefits by a child does not indicate their likelihood to be a future public charge.** Children are more likely than adults to live in poverty, so the impacts will be overbroad for children. [33] But even for children who spend a year or more living in poverty, the large majority graduate from high school and they are

[31] Administration for Children and Families, "Temporary Assistance for Needy Families (TANF) Caseload Data – Fiscal Year (FY) 2021," (December 20, 2021), available at https://www.acf.hhs.gov/sites/default/files/documents/ofa/fy2021_tanf_caseload.pdf.
[32] Administration for Children and Families, "Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2020," (November 1, 2021), available at https://www.acf.hhs.gov/ofa/data/characteristics-and-financial-circumstances-tanf-recipients-fiscal-year-2020.
[33] Caroline Ratcliffe, "Child Poverty and Adult Success," (Washington, DC: Urban Institute, September 2015, https://www.urban.org/sites/default/files/publication/65766/2000369-Child-Poverty-and-Adult-Success.pdf.

more likely than not to be working as young adults.[34] When poverty is controlled for, the race and ethnicity of children is largely unrelated to adult outcomes.[35] In fact, research has found that the children of immigrant fathers have had consistently (historically and through the present) higher upward income mobility than those of similarly situated U.S. born fathers – despite dramatic shifts in the countries immigrants have arrived from over the last century.[36] At the same time, benefit use by children in fact leads to increased income throughout their lifetimes and benefits the economy.[37]

- **Children are not accountable for their presence in the United States nor any application for public benefits on their behalf.** Children should not be held accountable as public charges since they are generally not responsible for immigrating to the United States or being enrolled in benefits.

There is no legal impediment to DHS providing further criteria to officers about how to interpret the statutory factor of age based on these considerations. Addressing the overrepresentation and irrelevance of child benefit use to public charge determinations through a presumption against determinations that children are a public charge (or some other similar heightened standard) is in fact, based on evidentiary data, the most reasonable interpretation of the statutory factors. Such a standard is most appropriate in regulation (as opposed to subregulatory guidance), since it would be a substantive change and will have a binding effect. If DHS chooses not to implement this standard in regulation, the agency should include it in future guidance—though that would leave children in a more precarious position.

DHS should implement the proposal to require detailed written denial decisions considering all factors, and strengthen or conform the requirement for children.

We strongly support the NPRM's requirement for written denial decisions that "reflect consideration of each of the [required] factors" and "specifically articulate the reasons for the officer's determination." The similar and long-standing requirement in the 1999 field guidance, which was altered in the 2019 final rule with no reasonable explanation and in conflict with § 8 C.F.R. 103.3(a)(1)(i), should be reinstated. Such a policy is critical to the

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[34] *Id*.
[35] *Id*.
[36] Ran Abramitzky et al., "Intergenerational Mobility of Immigrants in the U.S. Over Two Centuries," National Bureau of Economic Research Working Paper Series, October 2019, https://www.nber.org/papers/w26408.
[37] E. Park, Op. Cit. 16.
National Academies of Sciences, Engineering, and Medicine Consensus Study Report, "A Roadmap to Reducing Child Poverty," (2019), https://nap.nationalacademies.org/catalog/25246/a-roadmap-to-reducing-child-poverty.

equitable implementation of the public charge standard, because evidence shows that accuracy increases when evaluators are accountable.[38] This policy will make officers less likely to make erroneous decisions rooted in implicit bias *and* will create written records that allow DHS to investigate patterns of bias, intentional or not. DHS must take this step to help counteract the legacy of racism, xenophobia, and other forms of discrimination in the U.S. immigration system.

We recommend that DHS improve this policy by conforming it to our recommendation above that DHS apply a heightened standard for a finding that a child is a public charge. DHS could accomplish this by specifically referencing the standard for children in the regulation or otherwise clarifying in the preamble to the final rule that "consideration of each of the factors" in § 212.22(a) includes consideration of and "specifically articulating" reasoning applying the heightened standard for children.

DHS should finalize the proposal to define receipt of benefits to only include the named beneficiary of benefits.

Over six million U.S. citizen children lived in mixed-status families.[39] Many other mixed-status families include immigrant children or other family members who are eligible for benefits. For families like these, it is essential that immigrant parents (or other family members) feel safe applying for benefits for their children or relatives. As noted earlier, the 2019 final rule was associated with sharp declines in participation in TANF, SNAP, and Medicaid for U.S.-citizen children in mixed status families, relative to families with only citizens.[40] We strongly support the proposed policies in the NPRM which reflect more careful consideration of the evidence about U.S. family composition and will help mitigate the harm caused by the 2019 rule.

Specifically, we strongly support the definition of receipt of benefits to include only those where the individual is "listed as a beneficiary," and exclude "receipt of public benefits solely on behalf of another individual." We likewise support the clarification that assistance with the application process does not constitute receipt of benefits. These policies will make parents (and other family members) feel safe in applying for benefits for their children or relatives and will help mitigate the chilling effects of the 2019 final rule.

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[38] Neal P. Mero, et al., "Effects of Rater Accountability on the Accuracy and the Favorability of Performance Ratings," Journal of Applied Psychology 80(4): 517-524 (1995), available at https://info.catme.org/wp-content/uploads/Mero-accountability.pdf.
[39] National Immigration Forum, "Fact Sheet: Mixed Status Families and COVID-19 Economic Relief," (August 12, 2020), available at https://immigrationforum.org/article/mixed-status-families-and-covid-19-economic-relief.
[40] R. Capps, Op. Cit. 4.

We also support the NPRM excluding from the definition of "receipt of benefits" situations where an individual has only applied for benefits or has been approved for future receipt, but has not actually received benefits.

III. Conclusion

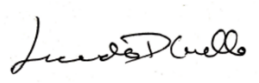
The 2019 final rule was a radical departure from the history of public charge policy that contradicted well-established health policy evidence and led to great harms for many families, including immigrants and citizens. In addition, the 2019 policy was difficult to administer and burdensome for officers and families, and discriminatory in design and impact.

DHS's new NPRM corrects these flaws and is consistent with the history, statute, and evidence on public charge. The NPRM help reverse the terrible chilling effect caused by the 2019 rule. We urge DHS to finalize the NPRM, subject to several evidence-based improvements that we have recommended. In particular, we urge DHS to completely exclude Medicaid from consideration, as there is almost no benefit to including Medicaid while it leads great confusion and harms for children and families.

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.[41]

If you have questions regarding our comments, you may contact Leo Cuello at leo.cuello@georgetown.edu.

Sincerely,



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[41] H. Bernstein, Op. Cit. 6.