December 10, 2018

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Chief, Regulatory Coordination Division
Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Re: DHS Docket No. USCIS-2010-0012

To Whom It May Concern:

We are writing on behalf of the Chronic Illness and Disability Partnership, a coalition of national organizations representing older adults and people living with a wide range of chronic illnesses and disabilities, including cancer, cystic fibrosis, diabetes, HIV, Hepatitis B and C, multiple sclerosis, and mental health and substance use disorders. We represent the 117 million Americans estimated to be living with a chronic illness and/or disability and the 48 million older Americans, many of whom rely upon public benefits to obtain health care services, nutrition, and housing needed to live healthy, productive lives. While our organizations are national in scope, we also affiliate with strong regional, state, and community-based advocacy networks.

We appreciate the opportunity to provide comments to the proposed rule, *Inadmissibility on Public Charge Grounds*, issued by the Department of Homeland Security (DHS). The public charge definition and application has historically been limited, particularly with regard to public health and healthcare programs. We are concerned that the proposal to expand the public programs and circumstances that will be will be negatively weighed in a public charge inquiry will harm vulnerable populations, including older adults and people living with chronic illness or disabilities, and have disastrous individual and public health consequences. Moreover, the proposal and the language used to justify this policy shift is an affront to the dignity of millions of immigrants in this country and is already having a chilling effect on immigrants' ability to access vital health and other services for which they are eligible. The proposed public charge policy, if enacted, will have a sweeping negative impact on access to vital health services across all immigrant categories, not just those directly implicated in the rule. It is well-documented

that access to public benefits and services are critical to ensuring that immigrants are successful in this country. This proposal negatively weighs factors such as language skills, education, age, and health status based on nefarious assumptions about which immigrants are more likely to be self-sufficient members of their communities, and penalizes use of services that support upward mobility and self-sufficiency. The proposed rule would cause serious harm to immigrants and their families, localities, states, and health care providers and facilities, and DHS provides no justification for why changes are needed. We urge DHS to consider the recommendations and comments detailed below and rescind the proposed rule in its entirety.

The New Definition of Public Charge is Overly Broad and Unworkable

The proposed rule greatly expands the definition of public charge, from the current limited test of whether an immigrant is likely to become "primarily dependent" on government resources to a far more expansive inquiry into whether an immigrant has received, is receiving, or is likely to receive public benefits, broadly defined. The proposed rule abandons the enduring meaning of a public charge as a person who depends on the government for subsistence, changing it to anyone who simply receives assistance with health care, nutrition, or housing. This shift drastically increases the scope of who can be considered a public charge to include not only people who receive benefits as the main source of support, but also older adults who use basic needs programs to supplement their savings or fixed incomes during retirement, and people with chronic illnesses or disabilities who depend on public programs for management of symptoms and overall long-term wellness. Although the proposed rule acknowledges that a public charge determination is supposed to be prospective, the proposed criteria used to determine whether or not an applicant will become a public charge are actually retrospective; the broad discretion given to immigration officials to deny green card applications of individuals "likely" to use public benefits in the future means many applicants face the risk of being denied because of demographic and socioeconomic characteristics that the rule considers signs of likely future benefit use.[1] This expansion is a departure from existing policy and creates an unworkable, overly broad definition that will be impossible to implement fairly. Experts estimate that under the new definition, 94% of all noncitizens who entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination under the proposed rule.[2]

Discouraging Use of Public Benefits Harms All Immigrant Families and Their Communities

The fear created by this proposed rule would extend far beyond individuals who are subject to the public charge test; it will also harm immigrants who are not subject to the public charge test, as well as their families and communities. The widespread "chilling effect" that causes families to withdraw from benefits—benefits for which they are lawfully eligible, and which they pay for with their tax dollars—due to fear is already evident as a result of rumors of the rule. Even though the rule is not final, immigrant families have already begun to disenroll from

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[1] Randy Caps et al., *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration, Migration Policy Institute* (Nov. 2018), https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration.

[2] Kaiser Family Foundation, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid* (Oct. 11, 2018), https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/.

public programs, forgoing vital health, nutrition, and housing assistance, for fear that using these services will lead to adverse immigration-related outcomes for themselves and their families. Community providers have already reported changes in health care use, including decreased participation in Medicaid and other programs due to community fears stemming from the leaked draft regulations. This chilling effect is likely to be vastly over-inclusive due to the rule's vagueness on the relative importance of different factors; many of the immigrants disenrolling from these programs would not be subject to the public charge test or are using benefits that are not included in the proposed rule. Historical evidence from the 1996 PRWORA policy changes, which is cited in the NPRM itself, demonstrates that public information alone cannot prevent these damaging consequences due to the complexity of immigration policies; even among groups of immigrants who were explicitly excluded from the 1996 eligibility changes, and U.S. children in mixed status families, participation dropped dramatically. Additionally, direct care workers that provide critical assistance to millions of older adults and people with disabilities rely on these public programs. An estimated one million immigrants work in direct care, making up a quarter of the direct care workforce.[3] Caregiving tends to be low-wage and part-time work, so many of these direct care workers use public benefits programs to support themselves and their families—nearly half of immigrant direct care workers live at or below 200 percent of the federal poverty level, and more than 40% rely on programs such as SNAP and Medicaid.[4] As our aging communities grow, so does our reliance on immigrants to provide even more care. If direct care workers are unable or afraid to access programs that provide health care, nutrition, and housing, many would be unable to afford to remain in the U.S., which would lead to a shortage in direct care workers and leave older Americans and people with disabilities without access to the caregiving they need.

Healthcare and Safety Net Programs Should Be Excluded from the Public Charge Inquiry

The proposed expansion of the number of programs – including Medicaid and Medicare Part D subsidies – use or likely use of which would be weighed negatively in a public charge consideration, is unprecedented and should be rolled back. Historically, the public charge definition and application has been limited, excluding vital public health, healthcare, and safety net programs. This limited approach to public charge has been important in encouraging access to critical public health services, particularly for older adults and people living with chronic illnesses or disabilities.

Medicaid ensures that low-income individuals with higher health needs have access to comprehensive health care services that are more affordable than what they would receive from job-based or private coverage. More than 23 million adults under age 65, about 12 percent of all adults, have a disability.[5] One in three adults under age 65 enrolled in Medicaid have a disability, and nearly 12 million seniors and people living with disabilities are enrolled in

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[3] Robert Espinoza, *Immigrants and the Direct Care Workforce*, PHI (June 20, 2017), https://phinational.org/resource/immigrants-and-the-direct-care-workforce/.

[4] *Id*.

[5] Center on Budget and Policy Priorities, *Medicaid Works for People with Disabilities* (Aug. 19, 2017), https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities.

both Medicare and Medicaid.[6] Medicaid provides essential care and supportive services that help many of these individuals remain in their homes and communities. The Kaiser Family Foundation estimates that as a result of the policy itself and the chilling effect on access to services, between 2.1 and 4.9 million individuals could disenroll from Medicaid alone if this public charge policy goes into effect.[7] Medicaid is the primary payer for essential long-term services and supports, which provides nursing home care and home- and community-based services that help older adults and people living with disabilities or chronic illness live in their homes and communities. Many of these services, including personal attendant care, wheelchairs, lifts, and supportive housing services are typically unavailable through private insurance and too costly for all but the wealthiest people to afford out of pocket. Medicaid programs in some states also provide supportive employment programs to help people with disabilities join the workforce and maintain employment. Medicaid also supports crucial education-related services for children with disabilities; although the proposal excludes Medicaid-funded services provided to children in schools under the Individuals with Disabilities Education Act (IDEA), it will nonetheless discourage parents in immigrant families from seeking special education for children who need it in order to succeed in their education and throughout their adult lives. Since its inception, Medicaid has been intended as a source of coverage for medically needy groups, including low-income seniors and people of all ages living with disabilities or chronic illnesses. The proposal undermines the purpose of this vital safety net by penalizing immigrants and their families who use Medicaid for its intended purpose.

Medicare is similarly a lifeline for low-income people living with disabilities and most seniors, including immigrants who have worked for many years in the U.S. and earned this benefit. Although Medicare coverage itself is not included in the proposed expansion of benefits that would be considered for public charge determinations, the inclusion of Medicaid and Medicare Part D premium and cost-sharing subsidies will cause major harm to older immigrants, people living with disabilities, and their families. Medicare provides coverage for hospital care, doctor visits, and prescription drugs, but many rely on these other programs to help them afford out-of-pocket costs. Almost 1 in 3 Medicare beneficiaries enrolled in Part D prescription drug coverage get "Extra Help" with premiums and cost-sharing. Additionally, nearly 12 million seniors and people living with disabilities are enrolled in both Medicare and Medicaid, and 1 in 5 Medicare beneficiaries rely on Medicaid to help them pay for Medicare premiums and cost-sharing.[8] Medicaid is also critical for long-term care, home- and community-based services, dental, transportation, and other services that Medicare does not cover and that low-income older adults and people living with disabilities could not otherwise afford. These Medicaid-

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[6] *Id*.; Justice in Aging, *Public Charge: A Threat to the Health & Well-Being of Older Adults in Immigrant Families* (Oct. 17, 2018), http://www.justiceinaging.org/wp-content/uploads/2018/09/Public-Charge_A-Threat-to-the-Health-Wellbeing-of-Older-Adults-in-Immigrant-Families.pdf?eType=EmailBlastContent&eId=f896125e-2d18-4732-aadd-321e9ed6f305.

[7] Kaiser Family Foundation, Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid (2018), available at https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/.

[8] Justice in Aging, *supra* note 6.

funded services enable older adults and people living with disabilities to thrive, and to live with dignity at home with their families and in their communities.

Creating a policy barrier and related chilling effect on access to Medicaid and Medicare will cause dangerous disruptions in treatment and access to vital health care and supportive services for older adults and people living with chronic illnesses and disabilities, as individuals leave these programs for fear of immigration-related implications. Programs like Medicaid and Medicare serve vital public health functions and their use should not be discouraged. Having health insurance is especially important for older adults and people with chronic illness or disabilities because they have greater health needs. Without ongoing coverage and the assistance they need to afford prescription drugs and other care and services, seniors and people with chronic illness are likely to develop more serious health care conditions, driving up the cost of care and creating a new uncompensated care burden on health care providers. Penalizing use of these important programs will lead to greater healthcare costs as a result of deferred care, increased use of emergency rooms, and lack of access to regular care and treatment. Forcing older adults and people living with chronic illnesses or disabilities to choose between their healthcare and their immigration status or the immigration status of their family members is bad for both individual and public health because the person may forego their medical treatment in order to avoid a public charge determination.

For the same individual and public health reasons, we also oppose negatively weighing use of safety net programs like SNAP and housing assistance. The proposed rule would cause major harm to older immigrants and people living with chronic illness or disabilities, and to their families and communities, by discouraging people living in immigrant families in the U.S. from accessing services they need. These programs are designed to allow individuals to be self-sufficient. Access to food and stable housing is associated with better health outcomes, including decreased emergency room visits. The proposal would prevent immigrants from using programs their tax dollars help support, preventing access to essential health care, nutritious food, and secure housing. This would increase poverty, hunger, poor health, and unstable housing by discouraging enrollment in programs that improve health, food security, nutrition, and economic security. The rule does not recognize that access to benefits that improve health or provide people with the opportunity to complete education and training are highly significant positive factors that contribute to future economic self-sufficiency. Research shows that benefits that are included in the public charge determination, including SNAP and Medicaid, have positive long-term effects on recipients, and there is significant data on how generations improve their economic contributions over time. Discouraging older adults, people living with chronic illnesses or disabilities, and their families from receiving health, nutrition, housing, or educational supports for their children and grandchildren will only make it harder for them to achieve economic security in the future.

The proposed rule would have profound consequences for older adults, people living with chronic illness or disabilities, and their families' well-being and long-term success. If immigrant families are afraid to access nutrition assistance programs, more seniors and people with chronic illness will be food insecure and at risk of unhealthy eating which can cause or

exacerbate other health conditions and unnecessarily burden the healthcare system. If immigrant families are afraid to seek housing assistance, seniors with limited fixed incomes, people with chronic illness or disabilities, and their families will have fewer resources to spend on other basic needs, including food, medicine, transportation, and clothing. Disability is one of the strongest known factors that affect a household's food insecurity. Having a family member with a disability can both raise costs and lower earnings, making it harder to meet basic needs such as food. In 2011, about 15% of all U.S. households in 2011 were food insecure; however, the rates of food insecurity in households that include at least one working-age adult living with a disability are substantially higher, even in cases where the disability does not prevent employment.[9] Young people living with disabilities are also more likely to be food insecure than other young people.[10] Food insecurity is also associated with higher rates of chronic illnesses, particularly for low- and moderate-income households; research from the U.S. Department of Agriculture concludes that, in some cases, food security status is more strongly predictive of chronic illness than income.[11] Additionally, federal nutrition programs are proven to be crucial to older adults' ability to stay healthy and age in place. Federal housing assistance programs are equally important, providing support to over 1.7 million households with older adults who would otherwise be unable to afford the cost of shelter.[12] Disability and chronic illness are also known factors that impact housing stability, and people who are stably housed show consistent improvement in areas such as health, reduced hospital stays, and reduced health care costs.[13] Forcing families to leave these crucial programs in order to avoid a public charge determination harms not only immigrants who are seeking entry to the U.S. or status change, but also family members who have been in the U.S. for many years and even those who are U.S. citizens. Families will disenroll from public benefit programs for fear of adverse immigration-related outcomes for relatives that live abroad and may seek entry to the U.S. The proposed rule penalizes families that are already at increased risk of food insecurity and housing instability by forcing them to choose between their immigration status and keeping food on the table, paying their bills, and maintaining safe and stable housing.

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[9] In 2009-2010, one-third of households with a working-age adult who was unable to work due to disability were food insecure, and one-fourth of households that include an adult living with a disability that did not prevent employment were food insecure. Alisha Coleman-Jensen and Mark Nord, *Disability Is an Important Risk Factor for Food Insecurity*, Economic Research Service, U.S. Department of Agriculture (May 6, 2013), https://www.ers.usda.gov/amber-waves/2013/may/disability-is-an-important-risk-factor-for-food-insecurity.

[10] Center on Budget and Policy Priorities, *Young People with Disabilities Vulnerable to Food Insecurity* (Sept. 26, 2016), https://www.cbpp.org/blog/young-people-with-disabilities-vulnerable-to-food-insecurity (finding that households that include children who have special needs are 24 percent more likely to be food insecure than other households).

[11] Christian A. Gregory and Alisha Coleman-Jensen, *Food Insecurity, Chronic Disease, and Health Among Working-Age Adults*, Economic Research Service, U.S. Department of Agriculture (July 2017), https://www.ers.usda.gov/webdocs/publications/84467/err-235.pdf?v=0; Dominic Decker and Mary Flynn, *Food Insecurity and Chronic Disease: Addressing Food Access as a Healthcare Issue*, Rhode Island Medical Journal (May 2018), http://www.rimed.org/rimedicaljournal/2018/05/2018-05-28-cont-decker.pdf.

[12] Justice in Aging, *supra* note 6.

[13] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Recovery to Practice* (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/slides-homelessness1_20171004.pdf.

DHS asks for comments on whether additional programs should be added to the enumerated list and whether public benefits received that are not enumerated in the rule should nonetheless be counted negatively in the totality of the circumstances review. For reasons stated above, we do not believe additional programs should be added and believe that the public charge determination should remain limited. We also urge DHS not to allow public benefits that are not explicitly enumerated in the rule to be weighed negatively in the totality of the circumstances review. Because immigrants subject to public charge would have no way of knowing which benefits were allowable and which were not, this proposal would have a significant chilling effect on access to a range of services, including public health and emergency services that are excluded from the public charge inquiry.

DHS also asks for comments on whether the Children's Health Insurance Program (CHIP) should be added to the list of enumerated programs. We strongly oppose this proposal. CHIP is a vital safety net for millions of children and young adults. For the same individual and public health reasons stated above, we believe that adding CHIP as a negative factor to the public charge determination will jeopardize access to vital services for the young people and pregnant women served by CHIP. Together, Medicaid and CHIP coverage half of U.S. children with special health care needs.[14] Moreover, CHIP has been expanded by many states to ensure that vulnerable immigrant populations, including pregnant women and children, have access to services. Penalizing use of CHIP undercuts the sound public policies many states have put in place to ensure this important safety net is available to immigrants.

The Expanded Disability and Health Status Factors Are Discriminatory

The proposal's expansion of the disability and health status provisions are discriminatory and should be withdrawn. If this rule were implemented, it will be nearly impossible for older adults and people living with chronic illnesses or disabilities to pass the "public charge" test under the new criteria. By weighing a disability negatively, without taking into account any accommodation to support someone living with a disability, the proposal will have the effect of creating a bar to entry or adjustment of status solely based on a person's disability or health status. Medicaid, Medicare Part D, and other programs proposed by DHS as negative factors for public charge review serve to support individuals to live self-sufficient, full, and productive lives. Given that 1 in 3 adults under age 65 enrolled in Medicaid have a disability and nearly 12 million seniors and people living with disabilities are enrolled in both Medicare and Medicaid, weighing Medicaid negatively undercuts the very programs that are meant to support self-sufficiency, further punishing anyone with a disability simply for having a disability.[15]

The proposed treatment of individuals living with a serious medical condition is also discriminatory and arbitrary. The proposed rule would negatively weigh a diagnosis of an illness

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[14] MaryBeth Musumeci and Julia Foutz, *Medicaid's Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending* (Feb. 22, 2018), https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/.

[15] Center on Budget and Policy Priorities, *supra* note 5; Justice in Aging, *supra* note 6.

that is “likely to require extensive medical treatment or institutionalization.” A diagnosis will be even more heavily negatively weighed unless the individual demonstrates he or she will be able to purchase private health insurance or has other resources to cover foreseeable medical costs. This incredibly broad inquiry into a person’s health status will arbitrarily punish older adults and individuals living with chronic illnesses or disabilities and is not based in either sound science or public health principles. The proposed rule could make living with a chronic illness or disability an insurmountable hurdle in a public charge determination, even in cases of chronic but manageable conditions such as HIV. The combination of penalizing someone’s medical condition and negatively weighing use of benefits and services that help to treat that medical condition will create an insurmountable bar for many older adults and people living with chronic illnesses or disabilities seeking to enter this country or adjust their status.

The New Income Criteria Are Arbitrary

The proposed rule introduces unprecedented criteria such as an income test and weighs negatively many factors that have never been relevant and will make it more difficult for older adults and people living with chronic illness or disabilities to pass. By introducing an arbitrary and unprecedent income test that treats even full-time work at low wages as failing to contribute to society, the proposed rule favors wealthy immigrants while making it very difficult for low-income immigrants to meet the public charge determination. The rule’s emphasis on employment also disproportionately impacts women by making it more difficult for adults who stay at home raising children, or caring for children and other relatives with higher health needs, to get green cards. The income test similarly penalizes any positive weight that an affidavit of support could provide if the sponsor has an income of less than 125% of federal poverty level. A bright line income test is not reflective of a person’s value to this country or potential to meaningfully contribute to a community. Basing entry into this country and adjustment of status on wealth is not only anathema to longstanding American values of upward mobility, but it also destabilizes financial security of immigrant families already here, particularly in instances of family-based green card petitions. These changes amount to a sea change in American policy towards immigration, counting wealth and income as the primary indicators of a person’s future contribution. We urge DHS to reconsider this bright line test.

The Proposed Rule Discourages Intergenerational Families

The proposal targets family-based immigration and low and moderate wage workers, which will have a disproportionate impact on seniors, children, and individuals with chronic illnesses or disabilities who depend on family members for support, as well as relatives who are caregivers for others in their family. Instead of recognizing the value of intergenerational families who support each other, the proposed rule callously labels parents and grandparents as a burden because of their age, health needs, and limited English proficient (LEP) status and ignores the critical roles many grandparents play in caring for their grandchildren and other family members, often enabling others to work. The number of parents of U.S. citizens who have been admitted as legal permanent residents nearly tripled between 1994 and 2017 and now account for almost 15% of all admissions and almost 30% of family-based admissions. Under the proposal, many U.S. citizens would no longer be able to welcome their own parents into the country, even after they signed a commitment to support them. Over 1.1. million noncitizens

age 62 and older live in low- or moderate-income households,[16] meaning that they would have no "heavily weighed" positive factors to offset the fact that their age is considered a negative factor. Families could be penalized for sharing housing or providing significant support to older relatives, children, or family members with a chronic illness or disability, as this would increase their household size and force them to demonstrate higher levels of income to avoid being considered a public charge.

English Proficiency and Education Criteria Are Far Too Broad

We also object to the provisions related to negatively weighing lack of English language proficiency and formal education. The rule indicates a preference for immigrants who speak English, which would mark a fundamental change from our nation's historic commitment to welcoming and integrating immigrants. This preference is particularly problematic when a majority of older immigrants are LEP. It is well-documented that access to public benefits and services are critical to ensuring that immigrants acquire the language and education skills necessary to be successful. However, the proposed rule both negatively weighs the lack of education and English proficiency, while at the same time penalizing use of the services that enable immigrants to be self-sufficient members of their communities. The expanded negative weights for English language proficiency and educational/skills attainment conflict with longstanding policy and principles that support upward mobility and self-sufficiency.

In light of the above concerns, we urge DHS to withdraw this proposed rule in its entirety, and instead allow the longstanding limited public charge policy included in the 1999 field guidance on public charge to remain in effect.

Thank you for the opportunity to comment this proposed rule. We urge DHS to rescind this harmful proposed rule and to protect the dignity, health, and welfare of all immigrants. Please contact Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), Carmel Shachar with the Treatment Access Expansion Project (cshachar@law.harvard.edu), or Jean McGuire at Northeastern University (j.mcguire@neu.edu) if we can be of assistance.

Respectfully submitted by the co-chairs of the Chronic Illness and Disability Partnership,

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Robert Greenwald
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[16] Manatt, *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard* (Oct. 11, 2018), https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population#DataDashboard.

Northeastern University