December 10, 2018

VIA ELECTRONIC TRANSMISSION

Kirstjen M. Nielsen, Secretary of Homeland Security
U.S. Department of Homeland Security
245 Murray Lane SW
Washington, D.C. 20528

Re: Inadmissibility on Public Charge Grounds (DHS Docket No. USCIS-2010-0012).

Dear Secretary Nielsen:

Planned Parenthood Federation of America (Planned Parenthood) and Planned Parenthood Action Fund (Action Fund) submit these comments in response to the notice of proposed rulemaking (Proposed Rule) issued by the U.S. Department of Homeland Security (the Department) entitled, "Inadmissibility on Public Charge Grounds," and published in the Federal Register at 83 Fed. Reg. 51,114 on October 10, 2018.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's more than 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted diseases (STDs), and other essential care to 2.4 million patients. We also provide abortion services and ensure that women have accurate information about all of their reproductive health care options. One in five women in the U.S. has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150 percent of the Federal Poverty Level (FPL), and many are beneficiaries of the public programs implicated by the Proposed Rule, including Medicaid.

By virtue of our expertise as a provider and advocate, Planned Parenthood is uniquely situated to provide input on policy proposals that affect the health of people, including the communities Planned Parenthood serves, across the country. Accordingly, this letter attends primarily to the Proposed Rule's incredibly problematic health-related consequences. But we also write to

stress that both the "public charge" doctrine in U.S. law and its proposed expansion are fundamentally at odds with Planned Parenthood's broader commitments to fairness, equal treatment, and equity for immigrants in this country—all of which are essential to Planned Parenthood's mission. We disagree with the policies and rhetoric of this administration that have constructed a false opposition between immigrant families and the rest of America. This narrative has been repeatedly used to justify more hostility toward, discrimination against, and exclusion of immigrants, including from basic health care services and programs. The Proposed Rule is just one in a long line of efforts by the administration to undermine the health and needs of immigrants, alongside other groups of people who lack power in this country.

It is for these reasons, and the reasons specified below, that we strongly oppose the Department's proposal. Specifically, the Proposed Rule would result in adverse health-related consequences that far exceed those estimated by the Department. These harmful effects would include reducing access to health care for millions, further entrenching health inequities, and imposing unnecessary burdens on the health care system. Moreover, the Department's purported goal of promoting "self-sufficiency" among immigrant populations appears to bear little or no connection to the Proposed Rule's terms. In fact, it appears that the Proposed Rule's primary effect would be to penalize immigrants and their families for accessing benefits for which they are eligible—making it more difficult for them to live, work, and contribute to their communities. Accordingly, we strongly urge the Department to withdraw the Proposed Rule.

I. The Proposed Rule would harm the health of communities, further entrench inequities, and unnecessarily burden the health care system.

The Proposed Rule would significantly expand the Department's power to prevent immigrants from entering the U.S., or from adjusting their immigration status, on "public charge" grounds. Under the Proposed Rule, officials would use an individual's receipt of an expanded range of public benefits as evidence against them in "public charge" determinations (proposed § 212.21(b)). This list of public benefits would be amended to newly include Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Medicare part D, and several housing assistance programs—all of which are, under current rules, explicitly excluded from consideration. Also, the Proposed Rule would highlight certain factors that would weigh heavily in favor of or against a "public charge" finding (proposed § 212.22(c)). For instance, significant negative weight would be attached to receiving public benefits or having a health condition that affects an individual's ability to work or care for oneself. Further, the Department proposes to consider other factors, such as earnings below 125 percent of the Federal Poverty Level (FPL) or having a large family, as negative elements in its analysis (proposed § 212.22(b)). These changes, along with the Proposed Rule's other features, would combine to establish a significantly more restrictive "public charge" test than is currently used.

These changes would have wide-ranging negative health consequences, reverberating far beyond those individuals to whom the new "public charge" rules would apply. The Proposed Rule's consequences, moreover, would exacerbate health challenges for certain populations,

including women, people of color, LGBTQ people, people living with HIV, and members of other groups that already face difficulties in accessing health care. Furthermore, the Proposed Rule would place unnecessary burdens on safety-net health care providers, reducing timely access to critical health services in communities across the country.

Furthermore, many of these impacts are addressed incompletely, if at all, in the Department's regulatory impact analysis. Consistent with instructions from the Office of Information and Regulatory Affairs within the Office of Management and Budget, federal agencies must do their best to estimate the costs associated with proposed regulations, quantifying such costs where possible.[1] This estimate must account for any adverse health consequences that are likely to result from regulatory action.[2] A careful assessment of costs is necessary both to ensure that policies are the product of reasoned decision-making, and to promote transparency and accountability in the regulatory process.[3] If the Department had undertaken a true accounting of the Proposed Rule's effects, we believe it would have concluded—as we have—that the proposed changes cannot be justified. For similar reasons, we believe the Department cannot justify extending the Proposed Rule's application to the beneficiaries of other programs, such as the Children's Health Insurance Program (CHIP).

A. The Proposed Rule would directly and indirectly jeopardize the health of a large population of immigrants and their families.

Under the Proposed Rule, many noncitizens without lawful permanent resident (LPR) status would forgo public benefits that they are legally entitled to access, such as Medicaid, because using such benefits would have a negative effect on their ability to adjust their immigration status. According the Center for American Progress, even considering only the rule's direct effects, it would apply to roughly 900,000 immigrants and another 176 million non-immigrants each year.[4]

The rule's impact, however, would extend far beyond those who would be subject to its terms. In fact, the proposed changes would discourage the use of public benefits generally among a much wider immigrant population. Given the rule's complexity, the Department's proposal to give itself broad discretion in making "public charge" determinations, and the varying scope of draft versions of the rule leaked over the past year, the proposed change in policy would generate fear and confusion among immigrants and their families that would deter them from seeking a variety of public benefits.

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[1] Office of Information and Regulatory Affairs, *Circular a-4, "Regulatory Impact Analysis: A Primer,"* 3, (Aug. 2011), available at https://reginfo.gov/public/jsp/Utilities/circular-a-4_regulatory-impact-analysis-a-primer.pdf.
[2] *Id*. at 8.
[3] *Id*. at 2.
[4] Center for American Progress, "Trump's 'Public Charge' Rule Would Radically Change Legal Immigration (Nov. 2018), available at https://www.americanprogress.org/issues/poverty/reports/2018/11/27/461461/trumps-public-charge-rule-radically-change-legal-immigration/.

The Department ignores this secondary effect of the Proposed Rule in its evaluation of the policy's consequences. Despite its obligation to completely assess the rule's costs, the Department omits discussion of evidence and data essential to understanding the likelihood that the Proposed Rule would indirectly place a "chilling effect" on the receipt of public benefits among a much broader group of immigrants and their families. It fails, moreover, to provide any estimate of the health-related costs that are likely to result from decisions to disenroll from public programs, such as Medicaid, by immigrants and their families to whom the Proposed Rule would not technically apply.

In refusing to acknowledge these costs in its analysis, the Department ignores the lessons of history and the available research. The Proposed Rule itself notes that the welfare changes of 1996 resulted in enrollment reductions in public programs ranging from 21 to 54 percent for the very same reason.[5] And the Department's 1999 field guidance, in explicitly excluding most non-cash benefits from consideration in the "public charge" test, reasoned that to do otherwise would "deter[] eligible aliens and their families, including U.S. citizen children, from seeking important health and nutrition benefits that they are legally entitled to receive. This reluctance to access benefits has an adverse impact not just on potential recipients but on public health and the general welfare."[6]

Unfortunately, this phenomenon is already manifesting in immigrant communities. For example, health and nutrition providers have noticed an increase in canceled appointments and requests to disenroll from means-tested programs.[7] Researchers have also found that early childhood education programs have reported drops in attendance and applications, reduced participation from immigrant communities in classrooms and at events, and an uptick in missed appointments at health clinics.[8] In a 2018 survey of health care providers in California, more than two-thirds noted an increase in parents' concerns about enrolling their children in Medicaid; the Women, Infants, and Children (WIC) program; and the Supplemental Nutrition Assistance Program (SNAP).[9] Nearly half reported an increase in skipped scheduled health care appointments.[10]

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[5] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,266 (Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212-214, 245, 248)

[6] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,692, (May 26, 1999).

[7] Jennifer Laird et al., Columbia Population Research Center, "Foregoing Food Assistance Out of Fear: Changes to 'Public Charge' Rule May Put 500,000 More U.S. Citizen Children at Risk of Moving into Poverty" (2018), available at https://www.povertycenter.columbia.edu/news-internal/2018/3/28/changes-to-public-charge-rule-may-put-500000-more-us-citizen-children-at-risk-of-moving-into-poverty.

[8] Hannah Mathews et al., The Center for Law and Social Policy, *Immigration Policy's Harmful Impacts on Early Care and Education* (2018), available at https://www.clasp.org/publications/report/brief/immigration-policy-s-harmful-impacts-early-care-and-education.

[9] The Children's Partnership, *California Children in Immigrant Families: The Health Provider Perspective*, available at https://www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Inforgraphic-.pdf.

The impact of the Proposed Rule on health coverage alone would be devastating. Medicaid is a vital part of our nation's health care system and plays a major role in ensuring access to primary and preventive health care services, particularly for women. Nearly 60 percent of Medicaid enrollees are women and rely on Medicaid coverage for essential primary and preventive care, including reproductive health care services such as lifesaving cancer screenings and birth control.[11] And, in half of all states, Medicaid finances 50 percent or more of births.[12] Due to racism and other systemic barriers that have contributed to income inequality, some racial and ethnic groups form an outsized proportion of Medicaid enrollees: 30 percent of African-American women and 24 percent of Hispanic women are enrolled in Medicaid, compared to only 14 percent of white women.[13] Thus, it is women—especially women of color—who stand to lose the most when access to Medicaid coverage is restricted.

A recent analysis prepared by Kaiser Family Foundation on the Proposed Rule's impact on health programs estimates that it could cause between 2.1 and 4.9 million Medicaid/CHIP enrollees to disenroll.[14] This estimate reflects both disenrollment among noncitizens without LPR status as well as among a broader group of enrollees in immigrant families, including U.S.-born children, due to increased fear and confusion. Nearly all noncitizens who entered the U.S. without LPR status have at least one characteristic that the Department could potentially weigh negatively in a "public charge" determination.[15] Over four in ten have characteristics that the Department could consider a heavily weighted factor.[16] For example, over one-third of noncitizens without LPR status in the U.S. have incomes below the 125 percent FPL standard that the Proposed Rule would establish.[17] And just over one in four are enrolled in a public program that the rule identifies as a public benefit.[18] Similarly, the Urban Institute has suggested that the Proposed Rule could potentially affect an estimated 2.2 million Medicaid/CHIP enrolled U.S.-citizen children with Medicaid-enrolled noncitizen parents nationwide.[19] By causing major

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[10] *Id*.
[11] Kaiser Family Foundation, "Medicaid Enrollees by Gender," available at https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender.
[12] Kaiser Family Foundation, "Births Financed by Medicaid," available at https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid.
[13] Hannah Katch et al., Center for Budget and Policy Priorities, "Medicaid Works for Women—But Proposed Cuts Would Have Harsh, Disproportionate Impact" (2017), available at https://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact.
[14] Samantha Artiga et al., Kaiser Family Foundation, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid* (Oct. 2018), available at http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid.
[15] *Id*.
[16] *Id*.
[17] *Id*.
[18] *Id*.
[19] Genevieve M. Kenney, Urban Institute, *Proposed Public Charge Rule Could Jeopardize Recent Coverage Gains among Citizen Children* (Dec. 2018), available at

declines in enrollment, the Proposed Rule risks reversing the tremendous gains in insurance coverage rates that we have seen since the implementation of the Affordable Care Act and undoing progress in closing the gap in coverage for immigrant populations.[20]

Declines in health coverage for people with low incomes would lead to a range of negative consequences on health, financial stability, and employment. Medicaid plays a key role in keeping people, including working parents and their children, healthy by providing access to needed primary and preventive health care, as well as care for chronic conditions. Medicaid coverage improves access to care,[21] which in turn provides short- and long-term health benefits to enrollees, including fewer hospitalizations,[22] better oral health,[23] and lower rates of obesity,[24] among other benefits. Even mere eligibility for Medicaid is associated with these improved health outcomes.[25] As the Department notes, reduced participation in public programs such as Medicaid could lead to worse health outcomes.[26]

On top of protecting families' health, insurance coverage also protects their financial security, shielding them from high medical costs.[27] By enabling families to meet their health care needs, Medicaid supports families' ability to work and care for their children.[28] The majority of LPRs live in a family with at least one full-time worker, a rate equal to that of citizens.[29] But LPRs are more likely than citizens to live in families with low incomes and often work in jobs and industries that do not offer health coverage.[30] Disenrollment from health coverage through Medicaid or other

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https://www.urban.org/sites/default/files/publication/99453/proposed_public_charge_rule_could_jeopardize_recent_coverage_gains_among_citizen_children_0.pdf.

[20] *See* Sharon K. Long et al., "Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update," Health Affairs (Sept. 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/11/hlthaff.2017.0798.pdf.

[21] Hannah Katch, Center for Budget and Policy Priorities,"Yes, Medicaid Improves Access to Health Coverage and Care" (Dec. 2017), available at https://www.cbpp.org/blog/yes-medicaid-improves-access-to-health-coverage-and-care.

[22] *Id*.

[23] *See, e.g.*, Neal T. Wallace et al., "The Individual and Program Impacts of Eliminating Medicaid Dental Benefits in the Oregon Health Plan," *American Journal of Public Health* (Nov. 2011), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222412/.

[24] Karina Wagnerman et al., Georgetown University Center for Children and Families, *Medicaid Is A Smart Investment in Children* (Mar. 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

[25] Laura R. Wherry et al., *Childhood Medicaid Coverage and Later Life Health Care Utilization* (Apr. 2016), available at http://www-personal.umich.edu/~mille/WherryMillerKaestnerMeyer_040716.pdf.

[26] 83 Fed. Reg. at 51,270.

[27] Karina Wagnerman et al., Georgetown University Center for Children and Families, *Medicaid: How Does It Provide Economic Security for Families?* (Mar. 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.

[28] *Id*.

[29] Kaiser Family Foundation, "Proposed Changes to 'Public Charge' Policies for Immigrants: Implications for Health Coverage" (Sept. 2018), available at https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/.

[30] *Id*.

health care programs would make it more difficult for families to work or pursue education, ultimately contributing to poverty and financial instability.[31] The effects of declining Medicaid enrollment and the "chilling effect" on publicly funded health coverage in general would be compounded by reduced participation in the nutrition and housing assistance programs implicated by the Proposed Rule.

B. The Proposed Rule is likely to widen existing gaps in health for women, people of color, LGBTQ people, and other people who already experience health disparities.

The Proposed Rule's harms to the health and well-being of immigrants and their families would, moreover, disproportionately burden certain populations, including women, people of color, Latinos, LGBTQ people, people living with HIV and members of other disadvantaged groups. As a part of its evaluation of the costs of its Proposed Rule, the Department is instructed to analyze "distributional effects," which consists of "the impact of a regulatory action across the population and economy, divided up in various ways (e.g., income groups, race, sex, industrial sector, geography)."[32] Yet the Department fails to adequately identify and evaluate these effects. If it did, the Department would find that the Proposed Rule would have the unacceptable consequence of widening existing inequities for groups that already face considerable health challenges. The rule's outsized effects on some groups—*e.g.*, people with low incomes, immigrants—are addressed throughout this letter. But we identify a few of the other, most salient distributive impacts below.

Gender. Women would face disproportionate, adverse health consequences under the Proposed Rule. Noncitizen women are more likely to use the public benefits targeted by the Proposed Rule than are noncitizen men. As discussed above, women disproportionately rely on Medicaid for health care; in 2017, almost 47 percent of noncitizen Medicaid enrollees were women, while 40 percent were men and 13 percent were children.[33] Similarly, almost 48 percent of SNAP recipients were women in 2017, compared to 40 percent who were men and 12 percent who were children.[34] These programs, moreover, are essential to the ability of immigrant women to maintain financial stability and provide for their families, particularly in light of their heightened risk for economic insecurity given women's pay disparities[35] and other

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[31] *Id*.
[32] Office of Information and Regulatory Affairs, *Circular a-4, "Regulatory Impact Analysis: A Primer,"* 7-8, (Aug. 2011), available at https://reginfo.gov/public/jsp/Utilities/circular-a-4_regulatory-impact-analysis-a-primer.pdf.
[33] Calculations based on U.S. Census Bureau, 2017 Current Population Survey, using Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, and J. Robert Warren. Integrated Public Use Microdata Series, Current Population Survey: Version 6.0 [dataset]. Minneapolis, MN: IPUMS, 2018. https://doi.org/10.18128/D030.V6.0.
[34] *Id*.
[35] *See* National Women's Law Center, *Frequently Asked Questions About the Wage Gap* (2018), available at https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/09/Wage-Gap-FAQ.pdf; National Women's Law Center, *The Wage Gap: The Who, Why, How, and What to Do* (2017), available

discrimination,[36] overrepresentation in low-wage work,[37] and disproportionate responsibility for caregiving,[38] among other reasons.

The myriad health challenges that women already face would only be amplified by discouraging enrollment in programs that help to ensure they stay healthy. Without coverage, women are likely to forgo needed care, leading to worse health outcomes.[39] For instance, women who lack health insurance are less likely to receive life-saving preventive care, such as breast and cervical cancer screenings.[40] Lack of adequate health care—including reproductive health care and prenatal care—can contribute to already unacceptable rates of maternal mortality. This risk is particularly concerning for Black women, who face disproportionately high rates of maternal mortality due to existing barriers and systemic inequalities.[41] The Department itself notes that the Proposed Rule would have adverse health effects concentrated on maternal health,

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at https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/09/The-Wage-Gap-The-Who-How-Why-and-What-to-Do-2017-2.pdf; Elise Gould, Jessica Schieder & Kathleen Geier, Economic Policy Institute, *What is the Gender Pay Gap and Is It Real?* (2015), available at https://www.epi.org/publication/what-is-the-gender-pay-gap-and-is-it-real/.

[36] *See* National Women's Law Center, *Sexual Harassment in the Workplace* (2016), available at https://nwlc.org/wp-content/uploads/2016/11/Sexual-Harassment-Fact-Sheet.pdf; Institute for Women's Policy Research, *The Economic Cost of Intimate Partner Violence, Sexual Assault, and Stalking* (2017), available at https://iwpr.org/wp-content/uploads/2017/08/B367_Economic-Impacts-of-IPV-08.14.17.pdf; National Women's Law Center, "Standing with Immigrant Women Workers on May Day" (2017), available at https://nwlc.org/blog/standing-with-immigrant-women-workers-on-may-day/.

[37] *See* National Women's Law Center, *Low-Wage Jobs Held Primarily by Women Will Grow the Most Over the Next Decade* (2018), available at https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/04/Low-Wage-Jobs-Held-Primarily-by-Women-Will-Grow-the-Most-Over-the-Next-Decade-2018.pdf; American Immigration Council, *The Impact of Immigrant Women on America's Labor Force* (2017), available at https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force; National Women's Law Center, *Underpaid & Overloaded: Women in Low-wage Jobs* (2014), available at https://nwlc.org/wp-content/uploads/2015/08/final_nwlc_lowwagereport2014.pdf; National Women's Law Center, *Set Up to Fail: When Low-Wage Work Jeopardizes Parents' and Children's Success* (2016), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/01/FINAL-Set-Up-To-Fail-When-Low-Wage-Work-Jeopardizes-Parents'-and-Children's-Success.pdf.

[38] Women are more likely than men to raise children on their own, *see, e.g.*, U.S. Census Bureau, America's Families and Living Arrangements 2018, Tbl. A3, https://www.census.gov/data/tables/2018/demo/families/cps-2018.html, meaning that their incomes must stretch to support more family members.

[39] *See* Institute of Medicine (US) Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late* (2002), available at https://www.ncbi.nlm.nih.gov/pubmed/25057604.

[40] Munira Z. Gunja et al., Commonwealth Fund, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care* (Aug. 2017), available at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_aug_gunja_women_hlt_coverage_care_biennial.pdf.

[41] National Partnership for Women and Families, *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* (Apr. 2018), available at http://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html.

including worse health outcomes for those who are pregnant or breastfeeding, infants, and children.[42]

Half of uninsured women reported going without health care in 2016 because of cost, compared to 25 percent of women with Medicaid and 21 percent of women with private insurance. Immigrant women are already more likely to be uninsured (27 percent) than women overall (11 percent).[43] Immigrants of reproductive age fare even worse when it comes to uninsurance (37 percent), and the gap widens further for immigrant women with low incomes (48 percent).[44]

***Race and ethnicity*.** The Proposed Rule would have pronounced negative effects on people of color and Latinos. Several of the rule's features, including its favorable treatment of English-speaking immigrants (proposed § 212.21(b)) and high-wage earners (proposed § 212.21(b)-(c)) in "public charge" determinations, would target historically marginalized racial and ethnic groups. It is estimated that, in the U.S., 90 percent of the people likely to be affected by the Proposed Rule are people of color or Latino.[45] Of this group, 70 percent are Latino; 12 percent are Asian American and Pacific Islander; and 7 percent are Black.[46] Also, the Proposed Rule would create a higher risk for those seeking to immigrate from Mexico and Central America (with 60 percent of recent immigrants estimated to have two or more negative factors), the Caribbean (48 percent), Asia (41 percent), South America (40 percent); and Africa (34 percent).[47] By contrast, only 27 percent of immigrants from Europe, Canada, Australia, and New Zealand are predicted to have two or more negative factors.[48] Latinos and people of color in the U.S. already face historical and persistent health disparities due, in part, to racial bias and systemic barriers to achieving health and well-being.[49] Disincentivizing enrollment in health programs

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[42] 83 Fed. Reg. at 51,270.
[43] Usha Ranji et al., Kaiser Family Foundation, *Overview: 2017 Kaiser Women's Health Survey* (2018), available at https://www.kff.org/womens-health-policy/issue-brief/overview-2017-kaiser-womens-health-survey/.
[44] Guttmacher Institute, *Dramatic Gains in Insurance Coverage for Women of Reproductive Age Are Now in Jeopardy* (Jan. 2018), available at https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy.
[45] This number represents individuals and family members with at least one noncitizen in their household and who live in households with earned incomes under 250 percent FPL. Custom Tabulation by Manatt Phelps & Philips LLP, "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard" (2018), https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population (using 2012-2016 5-Year American Community Survey Public Use Microdata Sample (ACS/PUMS); 2012-2016 5-Year American Community Survey (ACS) estimates accessed via American FactFinder; Missouri Census Data Center (MCDC) MABLE PUMA-County Crosswalk).
[46] *Id*.
[47] Migration Policy Institute, *Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration* (Nov. 2018), available at https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration.
[48] *Id*.
[49] *See, e.g.*, Kaiser Family Foundation, *Disparities in Health and Health Care: Five Key Questions and Answers* (2018), available at https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

such as Medicaid and other public benefits, including nutrition and housing assistance, removes crucial supports that have proven to be effective in reducing these disparities.

LGBTQ status. The Proposed Rule would disproportionately affect LGBTQ immigrants and their families. Immigrants make up a significant population of the LGBTQ community: the Williams Institute estimates that there are 637,000 LGBT-identified individuals among the adult authorized immigrant population.[50] There are an estimated 24,700 noncitizens who are part of a same-sex couple with a U.S. citizen, with a quarter of these couples raising children.[51]

Discrimination and bias based on an individual's sexual orientation or gender identity contribute to economic insecurity for LGBTQ people, which could be used against them under the Proposed Rule's income standard (proposed § 212.21(b)-(c)). LGBTQ people in the U.S. experience rampant workplace discrimination. A 2017 survey found that 1 in 5 LGBTQ people experienced discrimination when applying for jobs and 22 percent reported experiencing discrimination in pay or promotions.[52] Sixteen percent of respondents to the 2015 U.S. Transgender Survey reported losing their job due to their gender identity or expression.[53] Respondents to that survey also reported a 15 percent unemployment rate, which was three times higher than the unemployment rate for the total U.S. population at the time.[54]

Moreover, due to family rejection and LGBTQ discrimination in housing, education, and health care, many LGBTQ people struggle to become economically secure in the U.S. Research shows that LGBTQ people, especially those that are Black, transgender, or women, are more likely to live in poverty, be food insecure, and experience higher unemployment and homelessness than non-LGBTQ people.[55] According to research by the Center for American Progress, LGBTQ people and their families are more likely to use SNAP, Medicaid, unemployment insurance and public housing assistance than non-LGBTQ people.[56]

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[50] Gary J. Gates, "LGBT Adult Immigrants in the United States" (Mar. 2013), available at https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/us-lgbt-immigrants-mar-2013/.
[51] *Id*.
[52] Sejal Singh and Laura E. Durso, Center for American Progress, "Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways" (May 2017), available at https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/.
[53] *Id*.
[54] *Id*.
[55] Lourdes Ashley Hunter et al., Center for American Progress, "Intersecting Injustice: A National Call to Action Addressing LGBTQ Poverty and Economic Justice for All" (2018), available at https://www.americanprogress.org/issues/ext/2018/05/10/450688/intersecting-injustice-national-call-action-addressing-lgbtq-poverty-economic-justice/.
[56] Caitlin Rooney et al., Center for American Progress, "Protecting Basic Living Standards for LGBTQ People" (Aug 2018), available at https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/.

HIV status. People with chronic illnesses, including people living with HIV/AIDS, would face increased health challenges under the Proposed Rule. Approximately 1.1 million people in the U.S. are living with HIV/AIDS.[57] Under the rule, the Department would consider an individual's medical conditions in making a "public charge" determination (proposed § 212.21(b)-(c)), which could mean using a person's HIV diagnosis to exclude both HIV-positive applicants and those seeking to unite with HIV-positive family members. The Proposed Rule may therefore incentivize noncitizens to terminate public benefits, such as health coverage through Medicaid, in order to protect their ability to adjust their status. In fact, reports are already emerging of individuals who are considering waiting to begin life-saving treatment in the belief that this will ensure their eligibility.[58] This would have very serious public health implications and threaten to undo hard-won progress towards ending the HIV/AIDS epidemic in the U.S. Furthermore, the idea of excluding people living with HIV based on "self-sufficiency" concerns reflects an outdated understanding of the infection. With appropriate treatment, care, and support, people living with HIV can expect to live long, healthy and productive lives.[59]

C. The Proposed Rule would place significant burdens on the health care system, particularly safety-net health care providers.

The Proposed Rule would impose significant burdens on safety-net health care providers which could, in turn, reduce access to care for entire communities. As discussed above, fear and confusion caused by the rule will cause many immigrants and their families to disenroll or avoid the use of a range of public benefits programs, including Medicaid. Declines in Medicaid enrollment are likely to result in a corresponding increase in uncompensated care in a variety of settings.[60] For example, people avoiding enrollment in Medicaid may forgo preventive care or chronic care management, instead waiting until their health situation becomes more acute (and more expensive to treat) before enrolling in coverage or accessing emergency services.[61]

This overall effect would be particularly concerning for safety-net health care providers such as safety-net hospitals, community health centers, and family planning health centers. Generally, such providers offer care to individuals that lack health insurance, regardless of their ability to pay. Receiving appropriate Medicaid reimbursement in exchange for care provided to Medicaid-eligible and enrolled patients is important to their ability to serve communities in need.

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[57] Centers for Disease Control and Prevention, "HIV/AIDS Basic Statistics" (Nov. 2018), available at https://www.cdc.gov/hiv/basics/statistics.html.

[58] *See, e.g.*, Community Catalyst, "For People Living with HIV/AIDS, the Revised Public Charge Rule Could Mean Life or Death" (Oct. 2018), available at https://www.communitycatalyst.org/blog/for-people-living-with-hiv-aids-the-revised-public-charge-rule-could-mean-life-death#.XA3t7BNKh-U.

[59] Centers for Disease Control and Prevention, "Living With HIV" (Jul. 2018), available at https://www.cdc.gov/hiv/basics/livingwithhiv/index.html.

[60] *See* 83 Fed. Reg. at 51,270.

[61] *See* Cindy Mann et al., Manatt Health, "Medicaid Payments at Risk for Hospitals Under Public Charge" (Nov. 2018), available at https://www.manatt.com/Insights/White-Papers/2018/Medicaid-Payments-at-Risk-for-Hospitals-Under-Publ.

In fact, Medicaid is the largest source of funding for community health centers.[62] It also forms the largest proportion of public funding for family planning services in the U.S.[63]

Under the Proposed Rule, safety-net providers that serve communities with high numbers of immigrant families are likely to see increases in the number of patients seeking needed care that newly lack Medicaid coverage. Following radical changes to the welfare system in 1996, safety-net providers reported losing patients with Medicaid and revenue while the number of uninsured patients rose.[64] The proposed changes to "public charge" would similarly shift health care costs onto safety-net providers. Providers, already under-resourced and overburdened,[65] may be forced to make reductions to staff, hours, or services in order to absorb the resulting financial impact in light of restrictions on Medicaid access.[66] In this sense, the Proposed Rule's harms would reverberate beyond individuals attempting to avoid adverse "public charge" determinations, reducing access to vital health care for entire communities.[67]

D. For similar reasons, the Department cannot justify extending the Proposed Rule's application to the beneficiaries of other programs, such as CHIP.

The Department requests comment on whether it should include the receipt of other benefits, such as coverage through the Children's Health Insurance Program (CHIP), in the "public charge" test. For reasons similar to those discussed above, we strongly advise the Department against doing so. At the outset, the rationale that the Department offers for considering CHIP as a public benefit under the Proposed Rule is flawed. The Department suggests that since federal expenditures for CHIP are significant, the program's inclusion is justified.[68] Yet cost-savings are irrelevant to whether a benefit should be included as part of the "public charge" test, which, according to the Department, is premised on promoting self-sufficiency.

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[62] Kaiser Family Foundation, "Community Health Centers: Recent Growth and the Role of the ACA" (Jan. 2017), available at https://www.kff.org/medicaid/issue-brief/community-health-centers-recent-growth-and-the-role-of-the-aca/.
[63] Guttmacher Institute, "Publicly Funded Family Planning Services in the United States" (Sept. 2016), available at https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states.
[64] Leighton Ku and Alyse Freilich, "Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston" (Feb. 2001), available at https://aspe.hhs.gov/system/files/pdf/72701/report.pdf.
[65] Dhruv Khullar et al., "Safety-Net Health Systems At Risk: Who Bears The Burden Of Uncompensated Care?," Health Affairs (May 2018), available at https://www.healthaffairs.org/do/10.1377/hblog20180503.138516/full/.
[66] Wendy E. Parmat, "The Health Impact of the Proposed Public Charge Rules," Health Affairs (Sept. 2018), available at https://www.healthaffairs.org/do/10.1377/hblog20180927.100295/full/.
[67] Cindy Mann et al., Manatt Health, "Medicaid Payments at Risk for Hospitals Under Public Charge" (Nov. 2018), available at https://www.manatt.com/Insights/White-Papers/2018/Medicaid-Payments-at-Risk-for-Hospitals-Under-Publ.
[68] 83 Fed. Reg. at 51,174 (noting that the Department is considering including CHIP "because the total Federal expenditure for the program remains significant," among other reasons).

Moreover, as with Medicaid and the other benefits implicated by the Proposed Rule, the inclusion of CHIP would likely lead to many eligible children forgoing health care benefits, whether because they are directly implicated by the rule, or because of the overall "chilling effect" it would generate. Nearly 9 million children across the country depend on CHIP for their health care.[69] CHIP has been a significant factor in dramatically reducing the rate of uninsured children across the U.S. According to the Kaiser Family Foundation, between 1997 (when CHIP was enacted) through 2012, the uninsured rate for children fell by half.[70] Moreover, Medicaid and CHIP together have contributed to lowering disparities in coverage affecting children of color.[71] The application of the "public charge" test to CHIP recipients would threaten to reverse these gains in health care access and equity in coverage.

II. The Department's attempt to justify the Proposed Rule by reference to promoting "self-sufficiency" is incoherent.

The Department claims that its proposed changes, such as counting Medicaid enrollment against individuals in "public charge" determinations, are aimed at promoting "self-sufficiency" among immigrants.[72] One need look no further than the Proposed Rule's preamble to see that this is untrue. There, the Department itself acknowledges that the rule could decrease the disposable income and increase the poverty of families and children, including U.S.-born children—and that immigrants could experience lost productivity, adverse health effects, medical expenses due to delayed health care, and increased disability claims.[73]

In fact, the Proposed Rule is more likely to reduce the ability of immigrants and their families to support themselves. The rule's inclusion of Medicaid is a telling example. Discouraging enrollment in Medicaid in the name of self-sufficiency reflects a fundamental misunderstanding of how a large segment of the population obtains health care. Medicaid is critical to the ability of immigrants in the workforce, especially those with low earnings, to cover routine preventive care as well as any unexpected medical needs. In 2016, approximately 24 percent of workers in the United States earned wages at or below the poverty-level.[74] Almost one-third of all workers earn

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[69] *See* Medicaid.gov, https://www.medicaid.gov/chip/index.html, based on 2017 Statistical Enrollment Report.

[70] Kaiser Family Foundation, "The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" (Jul. 2014), available at https://www.kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-the-research-tell-us.

[71] Econofact, "CHIP and Medicaid: Filling in the Gap in Children;s Health Insurance Coverage," (Jan. 2018), available at https://econofact.org/filling-in-the-gap-of-childrens-health-insurance-coverage-medicaid-and-chip.

[72] *See, e.g.*, 83 Fed. Reg. at 51,123; *Id*. at 51,160 ("Cash aid and non-cash benefits directed toward food, housing, and healthcare . . . bear directly on self-sufficiency.").

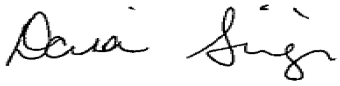
[73] 83 Fed. Reg. at 51,270, 51,277.

[74] Economic Policy Institute, State of Working America Data Library, "Poverty Level Wages," (Feb. 13, 2017), available at https://www.epi.org/data/#?subject=povwage; CPS ORG | Census Bureau (poverty threshold); *see also* https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references.

under $12 per hour.[75] A predominant characteristic of employers of this category of workers is that they do not offer employer-sponsored health insurance, and they do not pay enough for workers to buy insurance coverage on their own. In reality, almost no person in the U.S. would be insured without government assistance, and low-wage workers in particular rely on Medicaid for their health needs. For these reasons, counting Medicaid enrollment as a negative factor in the "public charge" test bears no rational connection to the Department's apparent goal of promoting self-sufficiency.

For the above reasons, we urge the Department to withdraw the Proposed Rule, and instead, turn its attention to improving the health of all people in the U.S.

Respectfully,



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[75] Economic Policy Institute and Oxfam America, *Few Rewards: An Agenda to Give America's Working Poor a Raise* (2016), available at https://www.oxfamamerica.org/static/media/files/Few_Rewards_Report_2016_web.pdf.