December 10, 2018

*Submitted Electronically via Regulations.gov*

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

**RE: DHS Docket No. USCIS-2010-0012; Proposed Rule on Inadmissibility on Public Charge Grounds**

Dear Ms. Deshommes:

On behalf of the American Heart Association and the American Stroke Association (AHA), we would like to express our significant concerns regarding the Department of Homeland Security's (DHS or the Department) notice of proposed rulemaking (NPRM or proposed rule) on inadmissibility on public charge grounds (public charge). We strongly oppose the proposed rule and urge the Department to withdraw it.

The American Heart Association is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease—the leading cause of death in the United States. Our nonprofit and nonpartisan organization includes more than 40 million volunteers and supporters committed to our goal of improving the cardiovascular health of all Americans, including immigrants and their families. The AHA funds innovative research to accelerate advances in preventing heart disease and stroke; works to advance strong public health policies; and provides critical tools and information to health care providers, patients, and families to prevent and treat these deadly diseases.

We have long advocated for policies that support and encourage everyone, including immigrants and their families, to have access to affordable, quality health insurance coverage and nutritious foods. In addition, recent research has established a clear link between stable housing and better health outcomes, including cardiovascular disease (CVD). Critically important public assistance programs like Medicaid, Medicare Part D, the Children's Health Insurance Program (CHIP), the Supplement Nutrition Assistance Program (SNAP), and housing

assistance have not previously been considered in immigration determinations, including public charge review, for good reason. These programs ensure that families – including U.S. citizen children living with an immigrant parent – have access to medical care, adequate nutrition, and safe shelter. Seeking a basic standard of living should not be a condition of remaining in the country and efforts to reform public charge policy should not impede access to health care, housing, or food.

We are deeply concerned that the proposed rule would harm the health and wellbeing of immigrants, their families, the communities in which they reside, and – as the Department itself suggests – American citizens. We therefore urge the Department to withdraw the proposed rule immediately. Any efforts to alter the current immigration system should not be done to the detriment of health and wellbeing of individuals and communities throughout the United States.

*The Proposed Rule Represents a Substantial and Unnecessary Change in Policy*

The proposed rule would alter the public charge test significantly. Under current policy, a public charge is defined as an immigrant who is "likely to become primarily dependent on the government for subsistence."[1] During the "Personal Responsibility and Work Opportunity Reconciliation Act of *1996"* (1996 welfare reform law), Congressional intent laid out in the conference report was clear: "public health, nutrition, and in-kind community service programs should not be considered in the public charge test."[2] Despite this clear declaration of intent issued by Congress, the proposed rule would expand the public charge definition to any immigrant who "receives one or more pubic benefits related to health care, nutrition, and housing, among others."[3] This shift to include non-cash-based programs, including programs designed to provide health care services to low-income individuals and meals to the food insecure, drastically increases the scope of those who can be considered a public charge. This increase would include not just people who receive benefits as the main source of support, but also people who use basic needs programs to supplement their earnings from low-wage work, many of whom work more than 40 hours a week but remain underemployed.

Additionally, under current guidance in effect since 1999, criteria for determining if an immigrant could be deemed a public charge has been limited to cash assistance for income maintenance and government funded long-term institutional care – and only when it represents the majority of a person's support.[4] If the proposed rule is finalized in its current form, immigration officials could consider a much wider range of government programs in the "public charge" determination. These programs include most Medicaid programs, SNAP, housing benefits, and even assistance for seniors who need help paying for prescription drugs through the Medicare Part D program.

The rule also makes other changes, such as introducing an income test and weighing negatively many factors that have never been relevant during previous determinations. For example, the proposed rule details how age (i.e. being a child or a senior), having a large family, or having a treatable medical condition could be held against immigrants seeking permanent legal status. This approach would be detrimental in improving health

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[1] 64 Fed. Reg. 28689
[2] H.R. Rep. No. 104-828 (Conference Report), at 144 (1996).
[3] Department of Homeland Security, *Proposed Rule: Inadmissibility on Public Charge Grounds*. 83 Fed. Reg. 51,114, 51,277. October 10, 2018.
[4] Ibid.

outcomes, given that CVD is projected to impact more than 100 million Americans in the United States by 2030.[5] The rule also indicates a preference for immigrants who speak English, which would mark a fundamental change from our nation's historic commitment to welcoming and integrating *all* immigrants. Because this rule targets family-based immigration as well as low and moderate wage workers, it will also have a disproportionate impact on people of color. These proposals amount to a sea change in American policy towards immigration, counting wealth and income as the primary indicators of a person's future contribution.

*Chilling Effect and Program Eligibility*

The proposed rule could create a chilling effect on immigrants and their families, making individuals afraid to access programs and undermining access to critical health, food, and other supports for eligible immigrants and their families. Among the most harmed by the proposed rule are children, including U.S. citizens and citizen children, whose participation in safety net programs would likely decrease, despite eligibility.

Approximately 25.9 million people could be potentially impacted by the proposed public charge rule, accounting for an estimated eight percent of the U.S. population. This number represents individuals and family members with at least one non-citizen in the household and who live in households with earned incomes under 250 percent of the federal poverty level. Of these 25.9 million people, approximately 9.2 million are children under 18 years of age who are family members of at least one noncitizen or are noncitizen themselves, representing approximately 13 percent of our nation's child population.[6]

In the proposed rule, the Department admits that reduced use of the safety net programs by eligible immigrants would lead to negative outcomes, including: "worse health outcomes, an increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children; reduced prescription adherence; increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment; increased prevalence of communicable diseases, among members of the U.S. citizen population who are not vaccinated; increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient; increased rates of poverty and housing instability; and reduced productivity and educational attainment."[7] States would incur increased costs to meet the needs associated with poorer health, education, and worker productivity – outcomes this proposed rule could create.

We also know that many vulnerable people are dual eligible – meaning they qualify for more than one safety net program. This proposed rule would spur immigrants who are legally authorized to participate in SNAP, Medicaid, Medicare Part D, and housing assistance not only forgo receiving benefits from these programs or disenroll, but would

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[5] American Heart Association. *Cardiovascular Disease: A Costly Burden to America.* October 2017. https://healthmetrics.heart.org/wp-content/uploads/2017/10/Cardiovascular-Disease-A-Costly-Burden.pdf. Accessed December 3, 2018.

[6] 2012-2016 5-Year American Community Survey Public Use Microdata Sample (ACS/PUMS); 20122016 5-Year American Community Survey (ACS) estimates accessed via American FactFinder; Missouri Census Data Center (MCDC) MABLE PUMA-County Crosswalk. Custom Tabulation by Manatt Health. September 30, 2018. https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[7] Department of Homeland Security, *Proposed Rule: Inadmissibility on Public Charge Grounds*. 83 Fed. Reg. 51,114, 51,277. October 10, 2018.

also discourage them from participating in other programs for which they are eligible and that are not covered by the proposed rule, such as WIC, school meals, summer meals, CACFP, the Affordable Care Act (ACA), CHIP, and other programs that help support health and wellbeing. For example, WIC, a program not targeted by the proposed rule – has reported that at least 18 states show enrollment declines of up to 20 percent,[8] a sign that even the threat of cutting access or jeopardizing immigration status spurs an exodus from all safety-net programs among immigrants.

The inclusion of SNAP and Medicaid in the public charge review will undermine state efforts to streamline enrollment processes and thus create a more burdensome screening process that will inevitably lead to new barriers and decreased participation, even for programs not covered under the proposed rule. For example, the Child Nutrition Act specifically authorizes WIC as adjunctively eligible for SNAP and Medicaid, reducing certification requirements and paperwork.[9] Almost 75 percent of WIC participants meet these eligibility criteria, and those service providers at the state and local level rely on streamline enrollment and certification procedures. In the school meals program, SNAP-participating children are direct certified at 92 percent.[10] Increasing direct certification of school meal eligibility has been not only a goal of Congress,[11] but takes a heavy burden off already overwhelmed school food service staff. This rule would generate confusion and create more work for federal, state, and local agencies; schools; and service providers as they try to interpret and navigate its implications.

Furthermore, these programs work in tandem with each other and a cut to one can lead to negative consequences for another. An investment in one safety net program is an investment for all. For example, WIC has shown to save in Medicaid costs: for every dollar spent on WIC, Medicaid cost savings for the first 60 days after birth range from $1.77 to $3.13 for newborns and mothers combined, and $2.84 to $3.90 for newborns alone.[12] The drop in WIC participation referenced earlier – despite not being included in the proposed rule – can lead to higher Medicaid spending. In addition, children who receive SNAP experience fewer hospitalizations than similar children who do not have access to SNAP.[13] We also see that families with access to both housing subsidies and other assistance programs – like SNAP – were 72 percent more likely to have stable housing.[14]

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[8] Evich HB. Immigrants, fearing Trump crackdown, drop out of nutrition programs. *Politico*. https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292. Accessed November 27, 2018.

[9] 42 U.S.C. § 1786(d)(2)(A)(ii), (iii).

[10] U.S. Department of Agriculture, Food and Nutrition Services. *Direct Certification in the National School Lunch Program.* October 2018. https://fns-prod.azureedge.net/sites/default/files/ops/NSLPDirectCertification2016.pdf. Accessed December 3, 2018.

[11] Ibid.

[12] U.S. Department of Agriculture. *The Savings in Medicaid Costs for Newborns and their Mothers from prenatal Participation in the WIC Program.* 1990. https://fns-prod-azureedge.net/sites/default/files/SavVol1-Pt1.pdf. Accessed November 20, 2018.

[13] Cook JT, et al. Child food insecurity increases risks posed by household food insecurity to young children's health. *Journal of Nutrition*. 2006.

[14] Sandel M., et al. Co-enrollment for child health: how receipt and loss of food and housing subsidies relate to housing security and statutes for streamlined, multi-subsidy application. *Journal of Applied Research on Children: Informing Policy for Children at Risk.* 2014.

*SNAP*

Despite being one of our costliest and most prevalent chronic diseases, CVD is largely preventable, and we can reduce its prevalence and cost by adopting healthy habits such as eating a nutritious diet. Among modifiable risk factors, poor dietary habits are a leading cause of death and disability. In particular, low-income people and vulnerable communities struggle to put food on the table – let alone healthy food – and are at the highest risk for heart failure.

For more than 50 years, SNAP has been vital in addressing food insecurity and nutrition in the United States. SNAP has a positive impact on health, educational attainment, and economic self-sufficiency;[15] indeed, food insecurity costs the United States $178 billion in preventable health care, educational, and lost work productivity. SNAP benefits insulate many vulnerable populations from food insecurity, including many low-income immigrants, children, people with disabilities, and older Americans. Food insecurity is associated with diabetes, heart disease, obesity, high blood pressure, chronic kidney disease, and depression,[16] and reduced participation in SNAP could cause a spike in the prevalence of chronic conditions associated with poor nutrition.[17]

Children whose pregnant mothers had access to SNAP have shown lower rates of infant mortality and low birthweight,[18] and children who participate in SNAP have a decreased likelihood of developing obesity, high blood pressure, heart disease, and diabetes[19] – all of which are costly, preventable chronic conditions. Food insecurity is also linked with

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[15] American Heart Association. Farm Bill Policy and the Supplemental Nutrition Assistance Program (SNAP). March 2017. http://www.heart.org/-/media/files/about-us/policy-positions/prevention-nutrition/farm-bill-policy-and-snap-ucm_494779.pdf?la=en&hash=6535F1BDA73DD46585CD868AB5A1AB0FDCD824. Accessed September 26, 2018.

[16] American Heart Association. Farm Bill Policy and the Supplemental Nutrition Assistance Program (SNAP). March 2017. http://www.heart.org/-/media/files/about-us/policy-positions/prevention-nutrition/farm-bill-policy-and-snap-ucm_494779.pdf?la=en&hash=6535F1BDA73DD46585CD868AB5A1AB0FDCD824. Accessed September 26, 2018.

[17] Food Research and Action Center. *Hunger and Health: The Role of the Supplemental Nutrition Assistance Program in Improving Health and Well-Being.* 2017. http://frac.org/wp-content/uploads/hunger-health-role-snap-improving-health-well-being.pdf. Accessed October 5, 2018.

[18] Shapiro, I. *The Safety Net's Impact: A State-by-State Look.* Center on Budget and Policy Priorities. August 2016. http://www.cbpp.org/blog/the-safety-nets-impact-a-state-by-state-look. Accessed September 26, 2018.

[19] Hoynes H, Schanzenbach DW, Almond D. Long-run impacts of childhood access to the safety net. *American Economic Review.* 2016; 106(4): 903-934. http://gspp.berkeley.edu/assets/uploads/research/pdf/Hoynes-Schanzenbach-Almong-AET-2016.pdf. Accessed September 26, 2018.

poor educational performance and academic outcomes in children.[20, 21, 22, 23] When a child of an immigrant mother participates in SNAP, that child is more likely to be in good or excellent health.[24] Reducing access to SNAP will lead to poorer health outcomes and higher health care costs.

Analysis of the impacts of the 1996 welfare reform law showed a sharp decline in SNAP participation (then called food stamps). Food stamp use fell by 43 percent among U.S. citizen children with a non-citizen parent in a five-year period, and 60 percent among refugees, even though their eligibility was not restricted by the law.[25] According to the Department, 2.5 percent of the eligible immigrant population would disenroll or forgo enrollment in SNAP under this rule. That decrease in enrollment amounts to 129,563 vulnerable people who would not receive critical benefits to ensure their families can eat. Families experiencing food insecurity may choose to forgo other necessary expenses to help stretch the budget, such as forgoing medicine, medical treatment, or rationing food. These coping strategies exacerbate existing chronic conditions and compromise health.[26]

By making it more difficult for immigrant families to access SNAP benefits, the proposed rule would worsen health outcomes and food insecurity and undercut efforts to address poverty. For example, according to the 2017 Census Bureau's Supplemental Poverty Measure, SNAP moved 3.4 million people out of poverty. Studies show that a mere six months on SNAP reduced the likelihood of food insecurity by one-third compared to similar households[27] and increased long-term food security.[28]

Prohibiting access to or discouraging use of SNAP benefits, as this rule would do, would cost more money in the long-run, worsen health outcomes, decrease academic success, lead to less workforce productivity, put a more onerous burden on states and the private

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[20] Jyoti DF, Frongillo EA, Jones SJ. Food insecurity affects school children's academic performance, weight gain, and social skills. *Journal of Nutrition*, 135, 2831-2839. 2005.
[21] Shanafelt A, Hearts MO, Wang Q, Nanney MS. Food insecurity and rural adolescent personal health, home, and academic environments. *Journal of School Health,* 86(6), 472-480. 2016.
[22] Nelson BB, Dudovitz RN, Coker TR, Barnert ES, Biely C, Li N, Szilagyi PG, Larson K, Halfon N, Zimmerman FJ, Chung PJ. Predictors of poor school readiness in children without developmental delay at age 2. *Pediatrics*, 138(2), e20154477. 2016.
[23] Howard LL. Does food insecurity at home affect non-cognitive performance at school? A longitudinal analysis of elementary student classroom behavior. *Economics of Education Review*, 30, 157-176. 2011.
[24] De Cuba SE, et al. Punishing Hard Work: The Unintended Consequences of Cutting SNAP Benefits. Children's HealthWatch. 2013.
[25] Batalova J, Fix M, Greenberg, M. *Chilling effects: the expected public charge rule and its impact on legal immigrant families' public benefits use.* Washington, DC: Migration Policy Institute. June 2018. https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.
[26] Food Research and Action Center. *Hunger and Health: The Role of the Supplemental Nutrition Assistance Program in Improving Health and Well-Being.* 2017. http://frac.org/wp-content/uploads/hunger-health-role-snap-improving-health-well-being.pdf. Accessed October 5, 2018.
[27] Mabli J, Worthington J. Supplemental Nutrition Assistance Program participation and child food security. *Pediatrics*. 2014.
[28] Vericker T and Mills G. Childhood Food Insecurity: The Mitigating Role of SNAP. Urban Institute. 2012.

sector, and hurt local economies. We recommend that DHS exclude SNAP from consideration in a public charge determination in the final rule.

*Housing Assistance*

Housing assistance, such as the Section 8 Housing Choice Voucher Program, Project-Based Section 8 Rental Assistance, Section 8 Moderate Rehabilitation, and Public Housing, make housing more affordable for low-income families, enabling them to move to safer neighborhoods and reduce housing insecurity. Subsidized housing programs have been associated with positive physical and mental health outcomes for children and their families, and the mitigation of several factors that can impair a child's academic success such as frequent moves, school transitions, and homelessness.[29]

Cutting access to housing assistance would result in rates of housing instability surging, productivity and educational attainment decreasing, and poverty increasing.[30] For example, according to the 2017 Census Bureau's Supplemental Poverty Measure, housing assistance moved 2.9 million people out of poverty.

Creating affordable housing addresses a most fundamental human need and is transformative for health and well-being. Experiencing housing instability limits access to preventive care, leads to poor health status, and can lead to chronic disease, like CVD. We recommend that DHS exclude housing assistance from consideration in a public charge determination in the final rule.

*Medicaid*

The AHA represents more than 100 million patients with CVD, including many who rely on Medicaid as their primary source of care.[31] In fact, 28 percent of adults with Medicaid coverage have a history of CVD[32] and the Medicaid program provides critical access to prevention, treatment, disease management and care coordination services for these individuals. Additionally, the connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance or are underinsured, have higher mortality rates[33] and poorer blood pressure control[34] than their insured counterparts. Further, uninsured stroke patients suffer from

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[29] Bailey KT, Cook JT, Ettinger de Cuba S, Casey PH, Chilton M, Coleman SM, Cutts DB, Heeren TC, Rose-Jacobs R, Black MM, Frank DA. Development of an index of subsidized housing availability and its relationship to housing insecurity. *Housing Policy Debate;* 26(1): 172-187. 2016.

[30] Kaiser Family Foundation. Proposed Changes to "Public Charge Policies for Immigrants: Implications for Health Coverage. September 2018. https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage. Accessed September 25, 2018.

[31] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf. Accessed June 19, 2017.

[32] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

[33] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*; 23(4): 223-233. 2004.

[34] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.

greater neurological impairments, longer hospital stays,[35] and a higher risk of death[36] than similar patients covered by health insurance. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid provides the coverage backbone for the health care services these individuals need.

The AHA is deeply concerned that including Medicaid in the public charge determination will result in coverage losses for immigrants and their families. Access to medical coverage and care can have serious implications for an individual's ability to work, attend school, and support their families. Locking immigrants out of the Medicaid program not only has a negative impact on their immediate ability to maintain or improve their health, but also reduces their ability to contribute back to their communities.

Conversely, the positive effects of access to Medicaid on health outcomes are clear. Medicaid coverage is associated with improved health in adults, improved health and developmental outcomes in children, and declines in infant mortality and morbidity.[37] As compared to children without health insurance, children enrolled in Medicaid in their early years have better health, educational, and employment outcomes not only in childhood but later as adults. In fact, Medicaid coverage in early childhood (birth to age 5) is associated with improved health in adulthood (ages 25 to 54), including lower likelihood of high blood pressure, heart disease, Type 2 diabetes, and obesity.[38] Policies that result in the mass exodus of families from these programs threaten to have decades-long ramifications for our nation's health and economic wellbeing.

Medicaid is also an indispensable funding source for safety-net hospitals and clinics, which are financially vulnerable. More than 35 percent of visits to safety-net hospitals are covered by Medicaid.[39] Medicaid is the single largest source of funding for community health centers in both Medicaid expansion and non-expansion states. In California, where one of every two children have an immigrant parent, more than half of all children are enrolled in the state's Medicaid program.[40] There is a direct relationship between the number of patients covered by Medicaid in a safety-net facility's service area and the facility's financial health. Community Health Centers in Medicaid expansion states have more locations, see more patients, and have better provider to patient ratios as

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[35] Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.
[36] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*; 298:2886 –2894. 2007.
[37] March of Dimes Issue Brief: Value of Medicaid, https://www.marchofdimes.org/materials/Value-of-Medicaid-Issue-Brief-April-2015.pdf.
[38] Boudreaux MH, Golberstein E, McAlpine DD. The long-term impacts of Medicaid exposure in early childhood: Evidence from the program's origin. J Health Econ. 2016;45:161-75. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785872/pdf/nihms-761668.pdf.
[39] Essential Data: Our Hospitals, Our Patients (America's Essential Hospitals 2017) https://essentialhospitals.org/wp-content/uploads/2017/06/AEH_VitalData_2017_Spreads_NoBleedCropMarks.pdf. Accessed December 10, 2018.
[40] California Department of Health Care Services Research and Analytic Studies Division. *Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group – September 2015*. Medi-Cal Statistical Brief. January 2016.

compared to non-expansion states.[41] Studies confirm a strong relationship between Medicaid coverage and hospital closures, with hospitals in Medicaid expansion states 84 percent less likely to close than those in non-expansion states.[42]

*CHIP*

The proposed rule requests specific feedback on the inclusion of CHIP in the determination process. CHIP is a program for working families who earn too much to be eligible for Medicaid without a share of cost. Making the receipt of CHIP a negative factor in the public charge assessment or including it in the "public charge" definition would exacerbate the problems with this rule by extending its reach further to moderate income working families – and applicants likely to earn a moderate income at some point in the future.

More than nine million children across the U.S. depend on CHIP for their health care.[43] Including CHIP in a public charge determination would likely lead parents to forgo enrolling eligible children because of the direct inclusion in the public charge determination and concern about its implications for their status as citizens. In addition to the harm that would be caused by this rule, the inclusion of CHIP would be counter to Congress' explicit intent in expanding coverage to lawfully present children and pregnant women. Section 214 of the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states a new option to cover, with regular federal matching dollars, lawfully residing children and pregnant women under Medicaid and CHIP during their first five years in the U.S. This was enacted because Congress recognized the public health, economic, and social benefits of ensuring that these populations have access to health care.

Continuous, consistent coverage without disruptions is especially critical for young children, as experts recommend 16 well-child visits before age six, to monitor their development and address any concerns or delays as early as possible. As noted by the Georgetown Center for Children and Families: a child's experiences and environments early in life have a lasting impact on his or her development and life trajectory.[44] The first months and years of a child's life are marked by rapid growth and brain development.

We are also concerned that DHS notes that the reason it does not include CHIP in the proposed rule is 1) that CHIP does not involve the same level of expenditures as other proposed programs under consideration for a public charge determination; and 2) that noncitizen participation is relatively low. Whether or not there is a large government expenditure on a particular program is irrelevant to the assessment of whether a particular individual may become a public charge. A public charge determination must be

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[41] Community Health Centers: Recent Growth and the Role of the ACA (Kaiser Family Foundation Issue Brief. 2017. https://www.kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/. Accessed December 10, 2018.

[42] Health Affairs. *Understanding The Relationship Between Medicaid Expansions And Hospital Closures*. January 2018. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0976. Accessed December 10, 2018.

[43] Centers for Medicare and Medicaid Services. Children's Health Insurance Program (CHIP). https://www.medicaid.gov/chip/index.html. Accessed December 10, 2018.

[44] Georgetown University Health Policy Institute Center for Children and Families. *Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers.* November 21, 2018. https://ccf.georgetown.edu/2018/11/21/using-medicaid-to-ensure-the-healthy-social-and-emotional-development-of-infants-and-toddlers/. Accessed December 3, 2018.

an individualized assessment, as required by the Immigration and Nationality Act, and not a backdoor way to try to reduce government expenditures on programs duly enacted by Congress.

Overall, we believe the benefits of excluding CHIP and Medicaid certainly outweigh their inclusion in a public charge determination. We recommend that DHS continue to exclude CHIP from consideration in a public charge determination in the final rule but also exclude receipt of Medicaid for the same reasons.

*Seniors*

The number of seniors in the United States who are immigrants is on the rise. Between 1990 and 2010, the number of immigrants age 65 and older grew from 2.7 million to nearly five million. This increase is due to the aging of the immigrant population who arrived during the 1980s and 1990s, as well as the rise in naturalized citizens who sponsor their parents to immigrate to the U.S. In fact, 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 percent of all admissions and almost 30 percent of family-based admissions.[45]

The proposed rule will undoubtedly impact seniors living in immigrant families in the U.S. who will be afraid to access the services they need. More than 1.1 million noncitizens ages 62 and older live in low-income households, meaning they are likely to rely on public assistance programs to meet their basic needs. [46] Having health insurance is especially important for older adults because they have greater health care needs. Medicare is a lifeline for most seniors, providing coverage for hospital and doctors' visits, and prescription drugs. However, many immigrant seniors are not eligible for Medicare.

Moreover, many Medicare beneficiaries rely on other programs to help them afford out-of-pocket costs. Almost one in three Medicare beneficiaries enrolled in the Part D prescription drug coverage get extra help with their premiums and copays through the low-income subsidy.[47] Reducing out-of-pocket costs has been identified as a key factor in improving medication adherence, and consequently improving health outcomes and reducing health care costs.[48] In fact, the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services have identified nonadherence to medical therapies as a leading factor in blood pressure control, which is an important risk factor for CVD outcomes.[49] If older immigrants are deterred from taking advantage of these

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[45] Department of Homeland Security. *2016 Yearbook of Immigration Statistics.* November 2017. www.dhs.gov/sites/default/files/publications/2016%20Yearbook%20of%20Immigration%20Statistics.pdf.

[46] Manatt. *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard.* October 11, 2018. https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population#DataDashboard. Accessed December 3, 2018.

[47] Kaiser Family Foundation. *Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing*. May 17, 2018. www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/. Accessed December 10, 2018.

[48] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes: a literature review. *Pharmacy and Therapeutics.* 2012; 37: 45-55.

[49] Ritchey M, Chang A, Powers C, Loustalot F, Schieb L, Ketcham M, Durthaler J, and Hong Y. Disparities in Antihypertensive Medication Nonadherence Among Medicare Part D Beneficiaries. *Centers for Disease Control and Prevention Vital Signs.* 2014. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6536e1.pdf. Accessed December 3, 2018.

prescription drug discounts for which they fully qualify, they may be unable to access or adhere to the medications they need but can no longer afford. Nearly seven million seniors ages 65 and older are enrolled in both Medicare and Medicaid, and one in five Medicare beneficiaries rely on Medicaid to help them pay for Medicare premiums and cost-sharing. Medicaid is also critical for long-term care, home and community-based services, dental care, transportation, and other services Medicare does not cover and older adults could not otherwise afford.[50] We recommend that DHS exclude Medicare Part D from consideration in a public charge determination in the final rule.

*Effect on Jobs and the Economy*

The Department does recognize that the proposed changes would have a detrimental impact on "state and local economies, large and small businesses, and individuals." However, the Department severely underestimates the extent of the damage the rule would have on employment and local economies.

As mentioned above, Medicaid is the largest source of funding for community health centers and makes up 35 percent of payments made to safety-net hospital systems. Decreasing the ability of immigrants to use the Medicaid program could have severe downstream impacts for hospitals and other community health care services by increasing uncompensated care costs and reducing access to routine and preventive care.

Hospital closures affect access to care for all residents of their service areas. A study of California hospitals found increased rates of deaths among inpatients in facilities located in hospital service areas where an emergency department had closed. Rates of death increased by ten percent among nonelderly adults and 15 percent among patients who had heart attacks. The impact of hospital closure on access to care is particularly significant in rural communities, which generally have difficulty attracting health care providers and which providers often leave in the wake of a hospital closure. The effects of hospital closures extend beyond reduced access to health care and poorer health outcomes. Hospitals are major employers and purchasers of goods and services. The loss of jobs associated with a hospital closure is especially devastating in rural areas, which have smaller populations and a historic reliance on declining industries. Moreover, some industries and employers will not locate in an area without a hospital, leaving communities without hospitals unable to attract some employers.

In SNAP, the proposed rule would directly hurt the more than a quarter of a million retailers that participate in SNAP, as well as agriculture producers.[51] In the former, more than 80 percent of these retailers are smaller and/or locally owned stores – contributing to the local economy[52] and job market. The latter is also noteworthy: in 2017 more than

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[50] Henry J. Kaiser Family Foundation. Medicaid Enrollment by Age. www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-age/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed December 3, 2018.

[51] Department of Homeland Security, *Proposed Rule: Inadmissibility on Public Charge Grounds*. 83 Fed. Reg. 51,114, 51,277. October 10, 2018.

[52] Wolkomir E. *SNAP Boosts Retailers and Local Economies.* Center for Budget and Policy Priorities. April 6, 2018. https://www.cbpp.org/research/food-assistance/snap-boosts-retailers-and-local-economies. Accessed December 2, 2018.

$22.4 million in SNAP benefits were spent at farmers markets.[53] Many farmers, farm workers, and their families are also beneficiaries of SNAP, which would mean these changes would hit them hard twice. In addition, immigrants are a pivotal part of the nation's agriculture labor force – increasing fear and a loss of access to critical safety net programs would mean a smaller, less healthy, and less productive food-growing work force.

The decrease in SNAP participation under the proposed rule would be harmful to local economic activity in real, tangible dollars. The U.S. Department of Agriculture estimates that every $5 in new SNAP benefits generates $9 in economic activity.[54] Because SNAP benefits are so urgently needed, the benefits are spent quickly – 97 percent of benefits are redeemed by the end of the month. This proposed rule would also have a profound impact on the economic output of retail grocery stores, as well as the availability of healthy foods for all consumers, as demand for these foods decrease. Cutting access to SNAP means less spending to support local economies.

The proposed rule simply and harmfully shifts the costs from the federal government to states, localities, and charitable and nonprofit organizations – sectors that are already struggling to meet the needs of their communities. If the federal government decides to pull out in investing in SNAP, the need for food and nutrition does not suddenly disappear. For example, after the 1996 welfare reform law was implemented, several states invested money to meet the need for food assistance – but that investment was not sustainable. In addition, charitable networks, such as food banks, pantries, religious congregations, and other emergency food providers are already overwhelmed, unable to serve all the people who need assistance. Feeding America, a nationwide network of more than 200 food banks, estimates that for every 12 meals SNAP provides, its network provides one.[55] The proposed rule put stress on already scarce resources at the state level and private sector, and it would create an unmanageable demand for nonprofits and other emergency food providers to absorb the increase need.

*The Health Care Workforce*

There are numerous immigrants in the health care workforce and across the highly-skilled labor industry. Employers that sponsor highly-skilled foreign workers could get swamped with red tape by the proposed changes to public charge policy, as their employees will have to navigate additional new barriers to prove that their change of status or extension of stay request is not likely to become a public charge. The proposal specifies that the U.S. Citizenship and Immigrations Services (USCIS) will, for the first time, be mandated to explicitly determine that a nonimmigrant beneficiary of either a change of status or extension of stay request is not likely to become a public charge, including an F-1 student changing status to H-1B or any L-1 or H-1B extension of stay. This proposed change will undoubtedly cause complications in the adjudication of

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[53] Farmers Market Coalition. Supplemental Nutrition Assistance Program (SNAP). https://farmersmarketcoalition.org/advocacy/snap/. Accessed December 10, 2018.

[54] Hanson K. *The Food Assistance National Input-Output Multiplier (FANIOM) Model and the Stimulus Effects of SNAP.* U.S. Department of Agriculture Economic Research Service. October 2010. https://www.ers.usda.gov/webdocs/publications/44748/8003_err103_reportsummary_1_.pdf?v=0. Accessed November 27, 2018.

[55] Food Research and Action Center. *The Hunger Impact of the Proposed Public Charge Rule.* http://frac.org/wp-content/uploads/hunger-impact-proposed-public-charge-rule.pdf. Accessed November 9, 2018.

nonimmigrant visa petitions filed by employers. Previously, employment-based immigrants with an offer of employment from an employer with the ability to pay has sufficed for USCIS. The proposed change specifies that such confirmed employment is a positive factor but not dispositive, which will lead to significant complications in the adjudication of adjustment of status applications filed by employment-based immigrants sponsored by U.S. employers in their underlying Immigrant Visa Petition.

As it relates to health care, one in four of America's doctors are foreign-born.[56] Many of these doctors, who are admitted to and stay in the country via temporary work and exchange visa categories, would now be subject to public charge under the proposed rule. Foreign-born doctors are integral in narrowing access gaps, eliminating barriers to health care, and meeting the needs of patients – especially the most vulnerable. According to a 2018 report by the American Immigration Council, in areas where more than 30 percent of the population lives below the federal poverty rate, nearly one-third of doctors are foreign-trained.[57] Moreover, 20.8 million people across the country live in areas where foreign trained doctors account for at least half of all doctors.[58] Rural clinics and public safety-net hospitals, in particular, rely on foreign medical school graduates to take care of isolated and vulnerable populations.

Year after year, research shows increasing physician shortages in both primary and specialty care, not only due to increased demand among the patient population, but significant strain on United States medical schools and teaching hospitals to supply enough doctors to meet that demand. In fact, by 2030, the United States could see a shortage of up to 120,000 physicians, posing serious consequences for patient care across the nation.[59] Lack of access to preventive health care providers could be the difference between a patient suffering a heart attack, or instead, lowering their blood pressure by living a healthier lifestyle or using medication. The shortage in physicians may also mean patients use emergency rooms as their primary source of care, which is a more expensive and less efficient way to provide care.

Further, a full 25 percent of home health aides are foreign-born and one-third receive public benefits.[60] If these workers forego health coverage, they will miss more days of work, burdening their employers and the vulnerable people for whom they provide care. Moreover, it is accepted wisdom that there will be an increased need for home care workers as the U.S. population ages. If candidates for these low-wage, yet critically important jobs are denied admission on public charge grounds or are unable to extend or change their nonimmigrant status due to low incomes, vulnerable seniors may be forced to leave their homes and receive more expensive care in nursing homes.

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[56] Migration Policy Institute. *Foreign-Born Health Care Workers in the United States.* June 27, 2012. https://www.migrationpolicy.org/article/foreign-born-health-care-workers-united-states. Accessed December 3, 2018.
[57] American Immigration Council. *Foreign-Trained Doctors are Critical to Serving Many U.S. Communities.* January 17, 2018. https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities. Accessed December 3, 2018.
[58] Ibid.
[59] Association of American Medical Colleges. *New Research Shows Increasing Physician Shortages in Both Primary and Specialty Care.* April 11, 2018. https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/. Accessed December 3, 2018.
[60] PHI. U.S. Home Health Care Workers: Key Facts. https://phinational.org/wp-content/uploads/legacy/phi-home-care-workers-key-facts.pdf. Accessed December 3, 2018.

The American Heart Association has long advocated the growth and diversification of the United States' health care workforce. We also believe that any initiative to reform health care should be attentive to the challenges associated with a changing population, including an increased demand for providers and a growing number of Americans with chronic and serious health conditions. Harsh policies such as the proposed expansion of public charge run counter to those efforts by discouraging – or altogether preventing – talented, foreign-born, highly skilled workers and health care professionals from pursuing careers in the United States. Just as important, limiting the ability of foreign medical graduates to immigrate to and practice in the United States would be detrimental to all Americans across the country – especially those in underserved areas – who are in desperate need of the medical care these doctors could provide.

*Chronic Illness*

The proposed rule would introduce into existing public charge evaluations a broad range of "heavily weighted negative factors" including an applicant's "medical condition that requires extensive treatment or institutionalization" and whether the applicant is uninsured and does not have sufficient resources to pay for medical costs related to the condition. Further, the rule also targets other, non-health care coverage programs that have a direct impact on health outcomes and chronic disease.[61] As advocates representing the interests of individuals living with chronic conditions and their families, we are deeply troubled by the discriminatory implications of such a policy and its potential impact on the millions of individuals with chronic illnesses or disabilities we serve.

Not only does this send the signal that individuals with chronic health conditions are "undesirable" but the proposed rule ignores the reality that chronic but treatable illnesses such heart disease, diabetes, cancer, or multiple sclerosis are not accurate indicators of future self-sufficiency and full-time employment capabilities. Relapsing-remitting conditions are characterized by wide variations in symptoms and effects, and most people with chronic conditions lead productive and independent lives throughout most of their adult years. In addition, and to which the Department alludes, it is counterintuitive to prohibit access to programs like SNAP and housing assistance that help prevent and mitigate chronic conditions, like CVD.

*Conclusion*

The Department's troubling approach to cutting access to and discouraging participation in safety net programs will not only increase costs and lead to more bureaucracy, but also jeopardizes the food security, health, well-being, and economic security of vulnerable immigrants. As an organization, we are committed to helping insure that all Americans, including immigrants and their families, have access to the resources they need to live longer, healthier lives free from cardiovascular disease and stroke. Given the substantial negative impact on the populations we serve, the AHA strongly opposes the proposed rule and urges the Department to immediately withdraw it.

We appreciate the opportunity to submit comments on the proposed rule. If you have any questions or would like to discuss these comments further, please contact Katie Berge, Government Relations Manager at katie.berge@heart.org or 202-785-7909 or

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[61] Department of Homeland Security, *Proposed Rule: Inadmissibility on Public Charge Grounds*. 83 Fed. Reg. 51,114, 51,277. October 10, 2018.

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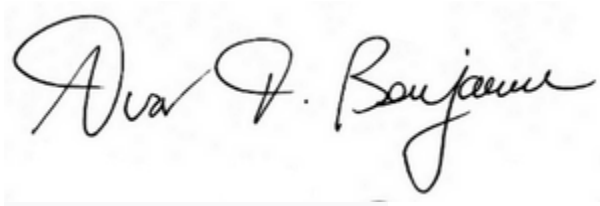
Sincerely,



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