AAPCHO

ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

December 7, 2018

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

Submitted electronically via www.regulations.gov.

Re: DHS Docket No. USCIS-2010-0012, RIN 1615-AA22, Comments in Response to Proposed Rulemaking: Inadmissibility on Public Charge Grounds

Dear Ms. Deshommes:

The Association of Asian Pacific Community Health Organizations (AAPCHO) submits these comments to express our strong opposition to the Department of Homeland Security's (DHS) Notice of Proposed Rulemaking (NPRM or proposed rule) on **Inadmissibility on Public Charge Grounds** published in the Federal Register on October 10, 2018. **We urge in the strongest possible way for the Department to withdraw the proposed rule in its entirety.**

AAPCHO is a national not-for-profit association of 32 community-based health care organizations, 28 of which are Federally Qualified Health Centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories, and freely associated states. Our members provide linguistically accessible, culturally appropriate, and financially affordable health care services to communities with high concentrations of medically underserved Asian Americans, Native Hawaiians and Pacific Islanders. In 2015, AAPCHO members served over 500,000 patients: 52 percent of these patients were best served in a language other than English; 88 percent had incomes at or below 200 percent of federal poverty level;[1] and 59 percent received health care coverage through Medicaid or the Children's Health Insurance Program (CHIP). The proposed rule would have a detrimental impact on the patients we serve.

The proposed rule radically changes the longstanding definition of "public charge" that is currently in use by immigration officials. Under the current definition of "public charge," only cash assistance programs and government funded long-term care (received or relied upon) by an applicant can be used to deny a person entry into the U.S. or deny legal permanent residency. The proposed rule dramatically expands that list to include the use of—or potential use of—non-emergency Medicaid, Medicare Part D low income subsidies, the

[1] AAPCHO. An Analysis of AAPCHO Health Centers. May, 2017. Available from http://www.aapcho.org/resources_db/aapcho-members-uds-fact-sheet/.

Supplemental Nutrition Assistance Program (SNAP, or food stamps), Section 8 housing assistance and other services as grounds for a public charge determination.

This proposed rule is a radical departure from existing policy, and its impacts on children, families, and older adults are sweeping and will impact millions of legally present immigrants. Nationally, 23 percent of all children in the U.S. (almost 18 million children aged 0-18 years old) have a parent who is an immigrant; two million of these children are of Asian descent.[2] This proposed rule is inconsistent with American values of fairness, equal treatment, and freedom from discrimination—and puts the health and well-being of these children and their families at risk. AAPCHO strongly opposes the proposed rule because:

- The proposed rule will result in fear and confusion about access to benefits for Asian American and Pacific Islander (AAPI) individuals, families and communities, undoing years of progress.
- The proposed rule endangers the health of AAPI immigrants, our communities and overall public health.
- The rule specifically discriminates against people with limited English proficiency.
- Health centers will be dramatically and negatively impacted by this proposed rule, undermining their ability to serve their patients.
- The proposed rule will eliminate the use of benefits that support immigrants' path to self-sufficiency and meaningful contribution to society.
- Health care costs, including emergency and hospital costs, will increase as immigrants delay or forgo preventive care and needed services, which could threaten the financial viability of health care facilities.
- The proposed rule threatens to discriminate against low income families and those with chronic health conditions, even if they have never applied for or enrolled in public support programs.

AAPCHO's specific comments are detailed below.

DETAILED COMMENTS

1. **The proposed rule will result in fear and confusion about access to benefits for Asian American and Pacific Islander (AAPI) individuals, families and communities, undoing years of progress.**

The proposed rule will have a dramatic impact on Asian American and Pacific Islander (AAPI) families and will **drive *eligible* AAPI patients away from health coverage and health care providers** by creating a "chilling effect," where families avoid critical services out of fear and confusion, even when they and their children are eligible.

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[2] Artiga S, Damico A, Garfield R. "Potential Effects of Public Charge Changes on Health Coverage for Citizen Children." Henry J. Kaiser Family Foundation, May 18, 2018. Accessed August 13, 2018.

In recent years, 3 out of every 10 individuals obtaining permanent residence status are from Asia and/or Pacific Island nations[3]; 40 percent of the millions of individuals and families waiting in long backlogs for family-based immigration are from Asia and/or Pacific Island nations[4]. All of these potential new Americans would be scrutinized under the new proposed rule and many would be deterred from participation in programs that they are eligible for and need to improve their and their families' health and well-being.

The proposed rule would deter many of these individuals and families from continuing to participate in critical health and other programs because they fear it will impact their immigration status. Initial reports from AAPCHO's members indicate that even people who are explicitly exempt from the proposed "public charge" rule—refugees, asylees, other immigrant groups, and *even U.S. citizens*—are confused by the "public charge" proposal and are becoming fearful of coming in for doctors' appointments.[5]

The timing of the new proposed "public charge" rule, with its expansive and radical nature, is a recipe for mass confusion among individuals and families who are eligible to receive services at our health centers. Children who come into our health centers for well-child visits and immunizations, or parents and older adults who come into our health centers for insulin or hypertensive medications will be fearful of being flagged by DHS. The enormity of these consequences threatens to drive entire families away from our health centers even if they are U.S. citizens and fully eligible for services.

As a result, the proposed rule threatens the incredible progress that AAPCHO health centers and other health care providers nationally have made in educating and signing up eligible families for insurance and programs for which they are legally eligible. Studies have shown that administrative barriers deter families from enrolling children, even when they are eligible.[6] AAPCHO health centers have worked to reduce those administrative barriers and misperceptions about eligibility requirements. If the proposed rule is implemented, children and families will disenroll from programs like Medicaid, SNAP and public housing, or not sign up in the first place.[7] Rates of uninsurance will increase; for example, if the proposed rule is implemented, AAPCHO estimates that up to 86,000 patients *at AAPCHO member health centers alone* will disenroll from Medicaid, which could threaten the financial viability of our health centers and/or limit the services our health centers can provide to individuals that keep communities healthy and productive.[8] Overall, research shows that the rule's chilling effect could cause between 354,000 and 646,000 community health center patients to forgo Medicaid coverage.[9]

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[3] Department of Homeland Security, Yearbook of Immigration Statistics 2016, https://www.dhs.gov/immigration-statistics/yearbook/2016.
[4] Department of State, Annual Report of Immigrant Visa Applicants, 2017, https://travel.state.gov/content/dam/visas/Statistics/Immigrant-Statistics/WaitingList/WaitingListItem_2017.pdf.
[5] A full list of exempted groups are listed on the USCIS' Public Charge web page.
[6] CHIPRA. Medicaid.gov: Keeping America Healthy. Accessed August 12, 2018.
[7] Emily Baumgaertner, "Spooked by Trump Proposals, Immigrants Abandon Public Nutrition Services." New York Times, March 6, 2018.
[8] AAPCHO analyzed the impact of the proposed "public charge" rule on AAPCHO member organizations. We drew from: Migration Policy Institute (MPI) estimates based on analysis of American Community Survey pooled data, 2014-16, taken from: Batalova, Jeanne, Michael Fix, and Mark Greenberg. 2018. Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use. Washington, DC: Migration Policy Institute. AAPCHO also used service utilization data from the Uniform Data System (UDS), 2016, Health Resources Services Administration (HRSA), the U.S. Dept. of Health and Human Services.
[9] Geiger Gibson / RCHN Community Health Foundation Research Collaborative. "How Could the Public Charge Proposed Rule Affect Community Health Centers?", November 2018. Available from https://www.rchnfoundation.org/?p=7294.

2. **The proposed rule endangers the health of AAPI immigrants, our communities and overall public health.**

This proposed rule undermines access to basic health, nutrition and other critical programs for eligible AAPI immigrants and family members. Research shows that policies that reduce coverage have negative health effects, particularly for low-income families and people with chronic health conditions.[10]

It would make child poverty worse by discouraging enrollment in programs that address health, hunger and economic security, with profound consequences on families' well-being and long-term success, and approximately 25.9 million people earning less than 250 percent of federal poverty level would be affected by the potentially chilling effects of the proposed public charge rule, including U.S. citizen children. Cutting services as a result of this proposed rule will have a ripple effect, hurting patients most immediately and then people who serve them which affects the entire community.

When they are insured, people are more willing to access preventive and primary care because there is less concern about surprise medical bills. Children who have coverage are more likely to get medical care for "common childhood conditions, such as sore throat, or for emergencies, such as a ruptured appendix." Children with health coverage have higher survival rates during emergencies than children who are uninsured. Research studies show that Medicaid coverage is effective in reducing infant and teen mortality.[11]

The Migration Policy Institute has estimated that 1.4 million AAPIs who are not U.S. citizens are members of families who have individuals who rely on Medicaid and the Children's Health Insurance Program (CHIP)[12]. This includes 182,000 children. The proposed rule explicitly counts use of Medicaid against a person's immigration status. Further, the proposal seeks comment on whether CHIP should be added to the list of negatively weighted programs, and we strongly oppose the addition of CHIP or any other program that supports the health, nutrition, housing or education of children to the list of negatively weighted programs.

Neither CHIP nor Medicaid nor any other program that supports the health, nutrition, housing, and/or education of children should be considered during a public charge determination. Together, Medicaid and CHIP provide basic health care for individuals, children, and families that allows them to work, have better economic futures, promotes self-sufficiency, and improves our collective public health. Even the Department concedes that the proposed rule would "increase poverty of certain families and children, including U.S. citizen children" and lead to "worse health outcomes, including prevalence of obesity and malnutrition, especially for pregnant and breastfeeding women, infants, and children," among other health impacts.

People with coverage also report improved mental health, and reduced clinical depression compared to people who are uninsured. Driving people away from using mental health services is a mistake, particularly for community health center patients who are already dealing with exposure to violence, stresses of poverty and

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[10] Benjamin Sommers, et al. Health Insurance Coverage and Health—What the Recent Evidence Tells Us. The New England Journal of Medicine, Massachusetts Medical Society, August 10, 2017.

[11] Julia Paradise, Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid. Henry J. Kaiser Family Foundation, March 23, 2017.

[12] Migration Policy Institute, Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use, June 2018,

who are living in neighborhoods that are severely under-resourced. For the children who we serve, there are lifelong consequences of mental health issues that are left unaddressed.

AAPCHO health centers see a disproportionate number of people with chronic conditions such as diabetes and hypertension. Our health centers also play a critical role in the control of infectious diseases, including tuberculosis, hepatitis B, measles, and influenza. Making families fearful of using their health coverage to access preventive services, such as vaccinating themselves and their children against influenza, measles, and hepatitis B endangers the public's health due to the increased likelihood of national infectious disease outbreaks caused by undervaccinated communities and undermines community health centers' critical role in protecting the public's health.

3. **The rule specifically discriminates against people with limited English proficiency.**

The proposed rule adds lack of English proficiency as a negative factor, meaning that people with limited English proficiency (LEP) will be negatively judged during their determination. This disproportionately harms AAPI immigrants and other populations with high levels of LEP. As decades of research have demonstrated, LEP patients have greater needs and often less access to community resources. AAPCHO's health centers serve LEP patients and provide in-language services that improve health and health care outcomes.

The agency's public charge statute does not include English proficiency as a factor to be considered in an individual's assessment and determination. It only refers to *education and skill*. This proposed rule does not offer a full justification for its proposal to add English proficiency, and its addition is not supported by its evidence. For example, the agency states that those who cannot "speak English may be unable to obtain employment in areas where only English is spoken." There is a significant difference between English proficiency and having no ability to speak the language, which the agency appears to conflate here. Many individuals, including those served by our member health centers, have limited but some English proficiency and are able to serve many employment roles contributing to their community. Second, the U.S. is a deeply multilingual country, where 63 million people speak a language other than English at home. In fact, there are at least 60 counties in the United States where over 50 percent of the population speaks a language other than English including some of the most heavily populated counties.

4. **Health centers will be dramatically and negatively impacted by this proposed rule, undermining their ability to serve their patients.**

Nationally, health centers serve 28 million underserved patients, including half of all AAPIs in poverty. The health center model and mission ensure access to affordable health care so that all individuals can contribute to their communities and reach their full potential. On average, patients use their health centers five times a year. Patients served range from children who are coming in for well-child visits and preventive vaccinations, parents, adults and children with infectious diseases like influenza, tuberculosis and viral hepatitis, and seniors with diabetes, hypertension, heart disease, arthritis, and other chronic diseases.

As currently drafted, this proposed rule is in direct contrast to the mission of community health centers. Health centers and other safety-net health care providers have seen the effects of changes to the public charge doctrine in the past. Following the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, a climate of fear and confusion was created among immigrants, preventing them from enrolling in critical programs and keeping them from seeking medical care.

The proposed rule creates undue administrative burden on health centers. Responding to increased numbers of patient inquiries, training staff on the policy changes, and having to manage disenrollment and re-enrollment processes (a.k.a. "churn") requires more staff time and adds unnecessary costs to health centers; this siphoning off of time and resources distracts from the actual provision of health care. Furthermore, disenrollment due to public charge will wipe out reductions in uninsured rates which health centers have worked hard to eliminate over the past several years.[13]

Furthermore, the proposed rule puts health care providers in the profound ethical dilemma of counseling patients on treatment options while knowing patients could face consequences in their immigration status if they decide to receive essential health care or get the medicines they need to remain healthy and productive. Already health care providers are beginning to field questions from patients and are having to explain the immigration risks of using health care services. This is in direct conflict with the Hippocratic oath that health care providers take to "do no harm."[14]

AAPCHO members are community health centers (more specifically known as Federally Qualified Health Centers or FQHCs) and other nonprofit community-based health organizations that primarily serve Medicaid and uninsured patients. FQHC services include medical, mental health, dental, lab, pharmacy, health education, and non-clinical "enabling" services including health insurance enrollment assistance, and interpretation and translation. The Medicaid program is the primary source of funding that supports AAPCHO's member health centers' ability to offer these services. As a result of patients forgoing Medicaid, health center revenue would markedly decrease. Total Medicaid revenue losses association with this rule range between $346 million and $624 million.[15] AAPCHO member health centers alone would suffer losses of approximately $65 million.

As health centers generally run on margins of less than 1 percent, they will have to cover these increased costs either with federal grant funding or by tapping into other vital funding streams that support the health center model of care. Because health centers will attempt to continue to see patients regardless of insurance status, uncompensated costs will go up, placing pressure on local communities to fill the funding gaps. Over time, the

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[13] Park JJ, Humble S, Sommers BD, Colditz GA, Epstein AM, Koh HK. Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders Under the Affordable Care Act. *JAMA Intern Med.* 2018;178(8):1128–1129. doi:10.1001/jamainternmed.2018.1476

[14] "Physicians regularly confront the effects of lack of access to adequate care and have a corresponding responsibility to contribute their expertise to societal decisions about what health care services should be included in a minimum package of care for all. Physicians should advocate for fair, informed decision making about basic health care." Code of Medical Ethics: Financing and Delivery of Health Care, AMA Code of Medical Ethics, American Medical Association. Accessed August 6, 2018.

[15] Geiger Gibson / RCHN Community Health Foundation Research Collaborative. "How Could the Public Charge Proposed Rule Affect Community Health Centers?", November 2018. Available from https://www.rchnfoundation.org/?p=7294.

multi-million-dollar loss to AAPCHO health centers will place pressure on health centers to cut services.[16] As health centers' capacity for patient care declines, between 295,000 and 538,000 patients nationwide could lose access to primary care.[17]

The majority of Medicaid funding at our health centers goes towards personnel. The team of clinic staff serving patients range from: front desk staff who register patients, enrollment staff who assist with Medicaid paperwork, medical assistants who take blood pressure and vitals, health educators who help with nutrition plans if patients have diabetes, high blood pressure, or heart disease. If patients are better served in a language other than English, bilingual staff serve the patient, or a trained interpreter provides assistance. If patients stop coming in for services, this places financial strain on our health centers and compromises our workforce.

5. **Eliminates the use of benefits that support immigrants' path to self-sufficiency and meaningful contribution to society**

AAPCHO members' patient populations are employed by industries and small businesses that do not typically offer their employees health insurance coverage, or if they do, the insurance is prohibitively expensive. Medicaid fills in these gaps and provides comprehensive coverage for patients and family members to work, go to school, and contribute back to society. Medicaid is a key support to help people stay healthy and well enough to work. Medicaid protects these families against the tremendous risk of enormous medical debt or bankruptcy if they get sick or get into an accident. Medicaid is a work support, not a handout. Supporting families to stay healthy, work and go to school benefits everyone.

According to the Bureau of Labor Statistics, overall in the U.S., 27.4 million immigrants (17.1 percent of the total U.S. labor force) are in the U.S. labor force.[18] These immigrant workers in the U.S. were more likely than native-born workers to be employed in service-oriented and non-management jobs:

- Service occupations (e.g., nutrition and beverage preparation, health assistants, maids and janitors, personal and home care);
- Production (e.g., factory workers, meat processing);
- Material moving (e.g., packing and moving, transportation/taxis, cleaning vehicles);
- Natural resources (e.g., farmworkers and laborers); and
- Construction, maintenance.

Asian Americans accounted for 25.2 percent of this immigrant labor force.[19] Many of the jobs that are available to people when they first arrive to the U.S. are low-wage service industry jobs that lack health

[16] AAPCHO estimates are based on data and estimates from: (1) the Migration Policy Institute (MPI) estimates based on analysis of American Community Survey pooled data, 2014-16 (2) Uniform Data System (UDS), 2016, Health Resources Services Administration (HRSA), the U.S. Dept. of Health and Human Services and (3) Kaiser Family Foundation, Medicaid Spending per Enrollee (Full or Partial Benefit), 2014.
[17] Geiger Gibson / RCHN Community Health Foundation Research Collaborative. "How Could the Public Charge Proposed Rule Affect Community Health Centers?", November 2018. Available from https://www.rchnfoundation.org/?p=7294.
[18] (Foreign-Born Workers: Labor Force Characteristics—2017, U.S. Dept. of Labor, Bureau of Labor Statistics, May 17, 2018).
[19] Ibid.

benefits. Immigrant workers earn less than U.S. born counterparts ($730/week versus $885 for U.S. born citizens).

This proposed rule will result in millions of people forgoing coverage through Medicaid. With no offer of employer-sponsored health insurance, or where premiums are too high, these individuals will have no other options for health insurance. They will become uninsured and forgo the preventive care and other services necessary to keep them healthy enough to work and be self-sufficient.

6. **Health care costs, including emergency and hospital costs, will increase as immigrants delay or forgo preventive care and needed services.**

The savings that AAPCHO health centers and other primary care providers generate will be lost under the proposed rule, because patients will delay or forgo primary care until health conditions escalate to an emergency situation. Studies have shown that patients who get the majority of their care at FQHCs save an average of $2,371 in total spending per patient annually, including 33 percent lower spending on specialty care, 27 percent lower inpatient costs and 25 percent fewer hospital admissions.[20] Additional studies have found that patients with continuous access to primary care providers have better patient outcomes, better satisfaction, and fewer hospitalizations.[21,22]

The proposed rule discourages immigrants who are lawfully-present from accessing public programs, including preventive and primary care. If patients drop out of Medicaid and avoid receiving health care from their health centers and primary care providers, emergency department visits and hospitalizations will rise. Waiting until a medical condition is advanced and serious endangers people's lives, places emotional stress and financial risk on families, and drives up costs for everyone.

7. **The proposed rule threatens to discriminate against low income families and those with chronic health conditions.**

The proposed rule would introduce an unprecedented income test that would make it significantly more difficult for low- and moderate-income legal immigrants to get a green card or extend or change their temporary status in the United States—putting AAPI and other immigrant families at high risk of being separated. **In particular, those earning less than 125 percent of federal poverty level, which is $31,375 for a family of four in the continental U.S. in 2018, could cause legal immigrants' green cards to be denied, which would also harm families with U.S. citizen children, since federal poverty level is determined by household size, even if no family members apply for any public benefits.** Only legally present immigrants earning more than 250 percent of federal poverty level would potentially have their incomes classified as a highly positive factor when their applications are reviewed for green card approval based on the proposed rule.

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[20] Laff, Michael. Study Finds Savings at Federally Qualified Health Centers, American Academy of Family Physicians (AAFP), October 10, 2016.

[21] Van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. Journal of Evaluation in Clinical Practice. Vol. 16, Issue 5, October 2010, pages 947-956.

[22] Pourat N, Davis A, Chen X, Vrungos S, Kominski G. In California, Primary Care Continuity was Associated with Reduced Emergency Department Use and Fewer Hospitalizations, 10.1377/hlthaff.2014.1165 HEALTH AFFAIRS 34, NO. 7 (2015): 1113–1120.

An estimated 25.9 million people would be potentially chilled by the proposed public charge rule, including U.S. citizen children. 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, equivalent to an income of $62,750 for a family of four living in the continental U.S. in 2018, which is above the 2018 U.S. median income, even if they have applied for no public benefits. Of these, approximately 9.2 million are children under 18 years old who are family members of at least one non-citizen or are non-citizens themselves.[23] According to the currently proposed changes to the public charge rule, these individuals would be at risk of having their green card applications denied, potentially separating families, including those with U.S. citizen children, even if these individuals are contributing to the U.S. economy through working and paying federal, state, and local taxes, and based on this proposed rule, these individuals may be afraid to enroll their U.S. citizen children in essential health and nutrition programs, even if their children are eligible for these services.

In addition, under the proposed rule, individuals with chronic medical conditions such as arthritis, heart disease, and other chronic diseases could be denied a green card, particularly if they are uninsured or underinsured, which discriminates against these individuals, and has the potential to separate families based on a diagnosis of a chronic medical condition that can be controlled if individuals have access to necessary health care. As individuals who are eligible for health and nutrition programs may be afraid to enroll in these programs that would provide access to health care through non-emergency Medicaid, Medicare Part D low income subsidies, and similar programs, the proposed change to the public charge rule would not only cause individuals to become needlessly uninsured because they are afraid to enroll in health insurance they are eligible for, but their being diagnosed with chronic health conditions that can be prevented and controlled with basic primary care services could cause them to be denied a green card and potentially separated from their families due to this proposed rule, which unfairly discriminates against individuals with pre-existing chronic health conditions.

We Urge DHS to Withdraw the Proposed Rule on "Public Charge"

Forty percent of the millions of individuals stuck in the U.S. immigration backlog are from Asian countries.[24] Even after getting a green card it can take ten years to become a U.S. citizen.[25] Yes, we need immigration reform, but attacking families' use of Medicaid, Medicare Part D, nutrition, housing and other programs is not it. We need a commonsense solution that reflects our fundamental American values of fairness, equal treatment, and freedom from discrimination.

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[23] 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, 9/30/2018. Found online at https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[24] Policy Blueprint for Action: Reforming the Immigration System. National Council of Asian Pacific Americans. Accessed August 13, 2018.

[25] Zong J, Batalova J, Hallock J. Frequently Requested Statistics on Immigrants and Immigration in the U.S., Migration Policy Institute, February 8, 2018. Accessed August 13, 2018.

We urge the administration to withdraw this proposal and re-focus on real policy issues: achieving affordable health care, providing jobs with health care, and commonsense immigration reform.

If you have any questions or need more information related to these comments, please do not hesitate to contact me at jeffc@aapcho.org.

Sincerely,

Jeffrey B. Caballero, MPH
Executive Director