NATIONAL ASSOCIATION OF
Community Health Centers

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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 via [www.regulations.gov](http://www.regulations.gov)*

**RE: Comments on DHS Docket No. USCIS-2010-0012 – Notice of Proposed Rulemaking on "Inadmissibility on Public Charge Grounds"**

On behalf of Community Health Centers (CHCs) and their 28 million patients across the country, we are writing to express our profound concern about the Administration's Notice of Proposed Rulemaking (NPRM) on public charge determinations.

The National Association of Community Health Centers (NACHC) is the national organization representing the more than 11,000 CHC sites across the country. CHCs are patient-centered organizations whose shared mission is to provide high-quality, affordable health care to all medically underserved patients, so they can have the opportunity to thrive, contribute to their communities, and reach their full potential. This proposed regulation will deter individuals -- including those seen at CHCs -- from addressing their own health care needs and those of their families, ultimately leading to worse health outcomes, higher costs, and reduced productivity. As these impacts are inconsistent with the CHC mission, we ask that the Administration reconsider this proposal.

We begin with a summary of our comments. We then provide general information on CHCs and their mission, in order to provide context for our concerns. Finally, we explain and provide evidence for our concerns.

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## Summary of Comments from the National Association of Community Health Centers

Community Health Centers (CHCs) are the backbone of the nation's primary care safety net. All CHCs are managed by their own patients and communities, and share a common mission of ensuring access to high-quality, affordable health care to all individuals, regardless of where they live, whether they have insurance, or their ability to pay. As the national organization representing CHCs, NACHC has profound concerns about the Administration's NPRM on public charge determinations, for the following reasons:

1. The NPRM may lead to worse health outcomes and decreased productivity for immigrants and their families, hampering their ability to become self-sufficient and contribute to their communities. Immigrants who might seek a Green Card in the near future will be deterred from participating in Medicaid, Medicare Part D, SNAP, and housing supports, potentially putting their health and productivity at risk. In addition, the "chilling effect" of these changes will spread far beyond the individuals and program directly impacted, as follows:
   - Individuals may refrain from seeking benefits that are not considered in public charge determinations, due to concerns about immigration consequences;
   - Individuals who are not subject to public charge determinations – such as refugees, asylees, and US citizens with immigrant family members – may refrain from using benefits, due to concerns about immigration consequences; and
   - Family members of immigrants who are subject to public charge may be negatively impacted, even if they are US citizens or not otherwise subject to public charge themselves.

2. The NPRM may discourage parents from seeking health care for their children, and including CHIP in public charge determinations will exacerbate this impact.

3. Given the important role that recent immigrants play in the US's food and personal care industries, risks to their health create could negatively impact the health of the broader population.

4. The NPRM may increase uncompensated care costs for CHCs and other safety net providers, potentially putting their financial stability at risk.

5. The NPRM may result in increased costs for US taxpayers.

6. The NPRM's cost-benefit analysis significantly underestimates the drop in participation in public benefits that could result from these proposed changes; it also fails to account for many significant costs that may result for safety net health care providers and other community organizations.

## Background on Community Health Centers (CHCs)

Community Health Centers are the "backbone" of the primary care safety net, and they all share three core characteristics:

- Mission-driven to ensure access to care for all individuals, particularly the medically underserved: By law and by mission, CHCs seek to ensure that all individuals have access to high-quality, affordable care -- regardless of where they live, whether they have insurance, or their ability to pay. CHCs are intentionally located in medically underserved areas or near underserved populations, and they never turn a patient away.

- Full range of services: Every CHC offers a full range of primary and preventive services, and a growing number also provide dental, behavioral health, and pharmacy services. CHCs also focus on addressing their patients' "social determinants of health". These are the non-medical factors that underlie and influence individuals' health status – such as their access to stable housing and adequate nutrition.

- Community-based and managed: Each CHC is governed by a Board of Directors, and by law a majority of the Board members are patients of the health center. CHCs cannot be owned or directed by outside organizations; as a result, each CHC is closely attuned to and aligned with the unique needs of its community.

CHCs currently serve over 28 million patients through more than 11,000 service delivery locations through the country. These patients include 1 in 9 children, 1 in 5 rural Americans, and 1 in 3 individuals living below poverty. Approximately 70 percent of CHC patients have incomes below the Federal Poverty Level (FPL); these individuals pay no more than a nominal fee for services. Another 20 percent of CHC patients have incomes below 101 – 200 percent FPL; they are charged on a sliding fee scale.

## NACHC Comments on the Public Charge NPRM

NACHC is profoundly concerned about the impacts that this proposal would have on immigrants, their families, and their communities, as well as on the health care "safety net" – including CHCs. Specifically:

**1. The NPRM will lead to worse health outcomes and decreased productivity for immigrants and their families, hampering their ability to become self-sufficient and contribute to their communities.**

The four categories of benefits specified in § 212.21(b) of the NPRM -- Medicaid, SNAP, public housing supports, and Medicare Part D subsidies – were all designed to keep individuals and families safe and healthy, so that they can thrive, contribute to their communities, and reach their full potential. However, this NPRM would create enormous negative consequences for immigrants who qualify for and use these benefits. The fear of triggering these consequences

may deter individuals from enrolling, or remaining enrolled in, these programs. The result would be worse health outcomes and lower productivity, reducing these individuals' ability to achieve self-sufficiency and contribute positively to their communities.

The NPRM's impact may extend far beyond legal immigrants who plan to seek a Green Card in the near future, and the four categories of benefits specified. It could result in a significant "chilling effect" – meaning that individuals may withdraw from, or not apply for, benefits for which they are eligible, even though receiving these benefits would have no impact on their immigration status. This chilling effect was widely observed following the passage of the Personal Responsibility and Work Opportunity Act (PRWOA) of 1996, and even within the past few months, as rumors about potential changes began circulating. This effect will manifest itself in several ways:

- Individuals may refrain from benefits that are not considered in public charge determinations due to misplaced concerns that doing so could harm their immigration status. CHCs are already witnessing this effect first-hand. As discussed above, CHCs are open to all and offer sliding fee discounts to all individuals within incomes below 200 percent FPL. CHCs around the country are already observing significant drops in visits by immigrant patients and their family members, due to concerns about the potential immigration consequences of seeking care.[1] For example, last winter a California health center that serves a large Asian immigrant population noted that its urgent care department was almost empty during the height of flu season – a dramatic drop which coincided with their patients first hearing about potential changes to public charge rules.

  This chilling effect has also been noted with regards to public immunization campaigns, raising concerns about public health impacts throughout entire communities. For example, soon after the passage of PROWA, public health officials battling the nation's largest outbreak of rubella stated that that "one of the problems in fighting the epidemic is that many in the Hispanic community are afraid of the health department because they equate it with the Immigration and Naturalization Service."[2] More recently, 75 cases of measles were confirmed in 2017 among a Somali-American community, and public health experts attributed this outbreak to low vaccination rates.[3]

  Chilling effects could also extend to programs that address the "social determinants" of health status, such as nutrition and housing. For example, the WIC program is widely agreed to "save lives and improve the health of nutritionally at-risk women, infants and children[4]"; in fact, the US Government website states that "[c]ollective findings of studies, reviews and reports demonstrate that the WIC Program is cost effective in protecting or improving the health/nutritional status of low-income women, infants and children."[5] The NPRM does not propose to include WIC in public charge determinations. Nonetheless, this past summer WIC agencies in at least 18 states reported drop of up to

[1] For example, see http://www.startribune.com/trump-proposal-stokes-anxiety-among-minnesota-immigrants/494863241/ and https://www.rollcall.com/news/politics/immigration-crackdown-raises-fears-seeking-health-care
[2] https://www.montanaprobono.net/geo/search/download.67362
[3] https://www.cdc.gov/measles/cases-outbreaks.html
[4] https://www.fns.usda.gov/wic/about-wic-how-wic-helps
[5] Ibid.

20 percent in enrollment, which they attributed largely to fears about the immigration policy – despite the fact that no changes had even been officially proposed.[6]

- Individuals who are not subject to public charge determinations – such as refugees, asylees, and US citizens with immigrant family members – may refrain from using benefits due to concerns and confusion about potential impacts on their immigration status. Following the passage of PRWOA, researchers documented extensive "statistical evidence of a withdrawal from benefits among populations whose eligibility was unchanged by the law[7], including refugees and U.S. citizen children."[8] For example, refugees' use of Medicaid dropped by 39 percent[9], and their use of Food Stamps fell 60 percent[10], even though the law did not restrict their eligibility for either program.

- Family members of immigrants who are subject to public charge may be negatively impacted, even if they are not subject to public charge themselves. When an individual is afraid to use benefits due to concerns about immigration consequences, their family members will often be negatively impacted, even if they are not subject to public charge determinations themselves. These impacts will be particularly acute among the one in four children in the United States who has at least one parent who is an immigrant.[11] If one of these parents is afraid to apply for SNAP for fear of the immigration consequences, then their children – who are generally US citizens[12] -- will be more likely to go hungry. If a mother is afraid to apply for WIC, her children will be at increased risk of low birth weight and other health problems. If a parent is concerned about accepting housing support, his US citizen children will lack safe, stable housing.

  Also, children's health and well-being is inextricably linked to that of their parents. Children fare better when their parents are healthy and stable - physically, emotionally, and financially. Parents who are unable to access adequate health care, nutrition, and housing for themselves face increased challenges in caring for their children. As such, any change that results in parents skipping or disenrolling from health, nutrition or housing programs could impact the health of their children throughout their life-span.

In summary, both the direct and "chilling" effects of this NPRM could lead to worse health outcomes and decreased productivity for immigrants and their families, in both in the immediate term and the long term. This is acknowledged in the proposed rule, which states that the rule could "increase poverty of certain families and children, including U.S. citizen children" and lead to "worse health outcomes… especially for pregnant and breastfeeding women, infants, and children", "reduced prescription adherence," and "increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated."

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[6] https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292

[7] Francisco I. Pedraza and Ling Zhu, "The 'Chilling Effect' of America's New Immigration Enforcement Regime," Pathways, Spring 2015, https://inequality.stanford.edu/sites/default/files/Pathways Spring 2015 Pedraza Zhu.pdf.

[8] https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families

[9] Michael E. Fix and Jeffrey S. Passel, Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997 (Washington, DC: Urban Institute, 1999), www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.

[10] Ibid.

[11] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

[12] Ibid. 86% of children who have at least one immigrant parent are US citizens.

These impacts are inconsistent with the CHC mission, which seeks to improve health outcomes by protecting and promoting the health of all underserved children and adults. We therefore ask that the Administration reconsider this proposal.

**2. The NPRM may discourage parents from seeking health care for their children, and including CHIP in public charge determinations could exacerbate this impact.**

Under the NPRM, if an immigrant child is uninsured and eligible for Medicaid, his parent will be faced with an untenable choice: either to enroll the child in coverage, knowing that doing so could prevent him from receiving a Green Card in the future, or to leave the child uninsured, hoping that he will suffer no long-term health consequences.

If CHIP were considered in public charge determinations, the number of parents and children who could face this untenable choice would be expanded significantly. Therefore, NACHC strongly opposes including CHIP in these determinations.

**3. Given the important role that recent immigrants play in the US's food and personal care industries, risks to their health create could negatively impact the health of the broader population.**

According the Forbes magazine, the most common job for newly-arrived immigrants is picking, grading and sorting agricultural products.[13] Other common jobs for new immigrants include personal care, cleaning, housekeeping, and taxi driving[14] – all roles which involve close physical proximity to other individuals. To the extent that new immigrants have physical contact with the food eaten by US citizens, as well as with the citizens themselves, they have the potential to spread communicable illnesses outside of their immediate communities. Thus, policies that discourage immigrants from seeking appropriate health care could place the health of the broader US population at risk.

**4. The NPRM could increase uncompensated care costs for CHCs and other safety net providers, potentially putting their financial stability at risk.**

In addition to the direct harm to immigrants and their families, this proposal could place significant financial strains on CHCs and other safety net providers, by increasing their uncompensated care costs while decreasing their revenues. This could occur in at least three ways:

- As discussed above, research clearly suggests that this proposal will deter immigrants from enrolling themselves and their children in Medicaid or CHIP. As health centers turn no one away -- regardless of whether they have insurance or are able to pay – CHCs will continue to care for these individuals, but will no longer receive Medicaid or CHIP reimbursement to help cover their costs.

[13] https://www.forbes.com/sites/karstenstrauss/2017/01/20/the-top-10-jobs-among-new-immigrants-and-what-they-show-us/#4127fd22141e
[14] Ibid.

- Uninsured persons tend to delay seeking care longer than insured persons, due to financial concerns[15]. As a result, by the time they finally seek care, they often are sicker and more expensive to treat – and more likely to end up in an emergency room or hospital. They are also more likely to develop prolonged, aggravated and even lifelong conditions that early medical intervention could have prevented or ameliorated.

- This rule could impact individuals' and families' ability to keep themselves healthy and productive, by impacting their "social determinants of health" such as access to stable housing and adequate food. This could ill lead to poorer health status and greater health care needs and costs in the long run.

All of these factors could result in higher uncompensated costs and lower reimbursement for CHCs and other safety net providers. Given that CHCs generally operate on margins of less than one percent, they would have to cover these shortfalls either with federal grants or by tapping into other vital funding streams that support the CHC model of care. Ultimately, this NPRM could negatively impact the financial stability of many CHCs.

**5. <u>The NPRM will result in increased costs for US taxpayers.</u>**

In addition to the impacts on immigrants, their families, and the safety net providers who care for them, this NPRM could increase costs and reduce revenues for US taxpayers overall. This would occur in several ways:

- <u>Increased costs for emergency Medicaid :</u> As discussed above, individuals who delay necessary medical care due to financial concerns are more likely to end up in an emergency room or hospital. To the extent that this care is covered under emergency Medicaid, US taxpayers will be required to cover these costs – costs which would have been lower if the individual has received care sooner.
- <u>Increased costs for services provided to US citizens – in both the short and long run:</u> As referenced above, 86 percent of children who have at least one immigrant parent are US citizens.[16] By discouraging immigrant mothers of US citizens from seeking prenatal care and WIC, this NPRM could increase the percentage of their children who are born prematurely and/or at a low birth weight (LBW). According to 2009 data from the March of Dimes, during the first year of life a premature/LBW infant incurred over $50,000 more in medical bills on average than an infant born at full gestation and/or weight[17]. To the extent that these children are US citizens, or their treatment qualifies as "emergency", these increased costs will often be borne by Medicaid or CHIP. In addition, LBW babies have a higher risk of physical and mental disabilities, including blindness, chronic lung disease and cerebral palsy.[18] These disabilities would result in higher taxpayer costs throughout the children's lifetimes, in the form of higher medical costs, increased education costs, and Social Security disability payments; they would

[15] For an overview of research concluding that uninsured persons delay seeking medical care, see https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

[16] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

[17] https://www.marchofdimes.org/news/premature-babies-cost-employers-127-billion-annually.aspx

[18] http://www.ncsl.org/research/health/low-birthweight-births.aspx

also reduce the children's chances of becoming self-sufficient and paying taxes as adults.

- Increased costs to control the spread of communicable diseases: To the extent that individuals delay care to avoid or treat communicable diseases, the health of their communities is placed at risk. This risk can lead not only to increased illness in the broader population, but also higher costs for taxpayers. For example, in 2004, a single case of measles was identified in Iowa; the costs incurred by the Iowa Department of Public Health to contain the disease totaled over $140,000.[19]
- Decreased tax revenues due to lower productivity for individuals who delayed care: As discussed above, individuals who delay care are more likely to develop prolonged, aggravated and even lifelong conditions that could have been lessened or prevented with early medical intervention. For example, stroke patients who arrive at the emergency room within three hours of their first symptoms often have less disability three months later than who delayed seeking care.[20] Thus, policies that discourage individuals from seeking medical care appropriately can increase their risk and level of disability; in turn, this reduces their ability to work and to pay taxes to their local, state, and national governments.

**6. The NPRM's cost-benefit analysis significantly underestimates the drop in participation in public benefits that will result from these proposed changes; it also fails to account for many significant costs that will result for safety net health care providers and other community organizations.**

In the Regulatory Impact Analysis (RIA), the Administration assumes that the regulation, if implemented as proposed, would cause lead to a 2.5 percent drop in enrollment in the four programs to be added to public charge determinations. NACHC believes that the RIA significantly underestimates the declines in participation in public benefits that could result from this rule, for the following reasons:

- The 2.5 percent disenrollment rate is far below actual disenrollment rates recorded after the passage of PRWOA. The Administration estimates the number of individuals likely to disenroll from or forego enrollment in a public benefit program as equal to 2.5 percent of the number of foreign-born non-citizens. By the Administration's own account, this estimate is significantly less than actual rates of disenrollment following the passage of PRWORA, which ranged from 21 to 54 percent, depending on the program. It is also significantly below rates of disenrollment that have already been observed in 2018 prior to the release of the NPRM, such as for WIC benefits.

- The RIA estimates consider only the four benefits proposed in the NPRM, while the chilling effect will lead to reduced enrollment in many other types of benefits: As discussed above, chilling effects spread far beyond the programs listed in the NPRM, and significant declines in participation have already been noted in programs such as

[19] https://www.ncbi.nlm.nih.gov/pubmed/15995008

[20] Fang J, Keenan NL, Ayala C, Dai S, Merritt R, Denny CH. Awareness of stroke warning symptoms—13 states and the District of Columbia, 2005. *MMWR* 2008;57:481–5.

> WIC, immunization campaigns and – most notably for us – primary health care services offered on a sliding-fee by CHCs.

Due to these shortcomings, NACHC requests that the Administration reconsider both its estimated rates of disenrollment, and the number of public programs that it considers in its RIA.

In addition, we are concerned that the NPRM's cost-benefit analysis fails to include estimates for the increase in uncompensated care costs for safety net providers, as well as many other indirect costs that would likely result if the rule were implemented as written. The NPRM explicitly lists several of these types of costs, including reduced revenues for:

> "healthcare providers participating in Medicaid, pharmacies that provide prescriptions to participants in the Medicare Part D Low Income Subsidy (LIS) program, companies that manufacture medical supplies or pharmaceuticals, grocery retailers participating in SNAP, agricultural producers who grow foods that are eligible for purchase using SNAP benefits, or landlords participating in federally funded housing programs."

Despite giving these examples of downstream costs, the NPRM fails to provide any numerical estimates for them. Such costs would be fairly straightforward to estimate, particularly given the data collected following the passage of PRWORA. We therefore request that the Administration estimate and consider these costs when analyzing the costs and benefits of this proposal.

In closing, this proposal could have numerous impacts that are in direct contradiction to the CHC mission of providing high-quality, affordable health care to all medically underserved patients, so they can have the opportunity to thrive, contribute to their communities, and reach their full potential. For this reason, we ask that the Administration reconsider this proposal.

Sincerely,

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