

Public Comment to oppose: “Inadmissibility on Public Charge Grounds”

DHS Docket No. USCIS 2010-0012

Agency: U.S. Citizenship and Immigration Services, Department of Homeland Security

December 10, 2018

We write on behalf of the François-Bagnoud Center for Health and Human Rights at Harvard University (Harvard FXB) to oppose the *U.S. Citizenship and Immigration Services* (USCIS) Proposed Rule: “Inadmissibility on Public Charge Grounds” and respectfully request that it be withdrawn.

Harvard FXB is an interdisciplinary center that conducts rigorous investigation of the most serious threats to health and wellbeing globally. We work closely with scholars, students, the international policy community, and civil society to engage in ongoing strategic efforts to promote equity and dignity for those oppressed by grave poverty and stigma around the world.

We are deeply concerned about the devastating impact that the public charge rule will have on immigrant communities and the broader public health. Media coverage of the draft rule has been impacting immigrant communities since February 2017, when it was first leaked; the Offices of Special Supplemental Nutrition Program for Women, Infants and Children were inundated with calls by immigrants request to have their names expunged from records.¹ This demonstrates an important point that goes far beyond the impact of the rule on the lives of the individuals to whom it pertains, the rule will have a broader chilling effect on many more families who are confused by the details of the rule, and choose to drop benefits for which they are eligible. The Fiscal Policy Institute estimates the potential chilling effect of the public charge rule will impact 24 million people, including 9 million children under 18.² Reduction in utilization of necessary health services and social benefits will plunge families into poverty,³ result in negative health outcomes⁴⁻⁶ and will have a ripple effect which harms the economy,² public hospitals and community health centers,^{7,8} and the broader public health.^{9,10} We will expound upon these points in greater detail in the comment below.

1) Millions of people will disenroll from essential benefit programs

The Department of Homeland Security acknowledges the reduction in Medicaid enrollment, which may occur in response to the public charge rule. However, it grossly underestimates that the proposed rule will reduce enrollment by only 2.5%.¹¹ Both previous research and extensive recent anecdotal evidence suggest that disenrollment rates will be much higher. Most studies looking at the impact of the public charge rule estimate Medicaid disenrollment rates ranging from 15% to 35%. These estimates include the potential chilling effect caused by fear that will likely lead individuals who are not directly impacted by the policy change to drop benefits. This chilling effect has been well-established through research after welfare reform resulted in decreased participation in public programs among immigrant families.¹²⁻¹⁵ Despite attempts to allay the fears of immigrants regarding their use of benefits, many eligible immigrants did not enroll themselves or their children out of fear even before the changes in the public charge rule were proposed.¹⁶ Recent research suggests that an increase in detentions and fear of deportation have increased families' fears of accessing public benefits, although policy changes have yet to be made.¹⁷

According to the Kaiser Family Foundation, 2.1 to 4.9 million Medicaid and CHIP enrollees living in a household with a noncitizen would disenroll from these programs.¹⁶ At these disenrollment rates, an estimated 875,000 to 2 million US-citizen children with a noncitizen parent could drop Medicaid/CHIP coverage despite remaining eligible. California Health Care Foundation notes that 4.8 million children in need of medical attention live in households with at least one noncitizen adult and are insured by Medicaid or CHIP. The study estimates that 700,000 to 1.7 million of those children are likely to be disenrolled from Medicaid or CHIP if the public charge rule is changed. Those disenrolled would include 122,000 to 285,000 children on prescribed medications, 102,000 to 238,000 newborns who will require multiple preventive visits and vaccines in their first five years, and 143,000 to 333,000 children with at least one potentially life-threatening condition, such as asthma, influenza, diabetes, epilepsy or cancer.¹⁸

A third study by Manatt uses data from the American Community survey to estimate that 41.1 million noncitizens and their family members living in the United States (12.7% of the total US population) could potentially be impacted as a result of the proposed changes in public charge

policy, including 10.7 million citizen children living in families with one or more noncitizen family members. The new income cutoffs make it much more likely for lower-income families to forego benefits. Nationwide, 25.9 million noncitizens and their family members below 250% of the Federal Poverty Level (FPL) are more likely to experience chilling impacts under the proposed public charge rule. The 14 million noncitizens and family members below 125% FPL are at greatest risk.¹⁹

Families may even avoid using health benefits, which are not part of the public charge rule, such as emergency Medicaid, because families need to apply for Medicaid in order to receive even emergency coverage and may refrain from doing so out of fear.⁸ Even if CHIP is not included in the final rule, families may decline to apply or disenroll from CHIP due to confusion or fear, as studies demonstrate that fewer than one-third of CHIP enrollees were accurately able to identify their type of coverage.²⁰

2) Declining Use of Health Benefits Will Cause Health Harm, Including Poor Outcomes, Preventable Deaths, and Increased Healthcare Costs

Adults and children who lose Medicaid/CHIP are likely to become uninsured,¹⁷ which will result in their foregoing necessary healthcare and lead to poor health outcomes, increased mortality rates and disability.^{18,21-23} Health insurance is an important predictor of access to healthcare. Families without health insurance will be unable to afford timely care and will go without care or experience healthcare delays.^{21,22} Decreased insurance coverage will lead patients to forego prenatal care and could lead to higher rates of low birth weight, infant morbidity and mortality, as well as decreased rates of well child visits and vaccinations.^{10,24} As the United States experiences a resurgence of communicable diseases such as measles and pertussis, lack of access to insurance may lead to further decreases in vaccination rates, which lead to disease outbreaks.^{9,10} Fear regarding immigration enforcement has also been linked to delays in care for communicable diseases.^{25,26} DHS acknowledges that worse health outcomes may result from the implementation of the proposed rule, including increased prevalence of communicable diseases and disease outbreaks.¹¹

Uninsured patients are much more likely to use more expensive emergency services than patients with insurance, who are more likely to access primary and preventive care.²⁷ Consistent adherence

with medical appointments and medications are essential to the care of chronic diseases, such as diabetes, high blood pressure, asthma, and HIV.⁴⁻⁶ Lack of consistent medical care for chronic conditions can result in poor health outcomes, increased mortality and increased healthcare costs.^{4-6,28-30} For example, delayed or lack of care for epilepsy can result in poor outcomes like permanent brain injury and associated increased costs.^{31,32}

Lack of health insurance also has important financial impacts on the uninsured and American society as a whole. Lack of insurance places people at risk of medical debt.³³ Medical debts contribute to over half of debt collections actions appearing on consumer credit reports in the United States³⁴ and contribute to almost half of all bankruptcies in the United States.³⁵ Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.³⁵ Lack of insurance is also associated with decreased productivity among American workers.³⁶

Public health insurance for children also has important financial benefits and has been demonstrated to reduce child poverty.³⁷ Prevention and treatment of childhood illnesses prevents children from missing school and allows parents to be more productive. Asthma-related school absences resulted in a loss in parental productivity of \$719.1 million in 1996.³⁸ Asthma deaths are largely preventable with appropriate care and cost society \$265 million in lost lifetime wages.³⁸

3) The Public Charge Rule Will Push People Into Poverty Resulting in Further Negative Health Impacts

A study published by the Center on Poverty and Social Policy at Columbia University estimates that up to 7.9 million people, including 2.9 million US citizen children will forgo SNAP benefits, as a result of the public charge rule change.³ These estimates take into account a chilling effect, which has already been taking place as social service agencies with large immigrant populations have reported an increase in canceled appointments and urgent requests for disenrollment in benefit programs.³⁹ Indeed, between 2016 and 2017, there was a 4% nationwide enrollment decline in SNAP, with declines as high as 10% in communities with large immigrant populations.⁴⁰ If households with at least one non-citizen disenroll from SNAP, the total US child poverty rate could increase from 12.2% to 13.2%, and the deep child poverty rate could increase from 2.6% to 3.1%. In

actual numbers, this means that more than 600,000 children could fall into poverty and nearly 300,000 children could fall into deep poverty.⁴⁰

Disenrollment in SNAP will cause affected individuals to lose food assistance and become food insecure. But, research also demonstrates that SNAP improves health throughout a person's life, reduces healthcare costs and improves self-sufficiency into adulthood.^{41,42} Poverty is inextricably linked to poor health, and higher income in the United States has been associated with greater longevity.⁴³ In fact, in a study, which examined income and life expectancy from 2001 to 2014, differences in life expectancy across income groups have increased over time, and wealthier individuals have seen significantly higher increases in life expectancy than their poorer counterparts.⁴³

Fear of utilizing housing benefits will also cause families to become homeless. Homeless individuals face significantly higher mortality rates⁴⁴ and housing assistance programs have been noted to decrease mortality rates.⁴⁵ Disruptive life events like homelessness at a young age may also have life-long health impacts for developing children.⁴⁶ A caregiver's ability to convey to children that they are safe and cared for is fundamental to healthy child development, which can be difficult for parents scrambling to keep a roof over their families' heads. Housing instability in childhood can have lifelong effects on children's physical and mental health.^{47,48}

4) Detentions, Deportations and Fear of Immigration Enforcement Negatively Impact Health of Immigrant Communities

A substantial body of research demonstrates the negative health effects of detention, deportation and fear of immigration enforcement. Decreased admissions of immigrants and increased family separations due to the public charge rule changes will likely exacerbate these health impacts. According to a study by the Migration Policy Institute, 69% of green-card applicants who are not refugees or other humanitarian admissions would have at least one characteristic considered a negative factor in the public charge test. If the new test were applied to the approximately 940,000 permanent residents admitted in FY 2017, about 650,000 would have been at risk of denial for having at least one negative factor. The proposed rule would therefore potentially reduce green card

issuance in the future substantially, making it more difficult for families to reunify.⁴⁹ Immigrants from Mexico and Central America, as well as working class individuals would be disproportionately more likely to be denied green-card status as a result of the new rule.⁴⁹

Both documented and undocumented immigrants report high levels of fear regarding immigration enforcement. Studies have demonstrated that such fear is associated with decreased utilization of health services, including preventive services and emergency department visits.^{25,50-61} Failure to access care can contribute to poor health status and result in suboptimal primary care outcomes and costly, acute care utilization in patients with asthma and diabetes.^{6,29,30,62}

Immigration enforcement and related sociopolitical stressors have also been linked with negative perinatal outcomes. After an immigration raid in Iowa, infants born to Latina mothers had a 24% greater risk of low birthweight when compared with the same period one year earlier.⁶³ A recent study in New York City before and after the 2017 US Presidential Inauguration found a significant increase in preterm births among Mexican and Central American immigrants after January 2017, when compared with the previous period.⁶⁴ Severe stressors can induce preterm birth, and in the case of this study, threatening political rhetoric or potential legislation, such as threatened policy changes like the public charge rule, may have impacted preterm birth rates of affected populations.⁶⁴

The new public charge changes may also result in denial of visas and green cards to increasing numbers of immigrants, and in turn increase the rates of family separations and associated fear and stress among immigrant families. US citizen children affected directly by parental deportation or detention have more depressive symptoms, lower freedom from anxiety and lower happiness and satisfaction scores.⁶⁵ Stressful life events, such as being separated from a parent can have lifelong impacts on the developing brain of a child⁶⁶ and can even alter gene expression and long-term development.⁶⁷ On the other hand, providing status to unauthorized immigrants, such as recipients of the Deferred Action for Childhood Arrivals program, significantly decreased adjustment and anxiety disorders among their children.⁶⁸

5) Public charge changes will negatively impact the health safety net, reducing revenue for health centers and hospitals in underserved communities

Community health centers and safety-net hospitals serve all patients with or without health insurance, regardless of their ability to pay. Community health centers (CHCs) depend on various sources of funding, including Medicaid (44%), federal health center operating grants (18%) and other federal, state and local grants (17%). CHCs receive only 10% of their funding from private health insurance. At community health centers across the country, 69% of patients who receive care have family incomes at or below the federal poverty level, with 91% having family incomes at or below 200% FPL. As Medicaid is the largest source of health center revenue, policies that affect Medicaid eligibility or enrollment can profoundly impact the ability of community health centers and public hospitals to continue to care for their underserved communities.

The Geiger Gibson/RHCM Community Health Foundation Research Collaborative estimates that 2.6 million patients may disenroll from Medicaid as a result of the public charge rule's chilling effect.⁷ As a result, health centers may experience a loss of between \$346 million and \$624 million dollars in a one-year period. Health centers will be forced to cut hours, close sites, and likely lay off 3,400 to 6,100 full time staff to compensate for these reductions.⁷ As a result, they may be able to serve between 290,000 to 538,000 fewer patients.⁷ At a moment in which the United States faces a national shortage of primary care physicians, this change could strike a devastating blow to the public health system, reducing healthcare access for our nation's most vulnerable communities. Community health centers provide care at over 11,000 sites in low-income urban and rural communities across the nation.⁶⁹ The spillover effects from the public charge rule will harm hundreds of thousands of patients born inside and outside of the United States.

Manatt Health estimates that 13.2 million Medicaid and CHIP recipients will be affected by the public charge rule. In 2016, these individuals accounted for an estimated \$68 billion in Medicaid and CHIP healthcare services. Hospital care comprises a substantial portion of those payments, and hospitals therefore risk of losing approximately \$17 billion in Medicare and CHIP payments per year, should the public charge rule be implemented.⁸ Patients who unenroll will continue to have health needs; however, they will avoid primary care and only access more costly emergency services.

Many safety net hospitals operate within narrow margins and could implement changes, which could affect all patients, as Medicaid payments decrease and uncompensated care increases.⁸

6) Immigrants subsidize the American health system

Contrary to popular belief and to the logic behind the new public charge rule, immigrants pay billions of dollars more into the American health system than they withdraw. According to a study published in *Health Affairs*, immigrants covered by private insurance and their employers contributed \$25 billion more in insurance premiums in 2014 than was spent on their care. In comparison, US-born enrollees spent nearly \$25 billion more than they paid for in premiums.⁷⁰ A second study demonstrates that immigrants similarly subsidize the Medicare trust fund. Immigrants accounted for 12.6% of premiums paid to private insurers in 2014, but only 9.1% of expenditures, contributing a surplus \$24.7 billion more to the Medicare pool than they withdrew.⁷¹ Between 2008 and 2014, immigrants contributed \$174.4 billion more than they withdrew in health benefits.⁷¹ This is likely due to the fact that immigrants are more likely to be younger and healthier compared with the American population. However, the findings suggest that reducing immigration could in fact reduce the numbers of healthy individuals in the insurance risk pool, thereby worsening the risk pool.^{70,71}

Conclusion:

In sum, the public charge rule could have a devastating impact on immigrant families and communities in the United States, which will have lifelong consequences for children and families. The chilling effect will drive millions of adults and children away from preventive services and life-saving care. As families forego essential housing and nutritional benefits, hundreds of thousands will be pushed into poverty and homelessness. Decreased vaccinations and untreated communicable diseases will place the American public at risk for outbreaks. Due to decreased revenues for the community health centers and hospitals, the public charge rule will debilitate the public health safety net, threatening healthcare access for millions of underserved communities of immigrants and US-born American citizens. The evidence clearly demonstrates the vital importance of these benefits for immigrant families and American society. Families should not have to choose between being

reunited with their loved ones and whether to feed their children or keep a doctor's appointment. The diversity of the United States is our greatest strength. The public charge policy aims to undermine that diversity by instituting changes to the immigration system, which discriminate against working class families, and immigrants from poor countries.

We once again respectfully urge you to withdraw the discriminatory U.S. Citizenship and Immigration Services (USCIS) Proposed Rule: "Inadmissibility on Public Charge Grounds."

Sincerely,



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Lara Jirmanus is a practicing family physician at Cambridge Health Alliance, a Clinical Instructor at Harvard Medical School and a Fellow at the FXB Center for Health and Human Rights at the Harvard T. H. Chan School of Public Health. Jirmanus has been involved in grassroots organizing, advocacy and research for many years, addressing worker and immigrant rights in the US and the impacts of conflict and displacement in the Middle East. Jirmanus completed her medical school training at the University of Massachusetts Medical School. She then completed a three-year family medicine residency at Boston University Medical Center. She then worked as a Chief Resident at the American University of Beirut (AUB) and a lecturer at the AUB Medical School. She completed a two year Global Women's Health Fellowship at Brigham and Women's Hospital in Boston, MA and a Master's in Public Health at the Harvard T. H. Chan School of Public Health.

Dr. Jirmanus has been a practicing physician for eight years, working in underserved communities with large immigrant populations in the Greater Boston area during this entire period. One-third of her practice has involved caring for children. She currently practices at Cambridge Health Alliance, one of the largest safety net hospitals in Massachusetts and where 56% of patients identify as non-white and 25% speak a language other than English. Due to her significant research with Syrian refugees, she convened and moderated a seminar at Harvard University in collaboration with the Harvard Middle East Initiative and the Harvard FXB Center for Health and Human Rights in 2016.

In February 2017, Jirmanus founded the Health and Law Immigrant Solidarity Network, a group of nearly 400 medical and legal professionals and community members working to support immigrant health in Eastern Massachusetts. She has spoken extensively on the topic of immigration and health at national and regional conferences, in continuing medical education events at her own institution and at local hospitals and universities. Her current research addresses the impact of immigration policies on health care utilization among patients at Massachusetts' two largest safety net hospitals, for which she has received funding from the American Board of Family Medicine and the Cambridge Health Alliance Foundation.

Arlan Fuller, JD, MA

Arlan Fuller is executive director of the FXB Center for Health and Human Rights at Harvard University and a research associate at the Harvard School of Public Health. His central areas of focus are in human rights law, international development, and US government operations and legislative strategy. He has led several research investigations focused on human rights and complex emergency response, as well as conducted field projects in both health and education service delivery.

Previously, he was the legislative assistant for international relations and trade policy to Congressman Sherrod Brown, at the time a senior member of the House International Relations Committee. In this role, he was responsible for the Congressman's policy campaign to increase US funding for global health efforts as well as organizing a legislative and whipping strategy with the House Democratic Caucus on trade policy issues. Mr. Fuller also worked for Senator Edward Kennedy, serving on the Senator's Health, Education, Labor and Pensions Committee staff, and focused on issues related to the National Institutes of Health.

Mr. Fuller received his BA in economics from the College of the Holy Cross. He holds a master's degree in peace and conflict studies from the University of Ulster, Northern Ireland, and a JD from Boston College Law School.

Mary T. Bassett, MD, MPH

Mary T. Bassett, MD, MPH, is director of the François-Xavier Bagnoud (FXB) Center for Health and Human Rights and FXB Professor of the Practice of Health and Human Rights in the department of Social and Behavioral Science at the Harvard T.H. Chan School of Public Health.

With more than 30 years of experience devoted to promoting health equity and social justice, both in the United States and abroad, Dr. Bassett's career has spanned academia, government, and not-for-profit work. From 2014 through summer 2018, she served as commissioner of the New York City Department of Health and Mental Hygiene, where she made racial justice a priority and worked to address the structural racism at the root of the city's persistent gaps in health between white New Yorkers and communities of color.

Early in her career, she served on the medical faculty at the University of Zimbabwe for 17 years, during which time she developed a range of AIDS prevention interventions. Building on this experience, she went on to serve as associate director of health equity at the Rockefeller Foundation's Southern Africa Office, overseeing its Africa AIDS portfolio. Since her return to the United States, she has served on the faculty of Columbia University, most recently as associate professor of clinical epidemiology in its Mailman School of Public Health.

In 2002, Dr. Bassett was appointed deputy commissioner of Health Promotion and Disease Prevention at the New York City Department of Health and Mental Hygiene. In this role, her signature program was the launch of District Public Health Offices in several neighborhoods long harmed by racial/ethnic and economic health inequities. These offices now lead targeted, multi-sectoral, multi-agency strategies to reduce excess burden of disease. From 2009 to 2014, Dr. Bassett served as program director for the Doris Duke Charitable Foundation's African Health Initiative and Child Well-Being Prevention Program.

Dr. Bassett's many awards and honors include the prestigious Frank A. Calderone Prize in Public Health, a Kenneth A. Forde Lifetime Achievement Award from Columbia University, a Victoria J. Mastrobuono Award for Women's Health, and the National Organization for Women's Champion of Public Health Award. She has also been elected a member of the National Academy of Medicine. For many years she served as an associate editor of the *American Journal of Public Health*. Her recent publications include articles in [*The Lancet*](#) and in the [*New England Journal of Medicine*](#) addressing structural racism and health inequities in the United States.

Dr. Bassett grew up in New York City. She received a BA in History and Science from Harvard University, an MD from Columbia University's College of Physicians and Surgeons (serving her residency at Harlem Hospital), and an MPH from the University of Washington.

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