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*Submitted Via Federal eRulemaking Portal at [www.regulations.gov](http://www.regulations.gov)*

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



RE: DHS Docket No. USCIS-2010-0012  
8 CFR Parts 103, 212, 213, 214, 245 and 248  
CIS No. 2499-10; RIN 1615-AA22

Washington Legislative  
Office  
915 15th Street, 6th  
floor  
Washington DC 20005  
(202) 544-1681  
[aclu.org](http://aclu.org)

Susan Herman  
*President*

Anthony Romero  
*Executive Director*

Faiz Shakir  
*National Political  
Director*

Dear Ms. Deshommes:

The American Civil Liberties Union (ACLU) submits these comments in strong opposition to the proposed regulations of the U.S. Department of Homeland Security entitled “Inadmissibility on Public Charge Grounds.” The proposed rules would disrupt decades of established understanding of the concept of public charge, and would impose harsh and unnecessary discrimination and exclusions on individuals who are otherwise eligible for entry or change of status.

The rules would needlessly harm immigrant families, including women and children. Immigrants with disabilities are especially singled out by the Department for adverse treatment, in contravention of the nondiscrimination principles repeatedly endorsed by the U.S. Congress. We urge that the proposal be withdrawn in its entirety, and that longstanding principles clarified in field guidance issued in 1999 remain in effect.

For nearly 100 years, the ACLU has been our nation’s guardian of liberty, working in courts, legislatures, and communities to defend and preserve the individual rights and liberties that the Constitution and the laws of the United States guarantee to all people in this country. With more than three million members, activists, and supporters, the ACLU is a nationwide organization that fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C. for the principle that every individual’s rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, gender identity or expression, disability, national origin, or record of arrest or conviction.

## **I. THE PROPOSED REGULATIONS WOULD RADICALLY CHANGE SETTLED IMMIGRATION POLICY, NEEDLESSLY HARMING INDIVIDUALS AND FAMILIES.**

Under longstanding Department policy, an immigrant seeking entry or change of status is considered a “public charge,” and thereby excludable, if she or he is “primarily dependent on the government for subsistence,” meaning that public benefits represent more than half of the person’s income and support. In making this assessment, the Department currently considers only two categories of public benefits: cash benefits such as Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF); and long-term institutionalization at government expense.

The proposed rules would radically expand the definition to include any noncitizen who simply “receives one or more public benefit” or who is “likely at any time in the future to receive one or more public benefit,” including Medicaid, Supplemental Nutrition Assistance Program (SNAP), housing supports, and additional programs. This would dramatically increase the scope of who would be considered a public charge to include people who are working, attending school, assisting in the home, or otherwise positively engaged in their communities, but who need or may need in the future basic non-cash supports.

### **A. The Proposal Upends Settled Immigration Policy.**

For almost two decades, through administrations of both political parties, U.S. immigration officials have explicitly reassured immigrant families that participation in programs like Medicaid and SNAP (formerly food stamps) would not affect their ability to become lawful permanent residents.<sup>1</sup> But if the proposed rules are finalized, immigration officials would begin considering a much wider range of government programs in the “public charge” determination, including:

- Medicaid (with limited exceptions including Medicaid coverage of an “emergency medical condition,” and certain disability services related to education);
- SNAP;
- Medicare Part D Low Income Subsidy (assistance in purchasing medicine); and
- Federal Public Housing, Section 8 housing vouchers and Section 8 Project Based rental assistance.

The proposal cites to purported cost-savings, but disregards a large body of research demonstrating increased employment and self-sufficiency associated with the receipt of benefits proposed to be included in the public charge assessment.<sup>2</sup>

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<sup>1</sup> U.S. Citizenship and Immigration Services, *Public Charge*, “Q. What publicly funded benefits may not be considered for public charge purposes?,” <https://www.uscis.gov/greencard/public-charge>.

<sup>2</sup> See, e.g., Nat’l Women’s Law Ctr., *Medicaid Is Vital for Women’s Jobs in Every Community* (2017) (Medicaid promotes employment of women), <https://nwlc.org/resources/medicaid-is-vital-for-womens->

The proposed rules would also direct officials to begin negatively weighing certain factors in the public charge analysis, including whether a person:

- Has income of less than 125 percent of the Federal Poverty Level (FPL);
- Is younger than 18 or older than 60;
- Has a large family; and
- Has a medical condition requiring ongoing care not covered by private insurance or private funds.

In addition, the proposal would add factors to be positively weighed, including whether a person:

- Has income above 250 percent of the FPL; and
- Demonstrates English proficiency.

These proposed changes to the public charge determination are contrary to settled immigration policy. In 1996, Congress adopted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which concerns eligibility of noncitizens for certain public benefits. Although PRWORA excluded certain categories of noncitizens from receiving certain benefits, Congress also specified that certain noncitizens are eligible for Medicaid, the Children’s Health Insurance Program (CHIP), and other federal means-tested benefits.<sup>3</sup> Shortly after, Congress enacted the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) that codified five factors considered as part of the public charge determination: age; health; family status; assets, resources, and financial status; and education and skills.<sup>4</sup> In enacting the IIRIRA, Congress made no changes to the PRWORA provisions permitting noncitizens to receive certain public benefits.

In 1999, after extensive consultation with other federal agencies,<sup>5</sup> the Department’s

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[jobs-in-every-community/](https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid); Ctr. On Budget & Pol’y Priorities, *Chart Book: The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion* (2018) (expanded Medicaid tied to better health outcomes, improved financial security, and more support for employment), <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>; Matthew Desmond & Carl Gershenson, Social Problems, *Housing and Employment Insecurity among the Working Poor* (2016) (housing loss tied to job loss), <https://scholar.harvard.edu/files/mdesmond/files/desmondgershenson.sp2016.pdf?m=1452638824>.

<sup>3</sup> See Pub. L. 104-193, tit. IV, 110 Stat. 2105, 2260-77.

<sup>4</sup> Omnibus Consolidated Appropriations Act, 1997, PL 104–208, 110 Stat 3009 (Sept. 30, 1996), Section 531.

<sup>5</sup> Department of Homeland Security, Inadmissibility on Public Charge Grounds, 83 FR 51114 (Oct. 10, 2018) (hereinafter “October 2018 Public Charge NPRM”), at 51133 (“When developing the proposed rule, INS consulted with Federal benefit-granting agencies such as the Department of Health and Human Services (HHS), the Social Security Administration (SSA), and the Department of Agriculture (USDA). The Deputy Secretary of HHS, which administers Temporary Assistance for Needy Families (TANF), Medicaid, the Children’s Health Insurance Program (CHIP), and other benefits, advised that the best evidence of whether an individual is relying primarily on the government for subsistence is either the receipt of public cash benefits for income maintenance purposes or institutionalization for long-term care at government expense.”).

predecessor, Immigration and Naturalization Services, issued a guidance document which clarified the assessment to be used to determine whether an individual is a “public charge” under the five statutory factors. The guidance document set out the standard that has been in place for two decades: a person is a “public charge” if they are or are likely to become “primarily dependent on the government for subsistence, as demonstrated by either: (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense.”<sup>6</sup> Since the issuance of the 1999 guidance, Congress has amended the public charge provision several times, but has never disrupted the agency’s standard.<sup>7</sup>

The Department now seeks to upend this settled understanding by making massive and unilateral changes to the legal landscape. Given that Congress expressed its intent in 1996 that certain noncitizens be eligible for public benefits, and given the continuous tenure of the 1999 guidance, as well as the additional reasons stated herein, it is arbitrary and capricious for the Department to now penalize these noncitizens for accessing or potentially accessing the listed benefits.

## **B. The Proposal Is Already Harming Immigrant Families – and Finalizing the Rules Would Cause More Harm.**

The 1999 guidance document responded to concerns that officers were improperly scrutinizing the use of health and nutrition programs in assessing public charge,<sup>8</sup> and sought to combat the “chilling effect” of the 1996 law by alleviating fears that were causing some immigrants to forego basic supports for which they were eligible.<sup>9</sup> Evidence before the agency when it was writing the guidance included:

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<sup>6</sup> Department of Justice, Immigration and Naturalization Service, Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 FR 28689-01 (May 26, 1999) (hereinafter 1999 Field Guidance); *see also* U.S. Department of Justice, Immigration and Naturalization Service, Michael A. Pearson, Executive Associate Commissioner, Office of Field Operations, Memorandum for All Regional Directors (May 20, 1999), at <https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-54070/0-0-0-54088/0-0-0-55744.html>.

<sup>7</sup> *See* Family Sponsor Immigration Act of 2002, PL 107–150, March 13, 2002, 116 Stat 74, at § 2; Violence Against Women and Department of Justice Reauthorization Act—Technical Corrections, PL 109–271, August 12, 2006, 120 Stat 750, at § 6(b); Violence Against Women Reauthorization Act of 2013, PL 113-4, March 7, 2013, 127 Stat 54, at § 804; *see also* Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, October 28, 2000, 114 Stat 1464, at § 1505 (exempting certain trafficking victims from public charge assessment); Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT ACT) ACT OF 2001, PL 107–56, October 26, 2001, 115 Stat 272, at § 423 (exempting certain surviving spouses and children from public charge assessment); Trafficking Victims Protection Reauthorization Act of 2003, PL 108–193, December 19, 2003, 117 Stat 2875, at § 4 (exempting certain trafficking victims from public charge assessment).

<sup>8</sup> 1999 Field Guidance at 28689-01 (“[O]fficers should not place any weight on the receipt of non-cash public benefits (other than institutionalization) or the receipt of cash benefits for purposes other than for income maintenance with respect to determinations of admissibility or eligibility for adjustment on public charge grounds.”)

<sup>9</sup> October 2018 Public Charge NPRM at 51133 (“INS sought to reduce negative public health and nutrition consequences generated by the confusion and to provide ... better guidance as to the types of public benefits that INS considered relevant to the public charge determinations. INS also sought to address the public’s concerns about immigrants’ fears of accepting public benefits for which they

accounts of pregnant women with gestational diabetes terrified of seeking care; a child with seizures rushed to the hospital whose parents were afraid to enroll in Medicaid at the hospital so he could continue treatment; and farmworker women afraid to enroll in a state-funded perinatal case management program.<sup>10</sup> As the 1999 guidance acknowledged, “[t]his reluctance to access benefits has an adverse impact not just on the potential recipients, but on public health and the general welfare.”<sup>11</sup> The Department’s present proposal acknowledges and cites to research demonstrating the chilling effect.<sup>12</sup>

This adverse impact is now occurring. After reports of changes to the public charge assessment started circulating in early 2017, immigrant families began foregoing critical services and benefits for which they are legally eligible out of fear for immigration consequences. Providers reported increased requests to disenroll from means-tested programs, increased canceled appointments at health clinics, and drops in attendance and applications at early childhood education programs.<sup>13</sup> A 2018 survey of California health care providers found that more than two-thirds (67 percent) saw an increased concern among immigrant parents about enrolling their children in Medi-Cal (California’s Medicaid program), WIC and CalFresh (California’s SNAP program), and nearly 40 percent saw an increased interest in disenrolling. Forty-two percent reported an increase in missed scheduled health care appointments.<sup>14</sup> And following the circulation of leaked drafts of the proposed rules earlier this year, immigrant families across the country began dropping out of the WIC program.<sup>15</sup>

Finalizing the proposed rules would only worsen this destructive trend. Researchers

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remained eligible, specifically in regards to medical care, children's immunizations, basic nutrition and treatment of medical conditions that may jeopardize public health. With its guidance, INS aimed to stem the fears that were causing noncitizens to refuse limited public benefits, such as transportation vouchers and child care assistance, so that they would be better able to obtain and retain employment and establish self-sufficiency.”)

<sup>10</sup> See Claudia Schlosberg et. al, National Immigration Law Center, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (1998), <https://www.montanaprobono.net/geo/search/download.67362>.

<sup>11</sup> 1999 Field Guidance at 28689-01.

<sup>12</sup> October 2018 Public Charge NPRM at 51264-69 (citing research and concluding that between 333,239 and 999,717 people will disenroll).

<sup>13</sup> Jennifer Laird, et al., *Forgoing Food Assistance Out Of Fear: Changes To “Public Charge” Rule May Put 500,000 More U.S. Citizen Children At Risk Of Moving Into Poverty*, 2:2 Poverty & Social Policy Brief (Apr. 5, 2018), [https://static1.squarespace.com/static/5743308460b5e922a25a6dc7/t/5af1a2b28a922db742154bbe/1525785266892/Poverty+and+Social+Policy+Brief\\_2\\_2.pdf](https://static1.squarespace.com/static/5743308460b5e922a25a6dc7/t/5af1a2b28a922db742154bbe/1525785266892/Poverty+and+Social+Policy+Brief_2_2.pdf); Hannah Matthews, et al., *Immigration Policy’s Harmful Impacts on Early Care and Education* (The Center for Law and Social Policy, Mar. 2018), [https://www.clasp.org/sites/default/files/publications/2018/03/2018\\_harmfulimpactsece.pdf](https://www.clasp.org/sites/default/files/publications/2018/03/2018_harmfulimpactsece.pdf).

<sup>14</sup> The Children’s Partnership, *Healthy Mind, Healthy Future: Promoting the Mental Health and Wellbeing of Children in Immigrant Families*, <https://www.childrenspartnership.org/wp-content/uploads/2018/08/Healthy-Mind-Healthy-Future-Report-Promoting-the-Mental-Health-and-Wellbeing-of-Children-in-Immigrant-Families.pdf.pdf> (Aug. 2018).

<sup>15</sup> Helena Bottemiller Ulrich, Politico, *Immigrants, Fearing Trump Crackdown, Drop Out of Nutrition Programs* (Sept. 3, 2018), <https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292>.



report that the rules would discourage millions of immigrants from accessing health, nutrition, and social services.<sup>16</sup> According to the Kaiser Family Foundation, between 2.1 million to 4.9 million Medicaid/CHIP enrollees could disenroll if the proposal is finalized – far more people than projected by the Department.<sup>17</sup> The chilling effects are further predicted to extend far beyond individual non-citizens to their entire household, including citizens. Approximately 25.9 million people, about 8 percent of the U.S. population, live in low-income households with at least one non-citizen member.<sup>18</sup> Ninety percent are people of color.<sup>19</sup> More than 9.2 million are children under 18,<sup>20</sup> many of whom are themselves U.S. citizens.

The proposed changes would needlessly harm individuals, families, and communities by discouraging people from using the basic public programs their tax dollars help support. The rules would have particular adverse consequences for immigrant women and their children, and for immigrants with disabilities.

## **II. THE PROPOSED REGULATIONS WOULD EXCLUDE, DISCRIMINATE AGAINST, AND NEEDLESSLY HARM IMMIGRANTS WITH DISABILITIES.**

The Department’s proposed “public charge” regulations would radically change U.S. immigration policy in a manner that would exclude and discriminate against qualified immigrants with disabilities. In particular, linking a public charge determination to the need for or receipt of Medicaid – and possibly CHIP – would devastate the fair inclusion of people with disabilities. Such an outcome is contrary

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<sup>16</sup> Jeanne Batalova, *et al.*, *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use* (Migration Policy Institute, 2018), <https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families>; Randy Capps, *et al.*, *Gauging the Impact of DHS’ Proposed Public-Charge Rule on U.S. Immigration* (Migration Policy Institute, 2018), <https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration>.

<sup>17</sup> Samantha Artiga, *et al.*, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid* (Kaiser Family Foundation, 2018), <https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/> (predicting disenrollment rates between 15 percent and 35 percent).

<sup>18</sup> 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. Custom Tabulation by Manatt Phelps & Philips LLP, *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard* (2018), <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population> (using 2012-2016 5-Year American Community Survey Public Use Microdata Sample (ACS/PUMS); 2012-2016 5-Year American Community Survey (ACS) estimates accessed via American FactFinder; Missouri Census Data Center (MCDC) MABLE PUMA-County Crosswalk).

<sup>19</sup> Of those potentially affected by the rule, 23.2 million are non-white, including 18.3 million Latinos, 3.2 million Asians, and 1.8 million Black people. To put this in perspective, among all people of color in the country (of all income levels and citizenship statuses), 33 percent of Latinos, 17 percent of Asians, and 4 percent of Black people would potentially be impacted by the proposed rule. By contrast, about 1.5 percent of white people would potentially be affected. Manatt Phelps & Philips LLP, *supra* n.18.

<sup>20</sup> Manatt Phelps & Philips LLP, *supra* n.18 (9.2 million children under 18 live in households with at least one non-citizen family member with income below 250% FPL).

to congressional lawmaking in the areas of disability nondiscrimination and immigration policy, and would needlessly harm immigrants with disabilities.

### **A. The Proposed Regulations Would Discriminate on the Basis of Disability Contrary to Bipartisan Congressional Lawmaking.**

For more than 35 years, the U.S. Congress, acting in a bipartisan manner, has passed and strengthened federal laws prohibiting disability discrimination. Congress enacted the Rehabilitation Act in 1973,<sup>21</sup> supervised and approved its implementing regulations in 1977,<sup>22</sup> and extended the Rehabilitation Act's prohibition on disability discrimination to the federal government itself in 1978.<sup>23</sup> In 1990, building again on the principles of the 1977 regulations, Congress adopted the Americans with Disabilities Act, extending the prohibition on disability discrimination to private employment, state and local government, and public accommodations (private businesses open to the public).<sup>24</sup> The purpose of the ADA, Congress stated, was "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."<sup>25</sup>

Also in 1990, consistent with the principles of the ADA, Congress amended the Immigration Code to eliminate discriminatory exclusions of people with certain listed disabilities.<sup>26</sup> These changes marked an end to explicitly ableist prohibitions on individuals with disabilities in the Immigration Code, exclusions that for more than 100 years were listed alongside the statutory public charge prohibition.<sup>27</sup>

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<sup>21</sup> 29 U.S.C. § 794.

<sup>22</sup> 45 C.F.R. pt. 84.

<sup>23</sup> PL 95-602 (HR 12467), 92 Stat 2955, at § 119 (November 6, 1978).

<sup>24</sup> 42 U.S.C. § 12101, *et seq.*

<sup>25</sup> 42 U.S.C. § 12101(b)(1).

<sup>26</sup> Immigration Act of 1990, PL 101-649, 104 Stat 4978, sections 601-603 (Nov. 29, 1990) (deleting and replacing language in 8 U.S.C. § 1812 excluding "[a]liens who are mentally retarded," "[a]liens who are insane," "[a]liens who have had one or more attacks of insanity," "[a]liens afflicted with psychopathic personality, or sexual deviation, or a mental defect," and "[a]liens who are ... chronic alcoholics").

<sup>27</sup> *See* 47 Cong. Ch. 376 § 2, 22 Stat. 214 (1882) (excluding not only the entry of "any person unable to take care of himself or herself without becoming a public charge," but also the entry of any "lunatic" or "idiot," terms then used to refer to people with psychiatric and intellectual disabilities); 57 Cong. Ch. 1012 § 2, 32 Stat. 1213 (1903) (excluding "[a]ll idiots, insane persons, epileptics, and persons who have been insane within five years previous; persons who have had two or more attacks of insanity at any time previously," alongside "persons likely to become a public charge"); 59 Cong Ch. 1134 § 2, 34 Stat. 898 (1907) (excluding additional disability categories alongside "public charge," including "imbeciles," "feeble-minded persons," and "persons not comprehended within any of the foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such mental or physical defect being of a nature which may affect the ability of such alien to earn a living"); Immigration Act of 1917, 39 Stat. 874 § 3 (1917) (prohibiting "idiots, imbeciles, feeble-minded persons, epileptics, insane persons; persons have had one or more attacks of insanity at any time previously; persons of constitutional psychopathic inferiority" ... persons afflicted with tuberculosis in any form or with a loathsome or dangerous contagious disease; persons not comprehended within any of the foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such physical defect being of a nature which may affect the ability of such alien to earn a living; ... persons likely to become a public charge" as well as persons who cannot read); Immigration and Nationality Act of 1952, 66 Stat. 182

In 1992, Congress passed the Rehabilitation Act Amendments of 1992 “to ensure that the precepts and values embedded in the Americans with Disabilities Act are reflected in the Rehabilitation Act of 1973.”<sup>28</sup> Congress found that:

[D]isability is a natural part of the human experience and in no way diminishes the right of individuals to—(A) live independently; (B) enjoy self-determination; (C) make choices; (D) contribute to society; (E) pursue meaningful careers; and (F) enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society[.]

[T]he goals of the Nation properly include the goal of providing individuals with disabilities with the tools necessary to ... achieve equality of opportunity, full inclusion and integration in society, employment, independent living, and economic and social self-sufficiency[.]<sup>29</sup>

Congress further declared that a purpose of the Rehabilitation Act is “to empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society.”<sup>30</sup>

Most recently, in 2008, Congress enacted the ADA Amendments Act, which clarified and expanded the definition of disability used both in the ADA and the Rehabilitation Act.<sup>31</sup> Also in 2008, Congress eliminated HIV and AIDS from the list of infectious diseases that would bar an individual from immigrating to or visiting the United States.<sup>32</sup>

Thus, the 1999 Field Guidance standard, which has lasted for nearly 20 years, sets out a balance between the public charge exclusion and Congress’s ongoing commitment to disability nondiscrimination. Among disabled individuals who seek to enter or to adjust their status:

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(1952) (excluding aliens “who are feeble-minded; ... who are insane; ... who have had one or more attacks of insanity; ... afflicted with psychopathic personality, epilepsy, or a mental defect; ... who are afflicted with tuberculosis in any form, or with leprosy, or any dangerous contagious disease; ... who are certified by the examining surgeon as having a physical defect, disease, or disability, when determined by the consular or immigration officer to be of such a nature that it may affect the ability of the alien to earn a living, unless the alien affirmatively establishes that he will not have to earn a living; ... [who] are likely at any time to become public charges; ... [and] [a]ny alien accompanying another alien ordered to be excluded and deported and certified to be helpless from sickness or mental or physical disability[.]”); *see also* P.L. 89-236 (H.R. 2580), 79 Stat. 911 (Oct. 3, 1965) (replacing term “feeble-minded” with “mentally retarded”).

<sup>28</sup> S. REP. 102-357, 2, 1992 U.S.C.C.A.N. 3712, 3713; *see also* 29 U.S.C. 791(g).

<sup>29</sup> 29 U.S.C. § 701(a)(3), (6).

<sup>30</sup> 29 U.S.C. § 701(b).

<sup>31</sup> ADA Amendments Act of 2008, PL 110-325, 122 Stat 3553 (Sept. 25, 2008) (amending the Rehabilitation Act of 1973 at 29 U.S.C. § 705).

<sup>32</sup> Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, Pub. L. 110-293 (July 30, 2008); 42 CFR 34.2(b).



- Only those disabled individuals who are “primarily dependent” upon cash benefits (meaning that cash benefits represent more than half of the person’s income), or who require long-term institutionalization at government expense, may be considered public charges; and
- All other disabled individuals – including those with significant or complex medical conditions, and those who require Medicaid (or CHIP) to maintain their health and wellness in the short- or long-term while pursuing employment, education, or other productive life activities – are not subject to exclusion under public charge.

A central insight of the 1999 Field Guidance is that the use of many public benefits does not translate to “dependence” on the government. Certain benefits, such as non-cash benefits that assist individuals with food, health care, and housing, are merely supplemental in nature. Moreover, access to Medicaid and CHIP, programs which provide cost-effective health care and disability equipment and supports, is precisely what enables many individuals with disabilities to become integrated, productive, and contributing members of their communities.

Excluding the receipt of Medicaid (and CHIP) from any public charge assessment is critical to disability nondiscrimination. In our nation’s complex system of disability and health care, receipt of Medicaid is inseparable from the status of being disabled. More than one in three working-age adults enrolled in Medicaid have a disability. Medicaid provides essential primary and preventive care, medical treatment for illnesses and chronic conditions. Medicaid also covers wheelchairs, lifts, supportive housing services, employment services, and home- and community-based services,<sup>33</sup> such as personal and attendant care services that help people with disabilities live, attend school, and work in the community. These services are not covered by private insurance.<sup>34</sup>

The relationship between Medicaid and disability does not exist because its recipients are a “burden,” dependent upon the government for subsistence. Rather, Medicaid is often the only program available to and appropriate for people with disabilities. The extent to which Medicaid functions as the exclusive option for individuals with disabilities cannot be overstated. Individuals with significant disabilities, including even highly educated professionals and business owners,<sup>35</sup>

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<sup>33</sup> Congressional Research Service, Who Pays For Long-Term Services and Supports? (Aug. 22, 2018), <https://fas.org/sgp/crs/misc/IF10343.pdf>.

<sup>34</sup> The Center on Budget and Policy Priorities, Medicaid Works for People with Disabilities (Aug. 29, 2017), <https://www.cbpp.org/research/health/medicaid-works-for-people-with-disabilities>.

<sup>35</sup> See, e.g., Andraea LaVant, “Congress: Medicaid Allows Me to Have a Job and Live Independently” (ACLU, Mar. 22, 2017) (“Almost immediately after starting at my new job, I learned that commercial/private insurance does not cover the services I need to live independently. I would still need to rely on the services supplied through Medicaid just to ensure that I could go to work and maintain the independence that I had worked so hard to attain.”), at <https://www.aclu.org/blog/disability-rights/congress-medicare-allows-me-have-job-and-live-independently>; Asim Dietrich, “Medicaid cuts are a matter of life or death for people with disabilities,” Arizona Capitol Times (July 13, 2017), at

typically must retain Medicaid coverage because no other public or private program covers the attendant care and medical equipment they need to get up, get dressed, and go to work. Recognizing that the disability services offered by Medicaid are not available through private insurance, Congress has enacted several pathways for people with disabilities to keep Medicaid even when they are fully participating in the workforce and have significant earnings.<sup>36</sup> This reflects the longstanding understanding of lawmakers that Medicaid is not only a health insurance program for low-income Americans, but is also a financing program for services and supports for Americans with disabilities.

Similarly, low- and middle-income working families raising children with significant disabilities typically must access Medicaid or CHIP for their children to ensure that they grow up and thrive as valued and integrated members of the community.<sup>37</sup> Further, many employed people with disabilities are uncovered by employer-provided plans (and do not earn enough to buy into an Affordable Care Act plan, particularly in the early years of their working lives).<sup>38</sup> Thus, for many disabled people, the only option for maintaining community participation including education and employment is Medicaid.

The connection between Medicaid and independence for people with disabilities has been repeatedly demonstrated. Across the country, more than 150,000 individuals with disabilities participate in Medicaid buy-in programs. These programs allow

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<https://azcapitoltimes.com/news/2017/07/13/medicaid-cuts-are-a-matter-of-life-or-death-for-people-with-disabilities/> (“Even with such a severe disability, I live a full life. I am an attorney who works on behalf of others with disabilities, I am a board member at a local disability advocacy organization called Ability 360, and I have an active social life. The only reason I am able to have such a full life is Medicaid.”).

<sup>36</sup> Brigitte Gavin and Marci McCoy-Roth, Review of studies regarding the Medicaid Buy-In Program (Boston University, Sargent College, Center for Psychiatric Rehabilitation, 2011), <http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/medicaid-buy-in/>; Social Security Administration, Continued Medicaid Eligibility (Section 1619(B)), <https://www.ssa.gov/disabilityresearch/wi/1619b.htm>; Medicaid and CHIP Payment and Access Commission, Promoting Continuity of Medicaid Coverage among Adults under Age 65 (Mar. 2014), <https://www.macpac.gov/publication/ch-2-promoting-continuity-of-medicaid-coverage-among-adults-under-age-65/>.

<sup>37</sup> MaryBeth Musumeci and Julia Foutz, “Medicaid’s Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending” (Kaiser Family Foundation, Feb. 22, 2018), <https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/> (“Medicaid and CHIP covered about half (48 percent) of all children with special health care needs in 2016. ... Most Medicaid/CHIP children with special health care needs live in low or middle income families. ... [All states] opt to cover children with significant disabilities living at home ..., which makes it possible for children with disabilities to receive necessary care while remaining at home with their families.”).

<sup>38</sup> Rachel Garfield, *et al.*, “Understanding the Intersection of Medicaid and Work” (Kaiser Family Foundation, Dec. 7, 2017), <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/> (“Among Medicaid adults (including parents and childless adults — the group targeted by the Medicaid expansion), nearly 8 in 10 live in working families, and a majority are working themselves. Nearly half of working Medicaid enrollees are employed by small firms, and many work in industries with low employer-sponsored insurance offer rates. ... [I]ndividuals have reported that receiving medication for conditions like asthma or rheumatoid arthritis through Medicaid is critical in supporting their ability to work.”).

disabled individuals to retain Medicaid coverage while participating in the labor force. Numerous studies have found that Medicaid buy-in participants earn more money, work more hours, contribute more in taxes, and rely less on food stamps than people with disabilities who are not enrolled.<sup>39</sup> Similarly, studies published in 2017 and 2018 showed that people with disabilities in Medicaid expansion states are more likely to be employed than disabled individuals in other states.<sup>40</sup> And Medicaid waiver programs provide cost-effective supports to more than 1 million disabled individuals living in the community.<sup>41</sup> Medicaid also funds supported employment services to assist people with psychiatric, developmental and intellectual disabilities to enter and maintain participation in the workforce.<sup>42</sup> In short, Medicaid is central to the increased integration of people with disabilities in our society – an explicit aim of federal lawmakers, and one recognized by the U.S. Supreme Court.<sup>43</sup>

The proposed regulations would upend the balance between public charge and disability inclusion set out in the 1999 Field Guidance, and would revive invidious disability discrimination in immigration determinations. Specifically, instead of disregarding Medicaid and other cost-effective non-cash benefits and programs, as instructed by the 1999 Field Guidance, the new rules would exclude and penalize qualified individuals with disabilities who need Medicaid. The new rules would also consider as a factor whether individuals need ongoing medical treatment, whether or not through the Medicaid program.

The proposed rules would:

- Define a person as being a “public charge” based solely on the receipt of Medicaid.<sup>44</sup>

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<sup>39</sup> Brigitte Gavin and Marci McCoy-Roth, *supra*, n.36.

<sup>40</sup> Jean P. Hall, Ph.D., *et al.*, “Effect of Medicaid Expansion on Workforce Participation for People With Disabilities,” 107:2 *American Journal of Public Health* 262 (Feb. 2017), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303543>; Jean P. Hall, Ph.D., *et al.*, “Medicaid Expansion as an Employment Incentive Program for People With Disabilities,” 108:9 *American Journal of Public Health* 1235 (Aug. 2018), <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304536?journalCode=ajph>; Nanette Relave, “Improving Employment for People with Disabilities: Medicaid Infrastructure Grants Make a Difference,” *Policy & Practice* 21 (Dec. 2013).

<sup>41</sup> Centers for Medicare and Medicaid Services, “Medicaid & CHIP: Strengthening Coverage, Improving Health” (Jan. 2017), <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>.

<sup>42</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services (Sept. 16, 2011), at <https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf> (discussing the use of waiver supports to increase employment opportunities for individuals with disabilities).

<sup>43</sup> See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999) (discussing ADA and Rehabilitation Act regulations on integration, and recognizing that the unjustified institutional isolation of persons with disabilities is a form of disability discrimination).

<sup>44</sup> See Proposed 8 C.F.R. § 212.21(a) (“Public charge means an alien who receives one or more public benefit, as defined in paragraph (b)[.]”), (b)(2)(i) (“Public benefit means: ... Any of one or more of the following non-monetizable benefits if received for more than 12 months in the aggregate within a 36

- Consider in the “health” factor “whether ... the alien has been diagnosed with a medical condition that is likely to require extensive medical treatment ... or that will interfere with the alien’s ability to provide and care for him- or herself, to attend school, or to work upon admission or adjustment of status.”<sup>45</sup>
- Consider in the “assets” factor “[w]hether the alien has private health insurance or the financial resources to pay for reasonably foreseeable medical costs related to a medical condition that is likely to require extensive medical treatment ... or that will interfere with the alien’s ability to provide care for him- or herself, to attend school, or to work.”<sup>46</sup>
- Find a “heavily weighted negative factor” where “[t]he alien is currently receiving or ... approved to receive one or more public benefit, [including Medicaid],” or “[t]he alien has received one or more public benefit, [including Medicaid], within the 36 months immediately preceding the alien’s application[.]”<sup>47</sup>
- Find a “heavily weighted negative factor” where “[t]he alien has been diagnosed with a medical condition that is likely to require extensive medical treatment ... or that will interfere with the alien’s ability to provide for him- or herself, attend school, or work; and ... is uninsured and has neither the prospect of obtaining private health insurance, or the financial resources to pay for reasonably foreseeable medical costs related to a the medical condition[.]”<sup>48</sup>

Thus, individually and collectively, the proposed rules would exclude and penalize: qualified individuals with disabilities who need Medicaid to live, work, attend school, and participate in the community; qualified individuals with disabilities who need ongoing medical treatment; and qualified individuals with disabilities for whom Medicaid is the only appropriate or available program. Effectively, the Department proposes to eliminate the ability of people with Down syndrome, autism, cerebral palsy and countless other disabilities, and their families, to pursue American residency.

Moreover, the proposed rules would permit consideration of additional non-cash supports such as SNAP and housing assistance, and at staggeringly low thresholds (15 percent of federal poverty level, or about \$150 a month for one person). And the proposal invites comment on whether receipt of benefits under CHIP should also weigh into the public charge assessment.<sup>49</sup> Including CHIP and additional non-cash supports in the analysis would further exclude and penalize disabled individuals,

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month period (such that, for instance, receipt of two non-monetizable benefits in one month counts as two months): ... Medicaid[.]”); *see also id.* at (3) (defining “public benefit” as including the “receipt of a combination of monetizable benefits” and “non-monetizable benefits”).

<sup>45</sup> *Id.* at § 212.22(b)(2).

<sup>46</sup> *Id.* at § 212.22 (b)(4)(ii)(I).

<sup>47</sup> *See* Proposed 8 C.F.R. § 212.22(c)(1)(ii), (iii).

<sup>48</sup> *See* Proposed 8 C.F.R. § 212.22(c)(1)(iv)(A).

<sup>49</sup> *See* Notice of Proposed Rulemaking, Section 5(B)(2)(g) (Request for Comment Regarding the Children’s Health Insurance Program (CHIP)).

including children. Additional provisions of the proposed rules would cause further disability discrimination. For example, including English proficiency<sup>50</sup> in the assessment of the “education and skills” factor would discriminate against Deaf immigrants and immigrants with intellectual and developmental disabilities, in addition to irrationally and incorrectly assuming that individuals with limited English proficiency are unlikely to be employable.

The proposed rules are irrational. While purportedly aimed at promoting self-sufficiency, the rules would penalize participation in Medicaid (and potentially CHIP), as well as other non-cash supports. Yet Medicaid and CHIP are central to self-sufficiency for individuals with disabilities. For example, the proposed rules irrationally and arbitrarily conclude that individuals who participate or are likely to participate in Medicaid are more likely to be a public charge, even though the evidence shows that people with disabilities who have access to Medicaid are *more* likely to be employed. The proposal fails to acknowledge that participation in these programs is a *positive*, not a negative, factor. And the rules would turn longstanding disability policy on its head by failing to recognize that disabled individuals, with supports, can care for themselves, attend school, and work.

The Department’s proposed changes to the public charge assessment are contrary to decades of bipartisan congressional lawmaking regarding disability inclusion. If finalized, the proposal would result in the exclusion of countless individuals with disabilities who would otherwise make valuable contributions to our communities and the economy. The rules should be rejected.

## **B. The Proposed Regulations Would Needlessly Harm People with Disabilities and Their Families.**

The proposed rules would have particular impacts upon immigrant households that include people with disabilities. Twenty percent of all SNAP household include a nonelderly person with a disability.<sup>51</sup> And about one-third of adults under age 65 enrolled in Medicaid have a disability. This compares to about 12 percent of adults in the general population.<sup>52</sup> Medicaid delivers essential health care as well as long-term supports and services that allow people with disabilities to live and work in the community. Including Medicaid in the public charge analysis would cause broad decreases in enrollment for individuals with disabilities.<sup>53</sup> Such decreased

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<sup>50</sup> See Proposed 8 C.F.R. § 212.22(b)(5)(ii)(D) (including “[w]hether the alien is proficient in English” as evidence under the “education and skills” factor).

<sup>51</sup> Food Research & Action Center, SNAP Matters for People with Disabilities (July 2015), [http://frac.org/wp-content/uploads/snap\\_matters\\_people\\_with\\_disabilities.pdf](http://frac.org/wp-content/uploads/snap_matters_people_with_disabilities.pdf).

<sup>52</sup> See, e.g., Nationwide Adult Medicaid CAHPS, *Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings from a 2014-2015 Nationwide Survey of Medicaid Beneficiaries* (2016), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/namcahpsdisabilitybrief.pdf>.

<sup>53</sup> See Proposed Changes to “Public Charge” Policies for Immigrants: Implications for Health Coverage (Kaiser Family Foundation, Sept. 24, 2018) (discussing likelihood of broad disenrollment by all immigrants). Further, community providers have already reported changes in health care use,



enrollment would cause predictable harms to individuals with disabilities, including worse health outcomes,<sup>54</sup> reduced prescription adherence, increased emergency room use due to delayed treatment,<sup>55</sup> decreased employment, and decreased educational success. Studies show that lack of access to Medicaid is associated with lower employment for people with disabilities.<sup>56</sup> The Notice of Proposed Rulemaking acknowledges these very harms in its preamble.

The rules would needlessly harm children with disabilities. Children’s well-being is inseparable from their parents’ and families’ well-being, so help received by parents is central to children’s health and well-being in the short- and long-term. More than 7 million children with disabilities or other conditions needing medical attention live in households with at least one noncitizen adult. Nearly 5 million are insured by Medicaid or CHIP.<sup>57</sup> The proposed changes would negatively affect these children. Due to the direct impacts and the chilling effect of the rule, many eligible children likely would forego Medicaid and CHIP—and health care services altogether—if their parents think they will be subject to a public charge determination. Up to 1.7 million of these children (or 35 percent) could be disenrolled from health coverage.<sup>58</sup> Still more could lose other non-cash benefits under the proposal, such as SNAP or housing assistance.

Without coverage, families with children with disabilities are unable to afford timely care, and children are likely to go without care or experience delays in getting needed care. Delayed or forgone care contributes to worsening and more costly health conditions.<sup>59</sup> The loss of food and housing supports would further

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including decreased participation in Medicaid and other programs due to community fears stemming from the leaked draft regulations.

<sup>54</sup> Institute of Medicine, Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late* (2002) (“The best evidence suggests that health insurance is associated with more appropriate use of health care services and better health outcomes for adults.”), <https://www.ncbi.nlm.nih.gov/books/NBK220639/>.

<sup>55</sup> Jonathan Hirohiko Watanabe and John P. Ney, *Association of increased emergency room costs for patients without access to necessary medications*, 11:4 Research in Social and Administrative Pharmacy (July-August 2015); see also *Diverting Non-Urgent Emergency Room Use: Can It Provide Better Care and Lower Costs?*, Subcommittee on Primary Health and Aging, Committee on Health, Education, Labor, and Pensions (May 11, 2011) (containing bipartisan agreement that ER visits are much more expensive than primary care visits).

<sup>56</sup> See Hall, *et al.* (2017 and 2018) (discussing lower employment rates among people with disabilities in states without expanded Medicaid).

<sup>57</sup> California Health Care Foundation, “Changing Public Charge Immigration Rules: The Potential Impact on Children Who Need Care” (Oct. 2018) <https://www.chcf.org/wp-content/uploads/2018/10/ChangingPublicChargeImmigrationRules.pdf>.

<sup>58</sup> *Id.* (1.7 million would include: 143,000 to 333,000 children with at least one potentially life-threatening condition, including asthma, influenza, diabetes, epilepsy, or cancer; 122,000 to 285,000 children on prescribed medications; and 53,000 to 124,000 children with musculoskeletal and rheumatologic conditions like fractures and joint disorders); see also Samantha Artiga, “Potential Effects of Public Charge Changes on Health Coverage for Citizen Children” (Kaiser Family Foundation, May 18, 2018), <https://www.kff.org/disparities-policy/issue-brief/potential-effects-of-public-charge-changes-on-health-coverage-for-citizen-children/>.

<sup>59</sup> California Health Care Foundation, *supra*, n.57 (discussing poor outcomes including death caused by delayed or foregone treatment of epilepsy and asthma in childhood).



jeopardize these children.<sup>60</sup>

The proposed rules would further undermine public health, particularly for disabled individuals who have weakened immune systems, including people with leukemia, HIV/AIDS, or another immune system disorder, or people receiving chemotherapy or who have received organ transplants. As a result of the direct impacts of the rule, together with the chilling effect, lawfully residing immigrants will forego vaccinations, medications, and other primary care. This will cause foreseeable and avoidable harms to disabled individuals of all immigration statuses.

### III. THE PROPOSED REGULATIONS WOULD HARM IMMIGRANT WOMEN AND THEIR CHILDREN.

While noncitizen women only make up a small share of public benefits participants overall,<sup>61</sup> women together with their children predominate among noncitizen participants.<sup>62</sup> Noncitizen women and children are also most likely to be among those who would be both eligible to participate in programs such as Medicaid and SNAP, and subject to the public charge assessment.<sup>63</sup>

Immigrant women already face a heightened risk of economic insecurity due to pay disparities,<sup>64</sup> discrimination,<sup>65</sup> overrepresentation in low-wage work,<sup>66</sup> and

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<sup>60</sup> This occurred after 1986 changes to federal benefits that limited access to cash support and food stamps. Children in families that experienced reduced cash assistance had increased rates of food insecurity and higher rates of hospitalization. John T. Cook, et al., *Welfare Reform and the Health of Young Children: A Sentinel Survey in 6 US Cities*, 156 *Arch. Pediatr. Adolesc. Med.* 678 (July 2002), [http://cdn2.hubspot.net/hubfs/235578/pdfs\\_and\\_other\\_documents/Welfare\\_Reform\\_and\\_the\\_Health\\_of\\_Young\\_Children\\_0.pdf?t=1507297523113](http://cdn2.hubspot.net/hubfs/235578/pdfs_and_other_documents/Welfare_Reform_and_the_Health_of_Young_Children_0.pdf?t=1507297523113).

<sup>61</sup> Noncitizen women constituted about 4 percent of all SNAP and Medicaid recipients in 2017. National Women's Law Center calculations based on U.S. Census Bureau, 2017 Current Population Survey, using Integrated Public Use Microdata Series (IPUMS), Current Population Survey: Version 6.0 [dataset] (2018), <https://doi.org/10.18128/D030.V6.0>. This share is also roughly proportional to noncitizen women's share of the population (3.3 percent in 2017). *Id.*

<sup>62</sup> In 2017, almost 47 percent of noncitizens enrolled in Medicaid were women (while 40 percent were men and 13 percent children). Almost 48 percent of noncitizens participating in SNAP were women (while 40 percent were men and 12 percent were children). National Women's Law Center calculations, *see* n.21.

<sup>63</sup> This is because of the complex rules governing benefits and immigration status adopted by Congress. National Immigration Law Center, *Immigrant Eligibility for Federal Programs*, Table 1, at [https://www.nilc.org/wp-content/uploads/2015/11/tbl1\\_ovrww-fed-pgms.pdf](https://www.nilc.org/wp-content/uploads/2015/11/tbl1_ovrww-fed-pgms.pdf) (emergency Medicaid coverage provided to all noncitizen women during labor and delivery, SNAP benefits provided to all qualified noncitizen children under 18, and state options permit Medicaid for all noncitizen pregnant women and permit Medicaid (and CHIP) for all noncitizen children under 21).

<sup>64</sup> Nat'l Women's Law Ctr., *Frequently Asked Questions About the Wage Gap* (2018) <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2018/09/Wage-Gap-FAQ.pdf>; Nat'l Women's Law Ctr., *The Wage Gap: The Who, Why, How, and What to Do* (2017), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/09/The-Wage-Gap-The-Who-How-Why-and-What-to-Do-2017-2.pdf>; Elise Gould, et al., *What is the Gender Pay Gap and Is It Real?* (Econ. Pol. Inst., 2015), <https://www.epi.org/publication/what-is-the-gender-pay-gap-and-is-it-real/>.

<sup>65</sup> Nat'l Women's Law Ctr., *Sexual Harassment in the Workplace* (2016), <https://nwlc.org/wp-content/uploads/2016/11/Sexual-Harassment-Fact-Sheet.pdf>; Institute for Women's Policy Research, *The Economic Cost of Intimate Partner Violence, Sexual Assault, and Stalking* (2017),

disproportionate responsibility for caregiving.<sup>67</sup> The participation of immigrant women in health, food, and housing programs is vitally important to their ability to provide a basic standard of living for themselves and their children. But the proposed rules would discourage and penalize participation. They should be rejected.

#### **A. The Proposal Would Harm Immigrant Women and Children By Penalizing and Discouraging Access to Health Care, Contrary to Federal and State Policy.**

The unprecedented proposal to consider Medicaid as part of the public charge determination threatens the health of immigrant women and their children. Medicaid is a critically important program for women<sup>68</sup> and children. Women who have health coverage are more likely to receive preventive care, such as breast cancer and cervical cancer screenings.<sup>69</sup> Children enrolled in Medicaid are covered for all medically necessary care including regular medical, vision, hearing, and dental screenings as well as the services necessary to correct or ameliorate physical or mental health conditions.<sup>70</sup> Studies show that Medicaid and CHIP coverage contribute to long-term positive outcomes in health, school performance and educational attainment, and economic success.<sup>71</sup>

Access to prenatal care is essential. The presence or absence of health coverage is

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[https://iwpr.org/wp-content/uploads/2017/08/B367\\_Economic-Impacts-of-IPV-08.14.17.pdf](https://iwpr.org/wp-content/uploads/2017/08/B367_Economic-Impacts-of-IPV-08.14.17.pdf); Maya Raghu, Nat'l Women's Law Center, *Standing with Immigrant Women Workers on May Day* (2017), <https://nwlc.org/blog/standing-with-immigrant-women-workers-on-may-day/>.

<sup>66</sup> Kayla Patrick, *et al.*, Nat'l Women's Law Ctr., *Low-Wage Jobs Held Primarily by Women Will Grow the Most Over the Next Decade* (2018), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/04/Low-Wage-Jobs-Held-Primarily-by-Women-Will-Grow-the-Most-Over-the-Next-Decade-2018.pdf>; American Immigration Council, *The Impact of Immigrant Women on America's Labor Force* (2017), <https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force>; Nat'l Women's Law Ctr., *Underpaid & Overloaded: Women in Low-wage Jobs* (2014), [https://nwlc.org/wp-content/uploads/2015/08/final\\_nwlc\\_lowwagereport2014.pdf](https://nwlc.org/wp-content/uploads/2015/08/final_nwlc_lowwagereport2014.pdf); Julie Vogtman & Karen Schulman, Nat'l Women's Law Ctr., *Set Up to Fail: When Low-Wage Work Jeopardizes Parents' and Children's Success* (2016), <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/01/FINAL-Set-Up-To-Fail-When-Low-Wage-Work-Jeopardizes-Parents'-and-Children's-Success.pdf>.

<sup>67</sup> Women are more likely than men to raise children on their own, see, e.g., U.S. Census Bureau, *America's Families and Living Arrangements 2018*, Tbl. A3, <https://www.census.gov/data/tables/2018/demo/families/cps-2018.html>, meaning that their incomes must stretch to support more family members.

<sup>68</sup> Medicaid covers a range of services women need. However, federal law restricts federal Medicaid coverage of abortion except if the pregnancy is the result of rape or incest, or if the woman's life is in danger. See, e.g., Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 202, 129 Stat. 2242, 2311 (2015).

<sup>69</sup> Munira Z. Gunja, *et al.*, *Women Gain Insurance and Improved Their Ability to Get Health Care* (The Commonwealth Fund, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and>.

<sup>70</sup> Samantha Artiga and Petry Ubri, *Key Issues in Children's Health Coverage* (Kaiser Family Foundation, Feb. 15, 2017), <https://www.kff.org/medicaid/issue-brief/key-issues-in-childrens-health-coverage/>.

<sup>71</sup> *Id.*

closely tied to infant mortality: between 2014 to 2016, infant mortality rates rose in non-Medicaid expansion states and declined in Medicaid expansion states.<sup>72</sup> Lack of access to health care contributes to higher rates of maternal mortality, higher rates of infant mortality, and increased risk of low-infant birth weight.<sup>73</sup> This is particularly dangerous for Black women, who already experience disproportionately high rates of maternal mortality.<sup>74</sup>

Immigrant women are already less likely to be insured than their citizen counterparts. Twenty-seven percent of noncitizen immigrant women are uninsured, compared to 11 percent for women overall.<sup>75</sup> Immigrant women of reproductive age fare even worse: 34 percent of noncitizen women of reproductive age are uninsured, compared to nine percent for similarly situated citizens. The gap widens further for poor immigrant women: nearly half (48 percent) of noncitizen women of reproductive age living in poverty are uninsured, compared to 16 percent for similar citizen women.<sup>76</sup> People without health coverage are more likely to forego needed care, leading to worse health outcomes and increased mortality.<sup>77</sup> When women forego medical care, including preventive reproductive health care, easily treatable illnesses or medical conditions can escalate, leading to worsening of existing conditions, lengthening of illness, and death.<sup>78</sup> The proposed rules would decrease

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<sup>72</sup> Chintan B. Bhatt, MBBS, MPH and Consuelo M. Beck-Sagué, MD, “Medicaid Expansion and Infant Mortality in the United States,” 108:4 *Amer. J. Pub. Health* 565 (Apr. 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5844390/>.

<sup>73</sup> Sarah Partridge, *et al.*, “Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries over 8 Years,” 29:10 *American Journal of Perinatology* 787 (July 2012), [https://www.researchgate.net/publication/230573498\\_Inadequate\\_Prenatal\\_Care\\_Utilization\\_and\\_Risks\\_of\\_Infant\\_Mortality\\_and\\_Poor\\_Birth\\_Outcome\\_A\\_Retrospective\\_Analysis\\_of\\_28729765\\_US\\_Deliveries\\_over\\_8\\_Years](https://www.researchgate.net/publication/230573498_Inadequate_Prenatal_Care_Utilization_and_Risks_of_Infant_Mortality_and_Poor_Birth_Outcome_A_Retrospective_Analysis_of_28729765_US_Deliveries_over_8_Years).

<sup>74</sup> National Partnership for Women and Families, *Black Women’s Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* (2018), <http://www.nationalpartnership.org/research-library/maternal-health/black-womens-maternal-health-issue-brief.pdf>.

<sup>75</sup> Kaiser Family Foundation, *Women’s Health Insurance Coverage*, <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>.

<sup>76</sup> Guttmacher Institute, *Dramatic Gains in Insurance Coverage for Women of Reproductive Age Are Now in Jeopardy* (2018), <https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy>.

<sup>77</sup> Committee on the Consequences, Board on Health Services, Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (2002); Steffie Woolhandler & David U. Himmelstein, *Annals of Internal Medicine*, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly* (2017), <http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly>.

<sup>78</sup> Steffie Woolhandler & David U. Himmelstein, *Annals of Internal Medicine*, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly* (2017), <http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly>; Rachel West, *Expanding Medicaid in All States Would Save 14,000 Lives Per Year* (Center for American Progress, 2018); Committee on the Consequences, Board on Health Services, Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (2002); Adam Sonfield, *Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform’s Preventive Services Requirement* (Guttmacher Policy Review, 2012) <https://www.guttmacher.org/gpr/2012/10/beyond-contraception-overlooked-reproductive-health-benefits-health-reforms-preventive>.

coverage further, causing avoidable negative health consequences.

Recognizing the importance of health care for noncitizen pregnant women and children, most states including states with high numbers of immigrants such as California, New York, and Texas have chosen to make Medicaid available to either or both of these groups prior to the usual five-year waiting period and before they become “qualified” under federal law.<sup>79</sup> These state options are consistent with longstanding congressional intent. The Department’s proposal to now penalize participation in Medicaid – and possibly CHIP – is cruel, arbitrary, and capricious.

## **B. The Proposed Rules Would Harm Immigrant Children by Impeding Access to SNAP, Contrary to Longstanding National Policy.**

The proposed rules would also deter and penalize participation in SNAP, our nation’s primary food support program. Food insecurity is associated with some of the most common and costly health problems in the United States. The direct and indirect health-related costs of hunger and food insecurity in the U.S. have been estimated to be \$160 billion for 2014 alone.<sup>80</sup> While food insecurity affects the physical and mental health for people of all ages, food insecurity is especially detrimental to the health, development, and well-being of children in the short and long terms.<sup>81</sup>

Children in low-income immigrant families are typically entitled to participate in SNAP: many such children are themselves citizens,<sup>82</sup> and noncitizen children can participate under the benefit rules adopted by Congress.<sup>83</sup> Studies show that SNAP participation in childhood reduces food insecurity and promotes health and educational advancement.<sup>84</sup> According to Children’s HealthWatch, SNAP-recipient children of immigrant mothers were more likely to be in good or excellent health and live in a food-secure household compared to income-eligible non-participants.<sup>85</sup>

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<sup>79</sup> Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women (updated Sept. 9, 2016), at <https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html>.

<sup>80</sup> Food Research & Action Center, *The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being* (Dec. 2017), <http://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf>.

<sup>81</sup> *Id.*

<sup>82</sup> Pew Research Center, *Latino Children: A Majority Are U.S.-Born Offspring of Immigrants* (May 28, 2009), <http://www.pewhispanic.org/2009/05/28/latino-children-a-majority-are-us-born-offspring-of-immigrants/>.

<sup>83</sup> National Immigration Law Center, *Immigrant Eligibility for Federal Programs*, Table 1, at [https://www.nilc.org/wp-content/uploads/2015/11/tbl1\\_ovrww-fed-pgms.pdf](https://www.nilc.org/wp-content/uploads/2015/11/tbl1_ovrww-fed-pgms.pdf).

<sup>84</sup> Food Research & Action Center, *supra n.* 80; C.O. Ojinnaka and C. Heflin, *Supplemental Nutrition Assistance Program Size and Timing and Hypertension-Related Emergency Department Claims Among Medicaid Enrollees*, *Journal of the American Society of Hypertension* (Oct. 12, 2018) (participation in SNAP linked to decreases in emergency room visits).

<sup>85</sup> Food Research & Action Center, *supra n.* 80.

Childhood participation in SNAP is linked to adult economic self-sufficiency.<sup>86</sup>

If finalized, the rules would substantially increase poverty for immigrant children<sup>87</sup> and deny to them the benefits of SNAP, contrary to longstanding national policy. The proposal should be rejected.

#### IV. CONCLUSION

The proposed rules would harm immigrant families and disproportionately exclude and penalize individuals with disabilities, as well as women and children, without justification. The Department should immediately withdraw its current proposal, and dedicate its efforts to advancing policies that strengthen—rather than undermine—the ability of immigrants to support themselves and their families in the future.

Further, the proposed rules are inconsistent with longstanding law, policy and practice; and contrary to congressional intent regarding disability rights and inclusion, including Section 504 of the Rehabilitation Act. The 1999 guidance is consistent with congressional intent and case law, represents a balance between public charge and disability inclusion. It has been relied upon by immigrant families for decades. That standard should continue to be used in interpreting and applying the public charge law.

If you have any questions or comments, please contact Senior Policy Analyst Mike Garvey at [mgarvey@aclu.org](mailto:mgarvey@aclu.org).

Sincerely,



Faiz Shakir  
National Political Director



Mike Garvey  
Senior Policy Analyst



Claudia Center  
Senior Staff Attorney  
Disability Rights Program

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<sup>86</sup> Hilary Hoynes, *et al.*, Long-Run Impacts of Childhood Access to the Safety Net, 106:1 American Economic Review 903, 905-06 (2016).

<sup>87</sup> Jennifer Laird, *et al.*, *supra* n.13.