

October 14, 2021

The Honorable Alejandro Mayorkas  
Secretary  
Department of Homeland Security  
Residence and Admissibility Branch  
Residence and Naturalization Division  
Office of Policy and Strategy  
U.S. Citizenship and Immigration Services  
5900 Capital Gateway Drive  
Camp Springs, MD 20746

Re: DHS Docket No. USCIS-2021-0013: Public Charge Ground of Inadmissibility

Dear Secretary Mayorkas:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide information regarding the Public Charge Ground of Inadmissibility. The AMA strongly opposes any rules, regulations, or policies that would deter immigrants/nonimmigrants seeking visas and/or their dependents from utilizing non-cash public benefits such as, but not limited to, Medicaid, Supplemental Nutrition Assistance Program (SNAP), and housing assistance. Impeding access to non-cash public benefits for these individuals and families could undermine population health in general. We therefore strongly urge the Department of Homeland Security (DHS) to ensure that any proposed changes to public charge regulations do not adversely impact our country's health as a whole and are communicated clearly so that individuals who are otherwise eligible do not unnecessarily forgo public benefits available to them.

## PURPOSE AND DEFINITION OF PUBLIC CHARGE

### How should DHS define the term “public charge?”

The “Field Guidance on Deportability and Inadmissibility on Public Charge Grounds,” 64 FR 28689 (May 26, 1999) (hereinafter referred to as the 1999 Interim Field Guidance) is the applicable regulation that defines what it means to be a public charge.<sup>1</sup> The current definition states that a public charge is an immigrant that is 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” unless they fall under an exempted category.<sup>2</sup> The 1999 Interim Field Guidance notes that Medicaid and other health insurance and health

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<sup>1</sup> <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge>.

<sup>2</sup> <https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf>.

services, other than support for long-term institutional care, are not to be considered for public charge purposes.<sup>3</sup>

However, this guidance is not part of the official definition and, due to the temporary changes made during the Trump Administration that re-defined the term “public charge” as “an alien who receives one or more public benefits,”<sup>4</sup> a significant amount of confusion has arisen concerning what factors will be taken into account when determining if an individual is “primarily dependent on the government for subsistence.” The AMA supports federal policy that allows physicians to treat immigrant children, regardless of legal status. We also support federal policy that ensures appropriate care for pregnant immigrants and policies that do not deny or restrict legal immigrants’ access and coverage of vital medical services regardless of immigration status. Therefore, it is imperative that the definition of public charge explicitly states that Medicaid and other health insurance and health care services will not be considered for public charge purposes rather than having that information as additional guidance.

**How might DHS define the term “public charge,” or otherwise draft its rule, so as to minimize confusion and uncertainty that could lead otherwise-eligible individuals to forgo the receipt of public benefits?**

Currently, there is comparatively little certainty in the application of the public charge determination. We believe the process for determining if an individual is a public charge should be refined so that applicants for citizenship will have greater confidence in the application process and outcome.

Receiving public benefits does not automatically make an individual a public charge. There are two tests that immigration officials use to assess public charge, as outlined in the Immigration and Nationality Act (INA). The first test is a “totality of the circumstances” test, which considers several factors listed at INA § 212(a)(4)(B) including a noncitizen’s: (1) age; (2) health; (3) family status; (4) assets, resources, and financial status; and (5) education and skills.<sup>5</sup> Historically, the Administration has focused its review primarily on financial sustainability. The second test requires certain applicants to submit a contract signed by the petitioner, Form I-864 Affidavit of Support, and, if necessary, an affidavit by an additional joint sponsor.<sup>6</sup>

Under the totality of the circumstances test “the existence or absence of a particular factor should never be the sole criteria for determining if an alien is likely to become a public charge.”<sup>7</sup> Instead, the determination of whether an individual would become primarily dependent on the government for subsistence is based on all the combined factors and is determined on a case-by-case basis. Therefore, past receipt of cash aid or long-term institutionalization is just one factor within the totality of the circumstances. “An officer must consider how long the person used the benefit or service, how long ago in the past this use occurred, and consider all relevant factors at time of application.”<sup>8</sup> U.S. Citizenship and Immigration Services (USCIS) guidance mandates that an officer must identify specific factors that demonstrate a likelihood that the applicant will become dependent on the government to make a public charge finding such as “mental or physical disability, advanced age, or other fact reasonably tending to

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<sup>3</sup> <https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf>.

<sup>4</sup> <https://www.uscis.gov/archive/final-rule-on-public-charge-ground-of-inadmissibility>.

<sup>5</sup> [https://www.ilrc.org/sites/default/files/resources/total\\_circum\\_assess\\_pub\\_charge\\_inadmis-20190503.pdf](https://www.ilrc.org/sites/default/files/resources/total_circum_assess_pub_charge_inadmis-20190503.pdf).

<sup>6</sup> INA § 212(a)(4)(C)-(D).

<sup>7</sup> 8 C.F.R. § 245a.18(d)(1).

<sup>8</sup> [https://www.ilrc.org/sites/default/files/resources/total\\_circum\\_assess\\_pub\\_charge\\_inadmis-20190503.pdf](https://www.ilrc.org/sites/default/files/resources/total_circum_assess_pub_charge_inadmis-20190503.pdf).

show that the burden of supporting the alien is likely to be cast on the public....”<sup>9</sup> As a result, a healthy person “in the prime of life” should not normally be found to be a public charge, especially if a friend or relative has provided an affidavit of support.<sup>10</sup>

However, the factors considered within the totality of the circumstances test and the weight applied to each factor vary greatly depending on the officer making the determination or the court to which an individual’s case is appealed. Some court cases have found that the prospective nature of the totality of the circumstances test requires that the determination be made not on speculation or conjecture about future abilities but rather based on specific circumstances and facts and may not negatively consider circumstances outside of the applicants control that may have temporarily caused the applicant to require public assistance.<sup>11</sup> Additionally, some courts have considered individuals that are healthy and of working age to be generally unlikely to become a public charge especially if they have employable skills or a work history.<sup>12</sup> Unfortunately, there is little to no regulatory guidance provided on how to balance the competing factors, especially when in many cases some factors have more impact than others.

Moreover, these guiderails, for the most part, were not put in place by regulations but rather through a patchwork of court cases from varying jurisdictions over the years and, to make matters more complicated, are not identical to the regulations governing the Department of State (DOS) in the Foreign Affairs Manual.<sup>13</sup> It is our understanding that immigrants who have received a visa abroad, which authorizes travel to the U.S., could be evaluated against a different standard when they reach a port of entry or when they file additional immigration applications inside the U.S. Such inconsistency among courts and agencies creates chaos in the legal immigration system. We believe that there should be more clarity around the totality of the circumstances test, and that the DOS Foreign Affairs Manual and the DHS regulations be identical. This would establish greater uniformity and predictability when determining what usage of public benefits will render an individual a public charge and will provide immigrants with assurance and encourage eligible individuals not to forgo the receipt of public benefits.

## STATUTORY FACTORS: HEALTH

### How should DHS define health for the purposes of a public charge inadmissibility determination?

Society has an obligation to make access to an adequate level of health care available to all its members, regardless of ability to pay or immigration status. Currently, the public charge rule states that the health requirement of the regulation will take into consideration “whether the alien’s health makes the alien more likely than not to become a public charge at any time in the future, including whether the alien has been diagnosed with a medical condition that is likely to require extensive medical treatment or

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<sup>9</sup> <https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf>.

<sup>10</sup> *Matter of Martinez-Lopez*, 10 I. & N. Dec. 409, 421–22 (BIA 1962).

<sup>11</sup> *U.S. ex rel. Duner v. Curran*, 10 F.2d 38, 41 (2d Cir. 1925); *see also Martinez-Lopez*, 10 I. & N. Dec. at 421 (“Some specific circumstances, such as mental or physical disability, advanced age, or other fact reasonably tending to show that the burden of supporting the alien is likely to be cast on the public, must be present.”); *U.S. ex rel. Mantler v. Comm’r of Immigration*, 3 F.2d 234, 235–36 (2d Cir. 1924); *Matter of A-*, 19 I. & N. Dec. 867, 870 (BIA 1988); *see also Gegiow v. Uhl*, 239 U.S. 3, 10 (1915).

<sup>12</sup> *See, e.g., Matter of A-*, 19 I. & N. Dec. at 869–70; *Matter of Martinez-Lopez*, 10 I. & N. Dec. at 421–22; *see also Ex parte Mitchell*, 256 F. 229, 235 (N.D.N.Y. 1919) (finding applicant is not a public charge because she “is a person capable of and fully able to earn her own living and provide for herself”); *Ex parte Sturgess*, 13 F.2d 624, 625 (6th Cir. 1926); *U.S. ex rel. Mantler*, 3 F.2d at 235–36.

<sup>13</sup> <https://fam.state.gov/FAM/09FAM/09FAM030208.html>.

institutionalization or that will interfere with the alien's ability to provide and care for himself or herself, to attend school, or to work upon admission or adjustment of status."<sup>14</sup>

However, the use of the term "medical condition" is so broad that it is unhelpful and potentially harmful to the public charge determination process. There is no guidance provided as to what qualifies as extensive medical treatment or what medical conditions would rise to the level of interfering with work or school.<sup>15</sup> This broad definition could potentially encompass individuals who need to use wheelchairs or children that have a learning disability such as dyslexia that requires an Individualized Education Plan.

Enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right and the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. As such, the definition of health in the public charge inadmissibility determination should be very narrow. Immigrants and non-immigrants who could potentially be determined to be public charges should not have any negative repercussions from accessing Medicaid, health insurance, or health services including for primary care that consists of the provision of a broad range of personal medical care (preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive, and coordinated by a licensed MD/DO physician over time. Additionally, individuals should not be penalized for receiving immunizations. Furthermore, the definition of health should include specific descriptions of what is considered to be medical conditions that are "likely to require extensive medical treatment" or "interfere" with the ability of an individual to attend school or work. The current definitions are vague and leave too much discretion for immigration officers to circumvent regulatory requirements surrounding medical examinations,<sup>16</sup> in essence acting as unqualified medical experts with no oversight.

**Should DHS consider disabilities and/or chronic health conditions as part of the health factor? If yes, how should DHS consider these conditions and why?**

The AMA has long-standing policy opposing discrimination based on a person's disability. The vast majority of people with chronic conditions are able to live and work independently as contributing members of society. Among persons with disabilities, foreign-born citizens were more likely to be employed than the U.S.-born.<sup>17</sup> Accordingly, chronic conditions or disabilities should not be considerations in public charge determinations except in cases where the condition or disability poses a danger to the applicant or others.

**How should the Rehabilitation Act of 1973's prohibition of discrimination on the basis of disability be considered in DHS's analysis of the health factor?**

The Rehabilitation Act prohibits discrimination against qualified individuals with disabilities by any program or activity receiving federal financial assistance, or by any program or activity conducted by a federal executive agency. The public charge rule is no exception. If anything, public charge should serve as an early example for new arrivals that we are a nation of laws that apply regardless of one's immigration status.

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<sup>14</sup> <https://www.law.cornell.edu/cfr/text/8/212.22>.

<sup>15</sup> <https://www.ama-assn.org/system/files/2019-10/State-of-Washington-v-US-Dept-of-Homeland-Security.pdf>.

<sup>16</sup> <https://www.law.cornell.edu/cfr/text/42/part-34>.

<sup>17</sup> Huiyun, Xiang. Disability and employment among U.S. working-age immigrants. *Am J Ind Med*, 2010.

**How should DHS consider the Report of Medical Examination and Vaccination Record, Form I-693, as part of the health factor?**

The AMA strongly believes that decisions on testing and the exclusion of immigrants to the U.S. should be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information. As such, having a physician perform the Report of Medical Examination and Vaccination Record (Form I-693) is still an important step in the immigration process.<sup>18</sup> However, this Form should be altered when making public charge determinations, especially when it comes to assessing curable illnesses.

Communicable diseases of public health significance currently are defined and include treatable diseases such as mumps, gonorrhea, syphilis, and human immunodeficiency virus (HIV).<sup>19</sup> Currently, individuals may be banned from immigration to the U.S. if they are determined, on a case-by-case basis, to have a communicable disease of public health significance, per Form I-693. However, immigration to the U.S. should not be restricted because of HIV status or based on another treatable illness. Moreover, the potential for rehabilitation, the opportunity to receive vaccinations, and the benefits of being able to access adequate medical care (maybe for the first time ever) should be taken into account and looked upon favorably in the public charge determination.

**Should DHS account for social determinants of health to avoid unintended disparate impacts on historically disadvantaged groups? If yes, how should DHS consider this limited access and why?**

Yes, DHS should account for social determinants of health to avoid unintended disparate impacts on historically disadvantaged groups. In general health care should be transparent, protect the most vulnerable patients and populations, pay special attention to historically disadvantaged groups, and monitor variations in care that cannot be explained on medical grounds to ensure that the defined threshold of basic care does not have a discriminatory impact. This is the only way that health equity, meaning optimal health for all, can be achieved. As such, it is important that public benefits continue to not be included in the public charge determination and that communication from DHS to the public is explicit about what is, and is not, considered in the determination. Additionally, communications from DHS to the public should be translated into the top languages spoken, beyond English, as identified by federal guidelines to ensure that individuals understand the public charge and its implementation.

**PUBLIC BENEFITS CONSIDERED**

**How should DHS address the possibility that individuals who are eligible for public benefits, including U.S. citizen relatives of noncitizens, would forgo the receipt of those benefits as a result of DHS's consideration of certain public benefits in the public charge inadmissibility determination? What data and information should DHS consider about the direct and indirect effects of past public charge policies in this regard?**

The lead up to, and short-term change of, the public charge rule had a far-reaching chilling effect on the immigrant population and caused eligible individuals to not access benefits during a time when they were most needed, the COVID-19 public health emergency (PHE).<sup>20</sup> The potential of a wide reaching chilling effect was openly acknowledged by DHS when the Trump era regulation was finalized and projected that

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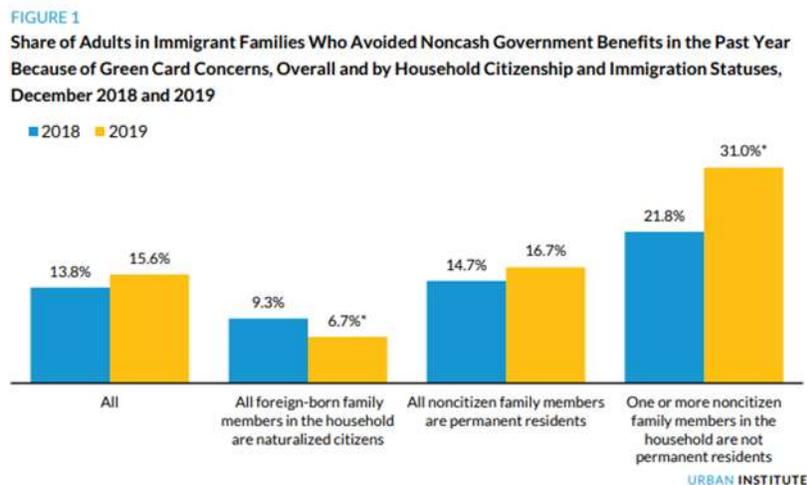
<sup>18</sup> <https://www.uscis.gov/sites/default/files/document/forms/i-693.pdf>.

<sup>19</sup> <https://www.uscis.gov/policy-manual/volume-8-part-b-chapter-6#footnote-2>.

<sup>20</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00763>.

the Administration would save \$1.46 billion since it was predicted that many individuals would “choose to disenroll from or forego enrollment in a public benefits program,” including those who were eligible for benefits.<sup>21</sup> This disregard for immigrant and population health has only compounded already existing “cultural and linguistic fear. A lot of noncitizens come from countries where trust in the government is not something you do...Filing petitions with the government and accessing the government for health is something very culturally different from anything they are used to...The fear in immigrant communities now is as great as it has ever been about possible removal from the country.”<sup>22</sup> This fear has undermined public health efforts and contributes to the inequity and vulnerability of the noncitizen, mixed status families, and the community at large.

The predictions of DHS have proven to be true. In 2019, half of the immigrant families surveyed stated that they had avoided using Medicaid, CHIP, or SNAP.<sup>23</sup> However, most individuals that chose to not access non-cash benefits were not subject to the public charge rule.<sup>24</sup>



Due to the changing nature of the public charge rule many immigrants fear accessing public benefits for themselves and even their U.S.-born children.<sup>26</sup> Between 2016 and 2019 children’s participation in Medicaid fell twice as quickly among U.S. citizen children with noncitizen household members as it did among children with only U.S. citizens in their household, even though eligibility did not change during this time.<sup>27</sup> It is estimated that, due to the announced change of the public charge rule under the Trump Administration, 260,000 children were removed or disenrolled from Medicaid, leaving these children

<sup>21</sup> <https://www.regulations.gov/document/USCIS-2010-0012-63741>.

<sup>22</sup> <https://pha.berkeley.edu/2020/12/29/the-history-of-the-public-charge-and-public-health/>.

<sup>23</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

<sup>24</sup> <https://www.networkforphl.org/resources/the-public-charge-rule-and-public-health/>.

<sup>25</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

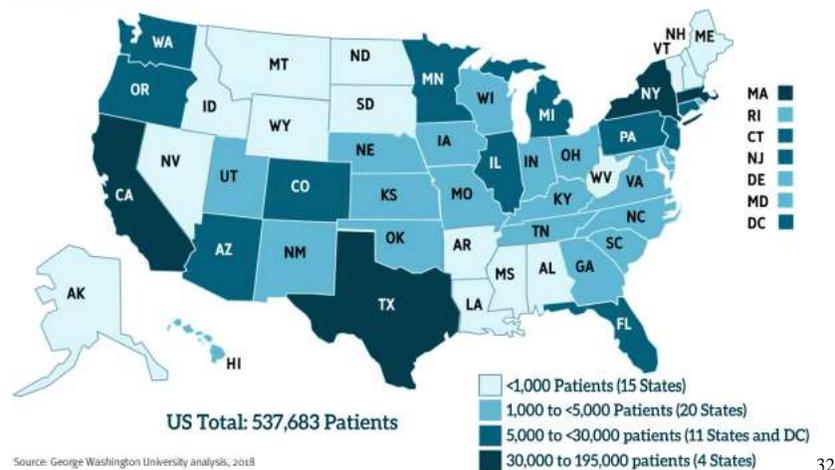
<sup>26</sup> [https://www.immigrationresearch.org/system/files/The%20Public-Charge%20Rule\\_%20Broad%20Impacts%2C%20But%20Few%20Will%20Be%20Denied%20Green%20Cards%20Based%20on%20Actual%20Benefits%20Use.pdf](https://www.immigrationresearch.org/system/files/The%20Public-Charge%20Rule_%20Broad%20Impacts%2C%20But%20Few%20Will%20Be%20Denied%20Green%20Cards%20Based%20on%20Actual%20Benefits%20Use.pdf).

<sup>27</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

without access to adequate health care.<sup>28</sup> This equates to a large gap in care between U.S. citizen children and noncitizen children, furthering health inequity.

However, the negative health consequences of the public charge rule are not only felt by children. “In a 2018 nationwide Urban Institute survey, 14 percent of all immigrants and 21 percent of those with low incomes reported withdrawing from or not enrolling in a public-benefit program due to fears of the rule.”<sup>29</sup> In 2019, in California alone, one in four (25 percent) of low income adults reported avoiding public programs due to the fear that it would negatively influence their or their family’s immigration status.<sup>30</sup> This chilling effect has been felt by every state and has the strong potential to significantly decrease the overall health of the nation since similar figures (26.2 percent) of low-income immigrant families have reported chilling effects nationally.<sup>31</sup>

Figure 2. Estimated Health Center Patients Lost Due to the Public Charge Rule (High Estimate)



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Using Census Bureau data, researchers have found that during the PHE “the public charge policy likely caused 2.1 million essential workers and household members to forgo Medicaid and 1.3 million to forgo SNAP” during a time when 41.4 percent of low-income immigrant families are experiencing food insecurity and 52.1 are worried about being able to pay for medical costs.<sup>33</sup> Moreover, according to the Urban Institute, about 70 percent of community-based organizations reported that the public charge policy deterred their clients from seeking COVID-19 testing and treatment.<sup>34</sup> The same survey discovered that

<sup>28</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00920>.

<sup>29</sup> <https://www.immigrationresearch.org/system/files/The%20Public-Charge%20Rule%20Broad%20Impacts%2C%20But%20Few%20Will%20Be%20Denied%20Green%20Cards%20Based%20on%20Actual%20Benefits%20Use.pdf>.

<sup>30</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

<sup>31</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

<sup>32</sup> <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf>.

<sup>33</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

<sup>34</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

43 percent of organizations reported that “some” clients are avoiding COVID-19 testing or treatment because of immigration enforcement or immigration status concerns. An additional 26 percent indicated that “almost everyone” or “many” clients had been deterred from COVID-19 testing or treatment by immigration concerns.<sup>35</sup>

The lack of knowledge and fear surrounding public charge determinations has caused individuals to avoid receiving basic care like vaccines. Due to COVID-19, this is a particularly dangerous time to be dissuading individuals from receiving vaccinations. Polls have found that 35 percent of immigrant respondents, including 63 percent of potentially undocumented Hispanic adults, reported that they were concerned that if they received the COVID-19 vaccine it would negatively affect their or their family’s immigration status.<sup>36</sup> This is a poignant example of the chilling effects of the public charge rule and the ineffective information provided by the U.S. government since, of those surveyed, over half were not aware that vaccines are free for all U.S. residents and that all individuals are eligible for the COVID-19 vaccine regardless of immigration status.<sup>37</sup>

It is not just the number of patients that disenrolled or avoided public health benefits, but also the long-term health implications for the immigrant population that DHS needs to consider when potentially revising the public charge rule. When the 2018 changes were being discussed it was shown that immigrants and their families chose to avoid care for more manageable health problems until those problems became much larger health complications.<sup>38</sup> Delayed treatment can be extremely detrimental to the patient and can lead to chronic illness, disability, and in extreme cases death. Moreover, without the ability to pay for, and therefore access, proper medical care it is highly probable that “rates of obesity, unplanned or unhealthy pregnancy, and mental illness are likely to become problems, which carry their own public health burdens.”<sup>39</sup>

Furthermore, DHS should bear in mind that the impact of the chilling effect is not just felt by recipients of benefits but is also by those who serve them. In 2018, before the implementation of the Trump era public charge modifications, it was estimated that Medicaid revenue would decline by somewhere between \$346 million and \$624 million in a one-year period.<sup>40</sup> This would equate to somewhere between 295,000 and 538,000 less patients being provided care.<sup>41</sup> “In order to offset this revenue loss, health centers [would have to] reduce sites, hours, services and staffing. We estimate that...staffing would drop by 6,100 full-time equivalent medical staff.”<sup>42</sup>

These losses resulting from changes during the previous Administration would have deeply, and potentially permanently, negatively impacted community health centers:

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<sup>35</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

<sup>36</sup> <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/view/footnotes/>.

<sup>37</sup> <https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf>.

<sup>38</sup> <https://healthcity.bmc.org/policy-and-industry/public-charge-rule-and-hidden-impact-public-health>.

<sup>39</sup> <https://healthcity.bmc.org/policy-and-industry/public-charge-rule-and-hidden-impact-public-health>.

<sup>40</sup> <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf>.

<sup>41</sup> <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf>.

<sup>42</sup> <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf>.

Table 1. Estimates of Impacts of Public Charge Rule on Community Health Centers (Over One Year)  
 Low estimates for legal non-citizen immigrants directly affected. High estimates for members of immigrant families losing Medicaid due to chilling effect.

	Health Center Patients Losing Medicaid		Loss in Health Center Medicaid Revenue		Loss in Total Number of Health Center Patients		Loss in Total Health Center Medical Staff	
	Legal Non-Citizen Immigrants	Legal Non-Citizen Immigrants and Family Members	Low	High	Low	High	Low	High
	Low	High	Low	High	Low	High	Low	High
<b>US Total</b>	<b>-354,334</b>	<b>-645,502</b>	<b>-\$345,673,184</b>	<b>-\$623,753,853</b>	<b>-294,642</b>	<b>-537,683</b>	<b>-3,373</b>	<b>-6,075</b>
Alabama	-502	-1,172	-\$225,564	-\$526,557	-365	-851	-2	-6
Alaska	-231	-487	-\$471,897	-\$996,953	-149	-315	-3	-7
Arizona	-11,166	-13,508	-\$10,595,610	-\$12,817,305	-9,900	-11,976	-116	-141
Arkansas	-573	-1,120	-\$394,544	-\$771,900	-425	-832	-5	-9
California	-115,357	-219,646	-\$126,143,256	-\$240,183,200	-102,201	-194,595	-1,139	-2,169
Colorado	-6,555	-13,634	-\$5,696,253	-\$11,848,222	-5,143	-10,697	-63	-131
Connecticut	-4,984	-12,878	-\$4,408,901	-\$11,391,917	-4,208	-10,873	-44	-113
Delaware	-1,140	-1,754	-\$553,818	-\$852,250	-696	-1,071	-6	-9
Dist. of Columbia	-4,245	-6,169	-\$9,953,898	-\$14,464,689	-4,258	-6,188	-106	-154
Florida	-13,114	-26,703	-\$7,813,025	-\$15,909,023	-9,334	-19,006	-94	-192
Georgia	-754	-2,434	-\$254,034	-\$820,574	-310	-1,003	-3	-10
Hawaii	-1,034	-1,692	-\$1,008,457	-\$1,650,632	-736	-1,205	-10	-16
Idaho	-265	-1,057	-\$225,677	-\$900,226	-202	-805	-2	-9
Illinois	-9,404	-21,461	-\$5,948,171	-\$13,574,467	-7,417	-16,927	-64	-147
Indiana	-2,865	-4,618	-\$1,817,859	-\$2,930,274	-2,312	-3,727	-20	-32
Iowa	-2,513	-3,090	-\$1,963,423	-\$2,414,045	-2,249	-2,765	-19	-24
Kansas	-864	-1,445	-\$471,669	-\$789,340	-623	-1,042	-6	-10
Kentucky	-2,983	-3,277	-\$1,951,046	-\$2,143,024	-2,062	-2,265	-22	-24
Louisiana	-331	-1,198	-\$155,599	-\$563,779	-164	-595	-2	-6
Maine	-270	-529	-\$233,447	-\$457,375	-224	-438	-2	-5
Maryland	-2,060	-3,813	-\$1,782,988	-\$3,300,834	-1,628	-3,013	-20	-37
Massachusetts	-39,382	-53,841	-\$32,471,101	-\$44,392,363	-23,251	-31,787	-335	-458
Michigan	-5,185	-8,219	-\$3,839,013	-\$6,084,838	-3,899	-6,180	-40	-64
Minnesota	-3,497	-7,038	-\$2,658,967	-\$5,251,271	-2,530	-5,093	-25	-49
Mississippi	-30	-643	-\$9,842	-\$210,900	-15	-312	0	-2
Missouri	-438	-1,630	-\$345,504	-\$1,286,065	-417	-1,552	-4	-15
Montana	-199	-286	-\$137,605	-\$197,994	-124	-179	-1	-2
Nebraska	-1,197	-1,631	-\$623,129	-\$849,313	-742	-1,012	-8	-11
Nevada	-337	-847	-\$581,865	-\$1,463,941	-390	-981	-8	-20
New Hampshire	-472	-858	-\$366,666	-\$666,839	-290	-528	-4	-7
New Jersey	-6,888	-17,228	-\$2,799,363	-\$7,001,699	-3,406	-8,520	-27	-66
New Mexico	-3,234	-6,139	-\$3,349,127	-\$5,363,475	-2,693	-4,313	-35	-56
New York	-48,224	-88,697	-\$55,237,669	-\$101,597,422	-41,733	-76,758	-495	-911
North Carolina	-1,997	-6,115	-\$1,070,195	-\$3,276,186	-1,376	-4,211	-12	-38
North Dakota	-311	-421	-\$273,951	-\$370,515	-300	-405	-3	-5
Ohio	-2,538	-4,602	-\$1,401,176	-\$2,540,892	-1,799	-3,262	-16	-29
Oklahoma	-490	-1,696	-\$312,067	-\$1,079,861	-373	-1,291	-4	-12
Oregon	-5,214	-9,668	-\$8,251,838	-\$15,300,182	-4,890	-9,066	-80	-148
Pennsylvania	-8,032	-13,008	-\$7,616,148	-\$12,335,111	-7,967	-12,903	-83	-135
Rhode Island	-3,075	-4,545	-\$3,003,273	-\$4,439,375	-3,036	-4,488	-33	-49
South Carolina	-319	-1,929	-\$209,046	-\$1,263,821	-203	-1,227	-2	-15
South Dakota	-719	-884	-\$485,598	-\$597,119	-614	-755	-6	-7
Tennessee	-903	-2,172	-\$347,224	-\$938,841	-533	-1,440	-5	-12
Texas	-15,876	-31,333	-\$13,410,285	-\$26,466,577	-17,137	-33,822	-156	-308
Utah	-1,547	-2,842	-\$1,369,508	-\$2,516,979	-1,426	-2,622	-16	-29
Vermont	-198	-350	-\$166,063	-\$293,264	-167	-295	-2	-3
Virginia	-661	-1,692	-\$458,375	-\$1,173,334	-577	-1,477	-5	-13
Washington	-18,168	-29,907	-\$19,832,337	-\$32,646,223	-17,036	-28,043	-190	-312
West Virginia	-259	-495	-\$172,518	-\$330,056	-214	-409	-2	-4
Wisconsin	-3,154	-4,990	-\$2,708,512	-\$4,285,574	-2,806	-4,439	-28	-44
Wyoming	-81	-108	-\$96,085	-\$127,240	-91	-121	-1	-1

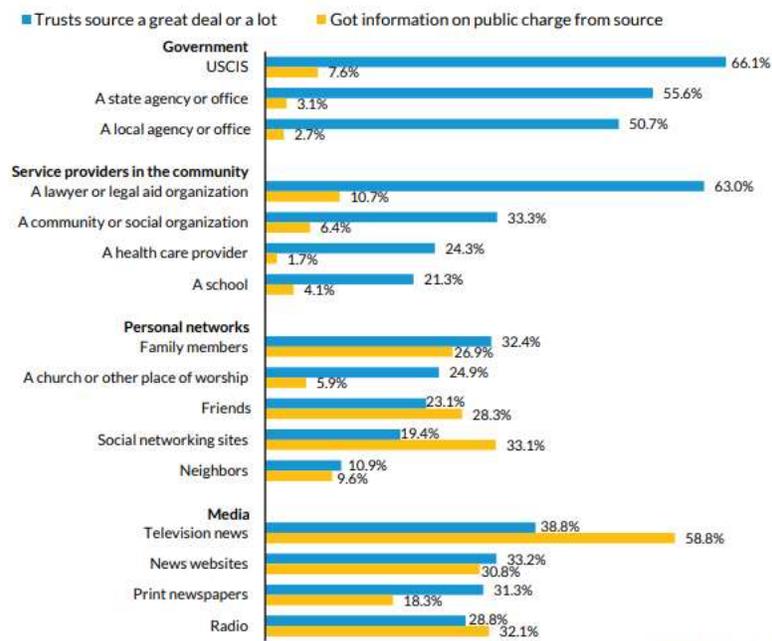
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If DHS decides to make changes to the public charge rule, it is imperative that there is extensive and accurate outreach to immigrant populations to explain any changes that have been made and to provide individualized guidance to ensure that eligible individuals do not forgo the use of much needed benefits. Immigrants trust government sources, with U.S. Citizenship and Immigration Services being the most trusted source at 66.1 percent “followed by legal professionals (63.0 percent), state government agencies (55.6 percent), and local government agencies (50.7 percent). However, very small shares [of immigrants]

<sup>43</sup> <https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf>.

reported getting information on the public charge rule from these sources; most reported getting information on the rule from the media or personal networks, which they trust less.<sup>44</sup> According to a *JAMA* study, 79 percent of respondents had heard of the public charge rule from news sources or social media and 45.2 percent of respondents were very concerned or somewhat concerned about the possible impact the rule would have on their friends or family.<sup>45</sup> This dissemination of information from nongovernment sources has resulted in 65.5 percent of adults in immigrant families reporting that they were confident that they understood the public charge rule even though “only 22.7 percent knew it does not apply to citizenship applications, and only 19.1 percent knew children’s enrollment in Medicaid [would] not be considered in their parents’ public charge determinations.”<sup>46</sup>

**FIGURE 5**  
**Trusted Sources of Information on How Using Public Benefits Affects Immigration Status and Sources of Information on the Public Charge Rule Consulted by Adults in Immigrant Families Who Have Heard About the Rule, December 2019**



Source: Well-Being and Basic Needs Survey, December 2019.

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As such, since the government is the most trusted and accurate source of information, we would encourage the Administration to provide ample communications concerning any changes that are made to the public charge rule.

Moreover, it is imperative that Hispanic families and families with children are provided with targeted accurate information. Due to anti-immigrant public rhetoric targeting Hispanic individuals, immigrants at

<sup>44</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

<sup>45</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768245>.

<sup>46</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

<sup>47</sup> [https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019\\_2.pdf](https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_2.pdf).

the Mexico-U.S. border, and a continued narrative of immigrant Hispanics as undesirable it has been shown that “Hispanic adults in immigrant families were more than twice as likely (20.6 percent) as non-Hispanic white and non-Hispanic nonwhite adults in immigrant families (8.5 percent and 0 percent, respectively) to report chilling effects in their families.”<sup>48</sup> Likewise, households with children under age 19 were 17.4 percent more likely to report chilling effects than those without children.<sup>49</sup> DHS should partner with churches, faith institutions, and other trusted groups in the community to ensure the dissemination of accurate information and to combat misinformation surrounding public charge.

Finally, as noted above, health care and access to health care such as Medicaid and the marketplace should continue to not be considered in public charge determinations. Blanket policy concerning access to health care will help to ensure that there is less confusion in the immigrant community and hopefully guarantee that more individuals are provided with proper medical care. If needed, the Administration should provide additional health services for immigrants that are experiencing the chilling effect to ensure that proper care is available and accessed by this population.

**What aspects of the 1999 Interim Field Guidance, if any, should be included in a future public charge inadmissibility rulemaking and why?**

There are a number of changes that should be made to the 1999 Interim Field Guidance in order to improve the public charge determination process. However, the fact that past, current, or future receipt of non-cash benefits and special-purpose cash benefits that are not intended for income maintenance are not considered in the public charge determination is a positive aspect of the guidance and this aspect should be maintained and expanded. Benefits that are currently not included in the public charge determination, and should continue to not be considered include:

- Medicaid and other health insurance and health services (other than support for long term institutional care), including public assistance for immunizations and for testing and treatment of symptoms of communicable diseases, health clinics, short-term rehabilitation services, and emergency medical services;
- The Children’s Health Insurance Program;
- Nutrition programs, including food stamps; the Special Supplemental Nutrition Program for Women, Infants and Children; the National School Lunch and School Breakfast Program; and other supplementary and emergency food assistance programs;
- Housing benefits;
- Childcare services;
- Services and assistances under VAWA
- Energy assistance, such as the Low Income Home Energy Assistance Program;
- Emergency disaster relief;
- Foster care and adoption assistance;
- Educational assistance, including benefits under the Head Start Act and aid for elementary, secondary, or higher education;
- Job training programs;

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<sup>48</sup> <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.

<sup>49</sup> <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>.

The Honorable Alejandro Mayorkas

October 14, 2021

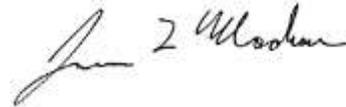
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- In-kind, community-based programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter); and
- Cash payments that have been earned (such as Title II Social Security benefits), government pensions, and veterans' benefits, among other forms of earned benefits.<sup>50</sup>

The AMA supports not including these benefits in public charge determinations and believes that this list based on the 1999 Interim Field Guidance should be maintained and expanded.

We appreciate the opportunity to provide information and urge DHS to carefully consider any future alterations to the public charge regulation so that all individuals, regardless of immigration status, have access to health care without a fear of deportation. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org), or by calling 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and "M".

James L. Madara. MD

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<sup>50</sup> <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/public-charge-resources>.