AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Antony Blinken
Secretary of State
United States Department of State
Visa Services
Bureau of Consular Affairs
600 19th Street, NW
Washington, DC 20006

Re: Visas: Ineligibility Based on Public Charge Grounds Docket DOS-2021-0034 and RIN 1400-AE87

Dear Secretary Blinken:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on "Visas: Ineligibility Based on Public Charge Grounds" Docket DOS-2021-0034 and RIN 1400-AE87.[1] The AMA strongly opposes any rules, regulations, or policies that would deter immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing non-cash public benefits including, 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. **Therefore, we strongly urge the Department of State (DOS) to rescind the interim final rule (IFR) and, at a minimum and in accordance with the Department of Homeland Security (DHS), return to utilizing 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) to administer public charge determinations.**[2] Additionally, if any proposed changes are implemented, it is imperative that DOS ensure that any 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 utilizing public benefits.

**The definition of the term "public charge" should match that of DHS and should not be unduly restrictive.**

The AMA strongly opposes the change in the definition of public charge. The IFR substantially broadens the definition of public charge by defining it as "an alien who receives one or more public benefits…for more than 12 months in the aggregate within any 36-month period (such that, for instance, receipt of two benefits in one month counts as two months' worth of benefits)." This definition is unduly restrictive and not in alignment with the current definition that is being utilized by DHS.

DHS has reverted to using the 1999 Interim Field Guidance which defines public charge as an immigrant that is likely to become "primarily dependent on the government for subsistence, as demonstrated by

[1] https://www.federalregister.gov/documents/2021/11/17/2021-25038/visas-ineligibility-based-on-public-charge-grounds.
[2] https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge.

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. As such, if DOS does not change its definition to align with the DHS definition it will likely make the DOS visa determinations extremely different from the decisions rendered by DHS, which would cause increased confusion and unnecessary suffering on the part of immigrant applicants, as was seen when the Administration tried to expand DHS' definition of public charge in 2019. We believe that the DOS Foreign Affairs Manual and the DHS regulations should 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 the public benefits they are entitled to.

**The definition of "public benefits" should match that of DHS and should not include health care benefits.**

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.

However, instead of providing greater access to health services, the current DOS definition of "public benefits" will inhibit care. The DOS stated that it wanted to align its public benefit definition with the definition in the 2019 DHS former final rule to include non-emergency Medicaid, SNAP, and public housing and rental assistance programs. However, since the 2019 DHS rule is no longer in place, if this DOS definition is implemented, DOS and DHS definitions would not align. In the IFR, DOS defines public benefits as any Federal, State, local, or tribal cash assistance for income maintenance (other than tax credits), including: Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Federal, State or local cash benefit programs for income maintenance (often called "General Assistance" in the State context, but which also exist under other names); SNAP, Medicaid except for: Benefits received for an emergency medical condition; services or benefits funded by Medicaid but provided under the Individuals with Disabilities Education Act (IDEA); school-based services or benefits provided to individuals who are at or below the oldest age eligible for secondary education as determined under State or local law; or benefits received by an alien under 21 years of age, or a woman during pregnancy (and during the 60-day period beginning on the last day of the pregnancy); and public housing and rental assistance programs. Additionally, the DOS IFR proposes to allow consular officers to deny visa applications to applicants if the officer determines that the applicant "could become at any time a public charge" under the expanded definition however, benefits received before October 15, 2019, will not be considered.

Conversely, DHS has a much narrower definition of what public benefits are, per the 1999 Interim Field Guidance. For example, DHS does not count Medicaid or other health insurance and health services (other than support for long term institutional care), 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; educational assistance, including benefits under the Head Start Act and aid for elementary, secondary, or higher education; and cash payments that have been earned, in addition to other benefits. As such, due to these conflicting definitions, individuals would be subject to unnecessary DOS public charge determinations.

Additionally, per the 2019 DHS former final rule, we know that these proposed changes will negatively impact population health. The U.S. Centers for Disease Control and Prevention (CDC) defines population health as providing "an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve."[3] We all have an important role to play in population health. According to the CDC, there are numerous advantages to developing policies that improve population health such as: a reduction in mortality, a reduction in medical costs, and a reduction in life expectancy inequity. Linking individuals and families to needed medical and social supports is a core public health function that can add both health and economic value.[4]

The lead-up to the 2019 DHS former final rule demonstrated the negative repercussions of potentially enacting this definitional change. This attempted change to 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).[5] The potential of a wide-reaching chilling effect was openly acknowledged by DHS when the Trump era regulation was finalized and it was projected that 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.[6] This disregard for immigrant and population health has only compounded already existing "cultural and linguistic fear….Filing petitions with the government and accessing the government for health is something very culturally different from anything they're used to….The fear in immigrant communities now is as great as it has ever been about possible removal from the country."[7] 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.[8] However, most individuals that chose to not access non-cash benefits were not subject to the public charge rule.[9]

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.[10] 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.[11] 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 without access to adequate health care.[12] This equates to a large gap in care between U.S. citizen children and noncitizen children and further perpetuates health inequity.

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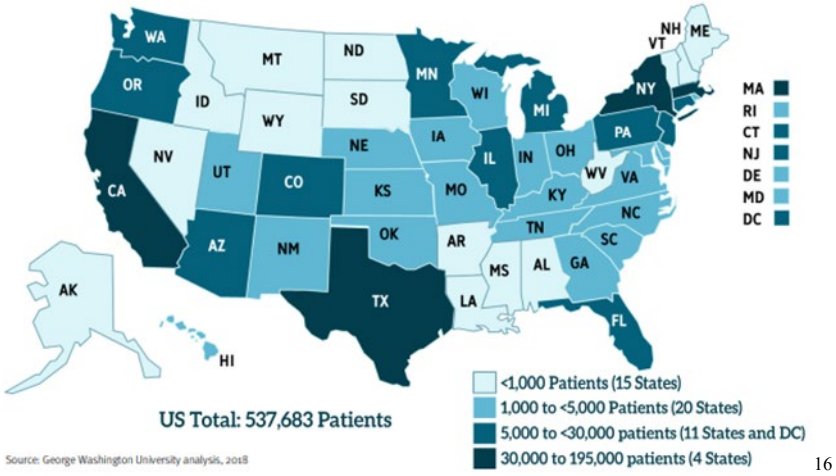
[3] https://www.cdc.gov/pophealthtraining/whatis.html.
[4] https://works.bepress.com/glen_mays/307/.
[5] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00763.
[6] https://www.regulations.gov/document/USCIS-2010-0012-63741.
[7] https://pha.berkeley.edu/2020/12/29/the-history-of-the-public-charge-and-public-health/.
[8] 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.
[9] https://www.networkforphl.org/resources/the-public-charge-rule-and-public-health/.
[10] 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.
[11] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.
[12] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00920.

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."[13] In 2019, in California alone, one in four (25 percent) low income adults reported avoiding public programs due to the fear that it would negatively influence their or their family's immigration status.[14] 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.[15]

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



[16]

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.[17] 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.[18] The same survey discovered that 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

[13] 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.
[14] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.
[15] 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.
[16] https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.
[17] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.
[18] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.

that "almost everyone" or "many" clients had been deterred from COVID-19 testing or treatment by immigration concerns.[19]

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.[20] 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.[21]

However, 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 DOS 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.[22] 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."[23]

Furthermore, DOS should bear in mind that the impact of the chilling effect is not just felt by recipients of benefits but 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.[24] This would equate to somewhere between 295,000 and 538,000 less patients being provided care.[25] "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."[26]

These losses resulting from changes during the previous Administration would have deeply, and potentially permanently, negatively impacted community health centers and if the DOS rule is implemented these losses could still be actualized:

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[19] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.
[20] https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/view/footnotes/.
[21] https://protectingimmigrantfamilies.org/wp-content/uploads/2021/08/Research-Documents-Harm-of-Public-Charge-Policy-During-the-COVID-19-Pandemic-2.pdf.
[22] https://healthcity.bmc.org/policy-and-industry/public-charge-rule-and-hidden-impact-public-health.
[23] https://healthcity.bmc.org/policy-and-industry/public-charge-rule-and-hidden-impact-public-health.
[24] https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.
[25] https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.
[26] 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 |
| **US Total** | **-354,334** | **-645,502** | **-$345,673,184** | **-$623,753,853** | **-294,642** | **-537,683** | **-3,373** | **-6,075** |
| 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 | -$5,351,271 | -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 | -3,834 | -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 | -803 | -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 |

[27]

Finally, as noted above, health care and access to health care such as Medicaid and the marketplace should not be considered in public charge determinations. It is in the best interest of the nation to ensure that the DOS definition of public benefits is not implemented so that individuals can continue to access health care including SNAP, Medicaid, and benefits provided to pregnant women. Instead, a blanket policy that allows access to health care without it counting against an individual's public charge determination should be implemented and will help to ensure that there is less confusion in the immigrant

[27] https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Public%20Charge%20Brief.pdf.

community and hopefully guarantee that more individuals are provided with proper medical care. In addition to expanding the medical benefits that immigrants can access, the Administration should disseminate accurate information about the health services that immigrants can access so that the immigrant population does not experience a chilling effect and proper care is available to and accessed by this population. Finally, the Administration must clarify that the October 15, 2019, date is no longer accurate and that any benefits received during the COVID-19 pandemic will not count against the applicant.

**The totality of the circumstances test should be applied with more uniformity and should have the same application within DOS and DHS.**

The DOS IFR, will now require consular officers to use a "more likely than not" standard and take into account the totality of a foreign national's circumstances at the time of a visa application when considering the likelihood of the individual's becoming a public charge. At a minimum, the factors would include the immigrant's: age, health, family status, assets, resources, financial status, education, and skills. 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 accessing health benefits does not count against an applicant and 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. In the "totality of the circumstances" test[28] the Administration has historically focused its review primarily on financial sustainability. However, 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."[29] Instead, the determination of whether an individual would become a public charge 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."[30] 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 show that the burden of supporting the alien is likely to be cast on the public.…"[31] 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.[32]

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 require 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.[33] Additionally, some courts have considered individuals who are healthy and of

[28] https://www.ilrc.org/sites/default/files/resources/total_circum_assess_pub_charge_inadmis-20190503.pdf.
[29] 8 C.F.R. § 245a.18(d)(1).
[30] https://www.ilrc.org/sites/default/files/resources/total_circum_assess_pub_charge_inadmis-20190503.pdf.
[31] https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf.
[32] *Matter of Martinez-Lopez*, 10 I. & N. Dec. 409, 421–22 (BIA 1962).
[33] *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

working age to be generally unlikely to become a public charge especially if they have employable skills or a work history.[34] 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, the DOS attempt to provide guidance on "heavily weighted factors" is minimal at best. The IFR does not state how heavily a factor should be weighted and how this compares to a factor that is not heavily weighted. For example, the IFR does not provide if one heavily weighted factor counts for two not heavily weighted factors. As such, the guidelines and weight provided to each factor is insufficient and does little to help the applicant navigate the process or predict the outcome of their application.

Additionally, the IFR places consular officers in the precarious position of making a visa determination based on a forward-looking, more expansive public charge test; even if a person is not currently or has not previously used a public benefit (which may be the case in visa applicants applying overseas), this means that an officer must subjectively assess the likelihood of future use by the individual on a case-by-case basis. Many families are considered mixed-status families, meaning the family includes members with different immigration statuses and/or visas and it is our firm belief that this expanded public charge test will continue to foster and increase toxic stress, confusion, and fear within families that could be torn apart due to the subjective determination of consular officials. According to one survey conducted prior to the DHS final rule, one in seven adults in immigrant families reported avoiding public benefit programs for fear of risking future green card status.[35]

Moreover, if the IFR is implemented, these guiderails will not be identical to the guiderails that are utilized by DHS.[36] As such, 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 should 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. Furthermore, we believe the DOS IFR, like the 2019 DHS final rule, will have a chilling effect on immigrant families and be utilized to deter these individuals and families from applying for visas and as such should not be implemented.

**The health components of the IFR should be better defined.**

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. As such, the AMA strongly opposes the expansion of health-related factors that consular officers, with no substantial health care training, must consider in determining visa eligibility. Under the IFR a consular officer will consider "whether the alien, has been

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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).

[34] *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.

[35] https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018.

[36] https://fam.state.gov/FAM/09FAM/09FAM030208.html.

diagnosed with a medical condition that is likely to require extensive medical care or institutionalization, or that will interfere with the alien's ability to provide and care for himself or herself, to attend school, or to work, if authorized."[37] The new provision adds that consular officers will consider the report of a medical examination performed by the panel physician where such examination is required, including any medical conditions noted by the panel physician.

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.[38] This broad definition could potentially encompass individuals who need to use wheelchairs or children that have a learning disability that requires an Individualized Education Plan such as dyslexia.

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 that 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. Furthermore, the definition of health should include specific descriptions of 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 officers to circumvent regulatory requirements surrounding medical examinations,[39] in essence acting as unqualified medical experts with no oversight. As such, the health components of the IFR should be better defined and should not include any health care benefits that are received by immigrants.

The AMA believes every individual, regardless of immigration status, deserves timely, accessible, quality health care, nutrition, and housing. The policy changes in the IFR have the potential to worsen population health and therefore, we urge the Administration to rethink these proposed policy changes, rescind the IFR and, at a minimum and in accordance with the DHS, return to utilizing the 1999 Interim Field Guidance to administer public charge determinations. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or by calling 202-789-7409.

Sincerely,

James L. Madara, MD

[37] https://www.federalregister.gov/documents/2019/10/11/2019-22399/visas-ineligibility-based-on-public-charge-grounds.
[38] https://www.ama-assn.org/system/files/2019-10/State-of-Washington-v-US-Dept-of-Homeland-Security.pdf.
[39] https://www.law.cornell.edu/cfr/text/42/part-34.