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Samantha L. 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: Inadmissibility on Public Charge Grounds (RIN 1615-AA22), 83 Fed. Reg. 51114; DHS Docket No. USCIS-2010-0012

Dear Chief Deshommes:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments to the U.S. Department of Homeland Security (DHS) in response to the Notice of Proposed Rulemaking (Proposed Rule or Proposal) on “Inadmissibility on Public Charge Grounds” issued by the U.S. Citizenship and Immigration Services (USCIS). We are deeply concerned about this Proposal’s potential negative impact on individuals and families who are seeking admission into the U.S., an extension of stay, or change in immigration status to access health care services. Impeding access to health-related benefits for these individuals and families could undermine population health in general, and thus we strongly urge the Administration to withdraw the Proposed Rule.

New Definition of Public Charge and Public Benefits

DHS is proposing to re-define the term “public charge” as “an alien who receives one or more public benefits.” Specifically, the Administration seeks to move away from the narrow definition for public charge inadmissibility outlined in its [Field Guidance on Deportability and Inadmissibility on Public Charge Grounds](#), 64 FR 28689 (May 26, 1999). In the 1999 guidance document the federal government defined “public charge” for purposes of both admission/adjustment as “an alien who 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.” This Proposal is more than a technical change to U.S. immigration policy, it is a dramatic shift. On its face, the proposed change in the definition of public charge may seem innocuous, but when coupled with an expansion of the list of public benefits immigration officials may consider in determining inadmissibility, the Proposed Rule will have a chilling effect on the ability of both individuals and their dependents to access critical public medical, nutritional, and housing services.

Under the new Proposed Rule, the public charge definition would be dramatically broadened to make it more difficult for noncitizens following all legal requirements to enter the country and advance through the immigration process. The Proposed Rule would deny entry or permanent legal status for noncitizens who may receive one or more public benefits including, for the first time, non-emergency Medicaid,

Medicare Part D low-income subsidies, the Supplemental Nutrition Assistance Program (SNAP), and several public housing programs. The Administration is also considering adding the Children's Health Insurance Program (CHIP) to the list of programs that would count toward inadmissibility on public charge grounds and specifically asks the public for comment. We believe these proposed changes will cause both short- and long-term harm to the health and well-being of not just the millions of individuals and families seeking to be admitted to the U.S., extend their stay in the U.S., or change their immigration status, but to the health of the public in general.

While we agree with the Administration that the true quantifiable impacts of this regulatory action on individuals and families are difficult to discern; we believe that the estimates DHS provides in the Proposed Rule and detailed below are too low. We further believe that the Proposed Rule has the potential to erode family stability and decrease disposable income of families and children because the action provides a strong disincentive for the receipt or use of public benefits by noncitizens, as well as their household members, including U.S. children.

Non-Emergency Medicaid¹

Under the Proposed Rule, it is estimated that the average annual public benefits payments for Medicaid total \$477.4 billion, or \$7,426.59 per beneficiary. DHS estimates that there are approximately 1.69 million households with at least one foreign-born noncitizen, and 5.69 million people living in households that include foreign-born noncitizens, receiving non-cash benefits from the Medicaid Program.²

Supplemental Nutrition Assistance Program

Under the Proposed Rule, it is estimated that the average annual public benefits payments for SNAP total \$69.2 billion, or \$1,527.59 per beneficiary. DHS estimates that there are approximately 1.55 million households with at least one foreign-born noncitizen and 5.18 million people living in households including foreign-born noncitizens, receiving non-cash benefits from SNAP.³

Low Income Subsidy (LIS) for Medicare Part D Prescription Drug Coverage

Under the Proposed Rule, it is estimated that average annual public benefits payments for the LIS for Medicare Part D Prescription Drug coverage amounts to \$25.4 billion, or \$2,099.17 per beneficiary. DHS estimates that there are approximately 319,000 households with at least one foreign-born noncitizen, and 1.07 million people living in households including foreign-born noncitizens, receiving non-cash benefits in the form of LIS for Medicare Part D Prescription Drug Coverage.⁴

DHS states in the Proposed Rule that, "Research shows that when eligibility rules change for public benefits programs there is evidence of a "chilling effect" that discourages immigrants from using public benefits programs for which they are still eligible.⁵ We agree and strongly urge DHS to rescind the Proposed Rule. Including these vital medical and nutritional services as factors to be used in a public

¹ <https://www.macpac.gov/wp-content/uploads/2018/10/Proposed-Rule-Inadmissibility-on-Public-Charge-Grounds.pdf>

² 83 FR 51262, Table 49

³ Id.

⁴ Id.

⁵ 83 FR 51266.

charge determination is contrary to the fundamental principles underlying these programs, which provide health care coverage and nutritional support to individuals, children, and families in need.

In addition, DHS assumes a “2.5 percent rate of disenrollment or foregone enrollment across each of the public benefits programs since the individuals intending to adjust status are most likely to disenroll from or forego enrollment in public benefits programs in order to preserve their chances of adjusting status.”⁶ We believe that 2.5 percent is too low of an estimate. We believe that the disenrollment rates will be higher based on the chilling effect this Proposal will have on enrollment in health coverage among these families. Although DHS recognizes previous research showing that chilling effects led to enrollment reductions, it does not appear to account for a chilling effect in its estimates. Instead, it is our understanding that DHS assumes that all individuals directly affected by the public charge rule (i.e., those applying to adjust status) drop coverage but no disenrollment effects among their family members or among other noncitizen families.⁷ Instead we support the Medicaid and CHIP Payment and Access Commission’s initial estimates that use a range of 15 to 35 percent suggesting that 2.1 to 4.9 million Medicaid enrollees may disenroll.⁸

Children’s Health Insurance Program

DHS is also specifically seeking comment regarding whether CHIP should be included as a factor to be used in public charge determinations, under the Proposed Rule. According to the Centers for Medicare & Medicaid Services, 46 States and the District of Columbia cover children up to or above 200 percent of the Federal Poverty Level (FPL), and 24 of these states offer coverage to children in families with income at 250 percent of the FPL or higher. States may receive the CHIP enhanced match for coverage up to 300 percent of the FPL.⁹ While coverage differs from state to state, all states provide comprehensive coverage, such as routine check-ups, immunizations, doctor visits, and prescriptions. The program is funded jointly by states and the federal government. DHS estimates that the average annual public benefits payments for CHIP totals \$15 billion, or \$2,324.52 per beneficiary. DHS further estimates that approximately 6.46 million children are enrolled in CHIP, with 0.7 percent of noncitizens reporting receiving benefits under this program.¹⁰ However, it is important to note that in 2016, nearly 10.4 million citizen children lived with at least one noncitizen parent, with approximately 56 percent holding Medicaid or CHIP coverage.¹¹ Thus, the “chilling effect” on CHIP if it is included in the public charge may be substantially larger than anticipated.

Unintended Consequences

DHS seeks comment on possible unintended consequences of the Proposed Rule. We agree with DHS’ initial list of primary non-monetized potential negative consequences, such as:

⁶ 83 FR 51266.

⁷ 83 FR 51262-51269.

⁸ <https://www.macpac.gov/wp-content/uploads/2018/10/Proposed-Rule-Inadmissibility-on-Public-Charge-Grounds.pdf>

⁹ 83 FR 51174.

¹⁰ 83 FR 51161.

¹¹ https://www.kff.org/report-section/potential-effects-of-public-charge-changes-on-health-coverage-for-citizen-children-issue-brief/#endnote_link_257512-5

- Worsening of health outcomes, including increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children, and reduced prescription adherence;
- Increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment;
- Increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated;
- Increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient;
- Increased rates of poverty and housing instability; and
- Reduced productivity and educational attainment.

We also believe the following should be added to the Administration's list of negative unintended consequences:

- States will lose Medicaid and CHIP funding and hospitals would see a loss in Medicaid payments that would be coupled with an increase in uncompensated care for those individuals seeking care;¹²
- Increased percentage of uninsured patients and widespread decrease in access to health care services;
- Decreased management of chronic conditions such as diabetes and hypertension; and
- Increased prevalence of malnutrition due to decreased utilization of SNAP.

Again, while we agree with the Administration that the true quantifiable impacts of this proposed regulatory action on families may be difficult to discern, we also strongly agree with DHS "that the proposed rule may decrease disposable income and increase the poverty of certain families and children, including U.S. citizens." We remain very concerned that the Proposed Rule would force noncitizens, especially those with children, to choose between receiving essential medical/nutritional care or pursuit of their application for admission/adjustment.

The AMA supports federal policy that allows physicians to treat immigrant children, regardless of legal status. We also support federal policy that does not deny or restrict legal immigrants' access and coverage of vital medical services regardless of immigration status. We are concerned that the Proposed Rule would compromise the availability of preventive and emergency medical care, reduce access to health insurance coverage, cause widespread increases in uncompensated care, and worsen health disparities within immigrant communities. We are also concerned with the impact of the Proposed Rule on population health. In a recent [commentary](#) in the *New England Journal of Medicine*, researchers who have studied the effects of public policy on low-income families, including immigrant households, stated that "if this rule takes effect, it will most likely harm the health of millions of people and undo decades of work by providers nationwide to increase access to medical care for immigrants and their families."¹³

¹² We believe that if Medicaid funding is reduced and uncompensated care increases under the Proposed Rule, hospitals around the country will make changes that may impact all patients, not only the immigrants targeted by the Proposed Rule.

¹³ <https://www.nejm.org/doi/pdf/10.1056/NEJMp1808020>

Data and Privacy Concerns

Another potentially serious unintended consequence of the Proposed Rule is its impact on patient data. As a result of the proposed changes to the public charge, physicians may feel compelled not to include data about any public benefit immigrant families are receiving—though information about such benefits are part of the “social determinants of health” assessment seen as key to care coordination. To complicate the matter further, immigration authorities may seize electronic health records as part of their investigations, which raises several questions about both the accuracy and security of patient data and privacy of health information. Of concern, there may be potential violations to the Health Insurance Portability and Accountability Act of 1996 depending on how the federal government seeks to track insurance coverage and an individual’s medical condition. Therefore, we remain deeply concerned about the impact the Proposed Rule will have on patient data and privacy.

Consideration of Additional Negative Factors and the Totality of the Circumstances Test

Current law on the public charge requires the consideration of a noncitizen’s: (1) age, (2) health, (3) family status, (4) assets, resources, and financial status; and (5) education and skills. Historically, the Administration has focused its review primarily on financial sustainability. The Proposed Rule, however, would add several new “Totality of the Circumstances Test” Factors. It would expand the family status factor to include a noncitizen’s household size and total number of children, including U.S. citizen children; expand the education and skills factor to include English language proficiency; and expand the health factor to include being diagnosed with a medical condition that is likely to require extensive medical treatment or institutionalization. The AMA is deeply concerned about the consideration by the Administration of these additional negative factors in public charge determinations.

In the Proposed Rule DHS is seeking to clarify the expanded health factors to be considered in the public charge test to specifically include chronic conditions identified by the U.S. Centers for Disease Control and Prevention (CDC), such as heart disease, stroke, cancer, diabetes, obesity, arthritis, epilepsy, and tooth decay. DHS notes that chronic disease accounts for the majority of health care costs in the U.S. However, DHS fails to consider that with access to health insurance (e.g., Medicaid), preventive medical treatment, and health care professionals, individuals with chronic medical conditions can exhibit drastic improvements in their health and productivity. The federal government has funded and developed programs specifically to address the issue of educating the general public (both U.S. citizens and noncitizens and in multiple languages other than English) about the benefits of preventive care and the importance of health care education. Programs such as the National Diabetes Education Program (NDEP) develop resources aimed at reducing the burden of diabetes and prediabetes by providing culturally and linguistically appropriate educational resources for a range of individuals and groups—ethnic minorities, hard-to-reach populations, community- and faith-based organizations, and health care providers. NDEP materials are provided through a collaborative effort between the CDC and the National Institutes of Health, the leaders in health and science within the federal government.¹⁴ The Proposed Rule would undermine national efforts to provide resources to the public about the benefits of preventive care and the importance of health care education, with respect to many of the chronic diseases identified by DHS to be directly included in the public charge test.

¹⁴ <https://www.cdc.gov/diabetes/ndep/index.html>

DHS is seeking comment on whether 36 months is an appropriate period of time to examine an individual's receipt of public benefits such as non-Medicaid. DHS is also seeking comment on whether it should consider receipt of designated monetizable public benefits, such as SNAP, at or below the 15 percent threshold as evidence in the totality of the circumstances test. We believe this proposal is unworkable—DHS should not expand the list of public benefits to be included as evidence in the totality of the circumstances test, and thus no period of time or threshold amount is appropriate.

DHS is also seeking comment on the best mechanism to administer public charge inadmissibility determinations for those who receive benefits while under the age of majority (i.e., 18 years of age). DHS is specifically interested in whether or to what extent it should weigh past or current receipt of benefits in the totality of the circumstances test as a potential indicator of likely future receipt of public benefits. There are an estimated 6.46 million children enrolled in CHIP, with 0.7 percent of noncitizens reporting receiving benefits under this program. According to the U.S. Department of Health and Human Services' own report, receiving health coverage from CHIP/Medicaid makes children more likely to complete college and leads to higher earnings and better health, including fewer hospitalizations, as adults.¹⁵ We urge DHS to consider this report and not consider past or current receipt of public benefits an individual received while under the age of majority.

New Requirements for Nonimmigrants and the Impact on J-1 and H-1B Visa Physicians

The AMA believes that the Proposed Rule will directly impact both beneficiaries and providers of health care services in Medicaid and CHIP. It is our understanding that nonimmigrants applying for a change of status or an extension of stay will also be subject to the new public charge standard under the Proposed Rule. As part of the application and adjudication process, nonimmigrants, such as physicians on J-1 and H-1B visas, will need to demonstrate they are not using or receiving nor are likely to use or receive public benefits such as the medical and nutritional services described in the Proposed Rule. Additionally, it is our understanding that physicians on J-1 and H-1B visas would also be subject to the new expanded "Totality of the Circumstances Test" Factors mentioned above such as noncitizen's household size and total number of children, including U.S. citizen children; English language proficiency; and negative health factors such as being diagnosed with a medical condition that requires extensive medical treatment. As a result, the AMA's International Medical Graduate (IMG) members would be directly impacted by the Proposal. In 2016, 897,783 physicians were practicing in the U.S., 206,030 (23 percent) of whom did not graduate from a U.S. or Canadian medical school. Also, in 2016, 30,000 IMG residents were in U.S.-based residency training programs. Additionally, 36 percent of all practicing internists (i.e., primary care) were IMGs, (i.e., foreign-trained physicians) in 2016.¹⁶

Once accepted into a residency program via the match process, physicians who are foreign nationals must obtain a visa that permits participation in U.S. medical training. Foreign-born medical school graduates commonly apply for a J-1 visa through the U.S. Exchange Visitor Program, which allows Educational Commission For Foreign Medical Graduates (ECFMG) to sponsor visas for physicians participating in clinical training programs. However, the amount of time clinical trainees can stay in the U.S. through the ECFMG is limited generally to seven years, which is the time typically required to complete a residency program and a subsequent fellowship for sub-specialty training. After completing their residency, J-1 visa holders must generally return to their home countries for two years before they can return to the U.S.,

¹⁵ <https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf>

¹⁶ <http://annals.org/aim/fullarticle/2609645/importance-international-medical-graduates-united-states>

often on an H-1B (temporary highly skilled nonimmigrant) or L-1 (intracompany transferee) visa. International residency or fellowship graduates who are willing to work in medically underserved areas or with underserved patients for three years can apply for a waiver of the two-year residency requirement.

There are several federal agencies that sponsor international physicians for these types of waivers, including the Department of Veterans Affairs. This Proposed Rule has the potential to negatively impact the VA's ability to obtain physicians to provide timely, quality care to our nation's veterans. According to the ECFMG, in academic year 2017, there were 10,953 physicians approved for J-1 Visa Sponsorship.¹⁷ Additionally, 51 percent of all J-1 visa holders practiced internal medicine and 10 percent practiced pediatrics in calendar year 2017.¹⁸ An analysis of 2016 data from the U.S. Department of Labor Office of Foreign Labor Certification reveals that U.S. employers were certified to fill approximately 10,500 H-1B physician positions nationwide.¹⁹

An IMG may utilize the H-1B visa category if they are performing research or teaching or providing direct patient care. A physician may also obtain an H-1B visa by participating in a residency program. Nationwide, applicants to the H-1B program represented 1.4 percent of the active physician workforce, but there is wide variation state to state. New York state had the largest number of labor condition applicants (1,467), followed by Michigan and Illinois. North Dakota had the highest approved percentage of H1-B physicians, at 4.68 percent. Rhode Island, Michigan, Delaware, and Arkansas followed.²⁰

Whether the physician trains in the U.S. in J-1 status and then obtains a waiver of the two-year home residency requirement, or trains in H-1B status, the path to lawful permanent resident status following the completion of training is not guaranteed due to extreme backlogs in the federal government's processing of these applications. Thus, our IMGs do not need any additional obstacles put in their path as they seek to become permanent U.S. Citizens and continue to provide care to our most vulnerable residents in rural and underserved parts of our nation. Nearly 21 million people live in areas of the U.S. where foreign-trained doctors account for at least half of all doctors. As such, the impact of the Proposed Rule on this physician cohort would significantly undermine current efforts to address the worsening physician shortage, and directly impact patient populations across the U.S. considered medically underserved.²¹ The U.S. is facing a serious shortage of physicians, largely due to the growth and aging of the population and the impending retirements of older physicians. According to recent data, the U.S. could see a shortage of up to 120,000 physicians by 2030, impacting patient care across the nation.²²

¹⁷ <https://www.ecfm.org/forms/factcard.pdf>

¹⁸ <https://www.ecfm.org/resources/SpecialtiesPursuedbyJ-1Physicians2017.pdf>

¹⁹ https://jamanetwork.com/journals/jama/fullarticle/2620160?utm_medium=alert&utm_source=JAMAPublishAheadofPrint&utm_campaign=17-04-2017

²⁰ <https://www.medpagetoday.com/publichealthpolicy/by-the-numbers/64850>

²¹ <https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained-doctors-are-critical-to-serving-many-us-communities.pdf>

²² https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

Cost Savings of the Proposed Rule

In its outline of the potential cost savings of implementing the Proposed Rules, DHS points to savings accrued from noncitizens choosing to disenroll or forego public benefits for at least the 36 months prior to submitting their application for admission/adjustment. However, the AMA believes the Administration's emphasis on the immediate cost savings does not take into consideration our nation's historical focus on improving public health, increasing preventive care, and reducing health disparities.

In 1999, the CDC listed the "[Ten Great Public Health Achievements](#)" in the U.S. from 1990-1999. Among the greatest public health achievements listed were vaccinations, control of infectious diseases, and access to safer and healthier foods. The Proposed Rule, however, does not take these achievements into consideration; instead, it seeks to discourage immigrants from accessing vital public benefits such as medical care and nutritional services, which will have a direct negative impact on the gains the U.S. has made in the area of improving public health. We are concerned that the Proposed Rule would undermine our nation's efforts over the last decade to bolster the public's focus and understanding of the long-term benefits of seeking preventive services, such as well-child visits, blood pressure/diabetes/cholesterol tests, cancer screenings, and vaccines.²³ We think the Administration's Proposal will have a negative impact on the overall health of the nation.

The National Academy of Medicine (NAM) performed an assessment on the differences in the kinds and quality of health care received by U.S. racial and ethnic minorities and non-minorities. The NAM found that racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled. The sources of these disparities are complex, rooted in historic and contemporary inequalities, and involve many participants at several levels.²⁴ According to the NAM report, "the healthcare workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals."²⁵ We agree and believe that the Proposed Rule will undermine progress made in enhancing diversity in the physician workforce.

Failure to Harmonize with the U.S. Department of State

The AMA believes that the Administration has failed to harmonize DHS' Proposal with the U.S. Department of State's separate public charge regulations issued on January 3, 2018.²⁶ Specifically, the U.S. Department of State defined public charge as "primarily dependent" on public benefits and continued to exclude non-cash benefits. As a result, it is our understanding that immigrants who have received a visa abroad, which authorizes travel to the U.S., could be evaluated against a completely different standard when they reach a port of entry or when they file additional immigration applications inside the U.S. Such discord would create considerable and long-lasting chaos in the legal immigration system. We urge DHS to defer to the U.S. Department of State's public charge determinations.

²³ The Proposed Rule is extremely disjointed in that it exempts public health assistance for immunizations for immunizable diseases and for testing and treatment of symptoms of communicable diseases, which are covered under CHIP and Medicaid, but yet seeks comment regarding whether to include CHIP in the public charge test and whether to consider public benefits received while an individual is under age 18. The Proposed Rule is fragmented and unworkable and should be rescinded.

²⁴ <https://www.nap.edu/read/12875/chapter/2>

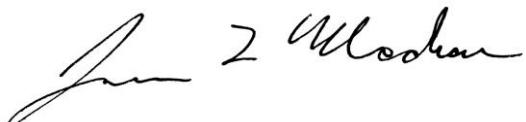
²⁵ <http://books.nap.edu/books/030908265X/html/1.html#pagetop>

²⁶ <https://fam.state.gov/fam/09fam/09fam030208.html>

Conclusion

The AMA believes every individual deserves timely, accessible, quality health care, nutrition, and housing. The policy changes in the Proposed Rule, however, would reverse the public health gains we have made in the last several decades in areas such as vaccinations, control of infectious diseases, and access to healthier foods. A policy of denying vital services to recent immigrants is not a pathway to ensure they become productive citizens, and it has the potential to worsen population health in general. We urge the Administration to rethink these proposed policy changes and withdraw the Proposed Rule.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with "James" on the left and "L. Madara" on the right.

James L. Madara, MD