AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

October 22, 2021

U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Submitted via www.regulations.gov

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

To whom it may concern:

The Association of Asian Pacific Community Health Organizations (AAPCHO) and the undersigned member community health centers/organizations write in response to the advance notice of proposed rulemaking (ANPRM) on the public charge ground of inadmissibility. The agency must move quickly to permanently remove the use of all health care and other benefits from the public charge determination to support the health and wellbeing of immigrants and their families.

AAPCHO is a national nonprofit association of community-based health care providers, primarily federally qualified health centers, that advocates for the unique and diverse health needs of Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NH/PIs). Community health centers serve nearly 30 million patients each year, including 1.6 million AAs and NH/PIs. AAPCHO members are critical health access providers to nearly three quarters of a million vulnerable and low-income patients, providing linguistically accessible, culturally appropriate, and financially affordable health care services. Among AAPCHO members, nearly half of patients served are limited English proficient (LEP) and 9 in 10 have incomes falling below 200 percent of the poverty line. Further, AAPCHO member community health centers employ multilingual staff and may serve as high as 99% LEP patients with some community health centers providing services in over 15 languages.

AAPCHO and our member community health centers have seen the chilling effects of public charge on our patients, who are foregoing essential services, disenrolling from benefits for which they are eligible, or just not showing up to receive necessary health care, despite the Biden Administration's recission of the Trump-era rule earlier this year. AA communities are especially impacted by anti-immigrant fears given that more than half (57%) of Asians living in the U.S. were born in another country.[1] A recent KFF survey conducted at AAPCHO member community health centers found that one quarter (25%) of Asian health center patients did not apply for or stopped participating in a government program to help them pay for health care, food, or housing in the past year due to immigration-related fears.[2] Additionally, more than 4 in 10 (44%) say that they worry a lot or some that they or a family member could be

[1] Key facts about Asian Americans, a diverse and growing population, April 29, 2021, available at: https://www.pewresearch.org/fact-tank/2021/04/29/key-facts-about-asian-americans/
[2] Asian Immigrant Experiences with Racism, Immigration-Related Fears, and the COVID-19 Pandemic, June 18 2021, available at: https://www.kff.org/coronavirus-covid-19/issue-brief/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/

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detained or deported. These fears have been compounded during the COVID-10 pandemic and leads to increased likelihood that immigrants will not seek or will delay care at a time when doing so is of paramount importance. Immigration laws should not discourage immigrants and their family members from seeking physical or mental health care, nutrition, or housing benefits for which they are eligible.

In addition to ensuring that the public charge test is narrow and does not amount to a wealth or income test, the public charge regulations must also be clear and comprehensible by diverse immigrant populations and organizations who assist them. More than half (54%) of patients surveyed at AAPCHO member community health centers reported that they do not have enough information about how recent changes to U.S. immigration policy affect them or their family. Clear regulations will set parameters so that immigrants, their families, and service providers can understand how a public charge assessment will be determined. The regulation should include guardrails to prevent a public charge determination from being used as a tool to discriminate against people of color, women, people with disabilities, older adults, or anyone else.

It is also imperative that the administration act with urgency and move through rulemaking that ends in a strong, clear, and compassionate final rule as soon as possible. Uncertainty and confusion around public charge, and immigration policies in general, continue to have considerable negative consequences on immigrants and their families.

Our specific responses are below:

How should DHS define the term ‘‘public charge’’?
DHS should define someone likely to become a public charge for inadmissibility purposes as a person who is “likely to become primarily and permanently reliant on the federal government to avoid destitution.” This would be consistent with congressional intent and the historical understanding of public charge as applying to a narrow set of immigrants who are likely to become a “public charge”. It is also consistent with case law. In 2020, the Second Circuit Court of Appeals relied on the Board of Immigration Appeals’ interpretation of “public charge” to mean a person who is “unable to support herself, either through work, savings, or family ties.”[3]

Under this definition, reliance on the federal government should not be taken into account unless:

- The federal government provides the primary source of income. Many people receive public benefits that supplement their earnings by improving their access to nutrition, health care, and other services. Using these supplemental benefits will not make someone a public charge.
- The reliance is permanent.
- The reliance is to avoid destitution.

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

The definition “likely to become primarily and permanently reliant on the federal government to avoid destitution" should guide any assessment of an applicant’s benefit use. Public charge regulations should clearly identify and update a list of the programs that do not count in order to minimize the chilling effect. We recommend that the new public charge rule:

[3] New York v. U.S. Department of Homeland Security, Docket Nos. 19-3591-10-3595, available at: https://ag.ny.gov/sites/default/files/ca2_opinion_-_public_charge.pdf

- Does not consider Medicaid – even for institutional long-term care – in a public charge determination. According to the Kaiser Family Foundation, in the U.S., one in three people turning 65 will require nursing home care in their lives, and Medicaid is the primary payer for long-term care in the US, covering six in ten nursing home residents.[4] We should not penalize immigrants for the problems in the country's health care system that make it difficult to get care at home and force people into institutional care. In addition, including any type of Medicaid benefit will confuse people and lead them to forego health care.
- Provide clear guidance on how to predict the likelihood of becoming a public charge based on past or current federal benefits use. Without such guidance, predicting who is likely to become a public charge "at any time in the future" is an act of speculation that could allow immigration officers to discriminate. The best way to ensure fairness is to ask adjudicators to look back at an applicant's use of certain federal public benefits for a finite lookback period–such as two or three years—as a way of gauging future likelihood.
- Exclude programs funded completely by state, local, tribal, and territorial governments. Clarify that state or local government funded programs—even if they provide cash assistance—are exercises of the powers traditionally reserved to the states and are not counted as factors in a public charge test. States and localities have a compelling interest in promoting health and safety that includes providing benefits at their own expense without barriers caused by federal policies. Since these benefits vary significantly by state, excluding non-federal programs will make the public charge rule easier for both immigrants and DHS adjudicators to understand.
- Exclude family members' and sponsors' use of benefits. Make clear that benefits used by an applicant's family members or sponsors do not count as factors in the applicant's public charge test. This is critical in minimizing the chilling effect of the public charge rule on access to benefits by people, including citizen children, who are not subject to a public charge determination but whose family members may seek LPR status in the future.
- Exclude any use of benefits by survivors of domestic violence and other serious crimes or exempt status, and by anyone during public emergencies. Benefits used by survivors of domestic violence or other serious crimes, or used by anyone during natural disasters, public health emergencies, or other extraordinary circumstances, such as the COVID-19 pandemic or in the aftermath of hurricanes and wildfires, should not be included as factors in a public charge determination. Use of these benefits is due entirely to external events and does not provide any information on the recipient's likelihood of becoming primarily reliant on federal government assistance at a future date.
- Specify that use of benefits as a child or when in an exempt status will not be included in a public charge determination, nor will benefits used when applying for an exempt status, regardless of a person's pathway to that status. DHS should ensure that federal benefits received by children—whose long-term economic contributions are generally *bolstered* by childhood receipt of benefits—be excluded from consideration. In addition, benefits received when in an exempt status, such as cash assistance provided to a refugee, should be excluded regardless of a person's pathway to adjustment of status. Finally, benefits received while an individual is applying for an exempt status should be excluded.

[4] Kaiser Family Foundation, Medicaid's Role in Nursing Home Care, June 2017, available at: https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.

Which factors (whether statutory factors or any other relevant factors identified by the commenter) are most predictive of whether a noncitizen is likely (or is not likely) to become a public charge?

Immigrants make extraordinary contributions to American life. Full use of health, nutrition, and income support programs by immigrant and U.S. citizens members of the community is good economics and good policy. Use of health care services, including prevention and chronic disease management, are predictive of better health outcomes. Receipt of health care, nutrition, or housing assistance is not an indication that a person is or will become primarily or permanently reliant on the government. These factors should not be used in a public charge determination.

How should an applicant's age be considered as part of the public charge inadmissibility determination?

An applicant's age should not be considered as part of the public charge inadmissibility determination. Being of advanced age and not working in the formal economy should not be viewed as a negative, particularly when an older member of the family is providing care for a spouse, a child, or other family member. In addition, if an older person has a sponsor, family, or community that will support them, they will be unlikely to become primarily and permanently dependent on the government. Minors (under 18) should be entirely exempted from public charge inadmissibility determination. Use of benefits as a child or when in an exempt group should not be included in a public charge determination, nor should benefits used when applying for an exempt status, regardless of a person's pathway to legal status.

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

Health, disability, and/or chronic conditions should not be considered as part of a public charge test. Judging individuals on their health status, chronic health conditions, and disabilities is discriminatory and feeds into the prejudicial view that individuals with underlying health conditions are "undesirable". Including health as a factor in the public charge determination ignores the reality that a chronic illness is not an accurate indicator of future self-sufficiency or employment capabilities.

The impact of including health, disability, and/or chronic conditions as part of the public charge determination would also disproportionately impact Asian and Pacific Islander immigrants and their families, furthering health disparities and negatively impacting immigration. AA and NH/PI communities have long faced disparities in their health and health outcomes, which have been exacerbated by COVID-19. Preceding the pandemic, AAs and NH/PIs experienced high rates of chronic disease, some of which have been shown to increase risks of serious illness or death if they contact COVID-19. For example, Asian Americans are 50 percent more likely to have diabetes; cancer is the leading cause of death among Asian Americans, and more than half of all Hepatitis B cases in the U.S. are within the Asian American community. Additionally, when compared to non-Hispanic whites, Pacific Islanders are 2.5 times more likely to have diabetes, and they are 80 percent more likely to be obese and 30 percent more likely to have asthma. What is more, including these factors in the public charge determination may incentivize individuals with chronic conditions to terminate their healthcare and forgo services to remain eligible to adjust their status--leading to delayed care and worse health outcomes.

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. Immigrants and their families face barriers to holistic health that are rooted in xenophobic and structural racism--and physical health cannot be separated from social health. Community health centers provide enabling services to address a combination of social determinants of health and barriers to access primary care and other important social services. This includes care coordination, health education, transportation, and assistance with obtaining food, shelter, and public benefits. DHS should account for social determinants of health, as Americans experience the same disparate impact, and immigrants should not be penalized for utilizing resources to address societal harms.

The impact of these policies on Asian and Pacific Islander immigrants' ability to access, for example, safe and stable housing or food and nutrition services impacts their health and health care outcomes. For example, an individual's asthma may be exacerbated by poor housing, lack of air conditioning, and community pollution. Policies must account for these challenges by not including health, health status, chronic conditions, or disabilities into the public charge determination.

How should DHS define and consider family status for the purposes of a public charge inadmissibility determination? How should an applicant's household size be considered as part of the family status factor? What definition of an applicant's household size should DHS use for the public charge inadmissibility determination?

DHS should consider the positives of having a large family, such as more people who can work and bring in income, care for children and elders, and support the family's success and resiliency. DHS should also consider families who are in different stages of being documented and eligible, and the fear of public charge that prevents them from seeking access to these programs. We encourage DHS to provide maximum clarity on how family status will impact public charge determinations to eliminate confusion and hesitation.

Household size should not be considered as part of the family status factor. We should not penalize people who are part of a large family, when family members play a role in supporting the whole family, whether in the home caring for loved ones, or outside the home at work or doing community service.

How should DHS address the challenges faced by those not served by a bank or similar financial institution in demonstrating their assets, resources, and financial status?

DHS should ensure that individuals not served by a bank or financial institution have an opportunity to demonstrate their resources. Financial institutions have a long history of practices that de-incentivize equitable participation in traditional banking. For example, redlining policies in housing caused direct and long-lasting harms to AA and NH/PI communities, and the effects of these harms are still felt today, even after the practice of redlining was outlawed. As recently as 2015, the Seattle Office of Civil Rights uncovered patterns of discrimination in housing rental practices. Entire neighborhoods remain segregated; some are still more than 90 percent white, even 50 years after redlining ended in practice and communities of color were free to move where they pleased.

Moreover, whether due to fear, uncertainty, discrimination, or any combination of the three, immigrants and their families may not have engaged with traditional financial institutions, and this should not negatively influence a public charge determination. DHS, for example, should not require a

credit score and/or credit history as they are unnecessary and overly burdensome. While credit scoring algorithms are supposedly designed to eliminate bias, they do not take into account factors like age, sex, religion, or race. However, algorithms can get around this by considering the social networks of an applicant, such as their neighborhood. Immigrants of all ethnic backgrounds are equally, if not more likely, than US citizens of any race to live in the lowest-income neighborhoods in fast-growing cities. This means an applicant who lives in a low-income community could be considered more of a risk than someone in a white-collar neighborhood. While race has not formally been taken into account, the ZIP code of residence is often viewed as a proxy for it. As such, a degree of racial discrimination has still been introduced into the credit system's algorithm regardless of the applicant's individual credit worthiness.

How should DHS consider an applicant's education and skills in making a public charge inadmissibility determination?

An applicant's education and skills should not be used in making a public charge inadmissibility determination. Immigrants meaningfully contribute to our communities and societies in a variety of different ways. However, DHS should consider education and skills that are valuable or likely to lead to employment as a potential positive to make up for other circumstances. For example, if an applicant does not currently have a job, but their education and skills indicate that they will find work, they are not likely to become a public charge.

Should DHS consider the receipt of public benefits (past and/or current) in the public charge inadmissibility determination? If yes, how should DHS consider the receipt of public benefits and why?

No. An individual's past use of health and other public benefits should not be considered in an inadmissibility determination. With regards to their health, health benefits allow individuals to get the preventive services and chronic care management they need--as well as to treat acute health needs. The COVID-19 pandemic has shown the critical importance of use of benefits as a public health measure to treat, heal, and educate people about the pandemic. The use of these services should be prioritized--not used against someone during a public charge determination.

For example, the research is clear that AA and NH/PI communities have been dramatically and negatively impacted by COVID-19. Our communities have been hard hit with high rates of infection and mortality. A recent analysis by National Council of Asian Pacific American Physicians and Asian American Research Center on Health found that Asian Americans have a higher case fatality rate that is disproportionately higher—up to five times greater—than the general population, indicating that Asian Americans are not getting access to diagnostic tests, are more likely to die from COVID-19 when they get infected, or both. Similarly, the National Pacific Islander COVID-19 Response Team in coordination with the University of California's NHPI Policy Lab reports that Pacific Islanders had among the highest confirmed rates of COVID-19 in the states that disaggregate NH/PI data from the Asian population, to include Utah, Arkansas, Alaska, California, Washington, Ohio, Illinois, Colorado, and Oregon.

If DHS does choose to consider the receipt of past benefits as part of the public charge determination, it must at a minimum exempt the use of benefits of an individual when they were a child (under age 18).

Which public benefits, if any, should not be considered as part of a public charge inadmissibility determination?

DHS should **exclude** all benefits from the public charge determination, including

- Medicaid – even for institutional long-term care – in a public charge determination
- Programs funded completely by state, local, tribal, and territorial governments.
- Use of benefits by survivors of domestic violence and other serious crimes or exempt status, and by anyone during public emergencies.

What costs, if any, has your agency or organization incurred in order to implement changes in public charge policy, such as revising enrollment procedures and public-facing materials?

The Trump-era public charge rule created a huge administrative burden on community health centers and community-based organizations. Responding to increased numbers of patient inquiries, training staff on the policy changes, and having to manage disenrollment and re-enrollment processes (aka "churn") requires more staff time and adds unnecessary costs to community health centers. Community health centers were forced to quickly adapt to the changing regulatory environment around public charge and ensure that staff understood and were equipped to answer questions or refer patients to experts who could. This required additional staff training and developing new workflows. Some community health centers stood up public charge multilingual "helplines" or provided legal training for staff. Many also partnered with organizations specializing in immigration advocacy and legal analysis. This siphoning of time and resources distracts from the actual provision of health care.

Until the Biden Administration issues a new public charge final rule, community health centers and their communities will continue to feel the impact of the chilling effects from the Trump Administration's rule; rescinding the Trump-era rule has proven to be insufficient to alleviating patient fears of public charge. Further, the cumulative impact of regulatory changes to Medicaid, the Affordable Care Act, and immigration policies has created a culture of fear that will take years of undoing. It is imperative the Biden Administration provides financial resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.

What costs, if any, has your agency or organization incurred as a result of reduction in enrollment, or disenrollment in public benefits programs generally? What costs, if any, has your agency or organization incurred as a result of disenrollment or reduction in enrollment in public benefits programs caused by the public charge ground of inadmissibility, the 1999 Interim Field Guidance, or the vacated 2019 Final Rule?

While community health centers do not gather information on an immigrant's immigration status, many reported steep drops in disenrollment requests or patients not showing up for scheduled appointments during the period that the Trump-era rule was under consideration and in effect. In the KFF survey conducted at AAPCHO member community health centers, one quarter (25%) of Asian health center patient respondents say that they or a member of their household did not apply for or stopped participating in a government program to help them pay for health care, food, or housing in the past year due to immigration-related fears.[5]

[5] Asian Patients Confront Multi Pandemics: Racism, Immigration, and COVID-19" Advocacy Brief, June 2021, available at: https://aapcho.org/asian-patients-confront-multi-pandemics-racism-immigration-and-covid-19-advocacy-brief/

Several AAPCHO members report that because public charge went into effect at about the same time as the COVID-19 pandemic began, patients stopped mentioning public charge specifically. Some members have reported that patients have just incorporated the fear of public charge into their lives and that immigration is now a barrier to their health care. AAPCHO community health centers experienced this as patients were afraid to take advantage of supports like cash and food assistance during the pandemic because of their fear that it could put their future immigration status at risk. For example, AAPCHO members report a significant drop in participants in the SNAP and WIC programs, with one AAPCHO member reporting that it had to close its WIC program entirely because of the lack of enrollment. This downturn is highly correlated with fear and confusion around public charge and immigration policy.

Moreover, 45% of health center patients have Medicaid and CHIP coverage. Over 1,300 community health centers nationwide hire enrollment assisters and conduct outreach and enrollment activities throughout the year to educate vulnerable and underserved communities on the benefits of health insurance coverage. Community health centers have a statutory obligation to provide care to all patients, regardless of their ability to pay. The vacated Trump-era rule created fear and hesitation that led to immigrants disenrolling or not enrolling in public benefits, like Medicaid. For community health centers to serve uninsured and underinsured patients, it is imperative patients enroll in health care coverage when they are eligible. On the front lines of the COVID-19 pandemic, there are multiple factors contributing to the loss of health center revenue since 2020. The pandemic has likely contributed to the increased health and financial needs and declines in health coverage among immigrant families. Unfortunately, restrictions limited immigrants' access to COVID-19 relief and made families reluctant to access services at facilities like community health centers.

AAPCHO and our member community health centers strongly encourage the Biden administration to issue a new rule on public charge that is limited and more reflective of a country that values and invites the innumerable contributions that immigrants make to our communities and nation. Many immigrants continue to be afraid because of the actions taken during the Trump administration. The distrust felt in these communities requires bold action that makes clear that public charge is a tool to be used only in the most extraordinary of circumstances for those who are primarily and permanently reliant on the federal government to avoid destitution. We urge the administration to move quickly to advance this rulemaking process and give immigrants confidence that they can access the health, nutrition, and other benefits for which they may be eligible without fear that it could jeopardize their immigration status.

Sincerely,

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Asian American Health Coalition dba HOPE Clinic
Asian Health Services
Center For Pan Asian Community Services
Charles B Wang Community Health Center
Community Clinic of Maui, Inc. dba Mālama I Ke Ola Health Center
International Community Health Services
Lana'i Community Health Center
North East Medical Services (NEMS)
Pacific Islander Center of Primary Care Excellence
Pacific Islands Primary Care Association
South Cove Community Health Center
Waimanalo Health Center