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*Submitted via www.regulations.gov*

Samantha Deshommes, Chief

Regulatory Coordination Division, Office of Policy and Strategy

U.S. Citizenship and Immigration Services

Department of Homeland Security

20 Massachusetts Ave NW

Washington, DC 20529-2140

RE: DHS Docket No. USCIS-2010-0012, RIN 1615-AA22, Comments in Response to Proposed Rulemaking: Inadmissibility on Public Charge Grounds

Dear Ms. Deshommes:

On behalf of Neighborcare Health, I appreciate this opportunity to respond to the Department of Homeland Security’s (DHS) Notice of Proposed Rulemaking (NPRM or proposed rule) concerning changes to “public charge” admissibility rules, published in the Federal Register on October 10, 2018. I am writing to express my and our organization’s strong opposition to these changes. The proposed rule would cause significant harm to the thousands of immigrants and their families that we serve who are legally in this country. As health care providers and a community health center we serve a disproportionate number of recent immigrants or family members of immigrants. DHS has provided no evidence that these changes are necessary at this time.

Our community health center serves a population of 75,000 patients, of which two-thirds are at or below 200% of the federal poverty level and of an ethnicity and race other than Caucasian. The vast majority of those we provide care to are gainfully employed and full contributors to our community. Our 800 staff working in over 27 clinics and locations are directly providing or supporting primary medical, dental, maternity and child health care as well as behavioral health services. We provide a key role in the prevention and treatment of illness for these patients, which in turn allows them to continue being full contributors to our community. As our community grows and with record levels of low unemployment (less than 4%) our community benefits from the direct contributions of our patient population to advance an economically vibrant community. If legal immigrants and their families are threatened with the proposed rules and placed at risk of not achieving permanent legal status through the use of our services, it will have an impact on them accessing health care to prevent or treat illness, which in turn can lead to unnecessary and costly emergency room visits.

Neighborcare Health will continue to strive to provide high-quality primary care to every individual that walks through the door, regardless of income, insurance coverage, immigration status, or any other factor, not only as a legal requirement under Section 330 of the Public Health Service Act, but also as the cornerstone of our mission.

**The Proposed Rule vs. Current and Historical Policy**

The proposed rule represents a set of massive changes in United States immigration, health, housing, and nutrition policy, but has not been accompanied by a strong or persuasive explanation of why these changes are needed at this time. Indeed, the policy appears to be at odds with the available public health evidence and seemingly disregards the potential impact to high-volume, low-margin safety net health care providers like community health centers.

Historically, the term “public charge” has referred to an immigrant who is “likely to become primarily dependent on the government for subsistence.” The proposed rule expands this definition to include any immigrant who simply “receives one or more public benefits,” fundamentally altering the character of “public charge” from denoting an individual who is primarily dependent on the government as their main source of support to one who merely receives assistance for housing, health care, or nutrition. This includes Neighborcare Health’s patients who use basic needs programs to supplement their earnings from low-wage work, and apparently disregards the well-documented public health value of these programs.

Under longstanding policy guidance, spanning three previous administrations and 10 congresses, only the need for cash assistance for income maintenance and government-funded long-term institutional care are considered under the public charge test, and only when assistance from these programs makes up the majority of an individual’s financial support. If finalized, this rule would compel immigration officials to consider a much wider range of programs in making a public charge determination, including most Medicaid programs, federal housing assistance, Supplemental Nutrition Assistance Program (SNAP), and even the Medicare Part D low-income prescription drug subsidy (a program for which a beneficiary must have demonstrated a sufficient work history).

Furthermore, the rule introduces an unprecedented income test. Over 79 percent of Washington community health center patients live at or below 150 percent of Federal Poverty Guidelines, including 70% of patients at Neighborcare Health, and although we do not collect data on patients’ immigration status, we believe that many of our patients who would be directly or indirectly affected by this rule fall into this group. It also negatively weighs factors which have never been considered relevant in the past. Under the NPRM, being a child or a senior, having a treatable medical condition, or even having a large family could be held against an individual seeking a visa or legal permanent resident status. The rule also indicates a preference for immigrants who speak English. This change would not only mark a major divergence from our nation’s historic commitment to welcoming and integrating immigrants, but also have a chilling effect on 13,000 of Neighborcare Health’s patients who are best served in a language other than English, likely leaving many discouraged from seeking care whether they are directly affected by this rule or not.

**Proposed Rule Negatively Impacts Non-Citizens and the Communities They Live In**

*Expensive and Dangerous Delay of Care.* As I reference above and to reiterate, this proposed rule creates a strong incentive for non-citizens to wait until their health problems become an emergency to seek care. We offer primary care to any individual regardless of insurance status, but our ability to serve the uninsured requires a relationship of trust with patients. If finalized, this rule’s provisions concerning non-emergency Medicaid and Medicare Part D could lead affected individuals to refrain from seeking care early, resulting in worse health outcomes and even leading to an increase in the prevalence of communicable diseases.

Eighteen percent or over 13,000 of our patients are uninsured. These patients experience significant personal and family challenges, and for a large number these proposed rules would create additional barriers by delaying lower, cost-effective treatments for them.

*Non-Medicaid and -Medicare Health Insurance Programs.* Although many non-citizens are not eligible for Medicaid or Medicare Part D, they may be eligible for Washington State-based low-income insurance programs that are easily confused with Medicaid or Medicare, and many may choose to disenroll from these programs. As a general rule, these programs cover some of the most challenging patient populations to treat, and continuous coverage is needed to keep their health challenges manageable. Without coverage, they are likely to delay care until forced to seek it in costly emergency department or urgent care settings, with the costs of their treatment passed on to insured patients.

*Nutrition and Housing Programs.* For over 50 years, the Section 330 Community Health Center program has charged its grantees with more than just the provision of primary care services. Neighborcare Health and other community health centers offer transportation assistance, nutrition counseling, and linkages to housing, food, and other supports. These social factors drive health outcomes, and since the passage of the Patient Protection and Affordable Care Act, community health centers have redoubled their efforts to address social determinants in order to improve lives and bring down global health care costs. The inclusion of SNAP and housing subsidies in the list of benefits that can render an individual a public charge means that many immigrants will avoid critical programs that can improve social determinants of health, making the work of health care providers more difficult and more expensive.

Neighborcare Health addresses key social determinants of health by providing direct nutritional education and access to nutrition for mothers and infants, direct support to individuals moving from homelessness to housing, and services with a success rate of 97% for those we help remain in housing for over one year.

*HIV/AIDS and Other Chronic Health Conditions.* This proposed rule would enable immigration officials to use a diagnosis of HIV, or numerous other chronic but treatable medical conditions, to exclude both applicants and applicants seeking to unite with disabled family members. Under its provisions, these individuals would be required to purchase private, “non-subsidized medical insurance”; for those living with HIV/AIDS and seeking coverage, anti-retroviral therapy is prohibitively expensive and normally not covered by private insurance. This sends the message that those living with chronic conditions are “undesirable,” disregarding the fact that, with treatment, many conditions are not an accurate indicator of future self-sufficiency and employment.

**Proposed Rule Creates a Chilling Effect on Individuals Who are Not Directly Impacted**

*Critical Supports for Exempted Individuals and Programs.* The proposed rule would create a chilling effect among immigrants, and family members of immigrants, who are exempt from its provisions, but not fully informed of its labyrinthine nuances. Based on enrollment patterns observed following the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, analysts anticipate that immigrants’ use of health, nutrition, and social services could decline markedly if the proposed rule is finalized.[[1]](#footnote-1) The Kaiser Family Foundation notes that “there [are] over 14 million Medicaid/CHIP enrollees living in a household with at least one noncitizen, and half of these enrollees were citizen children.”[[2]](#footnote-2) Though they would remain eligible even if the rule were finalized, confusion and fear may lead millions of current enrollees to drop their Medicaid or Children’s Health Insurance Program (CHIP) coverage for fear that they or their non-citizen household member could be stripped of or denied legal status or citizenship, or even targeted for further immigration action by DHS. The cost of providing health care to these newly uninsured individuals would fall heavily on hospital emergency departments and safety net health care providers, such as community health centers.

*Emergency Medicaid and Pregnant Women.* Although emergency Medicaid, which generally covers pregnancy and delivery services for women whose immigration status makes them otherwise ineligible, is exempted from the proposed rule, the belief that non-citizen and non-legal permanent resident women are ineligible for Medicaid will likely lead many to delay prenatal care. Lack of prenatal care and nutrition assistance for mothers will certainly have serious implications for their children, impacting birth and early life outcomes among an entire generation.

Neighborcare Health offers family medicine pregnancy services, providing prenatal care at several clinics. Family medicine providers are doctors, physician assistants (PA) and advanced registered nurse practitioners (ARNP) who provide care during and after pregnancy, assist with delivery, and care for newborns and as children grow. Our certified nurse midwives care for pregnant women and their families to create a birth experience that safely aligns with what the woman wants and needs. Once a child is born, the patient’s care team, which includes a medical provider, a nurse, a social worker and a nutritionist, will support new parents with regular check-ups and follow-up care, and care for children as they grow.

Poverty, immigration status, and discrimination are barriers to accessing quality maternal health and pregnancy services, and this can result in long-term behavioral and physical health issues for children. Research shows that difficult pregnancies can yield poor health outcomes for the child into adulthood, including increased risk of anxiety, emotional adjustment, attention deficit, and low birthweight which leads to physical health challenges. The latter may include chronic diseases such as diabetes, heart disease, and hypertension. It can also affect the child’s long-term educational attainment which in turn impacts economic stability. In short, poor pregnancy management eventually leads to real behavioral and physical health care costs that could otherwise be avoided. [[3]](#footnote-3), [[4]](#footnote-4), [[5]](#footnote-5), [[6]](#footnote-6), [[7]](#footnote-7)

*Citizen Children of Non-Citizen Parents.* In Washington State in 2016, there were 457,000 children with at least one immigrant parent.[[8]](#footnote-8) Over 87 percent of these were U.S. citizens,[[9]](#footnote-9) eligible for public benefits under the same standards as all other U.S. citizens. The proposed rule not only lays out serious consequences for receiving public benefits – i.e., potential denial of an immigration status adjustment – but establishes extremely complex procedures concerning lookback periods, exemptions, total cost of benefits as a percentage of Federal Poverty Guidelines, etc. As a result, many parents will likely choose to disenroll their eligible children from Medicaid and other programs.

Neighborcare Health has worked diligently to assist families with children to enroll in programs for which they qualify, to aid in raising healthy citizen children. Neighborcare’s eligibility specialists have expertise in the options available for these children and how to help their parents cope with the paperwork requirements that can be so daunting. We deliver this service not only in our primary medical and dental clinics, but for children and youth in over a dozen schools, as we are the largest provider of school-based health center services in Seattle. We help them enroll in Medicaid and get the care they need to remain healthy, support their learning, and grow into productive adults.

Children with access to Medicaid-covered care have fewer absences from school, are more likely to graduate from high school and college, and are more likely to have higher-paying jobs as adults.[[10]](#footnote-10) Likewise, children whose families receive housing and nutrition assistance are much more likely to exhibit better health outcomes. The proposed rule has a deeply negative impact on children of mixed-immigration status families – a child whose mother is forced to disenroll from housing assistance may also become homeless.

Parents’ health is key for their children’s health. As parents are given the tools to take better care of their health, they are able to model that behavior for their children and create a healthier environment in the home. Neighborcare has provided such tools in the communities in which we operate. We have created programs wherein community health workers, with the guidance of nutritionists, teach public housing residents how to cook healthy meals at home. We have also created walking groups to promote physical activity among neighbors in those communities. Further, we have helped residents maintain a community garden on public housing property, to empower them to grow fresh vegetables for their families.

*Children with Special Health Care Needs.* While many children in the U.S. – both in immigrant and native-born families – depend on public health insurance programs, Medicaid is uniquely critical for children with disabilities. Nearly half of children with a disability or special health care need rely on public insurance for essential services, including prescription drugs, physical or occupational therapy, and respite care. Due to the high cost of these services, they are generally out of reach for families that lack coverage. The proposed rule would undermine immigrants’ access to Medicaid, forcing them to choose between paying for these services and providing food or housing for other members of the family.

Children with chronic health conditions need access to these services to have a chance at a healthy future. For example, children with asthma must manage the condition or risk long-term poor health outcomes. Further, asthma disproportionately affects children of color.[[11]](#footnote-11) To address this, Neighborcare created a streamlined training module for clinical teams to understand how to do spirometry and were able to buy new spirometry equipment that links to the electronic health record. Our community health workers in public housing educate families with asthmatic children (and even adults) how to better maintain their household to avoid triggers for asthma attacks, including using non-toxic household cleaners, appropriate filtered vacuums, and better pillows.

While the proposed rule includes exceptions for services funded by Medicaid provided through the Individuals with Disabilities Education Act (IDEA), no plan has been put forward that would enable this carve-out to work in practice. Children with special needs cannot and do not receive Medicaid solely for educational services. The complex and confusing nature of these exceptions, consistent with the chilling effect we expect for other programs, will almost certainly not keep families from disenrolling in Medicaid.

We are hearing from would-be patients of Neighborcare they are fearful of accessing health care. These patients are immigrants and are increasingly fearful of using services they perceive as publicly funded. This includes care that may be covered through discretionary or charitable (non-governmental) funds. They perceive all of our services to be government-related and are foregoing accessing needed healthcare out of fear. This will only result in poor health outcomes in the near- and long-term.

**Children and Young Adults Should Not be Penalized for the Decisions of Their Parents or Caretakers**

*CHIP Should Not be Included in Final Rule.* Neighborcare Health urges DHS, in the strongest possible terms, not to include CHIP in the proposed rule’s provisions. This program addresses a critical coverage gap, targeting working families that earn too much to be eligible for Medicaid but cannot afford traditional private insurance. Making the receipt of CHIP coverage a negative factor in the public charge test, or including it in the definition of “public charge,” would place coverage for children out of reach for moderate-income working families, as well as applicants likely to earn a moderate income in the future.

Including CHIP in a public charge determination would likely lead to many eligible children forgoing health care benefits, both due to its inclusion in the rules and to the chilling effect described above. Continuous, consistent coverage is essential to the healthy development of young children – experts recommend 16 well-child visits before age six in order to identify and address any early life health concerns as soon as possible.[[12]](#footnote-12) Our family medicine providers and certified nurse midwives delivered 670 babies and provided follow up care to these babies and their mothers. In addition, over 21,000 children were served by Neighborcare Health’s community based clinics and our school-based health centers.

*Washington’s Cover All Kids Program.* For over 10 years, the state of Washington has been committed to ensuring coverage for all children, regardless of income or immigration status. Children up to 300 percent of Federal Poverty Guidelines receive free or subsidized health insurance through Apple Health for Kids through a mechanism that combines Medicaid, CHIP, and state dollars, and has been designed and administered to make the enrollment and billing process as seamless as possible for parents and providers. While children who are not currently eligible for Medicaid or CHIP due to their immigration status do not have their coverage subsidized by federal funding, including CHIP in public charge determinations is virtually certain to deter families who are eligible – but are not familiar with the complex, behind-the-scenes interplay of multiple state and federal funding streams – from enrolling their children out of an abundance of caution.

Children should not be punished for their parents’ decisions around immigrating to the U.S., and we should not play politics with children’s health.

**Impacts on Health Center Operations and Finances**

*Lack of Coverage and Health Center Financial Security.* As high-volume, low-margin, non-profit health care providers, community health centers rely on revenue from providing patient services to maintain a comprehensive suite of services, far beyond what a typical primary care practice may offer. These services include free transportation assistance, language assistance, health education, prescription drugs, nutrition counseling, and linkages to other community programs and social services.

In 2017, over 55% or 41,368 of our patients were covered by Medicaid, and revenues from Medicaid-covered services were the most important funding stream for our operations. As patients disenroll from Medicaid, CHIP, or other programs – either because they are directly affected, or due to the enrollment chilling effect described above – we expect our revenues to decline substantially, and the cost of uncompensated care for uninsured individuals and families to rise.

*Declines in Coverage Affect Federal Grant Activity and Health Workforce Programs.* As more previously-insured patients seek higher cost uncompensated care, more pressure will be put on the Public Health Service Act Section 330 grant that every community health center receives. Not only does this grant fund basic operations and capital expansions, it also funds care for the uninsured. Patients who would otherwise have the cost of their care covered through insurance programs would have their care funded through this extremely limited federal grant, either compelling Congress to increase the size of the Section 330 program or reduce the amount of care that health centers are able to provide.

In 2017, Neighborcare Health received $7,521,376 in federal Section 330 grant funds. These funds directly support and extend primary medical, dental care, care for women and children, and care for those experiencing homelessness—a national crisis. This includes care for uninsured individuals, immigrant or native. These services would become less available if these limited dollars had been distributed more widely, or worse yet, might have to be reduced or canceled.

Additionally, Neighborcare Health is concerned that unexpected shifts in our patient payer mix due to the proposed rule may affect our clinicians’ ability to access federal health workforce program assistance. Community health centers, as low-margin primary care providers, must compete with much larger, better-paying health systems for clinical providers, and thus rely on programs such as the National Health Service Corps and Federal-State Loan Repayment Program to attract and retain clinical providers. Our clinicians’ eligibility for these programs depends on a formula determined by previous years’ patient populations, and that formula is currently being revised by the Health Resources and Services Administration (HRSA). If Neighborcare Health’s current and future patients disenroll from their traditional coverage, that may affect our employees’ ability to receive educational loan assistance from these programs in unpredictable ways, reducing our competitiveness as an employer and impacting our ability to provide care not only to immigrants and their families, but to whole neighborhoods and communities. Even more worrying, if patients choose to forgo care altogether, it could artificially reduce our eligibility to hire more providers through these programs.

**Conclusion**

As CEO of Neighborcare Health I ask that DHS reconsider this effort immediately, and instead convene a national stakeholder workgroup to accomplish the administration’s goals without compromising the health of our patients and the financial security and operational integrity of our organization. We appreciate the opportunity to offer our comments. Please contact me at (206) 548-3050 with any questions about these comments.

Sincerely,

Michael Erikson

CEO, Neighborcare Health

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1. Jeanne Batalova, Michael Fix, and Mark Greenberg “Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use” (Washington, DC: Migration Policy Institute, 2018) <https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families>. [↑](#footnote-ref-1)
2. Samantha Artiga, Raphael Garfield, and Anthony Damico “Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid” (Washington, DC: Kaiser Family Foundation, 2018) <https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/>. [↑](#footnote-ref-2)
3. Talge, N. et al. Antenatal maternal stress and long‐term effects on child neurodevelopment: how and why? Journal of Child Psychology and Psychiatry 48:3/4 (2007), pp 245–261. [↑](#footnote-ref-3)
4. Maternal Substance Abuse and Child Development Project, Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences [↑](#footnote-ref-4)
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7. Maness, S et al. Associations Between Social Determinants of Health and Pregnancy Among Young People: A Systematic Review of Research Published During the Past 25 Years. Public Health Reports, 131: 86-99. [↑](#footnote-ref-7)
8. Migration Policy Institute, Children in U.S. Immigrant Families 2016#Washington, <https://www.migrationpolicy.org/programs/data-hub/charts/children-immigrant-families>. [↑](#footnote-ref-8)
9. *Ibid.* [↑](#footnote-ref-9)
10. Karina Wagnerman, Alisa Chester, and Joan Alker, *Medicaid is a Smart Investment in Children,* Georgetown University Center for Children and Families, March 2017, <https://ccf.georgetown.edu/2017/03/13/Medicaid-is-a-smart-investment-in-children/>. [↑](#footnote-ref-10)
11. Centers for Disease Control and Prevention (2011). *CDC Health Disparities and Inequalities Report.*  [↑](#footnote-ref-11)
12. Elizabeth Wright Burak, Georgetown Center for Children and Families, *Promoting Young Children’s Healthy Development in Medicaid and the Children’s Health Insurance Program (CHIP)*, Oct. 2018, <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1-pdf>. [↑](#footnote-ref-12)