

December 3, 2018

*Submitted via [www.regulations.gov](http://www.regulations.gov)*

Samantha Deshommès  
Regulatory Coordination Division, Office of Policy and Strategy  
US Citizenship and Immigration Services  
Department of Homeland Security  
20 Massachusetts Avenue NW  
Washington, DC 20529-2140

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

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments on the US Department of Homeland Security's (DHS) notice of proposed rulemaking (NPRM), "Inadmissibility on Public Charge Grounds," RIN 1615-AA22. The proposed rule would cause major harm to the health of immigrants and their families, as well as to health care providers and facilities that ensure access to needed services. NFPRHA urges that this rule be withdrawn in its entirety.

NFPRHA is a non-partisan 501(c)3 membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially in the safety net. Representing more than 850 members that operate or fund more than 3,500 health centers in the United States, NFPRHA conducts and participates in research; provides educational subject matter expertise to policy makers, health care providers, and the public; and offers its members varying levels of capacity-building support aimed at maximizing their effectiveness and financial sustainability as providers of essential health care.

NFPRHA believes that all people, regardless of their citizenship status, deserve affordable, confidential, and high-quality health care. The proposed rule would alter the public charge test dramatically, abandoning the enduring meaning of a public charge as a person who depends on the government for subsistence and changing it to anyone who simply receives assistance with health care, nutrition, or housing. Already, health care agencies are reporting increased fear from immigrant patients seeking access to reasonable, necessary public programs, even for programs not explicitly included in the proposed rule.<sup>i</sup> NFPRHA fears that the imposition of this rule will negatively impact immigrants' access to health care, including vital family planning and sexual health services. Indeed, DHS notes in the preamble to the rule that one of the cost savings from implementing this proposal comes from immigrants and their citizen family members disenrolling in public benefit programs for which they are eligible simply to avoid potential immigration scrutiny, even in cases in which the proposed rule would not apply.<sup>ii</sup>

### **Background on Publicly Funding Family Planning**

As providers of publicly funded family planning and sexual health services, NFPRHA's members and their patients primarily rely on Title X and Medicaid to support that care. Title X is the nation's only dedicated source of federal funds for family planning services. In 2017, close to 3,900 Title X-funded health centers provided essential family planning and sexual health care services to more than 4 million patients.<sup>iii</sup> These services included contraceptive services and supplies, STD testing and treatment, HIV testing, and cancer screenings. Title X-funded health centers provide care at no cost to patients with incomes at or below the federal poverty line (FPL) and on a sliding scale for people between 101% and 250% of FPL.

Furthermore, Medicaid has been the predominant funding source for publicly funded family planning care since the 1980s, with recent data showing that Medicaid provides 75% of the funds for public expenditures on family planning.<sup>iv</sup> This role is particularly vital because the federal government offers an enhanced match of 90% for family planning services, saving states money and encouraging robust access to this critical care. Medicaid law also guarantees enrollees access to family planning services at no cost to them and at their choice of provider.<sup>v</sup> Immigrants are not able to access family planning services under Medicaid unless they have a qualified status and have held that status for at least five years, though their citizen family members are eligible to participate.<sup>vi</sup>

### **Immigration Officials Have Already Rejected This Expanded Public Charge**

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) limited eligibility for "federal means-tested public benefits" to "qualified immigrants" and limited eligibility of lawful permanent residents for "means-tested public benefits" during their first five years in the United States. Importantly, in response to concerns that some consular officials and employees of the then-Immigration and Naturalization Service (INS) were inappropriately scrutinizing the use of health care and nutrition programs, and the strong evidence of chilling effects from the 1996 law, INS issued administrative guidance in 1999 protecting access to these services.<sup>vii</sup>

The preamble to the guidance clearly acknowledged that the reluctance to access benefits has an adverse impact not just on the potential recipients, but on public health and the general welfare.<sup>viii</sup> Some of the evidence before the agency when it was writing the guidance included detailed accounts of pregnant women with gestational diabetes terrified of seeking care, a child with seizures whose parents were afraid to enroll in Medicaid at the hospital being rushed to the hospital so he could continue treatment, and farmworker women afraid to enroll in a state-funded perinatal case management program.<sup>ix</sup>

The administrative guidance – which remains in effect – specified that non-cash programs such as Medicaid, Medicare, the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Head Start, child care, school nutrition, housing, energy assistance, emergency/disaster relief were *not* to be considered for purposes of a public charge determination.<sup>x</sup> The 1999 administrative guidance is

consistent with congressional intent and case law.<sup>xi</sup> Moreover, it has been relied upon by immigrant families for decades, and should continue to be used.

### **Millions of People, including Citizen Family Members, will be Harmed by the Rule**

If implemented, the proposed rule would diminish immigrants and their citizen family members' access to health services, which will have dire consequences for themselves and for public health. DHS outlines some of these negative consequences within the notice of proposed rulemaking, including the potential for poorer health outcomes, increased prevalence of communicable diseases, and increases in uncompensated care for health care providers, which could lead to a reduction in available providers in the safety net.<sup>xii</sup>

Approximately 25.9 million people, or an estimated 8% of the US population, would potentially be impacted by this rule.<sup>xiii</sup> This includes individuals and family members with at least one noncitizen in their household who have family incomes under 250% of FPL; when one family member fails to receive health care, housing, or nutrition benefits, the resources available to all family members, including children, decline.

Research is already showing the changes that families are making in response to the threat of a change in public charge law, even before any modifications go into effect. In a 2018 survey of health care providers in California, 67% noted an increase in parents' concerns about enrolling their children in Medi-Cal (California's Medicaid program), WIC and CalFresh (California's SNAP program), and 42% reported an increase in skipped scheduled health care appointments.<sup>xiv</sup> Furthermore, existing uncertainty about changes to immigration policy has had well-documented negative impacts on immigrants' health and well-being in immigrant families, including amplified mental health concerns, decreased performance in school, and increased financial stress.<sup>xv</sup>

### **The Rule will Limit Access to Critical Health Care and Coverage Programs, including Medicaid**

The proposed rule's unprecedented consideration of Medicaid as part of the public charge determination poses a dire threat to the health of immigrants. Under this proposed rule, immigrants who are eligible for Medicaid<sup>xvi</sup> and to whom the proposed rule would apply<sup>xvii</sup> could have their enrollment counted against them. This puts them in the untenable situation of having to decide between critical health coverage that keeps them healthy and being able to become a lawful permanent resident. The Kaiser Family Foundation estimates that 2.1 million to 4.9 million Medicaid or Children's Health Insurance Program (CHIP) enrollees could disenroll if the proposed rule is finalized.<sup>xviii</sup>

Losing, disenrolling, or avoiding Medicaid coverage would put women's health at risk. Women who have health coverage are more likely to receive preventive care, such as breast cancer and cervical cancer screenings.<sup>xix</sup> People with health insurance also have lower mortality rates.<sup>xx</sup> When people do not have health coverage, they are more likely to forgo needed care, leading to worse health outcomes.<sup>xxi</sup> Half of uninsured women reported going without health care in 2016 due to cost, compared to 25% of women with Medicaid and 21% of women with private health insurance.<sup>xxii</sup> Cost poses a particular barrier for women of color; in 2016, Latinx and Black

women were more likely than white women to say that cost kept them from seeing a doctor.<sup>xxiii</sup> Already, immigrant women are less likely to be insured than their citizen counterparts – 27% of noncitizen immigrant women are uninsured, compared to 11% of women overall.<sup>xxiv</sup> Women of reproductive age fare even worse: while 34% of noncitizen women of reproductive age are uninsured, 9% of citizen women of reproductive age are uninsured. The gap widens further for poor immigrant women: nearly half (48%) of noncitizen women of reproductive age living in poverty are uninsured, while 16% of citizen women of reproductive age living in poverty live without coverage.<sup>xxv</sup> The proposed rule would only make the situation worse, leading to worse health outcomes for immigrant women.

These threats to Medicaid will place added pressure on public health programs, such as Title X. Already, the family planning safety net can only support a portion of the need for publicly funded contraceptive care.<sup>xxvi</sup> When immigrant families lose access to Medicaid and CHIP they may turn to these programs to meet their basic needs. However, because community health programs rely on insurance programs, such as Medicaid, to remain open, the increased volume of uninsured patients will stretch already sparse resources. In 2017, Medicaid made up 44% of revenue at community health centers<sup>xxvii</sup> and 38% of revenue at Title X-funded health centers.<sup>xxviii</sup> A 2018 study found that implementation of this rule would cost community health centers between \$346 and \$624 million and lead to the loss of 3,373 to 6,075 medical staff positions at those agencies.<sup>xxix</sup>

### **Reduced Access to Family Planning Services Will Have Detrimental Effects on Patients**

Lack of access to family planning providers will lead to increased rates of unintended pregnancy and sexually transmitted diseases. NFPRHA is further concerned that patients who are pregnant will have reduced access to pre- and postpartum care.

Research shows that patient outcomes suffer when they lack access to family planning services. In Texas, following closures of health centers in 2011, patients' use of effective contraception methods dropped substantially. By 2014, Texas was meeting just 10% of the need for publicly funded contraceptive services and supplies with publicly supported providers,<sup>xxx</sup> and more than one-third of women in Texas reported that they couldn't afford their preferred method of birth control.<sup>xxxi</sup> This lack of access led to an increase in unintended pregnancies,<sup>xxxii</sup> particularly among teens.<sup>xxxiii</sup>

Furthermore, the Centers for Disease Control and Prevention reports that STD rates have risen sharply since 2013, including a very concerning rise in congenital syphilis, and that the United States continues to have unnecessarily high rates of HIV transmission.<sup>xxxiv</sup> Reducing access to quality health services will only exacerbate these problems. Timely treatment of STDs, including testing and treating the partners of patients with these illnesses, is critical to reduce their spread and to prevent lifelong consequences for patients' fertility. In addition, patients at risk of acquiring HIV and those who are HIV positive require ongoing monitoring to ensure they remain healthy and reduce the risk of transmission to sexual partners. If patients or their partners fear accessing medical services, they may acquire or spread these serious diseases.

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Finally, this proposed rule may discourage patients from obtaining prenatal care, which has ramifications their health and their birth outcomes.<sup>xxxv</sup> Lack of adequate health care, including prenatal care, contributes to higher rates of maternal mortality, higher rates of infant mortality, and increased risk of low-infant birth weight.<sup>xxxvi</sup> This is particularly dangerous for Black women, who already experience disproportionately high rates of maternal mortality, in part due to existing barriers to health care and systemic inequalities.<sup>xxxvii</sup> Similarly, the proposed rule may also discourage patients from seeking postpartum care, which is crucial to the health and well-being of new parents, newborns, and families.<sup>xxxviii</sup> Forgoing postpartum care could mean that people endure postpartum depression without proper medical, social, and psychological care, skip doctor's visits that address infant feeding, nutrition, physical activity, and family planning, or leave other postpartum health issues unaddressed.

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**For all of the foregoing reasons,** DHS should immediately withdraw this punitive proposed rule. If enacted, the rule would force families to choose between accessing needed supports and reuniting or staying together. Moreover, the proposed rule would have significant and widespread negative implications for the health of individuals, families, and communities.

Thank you for the opportunity to submit comments on the proposed rulemaking. Please do not hesitate to contact Lauren Weiss, Manager, Advocacy & Communications, at [lweiss@nfprha.org](mailto:lweiss@nfprha.org) to provide further information.



Clare Coleman  
President & CEO

<sup>i</sup> "Proposed Changes to 'Public Charge' Policies for Immigrants: Implications for Health Coverage." Kaiser Family Foundation (September 24, 2018). [www.kff.org](http://www.kff.org).

<sup>ii</sup> Department of Homeland Security. "Notice of proposed rulemaking: Inadmissibility on public charge grounds." *Federal Register* 83 no. 2018-21106 (October 10, 2018): 51117.

<sup>iii</sup> Christina Fowler et al. "Family Planning Annual Report: 2017." RTI International (August 2018). [www.hhs.gov/opa](http://www.hhs.gov/opa).

<sup>iv</sup> Adam Sonfield and Rachel Gold. "Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980 – 2015." Guttmacher Institute (2017). [www.guttmacher.org](http://www.guttmacher.org).

<sup>v</sup> 42 U.S.C. § 1396a(a)(23); 42 U.S.C. § 1396n(b).

<sup>vi</sup> Please note that some states have chosen to use state funds to waive the waiting period for pregnant persons and children.

<sup>vii</sup> Immigration and Naturalization Service, *Inadmissibility and Deportability on Public Charge Grounds, A Proposed Rule by the Immigration and Naturalization Service*, 64 Fed. Reg. 28676 (May 26, 1999), <https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-54070/0-0-0-56200/0-0-0-56785.html>.

<sup>viii</sup> Immigration and Naturalization Service, *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689 (May 26, 1999), <https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-54070/0-0-0-54088/0-0-0-55744.html>.

<sup>ix</sup> Note: The following report is an example of the data that was collected and shared at the time the Field Guidance was written. Claudia Schlosberg et. al, National Immigration Law Center, *The Impact of INS Public Charge Determinations on Immigrant Access to Health Care* (1998) <https://www.montanapobono.net/geo/search/download.67362>.

<sup>x</sup> 64 Fed. Reg. 28689, *supra* note 64.

<sup>xi</sup> Immigration and Naturalization Service, *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689 (May 26, 1999), <https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-54070/0-0-0-54088/0-0-0-55744.html>.

- <sup>xii</sup> Department of Homeland Security. "Notice of proposed rulemaking: Inadmissibility on public charge grounds." *Federal Register* 83 no. 2018-21106 (October 10, 2018): 51270.
- <sup>xiii</sup> This number represents individuals and family members with at least one non-citizen in the household and who live in households with earned incomes under 250 percent of the federal poverty level. Custom Tabulation by Manatt Phelps & Phillips LLP, *Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard* (2018), <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population> (using 2012-2016 5-Year American Community Survey Public Use Microdata Sample (ACS/PUMS); 2012-2016 5-Year American Community Survey (ACS) estimates accessed via American FactFinder; Missouri Census Data Center (MCDC) MABLE PUMA-County Crosswalk).
- <sup>xiv</sup> The Children's Partnership, *California Children in Immigrant Families: The Health Provider Perspective*, <https://www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Infographic.pdf>.
- <sup>xv</sup> Samantha Artiga and Barbara Lyons. "Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being." Kaiser Family Foundation (September 2018). [www.kff.org](http://www.kff.org).
- <sup>xvi</sup> With certain, limited exceptions, immigrants are barred from obtaining Medicaid for five years after they obtain "qualified" status. This means, for example, that an immigrant must wait five years after becoming a lawful permanent resident before they are eligible to receive Medicaid benefits.
- <sup>xvii</sup> Immigrants for whom the proposed rule would apply, and who are also eligible for Medicaid, include people who have been granted withholding of deportation, such as those eligible for DACA. Also included are people with protected statuses, such as asylees, who then decide to apply for a lawful permanent resident status through a quicker option, such as becoming engaged to a U.S. citizen.
- <sup>xviii</sup> Calculated assuming disenrollment rates between 15 percent and 35 percent. Samantha Artiga, Raphael Garfield, & Anthony Damico, Kaiser Family Foundation, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid* (2018), <https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/>.
- <sup>xix</sup> Munira Z. Gunja et al., The Commonwealth Fund, *Women Gain Insurance and Improved Their Ability to Get Health Care* (2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and>.
- <sup>xx</sup> Steffie Woolhandler & David U. Himmelstein, *Annals of Internal Medicine*, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly* (2017), <http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly>.
- <sup>xxi</sup> Committee on the Consequences, Board on Health Services, Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (2002).
- <sup>xxii</sup> Usha Ranji et al., Kaiser Family Foundation, *Overview: 2017 Kaiser Women's Health Survey* (2018), <https://www.kff.org/report-section/executive-summary-2017-kaiser-womens-health-survey/>.
- <sup>xxiii</sup> Kaiser Family Foundation, *Percent of Adult Women Who Did Not See a Doctor in the Past 12 Months Due to Cost*, <https://www.kff.org/womens-health-policy/state-indicator/percent-of-adult-women-who-did-not-see-a-doctor-in-the-past-12-months-due-to-cost-by-raceethnicity/?currentTimeframe=0&selectedDistributions=all-women&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>xxiv</sup> Kaiser Family Foundation, *Women's Health Insurance Coverage*, <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>.
- <sup>xxv</sup> Guttmacher Institute, *Dramatic Gains in Insurance Coverage for Women of Reproductive Age Are Now in Jeopardy* (2018), <https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy>.
- <sup>xxvi</sup> Jennifer Frost, Lori Frohwirth, and Mia Zolna. "Contraceptive Needs and Services, 2014 Update." Guttmacher Institute (September 2016). [www.guttmacher.org](http://www.guttmacher.org).
- <sup>xxvii</sup> 2017 Health Center Data. Health Resources & Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=d>.
- <sup>xxviii</sup> Christina Fowler et al. "Family Planning Annual Report: 2017." RTI International (August 2018). [www.hhs.gov/opa](http://www.hhs.gov/opa).
- <sup>xxix</sup> Leighton Ku et al. "How Could the Public Charge Proposed Rule Affect Community Health Centers?" Geiger Gibson/RCHN Community Health Foundation Research Collaborative (November 2018).
- <sup>xxx</sup> Jennifer Frost, Lori Frohwirth, and Mia Zolna, "Contraceptive Needs and Services, 2014 Update," Guttmacher Institute (September 2016).
- <sup>xxxi</sup> Ibid.
- <sup>xxxii</sup> Ibid.
- <sup>xxxiii</sup> "Trends in Teen Pregnancy and Childbearing," Department of Health and Human Services – Office of Adolescent Health (June 2016).; "Birth Rates (Live Births) per 1,000 Females Aged 15-19 Years, by Race and Hispanic Ethnicity, Select Years," Centers for Disease Control and Prevention (April 2015).
- <sup>xxxiv</sup> Centers for Disease Control and Prevention. "Sexually Transmitted Disease Surveillance 2017." U.S. Department of Health and Human Services (September 2018). [www.cdc.gov](http://www.cdc.gov).
- <sup>xxxv</sup> Megan M. Shellinger, et al., *Maternal and Child Health Journal*, *Improved Outcomes for Hispanic Women with Gestational Diabetes Using the Centering Pregnancy Group Prenatal Care Model* (2016), <https://link.springer.com/article/10.1007/s10995-016-2114-x>.
- <sup>xxxvi</sup> Jacques Balayla & Haim Arie Abenheim, *American Journal of Perinatology*, *Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries over 8 Years* (2012), [https://www.researchgate.net/profile/Jacques\\_Balayla2/publication/230573498\\_Inadequate\\_Prenatal\\_Care\\_Utilization\\_and\\_Risks\\_of\\_Infant\\_Mortality\\_and\\_Poor\\_Birth\\_Outcome\\_A\\_Retrospective\\_Analysis\\_of\\_28729765\\_US\\_Deliveries\\_over\\_8\\_Years/links/0deec526dabeb49c3f00000/Inadequate-Prenatal-Care-Utilization-and-Risks-of-Infant-Mortality-and-Poor-Birth-Outcome-A-Retrospective-Analysis-of-28-729-765-US-Deliveries-over-8-Years.pdf](https://www.researchgate.net/profile/Jacques_Balayla2/publication/230573498_Inadequate_Prenatal_Care_Utilization_and_Risks_of_Infant_Mortality_and_Poor_Birth_Outcome_A_Retrospective_Analysis_of_28729765_US_Deliveries_over_8_Years/links/0deec526dabeb49c3f00000/Inadequate-Prenatal-Care-Utilization-and-Risks-of-Infant-Mortality-and-Poor-Birth-Outcome-A-Retrospective-Analysis-of-28-729-765-US-Deliveries-over-8-Years.pdf).
- <sup>xxxvii</sup> National Partnership for Women and Families, *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* (2018), <http://www.nationalpartnership.org/research-library/maternal-health/black-womens-maternal-health-issue-brief.pdf>.
- <sup>xxxviii</sup> The American College of Obstetricians and Gynecologists, *Ob-Gyns Stress the Importance of Postpartum Care: The Fourth Trimester* (2016), <https://www.acog.org/About-ACOG/News-Room/News-Releases/2016/Ob-Gyns-Stress-the-Importance-of-Postpartum-Care-The-Fourth-Trimester?IsMobileSet=false>.