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December 10, 2018

Kirstjen M. Nielsen  
Secretary  
Department of Homeland Security  
20 Massachusetts Avenue, NW  
Washington, DC 20429-2140

submitted at: [www.regulations.gov](http://www.regulations.gov)

**RE: Inadmissibility on Public Charge Grounds, DHS Docket No. USCIS-2010-0012**

Dear Secretary Nielsen:

The Association of American Medical Colleges (“AAMC” or “the Association”) welcomes the opportunity to comment on the proposed rule, Inadmissibility on Public Charge Grounds, 83 *Fed. Reg.* 51114 (October 10, 2018). For the reasons discussed below **the AAMC strongly urges the Department of Homeland Security (DHS) to not finalize the proposed rule. Should DHS finalize a rule, the Association urges DHS to take whatever steps are necessary to limit the benefits that will be considered when determining that an individual is likely to be a public charge.**

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Our member institutions are committed to their missions of patient care, education, research, and community engagement and often are the providers of last resort for those without medical insurance. Patients rely on these institutions, knowing that regardless of their legal status in the United States, and regardless of their ability to pay, they will receive care. As DHS describes in the proposed rule, the impact of the proposals would be devastating not only to the health of individuals and to their financial security, but also to immigrant communities

already experiencing significant health disparities and may very well pose threats to public health. Although AAMC member teaching hospitals make up only 5% of all hospitals, they provide 25% of Medicaid hospitalizations and 31% of hospital charity care. Over the past several years teaching hospitals have been subjected to multiple Medicare payment cuts, further reducing their margins. Should this proposed rule be finalized, teaching hospitals expect that they will be asked to treat more and sicker patients who come to them without insurance, thereby increasing their burden and weakening the health care system and exacerbating existing health and healthcare disparities. The rule would apply to immigrants seeking admission to the United States, extension of stay, change of status, or adjustment of their status to become a lawful permanent resident. This comment letter focuses on the effect of the proposed rule on those immigrants who are already in this country, and how the rule imposes a barrier on individuals wishing to enter the country as graduate students, medical residents, physicians, scientists, or researchers.

### **Overview**

With this proposed rule, DHS significantly changes the longstanding guidance on the Public Charge law and seeks to establish new standards about which public benefits will be considered when immigrants seek to enter the United States or to change their status. Among the health-care related benefits that would be considered are Medicaid (other than certain limited Medicaid benefits such as emergency Medicaid available only to undocumented immigrants), and Medicare part D Low Income Subsidy (LIS). Other public benefits that would be considered include Temporary Assistance for Needy Families (TANF); federal, state, or local cash benefit programs for income maintenance; Supplemental Nutrition Assistance Program (SNAP); housing assistance under the Housing Choice Voucher Program; and institutionalization for long-term care at government expense. The Children's Health Insurance Program (CHIP) is not included though DHS asks for comments on whether it should be. DHS notes in the impact analysis of the proposed rule, the consequence of finalizing the proposal is that individuals who are lawfully entitled to a range of public benefits are likely to disenroll or forego them which could lead to: worse health outcomes; increased use of emergency rooms and emergency care; increased prevalence of communicable diseases; increased uncompensated care; increased rates of poverty and housing instability; and reduced productivity and educational attainment (83 Fed Reg 51270).

It is hard to see how these consequences will "better ensure that aliens subject to the public charge inadmissibility ground are self-sufficient" (83 Fed Reg 51116). Rather, the result of the changes by DHS will be to force individuals and entire communities into precarious circumstances that will undermine their ability to gain the self-sufficiency that the government hopes to encourage. With such an array of possible dire consequences, there is the potential for the impact to extend not only to those legally present in the country, but also to their families who will be reluctant to access benefits due to a lack of understanding about who is covered by this rule; concern that their use of these benefits will endanger others in the family;

and even to the communities in which they live; and the providers who will treat them regardless of ability to pay the **AAMC strongly urges DHS to not finalize the proposed rule.**

### **DHS Should Defer to the Department of State Public Charge Rule**

On January 3, 2018, the U.S. Department of State issued separate public charge regulations.<sup>1</sup> Specifically, the Department defined public charge as “primarily dependent” on public benefits and excluded non-cash benefits. As a result, it is possible that immigrants who received a visa abroad, which authorizes travel to the United States, may 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.

### **DHS Should Not Expand the Definition of “Public Charge”**

Federal law already significantly limits immigrant access to public benefits and allows certain categories of immigrants to access public benefits only after they have been in the country for a specified period. However, Congress allows states the option to lift restrictions on Medicaid or CHIP waiting periods for lawfully present pregnant women and children under the age of 21. The most recent data show that as of January 2018, 33 states have lessened restrictions for children and 25 states have done so for pregnant women<sup>2</sup>. Should the proposed rule be finalized, it will penalize these women and children for using these benefits, even though Congress and a majority of states acknowledge the value of providing this coverage.

Longstanding DHS guidance has been that an individual who is “primarily dependent” on public benefits may be considered likely to become a public charge and looks at only two types of government assistance --: cash assistance and institutionalization for long-term care -- to make this determination. The proposed rule makes a significant change to the definition of public charge, defining it as an immigrant “who receives one or more public benefit” (emphasis added). Among the public benefits to be considered are any federal, state, local or tribal cash assistance for income maintenance; Supplemental Nutrition Assistance Program; Section 8 Project-Based Rental Assistance; and, Medicaid. The proposed list of benefits includes those that are used by immigrants who are working but have low earnings and may not be able to afford food, housing, medical care without government assistance, and/or have a transportation need as they establish themselves in a new country. Some of the benefits, such as Medicaid, are used by immigrants who are in the workforce but face unexpected medical needs. These benefits play an essential role in keeping working adults and their children healthy and promote economic security. DHS should not finalize a rule that will erode the welfare of

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<sup>1</sup> <https://fam.state.gov/fam/09fam/09fam030208.html>

<sup>2</sup> Manny, C, et al, “Medicaid Payments At Risk for Hospitals Under the Public Charge Proposed Rule,” November 2018, page 6.

immigrant individuals and their families and affect their ability to be productive workers who contribute to the American economy.

The proposed rule establishes an exceedingly complex system of monetized and non-monetized benefits and includes factors of age, health, family status, assets, resources and financial status, education and skill; and, if required, an Affidavit of Support. DHS provides positive and negative examples of each factor and includes, in some instances, factors that are “heavily weighted positive” and “heavily weighted negative”. Further, DHS will look at both current and past use of benefits as evidence that someone may become a public charge in the future. The rule also proposes to consider whether the immigrant is likely at any time in the future to receive one or more public benefits “based on the totality of the alien’s circumstances.” To make these decisions, immigration officials are given broad discretion, creating a system that is likely to be applied inconsistently and producing an environment that will discourage those who are entitled to benefits not to use them out of fear that such use may lead to deportation. DHS is unlikely to have the expertise to predict whether a use of benefits may have long term need. For example, significant serious medical care can be very limited in duration if treated promptly (e.g., pneumonia, tuberculosis, acute fracture, treatable cervical cancer) and may have no effect on future productivity or use of other public benefits.

### **The Potential Chilling Effect of the Proposed Rule Would Further Erode the Financial Ability of Teaching Hospitals to Provide Care to Individuals**

DHS notes 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” (83 Fed Reg 51266). For the first year, DHS estimates that 333,239 households or members of households receiving public benefits will disenroll or forego enrollment, with the number rising to 999,717 by year three. Nearly one million people foregoing initial medical care will place an incredible burden on future use of the medical system, further advantage already underserved communities, and potentially harm the entire American public if certain diseases are not treated promptly (HIV, diarrheal infections, influenza, hepatitis). The estimate of harm is low as it does not factor in conditions which may spread to the wider community.

The AAMC believes that this is an enormous underestimate of the rule’s impact. While it is difficult to estimate the chilling effect of the rule, there were anecdotal reports that when a draft of this rule was released earlier this year SNAP saw a decline in participation among immigrant women<sup>3</sup>. The proposed rule does not include WIC as a public benefit. In an analogous situation, a newly released report from the Georgetown University Health Policy Institute<sup>4</sup> looking at impact of other immigration policies found that the number of uninsured children under 19 increased from 4.7 percent in 2016 to 5 percent in 2017, a statistically

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<https://www.urban.org/urban-wire/targeting-snap-expanded-public-charge-rule-could-worsen-food-insecurity><sup>3</sup>

<sup>4</sup> [https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018\\_Final\\_asof1128743pm.pdf](https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf)

significant change that is attributable to individuals not accessing Medicaid and CHIP. The authors noted that:

“Finally, one quarter of all children under 18 living in the United States have a parent who is an immigrant. Several policies targeting immigrant communities are likely deterring parents from enrolling their eligible children in Medicaid or CHIP despite the fact that most of these children are U.S. citizens.”

When Manatt Health analyzed the potential impact of the proposed rule they evaluated the possible “chilled population,” i.e., those individuals legally entitled to benefits who will be discouraged from accessing them for fear that they will trigger the public charge rule. Manatt estimates that if the rule is finalized as proposed, for one year the population subject to the risk of a chilling impact would be a total of 13.2 million individuals, with 4.4 million being noncitizens and 8.8 million being citizen family members of a noncitizen. This would translate into a potential financial impact of \$68 billion in health care services for Medicaid and CHIP<sup>5</sup> enrollees who are noncitizens (\$26 billion) or the citizen family members of a noncitizen (\$42 billion)<sup>6</sup>.

Payments to hospitals alone that are subject to by the chilling effect are estimated to be \$17 billion for one year. The AAMC estimates that 88% of our member teaching hospitals will be will be affected, with the following potential impact:

- Nearly \$6 million for noncitizen enrollees and over \$3 million for citizen enrollees who have a noncitizen family member)
- The average affect per hospital is estimated to be over \$24,400,000.

By implementing this proposed rule, we also expect that individuals will choose not to seek preventive care and care for chronic illnesses for fear of being labeled as public charges even though they are lawfully entitled to such care. Therefore, when they come to a hospital for treatment they will be sicker and costlier to treat. Individuals may also forgo needed follow-up care and will again wait until their circumstances are dire, creating a cycle that is bad for their health, will be bad for the health of their communities, and will further endanger the financial health of the providers who treat them.

### **CHIP Should Not Be a Benefit That Is Used to Determine if an Individual is Likely to Become a Public Charge**

As has been discussed above, the proposed rule is likely to have a significant chilling effect, not only on individuals who are entitled to Medicaid benefits, but also to those entitled to CHIP especially since distinguishing Medicaid coverage from CHIP coverage is very difficult, if not impossible, for enrollees. By Federal law, a single application is required to be used to apply for

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<sup>5</sup> As was discussed earlier in the paper, enrollees often are unable to distinguish whether they are enrolled in Medicaid or CHIP; therefore, the estimate combines the two programs to examine the potential chilling impact.

<sup>6</sup> <https://www.manatt.com/getattachment/0e36d325-3a2c-4906-b49a-8cfbff5a85bf/attachment.aspx>

both Medicaid and CHIP. States may even refer to their CHIP financed program as Medicaid. Nearly half of young children under the age of 3 had Medicaid/CHIP coverage in 2016.<sup>7</sup>

According to a study by Kaiser Family Foundation<sup>8</sup>, CHIP has resulted in “improvements in access and care [that] appears to lay the foundation for gains in school performance and educational attainment, which, in turn, hold promise for children’s long-term health and economic well-being, and for economic productivity at the societal level.” In other words, the benefits of CHIP lay the foundation for self-sufficiency in the future. Therefore, if the proposed rule is finalized, the AAMC urges DHS to take whatever steps are necessary to limit the benefits that will be considered as making an individual likely to be a public charge. CHIP should be excluded as a factor to be considered. It should be noted that for those states that use CHIP funding to finance the cost of Medicaid for children and some women, it is unclear how the proposed rule would treat these individuals’ use of Medicaid.

**DHS Should Acknowledge that Graduate Students, Medical Residents, Physicians, Scientists, and Researchers, With Signed Employment Letters (or the Equivalent) Are Not Likely to Become Public Charges**

The AAMC appreciates that DHS acknowledges that most employment-based immigrants “should have adequate income and resources to support themselves without resorting to seeking public benefits” (83 Fed Reg 51123). We also support that an example of a positive factor (found in Table 32, 83 Fed Reg 51210) is an annual gross household income of at least 125% of Federal Poverty guidelines based on household size. The Accreditation Council for Graduate Medical Education (ACGME) is the recognized accrediting body for residency programs. Among the requirements for institutional sponsors are the following: financial support for residents/fellows; hospital and health insurance benefits for residents/fellows and their eligible dependents; and, disability insurance for residents/fellows<sup>9</sup>. According to the AAMC’s Survey of Resident/Fellow Stipends and Benefits Report 2018-2019<sup>10</sup>, the weighted mean stipend for PGY-1 residents is \$56,126, an increase of 3.7% from the prior year. 182 of the institutions responding to the survey offer residents/fellows health insurance and 181 also offer health insurance for the spouse. It seems clear that residents and fellows will meet the standards of factors that are positively weighted.

Academic medicine is global, with training and research often occurring in multiple locations around the world. This ensures the transfer of knowledge among countries, advancement of US research goals, and support of health care advances internationally. Given the fact that scholars

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<sup>7</sup> <https://www.urban.org/urban-wire/together-medicaid-and-chip-cover-more-4-10-young-children-most-metropolitan-areas>

<sup>8</sup> [https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8615-the-impact-of-the-children\\_s-health-insurance-program-chip-what-does-the-research-tell-us.pdf](https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8615-the-impact-of-the-children_s-health-insurance-program-chip-what-does-the-research-tell-us.pdf)

<sup>9</sup>

<https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

<sup>10</sup> <https://www.aamc.org/download/493114/data/2018stipendsurveyreportfinal.pdf>

and scientists likely will have a significantly higher salary than learners, in addition to other benefits, DHS should be clear that an individual with a letter from a sponsoring institution stating that the individual will meet Federal income and insurance requirements will be considered sufficient proof to be admitted to the United States without delay. These individuals are unlikely to become “public charges.”

In other words, DHS should be clear that at the time of the visa application these individuals do not need to show proof of health insurance, but only a promise of insurance on enrollment or employment. To do otherwise may cause a delay in obtaining the visa which would be to the detriment of students, residents, scholars, and researchers whose work or education calendar is tied to the academic year, generally July 1 to June 30.

### **The Interaction of the Proposed Rule with COFA**

There are individuals who live and work in this country under the auspices of the Compacts of Free Association (COFA), an international agreement between the United States and three Pacific Island nations of the Federated States of Micronesia, the Marshall Island, and Palau. COFA allows “citizens of Micronesia to live and legally work in the U.S. without a visa, as well as have access to social and health services.”<sup>11</sup> The AAMC asks DHS to confirm that if the rule is finalized it will have no impact on individuals who are in the U.S. as part of COFA, even if they use public benefits.

### **DHS Should Not Finalize Form I-944, Declaration of Self-Sufficiency**

The AAMC is concerned that Form I-944, Declaration of Self-Sufficiency (83 Fed Reg 51254) which must be filed by an applicant registering for permanent residence or to adjust status will be overlooked by many comments due to its placement deep in the proposed rule.

We believe that the 15-page form and the accompanying 16 pages of instructions may themselves discourage immigrants from seeking public benefits to which they are lawfully entitled. The AAMC has the following comments on the form and instructions:

- Page 6 of Form I-944, Question 9 asks “Have you EVER applied for or received any public benefits as listed in the Instructions?” The proposed rule does not suggest that the mere application for public benefits should be considered, but rather the receipt of certain benefits. This question should be revised to the following: “Have you ever received any public benefits as listed in the Instructions?”
- Page 10 of Instructions says the following regarding:  

“Further, USCIS will not consider Medicaid provided payment for “emergency medical condition,” for services provided under the Individuals with Disabilities Education Act (IDEA), or for school-based non-emergency benefits provided to children who are at or below the oldest age of children eligible for secondary

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<sup>11</sup> <https://guides.library.manoa.hawaii.edu/c.php?g=105631&p=686651>

education as determined under State law. Please provide documentation of such payments under those conditions, and, if applicable, provide a statement and information regarding the “emergency medical condition” determination. USCIS will not consider these specific Medicaid provisions in the public charge determination. If you applied for or received Medicaid under these conditions, please indicate and explain so in **Part 10. Additional Information.**”

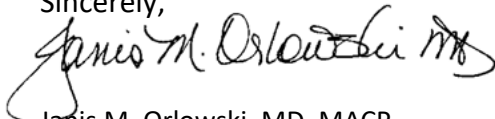
The applicant may not be aware of whether some treatment was paid for by Medicaid as an “emergency medical condition.” If the applicant is aware it will be necessary to return to the hospital that provided the treatment, creating an administrative and financial burden on both the patient and that hospital to supply the documentation needed to substantiate the applicant’s claim that the treatment was for an emergency medical condition. The AAMC suggests that DHS explore with HHS less burdensome ways in which this information can be supplied.

### **Conclusion**

The changes proposed in this rule pose a threat not only to the health and welfare of immigrants who are lawfully in this country, but also to their communities and the hospitals that care for them. For the reasons discussed above the AAMC asks DHS to not finalize the proposed rule. As DHS itself acknowledges, the proposed rule is likely to undermine the well-being of many who have come to this country and are working hard to better themselves and their communities.

If you have any questions, please contact Ivy Baer of my staff, [ibaer@aamc.org](mailto:ibaer@aamc.org) or 202-828-0499.

Sincerely,



Janis M. Orlowski, MD, MACP  
Chief Health Care Officer

Cc: Ivy Baer, AAMC