



December 10, 2018

Regulatory Coordination Division
Office of Policy and Strategy
U.S. Citizen and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Submitted electronically to www.regulations.gov

Re: USCIS-2010-0012

Dear Ms. Nielsen:

The National Council on Aging (NCOA) appreciates the opportunity to comment on the proposed rule, “Inadmissibility on Public Charge Grounds” (USCIS-2010-0012). The National Council on Aging (NCOA) is one of the nation’s leading nonprofit service and advocacy organization representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020. Our comments focus on the detrimental impact that the proposed rule would have on older adults. NCOA strongly urges the Department of Homeland Security (DHS) to withdraw this rule from consideration, given the negative impact it will have on immigrants, legal permanent residents and communities of the United States.

Importance of Benefits

DHS proposes changing the definition of “public charge,” from someone who is primarily dependent on the government for sustenance to someone who receives (or is deemed likely to receive) public benefits. DHS suggests that the primary purpose of this change is to encourage self-sufficiency. However, this change fails to recognize how critical public benefits are to older adults in order to age well and maintain self-sufficiency. Older adults often use these programs to supplement their fixed incomes during retirement or earnings from low-wage work. NCOA is particularly concerned that DHS proposes to expand the list of targeted public benefits to include Medicare Extra Help, SNAP, and Medicaid (including home and community-based services and Medicare Savings Programs). These benefits help provide economic stability to a large number of older adults, both U.S. citizens and foreign-born noncitizens.

Many older adults struggle with affording out-of-pocket costs for their prescription drugs. The Medicare Part D Low Income Subsidy, or Extra Help, was created by Congress in 2003 under the Medicare Modernization Act to assist low-income Medicare beneficiaries, up to 150% of poverty, with their medication costs. Most people with Extra Help pay no Part D plan premiums (up to a benchmark amount), no deductibles, and reduced costs at the pharmacy for their prescriptions. Cost of medications is a significant barrier to treat

and prevent costly chronic conditions. Medication non-adherence leads to higher healthcare costs. With the help of Medicare Extra Help, these Medicare beneficiaries have access to medically necessary treatment to manage chronic and life-threatening conditions, reducing preventable hospitalizations and other avoidable healthcare costs.¹ The Social Security Administration (SSA) estimates that older adults save an average of \$4000 per year on prescription drugs,² however the economic impact may be more substantial assuming improved medication adherence reduces other healthcare expenses. Currently, over 12 million low-income Medicare beneficiaries are able to access their drugs due to Extra Help. The loss of this benefit by noncitizens will create a barrier to effective treatment, cause them grave harm and have costly economic implications due to worsening disease progression and preventable health utilization.³

SNAP is also vitally important to helping older adults thrive. Over 5.4 million people over the age of 60 experience food insecurity each year. SNAP benefits help reduce the hunger experienced by these older adults. For an older adult living alone, SNAP can add an average of \$110 to their monthly budget. Studies have shown the downstream improvements in health and economic security that result from SNAP benefits. In a study of older adults dually enrolled in Medicare and Medicaid expanding SNAP participation led to a savings of \$19 million in inpatient hospital costs. A companion study found that usage of SNAP benefits is connected to reduced nursing home admissions and increased cost savings. SNAP also improves mental health outcomes – older SNAP beneficiaries are less likely to be depressed.⁴

Medicaid is a critical resource for Medicare beneficiaries. Almost 3 million low-income older adults on Medicare are in fair or poor health. Older adults on Medicare spend a large percentage of their income on out-of-pocket health care costs. In 2013, half of Medicare beneficiaries in Original Medicare spent at least 14% of their total income on health care costs. Medicaid, through Medicare Savings Programs (MSP), provides financial assistance for low-income Medicare beneficiaries. Three Medicare Savings Programs provide support to over 11.7 million beneficiaries as of 2017. These programs assist with Medicare Part B premiums for individuals up to 135% of poverty, a savings of \$1,400 a year. For individuals up to 100% of poverty, the Qualified Medicare Beneficiary (QMB) program also covers Medicare cost-sharing, such as deductibles and coinsurance, and Part A premiums for those without enough work quarters to qualify for premium-free Part A, which includes many older immigrants. Research has shown that low-income Medicare beneficiaries who do not receive financial assistance are more likely to forgo medically necessary care. Absent the support of these Medicaid programs, our nation's most vulnerable low-income Medicare beneficiaries may be unable to afford medically necessary care and support.

¹ "Seizing The Opportunity To Improve Medication Adherence," Health Affairs Blog, August 28, 2012

² <https://blog.ssa.gov/its-easy-to-get-extra-help-with-your-prescription-costs/>

³ Cutler RL, Fernandez-Llimos F, Frommer M, Benrimoj C, Garcia-Cardenas V. Economic impact of medication non-adherence by disease groups: a systematic review. *BMJ Open*. 2018;8(1):e016982. Published 2018 Jan 21. doi:10.1136/bmjopen-2017-016982

⁴ frac.org/wp-content/uploads/hunger-health-role-snap-improving-health-well-being.pdf

Extending the list of targeted benefits to Medicaid Home and Community-Based Services (HCBS) could also have devastating consequences for frail, vulnerable immigrants and their families. Those who must rely on these services typically spend-down onto Medicaid after exhausting their own personal savings and resources. Even for those who have worked and saved for retirement, once a person in their 80's or 90's can no longer function independently – through no fault of their own – it does not take long to exhaust remaining savings and need Medicaid to provide community services and supports. Denying such help will force people into expensive institutions when home care can be a less costly alternative that keeps families together and helps those in need to age with some dignity and independence. In some limited circumstances, compassionate providers may provide uncompensated care, but that would put them in a difficult financial position. Denying assistance to our nation's oldest, most disadvantaged seniors is an inhumane policy and should be rejected.

The impact on older individuals applying for Medicaid would be more complex and potentially larger than expected. As part of the Affordable Care Act, when individuals apply for coverage on the exchanges, they are assessed for coverage by other programs. Thus, individuals may get a determination of eligibility for Medicaid without realizing it. Additionally, Medicaid eligibility rules vary between states, depending on whether a state expanded Medicaid. Many states have also implemented a mandate for insurance coverage. As a result, the number of foreign-born noncitizens impacted by this proposed rule will vary greatly between states.

Usage of Benefits

DHS suggests that foreign-born noncitizens use public benefits at “substantial” rates. The analysis presented to justify this claim in the proposed rule is flawed. DHS indicates that the American Community Survey (ACS) and Survey of Income and Program Participation (SIPP) demonstrate substantial reliance by foreign-born noncitizens on public benefits. However, these surveys do not justify such a broad claim. Only the ACS provides further information on the usage of SNAP by foreign-born adults – 20% of foreign-born noncitizens use SNAP benefits, compared to 12.5% of citizens. Neither survey has complete information in terms of both percentage and absolute numbers of foreign-born adults using benefits. Thus, there is little empirical evidence that foreign-born noncitizens overuse public benefits.

DHS' estimate of foreign-born noncitizens utilizing benefits is imprecise. They reach an estimate by multiplying the total number of households receiving public benefits by 6.97%, which is the estimated percentage of the population that is foreign-born noncitizen. In reality, the foreign-born noncitizen population may access the targeted public benefits at varying rates from U.S. citizens, depending on the benefit. For example, the ACS estimates that foreign-born noncitizens enroll in SSI at lower rates than U.S. citizens, in contrast to SNAP benefits, which are used at a higher rate by foreign-born noncitizens. Additionally, the demographics of foreign-born noncitizens suggest that certain benefits are used less than others among this population – for example, according to the Kaiser Family Foundation, only 2% of foreign-born noncitizens are “low-income Medicare beneficiaries” (compared with 4% of U.S.

citizens). This suggests a low usage of Medicare Extra Help.⁵ Current restrictions on benefits for lawful permanent residents also depress the number of foreign-born noncitizens on benefits. For example, lawful permanent residents are generally barred from receiving full Medicaid benefits for five years after they enter the United States.⁶

When considering the usage of benefits by foreign-born noncitizens, DHS also fails to consider that noncitizens contribute tax dollars to fund Medicare. Research shows that immigrants heavily subsidize Medicare and pay more into the program than the benefits they use. Non-citizens pay into Medicare via payroll taxes. By discouraging foreign-born noncitizens from establishing legal permanent residency, DHS may discourage important funding for the Medicare Trust Fund.⁷

Totality Test

In addition to the receipt of benefits, DHS also identifies factors that would be considered in totality when making a public charge determination. NCOA is concerned about the negative impact these factors would have on a public charge determination. The rule considers having an income under 125% FPL as a negative factor. Under the new rule, DHS would also identify lack of private health insurance as a negative factor. This doesn't account for the fact that legal immigrants are more likely to be in low-paying jobs lacking insurance coverage than U.S. citizens.⁸

The totality test will be particularly harmful to older adults with disabilities. Although DHS suggests it is not singling out individuals with disabilities, by giving negative weight to factors such as significant disability or lack of private insurance, the totality test is immediately imposing a hurdle difficult for an individual with a disability to overcome. Similarly, by making age a negative factor in the determination, the proposed rule automatically singles out any foreign-born noncitizen over the age of 62. Older adults who have paid payroll taxes for Social Security and Medicare would nevertheless be targeted unfairly under this proposed rule, because of their age.

Chilling Effect

DHS also doesn't account appropriately for the chilling effect among immigrants who are eligible to get benefits. According to the proposed rule, DHS estimates that only 2.5% of households including foreign-born noncitizens will disenroll or forego enrollment in public benefits. This is an underestimate with faulty logic. Manatt conducted an analysis of the ACS to estimate the chilled population.⁹ Nationally, as many as 26 million people could be "chilled" from benefits, and either forego applying for benefits, or disenroll benefits. Of that group, over 2 million people are over the age of 62. As they note, while all families that have noncitizens may not want to use benefits because of the proposed

⁵ <http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid>

⁶ <https://www.macpac.gov/wp-content/uploads/2017/07/October-2018-Meeting-Transcript.pdf>

⁷ <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.1223>

⁸ <https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/>

⁹ <https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population#DataDashboard>

rule, the impact will be especially larger on lower income families. Of the approximately 2 million noncitizens over the age of 62, 1.1 million have an income less than 250% of the FPL.

Noncitizens withdrawing from benefits would in turn have negative ripple effects on the local and national economies. Hospitals and doctors would lose revenue, impacted people would buy less in supermarkets and other stores, and jobs would be lost. According to the USDA, every \$1 of SNAP benefits has a \$3 multiplier effect in the local economy, advantages and growth in the communities which would be significantly reduced by the effect of this rule as proposed. If even 25% of noncitizens that have the potential to experience a chilling effect withdraw from benefits, the Fiscal Policy Institute estimates this would lead to a potential loss of 164,000 jobs and \$24.1 billion in the economy.¹⁰

DHS discounts the chilling effect that resulted from welfare reform in the 1990s, but this is an instructive experience. Confusion about the changes in eligibility for benefits resulted in a sharp decline in immigrant participation in public benefits. Depending on the benefit, research shows that participation in benefits fell 20-60 percent. For example, the use of Medicaid declined among noncitizen households by 22 percent between 1994 and 1997.¹¹

NCOA also conducted its own survey among aging services professionals conducting benefits enrollment work, to understand the initial impact the proposed rule has had on immigrant seniors. According to NCOA's survey, 47% of respondents have noticed a chilling effect in which immigrants or their families have been reluctant to apply for benefits or access to social services. 45% of respondents have had clients ask about disenrolling from benefits, refusing congregate meals or food supplies, since the rule was proposed.

NCOA interviewed one community-based organization which serves primarily older adults in an Asian-American community. They reported a chilling effect in their community, in particular on potential first-time applicants who have chosen to not apply for Medicaid, as a result of their fear of being deemed a public charge. In one Section 8 apartment building, the organization serves approximately 70 Asian families. Ninety-five percent are legal permanent residents and have adult children that are U.S. citizens. However, many are nervous and discussing disenrolling from benefits. The organization has referred such individuals to legal services – but it is not clear that individuals in such a situation will get consistent and accurate advice nationwide. The organization is also trying to educate its clients – but it is tough to educate potentially affected individuals without scaring them.

At a recent meeting of the Medicaid and CHIP Payment and Access Commission (MACPAC), an advisory body to Congress, MACPAC noted that this proposed rule would put the current structures in place to determine eligibility for Medicaid and other public benefits at risk, if the implications of someone becoming eligible are unknown to

¹⁰ <http://fiscalpolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf>

¹¹ <https://www.macpac.gov/wp-content/uploads/2017/07/October-2018-Meeting-Transcript.pdf>

the person who is helping someone apply to benefits.¹²NCOA’s partners in outreach and enrollment would face this issue. At NCOA, we encourage enrollment counselors to use Benefits Checkup to help individuals determine their eligibility for various benefits – screening and assisting individuals to enroll in many disparate benefits that they are eligible for, but likely don’t know about. Thus, an older adult could go to an enrollment counselor with interest in Medicaid and get additional assistance with other benefits to help pay for their other basic living needs, including rental and food assistance. However, under the proposed rule, benefits counselors would need to account more strictly for a person’s immigration status and bear extra burden in their recommendations. By risking an individual’s legal status if they apply for benefits, this proposed rule weakens the foundation of longstanding outreach and enrollment efforts.

Direct Care Workers

Immigrants are of vital importance for older adults and their families relying on paid caregivers to meet the rapidly growing need for long-term services and supports provided by nursing home and home care aides. In 2016, Immigrants made up 25% of the direct care workforce, totaling over one million workers. With our rapidly growing 85+ population, and the fact that Baby Boomers have had relatively fewer children, our nation could be facing a future caregiving catastrophe. From 2006 to 2016, the number of immigrants providing direct care services grew by an estimated 52%. According to CareerCast, over the next 8 years, the forecasted growth in need for home health aides is 47% (more than 500,000) and 39% for personal care aides (approximately 750,000).¹³

Additionally, turnover rates among these direct care workers is very high, not only because of low wages and poor benefits, but because many aides reach a point in time when they can no longer do the physically demanding work required. Therefore, the pool of workers must be frequently replenished

The unfortunate reality is, we pay the people who care for frail elders so little that they must rely on government supports. Their median wage for home care aides is only about \$11 an hour—far below the income test included in the proposed rules. According to the Paraprofessional Healthcare Institute (PHI), among noncitizen immigrants, 44% (189,000 workers)—access public benefits, including Medicaid (67%) and food and nutrition assistance (57%). Among noncitizen immigrant direct care workers who access public benefits, 86% are women, 40% are Latino, and 30% are high school graduates.¹⁴

If the rule is enacted as proposed, a major source of personal care for older adults and people with disabilities would be eliminated. It would be virtually impossible for immigrants to come to the U.S. to work as home health or nursing home aides, creating an even more severe worker shortage than we already face. The consequences for our nation’s most vulnerable seniors would significant, as quality of care and quality of life would be jeopardized.

Grandfamilies

¹² <https://www.macpac.gov/wp-content/uploads/2017/07/October-2018-Meeting-Transcript.pdf>

¹³ <https://www.careercast.com/jobs-rated/toughest-jobs-to-fill-2018>

¹⁴ <https://phinational.org/news/new-public-charge-rule-would-devastate-the-caregiving-sector/>

If enacted, this rule would also significantly harm both noncitizens and U.S. citizens in families where a grandparent cares for a grandchild, also known as a “grandfamily.” Twenty-one percent of the 2.6 million children in grandfamilies are part of an immigrant family.¹⁵ In grandfamilies where a grandparent or grandchild is trying to obtain or maintain lawful permanent resident status, the chilling effect on benefits would be exacerbated, as members of the family would be likely to forego benefits out of fear of harming their family member(s) seeking to adjust or maintain their LPR status. If noncitizen older adults reduce usage of benefits as a result of this rule, that will not only impact their health and well-being, but also the health and well-being of family members who are citizens. This would increase the level of poverty in many families, and thus reduce disposable income. This policy will also impede noncitizen grandparents from reunifying with their families and grandchildren.

The rule also penalizes families through the totality test, for sharing housing or providing significant support to a parent or grandparent or other family member. This would increase their household size and force individuals to demonstrate higher levels of income to avoid being considered a public charge.

Thank you again for this opportunity to share our comments. This proposed rule will be harmful to millions of older adults who come to our country for a better life and to reunify with their families and detrimental to the communities where they reside. We strongly urge the Department to withdraw the rule immediately. If you have any questions or if we can be of any further assistance, please contact Samantha Zenlea at Samantha.Zenlea@ncoa.org.

Sincerely,

Samantha Zenlea
Senior Regulatory Policy Specialist

¹⁵ <https://www.gu.org/app/uploads/2018/10/Grandfamilies-Report-SOGF2018.pdf>