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December 7, 2018

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Office of Policy and Strategy
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Department of Homeland Security
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RE: DHS Docket No. USCIS– 2010–0012

Dear Ms. Deshommes:

Health Law Advocates, Inc. ("HLA") submits this comment in opposition to the Department of Homeland Security's ("DHS") proposed rulemaking entitled "Inadmissibility on Public Charge Grounds"[1] ("Proposed Rule"). HLA is a non-profit, public interest law firm headquartered in Boston that works directly with low income individuals.

Founded in 1995, HLA is committed to the mission of overcoming barriers to health care through providing no-cost legal services to vulnerable individuals. For the past 23 years, HLA has represented thousands of Massachusetts health care consumers in cases involving access to necessary medical services, including those covered through private insurance and our state Medicaid system, and medical debt collection. While Massachusetts has made great progress toward improving access to health care and has achieved the highest rate of insurance coverage in the nation, HLA's work over the past two decades illustrates how gaps remain, especially among our most vulnerable residents.

HLA opposes the Proposed Rule because it is a senseless departure from existing immigration policy. Moreover, the rule will not accomplish its stated goals of increasing the self-sufficiency of our nation's immigrants. This comment addresses the following issues:

[1] Inadmissibility on Public Charge Grounds, Department of Homeland Security Notice of Proposed Rulemaking, DHS Docket No. USCIS-2010-0012**,** 83 Fed. Reg. 196 (Oct. 10, 2018). *Federal Register: The Daily Journal of the United States*. Web. November 28, 2012.

1. The Proposed Rule underestimates the "chilling effect" it will have on immigrant communities;

2. The Proposed Rule will result in substantial costs for our health care system, and our state and local economies;

3. The Children's Health Insurance Program should not be considered as part of the public charge determination; and

4. Credit Reports are unreliable evidence of financial status and should not be relied upon for immigration determinations.

All documents referenced herein are intended to be considered as part of these comments. For your convenience, we have enclosed copies of each of the referenced documents identified by exhibit number along with a corresponding table of authorities.

1. The Proposed Rule Underestimates and Misrepresents the Chilling Effect on Immigrant Communities, Including Citizens and Children.

While the Proposed Rule acknowledges that there will be a "chilling effect" that discourages immigrants from using public benefits programs for which they are still eligible, DHS' estimate is inappropriately low based on incorrect assumptions that narrow the agency's calculus. For example, DHS wrongly assumes that the chilled population will be limited to only a portion of the immigrant population intending to apply for adjustment of status.[2] This assumption fails to account for individual citizens, often children, belonging to families with one or more undocumented individuals, who will disenroll from benefits along with the rest of their family. The rule also fails to account for the many non-citizens who fall in protected immigrant categories, such as refugees and asylees, who may disenroll from benefits because they wrongly believe that the public charge determination applies to them when, in fact, it does not. Moreover, DHS wrongly assumes that immigrants will disenroll only from those benefit programs referenced in the rule.

In fact, the fears experienced by immigrant communities around issues of immigration and deportation are not limited only to population or the programs directly affected by the Proposed Rule.[3] Numerous news outlets have already reported that refugees and asylum applicants are withdrawing from benefits despite falling outside the scope of the rule, and that individuals are refusing assistance from food pantries due to concern of failing a public charge determination.[4]

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[2] *Id.* at 51266.

[3] *See* Exhibit 1, Samantha Artiga & Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life*, KAISER FAMILY FOUND. (Dec. 2017), https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-issue-brief/; Exhibit 2, Samantha Artiga & Barbara Lyons, *Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being*, KAISER FAMILY FOUND. (Sept. 2018), https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being-issue-brief/.

[4] Exhibit 3, Maria Cramer, *Immigrants, refugees too afraid to seek critical help from food pantries, domestic violence resources,* BOSTON GLOBE (April 27, 2017), https://www.bostonglobe.com/metro/2017/04/26/immigrants-refugees-too-afraid-seek-critical-help-from-food-pantries-domestic-violence-resources/JrOJqOrYtHYeedLid9I69N/story.html; Exhibit 4, Beth Fertig, *City Immigrants Fear Being a 'Public Charge,'* N.Y. PUB. RADIO (Nov. 1, 2018), https://www.wnyc.org/story/city-immigrants-fear-being-public-charge/; Exhibit 5, Helena Bottemiller Evich, *Immigrants, Fearing Trump Crackdown, Drop Out of Nutrition Programs*,

Moreover, a growing body of academic research concludes that immigrant communities are presently afraid of accessing benefits despite the fact that there have not been any changes in the eligibility rules for SNAP and the Proposed Rule has not been put in effect. A recent study by Boston Medical Center researchers credited the Trump administration's immigration policies, including this Proposed Rule, with an unexpected decline in SNAP participation among immigrant mothers in 2018, a course reversal from steadily increasing utilization in prior years.[5] These reports and research echo the effect of welfare reform in the 1990s where fear and confusion caused immigrant families to withdraw from public benefits even where they were not directly affected by any policy change.[6]

Although DHS' analysis of the Proposed Rule's chilling effect does not account for the totality of the chilled population, other studies do.[7] The Fiscal Policy Institute states that more than 24 million people nationwide would experience chilling effects from the rule, including over nine million children.[8] In Massachusetts the chilled population could exceed 420,000. The Kaiser Family Foundation estimates that between 2.1 and 4.9 million individuals will disenroll from Medicaid nationwide.[9]

POLITICO (Sept. 3, 2018), https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292; Exhibit 6, Dylan Scott, *Study Suggests Trump Is Scaring Immigrant Families Off Food Stamps*, VOX (Nov. 15, 2018), https://www.vox.com/policy-and-politics/2018/11/15/18094901/trump-immigration-policy-food-stamps-snap.

[5] Exhibit 7, Allison Bovell-Ammon et al., *Trends in Food Insecurity and SNAP Participation Among Immigrant Families of US Born Young Children*, CHILDREN'S HEALTH WATCH (Nov. 12, 2018), http://childrenshealthwatch.org/wp-content/uploads/APHA-2018-Immigrants-FI-and-SNAP.pdf.

[6] *See* Exhibit 8, Neeraj Kaushal & Robert Kaestner, *Welfare Reform and Health Insurance of Immigrants*, HEALTH SERVS. RESEARCH (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/pdf/hesr_00381.pdf; Exhibit 9, Michael E. Fix & Jeffrey S. Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97,* URBAN INST., (March 1, 1999), https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Exhibit 10, Namratha R. Kandula et al., *The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants,* HEALTH SERVS. RESEARCH (Oct. 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/pdf/hesr_00301.pdf; Exhibit 11, Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, GUTTMACHER INST. (May 1, 2003), https://www.guttmacher.org/sites/default/files/article_files/gr060206.pdf.

[7] The importance of accurately assessing the chilling effect is not academic. The number of people who disenroll from public benefits directly increases the rule's costs and, as set forth, *infra*, assessing costs is an essential component of prudent policy making.

[8] Exhibit 12, FISCAL POL'Y INST., "ONLY WEALTHY IMMIGRANTS NEED APPLY," HOW A TRUMP RULE'S CHILLING EFFECT WILL HARM THE U.S., P. 1 (Oct. 10, 2018), http://fiscalpolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf; *see also* Exhibit 13, *Public Charge Proposed Rule: Potentially Chilling Population Data Dashboard,* MANATT HEALTH (Oct. 11, 2018), https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population; and Exhibit 14, Jeanne Batalova, Michael Fix & Mark Greenberg, *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families'Public Benefits Use*, MIGRATION POL'Y INST. (June 2018) https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.

[9] Exhibit 15, Samantha Artiga, Rachel Garfield & Anthony Damico, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KAISER FAMILY FOUND. (Oct. 11, 2018), http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid.

Of course, we would expect the chilling effect of the Proposed Rule to extend beyond those individuals who intend to seek adjustment of status or who receive the public benefits enumerated in the rule. The Proposed Rule is complex[10] and immigrants are unlikely to parse its terms. The rule's framework for how to determine whether someone is likely to be a public charge is also highly discretionary and therefore inherently uncertain. Moreover, the stakes for immigrants are high — many individuals have created a life in this country and cannot risk the prospect of leaving spouses, parents and children behind, while others cannot return to their countries of origin that are beset by war, crime or economic insecurity.

a. HLA Has Encountered the Broad Chilling Effect of the Proposed Rule Through Its Work Directly Representing Immigrants.

Further illustrating the inadequacy of DHS' analysis of the Proposed Rule's chilling effect, HLA and its sister organization, Health Care for All ("HCFA"), have received numerous inquiries indicating that fear and confusion regarding the Proposed Rule are already causing individuals to disenroll from benefits even before the rule has gone into effect. Some of the callers have been from protected immigrant groups that are not subject to the Proposed Rule.

In 2013, HLA began its Immigrant Health Care Access Initiative to address the many health care barriers facing low-income immigrants. In Massachusetts, non-citizen immigrants are insured at a significantly lower rate than their citizen counterparts. HLA works to improve immigrant access to health care by representing individuals in cases involving insurance appeals and service denials. HLA also actively engages in advocacy and created the Immigrant Health Care Access Coalition to coordinate policy advocacy and community organizing among organizations interested in health care for immigrants.

Similarly, HCFA operates the Health Insurance HelpLine, the only multilingual telephone service that assists Massachusetts residents of all income levels enroll in health insurance. The HelpLine is staffed by counselors trained on eligibility and enrollment for all state health insurance programs. Half of the calls to the HelpLine are conducted in languages other than English.[11]

Being on the front lines of health care coverage issues in Massachusetts, HLA and HCFA are uniquely positioned to hear directly from immigrants and other stakeholders in the state about the obstacles immigrants face accessing health care. Recently, both HLA and HCFA have received numerous inquiries from individuals who are not subject to the Proposed Rule, but who have nevertheless elected to disenroll from health coverage or who have refused covered services:

[10] Indeed, the text of the Proposed Rule first released on DHS' website is over 400 pages long and is difficult for even attorneys and advocates to understand.

[11] Based on HLA's and HCFA's experience working directly with immigrant communities, we are especially cognizant of the critical importance of multilingual support in our efforts to engage with the immigrant community. DHS' decision to accept only English language comments is misguided as it will serve only to limit the participation of the very individuals and immigrant groups that this Proposed Rule purports to directly affect. This unfortunate determination will lead to a biased and unbalanced record that systematically excludes the vital stories of millions of immigrants and their citizen families whose lives will be impacted by this rule.

- On August 15, 2018, HLA attorneys received an inquiry from an asylum applicant who was seeking to disenroll from Massachusetts Medicaid and who requested assistance with paying back all past medical claims due to fear of jeopardizing his asylum application.

- On October 10, 2018, HLA attorneys received an inquiry from a Massachusetts health plan that had encountered unusual resistance from a number of immigrant households who refused in-home services despite having coverage for the services. The health plan reported that individuals within the households refused the additional services out of concern that it would affect the immigration status of one or more members of the household.

- A Boston-based community health center reported sharp decreases in the number of immigrant patients seeking covered services in 2018 after news outlets reported on leaked drafts of the Proposed Rule.

Each of the stories, above, illustrate that immigrant communities are already being chilled by the Proposed Rule and that individuals are electing to forego coverage or services at great personal cost, even before any regulatory changes have gone into effect. Moreover, the example involving the asylum applicant shows that the chill extends far beyond the individuals directly impacted by DHS' policy change. For any agency cost benefit analysis to be accurate, it must take into consideration the full scope of the potentially chilled population and the benefit disenrollments that are likely to result.

2. <u>DHS Failed to Adequately Assess the Costs and Benefits of the Proposed Rule.</u>

DHS' cost-benefit analysis is inadequate because of its exceedingly narrow scope. Indeed, DHS focuses almost exclusively on direct costs such as filing fees and the costs of familiarization with the rule while making no effort to assess the value of the significant societal costs that are likely to result. In so doing, DHS' rulemaking process fails to account for the complexity of the American health care system and overlooks grave consequences that will likely impact immigrants and citizens alike.[12]

A thorough analysis is prudent because the agency cannot make rational policy decisions, including whether any regulatory changes are needed, without first assessing the potential costs and benefits. The public is also unable to comment on whether DHS appropriately weighed the costs and benefits where the agency has not engaged in any analysis.

HLA's work on behalf of low income individuals provides two reference points on the costly implications of the Proposed Rule. First, many of HLA's disabled clients have difficulty accessing in-home services despite having coverage for this care. Because immigrants comprise

[12] The Proposed Rule makes glancing reference to certain "qualitative effects" such as worse health outcomes, increased use of emergency rooms and emergent care, increased prevalence of communicable disease, increases in uncompensated care, increased rates of poverty and housing instability, and reduced productivity, but makes no attempt to analyze the significant costs of these impacts. Indeed, DHS claims without basis that it cannot analyze these impacts despite a well-established body of academic literature and government studies to the contrary. *See* Proposed Rule at 51236, 51270.

a significant proportion of the home health workforce in Massachusetts, and because the Proposed Rule will severely limit the supply of immigrants willing to work these jobs, the Proposed Rule will make it more difficult and expensive for disabled citizens to obtain needed in-home care. Second, HLA's project helping children with mental illness access treatment and avoid the juvenile justice system supports the conclusion that early access to health care leads to systemwide cost-savings and increases, rather than decreases, "self-sufficiency."

a. A Cost-Benefit Analysis is Required For Reasoned Decisionmaking.

Federal administrative agencies are responsible for engaging in reasoned decisionmaking and should not ignore the likely costs of proposed regulations. Consideration of costs and benefits reflects the understanding that reasonable regulation requires paying attention to the advantages and the disadvantages of agency decisions, and that administrative agencies should impose the least possible burden on society. To ensure that agency rule making does not cause more harm than good, agencies should look to the best reasonably attainable scientific, technical, economic, and other information.

It is unclear from the Proposed Rule why DHS failed to perform any assessment of costs other than only those most direct costs, such as filing fees and familiarization costs. DHS simply states that it "was not able to estimate potential lost productivity, health effects, additional medical expenses due to delayed health care treatment, or increased disability insurance claims as a result of this proposed rule."[13] However, well-established methodologies described in numerous published studies, including analysis conducted in prior agency rule making, provide a roadmap for how to assess the downstream costs of the Proposed Rule. For example, the following summaries describe several published studies and reports that either quantify some of the downstream impacts of the Proposed Rule or that discuss methodologies that could be applied to analyze the costs of the rule.

- Manatt Health analyzed the overall Medicaid and CHIP funds and hospital payments at risk if the Proposed Rule is finalized and concludes that the loss of coverage would result in poorer health and health outcomes for affected individuals. The study further concludes that the Proposed Rule could drive up uncompensated care costs for the nation's hospitals, causing financial strain, particularly for hospitals in states and communities with large immigrant populations. Massachusetts hospitals alone receive more than $457 million in Medicaid and CHIP payments that are at risk due to chilling from the Proposed Rule.[14]

[13] Proposed Rule at 51236.

[14] Exhibit 16, Cindy Mann, April Grady & Allison Orris, *Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule*, MANATT HEALTH 17 (Nov. 16, 2018), https://www.manatt.com/getattachment/0e36d325-3a2c-4906-b49a-8cfbff5a85bf/attachment.aspx.

- A study by the Blue Cross Blue Shield Foundation of Massachusetts estimates that the Proposed Rule could directly cause uncompensated care costs in Massachusetts hospitals to increase $100 to $350 million.[15]

- The Fiscal Policy Institute concluded that the Proposed Rule would cause significant economic ripple effects in Massachusetts and nationally consisting of losses to businesses, workers and jobs when individuals disenroll from Medicaid and SNAP. The study estimates that the Proposed Rule will result in direct losses to individuals of $7.5 to $17.5 billion in Medicaid and SNAP benefits, which would result in ripple effects and secondary economic losses of $14.5 to $33.8 billion.[16] Locally, the study estimates that Massachusetts will suffer direct losses of $237 to $554 million, and secondary economic losses of $465 million to $1.06 billion as a result of the rule.[17]

Moreover, as the following examples illustrate, many agencies, including DHS, engage in cost benefit analyses during rulemakings or in order to evaluate the effectiveness of programs.

- In 2015, DHS analyzed the effects that transitional care and discharge regulations had on various market participants, including hospitals, and compared the anticipated monetary costs of the rule to the expected benefits consisting primarily of decreased mortality or morbidity of patients.[18]

- In 2018, the Social Security Administration requested a data collection to determine whether the beneficial outcomes of a program, including increased employment and reduced benefit participation, are significant enough to justify the program's costs.[19]

- In 2018, the Department of Labor analyzed the lifetime costs to the economy from lost earnings, lower economic growth, lower tax revenues, and higher government spending, of youth who "disconnect" from school or work.[20] DOL also considered the costs the proposed regulation would have on small businesses.[21]

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[15] Exhibit 17, John Moreschi, The Proposed Public Charge Rule: An Overview and Implications in Massachusetts, Blue Cross Blue Shield Found. MA 3-4 (Dec. 2018), https://bluecrossmafoundation.org/sites/default/files/download/publication/BCBSF_PublicChargeReport_Dec2018_Final.pdf.

[16] *See* FISCAL POL'Y INST., "ONLY WEALTHY IMMIGRANTS NEED APPLY," HOW A TRUMP RULE'S CHILLING EFFECT WILL HARM THE U.S., *supra* note 8, at 1-3.

[17] Exhibit 18, FISCAL POL'Y INST., A DATA TABLE WITH ECONOMIC AND FISCAL IMPACT CALCULATIONS FOR ALL 50 STATES 1, (Oct. 10, 2018), http://fiscalpolicy.org/wp-content/uploads/2018/11/50-states-economic-impact-of-public-charge-1.pdf.

[18] 80 Fed. Reg. 68126, 68150 (Nov. 3, 2015), https://www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf.

[19] 83 Fed. Reg. 52042, 52046 (Oct. 15, 2018), https://www.gpo.gov/fdsys/pkg/FR-2018-10-15/pdf/2018-22339.pdf.

[20] 83 Fed. Reg. 48737, 48739 (Sept. 27, 2018), https://www.gpo.gov/fdsys/pkg/FR-2018-09-27/pdf/2018-20996.pdf.

[21] *Id.* at 48747.

Particularly where restricting immigration will likely contract the economy,[22] and where the effects of the Proposed Rule will be felt across virtually every sector of the economy, the agency should carefully weigh all the attendant costs and benefits of the Proposed Rule.

b. HLA's Mental Health Advocacy Program for Kids Project Confirms that Early Treatment of Mental Illness Helps Individuals and Taxpayers Avoid Significant Long Term Costs.

As set forth above, DHS fails to provide any empirical evidence that the Proposed Rule will accomplish its stated objective of ensuring "self-sufficiency" for people who are subject to the public charge test. Indeed, the data shows that if individuals do not receive adequate support early enough, particularly with respect to health care, they often become trapped in a cycle of poverty.[23] HLA's work with low-income health care consumers supports this view. In particular, HLA's representation of children with mental illness reveals that access to treatment often enables children to stay in school, while the alternatives include cascading negative impacts and a lifetime of diminished productivity. Moreover, HLA has found that early treatment of childhood mental illness saves significant costs that would otherwise be borne by state and local governments, hospital systems and taxpayers.

In 2008, HLA began a program focused on helping children with mental illness overcome barriers to treatment and avoid entanglements with the juvenile justice system. At the time, the Center for Mental Health Services Research at the University of Massachusetts Medical School reported that among court-involved youth who end up in state detention, 60-70 percent needed mental health care but that few received it. To address this need, HLA attorneys began to provide *pro bono* representation for children involved with the juvenile court, helping them obtain access to mental health services and often ending their court involvement. In the intervening years, the Mental Health Advocacy Program for Kids ("MHAP for Kids") has assisted more than 650 children access mental health care and other needed services.

In 2015, a research team from the Boston University School of Public Health commenced an in-depth, two-year program evaluation of MHAP for Kids to measure the program's effectiveness.[24] The BU team found that, prior to entry in the program, the participating children

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[22] Exhibit 19, Craig Torres, *Fed's Powell Says Reduced Immigration Could Slow U.S. Economy*, BLOOMBERG (Nov. 1, 2018), https://www.bloomberg.com/news/articles/2018-11-01/fed-s-powell-says-reduced-immigration-could-slow-u-s-economy.

[23] *See* Mary Corcoran, *Rags to Rags: Poverty and Mobility in the United States*, 21 Annual Rev. Sociology 237, (1995); Orley Ashenfelter & David Card (eds.), *Intergenerational Mobility in the Labor Market*, Amsterdam: North-Holland. Handbook of Labor Economics 3A: 1761-1800 (1999); *see also* Hilary Hoynes, Diane Whitmore Schanzenbach & Douglas Almond, *Long-Run Impacts of Childhood Access to the Safety Net*, 106 Am. Econ. Rev. 903, ("effects [of participating in food stamps] for economic self-sufficiency is large and statistically significant for women. . . .").

[24] The report presents program findings for a two-year period, from February 1, 2015 to March 1, 2017. *See* Exhibit 20, Emily Feinberg & Patricia Elliott, *Juvenile Court Mental Health Advocacy Project, Update to Final Report*, B.U. SCH. PUB. HEALTH 2 (Nov. 3, 2017), https://www.healthlawadvocates.org/get-legal-help/resources/document/BUSPH-J-MHAP-Evaluation-Final-Report-11.3.17.pdf [hereinafter the "BU Report"].

experienced a high rate of mental illness and significant barriers to mental health treatment.[25] As a result, the children suffered high rates of emergency mental health care and hospitalizations, detentions, and school truancy. Specifically, among the children participating in the MHAP for Kids program, the BU team found that:

- 83 percent were diagnosed with one or more mental illnesses with an average of 3.5 mental health related conditions per child;
- 89 percent experienced a barrier to mental health treatment;
- 63 percent accessed crisis or emergency mental health care services in the past year;
- 44 percent were hospitalized for psychiatric care in the past year;
- 37 percent were removed from their families and detained in a residential facility in the past year;
- 28 percent did not attend school at all or missed almost every day in the past three months; and
- 61 percent missed school more than one day per week in the past three months.[26]

These cascading consequences of untreated mental illness are costly. In Massachusetts, the average charge for a 7-day psychiatric hospitalization is $17,384.[27] In the study, 22 of the 158 children had a psychiatric hospitalization in the year prior to receiving services through the program and their average number of days in the hospital was 26.6.[28] Juvenile confinement[29] costs taxpayers between $32,457 and $112,814 per child per year, depending on whether the child is confined to a low, medium or high security facility.[30] If a child misses school due to an emergency hospitalization or detention, his chances of finishing high school diminish, which adversely impacts the individual's earning potential and other risk factors over the course of his lifetime. Over 26 percent of the youth in the MHAP for Kids program had missed almost every day of school in the three months prior to the research study's evaluation.[31]

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[25] *Id.* at 5-10.
[26] *Id.*

[27] The BU Report references costs in 2016 dollars. *Id.* at 21.

[28] BU Report, at 21.

[29] Children often enter the child welfare system through congregate care facilities, including Boston's Stabilization Treatment Assessment and Rapid Reintegration ("STARR") program. While these programs were conceived to help at risk youth receive the support they need, they are often unsuitable and ineffective and do more harm than good. *See* Exhibit 21, CITIZENS FOR JUVENILE JUSTICE, MISSED OPPORTUNITIES, PREVENTING YOUTH IN THE CHILD WELFARE SYSTEM FROM ENTERING THE JUVENILE JUSTICE SYSTEM 12 (Sept. 29, 2015), https://static1.squarespace.com/static/58ea378e414fb5fae5ba06c7/t/59020af046c3c44b405cb544/1493306111142/MissedOpportunities2015.pdf.

[30] BU Report, at 22.

After MHAP for Kids' intervention, however, the youth experienced dramatic improvements. Specifically, the BU team observed:

- Decreased use of emergency mental health services – while 70 percent of children had recently utilized emergency mental health services before entering the program, only 14 percent utilized emergency services afterward;[32]
- Reduced rates of juvenile detention – the number of children detained decreased from 14 percent to 6 percent and use of emergency shelters from 10 percent to 0;[33]
- Improved school attendance – 26 percent of youth in the evaluation missed almost every day of school in the past three months. At follow-up, this was reduced to only 10 percent;[34] and
- Parents reported taking less time off work and experienced overall improvements in the mental health of their families.[35]

The reduction in the rate of utilization of costly services by children who participate in the MHAP for Kids program is compelling evidence of the economic benefits of access to mental health treatment. Not only are children able to avoid the high *per diem* costs of emergency mental health hospitalization and juvenile detention, they also benefit from increases in high school graduation rates and workforce participation. Where the estimated lifetime burden to taxpayers for every 16-year-old youth who drops out of high school is approximately $275,000[36] in decreased earnings, lost taxes, additional health care, criminal justice and corrections, and other social service expenses, providing needed supports that interrupt the vicious cycle of poverty yields economic benefits for the entire community.

While the economic benefits of early access to mental health care should not be ignored, the most significant benefits are the profoundly positive impacts that mental health treatment has on the individual lives of our youth. Children who would otherwise have been removed for significant periods of time from their homes, schools and social networks because of repeated emergency psychiatric hospitalizations or detentions, were able to receive treatment that enabled them to continue in their daily lives. These children avoided the fate of thousands of less fortunate Massachusetts youth who lack adequate access to mental health treatment who, as a result, experience life interruptions from which it is difficult if not impossible to recover. Indeed, the Proposed Rule is likely to chill access to health care, including mental health care, for children – even citizen children – leading to a life-time of costs for the taxpayer.

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[31] *Id.* at 7.

[32] *Id.* at 7-8.

[33] *Id.* at 38.

[34] *Id.*

[35] *Id.* at 14-16, 37.

[36] *Id.* at 21.

c. The Proposed Rule Will Lead To Crippling Consequences for the Massachusetts In-Home Health Care Work Force

The Proposed Rule will also harm the ability of Massachusetts residents who depend on long term in-home services and supports to remain in their homes. HLA has encountered a disturbing trend where, even with insurance coverage for in-home services, many of HLA's disabled clients are unable to access care because of a shortage of nurses and home health aides. In Boston, immigrants comprise 53 percent of the home health work force.[37] In Massachusetts, 59 percent of home health workers receive public benefits, including 44 percent who are on Medicaid and 31 percent who receive food and nutritional assistance.[38] Twenty-eight percent of home health workers earn less than 138 percent of the federal poverty level ("FPL") and 45 percent of workers earn under 200 percent FPL.[39] The vast majority of immigrant home health workers will be subject to the Proposed Rule and, as a result, could be considered public charges because of their low income. In Massachusetts, approximately 5,600 home health workers are in the estimated potentially chilled population by the Proposed Rule and could decline to participate in the public benefit programs that enable them to maintain these jobs as a result.[40] Thus, the Proposed Rule will drive down the number of available immigrant workers precisely as the need for their services are increasing. The U.S. Department of Health and Human Services estimates that almost 70 percent of people turning 65 today will need long term services in the United States.[41]

Unfilled in-home service hours have a traumatic effect on disabled individuals and their families. Skilled nurses and home health aides serve critical functions by maintaining durable medical equipment, monitoring for new symptoms or reactions, and assisting with medications and other minor in-home procedures (such as checking blood glucose) among other supportive services. Parents or other family members often leave behind outside jobs to assume the role of primary caregiver if a disabled individual is unable to secure in-home services.

The following summaries of the experiences of HLA clients illustrate the difficulties that families face when they are unable to access in-home services.

- A.S. is a 9-year-old boy from Worcester who has significant mental and physical health issues that require in-home nursing care. Since 2013, A.S. has been covered for in-home

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[37] Exhibit 22, Paul Osterman, William Kimball & Christine Riordan, *Boston's Immigrants, an Essential Component of a Strong Economy*, JVS CTR. FOR ECON. OPPORTUNITY (May 10, 2017), https://www.jvs-boston.org/wp-content/uploads/2017/11/Osterman-Report-Final.pdf.

[38] Exhibit 23, *Workforce Data Center*, PHI, https://phinational.org/policy-research/workforce-data-center/#states=25&var=Public+Assistance&tab=State+Data (accessed Nov. 19, 2018).

[39] Exhibit 24, *Workforce Data Center*, PHI, https://phinational.org/policy-research/workforce-data-center/#var=Poverty&states=25 (accessed Nov. 19, 2018).

[40] *See* John Moreschi, *supra* note 16, at 5.

[41] Exhibit 25, *How Much Care Will You Need?*, U.S. DEP'T HEALTH & HUMAN SERVS., https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (accessed Nov. 19, 2018).

nursing services through Massachusetts Medicaid's Community Case Management program (CCM). CCM authorized 65 hours per week of medically necessary skilled nursing care for A.S., however, his family has filled only 48 of these approved weekly hours. And, for most of 2016, A.S.'s family could only fill 30 of his weekly hours, which was less than half of the hours that Massachusetts Medicaid determined that A.S. needed to maintain his safety at home. Because the family has not been able to find sufficient in-home care, A.S.'s mother has not been able to work full-time in over a year.

- K.F. is a 29-year-old who suffers from several complex medical, developmental and psychiatric conditions. K.F. is unable to care for herself or complete her activities of daily living without assistance. She is prescribed multiple medications that are adjusted frequently and pose risks for serious side effects. HLA represented K.F. in her appeal of Massachusetts Medicaid's decision to terminate her in-home services. During the appeal, K.F. was approved for 40 hours per week of home health aide services but never received them. When HLA contacted the home health agency about the home health aide services, the agency informed us that it was unable to meet the staffing demands because it simply did not have any home health aides available. K.F.'s mother needed to work full time and could not leave her job to care for her daughter. Thus, because the family could not access in-home services, K.F.'s mother was left with no alternative but to bring her severely disabled daughter to work with her everyday.

3. Considering CHIP Benefits in Public Charge Determinations Will Cause Significant Harm to Children, Including Those Whose Families Exceed the 250% Income Test, and Diminish their Chances of Becoming Self-Sufficient.

The Children's Health Insurance Program ("CHIP") should not be included for consideration in a public charge determination. Children need access to health care precisely because access to care facilitates positive outcomes and productivity later in life. Indeed, as discussed in section 2, *supra*, children who receive needed mental health services are more likely to be productive and self-sufficient, while those who do not will require more costly interventions later on.

Also, significantly, in Massachusetts, receiving coverage through CHIP does not indicate that a child's household income is unable to support the child because the Commonwealth provides coverage through CHIP at income levels that are significantly higher than elsewhere in the country.[42] In Massachusetts, children who are ineligible for Medicaid are nevertheless eligible for CHIP coverage up to 305 percent FPL, or $62,281 annually for a family of three.[43] The relatively high income limits for CHIP coverage are representative of Massachusetts' policy election to provide coverage at the highest income levels under Medicaid in an effort to achieve better health outcomes through universal insurance coverage. If CHIP were included in the final version of the Proposed Rule, it could lead to absurd results where a child is simultaneously

[42] Massachusetts' unique implementation of the CHIP program is emblematic of a larger problem — where the Proposed Rule does not distinguish between the differences in state administration of Medicaid and CHIP, people will be held to different standards depending on the state in which they reside.

[43] Exhibit 26, GEO. UNIV. CTR. FOR CHILDREN & FAMILIES AND AM. ACAD. PEDIATRICS, MASSACHUSETTS CHILDREN'S HEALTH INSURANCE PROGRAM FACT SHEET (Sept. 9, 2017), https://www.aap.org/en-us/Documents/fed_advocacy_chip_massachusetts.pdf.

found to have both heavily positive and negative weighted factors because he has a household income above 250 percent FPL, but also receives coverage through CHIP.

DHS has presented no evidence that withholding health care from immigrant children will promote their self-sufficiency. Moreover, it is fundamentally unfair to draw any negative inference from a child's CHIP eligibility when Massachusetts' administration of the program is designed to provide coverage at higher incomes.

4. <u>Credit Reports Are Not Reliable Evidence of Financial Status for Immigration Determinations.</u>

DHS' proposal to rely upon credit scores as evidence of financial status is misguided. HLA often assists individuals confront and combat the onslaught of the debt collection industry's attempts to pursue payment for medical debt. While the reporting of medical debt to credit bureaus is a frequent tactic by the debt collection industry, it is not an accurate or reliable measure of an individual's financial status.

Medical debt is one of the leading sources of credit reporting in the nation. Nearly one in five credit reports contain medical debt trade lines.[44] Nevertheless, due to the complex insurance and medical billing system in the U.S., credit reporting of medical debt is often unreliable. And, where most of the medical debt credit reporting is by third party agencies that have only indirect connections with the debt, the incidents of error are more prevalent.[45] Inaccurate medical debt reporting is representative of broader problems with a credit reporting industry riddled with accuracy issues.[46] While our lending system may rely on credit reports, the documented error rate with respect to medical debt in such reports make it inappropriate to rely on credit reporting in the context of immigration determinations that have lifelong consequences for individuals and their families.

HLA has encountered numerous cases where debt collectors have ultimately abandoned attempts to collect significant medical debts because they are unable to answer the most fundamental questions about the debt, such as, who, if anyone, provided the medical services, when were they provided, and what was charged. In the past year, HLA clients have had the following experiences with erroneous medical debt:

- It was only after a bill for $16,550.96 for emergency eye surgery was sent to collections, that V.S. learned there had been a one-month gap in his insurance plan through the Health Connector, Massachusetts' health insurance exchange, due to a verification

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[44] Exhibit 27, CFPB, CONSUMER CREDIT REPORTS: A STUDY OF MEDICAL AND NON-MEDICAL COLLECTIONS 5 (Dec. 2014), https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

[45] *Id.* at 6.

[46] Exhibit 28, Aaron Klein, *The Real Problem with Credit Reports is the Astounding Number of Errors*, BROOKINGS (Sept. 27, 2017), https://www.brookings.edu/research/the-real-problem-with-credit-reports-is-the-astounding-number-of-errors/.

document not being received on time because it had been faxed to the wrong number. First, HLA negotiated with the Health Connector to reinstate V.S.'s insurance for the time in question. HLA then worked with the collections agency to have the provider resubmit the bill for payment by the insurance company. When the claim was denied for being untimely, HLA contacted the insurance company to explain the course of events. After several months, the claim was paid in full by the insurance company, leaving V.S. to cover only the $22 co-pay.

- M.E., a 30 -year old year-old dual eligible (Medicare and Medicaid) from Malden, Massachusetts approached HLA for assistance with bills he received from two different hospitals in Wisconsin totaling just over $34,000. After confirming several times that he had approval for treatment in Wisconsin (the only place in the country that offers appropriate treatment for M.E.), M.E. was nevertheless inappropriately billed directly for these services. HLA worked with the insurance company to ultimately cover the care, but one provider sent the balance of the bill to collections. HLA communicated with the collection agency and advocated on M.E.'s behalf with the out-of-state provider to get the balance written off based on federal Medicare/Medicaid laws. After several months of negotiating, the insurer agreed to cover the treatment at no out-of-pocket expense to M.E.

While HLA's clients had legal representation to help them face medical debt collectors, many other consumers are not as fortunate. As a result, many consumers are unable to effectively remedy credit reporting errors. Immigrants are often even less equipped to confront the behemoth credit reporting industry and are particularly vulnerable to reporting errors. Adverse immigration determinations should not be added to the myriad negative consequences – such as difficulty renting an apartment and denials of employment – that can result from credit reporting errors.

Conclusion

HLA vigorously opposes the Proposed Rule. As an organization dedicated to improving access to health care for our state's most vulnerable residents, HLA is certain that the rule will not accomplish DHS' stated goals of increasing the self-sufficiency of our immigrant communities. Instead, it will cause devastating harm to individuals and needlessly disrupt our health care system and state and local economies. As a result, we urge the Secretary to abandon this Notice of Proposed Rule Making and leave the existing rule in place.

Please do not hesitate to contact us regarding any of the matters discussed above.

Very truly yours,

Justin J. Lowe
Legal Director

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To DHS Docket No. USCIS-2010-0012

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