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Choosing Between Healthcare and a Green Card: The Cost of Public Charge

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CHOOSING BETWEEN HEALTHCARE AND A GREEN CARD: THE COST OF PUBLIC CHARGE

ABSTRACT

Public charge policy has been part of the nation's infrastructure since its colonial beginnings. The policy originated as a barrier to protect taxpayers from individuals who posed a risk of becoming a charge on society, relying on public aid and governmental support. Congress last addressed the public charge statute in 1952 in the Immigration and Nationality Act, and it has been further developed at the will of the executive branch alongside the growth of immigration law and the welfare state. The Department of Homeland Security (DHS) proposed a rule change to the public charge policy to be implemented in October 2019, but the proposed rule change was temporarily halted by federal courts days before it went into effect, partially because it threatened public health and posed an extreme financial burden to healthcare centers. On January 27, 2020, the Supreme Court stayed the lower court's injunction in response to an emergency petition by the administration, effectively voiding the ban in forty-nine states and allowing the 2019 public charge policy to take effect while the issue is litigated in lower courts. The rule went into effect on February 24, 2020, a mere month prior to the onslaught of the COVID-19 outbreak in the United States. On July 29, 2020, DHS was enjoined from implementing the 2019 public charge policy for the duration of the national health emergency in response to the pandemic.

Public charge policy has fallen to the discretion of the executive branch in recent decades, and the last major policy guidance was issued in 1999. Congress did not overrule the executive agency in 1999, in a way signaling acceptance of the policy trend at the turn of the millennium; however, the 2019 rule change executed by DHS derails the agency's prior interpretation significantly. Public charge policy has historically been used by the federal government to discriminate, and it continues to be used as a political tool to exclude racial and ethnic minorities from accessing public health benefits. In burdening these minorities, the government in turn burdens the healthcare system. Without congressional action, the fate of public charge is decidedly unclear and the confusion and fear for noncitizens fueled by the 2019 rule will not abate. This Comment proposes that Congress revise the public charge statute to address concerns raised by the 2019 rule, at minimum ensuring that access to legally entitled health benefits are excluded from public charge consideration.

INTRODUCTION	203
I. BACKGROUND OF PUBLIC CHARGE POLICY	205
A. <i>Roots of Public Charge Policy in Immigration Law</i>	206
B. <i>Inadmissibility Versus Deportation in Public Charge</i>	208
C. <i>Battling Bias in Public Charge in the Twentieth Century</i>	210
D. <i>National Expansion of Public Benefits Versus Public Charge</i> .	213
1. <i>Development of Federal Welfare Support</i>	214
2. <i>The Two Paths of State Welfare Support</i>	216
3. <i>Development of Public Charge Following PRWORA</i>	217
4. <i>Federal Enactment of EMTALA</i>	218
II. THE 2019 PUBLIC CHARGE POLICY	219
A. <i>Expansion of Inadmissibility Under Public Charge in 2019</i>	220
B. <i>Growing Public Health Concerns from Growing Public Charge Policy</i>	222
C. <i>Damaging Effects of the 2019 Proposal and Upcoming Implementation</i>	225
III. THE POLITICAL AND FINANCIAL STRINGS ATTACHED TO PUBLIC CHARGE POLICY	227
A. <i>Political Weaponization of Public Charge</i>	227
B. <i>Public Charge is Changing, but at What Cost</i>	233
IV. NECESSARY CONGRESSIONAL ACTION	239
A. <i>Long Overdue Public Charge Review</i>	239
B. <i>Revisiting and Revising the Public Charge Statute</i>	242
CONCLUSION	247

INTRODUCTION

The Statue of Liberty stands in welcome on the shores of the United States and declares, “[g]ive me your tired, your poor, [y]our huddled masses yearning to breathe free,”¹ as a promise from the United States to honor and support immigrants in their endeavors. The ebb and flow of immigration along with the skyrocketing cost of healthcare combine to create significant controversy. As a result, immigration, health care, and the economy are the crux of American politics² and are prominent items on the agenda for the Trump Administration.³ At the intersection of these three platforms is public charge policy: a practice which determines admission of noncitizens into the United States based on the noncitizen’s likelihood of dependence on the federal government’s public services.⁴ From the first mention of public charge in our earliest immigration laws to the welfare reform legislation passed in the late twentieth century, public charge policy consistently centered around a dual commitment to enabling entry to noncitizens contributing to the economy and “a commitment to assist members of the community who fall on hard times.”⁵ In 2018, the Department of Homeland Security (DHS) reflected the Trump Administration’s political interests, following leaks that DHS planned to change the public charge rule, by substantially expanding the application of public charge inadmissibility⁶ and departing from the dual commitment they had balanced for over a century.⁷ The 2019 changes include consideration of a noncitizen’s previous use of public benefits that were excluded from the policy at the time, such as the subsidization of health care, and recognition of five distinct “heavily weighed” negative factors for the inadmissibility test, that will affect hundreds of thousands of immigrants in the country.⁸

¹ Emma Lazarus, *The New Colossus*, NAT’L PARK SERV., <https://www.nps.gov/stli/learn/historyculture/colossus.htm> (last updated Aug. 14, 2019).

² Frank Newport, *Top Issues for Voters: Healthcare, Economy, Immigration*, GALLUP (Nov. 2, 2018), <https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx>.

³ See, e.g., OFFICE OF MGMT. & BUDGET, BUDGET OF THE U.S. GOVERNMENT: A NEW FOUNDATION FOR AMERICAN GREATNESS: FISCAL YEAR 2018 15–17 (2017), <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/budget.pdf>.

⁴ 8 U.S.C. § 1182(a)(4); *Public Charge*, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/greencard/public-charge> (last updated Mar. 27, 2020).

⁵ Medha D. Makhlof, *The Public Charge Rule as Public Health Policy*, 16 IND. HEALTH L. REV. 177, 179 (2019).

⁶ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,116 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

⁷ Makhlof, *supra* note 5.

⁸ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. at 51,173, 51,198 (considering previously excluded public benefit programs and labeling “heavily weighed” negative factors); see Deepti Hajela, *Lawsuits Around U.S. Seek to Block Trump’s Public Charge Rule*, PBS (Oct 8, 2019, 4:19 PM), <https://www.pbs.org/>

A mere four days before the new public charge rule was to take effect, three district courts halted the rule nationwide.⁹ The district courts granted motions to stay the effective date of the proposed rule.¹⁰ While the temporary delay of the proposed change was celebrated by healthcare institutions and immigration advocates, the fight drags on both in court and in the daily life of many immigrants concerned about their uncertain status.¹¹ On January 27, 2020, the Supreme Court granted a stay in response to an emergency petition by the Trump Administration, lifting the nationwide injunction and allowing the 2019 public charge policy to take effect while legal challenges continue in lower courts.¹² DHS implemented the 2019 final public charge policy nationwide on February 24, 2020,¹³ a mere month prior to the onslaught of the COVID-19 outbreak in the United States.¹⁴ On July 29, 2020, DHS was enjoined from implementing the 2019 public charge policy for the duration of the national health emergency

newshour/nation/lawsuits-around-u-s-seek-to-block-trumps-public-charge-rule (noting the 382,000 immigrants directly affected by the 2019 policy).

⁹ Priscilla Alvarez, Geneva Sands & Tami Luhby, *Three Federal Judges Hit Trump on Immigration Policy Changes*, CNN (Oct. 11, 2019, 6:07 PM), <https://www.cnn.com/2019/10/11/politics/green-card-public-charge-rule-blocked/index.html>.

¹⁰ Order Granting Plaintiffs' Motion for a Preliminary Injunction at 3, *New York v. U.S. Dep't of Homeland Sec.*, No. 1:19-cv-07777-GBD (S.D.N.Y. Oct. 11, 2019); Order Granting Plaintiff States' Motion for Section 705 Stay and Preliminary Injunction at 58, *Washington v. U.S. Dep't of Homeland Sec.*, No. 4:19-cv-05210-RMP (E.D. Wash. Oct. 11, 2019); Preliminary Injunction at 92, *San Francisco v. U.S. Citizenship & Immigration Servs.*, No. 4:19-cv-04717-PJH (N.D. Cal. Oct. 11, 2019); Preliminary Injunction at 92, *La Clinica de la Raza v. Trump*, No. 19-cv-04980-PJH (N.D. Cal. Oct. 11, 2019); Preliminary Injunction at 92, *California v. U.S. Dep't of Homeland Sec.*, No. 19-cv-04975-PJH (N.D. Cal. Oct. 11, 2019) (addressing three related actions in one order, with each having moved for preliminary injunctive relief and being granted together).

¹¹ See *Make the Rd. N.Y. v. Cuccinelli*, 419 F. Supp. 3d 647, 667 (S.D.N.Y. 2019) (noting that nine lawsuits have been filed and cases against the proposed rule are currently being litigated).

¹² Robert Barnes & Maria Sacchetti, *Supreme Court Allows Trump Administration to Proceed with 'Wealth Test' Rules for Immigrants*, WASH. POST (Jan. 27, 2020, 6:54 PM), https://www.washingtonpost.com/politics/courts_law/supreme-court-allows-trump-administration-to-proceed-with-immigration-rules/2020/01/27/6adb9688-412c-11ea-aa6a-083d01b3ed18_story.html; see also Pete Williams, *In 5-4 Ruling, Supreme Court Allows Trump Plan to Deny Green Cards to Those Who May Need Government Aid*, NBC NEWS (Jan. 27, 2020, 3:55 PM), <https://www.nbcnews.com/politics/supreme-court/5-4-ruling-supreme-court-allows-trump-plan-deny-green-n1124056>. The Supreme Court denied requests to temporarily block the government from enforcing the 2019 public charge rule during the COVID-19 pandemic, discouraging immigrants from receiving testing and treatment through public health programs to which they are legally entitled. Amy Howe, *No Pause from Supreme Court for "Public Charge" Rule During COVID-19 Pandemic*, SCOTUSBLOG (Apr. 24, 2020, 8:30 PM), <https://www.scotusblog.com/2020/04/no-pause-from-supreme-court-for-public-charge-rule-during-covid-19-pandemic/>.

¹³ *Public Charge*, *supra* note 4. Illinois was protected by an injunction issued in a separate case, which was lifted on February 21, 2020. Barnes & Sacchetti, *supra* note 12; *Supreme Court Lifts Illinois Injunction on Public Charge Rule, Allowing Nationwide Implementation*, NAT'L LOW INCOME HOUS. COAL. (Mar. 2, 2020), <https://nlihc.org/resource/supreme-court-lifts-illinois-injunction-public-charge-rule-allowing-nationwide>.

¹⁴ *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, WHITE HOUSE (Mar. 13, 2020), <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

in response to the pandemic.¹⁵ Although the new policy is temporarily halted, the public charge statute has gone unaddressed by Congress for decades, and the most marginalized in society are falling through the gap.

This Comment argues that public charge policy has systematically been weaponized to intimidate noncitizens by taking a policy intended to protect American citizens and instead using it as a cover to further political bias and discourage immigrants from accessing public benefits to which they are legally entitled. This weaponization will inevitably increase the burden on taxpayers and businesses, namely healthcare centers, to support noncitizens further down the line. This Comment assembles data provided by healthcare institutions in the underlying litigation over the public charge policy. It also calls upon Congress to address the inconsistency between the 1996 welfare reform and the 2019 public charge policy regarding public health programs, revisit the public charge statute, and consider a limited, yet significant revision of the legislation to exclude government-funded health benefits from public charge inadmissibility consideration. Although the administrative law issues of the 2019 public charge rule are being litigated, this Comment focuses on the systemic problem of conflating public charge policy with access to healthcare, urging Congress to rethink this connection between immigration and the provision of healthcare entirely. Part I uncovers the background of public charge policy, including the legislative history and legal context of its evolution. Part II addresses the feared implications of the 2019 rule as a prime example of the misuse of the public charge policy. Part III argues that the development of public charge has been weaponized as a political tool of the federal administration at the expense of taxpayers and healthcare systems. Part IV prescribes specific congressional action to revise the public charge statute to exclude consideration of legally entitled health benefits.

I. BACKGROUND OF PUBLIC CHARGE POLICY

The public charge policy of today reflects centuries of evolving immigration law, political bias, and the rise and fall of the welfare state. Upon close analysis of the overall development of public charge policy from the early colonial period through the late twentieth century, the danger of an unrevised statute becomes undeniably clear. With unrelenting anti-immigrant propaganda and political fears of an ever-growing welfare agenda, current public charge policy has been warped to be unidentifiable from where it began. This Part connects the modern trend of public charge policy to its roots in immigration law, distinguishes the

¹⁵ *Public Charge*, *supra* note 4.

methods of inadmissibility and deportation under public charge policy, highlights the history of bias hidden behind public charge policy, and discusses the development of public charge with the rise and fall of the welfare state.

A. *Roots of Public Charge Policy in Immigration Law*

Public charge policy first appeared as early as the first colonies, which adopted “poor laws” recognizing claims for relief from colonists on a local, township basis.¹⁶ State immigration laws arose from these early colonial constructs, and, as the flow of impoverished immigrants seeking refuge from the Irish famine came to a peak in 1847, the Board of Commissioners for Emigration in New York prohibited the arrival of people who were “likely to become permanently a public charge.”¹⁷ State laws such as this one were the foundation for the nation’s first general immigration law in 1882, the Immigration Act, which prohibited the arrival on land of “any person unable to take care of himself or herself without becoming a public charge.”¹⁸

Between 1880 and 1920 the United States welcomed over twenty million immigrants as it entered a period of industrialization and urbanization.¹⁹ Over the same period, the federal government passed five immigration laws that provided a framework for the exclusion and deportation of immigrants. Less than a decade after the first general immigration law, Congress passed the Immigration Act of 1891 which expanded inadmissibility of immigrants to not only those who are currently deemed a public charge but also “persons likely to become a public charge.”²⁰ The expansion in this Act also included a deportation policy aimed at immigrants who had entered the United States within one year prior to becoming a public charge, placing the cost burden for a return ticket on

¹⁶ Ibrahim Hirsi, *Trump Administration’s ‘Public Charge’ Provision Has Roots in Colonial US*, WORLD (Dec. 19, 2018, 2:00 PM), <https://www.pri.org/stories/2018-12-19/trump-administration-s-public-charge-provision-has-roots-colonial-us>. These poor laws allowed towns to “expel transient beggars” and limited the arrival of disabled people and those deemed unable to financially support themselves by not allowing them to disembark from arriving ships and returning them to their countries of origin. TORRIE HESTER, HIDETAKA HIROTA, MARY E. MENDOZA, DIERDRE MOLONEY, MAE NGAI, LUCY SALYER & ELLIOTT YOUNG, HISTORIANS’ COMMENT: DHS NOTICE OF PROPOSED RULE “INADMISSIBILITY ON PUBLIC CHARGE GROUNDS” 2 (2018).

¹⁷ ORG. OF THE COMM’N, ANNUAL REPORTS OF THE COMMISSIONERS OF EMIGRATION OF THE STATE OF NEW YORK: FROM THE ORGANIZATION OF COMMISSION, app. at 2 (1861). Massachusetts built upon the expulsion factor of earlier colonial laws and established an immigrant deportation law reflecting anti-Irish sentiment in the state at the time. *See* GEN. CT. OF MASS., *An Act Relating to Alien Passengers*, in ACTS AND RESOLVES PASSED BY THE GENERAL COURT OF MASSACHUSETTS 338–39 (Dutton & Wentworth 1850).

¹⁸ An Act to Regulate Immigration, ch. 376, § 2, 22 Stat. 214 (1882).

¹⁹ *See U.S. Immigration Before 1965*, HISTORY, <https://www.history.com/topics/immigration/u-s-immigration-before-1965> (last updated May 16, 2019).

²⁰ Act of Mar. 3, 1891, ch. 551 § 1, 26 Stat. 1084 (1891).

the steamship company that facilitated their original arrival.²¹ Immigrants outside of the scrutinized one-year time frame, who had been integrated into local communities and had often begun their families in the United States, were not subject to deportation under this public charge provision.²² The following three immigration laws, passed in 1903, 1907, and finally 1917, gradually expanded the scrutinized time frame within which a recent immigrant was eligible for deportation from the original one-year trial period to a total of five years, where the law still currently stands.²³ The parameters for deportation reflected those for inadmissibility, in theory allowing the government to expel a person who had been incorrectly allowed access to the United States and would have otherwise been deemed a public charge prior to their entry—allowing flexibility for those who came across hardships after settling in the United States.²⁴

Public charge in these original laws, from colonial authorizations to the nation's early immigration acts, necessarily qualified those who were dependent on public aid and benefit programs for the "basic maintenance of their lives"²⁵ prior to their entry into the United States, a definition that has evolved substantially since the late nineteenth and early twentieth century.²⁶ For context, the United States granted entry to an average of one million people per year from 1905 to 1914; in 1916, the Immigration Bureau deemed 10,263—roughly 1% of arrivals—inadmissible on public charge grounds and deported 1,431 recent immigrants—roughly 1% of that number—under the same parameters.²⁷ The use of public healthcare programs was not considered to qualify an immigrant as a public charge in cases of deportability because, until the 1960s, there were no federally funded public health programs.²⁸ Instead, hospital expenses for new

²¹ Act of Mar. 3, 1891, ch. 551 § 11, 26 Stat. 1086 (1891).

²² HESTER ET AL., *supra* note 16.

²³ Act of Mar. 3, 1903, ch. 1012 § 20, 32 Stat. 1218 (1903); Act of Feb. 20, 1907, ch. 1134 § 20, 34 Stat. 898, 904–05 (1907); Immigration Act of 1917, ch. 29 § 19, 39 Stat. 874, 889 (1917); *see also* E. P. HUTCHINSON, LEGISLATIVE HISTORY OF AMERICAN IMMIGRATION POLICY 1798–1965, at 133 (1981) (explaining legislative developments of the Act of Mar. 3, 1903); Alina Das, *The Immigration Penalties of Criminal Convictions: Resurrecting Categorical Analysis in Immigration Law*, 86 N.Y.U. L. REV. 1669, 1689 (2011) (providing an overview of expansion of deportations relating to convictions).

²⁴ *See* § 11, 26 Stat. 1086.

²⁵ HESTER ET AL., *supra* note 16, at 3.

²⁶ *See* IMMIGR. SERV., ANNUAL REPORT OF THE COMMISSIONER-GENERAL OF IMMIGRATION TO THE SECRETARY OF THE TREASURY FOR THE FISCAL YEAR ENDED JUNE 30, 1897, at 4 (1897) (framing early federal deportations as a means of institutional removal).

²⁷ U.S. DEP'T OF LABOR, ANNUAL REPORT OF THE COMMISSIONER GENERAL OF IMMIGRATION 12 (1916); HESTER ET AL., *supra* note 16, at 3.

²⁸ *See* COMM. ON THE CONSEQUENCES OF UNINSURANCE, HEALTH INSURANCE IS A FAMILY MATTER 153 (2002).

immigrants were paid either by the steamship companies that originally transported them or by an “immigrant fund,” labeling them public charges under “temporary distress” that were effectively rehabilitated by the government.²⁹ Early application and interpretation of public charge limited deportability on the basis of public charge and focused inadmissibility on the reliance on public aid, forming the foundation for the development of the policy in the future. As this Comment discusses, the concept of relying on public aid for the “basic maintenance”³⁰ of living in the United States has changed considerably in the last century, and restricting access to public health benefits to which immigrants are now legally entitled does not honor the purpose of public charge policy.³¹

B. Inadmissibility Versus Deportation in Public Charge

Public charge assessment rears its head in two phases: (1) upon application and admission into the United States and (2) within five years following the time of entry.³² Since the early twentieth century, federal immigration statutes have clearly distinguished between public charge inadmissibility and public charge deportation, giving the latter a significantly stricter test.³³ The argument follows a basic understanding of sovereignty: the state is within its rights to exclude a person who has never entered the country, whereas dislodging a person from their home after they have integrated into the community presents higher stakes.³⁴ The stricter standard for this test limits discriminatory enforcement of the clause, and there is an underlying recognition that allowing immigrants to access public benefits would better integrate them into the community.³⁵ However, “undesirable” immigrants who were unhealthy or disabled—

²⁹ IMMIGR. SERV., ANNUAL REPORT OF THE COMMISSIONER-GENERAL OF IMMIGRATION TO THE SECRETARY OF THE TREASURY FOR THE FISCAL YEAR ENDED JUNE 30, 1896, at 10 (1896) (describing how 1,946 immigrants fell into temporary distress and became public charges from causes arising within 1 year of entry, but were not returned to their country of origin).

³⁰ HESTER ET AL., *supra* note 16, at 3.

³¹ See Robert A. Moffitt, *The Deserving Poor, the Family, and the U.S. Welfare System*, 52 DEMOGRAPHY 729, 730–34 (2015).

³² *The Public Charge Rule, Explained*, BOUNDLESS (Feb. 24, 2020), <https://www.boundless.com/blog/public-charge-rule-explained/>.

³³ *In re Harutunian*, 14 I. & N. Dec. 583, 587–88 (B.I.A. 1974).

³⁴ See *id.* at 585–86. The Board of Immigration Appeals (BIA) established a three-part test to determine deportability: (1) the state must charge the immigrant for services rendered by public benefit programs, (2) the state must demand payment from the person liable under the state’s law, and (3) there must be a failure to pay for the service charges. CONG. RSCH. SERV., PUBLIC CHARGE GROUNDS OF INADMISSIBILITY AND DEPORTABILITY: LEGAL OVERVIEW 4 (2017).

³⁵ See Leo M. Alpert, *The Alien and the Public Charge Clauses*, 49 YALE L.J. 18, 26–28 (1939) (describing court cases where, although warranted, the public charge deportability provision was not applied or was suspended for noncitizen families who were supported by welfare based on principles of promoting integration).

particularly mentally disabled—have a history of being deported under the public charge rule.³⁶ In 1926, 887 noncitizens were deported because they were “likely to become a public charge,” out of almost 11,000 total deportations that year.³⁷

In contrast, inadmissibility is determined by the Board of Immigration Appeals on the much broader “totality of the circumstances” test, including a variety of factors ranging from “age, health, family status, assets, resources, financial status, education, and skills.”³⁸ The Immigration and Nationality Act of 1952 expanded inadmissibility to extend beyond those attempting to temporarily enter the United States from abroad on a visa or green card to include immigrants already within the United States who were now seeking to become permanent residents.³⁹ Prior to 1952, temporary visitors seeking to become permanent residents first had to leave the country, apply through a U.S. consulate abroad, and face the inadmissibility test again as a prospective permanent resident.⁴⁰ Now, although an immigrant could apply to adjust their status without exiting the country, the totality of circumstances test includes circumstances that occurred while the immigrant was residing in the United States on a temporary basis.⁴¹

Although inadmissibility was intended to be a forward-looking test,⁴² the scope shifted as the categories for entry into the United States continued to grow.

³⁶ Polly J. Price, *Infecting the Body Politic: Observations on Health Security and the ‘Undesirable’ Immigrant*, 63 U. KAN. L. REV. 917, 941 (2015).

³⁷ *Id.*

³⁸ EM PUHL, TOTALITY OF THE CIRCUMSTANCES: ASSESSING THE PUBLIC CHARGE GROUND OF INADMISSIBILITY 2 (2019); *see* Immigration and Nationality Act of 1952, ch. 2 § 212(a), 66 Stat. 163, 189 (describing the classes of noncitizens ineligible for visas to be excluded from admission into the United States); *see also* *In re Perez*, 15 I. & N. Dec. 136, 137 (B.I.A. 1974) (“The determination of whether an alien is likely to become a public charge . . . is a prediction based upon the totality of the alien’s circumstances[.]”).

³⁹ Immigration and Nationality Act of 1952, ch. 2 § 214, 66 Stat. 163, 189. The Immigration and Nationality Act of 1952 created “nonimmigrant” categories for temporary entry into the United States to visit, work, or study. *Id.*; *see also* USCIS Policy Manual, Volume 7, Part A, Adjustment of Status Policies and Procedures, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/policy-manual/volume-7-part-a-chapter-1> (last updated May 21, 2020) [hereinafter *USCIS Policy Manual*] (summarizing the impact of the Immigration and Nationality Act of 1952).

⁴⁰ *See* USCIS Policy Manual, *supra* note 39.

⁴¹ *Id.*; *see* *In re Harutunian*, 14 I. & N. Dec. 583, 589 (B.I.A. 1974) (“It is a well established fact that an applicant for adjustment of status . . . is in the same posture as though he were an applicant before an American consular officer abroad[.]”); *see also* *President Donald J. Trump Is Ensuring Non-Citizens Do Not Abuse Our Nation’s Public Benefit*, WHITE HOUSE (Aug. 12, 2019) [hereinafter *Trump’s Statement on the 2019 Rule Change*], <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-ensuring-non-citizens-not-abuse-nations-public-benefit/> (“Aliens in the United States who are found likely to become public charges will also be barred from adjusting their immigration status.”).

⁴² Makhlof, *supra* note 5, at 185 (“Inadmissibility . . . is concerned with whether a noncitizen is ‘likely

Current law allows the public charge inadmissibility test to be applied at three distinct times in an immigrant's integration into the country: when they (1) apply for a visa to travel to the United States, (2) arrive at a port of entry, and (3) apply for lawful permanent resident status.⁴³ This Comment focuses on immigrants seeking the third point of integration and highlights the danger posed to those applying for permanent resident status, and consequently to healthcare centers and state governments, by the new restriction on public health benefits. The development of inadmissibility and deportation policy under the public charge rule exposes the room left for discrimination in the application of the statute, as the two facets were manipulated throughout the twentieth century.

C. *Battling Bias in Public Charge in the Twentieth Century*

The "likely to become a public charge" language⁴⁴ originally allowed for irregular enforcement of inadmissibility, subject to the biases of immigration agents reviewing cases. This irregular enforcement is mirrored in the 2019 public charge policy, which targets "undesirable" immigrants by expanding public charge considerations to include the access of public health benefits.⁴⁵

The public charge rule has historically been utilized as a tool for discriminatory exclusion. When immigrants were arriving on Ellis Island, the public charge policy gave immigration officials broad latitude to determine the potential to become a public charge, to the point that one immigration commissioner demanded that Southern and Eastern Europeans arriving on the shores have \$25 in cash alongside a ticket to their final destination.⁴⁶ If the migrants, many of whom were Jewish, did not have the money or the ticket, they were excluded and summarily deported.⁴⁷ Public charge has been notoriously, unevenly applied in its history and was hardly enforced until the Great Depression, when concerns regarding the burden of migrants in civil society peaked.⁴⁸ The disparity was especially apparent considering the treatment of European migrants compared to Mexican and African migrants; although European migrants relied heavily on a range of federal public benefits, they were

to become a public charge at some future time."').

⁴³ *Id.* at 177.

⁴⁴ *The Public Charge Rule, Explained*, *supra* note 32.

⁴⁵ *See infra* Part III.A. This Comment drives home how this discrimination exacerbates costs for hospitals who offer uncompensated care to immigrants too afraid to access public health programs. *See infra* Part III.B.

⁴⁶ *Public Charge Rule Has History of 'Racial Exclusion' Says Immigration Historian*, WORLD (Aug. 14, 2019, 5:00 PM), <https://www.pri.org/stories/2019-08-14/public-charge-rule-has-history-racial-exclusion-says-immigration-historian>.

⁴⁷ *Id.*

⁴⁸ *Id.*

not stigmatized for doing so and were able to access emergency relief services, social services, and aid for children.⁴⁹ Mexican migrants were severely penalized for attempting to rely on the same programs, and local governments turned their efforts to mass expulsion of stigmatized migrants during the Great Depression.⁵⁰ Immigration historians note that the term ‘likely to become a public charge’ has “always been used as a cover for more racially discriminatory immigration restrictions” and a desperate effort to restrict the entry of diverse migrants.⁵¹

Immigration officials had discretion to couple factors that were not, on their own, grounds for exclusion under public charge in making cases for inadmissibility.⁵² Desirability of immigrants in the workforce also affected the characterization of who was likely to become a public charge; those who were expected to provide cheap labor were welcomed into the country, whereas those who fit the bias of incurring high social welfare costs were barred from entry.⁵³ Bias from immigration officials unfairly targeted women seeking to enter the United States on their own, denying that women were capable of being self-supporting and independent in the economy.⁵⁴ Limiting the entry of immigrant women into the United States also played a significant political role, as there was mounting fear of a fast-growing population of children of recent immigrants that could pose a “social problem” to the nationalist tendencies of the time.⁵⁵ Historian Wendy Kline described a white middle class that was in jeopardy, faced with the social and economic change posed by a growing population of working-class immigrants.⁵⁶ Racially and ethnically marginalized groups were also often deemed economically unfit and doomed to become public charges,⁵⁷ such as Jewish “peddlers”⁵⁸ and “unclean[]” Indians in the early twentieth

⁴⁹ *Id.*

⁵⁰ ABRAHAM HOFFMAN, UNWANTED MEXICAN AMERICANS IN THE GREAT DEPRESSION: REPATRIATION PRESSURES, 1929–1939, at xiii (1974); see DEIRDRE MOLONEY, NATIONAL INSECURITIES: IMMIGRANTS AND U.S. DEPORTATION POLICY SINCE 1882, at 87, 92 (2012) (describing the Mexicans, including children born in the United States, that were repatriated in the 1930s); see also *Public Charge Rule Has History of ‘Racial Exclusion,’ Says Immigration Historian*, *supra* note 46 (“[M]any local governments used this dependence on relief to launch one of the greatest mass expulsions of Mexican and Mexican Americans during the Great Depression.”).

⁵¹ *Public Charge Rule Has History of ‘Racial Exclusion,’ Says Immigration Historian*, *supra* note 46.

⁵² See HESTER ET AL., *supra* note 16, at 3.

⁵³ LISA PARK, ENTITLED TO NOTHING: THE STRUGGLE FOR IMMIGRANT HEALTH CARE IN THE AGE OF WELFARE REFORM 57 (2011).

⁵⁴ MOLONEY, *supra* note 50, at 79–80; see also PARK, *supra* note 53 (explaining the perception of a woman’s role as “naturally” dependent and subordinate).

⁵⁵ See Park, *supra* note 53, at 55.

⁵⁶ WENDY KLINE, BUILDING A BETTER RACE: GENDER, SEXUALITY, AND EUGENICS FROM THE TURN OF THE CENTURY TO THE BABY BOOM 9, 14 (2001).

⁵⁷ MOLONEY, *supra* note 50, at 79–80.

⁵⁸ *Id.* at 83, 87 (noting that the stereotype was used to exclude Jewish immigrants from 1910s to 1940s).

century.⁵⁹ To limit these personal and institutional biases, quantifiable standards were established to determine if someone was likely to become a public charge, which continue to guide the policy today.⁶⁰

In contrast to inadmissibility, the public charge standard for deportability looked for a pattern of public aid dependence in recent immigrants, in which they became “completely dependent on public facilities,” such as hospitals, for support.⁶¹ However, if the cause for hospitalization did not exist before an immigrant was admitted to the United States, they were not in danger of deportation as a result of becoming a public charge. This distinction was intended to protect immigrants who relied on public support for a hospital stay after breaking their leg, in contrast to an immigrant who had been diagnosed with a long-term and debilitating illness prior to their entry, in which case they would be denied entry.⁶² The intended purpose of public health programs, which subsidized healthcare in the twentieth century (other than for long-term institutional care), was not to support immigrants financially but rather to supplement and integrate these new community members.⁶³ Biases began to arise as new social support programs, such as English classes, were implemented, and enforcement of the general deportation policy was abused similarly to the inadmissibility policy.⁶⁴ Regional economic downturns in the 1920s and the Great Depression in the 1930s led local authorities to deport employed immigrants, specifically hundreds of thousands of Mexican workers and their families, on the feeble grounds that they had utilized some city or county public benefits, even though they were not in danger of becoming completely dependent on public facilities for support.⁶⁵

⁵⁹ U.S. DEP’T OF LABOR, REPORTS OF THE DEPARTMENT OF LABOR: 1914, at 438–39 (1914) (including instruction from the head of the Bureau of Immigration to exclude people from India because they were “unclean[]” and were therefore unemployable).

⁶⁰ Enhanced Border Security and Visa Entry Reform, ch. 15 § 1182(a), 4 Stat. 706, 711 (2018); *cf.* An Act to Prohibit the Importation and Migration of Foreigners and Aliens Under Contract or Agreement to Perform Labor in the United States, its Territories, and the District of Columbia, ch. 164 § 1, 23 Stat. 332 (1885).

⁶¹ HESTER ET AL., *supra* note 16, at 4; *see also* Price, *supra* note 36, at 938 (“Beginning in the twentieth century, state governments played a limited role in mental health-based exclusions for immigrants, and this role was primarily to identify non-citizens for deportation on the ground that they had become a ‘public charge.’”).

⁶² *See* HESTER ET AL., *supra* note 16, at 4; Price, *supra* note 36, at 938 (“[I]t became a common practice for state health agencies and hospitals—especially mental health institutions—to engineer the deportation of any non-citizen who had become a public charge or who had spent even a small amount of time in a mental institution.”).

⁶³ Makhoulf, *supra* note 5, at 182.

⁶⁴ *See id.*; MOLONEY, *supra* note 50, at 142.

⁶⁵ *Id.* at 88, 92.

In contrast, the Immigration and Naturalization Service (INS) claimed that it did not consider immigrants who were suffering and receiving public relief as “victims of the general economic depression” subject to deportation.⁶⁶ Whereas Mexican immigrants were extrajudicially escorted out of the country by local authorities for using meager county benefits,⁶⁷ INS tempered its use of public charge to deport new immigrants, primarily benefiting Europeans and Canadians in the early 1930s.⁶⁸ Women faced intensified scrutiny as well, as the federal government used ‘likely to become a public charge’ language to deport them in cases of petty sexual misconduct after they arrived in the United States.⁶⁹ Federal cases moved on to eliminate criminal misconduct from being considered for public charge deportation, with Judge Learned Hand clarifying that the public charge policy referred to “dependency not delinquency” and likening deportation to exile and a “dreadful punishment” for crimes that were not deportable offenses.⁷⁰ The public charge statute has a history of being manipulated and stretched to reflect the political biases of the time, in effect unfairly targeting immigrants perceived undesirable by the government.

D. National Expansion of Public Benefits Versus Public Charge

As the nation began to develop a stronger welfare institution, anti-immigrant sentiment fueled fears of the welfare state being spread too thin to accommodate incoming noncitizens.⁷¹ Public charge policy was consequentially being developed both alongside and as a response to the growth of the welfare state. Beginning with the Social Security Act of 1935, federal and state governments began to administer large-scale welfare support through public benefit programs.⁷² This section first discusses the rise of federal welfare support for citizens and immigrants, beginning in the 1930s and continuing through the 1990s. Then it addresses the response from state welfare programs reacting to gaps left by the federal government following welfare reform and the development of public charge in the years following to ensure access to certain

⁶⁶ MAE NGAI, *IMPOSSIBLE SUBJECTS: ILLEGAL ALIENS AND THE MAKING OF MODERN AMERICA* 72 (2004).

⁶⁷ MOLONEY, *supra* note 50, at 88, 92.

⁶⁸ Mae Ngai, *The Strange Career of the Illegal Alien: Immigration Restriction and Deportation Policy in the United States, 1921–1965*, 21 *LAW & HIST. REV.* 69, 96 (2003). The deportation of Europeans and Canadians under public charge dropped from a high of nearly 2,000 in 1924 to fewer than 500 in 1932. *Id.*

⁶⁹ *Id.* at 94.

⁷⁰ *Id.* at 96.

⁷¹ See Act of Nov. 6, 1986, Pub. L. 99-603, 100 Stat. 3359; Makhlof, *supra* note 5, at 186.

⁷² See, e.g., Social Security Act of 1935, ch. 531 § 1, 49 Stat. 620; see also Makhlof, *supra* note 5, at 183 (describing welfare as “federal programs to provide need-based income support . . . to . . . the deserving poor”).

non-cash benefits to eligible immigrants. Finally, this section concludes by focusing on the crucial enactment of the Emergency Medical Treatment and Labor Act (EMTALA) as it implicates healthcare centers in the recent shift of public charge policy.

1. *Development of Federal Welfare Support*

As a result of the Great Depression, the federal government established the National Housing Act of 1934⁷³ and the U.S. Housing Act of 1937⁷⁴ to provide permanent, federally funded housing assistance.⁷⁵ From the 1960s to the 1970s, public benefit programs continued to expand significantly through the federal government, which established Medicaid, Medicare, food stamps, Head Start, job training programs, and child care for families receiving these welfare benefits⁷⁶ and generally did not differentiate between citizens and noncitizens at their conception.⁷⁷

At the same time, following the Immigration and Naturalization Act in 1965, the United States faced an increase in documented and undocumented immigration.⁷⁸ To reconcile these two expanding areas, Congress initially did not exclude lawfully present immigrants and refugees from utilizing public benefits.⁷⁹ The federal government scrutinized undocumented immigrants, however, and re-shaped the original public benefits programs from the 1960s to exclude the “unauthorized” community.⁸⁰ Similarly, in the 1970s, Congress limited access to federal public benefits, such as Supplemental Security Income (SSI),⁸¹ Medicaid, Aid to Families with Dependent Children (AFDC), food stamps, and federal unemployment insurance.⁸²

⁷³ National Housing Act of 1934, ch. 847 § 1, 48 Stat. 1246.

⁷⁴ U.S. Housing Act of 1937, ch. 896 § 1, 50 Stat. 888.

⁷⁵ See Peter M. Carrozzo, *A New Deal for the American Mortgage: The Home Owners' Loan Corporation, the National Housing Act and the Birth of the National Mortgage Market*, 17 U. MIAMI BUS. L. REV. 1, 24, 35–37 (2008).

⁷⁶ Makhoul, *supra* note 5, at 183.

⁷⁷ Eligibility for the programs were based on income rather than citizenship. *Id.* at 186.

⁷⁸ *U.S. Immigration Since 1965*, HISTORY, <https://www.history.com/topics/immigration/us-immigration-since-1965> (last updated June 7, 2019).

⁷⁹ Cybelle Fox, *Unauthorized Welfare: The Origins of Immigrant Status Restrictions in American Social Policy*, 102 J. AM. HIST. 1051, 1059 (2016).

⁸⁰ *Id.*

⁸¹ Social Security Amendments of 1972, Pub. L. No. 92-603, § 1614(a)(1)(B)(ii), 86 Stat. 1329, 1471.

⁸² Fox, *supra* note 79, at 1058–59 (“Between 1935 and 1971 no federal laws barred noncitizens, even unauthorized immigrants, from social security benefits, unemployment insurance, [Old Age Assistance], or ADC With the enactment of additional public assistance legislation—creating the food stamp program or Medicaid, for example—the same rules applied. Under federal law, both authorized and unauthorized immigrants were eligible for these programs on the same basis as citizens.”).

In the closing decades of the twentieth century, Congress's attitude toward lawfully present and documented immigrants turned sour, and it passed the Immigration Reform and Control Act of 1986, placing a "five-year bar" before new immigrants could access federal public benefits.⁸³ Ten years later, the federal government passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), welfare reform legislation that significantly altered immigrant access to federally funded public benefits.⁸⁴ The published incentive for this restriction was to "assure that aliens be self-reliant in accordance with national immigration policy" and reduce federal spending on public benefit programs.⁸⁵

The terms "qualified alien" and "non-qualified alien" were born at this time to distinguish between immigrants who would be barred from receiving federally funded public benefits for a period of five years from the time of qualification, from immigrants who would not be eligible to participate at all.⁸⁶ This five-year bar reflects the inadmissibility and deportation signposts established in early immigration law, giving immigrants five years to establish themselves before they could turn to federal assistance. At the time, certain benefit programs were unrestricted by immigration status, and federal courts rejected challenges to restrict immigrant access to these programs, such as K-12 education, on grounds of unconstitutional discrimination.⁸⁷ Services that were made available to persons within the United States regardless of immigration

⁸³ Immigration Reform and Control Act of 1986, Pub. L. 99-603, 100 Stat. 3359; Makhlof, *supra* note 5, at 187.

⁸⁴ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1612.

⁸⁵ H.R. REP. NO. 104-430, at 146 (1995) (Conf. Rep.), *as reprinted in* 1996 U.S.C.C.A.N. 2105, 2260 (describing the two main objectives of PRWORA as "to assure that aliens be self-reliant in accordance with national immigration policy . . . [and] to remove the incentive for illegal immigration provided by the availability of public benefits"). *See generally* Medha D. Makhlof, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235, 266 (2019) ("Controlling costs is a perennial goal of health care policy and reform efforts, and concerns about immigrants burdening the health care system have been the major rationale for restrictive policies. This argument is closely linked with the deterrence rationale, which is based on the idea that restrictive benefits laws act as a deterrent to foreigners who would come to the United States for the purpose of accessing such benefits, and discourage undocumented immigrants from staying in the United States long-term.").

⁸⁶ Makhlof, *supra* note 5, at 187–88 (citing PRWORA § 401(c)(1)(B), 110 Stat. at 2113 (codified in 42 U.S.C. § 601)) ("In general, non-qualified aliens are not eligible for federal programs that provide 'any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit.'"). Non-qualified individuals included temporary visitors, as well as undocumented immigrants. *See Non-citizens: Eligibility*, MACPAC, <https://www.macpac.gov/subtopic/noncitizens/> (last visited Sept. 3, 2020) ("Examples of non-qualified aliens include those who are unauthorized . . . as well as students and other nonimmigrants who are admitted for a temporary purpose."); *see also* PRWORA § 401(c)(1)(B), 110 Stat. 2105, 2261 (codified in 42 U.S.C. § 601).

⁸⁷ Plyer v. Doe, 457 U.S. 202, 230 (1982) (holding that to exclude undocumented immigrants from public schools is unconstitutional and would discriminate against and inevitably condemn an entire demographic).

status included emergency medical care, public health programs providing support for immunizations and treatment of communicable disease symptoms, school breakfast and lunch programs, K-12 public education, and short-term non-cash emergency disaster assistance.⁸⁸ Almost fifteen years after the welfare reform legislation that restricted access, the Affordable Care Act attempted to address the five-year bar on non-emergency public health insurance for lawfully present and qualified immigrants by allowing them to receive health insurance exchanges and subsidies; however, undocumented immigrants were still excluded from this benefit.⁸⁹

2. *The Two Paths of State Welfare Support*

States set down two divergent paths as a result of the federal welfare reform legislation in 1996. State attempts to deny legal immigrants access to state-funded public benefits generally did not survive court challenges because these laws violated the Equal Protection Clause.⁹⁰ The federal government, with its broad authority over immigration law, is within its power to determine when an immigrant may be eligible for federal programs, and states are mandated to conform under the Fourteenth Amendment.⁹¹ Any challenge or further restriction of an immigrant's right to access public programs is preempted by the federal government's control of immigration law, thus precluding states from acting on this subject.⁹²

However, some states set down a different path and began allocating state resources to provide a net to catch immigrants within the five-year bar or who are otherwise ineligible, such as undocumented travelers.⁹³ Currently, twenty-two states have programs that reflect the coverage of Temporary Assistance for Needy Families (TANF), which replaced AFDC, and aid those who were disqualified or deferred for five years as a result of PRWORA,⁹⁴ fifteen states authorize relief for indigent populations without any immigration status

⁸⁸ See *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. 51,114, 51,128, tbl.3 (listing programs that are exceptions from the definition of federal public benefit under PRWORA).

⁸⁹ HESTER ET AL., *supra* note 16, at 6.

⁹⁰ See, e.g., *Graham v. Richardson*, 403 U.S. 365, 376 (1971) (holding that limiting public assistance to immigrants integrated into the community over a long period of time is a violation of the Equal Protection Clause).

⁹¹ See *Mathews v. Diaz*, 426 U.S. 67, 77, 80–81, 84–85 (1976).

⁹² HESTER ET AL., *supra* note 16, at 7 (citing *De Canas v. Bica*, 424 U.S. 351 (1976); *LULAC I/II on Ca. Prop.* 187 (1994); *Ariz. Prop.* 200 (2004)).

⁹³ *Id.*

⁹⁴ *Id.* The twenty-two states with such coverage are California, Connecticut, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Minnesota, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, and Wisconsin. *Id.* at 11 n.33.

restrictions,⁹⁵ five states fund SSI replacement programs,⁹⁶ and some even go as far as to provide non-emergency medical care to undocumented immigrants.⁹⁷

3. *Development of Public Charge Following PRWORA*

Although Congress did not address public charge in PRWORA, the INS redefined public charge in 1999 to accommodate federal restrictions on immigrant access to public benefits and mean:

an alien who has become (for deportation purposes) or who is likely to become (for admission or adjustment purposes) ‘primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at [g]overnment expense.’⁹⁸

Therefore, to qualify for inadmissibility after applying for an adjustment of status, an applicant must have received SSI, cash assistance from TANF, state or local cash assistance programs for income maintenance, or Medicaid for long-term care in a nursing home or mental health institution.⁹⁹ This clarification was necessary as PRWORA had created confusion and fear in noncitizen communities, so much so that they began to avoid accessing medical care for the three years between 1996 and 1999 and may have jeopardized general public health as a result.¹⁰⁰ The purpose of the INS guidance was to “reduce the negative public health consequences” already in effect by ensuring that immigrants still eligible for health benefits would not have access to health care counted against them in their immigration applications.¹⁰¹ The redefinition did not include non-cash benefits because they “generally provide supplementary support in the form of vouchers or direct services to support nutrition, health,

⁹⁵ *Id.* at 7.

⁹⁶ *Id.* The five states that fund SSI replacement programs are California, Hawaii, Illinois, Maine, and New Hampshire. *Id.* at 11 n.34.

⁹⁷ *Id.* at 7, 11 n.36 (“Sixteen states and the District of Columbia use federal funds (CHIP) to provide prenatal care to women regardless of immigration status, under the CHIP option that allows states to enroll fetuses in CHIP. The District of Columbia and New York provide prenatal care to women regardless of immigration status, using local or state funds.”).

⁹⁸ Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676, 28,677 (proposed May 26, 1999) (codified at 8 C.F.R. pts. 212 and 237).

⁹⁹ *Id.* at 28,677–78.

¹⁰⁰ *Id.* at 28,676. Similarly, “the Urban Institute’s Well-Being and Basic Needs Survey (WBNS), fielded in December 2019 before the onset of the pandemic in the US, shows that many immigrant families went into the COVID-19 crisis afraid to access noncash public supports that might help them meet their family’s needs.” *Immigrant Families Hit Hard by the Pandemic May Be Afraid to Receive the Help They Need*, GCIR (June 5, 2020), <https://www.gcir.org/news/immigrant-families-hit-hard-pandemic-may-be-afraid-receive-help-they-need>.

¹⁰¹ Polly J. Price, *Immigration Policy and Public Health*, 16 IND. HEALTH L. REV. 235, 244 (2019).

and living condition needs” and do not reflect a complete dependence on the government.¹⁰² Such federally funded programs excluded from public charge consideration included Medicaid, use of health clinics, short-term rehabilitation services, prenatal care, emergency medical services, Children’s Health Insurance Program (CHIP), and Supplemental Nutrition Assistance Program (SNAP).¹⁰³ At the time, it was explicitly stated that these various non-cash benefits are, by nature, “supplemental and frequently support the general welfare.”¹⁰⁴ The restriction of these benefits would be punitive,¹⁰⁵ working to wring out all but the wealthiest and most able immigrants¹⁰⁶ and flying in the face of “our commitment to assist members of our communities,” which has been in the American system from the colonial era¹⁰⁷ and is engraved on the most paraded American landmark, the Statue of Liberty.¹⁰⁸

4. *Federal Enactment of EMTALA*

Congress enacted EMTALA in 1986,¹⁰⁹ before the passage of PWRORA. EMTALA is a crucial act that deeply alters the effect of public charge development on the healthcare industry.¹¹⁰ EMTALA’s impetus “undisputed[ly]” was a result of “highly publicized incidents” where patients were dumped from hospital emergency rooms based on the patient’s “financial inadequacy” to afford medical screenings and procedures that would otherwise be provided to a paying patient.¹¹¹ Although EMTALA does not fit cleanly into

¹⁰² Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676, 28,677–78 (proposed May 26, 1999) (codified at 8 C.F.R. pts. 212 and 237).

¹⁰³ See *id.* at 28,678–79. Other federally funded programs excluded from public charge consideration include housing benefits, child care services, energy assistance, foster care and adoption assistance, Head Start, job training programs, community-based programs like soup kitchens and crisis counseling, non-cash benefits under TANF including subsidized child care or transit subsidies, earned cash payments such as social security, government pensions and veterans’ benefits, and unemployment compensation. See *id.*

¹⁰⁴ *Id.* at 28,678.

¹⁰⁵ See Makhlouf, *supra* note 5, at 189.

¹⁰⁶ See Douglas C. Baynton, *Defectives in the Land: Disability and American Immigration Policy*, 24 J. AM. ETHNIC HIST. 31, 33 (2005).

¹⁰⁷ HESTER ET AL., *supra* note 16, at 1–2. *Contra* Prerna Lal, A History of Exclusion: U.S. Deportation Policy Since 1882, at 1 (Nov. 28, 2013) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2360963 (arguing “the gates to the American dream have not always been open to all”).

¹⁰⁸ See Lazarus, *supra* note 1.

¹⁰⁹ 42 U.S.C. § 1395dd (2011).

¹¹⁰ See BOSTON PLANNING & DEV. AGENCY, IMPACT OF PROPOSED FEDERAL IMMIGRATION RULE CHANGES ON BOSTON: PUBLIC CHARGE TEST FOR INADMISSIBILITY 8, n.d., <http://www.bostonplans.org/getattachment/e856c564-bf0f-47d4-9a44-75b430903f82>. See generally *Update on Access to Health Care for Immigrants and Their Families*, NAT’L IMMIGR. L. CTR., <https://www.nilc.org/issues/health-care/update-on-access-to-health-care-for-immigrants-and-their-families/> (last updated May 27, 2020).

¹¹¹ See *Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 268 (6th Cir. 1990).

a retrospective summary of public charge policy, its passage implicates healthcare centers in public charge discussions more than ever. The availability of emergency medical care to the poor and uninsured was a core concern of Congress when it enacted EMTALA,¹¹² although its protections are not limited to those with “insufficient resources.”¹¹³ EMTALA “imposes two primary obligations” on hospitals that receive federal Medicare funding: (1) to appropriately examine individuals that enter emergency rooms for medical treatment to determine if there is an emergency medical condition; and (2) to “stabilize” the patient’s condition prior to transfer or discharge in the event of a medical emergency.¹¹⁴ Congress aimed to “get patients into the system” who may not be treated otherwise¹¹⁵ and, in effect, created an unfunded mandate that shifted costs of emergency healthcare access to hospitals and states that fund public hospitals.¹¹⁶ Fifty-five percent of emergency care is left uncompensated, placing a “severe” financial burden on hospitals complying with EMTALA.¹¹⁷ It is evident that “at minimum,” Congress intended for all patients to be welcomed into emergency departments and cared for fairly, without being “simply . . . turned away.”¹¹⁸ The juxtaposition between the treatment of patients when they arrive at an emergency department in the United States and the new treatment of noncitizens when they attempt to access public health programs is stark and discouraging. At minimum, this Comment calls on Congress to ensure the cost burden on hospitals and local governments is not exacerbated by a manipulation of public charge policy to exclude noncitizens from accessing public health programs.

II. THE 2019 PUBLIC CHARGE POLICY

The 2019 public charge policy dramatically expands grounds for inadmissibility to immigrants and now includes accessing federally funded healthcare for which noncitizen populations are otherwise eligible, specifically Medicaid.¹¹⁹ Although the 2019 policy was temporarily halted in multiple federal district courts, the injunctions of the rule were not permanent, and the immigrant “wealth test” reared its head again after the executive branch had filed

¹¹² See *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991).

¹¹³ See *Arrington v. Wong*, 237 F.3d 1066, 1070 (9th Cir. 2001).

¹¹⁴ *Hardy v. New York City Health & Hosp. Corp.*, 164 F.3d 789, 792 (2d Cir. 1999).

¹¹⁵ *Id.* at 793.

¹¹⁶ Edward Monico, *Is EMTALA That Bad?*, 12 *AMA J. ETHICS* 471, 471–73 (2010).

¹¹⁷ See *id.* at 473.

¹¹⁸ See *Reynolds v. Mainegeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000).

¹¹⁹ Inadmissibility on Public Charge Grounds, 84 *Fed. Reg.* 41,292, 41,295–96 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212–14, 245, 248).

an emergency petition with the Supreme Court.¹²⁰ In a 5 to 4 decision, the Supreme Court stayed the nationwide injunction granted in a New York district court in October 2019.¹²¹ DHS implemented the rule for five months, beginning on February 24, 2020, before it was again halted by a district court judge stating, “the government’s interest fails to measure up to the gravity of this global pandemic that continues to threaten the lives and economic well-being of America’s residents.”¹²² The 2019 rule is an apt example of how easily the public charge policy can be mangled and misused, turning the colonial establishment of “poor laws” into the implementation of a stricter “wealth test” on noncitizens than has ever existed before, and the danger that can and will arise if it goes unaddressed by Congress.¹²³ Part II of this Comment highlights the central leaps the 2019 rule makes, the growing public health concerns rooted in the changing policy, and the major consequences immigrant families have experienced as a result of its proposal and implementation.

A. *Expansion of Inadmissibility Under Public Charge in 2019*

The 2019 policy unravels the meaning of “public charge” from a person becoming primarily dependent on the government, as it has long been understood and accepted, to a quantifiable and burdensome definition of “an alien who receives one or more public benefits.”¹²⁴ The public benefits considered for public charge had previously always been cash benefits or long-term institutionalization; now, DHS, previously INS, aims to include non-cash benefit programs that are vital to supporting low-income households.¹²⁵

Of the various federally funded benefits that were previously deemed essential to the public welfare and did not include restrictions based on immigration status, four subsections are now included as grounds for inadmissibility, as well as denial of an adjustment of status for lawful permanent residents.¹²⁶ The rule change will include use of non-emergency Medicaid,

¹²⁰ Barnes & Sacchetti, *supra* note 12.

¹²¹ Dep’t of Homeland Sec. v. New York, 140 S.Ct. 599 (2020). See *Statement from the Press Secretary*, WHITE HOUSE (Oct. 11, 2019), <https://www.whitehouse.gov/briefings-statements/statement-press-secretary-87/>.

¹²² Chris Dolmetsch, *Trump’s Green Card Wealth Test Rule Blocked During Pandemic*, BLOOMBERG LAW (July 30, 2020, 12:57 PM), https://news.bloomberglaw.com/us-law-week/trumps-green-card-wealth-test-rule-blocked-during-pandemic?context=search&index=4_.

¹²³ Hirsi, *supra* note 16; see also Barnes & Sacchetti, *supra* note 12 (publicizing the phrase “wealth test” to describe the public charge rule).

¹²⁴ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,157–58 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

¹²⁵ Makhoul, *supra* note 5, at 197–98.

¹²⁶ See *Trump’s Statement on the 2019 Rule Change*, *supra* note 41.

SNAP, Medicare Part D (low-income subsidy), and housing assistance such as public housing, housing vouchers, and rental assistance.¹²⁷ The rule also expands the totality of circumstances test to include specific “negatively weighed” factors when assessing a noncitizen’s age, health, skills, work experience, and dependents, such as earning under 125% of the federal poverty line, certain health conditions if the applicant does not have access to private health insurance, credit history, education, and proficiency of the English language.¹²⁸ To balance the negatively weighed factors, the 2019 rule proposed a single “heavily weighed positive” factor of having an income over 250% of the federal poverty line.¹²⁹ Consequently, even if a person does not use any of the enumerated federal and state benefits, they could still be deemed ‘likely to become a public charge.’¹³⁰

In addition to the inclusion of these public benefit programs, DHS has also expanded inadmissibility by including guidelines for the totality of the circumstances test. DHS has specified that enrollment in any public benefit program within the past thirty-six months from the date of application or a noncitizen’s lack of private health insurance will be regarded as a “heavily weighed negative factor” in considering the totality of the circumstances.¹³¹ Without the “financial resources to pay for reasonably foreseeable medical costs,” the federal government argues the individual is at a higher risk of becoming a public charge; in the policy, this factor is only required for individuals who have reported a medical condition that would require extensive medical treatment.¹³²

However, the executive branch released a proclamation to take effect less than three weeks from the enactment of the new public charge rule that significantly broadens the restriction on noncitizens seeking to enter the United States.¹³³ According to the proclamation, any individual seeking to enter the

¹²⁷ See *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. 51,114, 51,159–60 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

¹²⁸ *Id.* at 51,291–92.

¹²⁹ *Id.* at 51,292. The final 2019 rule lists three “heavily weighted positive factors,” adding consideration of whether an immigrant has private health insurance or is employed in the legal field and accruing an income exceeding 250% of the federal poverty level. *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292, 41,504 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

¹³⁰ See *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. at 41,502.

¹³¹ See *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. at 51,199–200; *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. at 41,504 (Aug. 14, 2019).

¹³² See *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. at 51,200.

¹³³ Donald J. Trump, *Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System*, WHITE HOUSE (Oct. 4, 2019), <https://www.whitehouse.gov/presidential-actions/presidential-proclamation-suspension-entry-immigrants-will-financially->

country has to provide proof of health insurance to take effect within thirty days of their entry into the United States.¹³⁴ If this proclamation stands alongside the new public charge policy, all noncitizens seeking to enter the United States after November 2019 will face a much higher hurdle than noncitizens already present within the United States and seeking to adjust their status.¹³⁵ DHS's change of public charge policy and the recent executive proclamation requiring health insurance reflect the federal administration's interest in overhauling immigration policy on the whole and moving to a "merit-based" system that favors wealthy immigrants and excludes noncitizens, even if they are not completely dependent on the government for support.¹³⁶

B. Growing Public Health Concerns from Growing Public Charge Policy

Since before the welfare reform legislation of 1996, public health concerns have guided the development of immigration and public charge policy. The World Health Organization describes social detriments of health (SDH) as economic and political "systems shaping the conditions of daily life" that impact birth, growth, work, life, and aging.¹³⁷ SDH impact "individual and population health"¹³⁸ in complex ways, and legal scholars have long established the public health concerns arising from shifting immigration policy over the decades.¹³⁹ Around the time Congress passed welfare reform in 1996, it also considered eliminating access to public healthcare services¹⁴⁰ and was met with significant objections on the basis that (1) noncitizens accounted for a small fraction of the beneficiaries of the services, and (2) restricting access to preventive healthcare would increase the cost of emergency medical care that would remain unrestricted.¹⁴¹ Under the new rule, DHS acknowledges and lists the harms that

burden-united-states-healthcare-system/.

¹³⁴ *Id.* The proclamation would not affect noncitizens already in the United States, and, in lieu of acquiring health insurance, a noncitizen can demonstrate that they have the financial means to cover medical costs. *Id.*

¹³⁵ *Id.*

¹³⁶ See Makhlof, *supra* note 5, at 197. So far, Congress has not implemented any drastic immigration change that reflects the temperament of the executive. *Id.*

¹³⁷ *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/social_determinants/en/ (last visited Sept. 3, 2020).

¹³⁸ Makhlof, *supra* note 5, at 189–90.

¹³⁹ See generally Price, *supra* note 101, at 245 (stating that public charge doctrine "could lead to . . . increased prevalence of communicable diseases, including among members of the U.S. citizen population") (citations omitted).

¹⁴⁰ See, e.g., S. 1664, 104th Cong. (1996) ("A BILL To . . . reduce the use of welfare by aliens[.]"); H.R. 999, 104th Cong. (1995) ("A BILL To . . . restrict alien eligibility for certain education, training, and other programs[.]"); H.R. 341, 104th Cong. (1995) ("A BILL To prohibit direct Federal financial benefits and unemployment benefits for illegal aliens.").

¹⁴¹ See generally Karen M. Longacher, *Losing the Forest for the Trees: How Current Immigration*

will inevitably be caused to individuals, families, and communities that are no longer free to access previously excluded public benefits, such as Medicaid. The 2019 policy indicates that

[d]isenrollment or foregoing enrollment in public benefits programs by aliens . . . could lead to:

- Worse health outcomes, including increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children, and reduced prescription adherence;
- Increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment;
- Increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated;
- Increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient; and
- Increased rates of poverty and housing instability; and
- Reduced productivity and educational attainment.¹⁴²

Within this language, DHS admits to two distinct concerns present in the objection to changing public charge policy since the late 1990s: (1) the resulting increased use and cost of emergency medical care and (2) an increase in communicable diseases within the entire population.¹⁴³

The 2019 public charge policy breaks from the historical development of public charge that was molded by concerns for public health, and although it explicitly names the harm that implementation will cause, it shirks all responsibility. Without access to programs such as Medicaid, noncitizen populations are predicted to react similarly to the welfare reform in 1996, when the common misunderstanding was that public health services were being restricted in the way DHS purports to be acting—the confusion and fear led to “significant, negative public health consequences across the country.”¹⁴⁴ The restriction of access to public benefits that were previously accepted and defined as “non-cash benefits [that] do not demonstrate primary dependence [on the government for assistance]”¹⁴⁵ is punitive, essentially punishing low-income

Proposals Overlook Crucial Issues, 11 TEMP. INT’L & COMP. L.J. 429, 443–44 (1997).

¹⁴² Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,270 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

¹⁴³ *Id.*

¹⁴⁴ Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676 (May 26, 1999) (codified at 8 C.F.R. pts. 212 and 237); see Price, *supra* note 101, at 244.

¹⁴⁵ Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. at 28,678.

immigrants for their low-income status when they cannot afford private health insurance.

For noncitizens already within the United States, the anticipated negative health consequences are clear and immediate, on themselves and on the general public.¹⁴⁶ In the 2019 rule, inadmissibility considerations for an adjustment of status from a temporary visitor to a legal permanent resident would consider the past thirty-six months that a noncitizen resided within the country, which public benefits the person accessed, and how often they accessed those benefits.¹⁴⁷ Noncitizens who were previously eligible to adjust their status would fail the inadmissibility “totality of circumstances” test,¹⁴⁸ and out of fear would wait another thirty-six months, now restricted from access to public benefits they previously leaned on.¹⁴⁹ The 2019 rule impacts the health and safety of the general American public who will be affected by the extreme choices noncitizens are having to make over the course of three or more years to qualify for permanent resident status within the United States.¹⁵⁰ Economic and political policies, such as restricting public benefits through public charge considerations, not only change the course of a noncitizen’s life, but also significantly impact the community overall.¹⁵¹

Although DHS issued the final rule in mid-August 2019, various studies by scholars and advocates were used as expert declarations in the lawsuits to halt the rule from taking effect. An estimate proposed that as many as 3.2 million fewer immigrants may not receive Medicaid because of the “chilling effect” of the 2019 rule; the resulting “loss of Medicaid coverage” could lead to as many as 4,000 excess deaths every year.¹⁵² An economist estimated that 1.8 million

¹⁴⁶ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. at 51,270.

¹⁴⁷ *Id.* at 51,199–51,200; see *Trump’s Statement on the 2019 Rule Change*, *supra* note 41.

¹⁴⁸ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. at 51,198–51,203.

¹⁴⁹ *Id.* at 51,270.

¹⁵⁰ See Makhlouf, *supra* note 5, at 208–09.

¹⁵¹ See *id.*

¹⁵² Leighton Ku, *New Evidence Demonstrates That the Public Charge Rule Will Harm Immigrant Families and Others*, HEALTH AFFS. (Oct. 9, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191008.70483/full/> (noting that the majority of the immigrants that will be affected are Latinx or Asian, and many have serious health problems such as diabetes, heart disease, or cancer). In the midst of global endeavors to combat COVID-19, state and local governments argue that the public charge limitations “imped[e] efforts to stop the spread of the coronavirus, preserve scarce hospital capacity and medical supplies, and protect the lives of everyone in our communities—citizens and noncitizens alike.” Motion by Government Plaintiffs at 14, Dep’t of Homeland Sec. v. New York, No. 19A785 (U.S. Apr. 13, 2020). The grave implications of disincentivizing immigrants from accessing healthcare services, including testing and treatment, during a public health crisis are clear: immigrants will be more likely to contract a “serious illness if infected and spread the virus inadvertently to others—risks that are heightened because immigrants make up a large proportion of the essential workers who continue to interact with the public.” *Id.* at 2.

fewer people would use SNAP benefits, even though many of them may be citizens.¹⁵³ Housing experts noted that a loss of housing security from the withholding of federal housing benefits would likely lead to worse health outcomes, emphasizing that even indirect changes in the 2019 rule are a clear detriment to public health.¹⁵⁴ Over sixty public health and policy scholars, chairs, and faculty, alongside the American Public Health Association and the American Academy of Nursing, joined an amicus brief in *La Clinica de la Raza v. Trump* describing how the 2019 public charge rule “threatens public health on a national scale.”¹⁵⁵ DHS acknowledges the noted concerns, the threat to public health, and the effect on SDH in its final proposal, further highlighting the risk the Trump Administration consciously undertook by steering public charge policy down a dangerous path.¹⁵⁶

C. Damaging Effects of the 2019 Proposal and Upcoming Implementation

Even though the proposed rule was just that—a proposal—for five months after the delay in implementation, immigrant communities that fear retaliation became wary of crackdowns on eligibility.¹⁵⁷ In the confusion caused by the proposed rule change, similarly to the confusion created after the passage of PRWORA,¹⁵⁸ many noncitizens stopped utilizing public benefits they are legally allowed to access before the rule even went into effect.¹⁵⁹ CASA, an

¹⁵³ Ku, *supra* note 152 (discussing how reduction in SNAP benefits would reduce food assistance payments by \$2 billion per year, and noting how this would also lower economic activity in the United States by \$3.2 billion annually). Ninez Ponce and Laurel Lucia estimated that the loss of federal Medicaid and SNAP benefits could “reduce economic output in California by as much as \$2.8 billion, leading to a loss of 17,700 jobs.” *Id.* Using a similar approach, an amicus brief submitted by the Fiscal Policy Institute and the Presidents’ Alliance on Higher Education and Immigration included estimates indicating that “the public charge rule could lead to \$14 to \$24 billion in economic output lost across the United States, also leading to substantial job losses.” *Id.*

¹⁵⁴ *Id.* The loss of housing benefits would also lead to “lower education attainment, and would lower lifetime earnings for certain individuals.” *Id.* The housing expert also noted that “harmful effects of the public charge rule could be exacerbated by a rule proposed by the Department of Housing and Urban Development that would keep ‘mixed status’ families from living together in public housing by barring non-citizen members.” *Id.* The attack on immigrant families and public health is brought from all directions, and it is a concerted, strategic effort to scare the most marginalized members of society from seeking stability within the United States. *Id.*

¹⁵⁵ See Brief of Amici Curiae Public Health at 1, *La Clinica de la Raza v. Trump*, No. 4:19-cv-04980-PJH (N.D. Cal. Oct. 11, 2019) (capitalization altered).

¹⁵⁶ See Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,408–09 (Aug. 14, 2019) (to be codified at C.F.R. pts. 103, 212, 213, 214, 245, and 248).

¹⁵⁷ Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676 (May 26, 1999) (codified at 8 C.F.R. pts. 121 and 237).

¹⁵⁸ See *id.*

¹⁵⁹ *New Lawsuit Argues Trump Administration’s “Public Charge” Rule Is Unconstitutionally Vague*, CASA (Sept. 16, 2019), <https://wearecasa.org/updates/new-lawsuit-argues-trump-administrations-public-charge-rule-is-unconstitutionally-vague/>.

organization with over 100,000 members in the mid-Atlantic region, is challenging the 2019 rule in Maryland on behalf of low-wage immigrants that it claims are unconstitutionally discriminated against.¹⁶⁰ CASA claimed to be “already experiencing the negative effects” of the new rule in September 2019, one month before any change was to take effect.¹⁶¹ Their members “stopped accepting or refused to apply for public benefits for themselves and their family members, including their children, because of fear that receiving any benefits will harm their ability to stay in the United States.”¹⁶² This experience was shared among immigrant communities across the nation.

For noncitizens within the country, any threat to their status or their ability to adjust their legal permanent resident status to obtain a green card manifests in a risk to be torn away from their families and children within the United States. Nearly 550,000 people apply for green cards every year, and of those, 380,000 are noncitizens already legally present within the United States who are attempting to change their status and are afraid of the risks posed by the proposal, and now the implementation, of the 2019 policy.¹⁶³ According to a comprehensive survey conducted by the Urban Institute, one in seven adults in immigrant families (13.7%) reported that they, or a family member, did not participate in non-cash government benefit programs for which they were eligible in 2018 for fear of risking a future green card.¹⁶⁴ In low-income families, 20.7% of adult immigrants reported their limitation of public benefits.¹⁶⁵

DHS leaked the proposed rule change in 2018 and only finalized it in August of 2019; yet, these communities suffered from the confusion and “chilling effects” caused by the federal government in seeking this rule change.¹⁶⁶ Even when the nationwide injunction was in effect, immigrant families were not able to breathe easily; now as lower courts consider the issue and the policy is on temporary hold pending the resolution of the COVID-19 pandemic, fear

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See Sarah Holder, *How Rule Changes About Public Benefits Could Affect Immigrants*, CITYLAB (Aug. 13, 2019, 5:09 PM), <https://www.citylab.com/equity/2019/08/public-charge-rule-legal-immigration-welfare-services-dhs/595987/>.

¹⁶⁴ Hamutal Bernstein, Dulce Gonzalez, Michael Karpman & Stephen Zuckerman, *One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, URB. INST. (May 22, 2019), <https://www.urban.org/research/publication/one-seven-adults-immigrant-families-reported-avoiding-public-benefit-programs-2018>. This evidence is the first instance of the systemic chilling effects resulting from the proposed rule among immigrant families. *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *The Public Charge Rule, Explained*, *supra* note 32.

continues to grip immigrant communities.¹⁶⁷ Of all the restrictive regulations proposed by the Trump Administration, this rule would have the “deepest, widest and most long term impact.”¹⁶⁸ The 2019 rule will “linger as a sword hanging over the heads of immigrant families and the communities in which they live, continuing to engender fear” as they struggle to achieve success and stability for their families as new members of American society.¹⁶⁹

III. THE POLITICAL AND FINANCIAL STRINGS ATTACHED TO PUBLIC CHARGE POLICY

The development of public charge policy has been weaponized by the federal government as a political tactic to force noncitizens to live in fear of fickle policy swaying to include public health programs at the whim of the executive branch. The cost of penalizing noncitizens from accessing public health programs they are entitled to is a cumulative result of cascading dominos—beginning with the rise in emergency care costs under EMTALA and indirectly leading to increased burdens on the healthcare industry, state and local governments, and effectively the taxpayer. This Part addresses the political strings attached to public charge policy and the subtle, yet powerful, threats, and costs posed by the implementation of the 2019 rule on states and the healthcare industry.

A. *Political Weaponization of Public Charge*

The 2019 rule unfairly targets noncitizens in the United States as sources of public charge. If the citizenship eligibility requirements from the 2019 rule were placed on people born within the United States, “nearly half of them would be deemed inadmissible on the grounds of becoming a public charge.”¹⁷⁰ Between 41% and 48% of native-born U.S. citizens use SNAP, TANF, SSI, housing assistance, or Medicaid, and these statistics have been consistent from 1997, after the passage of PRORWA, to 2017, before the leak of the proposed rule.¹⁷¹ For Medicaid, noncitizens only comprise 6.5% of enrolled patients, whereas

¹⁶⁷ See Wendy E. Parmet, *Five Victories for Public Health: Courts Enjoin the Public Charge Rule*, HEALTH AFFS. (Oct. 18, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191018.747447/full/>.

¹⁶⁸ Geneva Sands, *13 States Sue over Legal Immigration ‘Public Charge’ Rule*, CNN (Aug. 15, 2019, 1:11 PM), <https://www.cnn.com/2019/08/15/politics/13-states-sue-public-charge-immigration/index.html> (citations omitted).

¹⁶⁹ Ku, *supra* note 152.

¹⁷⁰ *Id.* (citing Decl. of Danilo Trisi at 3, *La Clinica de la Raza v. Trump*, No. 4:19-cv-04980-PJH (N.D. Cal. Oct. 11, 2019)).

¹⁷¹ *Id.* (citing Decl. of Danilo Trisi at 3, *La Clinica de la Raza v. Trump*, No. 4:19-cv-04980-PJH (N.D. Cal. Oct. 11, 2019)).

over 87% are patients born within the United States.¹⁷² The focus on noncitizens as public charge is simply one of the myriad ways the Trump Administration has targeted immigrants and their families, weaponizing the federal government against the people looking to the Statue of Liberty as a beacon of welcome and hope. United States Citizenship and Immigration Services Acting Director Ken Cuccinelli, a defendant in the litigation brought against the federal government for this 2019 rule, tweaked the famous poem at the base of the Statue of Liberty and commented, “Give me your tired and your poor who can stand on their own two feet and who will not become a public charge.”¹⁷³ Of the approximately 544,000 noncitizens applying for a green card every year, 382,000 are in categories that would be affected by the application of the 2019 rule.¹⁷⁴ The contrasting standards for access to public benefits for citizens and noncitizens exist in many countries,¹⁷⁵ and although most noncitizens remain ineligible for public benefits of any kind in the United States, the inclusion of non-cash benefits such as Medicaid for short-term care is an excessive restriction the executive branch implemented in 2020 for immigrants who are otherwise eligible.

Scholars have noted that this is not the first time the conflation of immigration and healthcare policies have been used to create unfounded fear of immigrants as a danger.¹⁷⁶ In an attempt to whip support for a southern border

¹⁷² Hajela, *supra* note 8 (“For food assistance, immigrants are 8.8 percent of recipients, with over 85 percent of participants being native-born.”).

¹⁷³ Alvarez et al., *supra* note 9.

¹⁷⁴ Hajela, *supra* note 8.

¹⁷⁵ See generally Wendy E. Parmet, *Symposium: The Worst of Health: Law and Policy at the Intersection of Health & Immigration*, 16 *IND. HEALTH L. REV.* 211, 231–32 (2019) (explaining why immigrants are “easy scapegoats” and “exclusionist immigration policy” is utilized to draw lines between citizens and noncitizens in the United States, Canada, and the United Kingdom).

¹⁷⁶ *Id.* at 213. On April 20, 2020, President Trump tweeted that the administration would be halting “most legal immigration to the United States in the wake of the COVID-19 epidemic,” following the limitation of coronavirus relief checks from many immigrants. Brian Bennett, *President Trump Has Blocked New Legal Immigrants. Here’s Where Else He’s Clamped Down on Immigration During the Coronavirus Outbreak*, *TIME* (Apr. 21, 2020, 10:13 PM), <https://time.com/5825141/president-trump-immigration-coronavirus/>. Seasonal workers are exempt from the halt to immigration, but over 10,000 migrants who crossed the border were removed from the country without being screened for asylum requests. *Id.* The Army Corps of Engineers are not being mobilized to combat coronavirus; instead, they are continuing to work with Customs and Border Patrol (CBP) to build a 450-mile border wall by the end of 2020. *Id.* Acting CBP Commissioner Mark Morgan claims that in light of COVID-19, “[n]ow more than ever, borders matter, border security matters, the wall matters,” manipulating fear of the pandemic to push the Trump Administration’s immigration agenda. *Id.*; see also Terence M. Garrett, *COVID-19, Wall Building, and the Effects on Migrant Protection Protocols by the Trump Administration: The Spectacle of the Worsening Human Rights Disaster on the Mexico-U.S. Border*, *ADMIN. THEORY & PRACTICE* (Apr. 9, 2020), <https://www.tandfonline.com/doi/full/10.1080/10841806.2020.1750212> (“While the Trump administration is not the first to implement anti-migrant policies, it is highly aggressive toward migrants and asylum seekers.”).

wall, President Trump claimed, “people with tremendous medical difficulty and medical problems are pouring in, and in many cases it’s contagious.”¹⁷⁷ This Administration is simultaneously (and inaccurately) claiming that people in need of medical support to contain contagious diseases are entering the country while also limiting immigrants’ access to healthcare, thereby furthering any perceived threat to public health.¹⁷⁸

The guise of furthering communicable disease control has been used to expand immigration control since the first immigration laws, and the Immigration and Naturalization Act allows the executive branch sole discretion to determine the list of communicable diseases that could be used to exclude immigrants.¹⁷⁹ HIV-positive noncitizens were barred from visiting or immigrating to the United States long after the disease was already endemic in the country.¹⁸⁰ When Congress acted in the 1990s, its focus was to exclude HIV-positive Haitian refugees from the United States; at this point, excluding immigrants with HIV would do nothing to prevent the spread of AIDS in the country, and health officials had already issued warnings that any discrimination and stigmatization of the disease would obstruct prevention efforts.¹⁸¹ HIV was further misunderstood and the public health suffered greatly from the association of the disease and its medical consequences as exclusive to specific groups of people by singling out Haitian refugees.¹⁸² Similarly, public health is not protected by excluding noncitizens on the basis of their potential use of Medicaid; however, it is further put in danger when people within the United States are restricted from accessing public benefits they are legally allowed to utilize.

Anti-immigrant sentiment has influenced policy regarding access to health programs for some time and on various levels. A campaign in California in 1994 described immigrants as a drain on the state’s healthcare system, and the state passed Proposition 187 to bar undocumented immigrants from accessing public health benefits by requiring healthcare workers to report anyone they suspected

¹⁷⁷ Philip Bump, *Trump’s Arguments for Necessity of Border Wall Have Already Been Broadly Debunked*, WASH. POST (Dec. 11, 2018), https://www.washingtonpost.com/politics/2018/12/11/trumps-arguments-necessity-border-wall-have-already-been-broadly-debunked/?utm_term=.6b440e812164/.

¹⁷⁸ *Id.*; see also Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,270 (Oct. 10, 2018) (to be codified at 8 C.F.R. at pts. 103, 212, 213, 214, 245 and 248) (noting “[i]ncreased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated”).

¹⁷⁹ Immigration and Nationality Act, 8 U.S.C. § 1182(a)(1)(A)(i) (2016).

¹⁸⁰ Parmet, *supra* note 175, at 216.

¹⁸¹ *Id.*

¹⁸² See PRESIDENTIAL COMM’N ON HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 128 (1988).

of being undocumented.¹⁸³ This sentiment traveled up to the federal government and garnered support for the passage of PRWORA in 1996.¹⁸⁴ When confronted by the financial crisis of 2008, many states first cut their inclusion of immigrants in public health benefits that were designed to supplement the hole created by PRWORA.¹⁸⁵ In the debates leading up to the passage of the Affordable Care Act in 2009, the rumor that the health benefits would cover undocumented immigrants as well as documented immigrants and citizens was a main point of contention.¹⁸⁶ The opposition to the inclusion of immigrants in a federally funded healthcare program prioritized the denial of healthcare to immigrants over ensuring that citizens were given access to healthcare through the Affordable Care Act.¹⁸⁷

The United States is not alone in its nationalist agenda: in Europe, immigrants are also blamed for diseases, and Brexit supporters believe that immigrants caused a decline in the quality of publicly funded health programs.¹⁸⁸ The former Polish Prime Minister spouted accusations of migrants similar to that of the United States' leadership, claiming migrants brought diseases to Europe that were "very dangerous" and "long absent" from the continent.¹⁸⁹ As migration has increased, European nations have also cut back on programs that cover immigrants.¹⁹⁰ The United States and some European nations have not established universal health care programs,¹⁹¹ and, as a result, it is difficult to argue for the allocation of public money to provide public health benefits to noncitizens before the benefits are guaranteed for their own citizens.¹⁹² The

¹⁸³ Parmet, *supra* note 175, at 216 (citing *CA's Anti-Immigrant Proposition 187 Is Voided, Ending State's Five-Year Battle with ACLU, Rights Groups*, ACLU (July 29, 1999), <https://www.aclu.org/press-releases/cas-anti-immigrant-proposition-187-voided-ending-states-five-year-battle-aclu-rights>). However, Proposition 187 was quickly enjoined by the courts and never went into effect. *Id.*

¹⁸⁴ *Id.* at 216–17.

¹⁸⁵ See, e.g., *Hong Pham v. Starkowski*, 16 A.3d 635, 637 (Conn. 2011). Massachusetts was one state that adopted a version of universal healthcare in 2006, which excluded legally present immigrants from what was the state's predecessor to the Affordable Care Act. Parmet, *supra* note 175, at 217.

¹⁸⁶ Parmet, *supra* note 175, at 217.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*; see *Public Wrong on Key Facts Around Brexit and Impact of EU Membership*, KING'S COLL. LONDON (Oct. 28, 2018), <https://www.kcl.ac.uk/news/public-wrong-on-key-facts-around-brexit-and-impact-of-eu-membership>.

¹⁸⁹ Jan Cienki, *Migrants Carry 'Parasites and Protozoa,' Warns Polish Opposition Leader*, POLITICO (Oct. 14, 2015, 6:21 PM), <https://www.politico.eu/article/migrants-asylum-poland-kaczynski-election/>.

¹⁹⁰ Parmet, *supra* note 175, at 218; see, e.g., Abby Young-Powell, *Austria Plans to Cut Benefits for Non-German Speaking Immigrants*, TELEGRAPH (May 29, 2018, 5:48 PM), <https://www.telegraph.co.uk/news/2018/05/29/austria-plans-cut-benefits-non-german-speaking-immigrants/>.

¹⁹¹ Parmet, *supra* note 175, at 218.

¹⁹² Price, *supra* note 36, at 918 (noting that sovereign countries prefer an "ideal class" of physically and mentally fit immigrants and exclude disabled persons, justified by the "nation's prerogative to choose its

global reach of anti-immigration sentiment does not, however, justify restricting immigrants who qualify for federal programs from accessing healthcare; it merely reflects the consequences of federal agencies conflating immigration policy with healthcare policy without proper oversight or congressional input. Allowing immigration officials to use their discretion regarding the perceived health status of a noncitizen in determining their qualifications for citizenship is incredibly dangerous, and although this issue expands beyond public charge policy, the 2019 rule will be misused as an instrument for racial and ethnic bias in immigration proceedings.

Under the most recent weaponization of public charge against “undesirable” immigrants, the disparate impact would be felt most strongly by people of color, pressuring as many as 18.3 million Latinx noncitizens and their family members from disenrolling or foregoing use of public benefit programs, including Medicaid; this number encompasses roughly 70% of the total noncitizen families at risk.¹⁹³ Additionally, DHS arbitrarily placed the income threshold for inclusion in public charge at 250% of the federal poverty line, “blocking 71% [of] applicants from Mexico and Central America, 69% from Africa, and 52% from Asia—but only 36% from Europe, Canada, and Oceania.”¹⁹⁴ The 2019 rule also listed English proficiency as a factor, emphasizing its disparate impact.¹⁹⁵ Six of the top seven countries with the highest rates of English proficiency are in Europe, whereas none are in Latin America or Africa; twenty-three of the twenty-four countries with the lowest rates of English proficiency, however, are in Latin America, Africa, and the Middle East.¹⁹⁶

Public charge is being changed and directed at immigrants that do not meet the Trump Administration’s expectation of wealth and stability and who are

membership”).

¹⁹³ Elizabeth G. Taylor, *National Health Law Program Comments Filed on Proposed Public Charge Rule Change*, NAT’L HEALTH L. PROGRAM, <https://healthlaw.org/resource/national-health-law-program-comments-filed-on-proposed-public-charge-rule/> (last visited June 29, 2020); see also *Public Charge Proposed Rule: Potentially Chilled Population Data*, MANATT (Oct. 11, 2018), <https://www.manatt.com/insights/articles/2018/public-charge-rule-potentially-chilled-population>.

¹⁹⁴ *Looming Immigration Directive Could Separate Nearly 200,000 Married Couples Each Year*, BOUNDLESS (Sept. 24, 2018), <https://www.boundless.com/blog/looming-immigration-directive-separate-nearly-200000-married-couples/>. There are additional ways in which the public charge rule will discriminate between noncitizens. *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191, 1202 (E.D. Wash. 2019); see Jynnah Radford, *Key Findings About U.S. Immigrants*, PEW RSCH. CTR. (June 17, 2019), <https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants/> (“54% [of immigrants from Mexico] and 46% [of immigrants from Central America] . . . do not have a high school diploma, vs. 9% of U.S. born.”).

¹⁹⁵ *Public Charge*, IMMIGRANT LEGAL RES. CTR., <https://www.ilrc.org/public-charge> (last visited June 7, 2020) (“The rules allow immigration officers to consider English proficiency (positive) or lack of English proficiency (negative)[.]”).

¹⁹⁶ EDUC. FIRST, EF ENGLISH PROFICIENCY INDEX 6–7 (2018).

unable to pay the “cover charge” to enter the country.¹⁹⁷ The 2019 iteration of public charge is being called a “racist wealth test” because it targets immigrants from majority non-white countries and immigrants who do not have the wealth to acquire private health insurance.¹⁹⁸ The same immigrants who will struggle to meet the parameters of the new public charge rule are also targets of SDH, including racism, and already face barriers to health equity.¹⁹⁹ Healthcare facilities serving marginalized communities, such as people of color and people living in poverty, are often under-resourced and under-staffed.²⁰⁰ Immigrants in these communities already face inequities in access to and quality of healthcare and are victims of racial and ethnic health disparities.²⁰¹ Frustrating the already disproportionate access to healthcare in these communities will further threaten public health and overwhelm the resources of hospitals struggling to manage uninsured patients, the majority of whom are from non-white populations.²⁰²

The public charge policy claims to ensure that the United States will not be overburdened by the inclusion of noncitizens that are reliant on the federal government for support; instead of achieving its goal, the 2019 policy is misconstrued and weaponized as a political tool to strike fear into the hearts of immigrant communities and discriminate against noncitizens that are not from Norway.²⁰³

¹⁹⁷ Alexandria Ocasio-Cortez (@AOC), TWITTER (Jan. 27, 2020, 2:52 PM), <https://twitter.com/AOC/status/1221883795672129540>; see also Andrew Chung, *U.S. Supreme Court Lets Hardline Trump Immigration Policy Take Effect*, REUTERS (Jan. 27, 2020, 1:34 PM), <https://www.reuters.com/article/us-usa-court-immigration/u-s-supreme-court-allows-trumps-public-charge-immigration-curb-idUSKBN1ZQ24N> (“Limiting legal immigration based on an applicant’s wealth is shameful and entirely un-American[.]”) (citations omitted).

¹⁹⁸ Andrea Germanos, ‘Shameful. Disgusting. Disgraceful.’: *Outrage After Supreme Court Allows Trump’s Public Charge Rule to Take Effect*, COMMON DREAMS (Jan. 27, 2020), <https://www.commondreams.org/news/2020/01/27/shameful-disgusting-disgraceful-outrage-after-supreme-court-allows-trumps-public>.

¹⁹⁹ See *Racism and Health*, AM. PUB. HEALTH ASS’N, <https://www.apha.org/topics-and-issues/health-equity/racism-and-health> (last visited Sept. 3, 2020).

²⁰⁰ *Institutional Racism in the Health Care System*, AM. ACAD. FAM. PHYSICIANS, <https://www.aafp.org/about/policies/all/institutional-racism.html> (last visited Sept. 3, 2020).

²⁰¹ *Id.* Although the impact of COVID-19 will continue to be tracked, current data indicates a disproportionate “burden of illness and death among racial and ethnic minority groups.” *Coronavirus Disease 2019 (COVID-19): COVID-19 in Racial and Ethnic Minority Groups*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html> (last visited Apr. 22, 2020) (“Existing health disparities, such as poorer underlying health and barriers to getting health care, might make members of many racial and ethnic minority groups especially vulnerable in public health emergencies like outbreaks of COVID-19.”); see also Ronald J. Daniels & Marc H. Morial, *The Covid-19 Racial Disparities Could Be Even Worse Than We Think*, WASH. POST (Apr. 23, 2020), <https://www.washingtonpost.com/opinions/2020/04/23/covid-19-racial-disparities-could-be-even-worse-than-we-think/>.

²⁰² *Coronavirus Disease 2019 (COVID-19): COVID-19 in Racial and Ethnic Minority Groups*, *supra* note 201.

²⁰³ Jen Kirby, *Trump Wants Fewer Immigrants from “Shithole Countries” and More from Places like Norway*, VOX (Jan. 11, 2018, 5:55 PM), <https://www.vox.com/2018/1/11/16880750/trump-immigrants-shithole->

B. *Public Charge Is Changing, but at What Cost?*

The danger to public health is not the inclusion of immigrants in society; rather, it is the exclusion of these families from accessing Medicaid and other federal non-cash benefit programs. The adverse health effects caused by not having health insurance are easy to spot; however, the more complex societal issues will result in increased costs and greater inefficiency for healthcare systems.²⁰⁴ PRWORA restricts unqualified immigrants, including undocumented immigrants and visitors, from accessing Medicaid and CHIP and introduced a five-year bar on qualified immigrants before they could utilize those programs.²⁰⁵ However, this restriction does not include access to emergency medical treatment under Emergency Medicaid.²⁰⁶ Emergency Medicaid reimburses hospitals that provide emergency medical treatment, as required by EMTALA, to examine and stabilize patients presenting emergencies.²⁰⁷ By including EMTALA in the coverage anyone within the United States is eligible to receive, even after the passage of PRWORA, Congress acknowledged the importance of addressing emergencies and reimbursing hospitals for the costs accumulated for treating immigrants that PRWORA otherwise excluded from receiving or participating in federal health insurance programs.²⁰⁸ Essentially, by limiting an immigrant's access to public benefits but guaranteeing that they will receive medical attention in an emergency situation, many immigrants that are generally unqualified or are within the five-year bar under PRWORA are forced to wait until an emergency medical situation before they can seek assistance "in the most expensive setting, the emergency room."²⁰⁹

countries-norway ("Trump reportedly referred to Haiti and countries in Africa as 'shithole countries' and called for more immigrants from places like Norway[.]"); *see also* *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191, 1204 (E.D. Wash. 2019) (recognizing that these "regulations...will make immigrant families fearful of seeking health care services like primary care and routine health screenings [and] will increase the burden of both disease and healthcare costs across the country").

²⁰⁴ *See* Parmet, *supra* note 175, at 223.

²⁰⁵ *See* PRWORA § 403(a), 110 Stat. 2105, 2265 (codified at 8 U.S.C. § 1613).

²⁰⁶ *Id.* at 2266.

²⁰⁷ 42 U.S.C. §§ 1395cc, 1395dd (2012).

²⁰⁸ *See* Parmet, *supra* note 175, at 219.

²⁰⁹ *Id.* In a nation struggling with the COVID-19 pandemic, uninsured immigrants will have no option but to wait for emergent and rapidly deteriorating health conditions before seeking medical care. The estimated cost of treating the uninsured who are hospitalized with COVID-19 will range from \$13.9 billion to \$41.8 billion, consuming 40% of the funding set aside for the healthcare industry by the CARES Act. Larry Levitt, Karen Schwartz & Eric Lopez, *Estimated Cost of Treating the Uninsured Hospitalized with COVID-19*, KAISER FAMILY FOUND. (Apr. 7, 2020), <https://www.kff.org/uninsured/issue-brief/estimated-cost-of-treating-the-uninsured-hospitalized-with-covid-19/>.

With the 2019 public charge rule placing restrictions on even eligible immigrants, those who are past the five-year bar, from accessing legally entitled health programs, the cost to hospitals will be even more exacerbated. By penalizing access to federally funded healthcare, the 2019 public charge policy ignores the implementation of the five-year bar, making it unappealing for non-immigrants,²¹⁰ even when they have satisfied the time limit, to take part in health programs designed to protect them and the larger community. Situations that are dangerous for the individual immigrant's health, such as a dialysis patient waiting until their condition is critical in order to be dialyzed in the emergency room or a cancer patient who does not have insurance waiting to receive ambulatory treatments prior to being admitted to the emergency room, are also more expensive for the hospital and federal government to treat once the patients' conditions have worsened to the point of requiring life-saving and stabilizing care.²¹¹ As a result, community health centers and "[s]afety net hospitals" are strained by uncompensated costs when patients cannot access, or are scared away from, otherwise public insurance programs and healthcare.²¹² These extra costs may result in health systems cutting back in other areas to break even, such as offering fewer services and even shutting down certain hospitals.²¹³

The restrictions posed by the 2019 public charge rule are detrimental, not only to public health but also to the healthcare industry. Projections estimate that hospitals alone would lose over \$17 billion annually due to a substantial portion of Medicaid and CHIP enrollees receiving care from and submitting payments to a hospital.²¹⁴ Safety net providers will be further burdened, especially in

²¹⁰ See *supra* notes 39 and 86.

²¹¹ PATRICIA ILLINGWORTH & WENDY E. PARMET, *THE HEALTH OF NEWCOMERS: IMMIGRATION, HEALTH POLICY, AND THE CASE FOR GLOBAL SOLIDARITY* 88–96 (2017).

²¹² Parmet, *supra* note 175, at 223.

²¹³ CINDY MANN, APRIL GRADY & ALLISON ORRIS, *MEDICAID PAYMENTS AT RISK FOR HOSPITALS UNDER THE PUBLIC CHARGE PROPOSED RULE 4* (2018). This concern is exacerbated when healthcare workers, 17% of whom were also immigrants in 2016, have to worry about cutbacks to H1 visas and the termination of DACA. Szilvia Altorjai & Jeanne Batalova, *Immigrant Health-Care Workers in the United States*, MIGRATION POL'Y INST. (June 28, 2017), <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states>; Casey Ross & Max Blau, *US Health Care Relies Heavily on Foreign Workers. Trump's Immigration Ban Is Raising Alarms* (Jan. 30, 2017), <https://www.statnews.com/2017/01/30/trump-immigration-ban-health-workers/>. "Approximately 6 million foreign-born workers are the foot soldiers in our frontline defense against COVID-19, employed in 'essential' jobs in areas such as health care, grocery stores, agriculture, and the medical supply chain." *Covid-19 Highlights the Need to Support Immigrants Now and into the Future*, GCIR (May 15, 2020), <https://www.gcir.org/news/covid-19-highlights-need-support-immigrants-now-and-future>.

²¹⁴ MANN ET AL., *supra* note 213, at 5; see also *DHS Public Charge Regulation Could Drive Medicaid Coverage Losses*, MANATT (Aug. 29, 2019), <https://www.manatt.com/insights/newsletters/manatt-on-health-medicare-edition/dhs-public-charge-regulation-could-drive-medicare> ("Estimates are based on Medicaid spending in 2016. Of the estimated \$17 billion in hospital payments potentially at risk in 2016, \$7 billion was

communities with large immigrant populations, as uncompensated care increases with the reliance on emergency room services.²¹⁵ The use of emergency medical services is not covered by the feared restrictions on public charge, and as such, immigrant families will have a strong incentive to skip accessing Medicaid and risk their adjustment of immigration status until a medical condition becomes emergent.²¹⁶ While these pseudo-uninsured patients forego preventive and routine care, they will still eventually be forced to turn to hospitals for “expensive acute care and inpatient procedures,” consequently raising uncompensated care costs for the hospital.²¹⁷

The threat to hospitals of losing Medicaid and CHIP patients as a result of the public charge policy is severe, best described in a report by Manatt Health on behalf of America’s Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children’s Hospital Association, and the Federation of American Hospitals.²¹⁸ The report projected significant economic consequences for hospitals:

Overall, the public charge proposed rule would have a significant negative impact on hospitals and the communities that rely upon them, particularly in areas with large immigrant populations. As uncompensated care costs rise, the destabilizing impact of the rule could threaten the investments hospitals make in serving their entire communities.²¹⁹

The 2019 rule would also treat even the presence of medical conditions, without the coverage of private insurance, as a negative factor in accessing a noncitizen’s likelihood of becoming a public charge.²²⁰ Immigrants who are uninsured, or those who are eligible to receive state health insurance benefits, may opt not to visit a physician or take diagnostic tests in order to avoid a medical diagnosis that may disqualify them from adjusting to permanent resident status.²²¹

Additionally, by including non-cash benefits such as SNAP and federal housing assistance as factors in determining a public charge, the 2019 rule would

associated with noncitizen enrollees and \$10 billion was associated with citizen enrollees who have a noncitizen family member.”)

²¹⁵ MANN ET AL., *supra* note 213, at 20.

²¹⁶ See *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. 51,114, 51,290 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248).

²¹⁷ MANN ET AL., *supra* note 213, at 5.

²¹⁸ *Id.* at 1.

²¹⁹ *Id.* at 5.

²²⁰ *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. at 51,182.

²²¹ Parmet, *supra* note 175, at 230.

reduce access to nutrition and housing programs that are positive SDH.²²² Without the support of these non-cash benefits and with the strong incentive to allow medical conditions to worsen and thus rely on the emergency room, hospitals and other health centers face a significant financial strain from the misuse of public charge.²²³ As a result, National Hospital Associations, including those involved in the Manatt Health report, released a joint statement requesting the administration withdraw the “harmful” proposal of the 2019 rule as soon as it was finalized.²²⁴ These hospital associations specifically named the restriction of Medicaid, concerned that it would “lead to delays in care” as a foreseeable negative impact.²²⁵ Lisa David, the President and CEO of Public Health Solutions, commented that the weaponization of public charge to restrict immigration on the basis of using non-cash benefit programs “is going to cost the [healthcare] system a lot of money.”²²⁶ Medicaid and CHIP, two non-cash benefit programs at risk, are critical to the financial stability of hospitals and other healthcare providers, accounting for nearly one out of every five healthcare dollars nationwide and paying for a range of care.²²⁷ One out of every three program dollars allocated to Medicaid and CHIP enrollees are spent exclusively on hospital-based care.²²⁸

State governments are the first domino to be hit if health insurance is limited, and, as such, fourteen states sued DHS in temporarily successful litigation for declaratory and injunctive relief.²²⁹ States would lose money they receive from

²²² See B. Cameron Webb & Dayna Bowen Matthew, *Housing: A Case for the Medicalization of Poverty*, 46 J.L. MED. & ETHICS 588, 591, 593 (2018); Megan Sandel & Matthew Desmond, *Investing in Housing for Health Improves Both Mission and Margin*, 318 J. AM. MED. ASS’N 2291, 2291 (2017); Nancy E. Adler, M. Maria Glymour & Jonathan Fielding, *Addressing Social Determinants of Health and Health Inequalities*, 316 J. AM. MED. ASS’N 1641, 1641 (2016).

²²³ For further information on non-cash benefits in the 2019 policy change, see *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292, 41,312 (Aug. 14, 2019). The reliance on emergency services and emergent care is uncontested, and DHS notes it as a potential result from the proposed rule. *Id.* at 41,313.

²²⁴ *Joint Statement from National Hospital Associations on DHS Public Charge Final Rule*, AM. HOSP. ASS’N (Aug. 12, 2019), <https://www.aha.org/press-releases/2019-08-12-joint-statement-national-hospital-associations-dhs-public-charge-final>.

²²⁵ *Id.*; see Kristalee Guerra, *The Policy and Politics of Illegal Immigrant Health Care in Texas*, 3 HOUSTON J. HEALTH L. & POL’Y 113 (2002) (including a brief discussion of the economic consequences resulting from denying preventive healthcare in states such as California and New York as well as a proposed suggestion for Texas).

²²⁶ *In Suit Against New Immigration Rule, California Claims Trump’s ‘Public Charge’ Change ‘Weaponizes Health Care’*, KHN (Aug. 19, 2019), <https://khn.org/morning-breakout/in-suit-against-new-immigration-rule-california-claims-trumps-public-charge-change-weaponizes-health-care/> (quotations omitted).

²²⁷ MANN ET AL., *supra* note 213, at 4, 20. This care ranges from routine checkups and prescription drugs to hospital stays for serious illnesses. *Id.* at 20.

²²⁸ MANN ET AL., *supra* note 213, at 20.

²²⁹ *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191, 1224 (E.D. Wash. 2019).

the federal government for public benefit programs, while simultaneously taking on an influx of immigrant patients who would switch from accessing federal programs to state programs that would not count against them as public benefits under the 2019 rule.²³⁰ While PRWORA placed a five-year ban on otherwise qualified immigrants, many states have elected to use state funds to cover those immigrants during the five-year span.²³¹ The states listed in the suits manage and administer healthcare services and Medicaid to their patients, and with the threat of reduced enrollment and a dramatic increase to state costs, ensuring that public charge does not include non-cash benefit programs is in their direct interest and in the interest of private hospitals within the state.²³²

Resulting harm also includes a shift of healthcare costs to the states in the form of increased emergency and uncompensated care. Uncompensated care refers to medical services that are unreimbursed, provided by hospitals to patients, and that result in “charity care or bad debts” when the uninsured patients are unable to pay their bills.²³³ The federal government is taking this opportunity to once again pass the bill of health insurance to the states.²³⁴ Immigrants will still need to seek medical treatment, but by forcing them to present with emergent cases that will not be reimbursed by the federal government, states and local hospitals take on the more expensive costs.²³⁵

On a macro level, the massive disenrollment from public assistance programs by immigrant families will reduce revenue to hospitals, grocery stores, and other providers, thereby significantly and adversely impacting state economies.²³⁶ Total economic output would be affected by nearly \$100 million, with economists from Washington’s State Department of Social and Health

²³⁰ *Id.* at 1204.

²³¹ 8 U.S.C. § 1622(a) (2018). “Although such state-only health benefits do not constitute ‘public benefits’ under the Rule’s public charge test, many noncitizens will fear that enrollment in state-funded programs (which often have the same name as the state’s Medicaid program) will carry adverse immigration consequences.” Complaint for Declaratory and Injunctive Relief at 89, *Washington v. U.S. Dep’t of Homeland Sec.*, No. 4:19-cv-05210-RMP (E.D. Wash. Aug. 14, 2019).

²³² *See* *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d at 1205–06.

²³³ Complaint for Declaratory and Injunctive Relief at 101, *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

²³⁴ *See* THERESE J. MCGUIRE & DAVID F. MERRIMAN, *HAS WELFARE REFORM CHANGED STATE EXPENDITURE PATTERNS?* 1 (2006). In 1996, Congress passed the cost to state and local governments with the enactment of PRWORA. *Id.*

²³⁵ “Further, because their conditions are more serious, they will require greater resources to treat.” Complaint for Declaratory and Injunctive Relief at 102, *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

²³⁶ *See* Order Granting Plaintiff States’ Motion for Section 705 Stay and Preliminary Injunction at 16–17, *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

Services placing the economic output affected in the state between \$41.8 million and \$97.5 million, with an annual reduction of wages totaling between \$15.7 million and \$36.7 million.²³⁷

Also affected by the federal government's weaponization of public charge are counties, such as Santa Clara County, California, that claim they will incur additional costs due to residents shifting toward services paid for and administered by counties.²³⁸ Santa Clara County, alongside the city and county of San Francisco, filed the first lawsuit to halt the proposed rule in August 2019.²³⁹ Local governments face similar fears about which state governments complained, arguing that by coercing residents to forego public benefits, new changes to public charge policy would increase programmatic and administrative costs to the counties' health and safety net systems.²⁴⁰ In addition, the complaint jointly filed by the city and county of San Francisco noted that restricting immigrants from accessing public benefits threatens the public health and reduces economic activity in the counties.²⁴¹

The origin of public charge policy was set out to protect U.S. citizens from people who may become a public charge, but instead it is being used to threaten the immigrant community at the expense of state and local governments and American businesses, namely the healthcare system, similar to the harm caused by PRWORA in 1996. As a result, taxpayers, who were intended to be financially protected from abuse of public benefit programs,²⁴² end up supporting the state and local governments' excess costs in the emergency room. EMTALA is still an unfunded mandate, and the inevitable rise in emergent patient care will be shouldered by the private hospitals that are legally required

²³⁷ Complaint for Declaratory and Injunctive Relief at 149, *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP). In addition, there would be a loss of approximately 334 to 782 jobs in the State of Washington. *Id.*

²³⁸ *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1124 (N.D. Cal. 2019).

²³⁹ Priscilla Alvarez, *Rule Targeting Legal Immigrants Draws First Lawsuit*, CNN (Aug. 13, 2019, 8:41 PM), <https://www.cnn.com/2019/08/13/politics/public-charge-rule-lawsuit/index.html>.

²⁴⁰ Complaint for Declaratory and Injunctive Relief at 11, *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1105 (N.D. Cal. 2019) (No. 3:19-cv-04717).

²⁴¹ Complaint for Declaratory and Injunctive Relief at 15, *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1105 (N.D. Cal. 2019) (No. 3:19-cv-04717). In addition to the loss of funding and revenue from federal dollars that states complained about, this complaint also mentioned the indirect effect as dollars have a "beneficial economic ripple effect as they circulate in the economy." *Id.* Economists from the Department of Agriculture determined that "SNAP benefits have a high multiplier effect as they circulate through the local economy—every dollar issued to a SNAP recipient results in \$1.79 in economic activity." *Id.* This same ripple effect will be seen from the restriction of Medicaid, and other non-cash benefit programs, overall negatively affecting the counties' economic growth. *See id.*

²⁴² *See Trump's Statement on the 2019 Rule Change*, *supra* note 41.

to stabilize patients.²⁴³ With hope of only limited reimbursement, healthcare institutions may resort to cutting back in services and closing local healthcare centers, a substantial cost to taxpayers nationwide.²⁴⁴

IV. NECESSARY CONGRESSIONAL ACTION

Congress has excluded most noncitizens—specifically those who are undocumented, visiting the country on student or tourist visas, or green-card holders who have not reached the five-year bar—from receiving government-funded healthcare as a critical part of the welfare reform legislation passed in 1996.²⁴⁵ Arguably, Congress may desire to support the intimidation of the immigrant community with the 2019 policy in line with its prior action to restrict accessibility to healthcare. However, there are considerable benefits of revising the public charge statute to exclude consideration of accessing public health benefits. This Comment is not arguing for an expansion of coverage to all noncitizens by amending PRWORA, it is simply advocating for a strategic update to the public charge statute. While such a revision is not radical and the immigrant population directly affected is less than 500,000 individuals—who are already legally within the United States and seeking to adjust their residency status—it is significant as it will sufficiently address specific concerns raised by healthcare organizations, state and local governments, and immigrant families following the proposal of the 2019 public charge rule. This Part first discusses why review of the public charge statute is long overdue before moving on to prescribe an exact and limited revision to the public charge statute of 1952. The revision proposed in this Part ensures the status quo remains in line with PRWORA by protecting the immigrant community eligible for public health benefits without expanding those benefits to noncitizens who were originally excluded by welfare reform.

A. *Long Overdue Public Charge Review*

Public charge policy has evolved over the development of this nation, and Congress has not revisited the statute since the passage of the INA in 1952,²⁴⁶ thus allowing the executive branch to direct the policy. Congressional action indirectly conflated the standards of public charge with the passage of welfare reform, and agency guidance served to clarify procedure without any modern

²⁴³ Lee Black, *Defining Hospitals' Obligation to Stabilize Patients Under EMTALA*, 8 AMA J. ETHICS 752, 752 (2006).

²⁴⁴ MANN ET AL., *supra* note 213, at 4.

²⁴⁵ See *supra* Part II.D.1.

²⁴⁶ See *USCIS Policy Manual*, *supra* note 39, at Chapter 1.B.2.

legislation to guide it.²⁴⁷ Although objections to the 2019 rule highlight the consistent, decades-old policy development that has formed modern public charge, congressional intent can only be detected from action taken regarding the flow of immigration or access to public benefits separately, instead of comprehensive legislation addressing the clear impact on both.

Plaintiffs opposing the 2019 public charge rule noted the rule's dismissal of INS regulation from 1999 and congressional intent in making Medicaid and other non-cash benefit programs accessible to noncitizens after they meet certain eligibility requirements. PRWORA allowed qualified immigrants to apply for and utilize public benefits after five years, but the 2019 rule "eviscerates Congress's intent by imposing an effective 'bait and switch'—punishing immigrants for using public benefits for which Congress itself made them eligible."²⁴⁸ The executive branch is readily abusing its discretion by implementing such a drastic shift in policy. While courts continue to litigate over the assault on immigrants' access to non-cash public benefits, congressional action is needed to ensure its stability.

There is a greater need for a new public charge statute than ever before, because the society welcoming and supporting immigrants is entirely different now. The level of government assistance for which noncitizens are eligible after the rise of the welfare state, even with the reform in 1996, reflects a society vastly different than in 1952.²⁴⁹ In this welfare state, federally funded healthcare programs are offered to eligible immigrants, and these immigrants are legally entitled to access healthcare, save for restrictions placed on them by encroaching immigration policy.²⁵⁰ Public charge takes on a whole new meaning with the vast availability of federal health programs, especially compared to its conceptualization in the nineteenth and early twentieth century.

The last time Congress indirectly questioned the zone of public charge policy was the passage of PRWORA. Welfare reform was passed with overwhelming support by the Republican party.²⁵¹ In the confusion arising from the language

²⁴⁷ See Order Granting Plaintiff States' Motion for Section 705 Stay and Preliminary Injunction at 40–41, 43–44, *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

²⁴⁸ Complaint for Declaratory and Injunctive Relief at 4, *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

²⁴⁹ See generally Robert A. Moffitt, *The Deserving Poor, the Family, and the U.S. Welfare System*, 52 *DEMOGRAPHY* 729 (2015) (discussing the changes of the welfare state throughout the late 1900s and early 2000s).

²⁵⁰ SONAL AMBEGAOKAR, *OPPORTUNITIES FOR MAXIMIZING REVENUE AND ACCESS TO CARE FOR IMMIGRANT POPULATIONS* 2–5 (n.d.).

²⁵¹ The final votes on the Conference Agreement passed in July of 1996 were 328 voting yes in the House

of the law, the field guidance published by INS directly addressed the definition of public charge to clarify that it continued along the historic understanding that a “charge” on the government reflected “a person . . . committed or entrusted to the care, custody, management, or support” of the government.²⁵² Further, it did not include the receipt of non-cash public benefits that were instead considered “supplemental [by] nature.”²⁵³ In the three-year period between the passage of PRWORA and the adoption of the field guidance, Congress had ample time to clarify the disconnect and establish clear standards for the use of non-cash public benefits, namely Medicaid. However, congressional inaction was interpreted as acceptance of the INS field guidance, and the public charge statute was not adjusted in the late 1990s as it should have been.²⁵⁴

Without congressional action, the executive branch is free to abuse its discretion by changing the field guidance DHS put in place in 1999,²⁵⁵ which the Trump Administration has been successful in doing. Without any congressional action in response to the field guidance from 1999, executive discretion to alter the public charge statute now is no different than before. The executive branch is advocating that Congress clearly intended to restrict noncitizens from “[depending] on public resources to meet their needs”²⁵⁶ as a way to justify the stark misstep with its 2019 rule. However, this rule is the prime example of how much power the executive branch is amassing regarding immigration policy. Although Congress has the power to govern immigration and access to federal benefits,²⁵⁷ it has not fulfilled its responsibility to govern

of Representatives and 78 voting yes in the Senate. *Social Security: Vote Tallies*, SOC. SEC. ADMIN., <https://www.ssa.gov/history/tally1996.html> (last visited May 25, 2020). Of these votes, Democrats split 98 to 97 in the House of Representatives and 25 to 21 in the Senate, with two and one members abstaining, respectively. *Id.*

²⁵² Inadmissibility and Deportability on Public Charge Grounds, 64 Fed. Reg. 28,676, 28,677 (proposed May 26, 1999) (codified at 8 C.F.R. pts. 212 and 237).

²⁵³ *Id.* at 28,677–78, 28,682, 28,685–86.

²⁵⁴ See Motion for Leave to File Amicus Brief at 9, *U.S. Dep’t of Homeland Sec. v. New York*, No. 19A785 (U.S. 2020).

²⁵⁵ The underlying litigation challenging the 2019 public charge policy argues the rule change is invalid under the Administrative Procedure Act. See *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1074 (N.D. Cal. 2019) (discussing the administrative law implications of the executive agency’s actions); see also Laura Wamsley, Pam Fessler & Richard Gonzales, *Federal Judges in 3 States Block Trump’s ‘Public Charge’ Rule for Green Cards*, NPR (Oct. 11, 2019, 2:56 PM), <https://www.npr.org/2019/10/11/769376154/n-y-judge-blocks-trump-administrations-public-charge-rule>.

²⁵⁶ See *Trump’s Statement on the 2019 Rule Change*, *supra* note 41.

²⁵⁷ Congress established the current laws governing immigration and public benefits in 1996 with PRWORA and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). See Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28,689, 28,689 (Mar. 26, 1999). See generally *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1097 (N.D. Cal. 2019) (describing the impact of Congressional revisions to immigration and access to federal benefits in the IIRIRA and PRWORA, respectively).

the public charge doctrine by providing a reasonable definition and detailed standards.

B. Revisiting and Revising the Public Charge Statute

The natural next step is for Congress to revisit and revise the public charge statute, especially regarding the use of Medicaid. If anything has become clear from the past decade of scholarly research, anecdotal data collection, and reporting and objections from various healthcare entities, it is that the government has received overwhelming and compelling evidence that healthcare should not enter into public charge considerations. Congress must amend the statute and direct executive agencies on how to consider public charge reliance and to explicitly exclude medical diagnoses and expenses for which immigrants are otherwise eligible. The government and American taxpayers do not benefit from dissuading noncitizens from using healthcare.²⁵⁸ Congress should revisit and revise the public charge statute, last addressed in 1952, to clarify that any health benefits legally entitled to immigrants will not be counted against them in public charge analysis, permanently halting the threat implemented by the 2019 rule. Revising the public charge statute to exclude consideration of health benefits will not be an expansion of eligibility because Congress has already legislated a framework for immigrants to access Medicaid and other non-cash benefits under PRWORA.

First, Congress needs to reconsider the benefits to public health when it excludes public health benefits from public charge. With the passage of PRWORA, and with the feared consequences of changing DHS' standards regarding public charge, public health has been continually placed on the chopping block. Scholars have fiercely advocated on behalf of preserving public health and warned against the danger of limiting access to publicly subsidized healthcare for any group of people within the United States.²⁵⁹ By ensuring that noncitizens have access to public health benefits, Congress will limit the spread of communicable diseases that can more easily be contained by the intentional coverage of as many people within the United States as possible.²⁶⁰ Additionally,

²⁵⁸ See Order Granting Plaintiffs' Motion for a Preliminary Injunction at 2, *New York v. U.S. Dep't of Homeland Sec.*, No. 1:19-cv-07777-GBD (S.D.N.Y. Oct. 11, 2019); *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191, 1204 (E.D. Wash. 2019); *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1074 (N.D. Cal. 2019); Complaint for Injunctive and Declaratory Relief at 1–2, *La Clinica de la Raza v. Trump*, No. 3:19-cv-4980 (N.D. Cal. Aug. 16, 2019); Preliminary Injunction Order at 4, *California v. U.S. Dep't of Homeland Sec.*, No. 19-cv-04975-PJH (N.D. Cal. Oct. 11, 2019).

²⁵⁹ See Price, *supra* note 101, at 248; Makhlof, *supra* note 5, at 178; Parmet, *supra* note 167, at 216, 218.

²⁶⁰ See Price, *supra* note 101, at 237 (stating that public charge doctrine "could lead to . . . increased prevalence of communicable diseases, including among members of the U.S. citizen population") (citation

Congress will address the chilling effects from dissuading use of important public benefits, such as “increases in maternal mortality, premature birth, low birth weight, behavioral and emotional problems among children, mental health issues, metabolism-related illnesses, and inflammatory diseases like arthritis.”²⁶¹ The families of immigrant parents, many of whom are citizens, will also benefit from the inclusion of the heads of household into health coverage: increases in parental coverage are “associated with increases in pediatric primary care.”²⁶² By addressing the negative health outcomes that are expected to cause disproportionate harm to people of color and exacerbate already existing disparities, Congress will ensure the communities most at risk from a disrupted public health system are covered.

Second, Congress needs to reconsider the significant financial impact that will be avoided when it excludes public health benefits from public charge. State and local governments, health systems and providers, and indirectly the American taxpayer will benefit from the strategic exclusion of accessing of Medicaid and federal health programs from consideration in public charge decisions.²⁶³ By ensuring that state and local governments receive federal funding for Medicaid, Congress will streamline the efficiency of receiving health benefits and support these systems in protecting the public health. As long as Congress continues not to guarantee that qualified noncitizens have access to public health insurance, states and counties are at risk of the shifting burden of cost to provide adequate public health benefits.²⁶⁴ Congress will bolster state and local economies and protect them from the loss of jobs, revenue, and healthcare business inevitably cascading from the restriction of non-cash federal public

omitted).

²⁶¹ Makhlof, *supra* note 5, at 199.

²⁶² Maya Venkataramani, Craig Evan Pollock & Eric T. Roberts, *Spillover Effect of Adult Medicaid Expansion on Children's Use of Preventive Services*, 140 PEDIATRICS 1, 6 (2017). On the other hand, if Congress does not act, “children will feel the effects if their parents lose access to health coverage and forgo medical care.” Parmet, *supra* note 175, at 230. Children born in the United States will also be impacted if their parents avoid using other non-cash benefits, such as SNAP or housing subsidies. *Id.* (“Food and housing, after all, affect everyone in a household. In addition, the health of households affects the health of their communities. When children can’t go to school because they or their parents are sick, when workers can’t be productive because they’re forgoing basic health care, communities as a whole suffer.”).

²⁶³ See Order Granting Plaintiffs’ Motion for a Preliminary Injunction at 2, *New York v. U.S. Dep’t of Homeland Sec.*, No. 1:19-cv-07777-GBD (S.D.N.Y. Oct. 11, 2019); *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191, 1204 (E.D. Wash. 2019); *City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1074 (N.D. Cal. 2019); Complaint for Injunctive and Declaratory Relief at 1–2, *La Clinica de la Raza v. Trump*, No. 3:19-cv-04980 (N.D. Cal. Aug. 16, 2019); Preliminary Injunction Order, *California v. U.S. Dep’t of Homeland Sec.*, No. 19-cv-04975-PJH (N.D. Cal. Oct. 11, 2019).

²⁶⁴ Order Granting Plaintiff States’ Motion for Section 705 Stay and Preliminary Injunction at 16–17, *Washington v. U.S. Dep’t of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

health benefits.²⁶⁵ Considering the unfunded mandate that requires hospitals and emergency departments to examine and stabilize patients with emergent medical conditions,²⁶⁶ Congress is strongly encouraged to provide federal funding to lower those costs and support health efforts to treat medical conditions early and preventively,²⁶⁷ for the good of the individual patient and the community's public health.

As the financial consequences of public charge expansion become more widely known, healthcare institutions will continue to advocate for coverage of public health benefits by the federal government. Without this coverage, these institutions are not only at risk for losing Medicaid revenue and paying the higher, uncompensated cost of emergency care, but they will also shoulder the burden of a rise in communicable diseases.²⁶⁸ The federal government claims to financially benefit from the limitation on federally funded public health programs; however, the cost is still a burden on the taxpayer because the responsibility is simply shifted to state and local governments, and the noncitizens within the United States will still need to access certain state benefits and those programs will become overwhelmed by the influx. Congress can prevent this strain on the healthcare system and additional unforeseen financial consequences to all affected providers from a massive cut to publicly subsidized healthcare.

Revising the public charge statute is relatively simple, as the governing law was enacted by Congress in the INA and was codified as 8 U.S.C. § 1182:

4) Public charge

(A) In general

Any alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible.

(B) Factors to be taken into account

(i) In determining whether an alien is

²⁶⁵ As noted earlier, the state of Washington's economic output could be affected up to \$97.5 million annually. *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191, 1208 (E.D. Wash. 2019).

²⁶⁶ 42 U.S.C. §§ 1395ccc, 1395ddd (2012).

²⁶⁷ *See Joint Statement from National Hospital Associations on DHS Public Charge Final Rule*, AM. HOSP. ASS'N (Aug. 12, 2019), <https://www.aha.org/press-releases/2019-08-12-joint-statement-national-hospital-associations-dhs-public-charge-final>.

²⁶⁸ *Order Granting Plaintiff States' Motion for Section 705 Stay and Preliminary Injunction* at 52, *Washington v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 1191 (E.D. Wash. 2019) (No. 4:19-cv-05210-RMP).

inadmissible under this paragraph, the consular officer or the Attorney General shall at a minimum consider the alien's-

- (I) age;
- (II) health;
- (III) family status;
- (IV) assets, resources, and financial status; and
- (V) education and skills.²⁶⁹

DHS's final rule on inadmissibility on public charge grounds builds on these factors and greatly raises the bar for inadmissibility by including accessing the public benefit of federal health programs as a negative factor in considering an immigrant's "assets, resources, and financial status" for inadmissibility purposes.²⁷⁰ The most effective way to curb the public health consequences and increased financial burden caused by the 2019 policy is for Congress to revise this language of the statute to include a limitation on the public benefits accessed. Congress should adopt the following language:

(iii) In determining whether an alien is inadmissible under this paragraph, the consular officer or the Attorney General shall exclude from consideration the alien's accessing of health benefits to which they are legally entitled.

With a short and simple revision, Congress can effectively stabilize the confusion and fear borne from the 2019 public charge policy, save states and the healthcare industry considerable revenue from Medicaid and temper the rise of emergency room visits, and address the public health concerns scholars have been warning about for decades.²⁷¹ The addition of one sentence will allow immigrants who can legally access Medicaid and CHIP to utilize these non-cash benefit programs without restriction and without allowing the use of these programs to count negatively toward their immigration applications. Congressional action will be slight, yet powerful, and it would ensure that any threat to legally entitled health benefits will no longer arise at the whim of executive agencies. Rather, it will be voted on by the legislative branch to be in line with welfare reform agreed upon and passed decades ago.

²⁶⁹ *Id.*

²⁷⁰ *Id.*

²⁷¹ See Michael D. Iseman & Jeffrey Starke, *Immigrants and Tuberculosis Control*, 332 NEW ENG. J. MED. 1094 (1995) (studying possible rise in tuberculosis); Tal A. Ziv & Bernard Lo, *Denial of Care to Illegal Immigrants: Proposition 187 in California*, 332 NEW ENG. J. MED. 1095, 1096-97 (1995) (describing public health concerns raised by Proposition 187).

The federal government has already acknowledged the importance of intentionally allowing access to some healthcare services without penalty, as they are also crucial to the well-being of society: emergency medical services,²⁷² services and benefits provided under the Individuals with Disabilities Education Act (IDEA),²⁷³ and pregnant noncitizens over the age of twenty-one can continue to access Medicaid without penalty.²⁷⁴ DHS acknowledges that “preservation of life from an immediate threat is an important policy consideration,” but leaves the determination of whether a condition is “emergent” to the state, outlining the case law that expanded the definition of “emergent.”²⁷⁵ These carve-outs have been established by the decades of policy governing public charge to date, and they have not been threatened by any federal or agency action, although the applicability of emergency medical services is still being governed by state case law. Revisiting the public charge statute and setting a clear policy that medical services will not be part of public charge consideration will defend against the further encroachment on public programs for noncitizens.

Protecting noncitizen communities and ensuring their access to Medicaid and CHIP is a moral imperative. Without these programs, noncitizens will have no choice but to allow their dangerous medical conditions to fester and ultimately risk their lives in an attempt to meet the ever-harshening criteria to become a lawful citizen of this country. Early public charge cases recognized that allowing access to public benefits better integrates noncitizens in the country;²⁷⁶ this access gives them a fighting chance to build a life alongside community members who are able to access legally entitled health benefits without fear of penalties on their immigration applications.

Congress clearly intended to allow health services to be covered under PRWORA for eligible immigrants,²⁷⁷ and in the same vein, Congress can

²⁷² See *supra* Part I.

²⁷³ See 20 U.S.C. § 1400 (2004).

²⁷⁴ KAISER FAMILY FOUND., CHANGES TO “PUBLIC CHARGE” INADMISSIBILITY RULE: IMPLICATIONS FOR HEALTH AND HEALTH COVERAGE 6 (2019).

²⁷⁵ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51,114, 51,169 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, and 248). DHS considers medical services received after a car accident to be emergent but did not answer whether treatment for leukemia that had reached a “crisis stage” would be considered necessary to preserve life from an immediate threat. *Id.* (citing *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259, 273 (Conn. 2005)).

²⁷⁶ See *The Public Charge Rule, Explained*, *supra* note 32; but see *Trump’s Statement on the 2019 Rule Change*, *supra* note 41 (arguing that allowing noncitizens to access public benefits is a drain on federal resources).

²⁷⁷ Health services were also covered under the IIRIRA of 1996. See *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28,689, 28,689 (Mar. 26, 1999). In a revision of public

legislate the exclusion of accessing these health benefits from public charge considerations in immigration. The potential for misuse and weaponization of public charge will persist as long as the statute from 1952 is not rectified by congressional action; until then, the executive branch will wield authoritative power and control the practice of public charge exclusion unchecked by legislation. Relying on judicial intervention is not a strong, permanent solution: the legislative branch is entrusted to establish parameters for the provision of federal public health programs, and the responsibility has been shirked, instead allowing DHS to outline guidance that will continue to misconstrue congressional intent to the benefit of the political whims of the executive.

CONCLUSION

Key findings from the Pew Research Center note the growth in immigration to the United States:

The U.S. foreign-born population reached a record 44.4 million in 2017. Since 1965, when U.S. immigration laws replaced a national quota system, the number of immigrants living in the U.S. has more than quadrupled. Immigrants today account for 13.6% of the U.S. population, nearly triple the share (4.7%) in 1970.²⁷⁸

charge, there is a unique opportunity to readdress the dangers posed by PRWORA as well. The five-year bar established for qualified immigrants sets an unreasonable standard, and the risks to public health and the costs to state governments have been well-documented and analyzed. Wendy E. Parmet, *Who's In?: Immigrants and Healthcare*, OXFORD HANDBOOK OF U.S. HEALTH 1033, 1041, 1046 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) (criticizing the exclusions under PRWORA); *see also* Polly J. Price, *Sovereignty, Citizenship and Public Health in the United States*, 17 N.Y.U. J. LEG. PUB. POL'Y 919, 919 (2014) (“[A] fragmented public health infrastructure mean[s] that the cost of health control measures falls on state and local governments[.]”). By disallowing unqualified immigrants, such as undocumented noncitizens and visitors, from utilizing Medicaid and CHIP in 1996, Congress introduced the first drastic limitation on welfare for noncitizens. Tanya Broder, Avideh Moussavian & Jonathan Blazer, *Overview of Immigrant Eligibility for Federal Programs*, NAT'L IMMIGR. L. CTR., <https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/> (last updated Dec. 2015). This intended reform was met with significant opposition, and it was feared that any encroachment on public health services would endanger the community and further ostracize immigrants entering the country. Audrey Singer, *Immigrants, Welfare Reform and the Coming Reauthorization Vote*, MIGRATION POL'Y INST. (Aug. 1, 2002), <https://www.migrationpolicy.org/article/immigrants-welfare-reform-and-coming-reauthorization-vote>. As expected, the encroachment on immigrant rights continues. The executive branch heavily relies on the passage of PRWORA and IIRIRA as precedent for the 2019 public charge rule, and as long as restrictions on immigrants accessing public health services are encouraged in this country's legislation, the fight over health insurance for noncitizens will not abate.

²⁷⁸ Jynnah Radford, *Key Findings About U.S. Immigrants*, PEW RSCH. CTR. (June 17, 2019), <https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants/> (citing *Selected U.S. Immigration Legislation and Executive Actions, 1790–2014*, PEW RSCH. CTR. (Sep. 28, 2015), <https://www.pewresearch.org/hispanic/2015/09/28/selected-u-s-immigration-legislation-and-executive-actions-1790-2014/>).

In reality, the 2019 public charge policy will negatively affect only 382,000 immigrants,²⁷⁹ some of whom will be taken off the chopping block if Congress decides to revisit the public charge statute. Although the implicated immigrants account for only a small percentage of the U.S. immigrant population, the rippling consequences of excluding a few hundred thousand immigrants from accessing legally entitled health benefits are disastrous. The fear gripping the immigrant community in the days leading up to the implementation of the 2019 policy was tangible; the confusion that leads families to pick between two necessities, their green cards or healthcare, asks an impossible question and scares people who are not affected by the rule change into shying away from accessing all public benefits. Congressional action to revise public charge will address considerable public health concerns raised by limiting healthcare access to the most vulnerable communities in the country and ensure all the people seeking to build a life in this country are able to do so safely. Congress should own the responsibility of legislating the public charge rule, and in doing so will also save states the cost incurred from a loss of public benefit program funding and an increase in uncompensated and emergent care. Congress will promote the financial stability of the healthcare industry, locking in a strong 17% of the economy,²⁸⁰ by giving healthcare centers the continued support of non-cash benefit programs, such as Medicaid and CHIP.

With renewed unpenalized access to these programs, immigrants will not wait to be treated as their condition worsens in the emergency room, consequently saving hospitals and other health centers significant financial strain from the misuse of public charge. Although the directly affected population is less than substantial, the threat posed to them is significant and can be rightfully avoided with direct and strong action by Congress. Revisiting and revising the public charge statute may not stop at the exclusion of healthcare programs for consideration; this Comment does not address the many further steps that can be taken to modernize half-century old legislation, yet it does open

²⁷⁹ Hajela, *supra* note 9.

²⁸⁰ *National Health Expenditure Data*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical> (last visited Sept. 3, 2020).

the door for the federal government to take a much closer and more intentional look at the effect healthcare access has on immigrants, public health, and the economy.

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