

**Intersecting Race, Health, and Law:
Consequences of the Public Charge Rule for the U.S. Hispanic Population**

by

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Abstract

On February 24, 2020, United States Citizenship and Immigration Services (USCIS) effected the Inadmissibility on Public Charge Grounds Final Rule (Public Charge Rule). The Public Charge Rule denies admission or denial of application or petition for an extension of stay or a change of status to any noncitizen who is deemed likely at any time to become a “public charge.” A public charge determination is based on a noncitizen’s use of specified public benefits, including Medicaid. I argue that a mass disenrollment by immigrants from Medicaid will cause severe poor health outcomes and economic burden on their local communities. The Public Charge Rule will lead to a decrease in Medicaid and CHIP enrollment by millions of otherwise eligible, noncitizen immigrants and their U.S. citizen children and family members. In effect, a loss of insurance coverage will lead to the public health implication of widespread poor health outcomes. Lastly, the Public Charge Rule will cause downstream tax burdens on local economies due to a consequential rise in uncompensated care provided in hospitals. The Public Charge Rule’s alleged purposes purported by the former Trump administration are unfulfilled. Instead, the Public Charge Rule discriminates against immigrants based on their class and follows the U.S. government’s longstanding tradition of racism toward immigrants.

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1.0 INTRODUCTION

In 2018, 44.8 million immigrants were living in the U.S., making up 13.7% of the nation's population.¹ Immigrants enrich our culture with diversity and offer productivity across a range of industries. Throughout history and now, Hispanic immigrants in particular have “afforded the United States myriad economic benefits, including lower prices for goods produced in industries that employ immigrant workers, increased demand for U.S. products, and higher wages and employment for domestic workers[;] ... [they have] added significantly to the economic prosperity enjoyed by average Americans.”² And yet, the U.S. government has exercised an ongoing, concerted effort to restrict immigration and limit immigrants' rights. A recent change in immigration policy, the Inadmissibility on Public Charge Grounds Final Rule (hereafter referred to as Public Charge Rule), has caused significant harm to the immigrant community.

On February 24, 2020, United States Citizenship and Immigration Services (USCIS) put the Public Charge Rule into effect, which allows a denial of admission or denial of application or petition for an extension of stay or a change of status if the noncitizen is at any time likely to become a “public charge.” During a public charge determination, USCIS considers an applicant or petitioner's enrollment in specified public benefit programs. The Public Charge Rule includes Medicaid as a public benefit considered during a public charge determination. Out of fear of losing status, many lawfully residing noncitizens are choosing to disenroll or not to enroll themselves and their children in Medicaid and CHIP. Uninsured adults and families have limited access to health care and are less likely to receive preventative medical services or care for

¹ Abby Budiman et al., *Facts on U.S. immigrants*, 2018, PEW RESEARCH CTR. (Aug. 20, 2020), <https://www.pewresearch.org/hispanic/2020/08/20/facts-on-u-s-immigrants/>.

² Marta Tienda & Susana Sanchez, *Latin American Immigration to the United States*, 142(3) DAEDALUS 48, 48-64 (2013).

chronic and major health conditions. Discouraging legally residing noncitizens from participation in Medicaid and other public benefit programs could render a population of millions at risk of poor health outcomes. The Public Charge Rule disproportionately burdens vulnerable, racial minority populations, particularly the U.S. Hispanic population.³ This is especially important, as U.S. Hispanic people and other racial minorities have disproportionately suffered from the COVID-19 pandemic. A mass increase of uninsured noncitizens will also trigger significant downstream costs that will likely burden health care institutions and local economies.

The former Trump administration was adamant the rule would protect American taxpayers and encourage self-sufficient success for immigrants. But the Public Charge Rule forces immigrants and immigrant families to choose between enrolling in necessary public benefits like Medicaid and risk being deemed a public charge, or disenrolling from public benefits to improve their chances of being able to remain in the U.S., but threaten their health status. The rule is discriminatory and unjustly penalizes lawfully residing immigrants of lower socioeconomic status (SES) who may need temporary public benefits. Ultimately, the Public Charge Rule has no just purpose, and will cause undue harm for millions of immigrants and their U.S. citizen family members.

³ For purposes of this Essay, I use the term “Hispanic” to refer to individuals originating from Latin America and Central America. The term “Hispanic” is interchangeable with “Latino/Latina.” The U.S. Office of Management and Budget (OMB) defines the ethnicity ‘Hispanic or Latino’ as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race.” *About Hispanic Origin*, U.S. CENSUS BUREAU, <https://www.census.gov/topics/population/hispanic-origin/about.html#:~:text=OMB%20defines%20%22Hispanic%20or%20Latino,or%20origin%20regardless%20of%20race> (last visited April 10, 2021).

2.0 BACKGROUND

2.1 The History of Racism in U.S. Immigration Law

*“[The] United States has an immigration dark side. A mean-spirited, anti-immigrant impulse has sporadically gripped the nation, particularly during times of social stress. During these times, the U.S. immigration laws have been harsh, discriminatory, and aggressively enforced.” – Kevin Johnson, J.D.*⁴

Immigration law in the U.S. has a long history of discrimination against low-income, non-white people seeking residence and citizenship. It can be argued that immigration law itself was founded on a racist and classist philosophy. From its inception, immigration law has broadly intended to “marginali[ze] poor and working immigrants of color” and deny noncitizens full access to rights and services otherwise accessible to white citizens.⁵ Early immigration law and policy centered on the themes of “assimilation and integration” of immigrants into white, American society, in which assimilability was defined in “explicit racial terms.”⁶ The racial dichotomy between who is considered white versus non-white has shifted throughout history⁷ to accommodate the nation’s present collective understanding of who deserves citizenship and who should be “denied ... full membership [into] American social life.”⁸ Although the racial targets shift over time, racist and classist rhetoric in immigration policy has proliferated into the present day.

To illustrate, one of the first instances of legal immigrant discrimination in explicit racial terms is a 1791 federal statute that restricted naturalized citizenship in the U.S. to “only ‘free

⁴ KEVIN JOHNSON, OPENING THE FLOODGATES: WHY AMERICA NEEDS TO RETHINK ITS BORDERS AND IMMIGRATION LAWS 2 (2007).

⁵ Trina Jones, *The Intersection of Race and Class in U.S. Immigration Law and Enforcement*, 72 LAW & CONTEMP. PROBS. 1, 2 (2009).

⁶ Katie Kelly, *Enforcing Stereotypes: The Self-fulfilling prophecies of U.S. Immigration Enforcement*, 66 UCLA L. REV. DISCOURSE 36, 42 (2018).

⁷ *Id.* at 42.

⁸ Jones, *supra* note 5, at 2.

white persons[.]”⁹ Another example, The Chinese Exclusion Act of 1882, barred Chinese laborers from entry into the U.S. for 10 years, and prevented Chinese immigrants from acquiring naturalized citizenship;¹⁰ the admission bar continued until 1952 with the enactment of the McCarran-Walter Act.¹¹ Further, the visa quota system was first established by the 1924 Immigration Act, in which the number of visas awarded to immigrants from a particular country was based on the percentage of U.S. citizens with ancestral lineage from that country.¹² Historical scholars note that this quota system was an attempt to “preserve the ideal of U.S. homogeneity” and manifested a racially discriminatory intent in the quotas themselves.¹³ The national quota system was codified in the Immigration and Nationality Act (INA) of 1952, but later dismantled in the amended INA of 1965 and replaced by a worldwide quota restriction on all immigrants.¹⁴

2.1.1 Immigration from Latin America

Between 1960 and 2010, Hispanic immigrants comprised between 31% and 41% of all new legal permanent residents in the U.S.¹⁵ Hispanic immigrants are people immigrating to the U.S. from Latin America, including countries in Central America and South America, as well as Mexico and the Caribbean.¹⁶ Hispanic immigration to the U.S. has been “part of a multiphasic demographic response to unequally distributed social and economic opportunities . . . determined by micro and macro-level” triggers, such as civil wars, natural disasters, political instability, and economic downturn.¹⁷ To illustrate, Columbian migration in the 20th Century was primarily

⁹ *Id.*

¹⁰ Kelly, *supra* note 6, at 43.

¹¹ Richard A. Boswell, *Racism and U.S. Immigration Law: Prospects for Reform After “9/11?”*, 7 J. GENDER RACE & JUST. 315, 323 (2003).

¹² Kelly, *supra* note 6, at 44.

¹³ *Id.*

¹⁴ Boswell, *supra* note 11, at 328.

¹⁵ Tienda & Sanchez, *supra* note 2.

¹⁶ *Id.*

¹⁷ *Id.*

fueled by “prolonged political instability, armed conflict and drug violence amid sporadic economic downturns.”¹⁸ Likewise, civil wars, political instability, and failing economies caused significant migration from El Salvador, Honduras, Guatemala, and the Dominican Republic.¹⁹ Migration from Latin America is also rooted in rigorous U.S. policy measures designed to regulate admissions, beginning with the aforementioned quota system of the Immigration Act of 1924.²⁰ Interestingly, the 1924 Act explicitly exempted independent countries in Central and South America from the quotas, including Mexico and the Dominican Republic, subsequently fueling major Hispanic immigration throughout the 20th Century.²¹ Another example of a U.S. policy measure is the 1966 Cuban Adjustment Act (CAA), which caused significant migration from Cuba after the Cuban Revolution; the Act “allowed Cuban exiles to apply for permanent residence” after living in the U.S. for one year.²² Throughout the 20th Century, immigration law directed toward Latin American countries has been “applied in a capricious or discriminatory manner.”²³ Nothing illustrates this notion better than U.S. immigration policy toward Mexico. Although Mexican immigration policy is only a partial representation of Hispanic immigration, it demonstrates the characteristic unfairness that defines U.S. immigration policy toward Hispanic people.²⁴

¹⁸ *Id.*

¹⁹ *Id.* “Emigration from El Salvador, the smallest but most densely populated of the Central American republics, is particularly noteworthy because of the sheer numbers that received LPR status – over 215,000 during the 1980s and an additional half million over the next two decades.” “[Guatemala] witnessed prolonged civil conflict, which escalated after 1978 and initiated a mass exodus of asylum seekers during 1980s and 1990s.” “By 2010 Guatemala became the fourth largest Latin-American-born group in the United States.” *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.*

Immigration policy specific to Mexican immigrants has oscillated between exclusion and free immigration dependent on the economic needs of the day.²⁵ Mexican immigrants have comprised the largest percentage of legal immigration from Latin America, accounting for 40% to 60% of all new legal permanent residents from Latin America between the 1960s and 1990s.²⁶ Between 1900 and 1924, businesses in the western U.S. “vigorously recruited Mexican labor” to fulfil labor shortages created by the exclusion of other racial groups.²⁷ Public sentiment toward Mexican immigrants became hostile with the stock market crash in 1929 as white Americans blamed them for ““taking away jobs from Americans ... [and] living off public relief.””²⁸ As a result, Congress made huge efforts in the 1930s to deport “nearly a half-million Mexican-Americans, including U.S. citizens” under the repatriation campaign,²⁹ thereby reducing the overall Mexican population in the U.S. by 41%.³⁰ Nevertheless, mobilization for World War II created yet again a shortage of cheap agricultural labor, and 168,000 Mexican laborers were recruited under Roosevelt’s *bracero* program between 1942 and 1945.³¹ In 1951 Congress gave the *bracero* program a permanent statutory basis in Public Law 78;³² although the law increased the number of visas for Mexican laborers to 200,000, the number of undocumented immigrants present in the U.S. began to rise.³³ The recession following the Korean War led to another anti-immigration movement, and over one million undocumented Mexican immigrants were deported

²⁵ David B. Oppenheimer, et al., *Playing the Trump Card: The Enduring Legacy of Racism in Immigration Law*, 26 BERKELEY LA RAZA L. J. 1, 35 (2016).

²⁶ Tienda & Sanchez, *supra* note 2.

²⁷ Oppenheimer, *supra* note 25, at 36.

²⁸ *Id.* at 37.

²⁹ Boswell, *supra* note 11, at 325.

³⁰ Oppenheimer, *supra* note 25, at 37.

³¹ *Id.*

³² DOUGLASS S. MASSEY ET AL., BEYOND SMOKE AND MIRRORS: MEXICAN IMMIGRATION IN AN ERA OF ECONOMIC INTEGRATION 36 (2002).

³³ Oppenheimer, *supra* note 25, at 38.

under “Operation Wetback” in 1954.³⁴ Nonetheless, nearly 5 million Mexican laborers were recruited by agricultural employers through the *bracero* program until its completion in 1965.

The following decade was rife with state legislatures attempting to pass anti-immigrant state laws.³⁵ In *Plyler v. Doe* for example, a Texas statute withheld educational funding and denied school enrollment to children illegally admitted into the U.S., but the Supreme Court found the law violated the Equal Protection Clause and struck it down in 1982.³⁶ Subsequent federal acts including the Immigration Reform and Control Act (IRCA) of 1986 and the Immigration Act of 1990 attempted to slow Mexican immigration by reducing immigrant benefits, tightening admissibility, increasing costs and sanctions on employers, streamlining criminal procedure, and increasing penalties for immigration violations.³⁷ The U.S.’s legacy of erratic admission and exclusion of Mexican immigrants, and the “unprecedented geographic dispersal of Latin American immigrants” over the 20th Century has created widespread anti-Hispanic and anti-immigration sentiment.³⁸ As a result, U.S. immigration law has fundamentally normalized racism toward Hispanic immigrants while simultaneously making significant efforts to strip basic rights from immigrants residing here.

2.1.2 Denying Public Benefits— PROWRA

Immigration law codified in the 20th Century has had nonpartisan Congressional support to restrict immigrant entry and access to public benefits. Relevant to the discussion of the Public Charge Rule is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PROWRA).³⁹ Signed into law by former President Bill Clinton, the statute’s 14th chapter, titled

³⁴ *Id.*

³⁵ Oppenheimer, *supra* note 25, at 38.

³⁶ *See Plyler v. Doe*, 457 U.S. 202 (1982).

³⁷ Oppenheimer, *supra* note 25, at 39.

³⁸ Tienda & Sanchez, *supra* note 2.

³⁹ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

“Restricting Welfare and Public Benefits for Aliens,” stripped all non-qualified aliens from eligibility for “any Federal public benefit” and “any State or local public benefit” as defined in the Act.⁴⁰ The Department of Health and Human Services (HHS) interpretation of “federal public benefit” included several integral health care coverage programs to be within the definition, including Medicare, Medicaid, Refugee Medical Assistance, and state Child Health Insurance Program (CHIP).⁴¹ The law made undocumented immigrants ineligible for all state and local public benefits unless the presiding state passed a new law after August 22, 1996 that affirmatively granted eligibility.⁴² PROWRA further created barriers to accessing federal benefits for lawful immigrants upon entry to the U.S. The law banned most lawful immigrants from receiving federal public benefits for a 5-year period from the date of entry with a qualified alien status; banned benefits include Temporary Assistance for Needy Families (TANF), Medicaid, CHIP, Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) and Supplemental Security Income (SSI).⁴³ As a result, PROWRA caused both lawful immigrants (for the initial 5-year period) and undocumented immigrants to have only limited access to specified public resources, such as Medicaid payments for emergency services for those who are “otherwise eligible for Medicaid *but for* their immigration status” (emphasis

⁴⁰ 8 U.S.C. 14 §§ 1611a, 1621a (1996). “State or local public benefit” is defined as: “(A) any grant, contract, loan, professional license, or commercial license provided by an agency of a State or local government or by appropriated funds of a State or local government; and (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government.” *Id.* “Federal public benefit” is defined as: “(A) any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.” *Id.*

⁴¹ OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *Summary of Immigrant Eligibility Restrictions Under Current Law* (Feb. 25, 2009), <https://aspe.hhs.gov/basic-report/summary-immigrant-eligibility-restrictions-under-current-law>.

⁴² *Id.*

⁴³ *Id.*

added).⁴⁴ The Public Charge Rule further broadened PROWRA's impact by creating a greater disincentive for immigrants to enroll in public benefits, or risk losing their immigration status.

2.2 Public Charge Final Rule Defined

On February 24, 2020, the United States Citizenship and Immigration Services (USCIS) effected the "Inadmissibility on Public Charge Grounds" final rule. To determine whether an alien is admissible to the U.S. or eligible for an adjustment of immigration status, USCIS looks to factors outlined in 8 C.F.R. 212.22 in order to designate whether an immigrant "is likely at any time to become a public charge." The primary statutory authority for the Public Charge Rule is the Immigration and Nationality Act of 1952 (INA), as amended.⁴⁵ Section 212(a)(4) of the INA, codified in 8 U.S.C. 1182(a)(4), states, "[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."⁴⁶ The initial proposal for the rule referred to an 1882 statutory provision that required most nonimmigrants seeking temporary admission to the U.S. to show they were not "likely to become a public charge;" though, the 1882 provision never defined the phrase.⁴⁷ The Department of Homeland Security (DHS) proposed to define the term with the new rule, and applied the definition to section 212(a)(4) of the INA.⁴⁸ Under the final rule, DHS defined the phrase "likely at any time to become a public charge" to mean "more likely than not any time in

⁴⁴ *Health Coverage of Immigrants*, KAISER FAMILY FOUND. (Feb. 2019), <http://files.kff.org/attachment/Fact-Sheet-Health-Coverage-for-Immigrants>.

⁴⁵ *Final Rule on Public Charge Ground of Inadmissibility*, U.S. CITIZENSHIP AND IMMIGR. SERV. (Feb. 24, 2020), <https://www.uscis.gov/archive/final-rule-on-public-charge-ground-of-inadmissibility>.

⁴⁶ *Id.*; *Final Rules on Public Charge Determination*, NAFSA (Mar. 29, 2021) <https://www.nafsa.org/regulatory-information/final-rules-public-charge-determinations> [hereinafter NAFSA] (citing 8 USC 1182 (a)(4)).

⁴⁷ Shawn Fremstad, *Trump's 'Public Charge' Rule Would Radically Change Legal Immigration*, CTR. FOR AMERICAN PROGRESS (Nov. 27, 2018), <https://www.americanprogress.org/issues/poverty/reports/2018/11/27/461461/trumps-public-charge-rule-radically-change-legal-immigration/>.

⁴⁸ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (Dec. 10, 2018) (to be codified at 8 CFR 103).

the future to receive one or more of the public benefits” for a time period of more than 12 months, within any 36-month period.⁴⁹

The Public Charge Rule prescribes how an alien may be inadmissible to the U.S. “based on the likelihood of becoming a public charge at any time in the future.”⁵⁰ Furthermore, the rule requires a lawful immigrant seeking an extension of stay or a change of status to “demonstrate that they have not received public benefits over the designated threshold since obtaining the nonimmigrant status they seek to extend or change.”⁵¹ The new rule requires DHS and the Department of State (DOS) to weigh all specified factors and use of public benefits as a “totality of an alien’s circumstances” review⁵² to make a prospective determination of whether applications are accepted or denied.⁵³

The Public Charge Rule applies to applicants for admission, “adjustment of status to that of a lawful permanent resident,” and “extension of nonimmigrants stay or change of nonimmigrant status[.]”⁵⁴ This specifically includes applicants seeking immigrant and nonimmigrant visas, adjustment of status, admission as an immigrant or nonimmigrant, lawful permanent residents returning to the U.S. after an absence of 6 months or longer, and nonimmigrant change of status and extension of status.⁵⁵ Factors considered by USCIS during a

⁴⁹ *Public Charge Fact Sheet*, U.S. CITIZENSHIP AND IMMIGR. SERV. (Feb. 27, 2020), <https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet>.

⁵⁰ *USCIS Announces Public Charge Rule Implementation Following Supreme Court Stay of Nationwide Injunctions*, U.S. CITIZENSHIP AND IMMIGR. SERV. (Jan. 30, 2020), <https://www.uscis.gov/news/news-releases/uscis-announces-public-charge-rule-implementation-following-supreme-court-stay-nationwide-injunctions>.

⁵¹ *Id.*

⁵² *Public Charge Fact Sheet*, *supra* note 49.

⁵³ NAFSA, *supra* note 46.

⁵⁴ *Public Charge Fact Sheet*, *supra* note 49.

⁵⁵ “Nonimmigrants presenting themselves at a port of entry are always considered as applying for admission to the United States;” permanent residents returning after an absence of 6 months or less are not subject to the rule; the inquiry for change of status and extension of stay applicants is not the full “totality of the circumstances” assessment of future likelihood of becoming a public charge that visa applicants, adjustment of status applicants, and applicants for admission at a port of entry are subjected to. Rather, it is a *backward-looking* inquiry to ascertain if the COS or EOS applicant actually received one of the specific public benefits “for more than 12 months in the aggregate within

review include, but are not limited to: age, health, “assets, resources, and financial status,” education and skills, prospective immigration status, and expected period of admission.⁵⁶ Public benefits considered by USCIS during a review include:

- Supplemental Security Income;
- Temporary Assistance for Needy Families;
- Any federal, state, local, or tribal cash benefit programs for income maintenance;
- Supplemental Nutrition Assistance Program [(food stamps)];
- Section 8 Project-Based Rental Assistance;
- Public Housing; and
- Medicaid.⁵⁷

In September 2019, the Kaiser Family Foundation estimated that nearly 80% of immigrants without legal permanent residence status had at least 1 characteristic that is weighed negatively on a DHS public charge review.⁵⁸

The final rule outlines exclusions for specific aliens, and specific public benefits and Medicaid benefits that are not to be considered during a review. Public benefits not considered include:

- Disaster relief;
- National school lunch programs;
- The Special Supplemental Nutrition Program for Women, Infants, and Children;

any 36-month period" since obtaining the nonimmigrant status that he or she seeks to extend, or from which he or she seeks to change." NAFSA, *supra* note 46.

⁵⁶ *Public Charge Fact Sheet*, *supra* note 49.

⁵⁷ *Id.*

⁵⁸ Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, KAISER FAMILY FOUND. (July 2019), <http://files.kff.org/attachment/Issue-Brief-Health-Coverage-and-Care-of-Undocumented-Immigrants>.

- The Children’s Health Insurance Program (CHIP);
- Subsidies for foster care and adoption;
- Government-subsidized student and mortgage loans;
- Energy assistance;
- Food pantries and homeless shelters; and
- Head Start.⁵⁹

Medicaid benefits not considered include:

- Treatment of emergency medical conditions;
- Services or benefits provided in connection with the individuals with Disabilities Education Act;
- School-based services or benefits provided to individuals who are at or below the oldest age eligible for secondary education as determined under state or local law;
- Use by aliens under the age of 21; and
- Use by pregnant women and by women within the 60-day period beginning on the last day of the pregnancy.”⁶⁰

Lastly, Congress exempted refugees, asylees, “certain T and U nonimmigrant visa applicants (human trafficking and certain crime [victims])”, and “[c]ertain self-petitioners under the Violence Against Women Act” from the Public Charge Rule.⁶¹

2.1 Public Charge Rule Litigation History

⁵⁹ *Public Charge Fact Sheet*, *supra* note 49.

⁶⁰ *Id.*

⁶¹ *Id.* If any of these exempted parties wanted to adjust their status to become a Lawful Permanent Resident in the future this rule would govern their behavior too.

Since its adoption in late 2019, the Public Charge Rule has had a dynamic litigation history, having been challenged in several federal courts. The Public Charge Rule was first proposed by DHS on October 10, 2018 with its publication in the Federal Register.⁶² The public submitted over 260,000 comments over the 2- month public comment period, closing on December 10, 2018.⁶³ DHS published the Public Charge Final Rule on August 14, 2019 in the Federal Register, with an effective date of October 15, 2019.⁶⁴ Two months later, DOS published the Public Charge Interim Final Rule in the Federal Register on October 11th, with an effective date of October 15, 2019.⁶⁵ Between October 11-14, 2019, several courts issued preliminary injunctions of the Interim Final Public Charge Rule in anticipation of its adoption.⁶⁶ The U.S. District Judge Phyllis Hamilton of California ruled that the plaintiffs were “likely to succeed on the merits with respect their claim that the Rule is arbitrary and capricious” based on their arguments that DHS failed to consider costs and benefits concerning “evidence when estimating disenrollment figures” and “concerns about health effects like disease outbreak.”⁶⁷ The U.S. District Judge Rosanna Malouf Peterson of Washington issued a nationwide injunction ruling that DHS had failed to cite statutory authority, “legislative history, or other resource that supports the interpretation that Congress has delegated to DHS the authority to expand the definition of who is inadmissible as a public charge[.]”⁶⁸

⁶² *Public Charge Timeline*, IMMIGRANT LEGAL RESOURCE CTR. (Feb. 2021), https://www.ilrc.org/sites/default/files/resources/2021.03_ilrc-public_charge_timeline-horizontal_0.pdf.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Preliminary Injunction at 53, *City and County of San Francisco, et al. v. U.S. Citizenship and Immigration Services, et al.*, 408 F. Supp. 3d 1057 (N.D. Cal. 2019) (No. 19-cv-04717-PJH, No. 19-cv-04975-PJH, No. 19-cv-04980-PJH), <https://oag.ca.gov/system/files/attachments/press-docs/120%20Order%20re%20PI.pdf>.

⁶⁸ Laurel Wamsley et al., *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>.

On January 27, 2020, the U.S. Supreme Court lifted the last remaining injunction blocking the Public Charge Rule's inception.⁶⁹ That same day, DHS announced the Rule would take effect on February 24, 2020 nationwide except Illinois.⁷⁰ On February 20, 2020, DOS also announced the Rule would take effect for consular offices on February 24, 2020.⁷¹ The following day, the Supreme Court ruled that the Rule would also take effect in Illinois.⁷² On February 24, 2020, both the DHS and DOS Public Charge Final Rules went into effect nationwide.⁷³

The final Public Charge Rule was implemented amidst the early stages of the COVID-19 pandemic. Just one day after the Rule's effective date, Center for Disease Control and Prevention (CDC) Director of the National Center for Immunization and Respiratory Diseases predicted COVID-19 was "heading toward pandemic status."⁷⁴ On March 11, 2020, the World Health Organization officially declared COVID-19 a pandemic, and on March 13th, former President Donald Trump declared COVID-19 a national emergency.⁷⁵ By June 10, 2020, the number of confirmed COVID-19 cases in the U.S. reached 2 million.⁷⁶ In response to the COVID-19 national emergency, both the DHS and DOS Public Charge Rule were enjoined nationwide on July 29, 2020. On August 12, 2020, the U.S. Court of Appeals for the Second Circuit limited the July injunction to only New York, Connecticut, and Vermont. On September 11, 2020, the Second Circuit granted the government's motion to lift the July injunction nationwide for the DHS Rule.

⁶⁹ *Public Charge Timeline*, *supra* note 62.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *A Timeline of COVID-19 Developments in 2020*, AJMC (Jan. 1, 2021), <https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020>.

⁷⁵ *Id.*

⁷⁶ *Id.*

But, on November 2, 2020 the U.S. District Court for the Northern District of Illinois vacated the DHS Rule nationwide, declaring that the Rule could not be applied in any cases.⁷⁷ The Federal District Judge Gary Feinerman held that “[given] the Seventh Circuit’s holding that, despite the Supreme Court’s stay, the Final Rule was substantively and procedurally invalid under the APA and preliminary injunctive relief was appropriate” the court would “not stay its vacatur of the Rule.”⁷⁸ The court entered a judgment vacating the Final Rule under a Rule 54(b) judgement, to proceed in litigation on an equal protection claim.⁷⁹ This vacatur was short-lived, however, as the Seventh Circuit Court of Appeals issued a temporary, administrative stay on the order vacating the Rule the following day.⁸⁰ On November 19th, the Seventh Circuit granted a stay pending appeal, replacing the November 3rd administrative stay. The November 3rd and 19th stays allowed DHS to continue implementing the Rule nationwide, during the appeal of the district court’s decision.⁸¹ On December 2, 2020, the Ninth Circuit Court of Appeals upheld injunctions against the Rule issued by California and Washington federal courts; however, the injunctions were not put into effect until the mandate issued.⁸² Under former President Trump, the federal government moved to stay the issuance of the Ninth Circuit mandate until the Supreme Court heard and could rule on the government’s petition.⁸³ On January 20, 2021, the

⁷⁷ *Inadmissibility on Public Charge Grounds Final Rule: Litigation*, U.S. CITIZENSHIP AND IMMIGR. SERV. (Mar. 19, 2021), <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/inadmissibility-on-public-charge-grounds-final-rule-litigation>.

⁷⁸ *Cook County Illinois, an Illinois governmental entity, and Illinois Coalition for Immigrant and Refugee Rights, Inc. v. Chad F. Wolf et al.*, 19 C 6334 (N.D. Ill. Nov. 2, 2020).

⁷⁹ *Id.*

⁸⁰ *Inadmissibility on Public Charge Grounds Final Rule: Litigation*, *supra* note 77; Stotler Hayes Group, LLC, *The U.S. Department of Homeland Security Public Charge Rule Status*, JDSUPRA (Nov. 17, 2020), <https://www.jdsupra.com/legalnews/the-u-s-department-of-homeland-security-81857/>.

⁸¹ *Public Charge Timeline*, *supra* note 62.

⁸² Constangy, Brooks, Smith & Prophete, LLP, *Public Charge Rule Is Still In Effect ... But For How Much Longer?*, JDSUPRA (Feb. 22, 2021), <https://www.jdsupra.com/legalnews/public-charge-rule-is-still-in-effect-6465996/>.

⁸³ *Id.*

Ninth Circuit granted the motion to stay, which effectively “[put on hold] the ability of the Biden Administration to enforce the injunctions.”⁸⁴

Several critical advancements have occurred with the Public Charge Rule during the writing of this Essay between February 2020 and March 2021. Changes made regarding the Public Charge Rule since the start of the Biden presidency are discussed in Section 6 Immigration Reform with the Biden Administration.

⁸⁴ *Id.*

3.0 ISSUE

3.1 Medicaid Disenrollment

The Public Charge Rule will likely cause a significant decrease in Medicaid enrollment by otherwise eligible immigrants and their family members, who may be U.S. citizens. The Public Charge Rule is likely to create broad “confusion and fear” across immigrant families about use and enrollment in public benefits for themselves and their children, regardless of whether the Rule directly impacts them.⁸⁵ Many individuals in the U.S. “live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens.” As a result, anecdotal reports show that noncitizens are choosing to disenroll or not to enroll themselves and their children, regardless of their child’s immigration or citizenship status, in Medicaid and CHIP “due to fears and uncertainty” surrounding the Public Charge Rule.⁸⁶ Although the Rule exempts CHIP from the public benefits considered in a public charge determination, many noncitizens fear that enrolling their U.S. citizen children in CHIP could threaten other family members’ immigration status.⁸⁷ Medicaid is a public insurance program that provides coverage for eligible, “low-income people, families and children, pregnant women, the elderly, and people with disabilities.”⁸⁸ CHIP is a “joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.”⁸⁹

News reports have called this phenomenon the Public Charge Rule’s “chilling effect,” where an estimated 23 million noncitizens and their citizen family members using public benefits

⁸⁵ *Changes to “Public Charge” Inadmissibility Rule: Implications for Health and Health Coverage*, KAISER FAMILY FOUND. (Aug. 12, 2019), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>.

⁸⁶ Artiga & Diaz, *supra* note 58.

⁸⁷ *Id.*

⁸⁸ *Medicaid & CHIP*, HEALTHCARE.GOV, <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> (last visited Apr. 10, 2021).

⁸⁹ *Id.*; *Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/chip/eligibility/index.html> (last visited Apr. 10, 2021).

could disenroll from crucial benefit programs.⁹⁰ Prior to the Public Charge Rule, over 13.5 million Medicaid and CHIP enrollees (both citizen and noncitizen), including 7.6 million children, lived in a household with at least one noncitizen.⁹¹ Medicaid disenrollment rates ranging from as low as 15% to 35% could account for a total disenrollment of 2.0 to 4.7 million noncitizens and citizens living in a mixed-status family from Medicaid and CHIP.⁹² A 2019 survey found that one in five adults in low-income immigrant families with children reported avoiding public benefit programs for fear of risking future green card status.⁹³ Research also suggests that fear of deportation is causing mixed status families to reject utilizing health care programs and services altogether for both themselves and their children, who are primarily U.S.-born citizens.⁹⁴ Out of 20 organizations who work with documented and undocumented immigrants, 17 reported witnessing legally eligible families either declining to enroll or disenrolling from public benefit programs, including Medicaid and CHIP.⁹⁵ Health care providers reported related concerns about parents disenrolling their children from CHIP and food assistance programs.⁹⁶

It is imperative to emphasize that the chilling effect is causing a broader disenrollment from public benefit programs than DHS intended. As stated, noncitizen parents are disenrolling

⁹⁰ Jeanne Batalova et al., *Millions Will Feel Chilling Effects of U.S. Public Charge Rule That Is Also Likely to Reshape Legal Immigration*, MIGRATION POLICY INST. (Aug. 2019), <https://www.migrationpolicy.org/news/chilling-effects-us-public-charge-rule-commentary>.

⁹¹ *Changes to “Public Charge” Inadmissibility Rule*, *supra* note 85.

⁹² *Id.*

⁹³ Artiga & Diaz, *supra* note 58; Jennifer M. Haley et al., *Brief: One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, URBAN INST. (Jun. 18, 2020), [https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019#:~:text=One%20in%20five%20adults%20in%20immigrant%20families%20with%20children%20\(20.4,percent%20of%20those%20without%20children](https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019#:~:text=One%20in%20five%20adults%20in%20immigrant%20families%20with%20children%20(20.4,percent%20of%20those%20without%20children).

⁹⁴ *Id.*

⁹⁵ Annie Lowrey, *Trump’s Anti-Immigrant Policies Are Scaring Eligible Families Away From the Safety Net*, THE ATLANTIC (Mar. 24, 2017), <https://www.theatlantic.com/business/archive/2017/03/trump-safety-net-latino-families/520779/>.

⁹⁶ *Id.*

their citizen and noncitizen children from CHIP out of fear that their own status could be jeopardized. In 2017, nearly 25% of U.S. children, close to 19 million, had an immigrant parent.⁹⁷ About 13% of U.S. children, almost 10 million, were U.S. citizens with a noncitizen parent.⁹⁸ The chilling effect of the Public Charge Rule could lead to millions of U.S. citizen children to lose health insurance. Furthermore, U.S. citizen adults are disenrolling from public benefit programs out of fear that their enrollment could jeopardize the status of their noncitizen family members. These phenomena are particularly significant because the Public Charge Rule does not apply to U.S. citizens, nor does enrollment in public benefits by a citizen family member affect a noncitizen family member's potential public charge determination. Also, CHIP is not a designated public benefit considered during a USCIS public charge determination, and therefore the Public Charge Rule does not consider a noncitizen child's enrollment in CHIP. Therefore, both disenrollment in public benefits by U.S. citizens and CHIP disenrollment are unexpected and unintended consequences of the Public Charge Rule.

A disenrollment of millions from Medicaid will have severe consequences for the health and safety of immigrant and mixed-status families. Mass Medicaid and CHIP disenrollment will cause a rise in uninsured adults and children, which leads to the downstream effects of increased poor health outcomes and uncompensated medical care. The economic burden of direct unmet costs of uncompensated care will inevitably shift to local economies and ultimately burden U.S. taxpayers.

⁹⁷ *Changes to "Public Charge" Inadmissibility Rule*, *supra* note 85.

⁹⁸ *Id.*

3.2 Impacts on the Hispanic Population

The growing U.S. Hispanic population stands to suffer significantly without the aid of Medicaid and other public benefits. The Hispanic population is “the largest and fastest-growing minority group” in the nation and comprises a large proportion of immigrants entering the U.S.⁹⁹ In 2018, half of the U.S. foreign-born population identified as Hispanic – 25% originating from Mexico, and 25% from other Latin American countries.¹⁰⁰ Approximately 34% of the total Hispanic population in 2018 were immigrants.¹⁰¹ Moreover, almost one third (31.4%) of the percentage of immigrants arriving to the U.S. in 2018 identified as Hispanic.¹⁰² A total of 60.6 million Hispanic people live in the U.S. as of July 1, 2019, accounting for 18.5% of the total nation’s population.¹⁰³

3.2.1 Hispanic Poverty & Dependence on Medicaid

The U.S. Hispanic population has a disproportionately higher rate of poverty compared to other racial groups. In effect, Hispanic people are particularly dependent on Medicaid for health care coverage. Hispanic people are 1.5 times more likely to experience poverty than the general population.¹⁰⁴ Although Hispanic people comprise 18.7%¹⁰⁵ of the population, they account for 28.1% of the nation’s total population in poverty.¹⁰⁶ In 2018, 18% of foreign-born Hispanic

⁹⁹ Martha Hostetter & Sarah Klein, *In Focus: Identifying and Addressing Health Disparities Among Hispanics*, THE COMMONWEALTH FUND (Dec. 27, 2018), https://www.commonwealthfund.org/publications/2018/dec/focus-identifying-and-addressing-health-disparities-among-hispanics?redirect_source=/publications/newsletter-article/2018/dec/focus-identifying-and-addressing-health-disparities-among.

¹⁰⁰ *Facts on U.S. immigrants, 2018*, *supra* note 1.

¹⁰¹ India J. Ornelas et al., *The Health of Undocumented Latinx Immigrants: What We Know and Future Directions*, 41 ANNUAL REV. OF PUBLIC HEALTH 289 (2020).

¹⁰² *Facts on U.S. immigrants, 2018*, *supra* note 1.

¹⁰³ *Hispanic Heritage Month 2020*, U.S. CENSUS BUREAU (Aug. 11, 2020), <https://www.census.gov/newsroom/facts-for-features/2020/hispanic-heritage-month.html#:~:text=60.6%20million&text=Hispanics%20constituted%2018.5%25%20of%20the%20nation's%20total%20population>.

¹⁰⁴ John Creamer, *Inequalities Persist Despite Decline in Poverty For All Major Race and Hispanic Origin Groups*, U.S. CENSUS BUREAU (Sep. 15, 2020), <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html>.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

people lived under the poverty line.¹⁰⁷ Further, 71% of foreign-born Hispanic people age 25 and older had an educational attainment of a high school diploma or less.¹⁰⁸ Low educational attainment is often a risk factor for poverty, and those living in poverty must depend on public benefits, like Medicaid, to survive. Medicaid provided coverage to 17.3 million Hispanic people in 2018, accounting for almost one third of all Medicaid enrollees that year.¹⁰⁹ Medicaid also covers more than half of all Hispanic children, making Medicaid a particularly crucial benefit for Hispanic families.¹¹⁰

3.2.2 Hispanic People are Losing Health Care Coverage

A loss of Medicaid further exacerbates the issue of low insurance rates among the Hispanic population. When compared to other racial groups, Hispanic people are less likely to have health care coverage, and consequently have less access to high-quality health care.¹¹¹ Currently, Hispanic people are 3 times more likely than non-Hispanic whites, and nearly 2 times more likely than blacks to be uninsured.¹¹² The uninsured rate among the Hispanic population has been particularly unsteady within the past decade. With the onset of the Affordable Care Act (ACA), from 2010 and 2016 non-elderly Hispanic people experienced the largest percentage point decrease in uninsured rate compared to other racial groups, falling from 32.6% to 19.1%.¹¹³ Between 2018 and 2019, however, the non-elderly Hispanic uninsured rate increased by 1%

¹⁰⁷ Luis Noe-Bustamante & Antonio Flores, *Facts on Latinos in the U.S.*, PEW RESEARCH CTR. (Sep. 16, 2019), <https://www.pewresearch.org/hispanic/fact-sheet/latinos-in-the-u-s-fact-sheet/>.

¹⁰⁸ *Id.*

¹⁰⁹ *Medicare and Medicaid are Important to Hispanic Americans*, NAT'L COMM. TO PRESERVE SOCIAL SECURITY & MEDICARE, <https://www.ncpssm.org/documents/medicare-policy-papers/medicare-and-medicare-are-important-to-hispanic-americans/> (last visited Apr. 10, 2021); Ariel Gelrud Shiro & Richard V. Reeves, *Latinos often lack access to healthcare and have poor health outcomes. Here's how we can change that*, BROOKINGS (Sep. 25, 2020), <https://www.brookings.edu/blog/how-we-rise/2020/09/25/latinos-often-lack-access-to-healthcare-and-have-poor-health-outcomes-heres-how-we-can-change-that/>.

¹¹⁰ NAT'L COMM. TO PRESERVE SOCIAL SECURITY & MEDICARE, *supra* note 109.

¹¹¹ Shiro & Reeves, *supra* note 109.

¹¹² Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, THE COMMONWEALTH FUND (Jan. 16, 2020), <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>.

¹¹³ *Id.*

from 10.3 million to 10.9 million (19.0% to 20.0%).¹¹⁴ This additional 612,000 uninsured Hispanic people, including 217,000 Hispanic children, accounted for more than half (57.0%) of the 1.1 million increase in the total uninsured population comprising all racial groups in 2019.¹¹⁵ Data shows that the decline in coverage for Hispanic people was primarily due to a decline in Medicaid coverage.¹¹⁶ Sources indicate that this recent 1% coverage loss by Hispanic people is likely in response to “growing immigration-related fears,” due particularly in part to the Public Charge Rule.¹¹⁷

3.2.3 Hispanic Health Outcomes

Although Hispanic people have on average lower incomes and worse access to health care than non-Hispanic racial groups, they are less likely to die from many leading causes of death, including heart disease and cancer, compared to non-Hispanic whites.¹¹⁸ One explanation for this phenomenon is the heterogeneity of the Hispanic population, as Hispanic people originate from more than 20 countries and have differing social circumstances.¹¹⁹ Nevertheless, Hispanic people face particular barriers to accessing health care and suffer poorer health outcomes on several measures compared to non-Hispanics.¹²⁰ Half of Hispanic people in the U.S. will develop diabetes in their lifetime, and they are 50% more likely to die from diabetes than non-Hispanic whites.¹²¹ Further, Hispanic people have a “66% greater risk of developing type 2 diabetes” and present worse health outcomes when diagnosed compared to non-Hispanic

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ Samantha Artiga et al., *Hispanic People are Facing Widening Gaps in Health Coverage*, KAISER FAMILY FOUND. (Nov. 6, 2020), <https://www.kff.org/policy-watch/hispanic-people-facing-widening-gaps-health-coverage/>.

¹¹⁸ Hostetter & Klein, *supra* note 99.

¹¹⁹ Hostetter & Klein, *supra* note 99.

¹²⁰ *Id.*

¹²¹ *Id.*

whites.”¹²² Hispanic people also exhibit higher prevalence rates of both chronic kidney disease and cirrhosis, at 14.8% compared to 10% for non-Hispanic whites. Health status also differs greatly depending on the country of origin. For example, the infant mortality rate for Puerto Ricans was more than double the rate for Mexicans, at 7.2 deaths per 1,000 live births compared to 3.0 deaths per 1,000 live births.¹²³ Health behaviors and outcomes are also generally worse for Hispanic people born in the U.S. compared to foreign-born Hispanic people.¹²⁴

Hispanic people experience particular challenges to achieving good health when considering their social determinants of health. As previously noted, Hispanic people experience high rates of poverty and exhibit the lowest rates of health insurance coverage of all major racial groups.¹²⁵ Poverty often leads to issues of food insufficiency and obesity.¹²⁶ Mexican American families report “not having sufficient food to eat sometimes” at much higher rates than non-Hispanic white families.¹²⁷ On the other hand, obesity is much more prevalent among Hispanic people, particularly among Hispanic women.¹²⁸ One third of Mexican women are obese compared to one-fifth of non-Hispanic white women.¹²⁹ Hispanic women are also twice as likely as Hispanic men to experience high blood pressure.¹³⁰ As I will note in Section 4.2, lacking insurance coverage is linked to worse health outcomes primarily because uninsured individuals do not receive adequate health care. Due to low insurance rates, Hispanic people are less likely to

¹²² Addie L. Fortmann et al., *Innovative Diabetes Interventions in the U.S. Hispanic Population*, 32(4) DIABETES SPECTRUM 295, 295-301 (2019).

¹²³ Hostetter & Klein, *supra* note 99.

¹²⁴ *Id.*

¹²⁵ Creamer, *supra* note 104; Shiro & Reeves, *supra* note 109.

¹²⁶ *Hispanic Health: Divergent and Changing*, PEW RESEARCH CTR. (Jan. 1, 2002), <https://www.pewresearch.org/hispanic/2002/01/01/hispanic-health-divergent-and-changing/>.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Hispanic Health*, CENTERS FOR DISEASE CONTROL AND PREVENTION (May 2015), <https://www.cdc.gov/vitalsigns/hispanic-health/index.html>.

seek preventative care services compared to non-Hispanic whites.¹³¹ The health care system is also frequently less accessible to Hispanic people due to language barriers, as nearly one third are not fluent in English.¹³²

¹³¹ Shiro & Reeves, *supra* note 109.

¹³² *Id.*

4.0 ANALYSIS

4.1 Classism & Racial Injustice: The Proposed Purpose of the Rule is Unfulfilled

The Public Charge Rule’s initial rule proposal published on October 10, 2018 does little to explain why DHS proposed the Rule. In the proposed Rule’s section “Background and Purpose of the Rule,” DHS stated that “there is a lack of academic literature and economic research examining the link between immigration and public benefits. . . and the strength of that connection.”¹³³ Furthermore, DHS stated that they did not “estimate potential lost productivity, health effects, additional medical expenses due to delayed health care treatment, or increased disability insurance claims as a result of [the] proposed rule.”¹³⁴ Instead, the former Trump administration announced the purpose of the proposed Public Charge Rule in several anecdotal public statements. When considering the Public Charge Rule’s actual outcomes, however, the anecdotal statements are incorrect and instead suggest a classist and racist motivation behind the Rule.

4.1.1 PURPORTED PURPOSE OF THE PUBLIC CHARGE RULE

On August 12, 2019, USCIS former Director Ken Cuccinello, as part of DHS, gave a press briefing to explain and justify the purpose of the Public Charge Rule.¹³⁵ Cuccinello first stated that the issued Rule “encourages and ensures self-reliance and self-sufficiency” for noncitizens seeking to enter and stay in the U.S.¹³⁶ He further claimed the Public Charge Rule would “help promote immigrant success” as they seek opportunity.¹³⁷ Throughout the briefing, Cuccinello repeatedly presented the ideas of “self-sufficiency” and “personal responsibility” as both an ideal for immigrants and necessary to ensure that “immigrants are able to support

¹³³ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. 103, 212, 213, 214, 245, 248).

¹³⁴ *Id.*

¹³⁵ Press Briefing, Ken Cuccinelli, Press Briefing by USCIS Acting Director Ken Cuccinelli (Aug. 12, 2019).

¹³⁶ *Id.*

¹³⁷ *Id.*

themselves and become successful.”¹³⁸ Cuccinello stressed that noncitizens should rely only on family and community sponsors and criticized a reliance on government aid.¹³⁹ He narrated this point through a tale of his own immigrant family history, claiming that his “family worked together to ensure that they could provide for their own needs, and they never expected the government to do it for them.”¹⁴⁰ He likened a financial reliance on family to a “hardworking spirit,” and touted this characteristic to be “central to our American identity.”¹⁴¹ He concluded the briefing with a lofty notion that Americans and legal immigrants alike have “pulled themselves up by their bootstraps” in order to achieve success.¹⁴²

On February 22, 2020, former White House Press Secretary Stephanie Grisham made a statement after the Supreme Court lifted the injunction on the Public Charge Rule. Among alleged benefits of the Public Charge Rule, Grisham stated the final Rule would “protect hardworking American taxpayers,” and “re-establish the fundamental legal principle” that immigrants “should be financially self-reliant and not dependent on the largess of [U.S.] taxpayers.”¹⁴³

4.1.2 Discussion

Statements made by the former Trump administration seem to suggest that the Public Charge Rule was promulgated for the overarching purposes of encouraging immigrant success and protecting American taxpayers. In practice, however, neither of these objectives are satisfied. Cuccinello’s statements in particular are both derogatory and discriminate against many noncitizens who are subject to the public charge determination. Cuccinello praises immigrants

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ Statement, Stephanie Grisham, Statement from the Press Secretary (Feb. 22, 2020).

who are financially self-sufficient and claims that reliance on government aid is quintessentially “unamerican;” while on average, 52.2 million (or 21.3%) of the U.S. population participate in one or more federal assistance programs per month.¹⁴⁴ If self-sufficiency was the true purpose, the Public Charge Rule effectively discriminates against noncitizens of lower-income, whereas noncitizens with higher-incomes fit the so-called “American ideal.” Next, the purpose of protecting U.S. taxpayers is unfounded and likely false. Explained later in Part 4.4 of the Analysis section, the vast majority of costs for uncompensated medical care are paid for by local taxpayers through higher tax rates. The downstream effects of the Public Charge Rule will likely burden U.S. taxpayers even more than before the Rule was in place. Both proposed purposes of the Public Charge Rule are without merit, and the Rule itself does not achieve its supposed objectives.

When considering the outcomes of the Public Charge Rule, the true purpose behind the Rule’s inception is far more troubling. Public benefits are typically used by low-income, low-socioeconomic status (SES) individuals in periods of financial need or instability. Therefore, the Public Charge Rule discriminates against low-SES immigrants in favor of higher-SES immigrants by restricting eligibility to enter or remain in this country only for lower-income immigrants. The Rule also penalizes low-SES immigrants who seek to enter or remain in the U.S. through lawful channels. A low-SES immigrant could be disincentivized from entering the U.S. legally or remaining legally, since immigrants deemed likely to become a public charge are inadmissible, and use of public benefits could jeopardize a residing immigrant’s status. To avoid the threat of deportation based on a public charge determination, low-SES immigrants are more likely to enter or remain in the U.S. illegally. In effect, the Public Charge Rule will further

¹⁴⁴ Shelley K. Irving & Tracy A Loveless, U.S. CENSUS BUREAU, U.S. DEP’T OF COM., DYNAMIC OF ECONOMIC WELL-BEING: PARTICIPATION IN GOVERNMENT PROGRAMS 2009-2012: WHO GETS ASSISTANCE? (May 2015).

exacerbate the ongoing issue of illegal immigration. Lastly, the Public Charge Rule has negative economic, health, and social consequences for legal immigrants already residing in the U.S., citizen children of noncitizen parents, and local communities. The former Trump administration superficially expected noncitizen immigrants to “succeed” once removed from public benefits. In truth, the Rule filters out low-income immigrants to allow only those with wealth to stay, and denies those who are less fortunate. Low-SES immigrants who choose to disenroll from public benefits to keep their status will likely face the consequences of serious health problems and financial risk.

4.2 The Rule Will Cause Poor Health Outcomes for Disenrolled Adults & Children

The Public Charge Rule considers Medicaid enrollment as a negative factor toward a noncitizen’s determination of admissibility. Medicaid is a public insurance program intended to help low-income families access health care. A person’s SES, their social standing or class, is intimately connected to his or her health status.¹⁴⁵ The literature demonstrates that acquiring health insurance coverage leads to improved health outcomes.¹⁴⁶ Removing Medicaid eligibility from noncitizens will put already vulnerable, low-SES families at risk of poorer health outcomes.

4.2.1 Scope of Medicaid

Medicaid was specifically designed to expand access to affordable health care for the U.S. population with low-income.¹⁴⁷ States elect to participate in Medicaid and have considerable leeway to design their medical assistance programs; but, those who participate are

¹⁴⁵ *Socioeconomic status*, AMERICAN PSYCHOLOGICAL ASS’N, <https://www.apa.org/topics/socioeconomic-status/> (last visited Apr. 10, 2021).

¹⁴⁶ INSTITUTE OF MEDICINE, *CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE* 6 (2002) [hereinafter *CARE WITHOUT COVERAGE*].

¹⁴⁷ OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEP’T OF HEALTH & HUMAN SERVICES, *Using Medicaid to Support Working Age Adults With Serious Mental Illnesses in the Community: A Handbook, A Brief History* (Jan. 24, 2005), at <https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook/brief-history-medicaid> [hereinafter *ASSISTANT SECRETARY FOR PLANNING AND EVALUATION*].

required to provide a foundation of basic health care services to recipients.¹⁴⁸ All 50 States have opted to participate in a State Medicaid program; as of April 2021, 39 States (including D.C.) have expanded Medicaid, and 12 states have not adopted expansion.¹⁴⁹ States that have chosen to expand Medicaid must cover nonelderly adults with income up to 138% of the federal poverty level (FPL).¹⁵⁰ States that have not expanded Medicaid institute their own FPL percentage for Medicaid eligibility.¹⁵¹ The 2021 FPL for an individual is an annual income of \$12,880.¹⁵² To illustrate, an individual must earn \$17,774.40 per year or less to be eligible for Medicaid in a State with a qualifying FPL of 138%.

4.2.2 Socioeconomic Status & Health Status

It is well established that an individual's SES and health status are tightly correlated.¹⁵³ SES has bidirectional effects, such that poor health may cause declines in income or loss of employment, and likewise poverty generates poor health outcomes.¹⁵⁴ In fact, socioeconomic disadvantage can have a “continuing and cumulative effect” when faced throughout an individual's lifetime.¹⁵⁵ Experiencing low-SES during childhood may affect health status in adulthood.¹⁵⁶ Poverty, low educational attainment, and economic hardship are associated “with higher rates of chronic illness, poor self-reported health status, disability, and lower life expectancy.”¹⁵⁷

¹⁴⁸ ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, *supra* note 147.

¹⁴⁹ *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUND. (Mar. 31, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

¹⁵⁰ Robin Rudowitz et al., *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAMILY FOUND. 3 (Mar. 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>.

¹⁵¹ *Id.*

¹⁵² An annual income of \$12,880 is the 2021 poverty guideline for the 48 contiguous states and the District of Columbia. OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, Poverty Guidelines (Jan. 8, 2020), <http://aspe.hhs.gov/poverty-guidelines>.

¹⁵³ CARE WITHOUT COVERAGE, *supra* note 146, at 37.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

4.2.3 Health Outcomes of Uninsured Adults

A loss of insurance is a major barrier to accessing health care services for low-income individuals. Insurance both increases one's likelihood of using medical care and facilitates the appropriate use of health care services.¹⁵⁸ Uninsured individuals are less likely to seek preventative care, such as chronic disease management, and often do not have a regular source of care or continuity of care.¹⁵⁹ One study found that over 30% of non-elderly, uninsured adults went without needed care in the past year due to cost, compared to only 5.3% with private insurance and 9.5% of adults with public insurance.¹⁶⁰ The study also found that poor access to health care among the uninsured was due, in part, because over 40% reported they did not have a regular source of care.¹⁶¹ Individuals without a regular source of health care are more likely to delay seeking emergency medical services, which can compromise health outcomes.¹⁶² Without properly managing chronic diseases, uninsured individuals with chronic illness have consistently worse clinical outcomes than insured patients.¹⁶³ To illustrate, on average uninsured cancer patients die sooner due to delayed diagnosis compared to insured cancer patients.¹⁶⁴ Uninsured individuals are also less likely to receive regular outpatient care and therefore are more likely to seek in-patient hospitalization for "avoidable health problems" and experience overall declines in health.¹⁶⁵ When hospitalized, uninsured patients have a higher mortality rate compared to insured patients.¹⁶⁶ Uninsured patients receiving in-patient care receive fewer diagnostic and therapeutic

¹⁵⁸ *Id.* at 7.

¹⁵⁹ *Id.*

¹⁶⁰ Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, KAISER FAMILY FOUND. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

¹⁶¹ *Id.*

¹⁶² CARE WITHOUT COVERAGE, *supra* note 146, at 12.

¹⁶³ *Id.* at 9.

¹⁶⁴ *Id.* at 8.

¹⁶⁵ Tolbert et al., *supra* note 160.

¹⁶⁶ *Id.*

services, have an increased risk of resultant injury due to substandard care, and have a greater risk of dying shortly after discharge.¹⁶⁷

Evidence across multiple research studies consistently shows that adults who are uninsured have poorer health outcomes and die prematurely.¹⁶⁸ Even short periods (one to four years) without insurance can result in a decline in general health, and receiving insufficient medical care or receiving care too late can have harmful effects on health.¹⁶⁹ Studies have found that adults have an increased risk of premature death when they are uninsured for longer periods of time.¹⁷⁰ Lacking insurance is correlated with a worse quality of life than those with insurance, due to poorer health status and shorter length of life.¹⁷¹ A lack of insurance also exacerbates disparities in morbidity and mortality rates among racial and ethnic groups.¹⁷² Vulnerable populations, such as racial minorities and low-SES populations, are already at risk of worse health and would benefit the most from obtaining insurance coverage.¹⁷³ Research shows that gaining back insurance coverage after being uninsured simultaneously improves access to health care and lessens the adverse effects of having been previously uninsured.¹⁷⁴

¹⁶⁷ CARE WITHOUT COVERAGE, *supra* note 146, at 12.

¹⁶⁸ *Id.* at 3-4.

¹⁶⁹ *Id.* at 4.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 7.

¹⁷² *Id.*

¹⁷³ *Id.* at 4, 14.

¹⁷⁴ Tolbert et al., *supra* note 160.

4.2.4 Health Outcomes of Uninsured Children

Children without health insurance coverage risk neglecting needed health care visits critical for healthy child development. In 2019, over 10% of uninsured children did not get needed medical care due to cost, compared to less than 1% of children with private insurance.¹⁷⁵ Further, 20% of uninsured children did not see a physician in the past year, compared to only 3.5% of insured children.¹⁷⁶ Evidence shows that providing health insurance coverage to previously uninsured, Medicaid and CHIP-eligible children results in “significantly better health status; improved access to medical, preventative, and dental care; greater use of preventative services; [and] a higher quality of well-child care[.]”¹⁷⁷

Public health insurance programs like CHIP substantially increase a child’s likelihood of receiving care and sustaining good health. Conversely, a lack of insurance coverage increases a child’s risk for illness and stress. Research suggests that “excessive and persistent adversity” in early life can lead to long-term health consequences into adulthood.¹⁷⁸ A high frequency of stress response activation in childhood can lead to greater risk for stress-related diseases in adulthood, including “cardiovascular disease, obesity, type 2 diabetes, respiratory and immunological disorders, and a range of mental health problems.”¹⁷⁹ Furthermore, when the immune system is activated, the body experiences an inflammatory response necessary to attack invading bacteria and viruses.¹⁸⁰ A constant state of inflammatory activation, however, leads to organ damage and

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ Glenn Flores et al., *The health and healthcare impact of providing insurance coverage to uninsured children: a prospective observational study*, 17 BMC PUBLIC HEALTH 553 (2017), available at <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-017-4363-z>.

¹⁷⁸ *InBrief: Connecting the Brain to the Rest of the Body*, CTR. ON THE DEVELOPING CHILD, HARVARD U., <https://developingchild.harvard.edu/resources/inbrief-connecting-the-brain-to-the-rest-of-the-body/> (last visited Apr. 10, 2021).

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

a less efficient immune response.¹⁸¹ Thus, researchers believe frequent immune system activation in early life makes children “more susceptible to recurrent infection and more prone to develop[ing] chronic inflammatory conditions [,] . . . including heart disease, diabetes, depression, arthritis, gastrointestinal disorders, autoimmune disorders, multiple types of cancer, and dementia[.]”¹⁸²

Uninsured children are also at risk of suffering developmental delays that could negatively impact academic achievement and opportunity later in life.¹⁸³ A “path can be traced” between lacking health insurance and a child failing to fulfill their academic potential.¹⁸⁴ Evidence shows that a relationship exists between illness, absence in school, and learning.¹⁸⁵ If an ill child cannot receive care, they are likely to miss more school, and therefore cannot fully benefit from their education and are unable to achieve typical developmental milestones.¹⁸⁶ Adequate care both improves health outcomes and enables normal development to ensure a child has the opportunity to succeed in their education and into the future.¹⁸⁷

4.2.5 Discussion

In 2018, over 6.3 million foreign-born people living in the U.S. reported earnings below the federal poverty level.¹⁸⁸ Though difficult to estimate, these numbers suggest that millions of immigrants could potentially disenroll from Medicaid or choose not to enroll themselves or their children in Medicaid and CHIP. Noncitizens who become uninsured risk significant harm to their

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ CARE WITHOUT COVERAGE, *supra* note 146, at 7, 73.

¹⁸⁴ *Id.* at 75.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ Because this is a census approximation, the estimated number of 6.3 million could be undercounted. The 6,317,000 account for approximately 13.8% of the total Foreign-Born population in 2018. U.S. CENSUS BUREAU, TABLE 2.13 POVERTY STATUS OF THE FOREIGN-BORN POPULATION BY SEX, AGE, AND YEAR OF ENTRY: 2018 (2019), <https://www.census.gov/data/tables/2019/demo/foreign-born/cps-2019.html>.

health, and premature death in severe cases. Noncitizen parents disenrolling their noncitizen and U.S. citizen children from Medicaid and CHIP due to the “chilling effect” of the Public Charge Rule could lead to lasting, damaging health, economic, and social consequences for the child.

4.3 The Rule Will Have Negative Economic Impacts

The Public Charge Rule could lead to millions of immigrants and their family members to disenroll from Medicaid and CHIP, causing widespread downstream costs. Immigrants and their families who lose insurance coverage will bear the financial burden of paying for their own care, and costs stemming from poorer health. A rise in uncompensated care increases the cost-burden on hospitals, potentially leading to hospital closures. Uncompensated care is largely paid for by public support from federal, state, and local governments; a rise in uncompensated care will ultimately lead to an increased local tax burden on taxpayers to fund public support for hospitals.

4.3.1 Financial Impact on Noncitizen Persons and Families

Uninsured families often have lower income and are therefore less likely to use health care services due to cost.¹⁸⁹ As a result, the “lost utilization” of medical care becomes costly when poor health, disability, and premature death ensues.¹⁹⁰ When uninsured families use health care, they bear a disproportionately higher percentage of costs from high out-of-pocket expenses, causing financial stress and insecurity.¹⁹¹ Research shows that uninsured individuals pay for nearly half of their health care out-of-pocket each year.¹⁹² Furthermore, hospitals often charge uninsured patients higher rates compared to rates charged against private and public insurers.¹⁹³ A 2019 study found that over 75% of uninsured adults reported they were “very or somewhat

¹⁸⁹ INSTITUTE OF MEDICINE, HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 59-90 (2003) [hereinafter HIDDEN COSTS].

¹⁹⁰ *Id.* at 59-60.

¹⁹¹ *Id.* at 15, 59-60.

¹⁹² Tolbert et al., *supra* note 160.

¹⁹³ *Id.*

worried about paying medical bills[.]” compared to only 47.6% of adults with public insurance, and 46.1% of adults with private insurance.¹⁹⁴ Moreover, uninsured adults were almost 2 times as likely to have problems paying medical bills compared to privately insured adults (24.1% versus 11.6%).¹⁹⁵ In contrast, a 2017 study found that providing insurance coverage to previously uninsured, Medicaid and CHIP-eligible children reduced out-of pocket costs and the overall family financial burden, saving families “approximately \$2,886 per year per child insured.”¹⁹⁶ Medicaid and CHIP are crucial programs for low-income families to maintain their financial security, stability, and health status.

4.3.2 Direct Costs of Uncompensated Health Care

“Noncitizens and their families that drop or forgo Medicaid or CHIP coverage as a result of the Public Charge Rule will continue to have the same health care needs. But now they will likely postpone treatment, forcing hospitals to provide uncompensated care in emergency rooms for conditions that could have been treated, or even prevented, through primary-care visits. These added costs will likely prevent hospitals from fully serving their patients and communities.”

- American Hospital Association et. al., Amici Curiae Brief to United States District Court Northern District of California¹⁹⁷

The national cost of uncompensated care for community hospitals totaled \$41.3 billion in 2018, not including underpayment from Medicaid and Medicare.¹⁹⁸ More than \$660 billion in

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ Glenn Flores et al., *supra* note 177.

¹⁹⁷ Proposed Amici Curiae Brief of the American Hospital Association et al. at 12, *City and County of San Francisco and County of Santa Clara v. U.S. Citizenship and Immigration Services et al.*, 944 F.3d 773 (9th Cir. 2019) (No. 4:19-cv-04717), <https://www.aha.org/system/files/media/file/2019/09/amici-curiae-brief-of-aha-hospital-groups-on-dhs-public-charge-rule-9-11-1019.pdf> [hereinafter AHA Proposed Amici Curiae Brief].

¹⁹⁸ *Fact Sheet: Uncompensated Hospital Care Cost*, AM. HOSP. ASS’N (Jan. 2020), <https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost>.

uncompensated care has been provided by hospitals since 2000.¹⁹⁹ This cost burden of billions is shared among both public and private entities, though ultimately, individuals acting as taxpayers, health care providers, employees, and health care consumers bear the majority of unmet costs.²⁰⁰

Hospitals cover costs of uncompensated care through federal, state, and local programs and subsidies, private health insurance, philanthropic support, and hospitals' own-sourced funds, such as private payer and self-pay surplus.²⁰¹ In an amicus brief opposing the Public Charge Rule, the American Hospital Association (AHA) and other health care groups wrote that “hospitals are at risk of spending as much as \$17 billion dollars every year in additional uncompensated care costs” as a result of the Public Charge Rule.²⁰² Furthermore, the AHA claimed the Public Charge Rule would force hospitals to provide uncompensated care in their emergency departments—the most expensive health care setting.²⁰³ The UnitedHealth Group reported that “[t]reating conditions that should be managed in the primary care setting costs 12 times more” when delivered in a hospital’s emergency department.²⁰⁴ The AHA also claimed that public and safety-net hospitals located and operating in “predominantly immigrant and lower-income communities” would face the largest burden of uncompensated care.²⁰⁵ A sharp increase in uninsured patients will force public and safety-net hospitals already in precarious financial positions “to make difficult operational and financial decisions, including whether they must limit certain other services, close free clinics, or shut down entirely.”²⁰⁶

¹⁹⁹ *Id.*

²⁰⁰ HIDDEN COSTS, *supra* note 189, at 53.

²⁰¹ *Id.* at 53-55.

²⁰² AHA Proposed Amici Curiae Brief, *supra* note 197, at 12.

²⁰³ *Id.* at 12-13.

²⁰⁴ Jacqueline LaPointe, *Public Charge Rule to Boost Uncompensated Care Costs, Hospitals Say*, REVCYCLE INTELLIGENCE XTELLIGENT HEALTHCARE MEDIA (Sept. 12, 2019), <https://revcycleintelligence.com/news/public-charge-rule-to-boost-uncompensated-care-costs-hospitals-say>.

²⁰⁵ AHA Proposed Amici Curiae Brief, *supra* note 197, at 13.

²⁰⁶ *Id.*

Despite the cost burden of uncompensated care on hospitals, between 75% and 85% of total direct costs of uncompensated care per year is paid for by public support from federal, state, and local governments.²⁰⁷ Federal subsidies account for 60% of governmental support funding uncompensated care costs in hospitals, through federal Medicare and Medicaid disproportionate share hospital (DSH) payments, portions of Medicare payments that support services to medically indigent patients, and supplemental Medicaid financing such as upper-payment limit (UPL) mechanisms.²⁰⁸ Hospitals also receive state and local subsidies and are allocated budget funds for hospital care and operational costs.²⁰⁹ State and local governments support uncompensated care in hospitals through tax appropriations, funding for indigent care programs, and Medicaid DSH and UPL payments.²¹⁰ When states provide in-kind care to the medically indigent, the direct costs disproportionately fall onto the local area where care is provided.²¹¹ Most direct costs for uncompensated care burden the average taxpayer and health care consumer in the form of higher local taxes, and a reduction of available funds and resources for other public programs.²¹²

4.3.3 Spillover & Opportunity Costs from Poor Health Outcomes

The vast majority of costs produced by a large uninsured population are not direct costs from uncompensated care, but rather result from the poorer health outcomes of those without insurance.²¹³ These “spillover costs” felt across communities emerge as financial risk and uncertainty experienced by individuals with poor health, demand on local budgets, a loss of public health resources, and less control of chronic and communicable diseases.²¹⁴

²⁰⁷ HIDDEN COSTS, *supra* note 189, at 5-6, 53.

²⁰⁸ *Id.* at 53-54.

²⁰⁹ *Id.*

²¹⁰ *Id.* at 54.

²¹¹ *Id.* at 6.

²¹² *Id.* at 58.

²¹³ *Id.* at 2.

²¹⁴ *Id.* at 58.

Uncompensated care also causes higher fiscal costs for other public programs, including Medicare, Social Security Disability Insurance, and the criminal justice system.²¹⁵

One last effect of uncompensated care is the opportunity cost, or loss of valued life. Opportunity costs account for losses of productivity that accrue by those experiencing poorer health.²¹⁶ The Institute of Medicine estimates that the aggregate, annual economic cost of poor health and premature death caused by uninsurance is between \$65 and \$130 billion per year uninsured.²¹⁷ These opportunity costs are the benefits that could be realized if acquiring insurance reduced both morbidity and mortality to the levels of comparable, insured individuals.²¹⁸

4.3.4 Discussion

The Public Charge Rule not only financially burdens the immigrants and families who become uninsured—it also has negative downstream economic implications for their entire communities. As noted in Section 4.1 of the Analysis section, former White House Press Secretary Stephanie Grisham claimed the Public Charge Rule would protect American taxpayers. In reality, the Rule induces additional financial burden on taxpayers through raised local taxes. A rise in uncompensated care depletes local resources and funding for other publicly funded community programs too. Public and safety-net hospitals closing due to increased uncompensated care depletes local accessibility of health care, and consequently threatens the health and livelihood of the low-income communities they serve. Local economies will also have to face the billions of dollars in opportunity costs from unemployed immigrants who grow ill

²¹⁵ *Id.* at 7.

²¹⁶ *Id.*

²¹⁷ *Id.* at 64.

²¹⁸ *Id.*

from inadequate health care and cannot work. These cumulative costs caused by the Public Charge Rule are systemic and will undeniably arise soon.

4.4 Impacts of COVID-19 on the Hispanic Population

The U.S. Hispanic population has experienced significant economic impacts and concerning health outcomes in response to the COVID-19 pandemic. Evidence indicates that Hispanic people are 1.3 times as likely to contract COVID-19 compared to non-Hispanic whites, and experience disproportionately higher mortality rates once they contract the virus.²¹⁹ Compared to non-Hispanic whites, Hispanic people are also 3.1 times as likely to be hospitalized for COVID-19 and 2.3 times as likely to die from COVID-19.²²⁰ Although racial minorities were found to be more likely than non-Hispanic whites to alter behaviors to help reduce the spread of the virus, Hispanic people experience inherent structural factors that increase their risk of contracting COVID-19.²²¹ For example, both Hispanic people and immigrants generally are “more likely to be essential employees with jobs that require them to leave their homes and place themselves and their families at risk.”²²² Additionally, 27% of the Hispanic population lived in multigenerational households in 2016, defined as “including two or more adult generations, or including grandparents and grandchildren younger than 25.”²²³ Hispanic people are also “more

²¹⁹ Gabriel R. Sanchez et al., *COVID-19 is having a devastating impact on the economic well-being of Latino families*, BROOKINGS (July 27, 2020), <https://www.brookings.edu/blog/how-we-rise/2020/07/27/covid-19-is-having-a-devastating-impact-on-the-economic-well-being-of-latino-families/>; *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Mar. 12, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

²²⁰ *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity*, *supra* note 219.

²²¹ Alexandra Hernandez-Vallant et al., *Compliant But Unprotected: Communities of Color Take Greater Action to Prevent the Spread of COVID-19 But Remain at Risk*, INTERDISCIPLINARY ASS'N FOR POPULATION HEALTH SCI., <https://iaphs.org/compliant-but-unprotected-communities-of-color-take-greater-action-to-prevent-the-spread-of-covid-19-but-remain-at-risk/> (last visited Apr. 10, 2021).

²²² *Id.*

²²³ D’Vera Cohn & Jeffrey S. Passel, *A record 64 million Americans live in multigenerational households*, PEW RESEARCH CTR. (Apr. 5, 2018), <https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/>.

likely to live in crowded households due to a lack of living wage and unaffordable housing.”²²⁴ These factors make following social distancing guidelines difficult for Hispanic families and therefore increase the risk of spreading COVID-19 to family members living in the same household.²²⁵

The Hispanic population has also been “particularly hit hard by the economic fallout of the pandemic.”²²⁶ Between the third quarters of 2019 and 2020, the unemployment rate for all Hispanic people rose from 4.2% to 11.2%, and rose 4.8% to 12.5% for Hispanic women.²²⁷ Approximately 29% of Hispanic families experienced a job loss due to COVID-19 by someone in their household.²²⁸ Similarly, 33% of Hispanic parents have experienced drops in revenue or had to shut down their small-businesses.²²⁹ With a rise in unemployment, many Hispanic people have lost employer-sponsored health insurance coverage. Many are also facing housing insecurity as 41% of Hispanic parents report having trouble paying rent or mortgage.²³⁰ The intersectionality of unemployment, being uninsured, experiencing housing insecurity, and having an increased risk of contracting and dying from COVID-19 makes the Hispanic population particularly vulnerable to policies like the Public Charge Rule in the present moment.

²²⁴ Miriam Delaney Heard, *The Effects of COVID-19 on America’s Hispanic and Latinx Communities*, NAT’L HEALTH L. PROGRAM (Aug. 11, 2020), <https://healthlaw.org/the-effects-of-covid-19-on-americas-hispanic-and-latinx-communities/>.

²²⁵ *Id.*

²²⁶ Artiga et al., *supra* note 117.

²²⁷ *Id.*

²²⁸ Sanchez et al., *supra* note 219.

²²⁹ *Id.*

²³⁰ *Id.*

5.0 SUMMARY— PUBLIC HEALTH IMPLICATIONS

The public health implications of the Public Charge Rule for the U.S. Hispanic population are momentous. The Public Charge Rule makes an immigrant inadmissible or ineligible for an adjustment of immigration status if they are deemed “likely at any time to become a public charge;” a public charge determination is characterized by a likelihood of receiving public benefits, like Medicaid.²³¹ Over a third of the U.S. Hispanic population were immigrants in 2018, and half of the U.S. foreign-born population identified as Hispanic.²³² Hispanic people comprise a significant portion of Medicaid enrollees, accounting for almost one third of all Medicaid enrollees in 2018.²³³ Medicaid also covers more than half of all Hispanic children.²³⁴ The Public Charge Rule’s chilling effect is causing immigrants to disenroll or not to enroll themselves and their family members, regardless of their U.S. citizenship, in Medicaid and CHIP “due to fears and uncertainty” surrounding the Rule.²³⁵ Millions of Medicaid and CHIP enrollees live in mixed immigration status households,²³⁶ and sources estimate that up to 23 million noncitizens and their U.S. citizen family members using public benefits could disenroll from crucial benefit programs.²³⁷

A loss of insurance is a major barrier to accessing health care services for low-income individuals and is directly correlated with poorer health outcomes and premature death.²³⁸ A loss of insurance for a child risks neglecting health care visits critical for healthy child development, diminished academic attainment, and long-term health consequences into adulthood. A loss of Medicaid can also create serious financial insecurity since uninsured individuals pay for nearly

²³¹ NAFSA, *supra* note 46; *Public Charge Fact Sheet*, *supra* note 49.

²³² Ornelas et al., *supra* note 101; *Facts on U.S. immigrants, 2018*, *supra* note 1.

²³³ NAT’L COMM. TO PRESERVE SOCIAL SECURITY & MEDICARE, *supra* note 109; Shiro & Reeves, *supra* note 109.

²³⁴ NAT’L COMM. TO PRESERVE SOCIAL SECURITY & MEDICARE, *supra* note 109.

²³⁵ Artiga & Diaz, *supra* note 58.

²³⁶ *Changes to “Public Charge” Inadmissibility Rule*, *supra* note 85.

²³⁷ Batalova, et al., MIGRATION POLICY INST., *supra* note 90.

²³⁸ CARE WITHOUT COVERAGE, *supra* note 146, at 3-4.

half of their care costs out-of-pocket per year.²³⁹ The U.S. Hispanic population already has a disproportionately higher rate of poverty compared to other racial groups.²⁴⁰ Since poor health declines an individual's SES and, likewise, poverty generates poor health outcomes,²⁴¹ millions of Hispanic immigrants and their U.S. citizen family members disenrolling from Medicaid and CHIP will be condemned to the incessant feedback loop of uninsurance, poverty, and poor health outcomes. In addition, Hispanic people are experiencing this negative feedback loop amidst the deadly threat of COVID-19, which creates an even greater risk of poor health outcomes or death.

²³⁹ Tolbert et al., *supra* note 160.

²⁴⁰ Creamer, *supra* note 104.

²⁴¹ CARE WITHOUT COVERAGE, *supra* note 146, at 37.

6.0 IMMIGRATION REFORM WITH THE BIDEN ADMINISTRATION

President Joe Biden’s 2020 presidential campaign ran in part on the promise to reform America’s immigration system, and “take urgent action” to undue damage caused by harmful immigration policies implemented by the former Trump administration.²⁴² In particular, Biden pledged to “[r]everse Trump’s public charge rule” because the “discriminatory” rule “undermines America’s character as [a] land of opportunity” by admitting only the wealthy.²⁴³ On February 2, 2021, President Biden signed Executive Order Number 14012 titled “Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans.”²⁴⁴ Section 4 of the Executive Order prompted a review by the Secretary of State, Attorney General, Secretary of Homeland Security, and other agency heads to “review all agency actions related to implementation of the public charge ground of inadmissibility in section 212(a)(4) of the . . . [INA], and the related ground of deportability in section 237(a)(5) of the INA[.]”²⁴⁵ As of April 2021, the review by DHS, in consultation with the Departments of Justice and States and other agencies, is still ongoing.²⁴⁶

As mentioned previously, on November 3, 2020, the U.S. Court of Appeals for the Seventh Circuit stayed the November 2, 2020 decision by the U.S. District Court for the Northern District of Illinois to vacate the Public Charge Rule nationwide. On March 9, 2021, “DHS moved to dismiss its appeal before the Seventh Circuit, and the Seventh Circuit dismissed its appeal” causing the original November 2nd order to vacate the Public Charge Rule to go into

²⁴² *The Biden Plan For Securing Our Values As A Nation Of Immigrants*, BIDEN HARRIS, <https://joebiden.com/immigration/> (last visited Apr. 11, 2021).

²⁴³ *Id.*

²⁴⁴ Exec. Order No. 14012, 86 Fed. Reg. 8,277 (Feb. 2, 2021) at 8,277.

²⁴⁵ *Id.* at 8,278.

²⁴⁶ *DHS Secretary Statement on the 2019 Public Charge Rule*, U.S. DEPT. OF HOMELAND SECURITY (Mar. 9, 2021), <https://www.dhs.gov/news/2021/03/09/dhs-secretary-statement-2019-public-charge-rule>.

effect, thereby preventing the Rule from being in effect.²⁴⁷ That same day, DHS Secretary Alejandro N. Mayorkas announced that “the government will no longer defend the 2019 public charge rule as doing so is neither in the public interest nor an efficient use of limited government resources.”²⁴⁸ On March 15, DHS published the “Inadmissibility on Public Charge Grounds; Implementation of Vacatur” rule, effected on March 9, 2021, that “implement[ed] the district court’s vacatur of the [Public Charge Rule],” causing the Rule to “no longer [have] any legal effect[.]”²⁴⁹ With this vacatur, USCIS immediately stopped applying the Public Charge Rule to all pending applications and petitions.²⁵⁰ USCIS is now applying the public charge inadmissibility statute in accordance with the 1999 Interim Field Guidance, the standard that was in place before the Public Charge Rule was employed.²⁵¹ Similarly, USCIS is not applying the “public benefits condition” to pending applications and petitions for extension of stay or change of status.²⁵² USCIS is not considering any information related to the Public Charge Rule in applications already submitted.²⁵³

Although the Seventh Circuit’s March 9th decision to lift its stay may feel like a victorious moment in this Public Charge Rule debate, several Republican state attorneys general who support the Public Charge Rule are currently “turning to the courts in hopes of preserving” Trump’s former immigration agenda.²⁵⁴ As of March 15, 2021, a dozen Republican state

²⁴⁷ Inadmissibility on Public Charge Grounds; Implementation of Vacatur, 86 Fed. Reg. 14221 (Mar. 15, 2021) (to be codified at 8 C.F.R. 103, 106, 212, 213, 214, 245, 248).

²⁴⁸ *DHS Secretary Statement on the 2019 Public Charge Rule*, HOMELAND SECURITY, *supra* note 246.

²⁴⁹ 86 Fed. Reg. 14221, *supra* note 247.

²⁵⁰ *Public Charge*, U.S. CITIZENSHIP & IMMIGR. SERV., <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge> (last visited Apr. 11, 2021).

²⁵¹ *Id.*

²⁵² *Id.*

²⁵³ *Id.* Applicant information not considered by USCIS includes: “information provided on Form I-944, evidence or documentation submitted with Form I-944, or information on the receipt of public benefits on Form I-129 (Part 6), Form I-129CW (Part 6), Form I-539 (Part 5), and Form I-539A (Part 3).” *Id.*

²⁵⁴ John Kruzell, *Republican AGs fight Biden rollback of Trump immigration agenda*, THE HILL (Mar. 15, 2021, 6:00 AM), <https://thehill.com/homenews/administration/543026-republican-ags-fight-biden-rollback-of-trump-immigration-agenda>.

attorneys led by the attorneys general offices of Mark Brnovich (Arizona, R) and Ken Paxton (Texas, R) are “seeking to litigate the [Public Charge Rule] issue in three different federal appeals courts” with hopes of eventually reaching the Supreme Court.²⁵⁵ Brnovich has publicly defended the Public Charge Rule, claiming the Rule “[e]nsures our government welfare programs won’t be overrun.”²⁵⁶ In a motion to intervene the Public Charge Rule decision on March 10, 2021, Brnovich addressed the Ninth Circuit Court of Appeals, claiming that “U.S. states would collectively pay out an additional \$1 billion annually in public benefits if the 2019 [Public Charge Rule] were struck down.”²⁵⁷

Courts generally view immigration law as “the exclusive purview of the federal government” and therefore legal challenges to the Public Charge Rule will likely “face an uphill battle.”²⁵⁸ Nevertheless, legal challenges to Biden’s immigration reforms will continue to mount as lawmakers are unlikely to reach bipartisan agreement on immigration issues.²⁵⁹ Also, because immigration reform is so politically polarized, it is very possible the Public Charge Rule could be supported by the next Republican presidential administration. Consequently, the future of the Public Charge Rule is uncertain.

²⁵⁵ *Id.*

²⁵⁶ John Kruzel, *Biden rescinds Trump’s ‘public charge’ rule*, THE HILL (Mar. 11, 2021, 7:25 PM), <https://thehill.com/regulation/court-battles/542860-biden-rescinds-trumps-public-charge-rule?rl=1>.

²⁵⁷ Daniel Wiessner, *States seek to take over defense of ‘public charge’ rule*, REUTERS (Mar. 11, 2021, 5:58 PM), <https://www.reuters.com/article/immigration-publiccharge/states-seek-to-take-over-defense-of-public-charge-rule-idUSL1N2L93DH>.

²⁵⁸ Kruzel, *Republican AGs fight Biden rollback*, *supra* note 252.

²⁵⁹ *Id.*

7.0 POLICY RECOMMENDATION

Since the vacatur, USCIS is not applying the Public Charge Rule, and therefore is not considering any use of public benefits to any pending applications, submitted applications, or petitions for extension of stay or charge of status. Nevertheless, Republican state attorneys general are seeking to litigate the Public Charge Rule issue. The future of the Public Charge Rule will ultimately be determined by the federal courts. The Supreme Court is the “final arbiter” and has “plenary authority to vacate the decisions of the lower courts when the circumstances warrant that action.”²⁶⁰ Since the Public Charge Rule vacatur is currently being challenged in three federal appeals courts and could eventually reach the Supreme Court, the future of the Rule is uncertain. Thus, the Public Charge Rule still has potential future public health implications for affected immigrants and their family members.

If the Public Charge Rule vacatur is reversed and the Rule is put into effect again, **DHS should remove Medicaid from the list of public benefits considered during a public charge determination.** Although all public benefit programs are useful resources for low-SES immigrant families, Medicaid is a crucial benefit that directly impacts health outcomes for millions of enrollees. Without Medicaid coverage, low-SES immigrants and their family members are unlikely to be able to afford other forms of health insurance. Therefore, millions of immigrants and their family members may go uninsured and risk severe adverse health outcomes.

²⁶⁰ *An Opinion Has Been Vacated—Now What?*, ROBINS KAPLAN LLP (Mar. 17, 2017), <https://www.robinskaplan.com/resources/publications/2017/03/an-opinion-has-been-vacated-now-what>.

8.0 CONCLUSION

The Public Charge Rule will lead to a significant decrease in Medicaid enrollment by otherwise eligible, noncitizen immigrants and their family members. A loss of insurance coverage will cause poor health outcomes for immigrants and their children. The Rule will also cause downstream tax burdens on local economies due to a rise in uncompensated care provided in hospitals. The Public Charge Rule's alleged purposes purported by the former Trump administration are unfulfilled. Instead, the Public Charge Rule discriminates against immigrants based on their class and follows the U.S. government's longstanding tradition of racism toward immigrants. The Public Charge Rule is a failed policy, with public health and economic implications too severe to justify a rule with no just purpose.

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