American Association of Community Psychiatrists

Our Vision:

Advocate and partner to **implement resiliency and recovery oriented services** while continuously improving systems for those we serve

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Influence health and social policies to develop and sustain coordinated public health and clinical delivery systems that are aligned with compatible funding and payment methods, guided by principles of social justice and evidence-informed clinical practices, and supplied by a systems-ready workforce.

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Create and sustain a professional community for those who work in public, community and non-traditional service settings

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Develop and disseminate knowledge and skills for effective and sustainable practices and systems to advance population health

AACP Position Statement

Reject Proposed Homeland Security Rule Changes Regarding "Inadmissibility on Public Charge Grounds"

The American Association of Community Psychiatrists (AACP) urges the Department of Homeland Security to ***reject*** its proposed changes to section 212(a)(4) of the Immigration and Nationality Act.

As background, the AACP, founded in 1985, represents psychiatrists across the United States who identify with serving people with behavioral disorders in state, local, and federal public service environments and other organized care settings. Our membership includes clinicians, healthcare executives, academics, and public policy experts. We are extremely concerned that the proposed rules, if passed, would limit access to medical and mental health care for a large number of people already living legally in the US – specifically, those awaiting green cards and their family members.

The language of the October 10th 2018 "Notice of proposed rulemaking" states the following on Page 91:

DHS proposes to define public benefit to include a specific list of cash aid and noncash medical care, housing, and food benefit programs where either (1) the

cumulative value of one or more such benefits that can be monetized (i.e., where DHS can determine the cash value of such benefit) exceeds 15 percent of the Federal Poverty Guidelines (FPG) for a household of one within a period of 12 consecutive months based on the per-month FPG for the months during which the benefits are received (hereafter referred to as the 15 percent of FPG or the proposed 15 percent standard or threshold); or (2) for benefits that cannot be monetized, the benefits are received for more than 12 months in the aggregate within a 36-month period. The proposed definition also addresses circumstances where an alien receives a combination of monetizable benefits equal to or below the 15 percent threshold together with one or more benefits that cannot be monetized. In such cases, DHS proposes that the threshold for duration of receipt of the non- monetizable benefits would be 9 months in the aggregate within a 36-month period.

Our position is that in an effort to manage immigration pressures, these proposed changes in defining "public charge" are clearly counterproductive to the nation's health. The following proposed provisions are particularly detrimental.

The most directly tangible effect would be the inclusion of Medicaid and Medicare Part D enrollment (for a cumulative 9 to 12 months within a 36month period) into a formula for evaluation of disqualification for a Green Card. Our criticisms, beyond the obviously humanitarian ones, concern healthcare costs. This provision would act as a powerful disincentive for legal immigrants to actually enroll in public health insurance. The logical result would be an increase in very costly emergency and inpatient care, the one thing that health economists and public policymakers, regardless of ideological view, all agree we must minimize in order to drive down the high burden of healthcare costs carried by all American workers and taxpayers. The number of legal immigrants receiving Medicaid in 2017 is estimated to be 17%, or 2.2 million people. Imagine healthcare costs if half of them avoid this insurance.

In 2017, 24%, or 73 million, US citizens were Medicaid enrollees. Regardless of citizenship, it is not uncommon for a person to be on Medicaid for relatively transient periods, even if over 12 months, before he or she obtains commercial insurance in an ongoing manner through employment. If the US economy continues to improve, legal immigrants will experience an upwardly mobile transition in health insurance coverage, not social stagnation, along with US citizens. In fact, it is documented that immigrants enjoy a lower unemployment rate than citizens. A related issue involves children, particularly youth, who may receive CHIP in the three years prior to legal

age, and therefore risk being automatically disqualified from eventual citizenship, even while entering the workforce.

Our second point involves addressing poverty, a well-documented social determinant of medical illness. Enabling legal immigrants to reach the point where they actually move solidly into the workforce is critical in promoting primary prevention of disease. Receiving benefits like SNAP support a person's effort to move ahead financially. As such, it is not unusual for individuals, particularly young adults –whether citizens or not, to use SNAP as they reach for personal solvency, particularly in many urban communities where daily costs, especially for housing, are high.

Adopting the proposed change in the rule regarding public charge is therefore short-sighted. It does not account for downstream issues of much higher healthcare costs, seriously undermining our nation's goal for improved healthcare for less cost and, ironically, creating less robust self-sufficiency among legal immigrants.