December 6, 2018

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

RE: Guttmacher Institute Comments on Department of Homeland Security's Proposed Rule: Inadmissibility on Public Charge Grounds (Docket No. USCIS-2010-0012, RIN 1615-AA22)

On October 10, 2018 the Department of Homeland Security (DHS) published to the Federal Register a rule proposing changes to the regulations on inadmissibility on "public charge" grounds, which determines whether an individual is able to enter the United States under section 212(a)(4) of the Immigration and Nationality Act (INA).[1]

I am pleased to submit the following comments on behalf of the Guttmacher Institute, a nonprofit, nonpartisan research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. The information and analysis it generates on reproductive health and rights issues are widely used and cited by researchers, policymakers, media and advocates across the ideological spectrum.

The proposed rule would threaten access to Medicaid coverage for immigrants and their families, worsen existing disparities in sexual and reproductive health care and coverage for immigrants, undermine the fundamental goals of Medicaid, and harm the ability of immigrants to support themselves and their families. For these reasons, we strongly oppose the changes outlined in the proposed rule and, in response to DHS's specific question, would also oppose adding the Children's Health Insurance Program (CHIP) to the list of "public charge" determinations.

Proposed Public Charge Rule Provisions

The proposed rule would amend the process for determining whether the federal government can deny an individual seeking entry into the United States, or seeking to adjust their immigration status to legal permanent resident (LPR). The proposed public charge rule would not apply to refugees, asylees, survivors

of domestic violence, victims of trafficking, special immigrant juveniles, or individuals with temporary protected status, as well as LPR status individuals seeking citizenship. While the current "public charge" rule is inherently problematic, the proposed rule would go even further to expand the definition of "public charge" that has been in effect for almost 20 years, which would detrimentally impact the economic security, health and well-being of immigrant women, families and communities.

Under current law, an individual may be considered a "public charge" if they are primarily dependent on the government for subsistence, which is determined through receipt of cash assistance including Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or government-funded long-term institutional care. The proposed rule would broaden the list of benefits considered "negative factors" in a public charge assessment to include Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Section 8 Housing Vouchers, public housing and Medicare Part D financial assistance. Additionally, the rule would modify the existing public charge test by adding a complex set of factors, including income level, education level and English proficiency. In addition, DHS is seeking input on the inclusion of the Children's Health Insurance Program (CHIP) among this list of public benefit considerations, but this program is not currently included in the proposed regulatory text.

Among other harms, the proposed rule would impose serious barriers to health care, including sexual and reproductive health care, for immigrants and their families. If implemented, immigrants may be denied LPR status if they participate in Medicaid and make use of its benefits, including Medicaid coverage for prenatal care and pregnancy-related services. The fear incited by these rules would extend far beyond any individual who may be directly subject to the "public charge" test. Rather, the rules would have a chilling effect that would discourage many people, including non-immigrant family members, from accessing benefits for which they are eligible, out of fear that they or a family member might be deemed a potential public charge.[2]

Importance of Medicaid for Reproductive Health

Medicaid is the central U.S. program for ensuring that low-income people have coverage for and access to family planning, pregnancy-related care, STI testing and treatment, and other reproductive health services.[3] The program is an essential source of health coverage for women of reproductive age (aged 15–44), covering 21% of those women nationwide in 2017.[4] Medicaid also covers a disproportionate share of marginalized women, including those who are in poor health, low-income, single parents, have disabilities or are women of color.[5,6] In 2016, for example, Medicaid covered 49% of reproductive-age women with incomes below the federal poverty level (FPL).[7] For some low-income women of color, Medicaid coverage was even higher: 60% of black women in families with incomes below 100% FPL were Medicaid recipients.

More specifically, Medicaid is central to the U.S. family planning effort. Federal Medicaid law and regulations include strong protections for coverage of family planning services and supplies, without cost-sharing and free of coercion. And about half of states have expanded eligibility for family planning services to individuals otherwise ineligible for Medicaid.[8] As a result, Medicaid accounts for 75% of all public dollars spent on family planning in the United States.[9] That overall U.S. family planning effort helped women and couples avoid 1.9 million unintended pregnancies in 2015, and the abortions, unplanned births and miscarriages that would otherwise follow.[10]

Medicaid is also crucial for pregnancy-related care. Federal Medicaid law includes long-standing protections for coverage of maternity care, including prenatal care, labor and delivery, and postpartum

care. With this extensive coverage, Medicaid covers roughly half of all U.S. births for women who would find it difficult, if not impossible, to pay out of pocket for pregnancy-related care and infant care.[11]

Medicaid also helps patients address HIV and other STIs, breast and cervical cancer, intimate partner violence, and other reproductive health–related issues. It does so by covering vaccinations (such as for the human papillomavirus), screening and testing services (such as Pap tests and STI tests), treatment services (ranging from antibiotics for chlamydia to radiation therapy for cancer), and counseling and referral (including for non-medical support services).

All of these services are necessary for the health and well-being of Medicaid enrollees over the course of their lives. For example, the typical U.S. woman spends roughly three years pregnant, postpartum or attempting to become pregnant (and therefore in need of pregnancy-related care) and about three decades trying to avoid pregnancy (and therefore in need of contraceptive care).[12] In fact, more than 99% of women who have ever been sexually active have used contraceptives in their lifetime,[13] whether to prevent or delay pregnancy or for other reasons, such as to treat menstruation-related pain or discomfort.[14] In addition, all sexually active people may be at risk of HIV and other STIs, and continue to be at risk of reproductive cancers for decades. Imposing barriers to these critical reproductive health services would inevitably lead to harm.

Disparities in Insurance Coverage and Use of Sexual and Reproductive Health Services

Immigrants already face myriad policy barriers to insurance coverage, as well as disparities in access to sexual and reproductive health care. Many lawfully present immigrants are ineligible to enroll in coverage through Medicaid and CHIP during their first five years of legal residency, while undocumented immigrants are largely barred from public coverage overall. Although most lawfully present immigrants are eligible to purchase private coverage through the Affordable Care Act's (ACA) health insurance marketplaces using premium tax credits and cost-sharing subsidies, undocumented immigrants are entirely barred from marketplace coverage.

One major exception to the five-year bar is that some states provide Medicaid coverage for pregnancy-related care for many women who are otherwise ineligible, such as lawfully residing pregnant women and children under the age of 18. Currently, 33 states and the District of Columbia provide Medicaid coverage for lawfully residing pregnant women, and 33 states and the District of Columbia provide coverage for immigrant individuals under age 18, regardless of date of entry.[15]

U.S. immigration policy also affects immigrants' access to coverage and care. For instance, the Deferred Action for Childhood Arrivals (DACA) Program, established in 2012, enables grantees—all of whom are of reproductive age—to lawfully remain in the country. But despite their lawful status, individuals granted DACA are barred from nearly all public coverage, ACA marketplace plans, and affordability programs. Their years in the United States do not count toward their five-year path to Medicaid eligibility. Recent attempts to repeal DACA, in addition to increasingly strict enforcement of immigration policies, have heightened fear and distress among immigrants, likely impeding their access to coverage and care.[16,17,18]

The complex web of policies dictating immigrants' eligibility for health insurance have contributed to considerable gaps in immigrant women's health coverage. In 2017, 32% of the 6.3 million noncitizen immigrant women of reproductive age were uninsured, compared to 9% percent of U.S.-born women.[19]

That disparity increased between 2013 and 2017, likely because many immigrants were barred from coverage advances under the ACA that benefitted millions of U.S.-born women.[20]

Similarly, a nationally representative Guttmacher study of women obtaining contraception at safety-net health centers funded by the Title X national family planning program in 2016 found that immigrant patients were significantly less likely to have coverage, compared to their U.S.-born counterparts (46% versus 75%).[21,22] Furthermore, this same study found that one in five (22%) insured immigrant Title X patients did not plan to use their coverage; the study authors suggest these women "may be experiencing real or perceived threats of actions against themselves or their family members because of their immigration status, and others may be experiencing language and other logistical barriers." Among those without coverage, immigrant women reported fewer attempts to obtain insurance in the past year, likely for similar reasons.

Immigrant women also face gaps in use of sexual and reproductive health services. One Guttmacher study found that, among women at risk of unintended pregnancy, only half of immigrant women had received contraceptive care in the previous year, compared to two-thirds of U.S.-born women.[23] Another study found that immigrant women are less likely to have used a contraceptive method deemed "highly effective" at preventing pregnancy (i.e., sterilization, IUDs and implants), with variations by race and ethnicity.[24] These trends may be driven in part by individual women's contraceptive needs and preferences, high up-front costs, and required placement by a clinician.

Evidence also suggests that immigrant women are less likely to receive other preventive services, such as Pap tests to detect and prevent cervical cancer and screening and vaccinations for hepatitis B, which can be life-threatening for infants.[25,26] Immigrant women, particularly those who are uninsured and noncitizens, are also significantly less likely to obtain mammograms.[27]

Creating Additional Barriers and Disparities in Health Care Coverage and Utilization

On top of these existing policy barriers and disparities around health care utilization, the proposed changes to the public charge determination are widely expected to decrease enrollment in and use of these programs among eligible individuals fearing punitive action, with pronounced ramifications for pregnant or postpartum women and children.[28] The administration itself recognizes that the proposed rule would harm enrollment in Medicaid, and subsequent use of health services among immigrant communities. In particular, the preamble of the proposed rule anticipates that the potential changes to public charge determination may lead to disenrollment or foregone enrollment in public benefits, including Medicaid, among non-citizens and citizens living in mixed status households. Furthermore, DHS asserts that reduced participation in Medicaid and other programs would negatively affect the health of immigrant families, including U.S.-born children, and that the rule may decrease disposable income and increase poverty rates among immigrant families.

Moreover, DHS likely underestimates the potential harm of this proposed rule. DHS recognizes evidence of a chilling effect in disenrollment from public benefits following the 1996 welfare reform changes, and postulates similar disenrollment effects with this proposed rule. However, in its calculations, DHS includes only individuals assumed to be directly affected by the rule (individuals applying to adjust their immigration status) and does not account for potential disenrollment by family members or other immigrant individuals who might withdraw or refrain from enrollment in Medicaid or other public benefits due to fear and confusion around the rule.[29]

For example, a calculation by the Kaiser Family Foundation takes into account the broader scope of immigrant individuals and families that might withdraw from Medicaid enrollment as a result of this rule, and calculated that between 2.1 million and 4.9 million Medicaid/CHIP enrollees living in a family with at least one noncitizen would disenroll from Medicaid/CHIP under this rule, which would result in a disenrollment rate between 15% and 35%.[30] Furthermore, immigrant individuals applying for insurance through state-based marketplaces may be affected, as the rule would consider any immigrant who has applied for Medicaid a potential public charge, even if they did not enroll. Some state-based marketplaces automatically generate a Medicaid application for individuals who seek marketplace enrollment, or generate a Medicaid application if an individual enrolled in a marketplace plan experiences a change in income.[31]

Furthermore, DHS has not accounted for disenrollment that has already happened, in anticipation of this rule. For example, one study showed that, even prior to the release of the proposed rule, immigrant families were already experiencing fears around participation in health and other public programs, causing disenrollment in public benefits.[32] Similar drops have been seen in enrollment for SNAP, which provides crucial benefits supporting the health and well-being of immigrant families.[33] Thus, not only does DHS explicitly recognize the potential harms to enrollment in Medicaid and other public benefits from this proposed rule, its calculations for the chilling effect of this rule fall short of the likely harms.

In addition, as DHS acknowledges in the preamble, the proposed rule would create specific barriers to coverage and care for pregnant women, and leading to subsequent negative maternal and infant health outcomes. Because of the widespread fear and confusion around the details of the rule, pregnant women may forego not only prenatal and other pregnancy-related health care services, but may avoid enrollment in the Women, Infants, and Children (WIC) Program, or health coverage or food assistance for themselves and their children, even if some of these programs aren't explicitly mentioned in the rule.[34] The avoidance of these public benefits could lead to negative health impacts such as poor birth outcomes, higher rates of infant and maternal mortality, and subsequently poor health, educational, and financial outcomes for children in immigrant families.

Furthermore, the proposed rule deprives immigrants of their sexual and reproductive rights and justice, undermining the health and economic stability of immigrants and communities of color, and forcing people in these communities to choose between their immigration status and making decisions about their health and their families.[35] If approved, the proposed rule would also be coercive when it comes to reproductive health. By dissuading immigrants from enrolling in public health insurance, the rule could effectively deny the ability to obtain the contraceptive methods that will work best for them, from a provider who they trust to offer respectful, patient-centered information and counseling. The United States has a long history of paternalism and coercion when it comes to reproductive health, particularly for low-income people and people of color, and this rule would likely exacerbate that problem.[36]

Undermining the Goals of Medicaid and the Rule's Own Stated Goal

The proposed rule runs contrary to Medicaid's central objective of providing coverage of and access to needed health care services. The vast majority of lawfully present immigrants are in a family with at least one full-time worker, but that is no guarantee that they will have private insurance. In fact, only 30% of U.S. workers with incomes below 100% FPL are even offered employer-sponsored insurance, and many of

them cannot afford the premiums.[37] This problem may be heighted for immigrants, because they are more likely than citizens to be low-income and to work jobs in industries that seldom offer health coverage.[38]

Furthermore, the federal government itself has historically argued that that the use of Medicaid and CHIP should not be considered in public charge determinations because these programs represent important health benefits that immigrants are legally entitled to receive, and because disenrollment in these benefits would have adverse impacts not only on the potential recipients, but on public health and general well-being.[39]

The impact of this proposed rule would also run contrary to its own stated goal of ensuring that individuals who enter the United States or apply for status change are "self-sufficient." By dissuading immigrants from enrolling in Medicaid coverage, this provision would enhance financial barriers to family planning care. That in turn would be counterproductive to "self-sufficiency," because a majority of women and decades of research report that family planning helps them to complete their education, get and keep a job, and take care of themselves and their families.[40,41]

Affordable health care more generally helps people achieve these goals by helping them address chronic and acute health issues that can interfere with their ability to work, study or care for others.[42] Studies on the impact of Medicaid expansion under the Affordable Care Act and other efforts to increase Medicaid coverage have found that new enrollees report improvements to their overall health status, reduced credit card and medical debt, less difficulty paying bills and more money left over to spend on other necessities.[43,44,45,46,47,48]

Children's Health Insurance Program (CHIP) Should Not Be Included in a Public Charge Determination

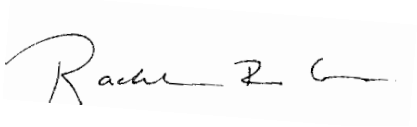
Including benefits from CHIP as a negative factor in the public charge assessment or including it in the "public charge" definition would likely lead to many eligible adolescents and pregnant women foregoing health care benefits, including the sexual and reproductive health care they want and need, both because of the direct inclusion in the public charge determination as well as the chilling effect detailed above.

In addition to the great harm that would be caused by the inclusion of CHIP, this would be counter to Congress' explicit intent in expanding coverage to lawfully present children and pregnant women. Section 214 of the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states a new option to cover, with regular federal matching dollars, lawfully residing children and pregnant women under Medicaid and CHIP during their first five years in the United States. This was enacted because Congress recognized the public health, economic, and social benefits of ensuring that these populations have access to care.

****

In sum, for the reasons outlined above, we urge DHS to withdraw the proposed rule on inadmissibility on pubic charge grounds. We hope you find these comments useful as you consider the proposal. If you need additional information about the issues raised in the letter, please contact Kinsey Hasstedt in the Institute's Washington office. She may be reached by phone at 202-296-4012, or by email at khasstedt@guttmacher.org

Thank you for your consideration.
Sincerely,



Rachel Benson Gold
Vice President for Public Policy

[1] U.S. Department of Homeland Security, Inadmissibility on public charge grounds, *Federal Register*, 2018, 83(196): 51114–51296, https://www.gpo.gov/fdsys/pkg/FR-2018-10-10/pdf/2018-21106.pdf.
[2] Bazar E, Some immigrants, fearful of political climate, shy away from Medi-Cal, *Kaiser Health News*, Feb. 22, 2017, https://khn.org/news/some-immigrants-fearful-of-political-climate-shy-away-from-medi-cal/.
[3] Sonfield A, Why protecting Medicaid means protecting sexual and reproductive health, *Guttmacher Policy Review,* 2017, 20:39–43, https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.
[4] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, *News in Context*, Dec. 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.
[5] Kaiser Family Foundation (KFF), Medicaid's role for women, *Fact Sheet*, Menlo Park, CA: KFF, 2017, https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.
[6] Gibson C and Huang P, Medicaid & reproductive justice, *Fact Sheet*, Washington, DC: National Health Law Program, 2018, http://www.healthlaw.org/issues/medicaid/waivers/fact-sheet-medicaid-reproductive-justice#.W3LlNM5KiUk.
[7] Guttmacher Institute, Dramatic gains in insurance coverage for women of reproductive age are now in jeopardy, *News in Context,* Jan. 17, 2018, https://www.guttmacher.org/article/2018/01/dramatic-gains-insurance-coverage-women-reproductive-age-are-now-jeopardy.
[8] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[9] Hasstedt K, Sonfield A and Gold RB, *Public Funding for Family Planning and Abortion Services, FY 1980–2015,* New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.
[10] Frost JJ, et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015,* New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.
[11] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.
[12] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform,* New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.
[13] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.
[14] Guttmacher Institute, Contraceptive use in the United States, *Fact Sheet*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.
[15] National Immigration Law Center, Health care coverage maps, 2018, https://www.nilc.org/issues/health-care/healthcoveragemaps/.
[16] Artiga S and Ubri P, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*, KFF Issue Brief, Menlo Park, CA: KFF, 2017, https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/.

[17] Vargas ED, Sanchez GR and Juárez M, Fear by association: perceptions of anti-immigrant policy and health outcomes, *Journal of Health Politics, Policy and Law*, 2017, 42(3):459–483, https://read.dukeupress.edu/jhppl/article-abstract/42/3/459/13888.

[18] Philbin MM et al., State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States, *Social Science & Medicine*, 2018, 1999:29–38, https://www.ncbi.nlm.nih.gov/pubmed/28410759.

[19] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, News in Context, Dec. 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

[20] Hasstedt K, Desai S and Ansari-Thomas Z, *Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States*, Issue Brief, New York: Commonwealth Fund, 2018, https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/immigrant-womens-access-sexual-reproductive-health-coverage .

[21] Hasstedt K, Why we cannot afford to undercut the Title X national family planning program, *Guttmacher Policy Review,* 2017, 20:20–23, https://www.guttmacher.org/gpr/2017/01/why-we-cannot-afford-undercut-title-x-national-family-planning-program.

[22] Kavanaugh ML, Zolna MR and Burke K, Use of health insurance among clients seeking contraceptive services at Title X-funded facilities in 2016, *Perspectives on Sexual and Reproductive Health*, 2018, 50(3):101–109, https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[23] Frost JJ, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010*, New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/us-womens-use-sexual-and-reproductive-health-services-trends-sources-care-and-factors.

[24] Tapales A, Douglas-Hall A and Whitehead A, The sexual and reproductive health of foreign-born women in the United States, *Contraception*, 2018, 98(1) :47–51, https://www.guttmacher.org/article/2018/02/sexual-and-reproductive-health-foreign-born-women-united-states.

[25] Echeverria SE and Carrasquillo O, The roles of citizenship status, acculturation, and health insurance in breast and cervical cancer screening among immigrant women, *Medical Care*, 2006, 44(8):788–792, https://www.ncbi.nlm.nih.gov/pubmed/16862042.

[26] Kilmer GA et al., Hepatitis B vaccination and screening among foreign-born women of reproductive age in the United States, 2013–2015, *Clinical Infectious Diseases*, 2018, https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciy479/5026244.

[27] Reyes AM and Miranda PY, Trends in cancer screening by citizenship and health insurance, 2000–2010, *Journal of Immigrant and Minority Health*, 2015,17(3):644–651, https://www.ncbi.nlm.nih.gov/pubmed/25187320.

[28] Parrott S, Gonzales S and Schott L, *Trump "Public Charge" Rule Would Prove Particularly Harsh for Pregnant Women and Children*, Washington, DC: Center on Budget and Policy Priorities (CBPP), 2018, https://www.cbpp.org/research/poverty-and-inequality/trump-public-charge-rule-would-prove-particularly-harsh-for-pregnant.

[29] Artiga S, Garfield R and Damico A, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KFF Issue Brief, Menlo Park, CA: KFF, 2018, https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/.

[30] Artiga S, Garfield R and Damico A, *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KFF Issue Brief, Menlo Park, CA: KFF, 2018, https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/.

[31] Corlette S, Proposed "public charge" rule risks immigrants' access to private coverage, too, CHIR blog, 2018, http://chirblog.org/proposed-public-charge-rule-risks-immigrants-access/.
[32] Artiga S and Lyons B, *Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being*, KFF Issue Brief, Menlo Park, CA: KFF, 2018, https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/.
[33] Scott D, Study suggests Trump is scaring immigrant families off food stamps, *Vox*, Nov. 15, 2018, https://www.vox.com/policy-and-politics/2018/11/15/18094901/trump-immigration-policy-food-stamps-snap.
[34] Parrott S, Gonzales S and Schott L, *Trump "Public Charge" Rule Would Prove Particularly Harsh for Pregnant Women and Children*, Washington, DC: Center on Budget and Policy Priorities (CBPP), 2018, https://www.cbpp.org/research/poverty-and-inequality/trump-public-charge-rule-would-prove-particularly-harsh-for-pregnant.
[35] National Asian Pacific American Women's Forum (NAPAWF), National Latina Institute for Reproductive Health and In Our Own Voice: National Black Women's Reproductive Justice Agenda, Public charge expansion proposed rule: a threat to women of color, *Fact Sheet*, Chicago: NAPAWF, 2018, https://www.napawf.org/publiccharge.html.
[36] Gold RB, Guarding against coercion while ensuring access: a delicate balance, *Guttmacher Policy Review,* 2014, 17(3):8–14, https://www.guttmacher.org/gpr/2014/09/guarding-against-coercion-while-ensuring-access-delicate-balance.
[37] Long M et al., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999–2014,* KFF Issue Brief, Menlo Park, CA: KFF, 2016, https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/.
[38] KFF, Proposed changes to "public charge" policies for immigrants: implications for health coverage, *Fact Sheet*, Menlo Park, CA:KFF, 2018, https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/.
[39] Immigration and Naturalization Service, U.S. Department of Justice, Field guidance on deportability and inadmissibility on public charge grounds, *Federal Register*, 1999, 64(101):28689–28693, https://www.gpo.gov/fdsys/pkg/FR-1999-05-26/pdf/99-13202.pdf.
[40] Frost JJ and Lindberg LD, Reasons for using contraception: perspectives of US women seeking care at specialized family planning clinics, *Contraception,* 2012, 87(4):465–472, https://www.guttmacher.org/article/2012/09/reasons-using-contraception-perspectives-us-women-seeking-care-specialized-family.
[41] Sonfield A, What women already know: documenting the social and economic benefits of family planning, *Guttmacher Policy Review,* 2013, 16(1):8–12, https://www.guttmacher.org/gpr/2013/03/what-women-already-know-documenting-social-and-economic-benefits-family-planning.
[42] Antonisse L and Garfield R, *The Relationship Between Work and Health: Findings from a Literature Review*, KFF Issue Brief, Menlo Park, CA: KFF, 2018, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.
[43] Hu L et al., The effect of the Patient Protection and Affordable Care Act Medicaid expansions on financial wellbeing, *National Bureau of Economic Research (NBER) Working Paper Series*, 2018, No. 22170, http://www.nber.org/papers/w22170.
[44] Dussault N, Pinkovskiy M and Zafar B, Is health insurance good for your financial health? Liberty Street Economics, 2016, http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct.
[45] Finkelstein A, The Oregon health insurance experiment: evidence from the first year, *NBER Working Paper Series*, 2011, No. 17190, http://www.nber.org/papers/w17190.

[46] Wagnerman K, Medicaid expansion reduced unpaid Medicaid debt, improved financial well-being for families, *Say Ahhh!* Blog, 2017, https://ccf.georgetown.edu/2017/08/02/medicaid-expansion-reduced-unpaid-medical-debt-improved-financial-well-being-for-families/.

[47] Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*, 2015, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf?ver=2016-12-30-085452-610.

[48] Sommers BD and Grabowski DC, What is Medicaid? More than meets the eye, *JAMA*, 2017, 318(8):695–696.