American Hospital Association®

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

December 7, 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, N.W.
Washington, C 20529-2140

RE: Notice of Proposed Rulemaking; Inadmissibility on Public Charge Grounds, DHS Docket No. USCIS-2010-0012, (Vol. 83, No. 196, October 10, 2018)

Dear Ms. Deshommes:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Homeland Security's (DHS) proposed rule that could limit legal immigrants' future immigration status based on their receipt of public benefits. Specifically, the rule proposes to change current policies that govern "public charge" determinations, which assess how likely it is that an individual will become dependent on government assistance (public benefits) for support and subsistence. Chief amongst these proposed changes is expanding the types of public benefit programs that could contribute to a "public charge" determination, to include Medicaid, Medicare Part D Low Income Subsidy, Supplemental Nutrition Assistance Program, subsidized housing and housing assistance.

Hospitals have long served as leaders in their communities by connecting individuals and families to needed public programs, thereby allowing them to maintain their health and well-being in order to remain productive members of their communities. **The policies proposed by this rule are contrary to this hospital mission of service to vulnerable members of our society.** If adopted millions of individuals would be at risk for loss of coverage – consequently putting hospital payments in jeopardy. This loss of coverage would inevitably lead to poor health

outcomes for legal immigrant communities and greater financial strain for the hospitals that serve them. **The AHA strongly opposes the DHS proposed rule on "public charge" and recommends that it be withdrawn.**

IMPLICATIONS OF THE "CHILLING EFFECT"

The implications of this rule are particularly troubling when examining the potential impact on the Medicaid program. While the proposed rule does not recommend eligibility changes to Medicaid, legally present immigrants, as well as their citizen family members, may choose to either drop or not apply for Medicaid coverage for fear of putting their future immigration status, either citizenship or permanent residency, in jeopardy. This "chilling effect" on coverage was first documented in research studying immigration-related welfare reform changes to Medicaid participation in the 1990s.[1] DHS references some of this research in explaining its own analysis of the potential impact of the rule's proposed changes. The department, however, estimates that only approximately 324,000 individuals per year (2.5 percent of legal immigrants) would likely drop coverage or forgo enrollment. This estimate is in sharp contrast to other recent analyses as it only examines individuals directly affected by the proposed changes and ignores of the impact on legal immigrant family members.[2] The Kaiser Family Foundation estimates that the consequences of the chilling effect could drive Medicaid disenrollment rates ranging from 15 percent to 35 percent for the affected populations.[3]

An analysis prepared by Manatt Health draws an even sharper focus on the implications of the chilling effect for the Medicaid program.[4] The report examined estimates for populations affected as well as Medicaid and Children's Health Insurance Program (CHIP) spending and the impact on hospitals payments. The findings are startling. As noted, the fear and confusion for lawfully present immigrants and their family members about whether the proposed rules would apply to their circumstances coupled with the discretionary nature of how these policy changes would be applied by DHS officials is likely to lead many to either drop or never apply for coverage for which they are eligible. According to the proposed rule, DHS officials can exercise significant discretion in applying policies that govern public charge determinations. The Manatt Health analysis estimates that as many as 13.2 million people could be affected by the rule's chilling effect, of which 4.4 million individuals are non-citizen adults and children with Medicaid

---

[1] Mann, C; Grady, A; Orris, A; "Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule" Manatt Health, November, 2018 https://www.manatt.com/Manatt/media/Media/PDF/White%20Papers/Medicaid-Payments-at-Risk-for-Hospitals.pdf

[2] Manatt, p. 11

[3] Artiga, S; Garfield, R and Damico, A, "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid," Kaiser Family Foundation, Issue Brief, October 2018, http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid

[4] Manatt, pp 5-14

and CHIP coverage, and 8.8 million are citizen adults and children with Medicaid and CHIP coverage who have family members that are non-citizens.

For the Medicaid and CHIP programs, the loss of covered individuals and families translates to an estimated $68 billion in health care services, in combined federal and state dollars, that would be at risk. More than one-third of the Medicaid and CHIP program spending in this estimate is attributable to services provided to children.[5] Finally, for hospitals, this loss of coverage translates into an estimated $17 billion in hospital payments at risk in one year based on 2016 spending. It is important to note that this estimate only examines the potential loss in Medicaid and CHIP payments to hospitals and does not account for the increase in uncompensated care that hospitals would incur by providing services to legal immigrants and their families. This loss of coverage ultimately transfers the financial burden to hospitals for the needed care provided to this population. In states such as Florida and Texas, home to many legal immigrants, the potential loss in Medicaid and CHIP payments to area hospitals is estimated to be $785 million and $1.9 billion, respectively, for a single year.[6] For many hospitals serving these vulnerable populations, the added financial stress could be insurmountable.

For the millions of legal immigrants and their families, many of whom are working and paying taxes, the loss of coverage and access to other public benefits could lead to poor health and loss of productivity. DHS recognizes that these are potential consequences to the policy changes recommended by the rule and also cites the potential for increases in the spread of communicable diseases, poverty and housing instability.[7] These far-reaching consequence are too high a price to pay for a legal immigrant's use of public benefits for which they are legitimately eligible.

Children's Health Insurance Program (CHIP). The proposed rule requests comment on whether CHIP should be included in the list of public benefits that could count against a legal immigrant's legal status. The Manatt Health analysis highlights that more than one-third of Medicaid and CHIP spending that is at risk is attributable to children. Most CHIP-funded children currently get their coverage through the Medicaid program.[8] Adding CHIP to the list of public benefit programs that could trigger a public charge determination only would exacerbate the loss of coverage for children; thereby undermining more than 20 years of bipartisan efforts to improve health care coverage for our nation's children. Explicitly listing CHIP as a public benefit program for purposes of making a public charge determination only would weaken this vital health care safety net. **The AHA opposes including CHIP in the list of public benefits.**

[5] Manatt p. 13
[6] Manatt p. 17-18
[7] 83 Fed Reg p. 51270
[8] Manatt p. 4

Public Benefit Definition and Benefit Thresholds. DHS proposes to expand the types of programs that can contribute to a public change determination, in addition to Medicaid, to include, Medicare Part D low-income subsidies, Supplemental Nutrition Assistance Program (food stamps), and select housing programs (currently the use of Temporary Assistance for Needy Families and long term care services in Medicaid are the only programs that determine a public charge). The AHA is opposed to DHS's expansion of public benefit programs that could trigger a public charge determination as well as the inclusion of additional categories based on amount and duration of public benefits. In addition to expanding the list of public benefit programs, the rule would create two new categories of public benefits – "monetizable" and "non-monetizable" benefits – with monetary and durational thresholds. For example, the monetary threshold would be the receipt of one or more public benefits where the cumulative value exceeds 15 percent of the federal poverty guidelines for a household of one ($1,821 in 2018). The durational threshold would be the receipt of one or more public benefits received for more than 12 months over a 36-month period. An individual that exceeds these thresholds through their public benefit use could trigger a public charge determination. Because these thresholds are set at such low amounts, it is likely that many legal immigrants using some level of public benefits could be putting their efforts to secure permanent residency status or citizenship at risk.

The implications of the proposed rule and the likely loss of coverage resulting from these policies would have a significant, detrimental impact on individuals, families, state Medicaid and CHIP programs and the hospitals serving these populations. The AHA opposes this proposed rule and recommends DHS withdraw it immediately.

Thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Molly Collins Offner, director of policy, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President