



December 7, 2018

Samantha Deshombres, 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

Submitted via: www.regulations.gov

Re: DHS Docket No. USCIS-2010-0012, RIN 1615-AA22, Comments in Response to Proposed Rulemaking:
Inadmissibility on Public Charge Grounds

Dear Ms. Deshombres:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments on the proposed rule, “Inadmissibility on Public Charge Grounds,” which would significantly expand the ability of the Department of Homeland Security (DHS) to classify a lawful immigrant as a burden on society and therefore to be inadmissible to the United States or ineligible for a green card for permanent residency. We are deeply concerned with the expansion of this “public charge” assessment to include Medicaid and other public benefits for which legal immigrants are eligible. As core safety net providers of health care services in California, we are committed to ensuring that all individuals have timely access to affordable, high-quality health care services. By including Medicaid, as well as other basic social services, the proposed rule could jeopardize the health and wellbeing of hundreds of thousands of law-abiding individuals and create a negative economic impact on public health care systems. **We respectfully request that you rescind the rule.**

California’s 21 public health care systems play a central role in the state’s safety net and health care landscape, delivering care to all who need it, regardless of ability to pay or circumstance. Although public health care systems represent six percent of all California hospitals statewide, they serve 2.85 million Californians each year and provide more than 11.5 million outpatient care visits each year. Public health care systems provide 35% of all hospital care to the Medicaid (Medi-Cal in California) population in their communities and provide nearly 40% of all hospital care to the state’s uninsured residents. They serve hundreds of thousands of Californians as their chosen source for primary, specialty, and hospital care. Public health care systems fill multiple and significant health care delivery roles, which have a profound impact on the health of millions of Californians. It is through this lens that we respectfully offer the comments below.

Overview of Proposed Changes

The proposed rule would dramatically expand the types of programs and services that the federal government would consider in assessing an individual’s dependency on public benefits. Longstanding policy requires immigrants who are applying for lawful permanent resident status, or admission to the U.S., to undergo a “public charge” determination. As part of this determination, immigration officials

assess current or prior receipt of certain public benefits (cash assistance and government funded institutionalization) within the context of the individual's circumstances to discern if the individual is likely to become primarily dependent on government assistance or become a public charge. If the immigrant is found to be a public charge, immigration officials may deny the application for permanent residency status or entry into the U.S.

Under the draft regulation, DHS proposes to expand the public benefits considered in a public charge determination to include, among other factors, receipt above a threshold amount of non-emergency Medi-Cal, the Supplemental Nutrition Assistance Program (CalFresh in California), the Medicare Part D Low-Income Subsidy Program, and housing supports. Receipt of these public benefits, especially recent or current receipt of these benefits, would be weighed heavily as negative factors against immigrants who wish to adjust their status, likely resulting in a greater number of public charge determinations made by DHS. Although these individuals are legally eligible to receive Medi-Cal services and other benefits, they would be penalized for their use of such services.

We are deeply concerned these proposed changes would result in reduced participation in Medi-Cal and other social programs – negatively affecting the health and financial stability of immigrant families and the growth and healthy development of their children who are predominantly U.S.-born. In addition to the effects of coverage loss, which are described in greater detail below, we expect that reduced participation in nutrition and other social support programs, such as housing, would likely compound these adverse impacts on health outcomes in our community. Housing and nutrition access have both been shown to positively improve health outcomes for high-risk populations and decrease health care costs.¹

Negative Impacts on Patients and Communities

If the proposed changes are implemented, we expect far reaching consequences in our ability to effectively care for our immigrant communities. Low-income families rely on public health care systems for preventive, primary, specialty, and surgical care – all of which are critical in ensuring that individuals and their families are safe, healthy, and productive. The changes outlined in the proposed rule would likely result in immigrants and their families forgoing essential services and delaying care until a health concern progressed, becoming more severe and costly. In addition, many immigrants currently and lawfully enrolled in Medi-Cal are expected to disenroll because participation in the program would negatively affect their chances of obtaining lawful permanent residency status and compromise their ability to eventually become citizens.

The scope and scale of this rule could extend beyond the immigrants targeted in the regulation. Due to the complexity of the rule and the considerable discretion DHS would have to make public charge determinations as proposed, we anticipate many more immigrant families will take cautionary steps to ensure that their immigration status is not compromised. Previous experience suggests that the proposed rule would likely lead to disenrollment among a broader group of individuals in immigrant families, even though the changes would not directly affect them.² For example, following the 1996

¹ Taylor, L., Xulin Tan A., Coyle, C., Ndumele, C., Rogan, E., Canavan, M., Curry, L., & Bradley, E. (2016). Leveraging the social determinants of health: What works? PLOS ONE 11(8): e0160217. doi:10.1371/journal.pone.0160217.

² Artiga, J., Garfield, R., & Damico, A. (2018). Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid. KFF. Available at: <https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/view/footnotes/#footnote-373368-6>

passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), studies of the chilling effect found disenrollment rates from 15% to 35% for all noncitizen immigrants and mixed-family children, and up to 60% for certain immigrant populations, such as refugees.³ If the changes proposed in this rule were to be adopted, the University of California estimates that between 317,000 and 741,000 Medi-Cal and Children’s Health Insurance Program (CHIP) recipients would disenroll from health benefits.⁴

DHS acknowledges that the proposed rule could increase poverty, including among families with citizen children – and that immigrants foregoing benefits could experience lost productivity, adverse health effects, medical expenses due to delayed health care, and reduced productivity and educational attainment.⁵ We agree, and expect that:

- Fewer families will access needed preventive care, leading to worse health outcomes, especially for pregnant or breastfeeding women, infants, and children;⁶
- More patients will rely on emergency department and acute services; and,
- The prevalence of communicable diseases will increase.

Combined, these changes would result in the provision of less efficient care delivery and poorer health outcomes.

The impact on children is particularly concerning; literature shows a change in lifetime outcomes based on available resources during childhood, making the need for strong social supports during early childhood especially important. For example, research has found vast disparities in income levels, college attendance rates, likelihood of becoming a single parent, and upward economic mobility during adulthood, between individuals who had grown up in high-poverty housing projects as children, and individuals who had grown up in lower-poverty neighborhoods.⁷ Research has also found that public benefits, such Medi-Cal and CalFresh, received during childhood, have significant effects that are economically important improvements in health (such as reduced emergency department utilization and mortality, and better health outcomes) both contemporaneous and in the longer term, and result in a

³ Ponce, N., Lucia, L., & Shimada, T. (2018). How proposed changes to the ‘Public Charge’ rule will affect health, hunger and the economy in California. *The UCLA Center for Health Policy Research*. Available at: <http://healthpolicy.ucla.edu/newsroom/Documents/2018/public-charge-seminar-slides-nov2018.pdf>.

⁴ Ponce, N., Lucia, L., & Shimada, T. (2018). Another report from Manatt similarly estimates that citizen children would be disproportionately subject to the chilling impacts of this proposed rule, comprising 88% of potentially impacted children, and 50% of total impacted individuals of any age. Mann, C., Grady, A., Orris, A., “Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule.” Manatt, November 2018. Available at <https://www.manatt.com/insights/newsletters/health-update/public-charge-proposed-rule-hospital-medicaid>.

⁵ U.S. Citizenship and Immigration Services, Department of Homeland Security, “Inadmissibility on Public Charge,” October 10, 2018, 51270.

⁶ Artiga, J., Garfield, R., & Damico, A. (2018).

⁷ Chetty, R., Hendren, N., & Katz, L. (2015). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity experiment. *The National Bureau of Economic Research*. Available at: https://www.nber.org/mtopublic/final/MTO_IRS_2015.pdf

positive benefit to taxpayers (through increases in human capital, adult health, labor market, earnings, and tax payments).⁸

These are the same reasons DHS cites in the preamble for why, in 1999, the Immigration and Naturalization Services (INS) declined to consider this broader list of benefits in public charge determinations (as outlined in their Interim Field Guidance). In that Guidance, INS sought *“to address the public’s concerns about immigrants’ fears of accepting public benefits from which they remained eligible, specifically in regards to medical care, children’s immunizations, basic nutrition and treatment of medical conditions that may jeopardize public health.”* INS was aiming to alleviate these fears because access to these benefits helped non-citizens retain employment and establish self-sufficiency.⁹ The preamble describes how INS consulted with the U.S. Department of Health and Human Services (HHS), among other agencies, regarding which benefits should be included in a public charge determination. HHS *“advised that the best evidence of whether an individual is relying primarily on the government for subsistence is either the receipt of public cash benefits from income maintenance purposes or institutionalization for long-term care at government expense.”*¹⁰

Indeed, the entire list of new health and social services benefits that are being proposed in this rule were considered in the past and deliberately not included in the public charge determination. The preamble goes on to argue that DHS is allowed to change its interpretation of how public charge determinations should be carried out, but DHS does not address why this change in policy is needed nor offer reassurance that it will not result in the very outcomes that were of concern in 1999 and that remain a concern today. In fact, later in the preamble DHS acknowledges these negative impacts, noting that *“[d]isenrollment or foregoing enrollment in public benefits programs by aliens otherwise eligible for these programs could lead to:*

- *Worse health outcomes, including increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children, and reduced prescription adherence;*
- *Increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment;*
- *Increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated;*
- *Increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient;*
- *Increased rates of poverty and housing instability; and*
- *Reduced productivity and educational attainment.”*¹¹

⁸ Hoynes, H. (2016). Why SNAP Matters: Effects on poverty, food insecurity and health. *University of California, Berkeley*. Available at: https://gspp.berkeley.edu/assets/uploads/faculty/customtab/Stanford_FSE_Hoynes_1-21-16.pdf

⁹ U.S. Citizenship and Immigration Services, Department of Homeland Security, “Inadmissibility on Public Charge,” October 10, 2018, 51133.

¹⁰ U.S. Citizenship and Immigration Services, Department of Homeland Security, “Inadmissibility on Public Charge,” October 10, 2018, 51133.

¹¹ U.S. Citizenship and Immigration Services, Department of Homeland Security, “Inadmissibility on Public Charge,” October 10, 2018, 51270.

We are deeply concerned about these devastating impacts and believe the risks outweigh any perceived benefit the administration believes is possible from finalizing the rule.

Negative Impacts on Public Health Care Systems

The combined direct impact and further chilling effects of this proposed rule could result in financial losses for public health care systems. Medi-Cal is an essential source of federal funding for our system that enables us to provide high quality care to 2.85 million Californians each year, and continuously improve service delivery and efficiencies. Significant disenrollment in Medi-Cal could result in fewer families accessing needed preventive care, leading to worse health outcomes, and more patients relying on the emergency department, all resulting in the provision of less efficient care delivery and poorer health outcomes. These consequences will also lead to reduced revenue for public health care systems, and increased costs associated with providing greater levels of uninsured care. Estimates from the University of California project losses in federal support for Medi-Cal in the range of \$509 million to \$1.187 billion statewide, assuming similar chilling effects as under PRWORA in the 1990s.¹² For public health care systems, we estimate that as much as \$1.4 billion in revenues associated with non-citizens and citizen family members of non-citizens could be at-risk if this proposed rule were to be finalized.¹³ These financial losses undermine efforts of public health care systems to deliver higher-quality care to patients including efforts to reduce readmissions, improve care coordination and chronic disease management, and prevent avoidable high-cost services.

Without ongoing sources of payment for services, public health care systems are limited in the remaining resources available to make ends meet. Medicaid Disproportionate Share (DSH) funds are a fixed pool of federal funds that support safety net hospitals like ours that serve a large number of low-income patients. Even with coverage expansion, public health care systems exhaust the full amount of funds available from that DSH pool today. Thus, an increase in uncompensated costs would not have a commensurate source of special safety net revenues to offset those costs. Medicaid DSH funds are also slated to dramatically decrease beginning in 2019, taking full effect in 2020, when the national allotment will decrease by 63% (unless cuts are further delayed by Congress). A proportionate cut to California would cause safety net hospitals to further lose \$800m annually that today is used to offset uncompensated care. Public health care systems are concerned about these significant losses, which would be further exacerbated by this proposed rule.

Negative Economic Impacts in the Community

In addition to individuals directly targeted by the proposed regulation and the public health care systems that serve them, the broader community would also experience harm. We expect significant local economic ripple effects if the proposed changes are adopted. Statewide, the University of California estimates that 7,600 to 17,700 jobs could be lost, primarily in the health care sector (47%) including hospitals, doctor's offices, labs, outpatient/ambulatory care centers, nursing homes, dental offices, insurers, and other health care settings.¹⁴

¹² Ponce, N., Lucia, L., & Shimada, T. (2018).

¹³ This estimate is based on an analysis by America's Essential Hospitals and Manatt Health, conducted in November 2018, and includes at-risk Medicaid and CHIP payments associated with noncitizen beneficiaries and at-risk payments associated with citizen beneficiaries who live with a non-citizen family member.

¹⁴ Ponce, N., Lucia, L., & Shimada, T. (2018).

An estimated \$1.2 to \$2.8 billion in economic output could also be lost due to the collective impact of the rule, through a reduction in federal benefits, lost state and local tax revenue, lost jobs, lost economic output, and lost revenue for our local businesses such as grocery stores.¹⁵ For example, an estimated 860,000 CalFresh recipients will likely disenroll from the program.¹⁶ CalFresh is a vital public benefit that provides food resources for struggling families, revenue for local businesses, and frees up household income for other basic needs.

The negative impacts of the proposed rule could do more harm to our communities than the potential small savings that could be achieved through reducing the number of people who use public benefits for which they are eligible. **We urge DHS to rescind its proposal to change the longstanding public charge determination policy.** Should the proposed rule be finalized as drafted, the expanded definition would punish lawfully present individuals and families, and result in higher costs for health care providers.

Thank you for the opportunity to submit comments.

Sincerely,

A handwritten signature in black ink, appearing to read 'Erica Murray', with a long horizontal flourish extending to the right.

Erica Murray
President and CEO

¹⁵ Ponce, N., Lucia, L., & Shimada, T. (2018).

¹⁶ Ponce, N., Lucia, L., & Shimada, T. (2018).