December 9, 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 the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members, thank you for the opportunity to offer comments on the Department of Homeland Security’s (DHS) proposed rule regarding the Inadmissibility on Public Charge Grounds. We have serious concerns regarding the implications of the rule to our nation’s healthcare infrastructure and overall patient health. As the Agency acknowledges in the rule Preamble, the proposal 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; and
- Increased rates of poverty and housing instability; and
- Reduced productivity and educational attainment.

These outcomes have real life consequences for our member hospitals and clinics, the patients they serve, and their communities. For these reasons we strongly oppose the DHS proposed rule on “public charge” and recommend that it be withdrawn. Our more detailed comments follow.
Public Charge Definition and Chilling Effect

Under long-standing immigration law, individuals who are deemed likely to become a “public charge” can be denied admission to the U.S. or, if they are already in the country legally, may be denied the ability to receive a green card as a lawful permanent resident.¹ The Immigration and Naturalization Service (INS) issued guidance in 1999 to define a public charge as someone who has become or who is likely to become “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.”² Medicaid services, except for long-term institutional care, were specifically excluded from the definition. The 1999 guidance noted that public charge clarification was necessary because ongoing confusion “detected eligible aliens and their families, including U.S. citizen children, from seeking important health and nutrition benefits that they are legally entitled to receive. This reluctance to access benefits has an adverse impact not just on the potential recipients, but on public health and the general welfare.”³

Under the proposed rule, DHS would vastly expand the types of benefits that Agency officials use in making public charge determinations. The proposal expands such benefits to include Medicaid services, Medicare Part D subsidies for low-income individuals, the Supplemental Nutrition Assistance Program (SNAP), and various forms of housing assistance.⁴ The inclusion of these benefits will have a “chilling effect” on enrollment in these programs by eligible legal immigrants and their family members, including U.S. citizens. This was recognized by INS in their 1999 guidance as noted above, and DHS has acknowledged this risk in the Agency’s current proposal.

In the Preamble of the proposed rule, DHS acknowledges the “chilling effect” that may occur when rules are changed and immigrants and their family members are discouraged from using public benefits for which they are eligible due to fear of real or perceived immigration consequences.⁵ Despite acknowledging the “chilling effect,” DHS does not estimate disenrollment or other chilling impacts among family members of noncitizens. This methodological deficiency results in a potential undercount of the actual impact. A study by Manatt Health using data from the American Community Survey estimates that the “potentially chilled population” comprises 22.2 million noncitizens and a total of 41.1

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¹ This would exclude refugees, asylees, survivors of trafficking and domestic violence and other specified groups of noncitizens who are not subject to the public charge test.
³ Ibid.
⁴ With respect to Medicaid, we recognize that the proposed rule specifically excludes treatment for emergency medical conditions, Medicaid school-based services, Medicaid services offered pursuant to the Individuals with Disabilities Education Act (IDEA) and coverage for foreign-born children of U.S. citizen parents who would be automatically eligible to become citizens.
million noncitizens and their family members currently residing in the United States. This is compared to the 324,000 estimate contained in the proposed rule analysis.

A separate analysis by Manatt Health examines the implications of the chilling effect for state Medicaid and CHIP programs as well as Medicaid hospital payments. For Arizona, the proposed rule puts at risk an estimated $1.9 billion in healthcare services for Medicaid and CHIP enrollees—$763 million for noncitizens and $1.2 billion for citizen family members of a noncitizen. (These amounts reflect one-year data for 2016.) Nearly 40 percent of dollars subject to the chilling effect are attributable to children. Overall, 17 percent of our state’s Medicaid and CHIP expenditures are at risk. Arizona hospitals could lose up to $383 million in payments annually. As DHS notes in the Preamble to the rule, loss in Medicaid and CHIP coverage could result in (1) increased use of emergency departments and emergent care as a method of primary healthcare due to delayed treatment and (2) increased uncompensated care in which treatment or services are not paid for by a third-party insurer or patient.

Arizona has recent experience with very situation when enrollment in our adult Medicaid program, Proposition 204, was frozen in 2011. The freeze resulted in a doubling of hospital uncompensated and crippled rural hospitals—several of which were forced to declare bankruptcy, shuttered, and/or merged with larger systems. We are not saying that the impact of the proposed public charge rule will have the exact impact as the Proposition 204 enrollment freeze, simply that we know there are real world consequences when disenrollment in social support programs occur. And states such as Arizona, which have a high concentration of immigrants, are especially vulnerable to the chilling effect that will result under the proposed public charge rule.

We are not alone in this belief. Various researchers have studied the use of public benefits following passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. They found that use of benefits by immigrants who were not made ineligible by the law dropped sharply, suggesting that the impact of the public charge rule could similarly impact enrollment. For example:

- While food stamp use in noncitizen families fell 43 percent between 1994 and 1998, it fell 60 percent among refugees even though PRWORA did not restrict their eligibility for food stamps.

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Another study covering the same period found that Medicaid use among refugees fell by 39 percent, compared to 17 percent among other noncitizens, even though refugees remained eligible for Medicaid after PRWORA.\textsuperscript{9}

These analyses support the very acknowledgement by DHS that the proposed public charge rule may indeed have a chilling effect on enrollment in social support programs by citizens and eligible immigrants alike. \textbf{For this reason and the commensurate impact that the chilling effect will have on health outcomes for immigrants and their families; communicable disease prevalence; poverty rates; use of emergency departments; and hospital uncompensated care we strongly oppose the proposed rule and urge DHS to withdraw it.}

\textbf{Public Charge & Intermittent Use of Benefits}

The proposed rule also redefines public charge as an “\textit{alien who receives one or more public benefits},” and establishes thresholds for use of public benefits to determine an individual to be a public charge. These thresholds would be tied to the value of the benefits received and/or total months a benefit was received. Specifically, for benefits that have a cash value or that can be translated into a cash value (e.g., cash assistance, SNAP, housing vouchers, or rental assistance), the threshold would be 15 percent of the federal poverty level (FPL) for a single person in a 12-month period ($1,821 as of 2018). For benefits that cannot be translated into a cash value (e.g., Medicaid and public housing), the threshold would be receipt of the benefit for 12 months within a 36-month period or 9 months if an individual receives both types of benefits (i.e., those with a cash value and those without a cash value).

The result of these proposed changes is even intermittent or limited benefit use could result in a public charge determination. This is because the proposed rule replaces the current standard of whether an immigrant is likely to be “primarily dependent” on a narrow set of public benefits with a proposal to define “public charge” as someone who uses one or more of a broader set of public benefits.\textsuperscript{10} While the rule includes monetary and durational thresholds that establish when an individual would be deemed to have used “one public benefit,” these thresholds are not only modest but also would be hard for individuals to calculate, adding to the likelihood that immigrants would forgo benefits rather than assume the risk of using them—thus contributing to the chilling effect.

It is well known that the use of Medicaid and other social support programs is countercyclical. Eligible immigrants and citizens alike turn to these programs, particularly Medicaid, in greater numbers during a recession when the job market constricts and loss of employee sponsored health insurance occurs. \textit{This intermittent use of the safety net should not be weighed against immigrants when making public charge determinations.}


\textsuperscript{10} See 83 Fed. Reg. at 51289 (proposing 8 C.F.R. § 212.21(a)).
Children’s Health Insurance Program

While the Children’s Health Insurance Program (CHIP) and Marketplace subsidies are not included in the list of public benefits that would contribute to public charge determination, DHS indicates CHIP is under active consideration for inclusion and is seeking comment. The Manatt Health analysis referenced above 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 nationwide and nearly 40 percent in Arizona.11 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 would weaken this vital health care safety net. **AzHHA thus opposes including CHIP in the list of public benefits.**

In closing, we understand and appreciate the Administration’s desire to promote self-sufficiency among immigrants as stated in the proposed rule. However, we strongly believe that this rule will not have such an effect. Rather it will lead to an increase in poverty rates as immigrants struggle to access healthcare and other effected services, such as housing. This will lead to poorer health outcomes, and place the public’s health at risk should communicable disease screening and treatments not occur. **With this in mind, we urge DHS to withdraw the proposed rule regarding the Inadmissibility on Public Charge Grounds.**

Thank you again for the opportunity to provide comment on the proposed rule. Please feel free to contact me at djohnston@azhha.org or 602-445-4300 should you have any questions.

Sincerely,

Debbie Johnston
Senior Vice President, Policy Development

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11 Mann, C; Grady, A; Orris, A; “Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule” Manatt Health, November, 2018