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Submitted via: www.regulations.gov

December 10, 2018

Ms. 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

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

Dear Ms. Deshommes:

On behalf of Dignity Health, I write to inform you of our concerns with the Department of Homeland Security's proposed regulation governing "Inadmissibility on Public Charge Grounds" that was published in the Federal Register on October 10, 2018 (Vol. 83, No. 196, pp. 51114-51296).

The proposed "public charge" rule would not only create significant barriers to health care access and endanger communities, but would also have far-reaching, devastating economic impact to cities, states and the nation—including hospitals across the country, especially safety net providers who care for low income, immigrant families and those most vulnerable. **As one of the largest, private, not-for profit healthcare systems in the country, Dignity Health is distinctly aware of the harm this proposed rule, if finalized, would have on—and in fact, is already causing in—the diverse communities it serves. Committed to a healing mission and values that call on a common spirt to care for all, Dignity Health respectfully urges the Department of Homeland Security (DHS) to withdraw the proposed rule.**

About Dignity Health and Our Commitment to a Healing Mission

Dignity Health is a 22-state network of more than 9,600 physicians, 63,000 employees, and over 400 care centers, including hospitals, urgent and occupational care, imaging centers, home health, and primary care clinics. Its 40 hospitals are located in Arizona, California and Nevada.

As the largest, private not-for-profit provider in California, Dignity Health has the highest share of Medicaid beneficiaries in the state, with growing shares in Arizona and Nevada. In FY 18, Dignity Health provided $889 million in community benefit, including $556 million in Medicaid shortfalls.

At Dignity Health, we believe the inherent dignity of the human person transcends race, religion, sexual orientation, gender identity, national origin, or economic status. Rooted in tradition, we also believe that health care is a basic human right for all. We stand by our mission to provide compassionate, high-quality health care to everyone who walks through our doors, regardless of immigration status or ability to pay. As Dignity Health continues to advocate for a transformed health care system, Dignity Health also continues to advocate for just and humane immigration policies. **Dignity Health is deeply concerned with the "public charge" proposed rule, which we believe disrespects the dignity of the human person and runs counter to advancing the common good that we are called to support. The proposed rule is in tension with who Dignity Health is as a healing mission, and it is an affront to the American values we lift up.**

<u>The Proposed Policy in Brief and Its Departure from Statute</u>

The Department of Homeland Security (DHS) entirely fails to consider whether this proposed policy is needed at all and whether it is the right approach to promoting the integration and success of immigrants. DHS proposes to change the definition of public charge in a radical departure from statute, practice and case law. In 1999, the Immigration and Naturalization Services, in field guidance, defined public charge as an immigrant who is "likely to become primarily dependent on the government for subsistence." This definition is in line with the historical and statutory interpretation of public charge. The proposed new definition would overturn that guidance that has not only stood for nearly 20 years, but has its basis in the entire history of U.S. public charge law. **DHS' proposed definition of public charge as an immigrant who, "receives one or more public benefits," is not in line with congressional and regulatory history and will lead to a dramatic upheaval of our immigration and public benefits systems. This change dramatically alters the longstanding policy goals around public charge. The proposed rule, if finalized, will only effectively diminish immigrants' ability towards greater self-sufficiency.**

As stated in the preamble, "DHS seeks to better ensure that aliens subject to the public charge inadmissibility ground are self-sufficient, i.e., do not depend on public resources to meet their needs, but rather rely on their own capabilities, as well as the resources of family members, sponsors, and private organizations."[1] It would be a mistake to predicate "self-sufficiency" on whether a person uses or not public benefits. Self-sufficiency takes into account interdependency, other established social norms and values, and various cultural adaptation skills, including accessing benefits for which immigrants are legally able to receive. We have seen countless hard-working immigrant women, men and families who have fallen on hard

[1] Department of Homeland Security, Proposed Rule: Inadmissibility on Public Charge Grounds, 83 Federal Register 51,114 (Oct 10, 2018)

times, struggle and persevere, get the help they can, live and flourish—heroic examples of self-sufficiency and what we have come to know as America's enduring story of home of the brave. The proposed rule goes against its own aims.

As part of its new approach to curtailing immigration and immigrants' use of public benefits, DHS proposes to expand the current list of public programs that would be considered under a public charge determination, to encompass Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), General Assistance cash benefits, the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), selected federal housing support, premium and cost-sharing subsidies under Medicare Part D, as well as Medicaid. In addition, the proposed rule adds harsher standards for personal circumstances that would make someone less likely to receive a green card or be granted entry to the U.S., such as having limited English proficiency, limited educational attainment, low income, being a child or being a senior. **From Dignity Health's particular perspective, the proposed addition of Medicaid and DHS' consideration of adding the Children's Health Insurance Programs to the already expanded list would be devastating to the individuals who rely on these programs, the community safety net that provides a disproportionate share of care to them, and their entire communities.**

<u>Health Impact on Children and Families</u>

Publicly-funded programs, like Medicaid, help families meet their basic health care needs and provide a buffer against the negative effects of adversity. Restricting access to these programs would be especially harmful to children's development and have implications for their wellbeing into adulthood. For example, children enrolled in Medicaid in their early years not only do better in childhood than children without health insurance, but also have better health, educational, and employment outcomes in adulthood.[2] Additionally, uninsured children are less likely to receive preventive care and necessary treatment when they are sick or injured, and are generally less healthy compared to children with health insurance.[3] Thus, treating health programs as a negative factor in the public charge assessment would have the paradoxical effect of making children less able to contribute as adult workers. **If this proposed rule were to be implemented, Dignity Health will further see negative health ramifications in our immigrant children and families since they would be discouraged to enroll into publicly funded insurance programs, like Medicaid.**

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[2] Rourke O'Brien and Cassandra Robertson, Medicaid and Intergenerational Economic Mobility, University of Wisconsin—Madison, Institute for Research on Poverty, 2015, https://search.library.wisc.edu/catalog/9910223409002121; Andrew Goodman-Bacon, The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes, NBER Working Paper No. 22899, 2016, www.nber.org/papers/w22899.

[3] Amanda R. Kreider, Benjamin French, Jaya Aysola, et al., "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families," JAMA Pediatrics 170 (2016).

Chilling Effect

Dignity Health's patient population includes immigrant families who will be harmed by the proposed rule's chilling effect, whether the rule applies to them or not. The fear created by these rules would extend far beyond any individual who may be subject to the "public charge" test. This will discourage many immigrant families from accessing benefits for which they are eligible.[4] This would include non-immigrant family members who would not be impacted by this rule directly, but may go without coverage due to fear.

This will especially impact Californians, where there are more than 13 million people enrolled in Medicaid, and where one of every two children has an immigrant parent and over half of all children are enrolled in the state's Medicaid program.[5] Since 2013, the uninsured rate in California has fallen from 17% to under 7% in 2017. These coverage gains have allowed California's families to access regular health care and lead healthier lives. Healthy families are better able to assimilate and contribute to the U.S. economy, and it is vital that patients and their families continue to access medical care and other social services without fear of adverse immigration consequences.

In 1996, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) codified the factors that had been used in public charge determinations for many years. It also established a new affidavit of support that could be used to overcome a public charge barrier. But, as immigration officials clarified in the following years, the law did not alter the public charge test itself. Another law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), restricted eligibility for public benefits, but also did not alter the public charge test. The enactment of the two laws, and some unlawful practices by federal and state agencies, generated confusion and panic within the immigrant community and discouraged many, even when qualified, from seeking critical health and nutrition benefits for fear of deportation. The Migration Policy Institute (MPI) found that during this time period there was a sharp decline of immigrants' use of public benefit programs like Medicaid & CHIP[6].

Dignity Health already is experiencing patients canceling appointments, avoiding health care treatment and services altogether. Our registration and community health staff is fielding a myriad of questions from patients and community members about the rule, and despite best efforts from staff, people are reticent to enroll. What is most heart-breaking is learning about a mom from the Southern California area who was too afraid to go to a hospital, and so delivered

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[4] Emily Bazar, Some Immigrants, Fearful of Political Climate, Shy Away from Medi-Cal (Kaiser Health News, Februray 22, 2017) https://khn.org/news/some-immigrants-fearful-of-political-climate-shy-away-from-medi-cal/

[5] California Department of Health Care Services Research and Analytic Studies Division. January 2016. Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group – September 2015. Medi-Cal Statistical Brief. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Penetration_Brief_ADA.PDF (pre-dates eligibility for children regardless of immigration status)

[6] Batalova, Jeanne, Michael Fix, and Mark Greenberg. 2018. Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use. Washington, DC: Migration Policy Institute. MPI estimates based on analysis of American Community Survey pooled data, 2014-16. The term "Non-citizen" as used by MPI includes people who are refugees and asylees, visa-holders, green-card holders, undocumented.

her baby alone at home. Though not finalized, the proposed rule is wreaking havoc, adding to the anti-immigrant environment communities are experiencing.

Financial Impact

Signaled by the 1996 precedent, Dignity Health is concerned that many of our immigrant patients could disenroll from programs that this proposed rule would add into the public charge determination. Medicaid is the largest source of funding in both Medicaid expansion and non-expansion states[7], making this funding indispensable. While many will likely forgo preventive and routine care, some people will still need to turn to hospitals for acute care and inpatient procedures. Dignity Health will undoubtedly see an increase in uncompensated care. As people defer or delay their care due to lack of insurance, their medical conditions may worsen and cost of care may become more expensive than if treated sooner in a more appropriate care setting other than the emergency department, where cost of care is highest.

The proposed rule would also significantly increase administrative costs, as our hospitals would need to devote considerable time and resources to educating frontline and clinical staff about the various ways patients would be impacted by the rule's provisions. If finalized, the proposed rule will cause financial strain on our system, compromising our ability to do more in the communities we serve, such as expanding services, clinical innovations and other community benefit programming and investments that address social and environmental determinants of health issues.

These findings, in a recent report prepared by Manatt [8], are alarming:

- The potentially affected Medicaid and CHIP population is estimated at **13.2 million** (4.4 million noncitizen adults and children, as well as 8.8 million citizen adults and children who are the family members of a noncitizen)[9]
- These enrollees accounted for an estimated **$68 billion** in Medicaid and CHIP healthcare services, including enrollees who are noncitizens ($26 billion) and those who are citizen family members of a noncitizen ($42 billion)[10]
- Hospital payments at risk under the public charge rule total an estimated **$17 billion** ($7 billion for noncitizen enrolled and $10 billion for citizen enrollees who have a noncitizen family member)

[7] Community Health Centers: Recent Growth and the Role of the ACA (Kaiser Family Foundation Issue Brief, 2017) https://www.kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/

[8] Mann, Cindy, Grady, April, Orris, Allison. 2018. Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule. Prepared by Manatt, Phelps & Philips, LLP on behalf of America's Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children's Hospital Association, and the Federation of American Hospitals. Findings are based on 2016 national data.

[9] This does not count all legal immigrants and family members who are eligible for Medicaid or CHIP, but only those who actually receive coverage.

[10] All dollar estimates in this analysis are one-year numbers and represent combined federal and state spending; the health and financial implications of this rule would extend indefinitely.

If this rule is finalized as drafted, Dignity Health will see an increase of uninsured patients and a decrease in Medicaid funding. A closer at look at our tristate service areas—Arizona, California, and Nevada—under the proposed rule, the chilling effect would be devastating. Dignity Health is particularly concerned that California and Nevada are among the states with the largest percentages of Medicaid and CHIP spending at risk of chilling impacts—26% and 24% (or $21.9 billion and $832 million), respectively. In dollar terms, Arizona is one of the highest at $2 billion (or 17%). **Medicaid and CHIP total hospital payments subject to chilling effect in states where Dignity Health hospitals are located are estimated at $383 million in Arizona, $5.2 billion in California, and $172 million in Nevada.[11] Given Dignity Health's large Medicaid and CHIP shares in these states, we are looking at several hundreds of millions of dollars of hospital payments subject to chilling effect.**

For the reasons stated above, Dignity Health urges DHS to withdraw this proposal and instead advance policies that strengthen—rather than undermine—the ability of our communities to flourish. By the DHS's own admission, the proposed rule "has the potential to erode family stability and decrease disposable income of families and children because the action provides a strong disincentive for the receipt or use of public benefits by aliens, as well as their household members, including U.S. children." Targeting low-income families will only exacerbate unmet health care needs, hunger and food insecurity, homelessness, poverty, and other issues, including overburdening safety net systems in communities. America is better than what this proposed rule assumes. Who we are as a nation calls upon values that tell us we can and must do better for the health and well-being of children, families, and communities, especially those among us who are poor and vulnerable.

Thank you for the opportunity to provide Dignity Health's comments.

Sincerely,

Rachelle R. Wenger
Director, Public Policy & Community Advocacy

[11] Mann, Cindy, Grady, April, Orris, Allison. 2018. Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule. Prepared by Manatt, Phelps & Philips, LLP on behalf of America's Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children's Hospital Association, and the Federation of American Hospitals. Findings are based on 2016 national data.