



AMERICA'S ESSENTIAL HOSPITALS

October 22, 2021

The Honorable Alejandro Mayorkas
Secretary
U.S. Department of Homeland Security
3801 Nebraska Avenue, NW
Washington, DC 20016

Ref: CIS No. 2696-21; DHS Docket No. USCIS–2021–0013: Public Charge Ground of Inadmissibility

Dear Secretary Mayorkas:

Thank you for the opportunity to submit comments on the above-captioned advance notice of proposed rulemaking. America's Essential Hospitals appreciates the steps the Department of Homeland Security (DHS) has taken to reverse the damaging 2019 rule on the public charge ground of inadmissibility and replace it with a definition that does not cause fear in immigrant communities or discourage individuals from accessing public services for which they are eligible. By expanding the scope of benefits considered in determining eligibility for immigration status, the public charge definition from the 2019 final rule has been damaging to the nation's health care system, marginalized patients, and state and local economies. The changes have been costly to federal, state, and local governments and detrimental to public health, and they reversed the substantial progress providers have made in delivering care to patients in the most appropriate and cost-effective settings. As exemplified during the COVID-19 pandemic, public health crises disproportionately affect people of color, including immigrants. Ensuring access to care for these populations is critical to the nation's public health response.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all, including underrepresented people and underserved communities. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care—that is, services the hospital provides but for which it receives no reimbursement. The average essential hospital provides \$56 million in uncompensated care annually, seven times more than other hospitals. Three-quarters of their patients are uninsured or covered by Medicare or Medicaid, and more than half of patients seen at essential hospitals are people of color. Our members provide state-of-the-art, patient-centered care while operating on financial margins half that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.¹

Essential hospitals' involvement in their communities goes beyond the direct provision of health care—they are leaders in tackling the social determinants of health that shape the well-being of their marginalized communities. Part of their mission is their commitment to confronting structural racism as a public health threat. As an association, we are dedicated to

¹ Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed October 5, 2021.

acknowledging and addressing the deeply entrenched historical racism that plays a critical role in determining the health and well-being of each member of our members' communities. Harmful policies that deter immigration and prohibit the use of public benefits, particularly among people of color and low-income individuals, are emblematic of the structural racism embedded in the nation's laws. As DHS participates in the rulemaking process, the agency should ensure the public charge definition is clear and equitable and does not unfairly target marginalized communities.

We applaud DHS for acknowledging the damage the 2019 rule caused and working to replace it with a more equitable, consistent definition. The now-rescinded 2019 public charge final rule caused fear and confusion among immigrants, putting these individuals and their families at risk and hampering the public health response to COVID-19. Patients forgoing public insurance programs and seeking care at hospitals without insurance strained the tight budgets of essential hospitals. The detrimental effects of the rule reached even further—it harmed the nation's health care system at large, resulting in increased health care costs and worse health outcomes. The impact of the 2019 public charge rule reached beyond immigration to affect health care, housing, nutrition, employment, and other sectors of the economy. In developing a new public charge definition, it is imperative that DHS consider the important role these varied social determinants of health have on the well-being of immigrants and all Americans.

1. DHS should limit the types of public benefit programs considered in the public charge definition to exclude all in-kind benefit programs and clarify that family members' receipt of benefits is not considered in the public charge determination.

In the advance notice, DHS seeks comment on the types of public benefits to include in the public charge definition. Under the 1999 interim field guidance—the policy DHS currently follows—the agency only considers cash benefit programs and institutionalization for long-term care in the public charge determination. The 2019 public charge final rule expanded the list of benefits to include multiple public programs spanning various government agencies, including non-emergency Medicaid benefits, housing benefits, and nutritional benefits. **We urge DHS to exclude all in-kind public benefit programs, including all types of Medicaid benefits, from the public charge definition.**

DHS seeks comment on the possibility that public charge policies will result in individuals who are otherwise eligible for benefits, including U.S. citizen children of noncitizens, forgoing public benefits. As the fallout from the 2019 final rule demonstrated, inclusion of public benefit programs in the public charge definition directly impacts immigrant access to vital benefits, such as Medicaid. Including these benefits in the public charge definition deters individuals, including citizens, from enrolling in these programs and causes many current beneficiaries to disenroll or consider disenrolling.

Research on the public charge rule and public benefits confirmed that immigrants and their U.S. citizen family members either avoided enrolling in benefit programs altogether, or disenrolled from benefits, beginning even before the rule was finalized. In 2019, nearly one-third of immigrant families with one family member who was not a permanent resident reported avoiding government benefit programs. Half of these families said they avoided enrolling in programs such as Medicaid and nutritional programs.² A survey of immigrants in California reinforced this trend, finding that 25 percent of low-income immigrant adults avoided public benefit programs, including Medicaid and nutritional benefit programs,

² Urban Institute. Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019. May 2020. https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf. Accessed October 5, 2021.

exacerbating food insecurity and hindering access to health care.³ Census data from 2019 has validated these studies, finding that U.S. citizen children with a noncitizen in their household also saw a sharp decline in enrollment in public benefit programs in 2019 (nearly 20 percent for Medicaid and 36 percent for nutritional assistance).⁴

The inclusion of benefit programs in the public charge definition deters millions of marginalized individuals from seeking health care and other benefit programs directly tied to health and well-being. Medicaid covered 75 million people in 2021, the Supplemental Nutrition Assistance Program covered 42 million people, more than 10 million individuals received federal rental assistance in 2018, and approximately 1 million families live in public housing.⁵ Together, these programs form a key part of the social safety net, addressing social determinants of health that shape the lives of individuals in underserved communities plagued by the lingering effects of structural racism. The Medicaid program is an integral part of the American health care system, providing coverage of primary care, prenatal care, mental health and substance misuse services, specialty care, prescription drug coverage, and a variety of wraparound services. Medicaid also is a critical source of coverage for children, paying for routine check-ups, oral and vision care, and treatment for chronic conditions. Care reimbursed by Medicaid drives improved outcomes; reduces emergency department use and unnecessary hospitalizations; and helps decrease infant and child mortality rates.⁶ The benefits of Medicaid go beyond health care—individuals who receive Medicaid go on to become productive members of the workforce and realize better employment and educational attainment, thus strengthening the economy.⁷ The program also lifts millions of individuals out of poverty, making them self-sufficient and less dependent on government programs in the long run.⁸ Similarly, nutritional and housing programs tackle food and housing insecurity, leading to better health outcomes.⁹ The sustained viability of and access to these programs is critical to empowering individuals to lift themselves out of poverty because of these programs' link to general well-being, the economy, and educational attainment.

In addition to excluding the in-kind benefits added by the 2019 public charge rule, DHS should remove Medicaid long-term care benefits from the list of considerations in the public charge determination. The 1999 field guidance, in addition

³ UCLA center for Health Policy Research. One in 4 Low-Income Immigrant Adults in California Avoided Public Programs, Likely Worsening Food Insecurity and Access to Health Care. March 2021. <https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/publiccharge-policybrief-mar2021.pdf>. Accessed October 5, 2021.

⁴ Migration Policy Institute. Anticipated “Chilling Effects” of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families. December 2020. <https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real>. Accessed October 5, 2021.

⁵ Centers for Medicare & Medicaid Services. April 2021 Medicaid & CHIP Enrollment Highlights. <https://www.medicare.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>. Accessed October 5, 2021; U.S. Department of Agriculture. SNAP Data Tables. <https://fns-prod.azureedge.net/sites/default/files/resource-files/34SNAPmonthly-9.pdf>. Accessed October 5, 2021; Center for Budget and Policy Priorities. U.S. Federal Rental Assistance Fact Sheet. June 1, 2021. <https://www.cbpp.org/sites/default/files/atoms/files/12-10-19hou-factsheet-us.pdf>. Accessed October 5, 2021; U.S. Department of Housing and Urban Development. HUD’s Public Housing Program. https://www.hud.gov/topics/rental_assistance/phprog. Accessed October 5, 2021.

⁶ Wherry LR, et al. Childhood Medicaid Coverage and Later Life Health Care Utilization. February 2015. <https://www.nber.org/papers/w20929/>. Accessed October 15, 2021; Goodman-Bacon A. Public Insurance and Mortality: Evidence from Medicaid Implementation. November 25, 2015. http://www-personal.umich.edu/~ajgb/medicaid_ajgb.pdf. Accessed October 5, 2021.

⁷ Cohodes S, et al. The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions. May 2014. <https://www.nber.org/papers/w20178>. Accessed October 5, 2021.

⁸ Sommers BD, Oellerich D. The Poverty-Reducing Effect of Medicaid. *Journal of Health Economics*. 2013;32(5):816–832.

⁹ Gunderson C, Ziliak J. Food Insecurity and Health Outcomes. *Health Affairs*. November 2015. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0645>. Accessed October 5, 2021.

to including cash benefits, included programs such as Medicaid that support noncitizens who receive long-term care. Long-term care includes a variety of health care, health-related, and social services that help individuals with disabilities, such as nursing home care. Medicaid is the primary payer of nursing home care, covering services not covered by Medicare and other payers. The Kaiser Family Foundation estimates that one in three people over the age of 65 will require nursing home care at some point in their lives.¹⁰ Given the importance of long-term care to the disabled and elderly population, DHS should not include these benefits in the public charge definition.

As demonstrated by the research cited above, the 2019 public charge rule not only directly affected noncitizens but also affected lawful permanent residents and U.S. citizens, who are lawfully eligible for these benefit programs. **In addition to limiting the types of benefit programs in the public charge definition, the new rule should clearly state that the receipt of benefits by family members of applicants for immigrant status will not be considered in determining whether to grant the application.** Excluding these vital benefit programs from the public charge definition, and clearly communicating that enrollment in these programs will not jeopardize immigration status of eligible family members, is critical to reassuring immigrant communities going forward.

2. DHS should ensure its future public charge regulations do not lead to increased costs and strain the budgets of essential hospitals.

As DHS drafts the public charge regulations, it should ensure the benefits it includes in the public charge definition do not increase costs and strain the budgets of essential hospitals. In the advance notice, DHS requests feedback on costs incurred by organizations as a result of reduced enrollment or disenrollment from public benefit programs. An analysis of the 2018 public charge proposed rule commissioned by America's Essential Hospitals and performed by Manatt Health demonstrated the far-reaching impact of including Medicaid benefits on hospital uncompensated care costs.¹¹ The inclusion of Medicaid in the list of public benefits causes insurance losses, resulting in higher uninsurance rates and worse health outcomes. Our analysis revealed that more than 13 million Medicaid and Children's Health Insurance Program (CHIP) enrollees would be subject to the chilling effect of the rule.¹² These individuals are here lawfully, either as citizens or with some form of legal immigration status, but could reconsider the value of remaining covered out of fear of immigration-related consequences for themselves or a family member. The analysis did not account for individuals who are eligible but not currently enrolled in Medicaid or CHIP and might choose not to enroll out of fear, and therefore actually understates the potential population at risk of forgoing health benefits.

As part of our analysis, we calculated the hospital payments at risk for the 13 million beneficiaries likely to experience a chilling effect from this proposal. Based on Medicaid and CHIP payment data from 2016, hospitals could lose up to \$17 billion annually in payments from these programs. This impact would be especially pronounced for essential hospitals. The \$4.5 billion at-risk Medicaid and CHIP payments at essential hospitals make up 26 percent of the total at-risk amount, while essential hospitals constitute only 4 percent of all hospitals in the analysis. This disproportionate impact is unsustainable for essential hospitals, which already operate on margins narrower than the average hospital and provide seven times more uncompensated care. If Medicaid is again included in the public charge definition, the chilling

¹⁰ Kaiser Family Foundation. Medicaid's Role in Nursing Home Care. June 20, 2017.

<https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/>. Accessed October 5, 2021.

¹¹ Manatt Health. Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule. November 2018. https://www.manatt.com/Manatt/media/Documents/Articles/Medicaid-Payments-at-Risk-for-Hospitals-Under-the-Public-Charge-Proposed-Rule_Manatt-Health_Nov-2018.PDF. Accessed October 5, 2021.

¹² The analysis included CHIP benefits because DHS in the 2018 proposed rule sought comment on including CHIP benefits and because CHIP serves as a financing source for Medicaid coverage.

effect and the associated decline in Medicaid revenues would further increase uncompensated care and drive up costs for essential hospitals.

Given their role as large employers in their communities, the closure or scaling back of essential hospital operations would have a ripple effect on local and state economies. One study examined the potential economic loss to the United States resulting from disenrollment from health and nutritional benefit programs related to DHS' proposal; it found that the economic ripple effects of lost jobs could exceed \$30 billion.¹³ For hospitals, loss of important Medicaid payments would affect operations. A shutdown or scaling back of hospital operations would reduce employment and the hospital's economic contribution from spending on goods and services.

3. DHS should exclude health, nutritional, and housing benefits from the public charge definition to ensure the rule does not undermine public health efforts.

DHS should ensure its future public charge regulations do not counteract public health efforts. In addition to worse health outcomes for individuals directly affected by the loss of insurance, the inclusion of health and other benefits in the public charge policy will be felt by others in their communities and across the country. As people put off receiving necessary preventive and primary care, including immunizations, they will be at higher risk for acquiring communicable diseases that they might transmit to others in their communities, whether at their homes or in their workplaces. In this way, the inclusion of benefits in the public charge definition leads to a higher likelihood of outbreaks of transmissible diseases. The public health consequences of delaying health care and benefit application have been underscored by the COVID-19 pandemic, which has disproportionately affected people of color, including immigrants.¹⁴ The negative effects of COVID-19 go beyond health care to include economic impacts on people of color. As we continue to respond to COVID-19 and prepare for future public health emergencies, it is vital that all individuals who are eligible for health benefits enroll for these benefits and that people do not delay seeking necessary care.

Further, inclusion of housing and nutritional benefits counteracts the progress that policymakers, health care providers, and other community partners have made in addressing factors beyond clinical care that influence a person's health, including their social, economic, and environmental circumstances. Disenrollment from or delayed enrollment in these programs will inevitably drive up poverty rates, homelessness, and malnutrition, all of which lead to adverse health outcomes and undermine public health.

4. DHS should consider the affidavit of support as sufficient evidence that an applicant for immigration status is unlikely to become a public charge and should apply the statutory factors in a nondiscriminatory and equitable manner.

The public charge provision of the immigration statute lists factors immigration officers must consider when determining an individual's likelihood of becoming a public charge: age; health; family status; assets, resources, and financial status; and education and skills. The statute also allows immigration officers to consider an affidavit of support in making a public charge determination. Affidavits of support are submitted by U.S. citizen or lawful permanent resident sponsors on behalf of applicants for immigration status, certifying that the applicant will not

¹³ Fiscal Policy Institute. Only Wealthy Immigrants Need Apply: How a Trump Rule's Chilling Effect Will Harm the U.S. October 10, 2018. <http://fiscalpolicy.org/wp-content/uploads/2018/10/US-Impact-of-Public-Charge.pdf>. Accessed October 5, 2021.

¹⁴ Artiga S, et al. Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19. Kaiser Family Foundation. April 7, 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>. Accessed October 5, 2021.

become a public charge and that the sponsor will use their financial resources to repay the cash value of any benefits the applicant uses in the future. **DHS should allow a properly filed affidavit of support to serve as sufficient evidence of the applicant overcoming the public charge ground of inadmissibility.** Giving full weight to the affidavit of support will provide consistency in the application of the public charge definition, as it will remove subjectivity in the application of other statutory factors by immigration officers. Further, it is consistent with the 1999 field guidance, which states the affidavit of support is meant to overcome the public charge ground of inadmissibility.

DHS should interpret other statutory factors in a way that does not disfavor people of color, women, and people with disabilities. In the 2019 final rule, DHS provided more categories of evidence to evaluate under each of the statutory factors. For example, under the assets, resources, and financial status statutory factor, DHS finalized that a gross household income below 125 percent of the federal poverty guidelines (FPG) would be considered a negative factor. Household income over 250 percent of the FPG would be considered a heavily weighted positive factor. Placing excessive weight on income, either as a positive or negative factor, disfavors women and people of color, who on average have incomes lower than those of men and white people.¹⁵ DHS included other factors, such as proficiency in English and educational history, in the public charge test, which also are biased against the same populations, while not necessarily indicative of an individual's likelihood to become dependent on the government for subsistence. Including such factors only serves to perpetuate the structural racism that results in disparities such as the income gap.

Under DHS' longstanding application of the public charge standard, which requires a medical examination, the agency evaluates individuals for physical or mental conditions, including serious disease or disability. This policy discriminates against disabled individuals and should be eliminated from the public charge test. Further, in the 2019 final rule, DHS said it also would consider if an individual is the primary caregiver for a disabled household member as a negative factor in making a public charge determination. DHS should ensure that the new public charge rule does not incorporate the caregiver criterion, which has no relation to whether an individual is likely to become dependent on the government for subsistence and discriminates against disabled individuals.

5. DHS should ensure the public charge regulations are clear to the general public, state and local agencies, and health care providers.

DHS also should ensure public charge regulations are clear to all stakeholders and clearly communicate what the rule means for noncitizens, their ability to apply for benefits, and their applications for immigration status. The 2018 proposed rule and subsequent 2019 final rule were overly complex, requiring hospitals, community organizations, state and local agencies, and other stakeholders to invest significant resources in patient education.

Hospitals are large, complex organizations with thousands of administrative and clinical staff across multiple units and physical locations of the hospital. Staff placed throughout these ambulatory networks interact with patients and receive questions from patients on the appropriateness of applying for benefits and receiving health care services.

Even before the public charge rule was finalized, providers were fielding questions from patients on the implications of changes in immigration policy. Once the rule was finalized, providers (who are not immigration experts) invested substantial staff time to understand the

¹⁵ Pew Research Center. Incomes of whites, blacks, Hispanics and Asians in the U.S., 1970 and 2016. July 12, 2018. <https://www.pewresearch.org/social-trends/2018/07/12/incomes-of-whites-blacks-hispanics-and-asians-in-the-u-s-1970-and-2016/>. Accessed October 5, 2021; Pew Research Center. Gender pay gap in U.S. held steady in 2020. May 25, 2021. <https://www.pewresearch.org/fact-tank/2021/05/25/gender-pay-gap-facts/>. Accessed October 5, 2021.

nuances of the rule and communicate the implications of the rule to their communities, in the form of educational materials. Providers also had to train their front-line staff, including educating them about the rule and how it could affect patient eligibility and access to health care.

One of the first points of contact between hospitals and patients is the intake process, when hospitals collect information from patients on their insurance status. Understandably, patients might have questions for hospital intake staff about whether their receipt of benefits will imperil their current or future immigration status, although these staff are not necessarily the best equipped to answer such questions. In addition to intake staff, hospitals and other health care providers employ eligibility and enrollment counselors who assist patients with determining eligibility for benefits and processing their applications for insurance or other health-related programs. These staff are at multiple points of contact, including in hospitals' vast networks of clinics and in their main campus. The 2019 public charge rule put hospital staff in the difficult position of having to tread the line between providing health care and legal advice, which goes beyond their current scope and responsibilities. Most of the questions they received were legal in nature and are not appropriate questions for hospital staff to answer.

In addition, state and local agencies already had established consumer-facing communications in the form of applications, application instructions, training for staff, and forms and posters displayed to applicants in public areas. These messages were based on the existing public charge definition, which had been consistent since 1999. These states and localities had to recreate their communications materials to accurately capture the changes in the 2019 rule, only to switch back and forth between the 2019 rule and the 1999 guidance as DHS paused implementation of the rule in response to legal challenges.

To avoid placing undue burden on hospitals, as well as state and local benefit administration agencies, DHS should ensure the rule is clear and engage in public education and communication campaigns to explain its implications. These efforts should include materials from DHS clearly stating which benefits are in the public charge determination, which populations are affected by the public charge determination, and how receipt of benefits could affect immigration status. After the 2019 final rule, this work was primarily done by providers and state and local agencies. To ensure consistent and accurate messaging about the implications of the rule, DHS should lead efforts to publish these materials. Further, DHS should work with federal and state agencies responsible for the various benefit programs (such as the Centers for Medicare & Medicaid Services and state Medicaid agencies) to clearly encourage current and prospective beneficiaries of Medicaid and other benefit programs to enroll in these programs when appropriate. For example, the Center for Medicaid and CHIP Services (CMCS) in July released an informational bulletin to states informing them that the 2019 public charge rule had been rescinded and encouraging them to safeguard applicant and beneficiary information. We commend CMCS for this effort and believe DHS should work with CMCS and other relevant agencies to issue similar communications on the importance of enrolling in public benefits once a new rule is finalized.

6. DHS should work with other federal agencies with jurisdiction over immigration to ensure alignment in finalizing and implementing the public charge definition.

While DHS oversees immigration applications and admissibility decisions for individuals within the United States and at U.S. borders and ports, other federal agencies have jurisdiction over other aspects of immigration. The Department of State (DOS) is responsible for immigration applications from abroad through U.S. embassies and consulates, and the Department of Justice (DOJ), through the Executive Office of Immigration Review and the Board of Immigration Appeals, has jurisdiction over deporting individuals already in the country. In conjunction with the 2019 DHS public charge final rule, DOS issued a rule adopting the same definition of public charge. This rule has been on hold due to federal court decisions.

Under the previous administration, DOJ submitted a public charge proposed rule to the Office of Management and Budget for review but then withdrew this rule. **DHS should work with DOJ and DOS to ensure its forthcoming public charge definition is consistent across all federal agencies with overlapping jurisdiction on public charge determinations.**

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO