AMERICA'S ESSENTIAL HOSPITALS

April 25, 2022

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

Ref: CIS No. 2715-22; DHS Docket No. USCIS-2021-0013: Public Charge Ground of Inadmissibility

Dear Secretary Mayorkas:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates the steps the Department of Homeland Security (DHS) has taken to reverse the damaging 2019 final 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 marginalized patients, health care system, 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]

[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 April 6, 2022.

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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 a commitment to confronting structural racism as a public health threat. As an association, we are dedicated to acknowledging and addressing the deeply entrenched historical racism that plays a critical role in determining the health and well-being of each member of essential hospitals' communities. Harmful policies that deter immigration and prohibit the use of public benefits, particularly among people of color and low-income individuals, reflect the structural racism embedded in the nation's laws. As DHS works to finalize a new public charge regulation, 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 final rule caused and working to replace it with a more equitable, consistent definition. The now-rescinded 2019 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 for DHS to 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.**

In the rule, DHS proposes a new definition of public charge: an individual "likely at any time to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or long-term institutionalization at government expense." This definition closely resembles the definition in 1999 interim field guidance DHS followed for 20 years until the 2019 public charge final rule. The 2019 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 strongly support DHS' proposal to remove short-term Medicaid benefits, housing benefits, and nutritional benefits from the public charge definition. **However, we urge DHS to go one step further and exclude Medicaid long-term care from the public charge definition.**

As the fallout from the 2019 final rule demonstrated, including 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 2019 final 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, 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]

Including benefit programs in the public charge definition deterred millions of marginalized individuals from seeking health care and other benefit programs directly tied to health and well-being. Medicaid covered 79 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 nation's 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-

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[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 April 6, 2022.

[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 April 6, 2022.

[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 April 6, 2022.

[5] Centers for Medicare & Medicaid Services. November 2021 Medicaid & CHIP Enrollment Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed April 6, 2022; U.S. Department of Agriculture. SNAP Data Tables. https://fns-prod.azureedge.us/sites/default/files/resource-files/34SNAPmonthly-3.pdf. Accessed April 6, 2022; Center for Budget and Policy Priorities. U.S. Federal Rental Assistance Fact Sheet. Updated January 19, 2022. https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#US. Accessed April 6, 2022; U.S. Department of Housing and Urban Development. HUD's Public Housing Program. https://www.hud.gov/topics/rental_assistance/phprog. Accessed April 6, 2022.

[6] Wherry LR, et al. Childhood Medicaid Coverage and Later Life Health Care Utilization. February 2015. https://www.nber.org/papers/w20929/. Accessed April 6, 2022; Goodman-Bacon A. Public Insurance and Mortality: Evidence from Medicaid Implementation. November 25, 2015. http://www-personal.umich.edu/~ajgb/medicaid_ajgb.pdf. Accessed April 6, 2022.

[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 April 6, 2022.

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 final rule, DHS should remove Medicaid long-term care benefits from the list of benefits considered in the public charge determination. Medicaid's importance goes beyond its role in providing short-term acute care—Medicaid is the primary source of coverage for long-term care, such as nursing home care. The 1999 field guidance, in addition 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 pays for care provided to nearly two-thirds of nursing home residents.[10] The Kaiser Family Foundation estimates that one in three people older than 65 will require nursing home care at some point in their lives.[11] In addition to undermining this important source of coverage for elderly and disabled individuals, including one subset of Medicaid benefits in the public charge determination will be confusing for individuals seeking to apply for other types of Medicaid benefits. Given the importance of long-term care to the disabled and elderly population, DHS should not include these benefits in the public charge definition.

In addition to leading to these detrimental health outcomes, including Medicaid in the public charge determination also leads to higher costs for hospitals and other providers, particularly those committed to serving marginalized populations. Including Medicaid in the list of public benefits causes insurance losses, resulting in higher uninsurance rates and higher levels of uncompensated care for these hospitals already operating on narrow margins. If Medicaid is again included in the public charge definition, the chilling effect and the associated decline in Medicaid revenues would further increase uncompensated care and drive up costs for essential hospitals.

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[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 April 6, 2022.
[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 April 6, 2022.
[11] Ibid.

2. **DHS should exclude the receipt of local, state, tribal, and territorial cash assistance from the public charge determination.**

DHS proposes to define public cash assistance for income maintenance as:

- Supplemental Security Income (SSI);
- cash assistance for income maintenance under the Temporary Assistance for Needy Families (TANF) program; or
- state, tribal, territorial, or local cash benefit programs for income maintenance.

While we agree that receipt of federal cash benefits (SSI and TANF) is more indicative of dependence on the government, DHS should exclude state, tribal, territorial, and local cash benefit programs from the public charge definition.

State- and local government–funded programs are an exercise of the powers traditionally reserved for states and localities to ensure the health and safety of their populations. Further, the details of these benefit programs vary substantially across states and localities, and they evolve constantly as states and local governments seek new ways to support their residents. For example, in 2021, more than 20 localities piloted guaranteed income programs. In addition, at least seven states and many localities provided disaster cash for immigrants excluded from federal assistance, and five states newly expanded their earned income tax credit to reach certain immigrants.[12]

Clearly communicating which of these programs the public charge determination includes will challenge DHS and immigration advocates advising their clients on whether to apply for benefits. Immigration advocates not versed in the nuances of each state and local program might advise their clients to avoid local and state programs altogether, for fear of triggering a public charge determination in the future. This would result in a chilling effect, discouraging noncitizens from accessing benefits integral to their health and well-being. **Focusing instead on receipt of federal cash benefits would allow for a single, uniform federal standard while giving states, localities, and other jurisdictions discretion in how they promote the health and safety of their populations.**

3. **DHS should finalize its proposed definition of "receipt" of public benefits to ensure individuals are not penalized for merely applying for benefits or for others' receipt of benefits.**

DHS proposes to define "receipt of public benefits" as occurring when "a public benefit-granting agency provides public benefits to a noncitizen, but only where the noncitizen is listed as the beneficiary." Under the proposed rule, applying for or having an approved application for a public benefit on one's own behalf or on behalf of another would not constitute receipt of public benefits by the applicant. DHS also clarifies that a noncitizen's receipt of public benefits on behalf another individual, or the receipt of public benefits by another individual, would not count as receipt of public benefits by the noncitizen. **We urge DHS to finalize this definition of the receipt of public benefits, because it will be straightforward for reviewing immigration officers to administer and it will mitigate the chilling effect that deters eligible individuals from applying for benefits. DHS can take the**

[12] The National Immigration Law Center. State Immigrant Rights Highlights 2021: Advancing Community Health and Well-Being. https://www.nilc.org/wp-content/uploads/2022/01/NILC-Advocacy_WITSReport_011422.pdf. Accessed April 25, 2022.

additional step of specifying a non-exhaustive list of examples of what does not count as receipt of benefits. For example, a noncitizen parent applying for Temporary Assistance for Needy Families benefits on behalf of a child could be explicitly referenced in this list.

DHS seeks comment on how to communicate to certain groups, such as parents of U.S. citizens, that their children's receipts of benefits will not count against them in any future public charge determinations. In addition to finalizing its proposed definition, which states that the receipt of benefits by another individual does not count against the noncitizen who later applies for immigration benefits, DHS can specify that receipt of benefits by family members is not considered in the public charge determination. Clearly communicating that enrollment in these programs will not jeopardize immigration status of eligible family members is critical to reassuring immigrant communities going forward.

4. **DHS should finalize the totality of the circumstances test 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. DHS proposes a public charge determination must be based on a totality of circumstances considering all these statutory factors, without any one factor being dispositive. DHS does not propose to specify the standard and evidence required for each statutory factor, as it had done in the 2019 final rule. In the 2019 final rule, DHS had categorized certain factors into heavily weighted negative and positive factors. **The consideration of heavily weighted factors discriminated against marginalized populations and was untenable to administer. 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 less than 125 percent of the federal poverty guidelines (FPG) would be considered a negative factor. Household income greater than 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.[13] 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. **By requiring immigration officers to consider the statutory factors in their totality, without assigning weights and prescribing specific evidence to be considered for each factor, DHS can ensure the public charge definition is administered equitably and efficiently.**

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[13] 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 April 6, 2022; Pew Research Center. Some gender disparities widened in the U.S. workforce during the pandemic. January 14, 2022. https://www.pewresearch.org/fact-tank/2022/01/14/some-gender-disparities-widened-in-the-u-s-workforce-during-the-pandemic/. Accessed April 6, 2022.

5. **DHS should consider the affidavit of support as sufficient evidence that an applicant for immigration status is unlikely to become a public charge.**

In addition to the statutory factors referenced above, the immigration 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 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.

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

Throughout the proposed rule, DHS seeks comment on shaping public communications after the publication of a final rule to mitigate chilling effects among U.S. citizens and noncitizens. **DHS 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. 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 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 final 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 of expertise 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 final 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 in multiple languages 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. DHS also should organize public listening sessions in affected communities to explain the rule and its implications for noncitizens seeking to apply for public benefits. Further, DHS should work with federal and state agencies responsible for the various benefit programs (such as the Centers for Medicare & Medicaid Services, state Medicaid agencies, the U.S. Department of Agriculture, and the U.S. Department of Housing and Urban Development) 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 final 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.

7. **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 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 public charge definition is consistent across all federal agencies with overlapping jurisdiction on public charge determinations.**

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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,

Bruce Siegel, MD, MPH
President and CEO