December 7, 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 NW, Washington, DC 20529–2140

Ref: *CIS No. 2499–10; DHS Docket No. USCIS– 2010–0012: RIN 1615–AA22*

RE: Notice of Proposed Rulemaking; Inadmissibility on Public Charge Grounds; Federal Register (Vol. 83, No. 196, Oct. 10, 2018)

Dear Ms. Deshommes,

On behalf of our 130-member hospitals and health systems in our state, the North Carolina Healthcare Association (NCHA) appreciates the opportunity to comment on proposed changes to the Department of Homeland Security proposal to "prescribe how it determines whether an alien is inadmissible to the United States under section 212(a)(4) of the Immigration and Nationality Act (INA) because he or she is likely at any time to become a public charge."

In promoting this rule change, the US Department of Homeland Security seeks to better ensure that aliens subject to the public charge inadmissibility ground are self-sufficient. Under current Immigration law and guidance, individuals that are likely to become a "public charge," or to become reliant upon the government for financial support, can be denied admission to the United States. Or, if those individuals are already in the country, they can be denied the ability to adjust their status in order to obtain a green card as a lawful permanent resident.

NCHA does not support the proposed changes to this rule for the following reasons:

The new rule could deter enrollment in Medicaid and the Children's Health Insurance Program (CHIP), and as a result, children and adults who are lawfully in the country could become uninsured.

One of the most critical types of public benefits that would be specifically included in the proposal is Medicaid. While not all Medicaid eligible immigrants will be subject to a "public charge" determination, the change would likely cause many immigrants, both eligible and ineligible, to avoid enrolling in Medicaid and the Children's Health Insurance Program (CHIP). This proposal will increase the number of immigrant adults and children without Medicaid coverage presenting to North Carolina Health Systems. This will also **result in poorer health outcomes for Medicaid eligible immigrants who choose not to apply for benefits, greater uncompensated care burdens for those hospitals and other care providers who care for them, and greater stress on community programs and services in immigrant communities.**

<u>Impact Estimates</u>
The Department of Homeland Security's estimate is for a total reduction in transfer payments from Federal and State Governments of approximately $2.27 billion annually due to disenrollment or foregone enrollment in public benefit programs by aliens who may be receiving public benefits. The Department acknowledges that "the primary source of the consequences and indirect impacts of the

proposed rule would be costs to various entities that the rule does not directly regulate, such as hospital systems, state agencies and other organizations that provide public assistance to aliens and their households." *(p. 51117)* Hospitals provide a substantial share of care to Medicaid and CHIP enrollees. The Department also recognizes that the rule may increase poverty of certain families and children, including US citizen children.

The proposal increases the risk of being denied entry or adjusting immigration status and obtaining a green card as a lawful permanent resident. This will have a chilling effect on immigrants applying for benefits. Manatt Health reports that this effect has been observed in previous changes contemplated for the SNAP Program following release of a draft of the proposed rule. Agencies that administer the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and SNAP observed a decline in participation among immigrant women. Manatt concludes that, if immigrants perceive that applying for or holding Medicaid benefits will jeopardize the opportunity to extend their status, they will be less likely to apply for or retain those benefits.

In 2016, an estimated $68 billion (combined federal and state spending) in Medicaid and CHIP healthcare services were provided to noncitizens ($26 billion) and those who are citizen family members of a noncitizen ($42 billion). Hospitals provide a substantial share of this care, and are estimated to have $17 billion (in 2016 payments) at risk under this rule. Manatt projects that **North Carolina hospitals will have $216 million in payments at risk due to lowered Medicaid/CHIP beneficiary levels caused by the chilling effect.** Similarly, the Kaiser Family Foundation has found that there will be reduced participation in Medicaid and other programs that negatively affect the health and financial stability and the growth and healthy development of children whose parents are affected.

Federal EMTALA Requirement

North Carolina hospitals are full service providers to patients covered by Medicare, Medicaid and other government and third party payers. The *Federal Emergency Medical Treatment and Labor Act* requires that a hospital attend to any person seeking emergency services, regardless of immigration status or insurance status. More of the care delivered by hospitals will be recorded as uncompensated care if otherwise eligible but uninsured patients elect not to apply for Medicaid benefits. The Department acknowledged these concerns in the preamble to the rule, noting that there is likely to be increased emergency room use and emergent care due to delayed treatment, increased prevalence of diseases, and an increase in uncompensated care.

North Carolina Outcomes

Data from The *Migration Policy Institute* show that, in North Carolina, 32.5% of foreign born civilian non-institutionalized populations lack health insurance, a much higher percentage than the 8.5% of those born in the USA. (North Carolina is one of 14 states that has not elected to expand Medicaid under The Affordable Care Act.) *Migration Policy Institute* data also show lower annual income levels for full time year round workers who are not born in the USA. Without other insurance, the population affected by this regulation is unlikely to have other payment options, with limited opportunities for preventive and primary care. This increases the likelihood that they will eventually need the higher cost services of a hospital. North Carolina hospital systems will therefore be subject to greater financial stress, on top of the decreasing reimbursements from other Federal and State Government payors.

The North Carolina Healthcare Association requests that the US Department of Homeland Security reject these proposed changes to the Public Charge determination process.

Thank you for your consideration of our comments. Please feel free to contact Mike Vicario (mvicario@ncha.org) or myself if you have questions or concerns.

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association