October 21, 2021

Alejandro N. Mayorkas
Secretary
Department of Homeland Security
20 Massachusetts Avenue, NW
Washington, DC 20529-2140

SUBJECT: [IS No. 2696–21; DHS Docket No. USCIS– 2021–0013; Public Charge Ground of Inadmissibility; Advanced Notice of Proposed Rulemaking; Federal Register (Vol. 86, No. 160), August 23, 2021

Dear Secretary Mayorkas:

On behalf of our more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the advanced notice of proposed rulemaking to inform a future regulatory proposal on the public charge ground of inadmissibility. CHA appreciates that the Department of Homeland Security (DHS) and U.S. Citizenship and Immigration Services (USCIS) are seeking broad stakeholder feedback to ensure future policies are clear, consistent, and do not cause undue fear among immigrant families accessing the public services available to them.

Caring for the sick and healing the injured — without regard to a patient's ethnicity or citizenship status — is the mission of all hospitals. California is home to nearly 11 million immigrants, more than any other state, accounting for 27% of the state's population[1]. As such, California is disproportionately impacted by public charge policies that cause fear or confusion in the immigrant community. The August 2019 final rule titled *Inadmissibility on Public Charge Grounds* had a significant chilling effect on immigrants seeking health care services. A report from the University of California Los Angeles Center for Health Policy Research found that, in 2019, 25% of low-income immigrant adults in California reported avoiding public programs such as Medicaid (Medi-Cal, in California) and Supplemental Nutrition Assistance Program (SNAP) — fearing a negative impact on their immigration status.[2]

Hospitals understand that the health and well-being of our communities are at risk when community members forgo basic needs such as food, housing, and health care services out of fear for their immigration status. People who avoid seeking necessary medical care will have poorer health outcomes.

[1] https://www.ppic.org/publication/immigrants-in-california/
[2] https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/publiccharge-policybrief-mar2021.pdf

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For example, it is well established that pregnant women who go without prenatal care are more likely to deliver prematurely — significantly increasing the risk of maternal and infant mortality. In addition, young children who are left unvaccinated are likely to contract preventable childhood diseases and risk spreading those diseases to those who cannot be vaccinated, and individuals who suffer from chronic health conditions and lack access to a regular source of care and low-cost medications experience disease progression that results in preventable morbidity and mortality. The COVID-19 public health emergency has further underscored the necessity of ensuring access to health care for all by demonstrating the impacts that public health crises can have on the overall health of our communities. **We urge DHS to ensure its future proposals do not create a barrier to individuals accessing needed health care services and other programs that are essential to our collective well-being.**

The COVID-19 pandemic has also highlighted health care disparities and inequities within our health system, particularly for immigrant communities. Hospitals are committed to achieving health equity, but we are concerned that disparities will only be exacerbated if immigrants avoid medical treatment over fear of an adverse impact on their immigration status. **We urge DHS to consider how its future proposals will impact national efforts to address health equity for communities of color, and especially communities with significant immigrant populations.**

The chilling effect of unnecessarily restrictive public charge policies also has a negative financial impact on hospitals, especially those that serve large immigrant populations. If immigrants and their families decline to participate in public health insurance programs for which they are eligible due to fear of adverse consequences to their immigration status, they may forgo care for treatable conditions. And once their condition deteriorates to the point where care is unavoidable, they will be forced to seek treatment in emergency departments — the least cost- and clinically-effective setting for managing illnesses and chronic conditions. Increased emergency room use by the uninsured leads to greater financial burden on hospitals, which are required to provide care to all patients, regardless of their ability to pay. This increase in uncompensated care and financial strain further threatens access to care — particularly to labor and delivery services and treatment for mental health and substance use disorder — for all who need it.

As USCIS considers a proposed rule, we urge the agency to ensure its policies are clearly understood and can be consistently applied. When the 2019 final rule was promulgated, many hospital employees were approached to answer questions on how accessing health care benefits and services would affect a particular individual's immigration status. Hospitals are not in the position to provide immigration advice and do not ask patients about their immigration status or report undocumented individuals to federal immigration officials. However, the inability to point to clear, concise information on these questions can impede the special trust between patients and health care providers, further perpetuating the chilling effects of public charge policies**.** DHS and USCIS have an important opportunity to clarify their policies to ensure that immigrants do not unnecessarily avoid the care they need and the benefits they are eligible for.

In particular, we urge USCIS to clarify in its proposed rule that acceptance of public health insurance benefits for which an immigrant is eligible — including Medi-Cal and the Children's Health Insurance Program (CHIP) — would not be considered a factor in determining whether they are likely to become a public charge. This should also include populations covered by Medicaid via state-only financing mechanisms, such as the population of low-income individuals 50 and older, regardless of

immigration status, who will become eligible for Medi-Cal in May 2022[3]. USCIS should also specify that receipt of tax subsidies to purchase health insurance on the federal or state-based exchanges like Covered California is not considered for the definition of public charge. In addition, we urge USCIS to clarify that the receipt of any benefits to address COVID-19, including testing, treatment, or vaccination, is not considered for public charge purposes.

Similarly, USCIS should simplify and consistently apply its policies across programs such as SNAP, referred to as CalFresh in California; low-income subsidies for prescription drug costs under Medicare Part D; and the Section 8 Housing Choice Voucher Program, Section 8 Project-Based Rental Assistance, and public housing by ensuring that these not be included in the determination of public charge if the individual was legally entitled to apply for and receive such benefits. These are important social programs that lead to healthier, more stable communities for all, and should not become a source of confusion about an individual's current or future immigration status.

CHA appreciates the opportunity to provide DHS with our comments. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy

[3] https://www.gov.ca.gov/2021/07/27/governor-newsom-signs-into-law-first-in-the-nation-expansion-of-medi-cal-to-undocumented-californians-age-50-and-over-bold-initiatives-to-advance-more-equitable-and-prevention-focused-health-care/