Washington State Hospital Association

U.S. Citizenship and Immigration Services,
Department of Homeland Security,
20 Massachusetts Avenue NW,
Washington, DC 20529-2140

December 10, 2018

Re: CIS No. 2499-10; DHS Docket Number USCIS – 2010-2012, RIN 1615-AA22, Comments in Response to Proposed Rulemaking: Inadmissibility on Public Charge Grounds

Dear Secretary Nielsen,

On behalf of all 108 hospitals and health systems who serve Washington state residents, we write to oppose the proposed rule by the Department of Homeland Security (DHS) regarding "Inadmissibility on Public Charge Grounds," DHS Docket No. USCIS-2010-012.

If implemented, the rule will increase uninsured rates, and in turn, trigger a rise in uncompensated care costs, de-stabilizing hospitals, particularly in more rural areas, and undermine the health of communities broadly. The rule's impact is greater than acknowledged by DHS. As discussed below, in order to understand the magnitude of the potential consequences to hospitals and their capacity to provide health care, a crucial first step is to acknowledge how far the chilling effect will reach and how much Medicaid and Children's Health Insurance Program (CHIP) funding is at risk.

Our comments concentrate on the proposed rule's impact on hospitals and their provision of health care to the communities they serve. However, the harm to those directly subject to the changes to the public charge determination bears emphasizing. As DHS acknowledges, the rule encourages people to disenroll or forego public programs, such as Medicaid and CHIP, and that will in turn lead to worse health outcomes, adverse health effects, and lost productivity [FR 512334]. Simply put, the rule runs counter to its stated objective to make a small population of legal immigrants more self-sufficient [FR 51116]. Rather than encourage self-sufficiency, the rule weakens people's capacity to build healthy and productive lives. The rule also stymies efforts to tackle intractable public health issues, namely prevalence of communicable disease, widespread vaccination, prevalence of obesity and malnutrition (especially for pregnant or breastfeeding woman, infants and children), use of emergency departments for primary care or delayed treatment, and reduced productivity and educational attainment [FR 51270].

Measuring the "Chilling Effect"

In response to DHS's request for comment on the estimation of the disenrollment or foregone enrollment rate used in its analysis [FR 51269]. Under its cost-benefit analysis, and notwithstanding a general recognition to the contrary [FR 51260], DHS appears to quantitatively limit the people who may be discouraged from accessing public programs, such as Medicaid and CHIP, to foreign-born immigrants seeking to adjust their status [FR 51266]. In fact, we recognize many more people who will be subject to the chilling effect: (1) Noncitizens with permanent status in the same household as a noncitizen with impermanent status; (2) US citizens in the same household as a noncitizen with impermanent status, namely children; and (3) noncitizen and US citizens alike who are enrolled in services which are not the subject of the rule but nevertheless fear the consequences associated with receipt of those services. WSHA and our members are concerned that these people are invisible in DHS's consideration of the rule.

WSHA and our members are especially concerned about the number of children enrolled in Medicaid and CHIP, and the impact this rule will have on their enrollment. Federal law requires a single application for CHIP and Medicaid.[1] The two programs are intertwined, and a drop or foregoing of Medicaid will necessarily impact family households, regardless of who may be subject to a public charge determination. Further, we know that when a draft of the rule was leaked last Spring, women's participation rates in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) dropped.[2] Taking these factors into account, the mere consideration of CHIP is likely to encourage parents to disenroll or forego Medicaid enrollment, regardless of their or their children's status. We urge DHS to take into account the much broader population of impacted people.

Measuring the Costs to Hospitals and Health Care

In addition to neglecting large swaths of impacted people, the cost-benefit analysis also takes a myopic view of Medicaid. The rule considers Medicaid only as a reflection of self-sufficiency; it neglects to take into account that it is also a major payor in our health care system.

Quantifying the total Medicaid and CHIP funding and hospital spending at risk. When people drop Medicaid/CHIP coverage that takes federal and state dollars out of the system. Contrary to DHS's assertion that federal transfer payments "do not directly affect the total resources available to society" [FR 51267], the reality is that most Medicaid spending is through a manage care model. Further, and contrary to DHS only factoring federal dollars under the cost benefit analysis [FR 51268], state dollars are directly at risk.[3] One analysis considered the combined state and federal spending at risk due to the proposed rule for one year and found that Washington will be among the most negatively impacted states in the country. Twelve percent of its total Medicaid and CHIP spending is at risk.[4] In dollar terms, that's nearly $1.4B.[5] More than one-third of Medicaid and CHIP spending at risk is attributable to children and that share is largest among citizens with a noncitizen family member.[6] In Washington, that represents more than 20 percentage of Medicaid and CHIP spending at risk which is attributable to children. The downstream effect to hospitals is substantial. Washington State's one-year Medicaid and CHIP hospital payments at risk total $329M.[7] Of that amount, $181M is attributable to citizen family members of a noncitizen.[8]

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[1] Cindy Mann, April Grady, Allison Orris, 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 [Manatt]

[2] Helena Bottemiller Evich, Politico, "Immigrants, fearing Trump crackdown, drop out of nutrition programs" (Sept. 3, 2018), https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292. See also Samantha Artiga & Barbara Lyons, Kaiser Family Foundation, "Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being" (Sept. 18, 2018), https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/

[3] DHS states that the cost to state and local government is none [FR 51235]. However, uncompensated care costs burden state budgets, because many states cover a portion of these costs, at least for public hospitals and other safety net providers. See Jessica Schubel and Matt Broaddus, "Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect", Center on Budget and Policy Priorities, May 23, 2018: https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage (accessed Dec 3, 2018) at 1-2 [Schubel, CBPP].

[4] Manatt, supra, Exhibit 3: Medicaid and CHIP Spending Subject to Chilling Effect, by State (2016; dollars in Millions)

[5] Id.

[6] Manatt, supra, Exhibit 4: Share of Medicaid and CHIP Spending Subject to Chilling Effect that is Attributable to Children, by State (2016).

[7] Manatt, supra, Exhibit 6: Medicaid and CHIP Hospitals Payments Subject to Chilling Effect, by State (2016; dollars in Millions).

[8] Id.

Quantifying uncompensated care costs. DHS characterizes the "increase use of emergency rooms and emergent care as a method of primary health care due to delayed treatment," and "increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient" as "non-monetized potential consequences" [FR 51270]. We beg to differ.

Lost funding, as discussed above, translates directly into loss of access to less expensive services for patients, such as primary care, as well as an increase in uncompensated care costs for hospitals. These costs include the actual cost to providing services to uninsured and under-insured individuals. Washington hospitals provide this care as part of their mission to serve their communities. Washington is also one of the few states that has a law requiring hospitals to provide "charity care."[9] Hospitals take this obligation seriously, but not without facing competing pressures. Uncompensated care costs challenge hospitals to invest in new technologies and equipment, maintain needed capacity to serve patients, and most crucially, keep their doors open.[10]

We know that uncompensated care costs rise and fall with uninsured rates. According to one analysis, between 2013 and 2015, as the nationwide uninsured rate fell from 14.5 percent to 9.4 percent (a 35 percent decline), uncompensated care costs as a share of hospital operating expenses fell by 30 percent.[11] In Washington, the uninsured rate saw a 53% decline, with a corresponding 64% decline in uncompensated care costs, or $453M.[12] State government analysis suggests that a 1 percentage point difference in the uninsured rate is equal to $167M in uncompensated care, based on approximately 73,000 individuals' changing coverage.[13]

According to state data, there are 99,461 individuals receiving Medicaid coverage on state and federally funded programs that could potentially be impacted if this policy is implemented. There are an additional 140,612 families where a member of the household may be subject to a public charge determination and another family member receives coverage through Medicaid dollars (i.e. Medicaid and CHIP). Based on these numbers and recognizing the precedent for a "steep decline" in enrollment among immigrants [FR 51266], the proposed rule would cause uncompensated care costs to soar. In 2016, even with the benefit of lower uninsured rates compared to other states, Washington hospitals provided more than $200M in charity care costs.[14] Assuming the above forecast is true, this rule will de-stabilize hospitals, particularly in more rural areas, and undermine the health of communities broadly. Washington has 45 rural hospitals, 36 of which do not have healthy operating margins.[15]

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[9] Washington State Hospital Association, Washington's Charity Care Law, http://www.wsha.org/for-patients/financial-assistance/washingtons-charity-care-law/

[10] Schubel, CBPP, supra at 1

[11] Id.

[12] Id, Appendix Table 1: Uncompensated Care Costs Fall as Uninsured Rate Falls.

[13] The uncompensated care estimates in Washington are based on government staff analysis of Washington State Department of Health's hospital Quarterly Reports: https://www.doh.wa.gov/DataandStatisticalReports/HealthCareinWashington/HospitalandPatientData/HospitalFinancialData/QuarterlyReports

[14] Analysis prepared by Washington State Hospital Association Decision Support staff on December 22, 2017 based on Washington Department of Health Year End Financial Statements: https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/YearEndReports

[15] Assuming that a healthy margin is 5%. Of the nine remaining hospitals, the majority are formally or informally affiliated with hospital systems. See Ben Lindekugel, et al, "Rural Transformation, Washington State Hospital Association and Association of Washington Public Hospital Districts": http://www.wsha.org/articles/wsha-and-awphds-42nd-annual-rural-hospital-leadership-conference-resources/ (accessed December 3, 2018).

It is also important to bear in mind that although the proposed rule excludes emergency medical conditions covered by Medicaid from the public charge determination, families will still need to apply for and receive Medicaid coverage for such care to be funded, and many families likely would refrain from doing so."[16] In which case, hospitals can expect to see patients who are sicker and require more expensive treatment—for which they alone would bear the cost. If Medicaid funding drops and uncompensated care rises, hospitals will likely be forced to make changes that would impact all patients, not just the immigrants targeted by the proposed rule.[17]

Indirect impact is not the same as insubstantial impact. In the proposed rule, DHS categorizes its impact on hospitals and health systems as "indirect" [FR 51260]. We urge DHS not to conflate indirect with insubstantial. As the foregoing figures demonstrate, the rule's impact extends well beyond those who may be subject to a public charge determination, and could hamstring hospitals and health systems and jeopardize the health and wellbeing of Washington state residents, noncitizens and citizens alike, in the process. The rule's stated end cannot possibly justify the means.

Again, we urge you to withdraw the rule.

Thank you for your consideration.

Sincerely,

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[16] Manatt, supra at 7, and accompanying references in footnote 10.
[17] Manatt, supra at 4, 20.