WISCONSIN HOSPITAL ASSOCIATION

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December 10, 2018

Samantha Deshommes
Chief of 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

Re: Comments on Proposed Rule: Inadmissibility on Public Charge Grounds, DHS Docket No. USCIS-2010-0012

Dear Ms. Deshommes:

On behalf of our more than 135 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the U.S. Department of Homeland Security (DHS) proposed rule relating to Inadmissibility on Public Charge Grounds.

WHA was established in 1920 and is a voluntary membership association. We are proud to say that we represent all of Wisconsin's hospitals. Our members include small, mid, and large-sized hospitals, including many Critical Access Hospitals and several large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Background

While WHA does not typically comment on proposals related to immigration, this proposed rule would have adverse consequences for both public health and hospital financial stability. To understand that, it is important to contextualize how US Immigration policy currently intersects with public benefits.

As you know, the Federal Immigration Act of 1882 required a prospective immigrant seeking entry to the United States to be able to take care of himself or herself without becoming a public charge. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, and subsequent rulemaking by the Clinton Administration in 1999 clarified that certain legal immigrants could use means-tested government benefits such as Medicaid without fear of being considered a public charge and endangering their legal status. It also imposed a five-year waiting period for non-emergency benefits while allowing states to waive that requirement (a requirement that Wisconsin does not waive).

Additionally, undocumented persons or illegal immigrants are not eligible for public benefits such as Medicaid. Despite this, hospitals are still obligated by the Emergency Treatment and Labor Act (EMTALA) to provide them with emergency care, and important partners like Wisconsin's Federally Qualified Health Centers are obligated to provide them with other primary and acute care.

Do not Include Medicaid as a Public Benefit Subject to Determining Whether Someone is Likely to Become a Public Charge for Current Lawful Permanent Residents Applying for an Adjustment to Immigration Status in the Final Rule

WHA and our members are most concerned about DHS's proposal to add Medicaid to the list of public benefit programs considered when determining whether an immigrant would be considered a public charge. Medicaid has historically

served as a safety-net program that provides health insurance to the needy during tough times, such as loss of job or other income. **We are particularly concerned about applying this policy to immigrants already in the US, as we believe such a policy will increase uncompensated care for hospitals, by increasing the number of individuals who will choose to become uninsured rather than jeopardize their own or a family member's legal immigration status.**

Hospitals have already been hit with a number of instances where federal agencies have unfairly changed the rules midgame, resulting in significant reimbursement cuts. Not only would this be another example of this, but it would also lead to worse health outcomes as those who become uninsured delay care, ultimately seeking it in a hospital emergency room. This is a fact DHS acknowledges, stating in the proposed rule:

> "Disenrollment or foregoing enrollment in public benefits program by aliens otherwise eligible for these programs could lead to:
>
> - Worse health outcomes, including increased prevalence of obesity and malnutrition, especially for pregnant or breastfeeding women, infants, or children, and reduced prescription adherence;
> - **Increased use of emergency rooms and emergent care as a method of primary health care due to delayed treatment;**
> - Increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated;
> - **Increases in uncompensated care in which a treatment or service is not paid for by an insurer or patient; "**

DHS's Estimate of the Impacted Population is Likely Low

Due to the complexity of federal immigration and federal and state Medicaid laws, and the added complexity in how they intersect, it is difficult to accurately estimate how many people this rule change could impact. While DHS itself estimates 142,136 people would leave Medicaid annually under to this proposed change, that is likely a very low estimate. Consider the following immigration statistics for Wisconsin:

- 2,000 - the number of Wisconsin applications pending to apply for permanent residence or adjust immigration status at any given time, according to the Migration Policy Institute.
- 157,000 – the number of immigrants currently residing in Wisconsin, including lawful permanent residents (green-card holders), refugees and asylees, temporary visas, and those without legal status.
    - 25% - the percent of this population eligible for Medicaid
    - 43% - the percent of this population eligible for subsidies under the Affordable Care Act (ACA).
    - 68% - the combined percent of this population eligible for some level of public assistance to obtain health insurance.
- 285,000 – the total number of immigrants, or family members living with immigrants in WI.

The most conservative estimate of Wisconsin's potential population impacted by this proposed rule would be some subset of the 2,000 applying for a change in enrollment status at any given time. However, confusion about how these complex policies interact will likely lead family members of immigrants to forgo Medicaid, and even subsidized insurance on the ACA, over fears that such subsidies will threaten their own or a family member's immigration status. This means that the true impacted population is more likely to be an unknown subset of the 285,000 Wisconsinites who are either immigrants themselves, or have family members who are immigrants.

The Proposed Rule Will Negatively Impact Hospital Financial Stability

In the last few years, Wisconsin hospitals have experienced federal Medicaid cuts of hundreds of millions of dollars under the Affordable Care Act, Sequestration, and provider payment cuts made under rule issued by the Centers for Medicare and Medicaid Services (CMS). We have also seen uncompensated care costs rise under Medicare: from 2016

to 2017, Wisconsin's Medicare bad debt increased from $188 million to $215 million while the difference in what Medicare pays and what it costs hospitals to provide services increased from $1.77 billion to $2.14 billion over the same time period. The proposed policy will only exacerbate these challenges for Wisconsin's safety-net hospitals.

DHS itself again acknowledges this, stating "DHS recognizes that reductions in federal and state transfers under federal benefit programs may have downstream and upstream impacts on state and local economies, large and small businesses, and individuals. For example, the rule might result in reduced revenues for healthcare providers participating in Medicaid." While it is hard to quantify that impact, Manatt Health estimates it could lead to about 4% of Wisconsin's Medicaid population disenrolling for fear of negative immigration status repercussions. This would translate into Medicaid spending cuts of about $337 million annually in Wisconsin alone. A majority of these impacts will be felt by providers like Wisconsin's hospitals despite the fact that it will not lead to an equal decrease in the amount of care hospitals will be providing, for reasons previously discussed.

The Proposed Rule Unfairly Targets Medicaid Recipients

The Affordable Care Act has led to substantial coverage gains for Wisconsin's citizens. Since implementation, Wisconsin has seen more than 200,000 citizens gain insurance coverage and our uninsured rate has been cut in half, from 11% in 2013 to 5.3% as of 2016. Wisconsin chose a unique model to achieve these gains, by making anyone under 100% of the Federal Poverty Level (FPL) eligible for Medicaid, while anyone above 100% FPL is eligible for subsidized coverage in the Affordable Care Act exchanges. Wisconsin was the only state in the nation that did not use the Federal Medicaid Expansion option but still was able to ensure no gap in health insurance coverage.

Wisconsin policy makers recognized that both Medicaid and the ACA exchanges serve as important safety nets that provide stability for Wisconsinites who need access to affordable health care. Both options allow Wisconsinites to earn income from work and yet maintain the security of health care coverage, and both populations receive federal subsidies. In many cases, the subsidy for a member on the ACA exchange exceeds that for an individual on Medicaid. From a policy standpoint, this creates an uneven playing field: It unfairly penalizes those with lower incomes on Medicaid though they may actually receive a lower subsidy than an individual with a higher income who receives subsidized insurance on the ACA exchange.

DHS Should Consider Healthcare Workforce Impacts in Its Immigration Policies

The repeated failure of Congress to address our nation's longstanding need for comprehensive immigration reform has exacerbated workforce shortages across every industry, and hospitals are no exception. Hospitals rely on a steady supply of both high-skilled and low-skilled workers in order to fill open physician slots and entry level positions, such as cafeteria workers, custodians, and nursing assistants. When these support positions go unfilled, it means the higher skilled hospital professions spend less of their time delivering skilled health care and more of their time carrying out the essential tasks these unfilled positions would otherwise be handling. Additionally, these entry level positions can become a pipeline into higher level positions as the workers gain skills and become aware of careers that boost pay and offer more fulfillment.

Wisconsin currently has more job openings than workers, making filling important hospital positions very difficult. Due to a rapidly aging population, demand for health care jobs is projected to increase by more than 30% by 2030. More workers are needed to fill a labor pool for entry-level jobs, a pool the health care industry shares with the restaurant, retail, and convenience store industries. Entry level jobs in these industries typically have easier hours and job descriptions for similar pay. It is important that DHS immigration policies do not short-change the important contributions these low-skilled immigrants make to our economy; they fill important positions while contributing tax revenue to fund the government, and they are essential for filling Wisconsin's healthcare workforce needs.

In conclusion, we ask DHS not to finalize the proposal to include Medicaid in the public charge calculation for immigrants currently in the US. Such a proposal would lead to increases in uncompensated care for Wisconsin hospitals and poorer

health outcomes. It would also unfairly target Medicaid recipients over those who receive subsidies on the ACA exchanges and could worsen future workforce challenges for hospitals.

WHA appreciates the opportunity to comment on this proposed rule.

Sincerely,

Eric Borgerding
Wisconsin Hospital Association President & CEO