COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Member Driven. Patient Focused.

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U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
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Submitted via www.regulations.gov

Re: Comments on DHS Docket No. USCIS-2010-0012 – Notice of Proposed Rulemaking on "Inadmissibility on Public Charge Grounds"

The Community Clinic Association of Los Angeles County (CCALAC) is grateful for the opportunity to comment on U.S. Citizenship and Immigration Services' Notice of Proposed Rulemaking (NPRM), "Inadmissibility on Public Charge Grounds," Docket No. USCIS-2010-0012, RIN 1615-AA22.

CCALAC represents 65 nonprofit community clinics and health centers that operate more than 350 sites throughout Los Angeles County and serve over 1.6 million low-income, uninsured and underserved individuals each year. CCALAC's member clinics are patient-centered organizations whose mission is to provide high-quality, affordable health care to all medically underserved patients, so they can have the opportunity to thrive, contribute to their communities, and reach their full potential.

CCALAC strongly opposes the Department of Homeland Security's proposed changes to public charge and we urge that the rule be withdrawn in its entirety. Under current policy, only cash assistance for income maintenance and government funded long-term care received by an applicant can be taken into consideration in the "public charge" test. The proposed rule would broaden the list of benefits that can be considered in a public charge assessment to include consideration of Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Section 8 Housing Vouchers, public housing and the Medicare Part D Low Income Subsidy (LIS). Additionally, the proposal would add a complex set of factors to the public charge determination, including income, family size, education, English proficiency, and health.

The proposed rule will deter individuals -- including health center patients -- from addressing their health care needs and accessing the programs and services they need to thrive, ultimately leading to worse health outcomes, higher costs, and harm to our communities. As these impacts are inconsistent with the health center mission, and will have far-reaching impacts on our communities, we ask that the administration reconsider this proposal.

The following comments reflect our profound concerns in the following areas:

1) The proposal is a radical departure from current public charge policy and is inconsistent with the historical understanding and intent of public charge.
2) The proposal will lead to worse health outcomes for immigrants and their families harming their ability to support themselves and contribute to their communities.
3) The proposal will increase uncompensated care costs and impact the financial stability of health centers and other safety net health care providers.
4) The proposal will harm local and state economies and ultimately increase costs for US taxpayers.
5) The proposal significantly underestimates the impact of the changes being proposed.

1. The proposal is a radical departure from current public charge policy and is inconsistent with the historical understanding and intent of public charge.

The proposed rule would reverse more than a century of existing law, policy, and practice in interpreting public charge. When the concept was first created, public charge was understood to refer to a person who was *completely* dependent on public facilities, such as poor houses, hospitals, and asylums. While the administration claims the NPRM simply provides clarification and guidance regarding existing law, in truth, the proposed changes would radically alter the concept of public charge, abandoning the long-standing concept of a public charge as someone who is primarily dependent on the government for subsistence, and instead defining it as anyone who receives "financial support from the general public through government funding (i.e. public benefits)."

For almost two decades, U.S. immigration officials have provided explicit reassurances that participation in programs like Medicaid and SNAP would not affect immigrants' ability to become lawful permanent residents.[1] CCALAC members, and health centers across California and the rest of the country, train their staff to assure patients that using health and nutrition benefit programs will not make them a public charge or harm their immigration status. If the proposed changes take effect, health centers will have to walk back those reassurances, re-train staff and try to find a way to message a new, drastically altered, and highly complex, reality, to their immigrant patients. Health centers are already seeing that counseling patients on the proposed changes goes far beyond the capability and legal boundaries for health center staff, and will require intensive investment of time and resources.

The proposed changes introduce criteria for permanent residence that a significant portion of green card recipients and U.S. citizens would not meet. A recent study by the Migration Policy Institute found that of recent green card recipients, over two-thirds would have at least one negative factor and more than 40 percent would have two or more negative factors under the criteria being proposed. Only 39 percent of green card applicants subject to a public charge test in 2017 had incomes at or above 250 percent of the federal poverty level - the one "heavily weighed" positive factor in the proposed rule.[2]

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[1] U.S. Citizenship and Immigration services, "Public Charge," n.d. https://www.uscis.gov/greencard/public-charge.

[2] Randy Capps, Mark Greenberg, Michael Fix, and Jie Zong, "Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration," Migration Policy Institute, November 2018, https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration.

Many U.S. born citizens do not meet the criteria being proposed. For example, requiring financial ability to pay for health care is a standard that many citizens cannot meet; nearly one in two sick Americans cannot afford health care, even those with health insurance.[3] If the proposed criteria were applied to U.S. citizens, the millions of low-and moderate-income people who receive help paying for health, nutrition and housing in any given year would potentially be deemed not "worthy" of residing in the U.S. Because the standards are so difficult to meet, if these changes are implemented, denials of applications for permanent residency will likely increase dramatically.

The proposed rule is also unclear about how exactly the new criteria would be applied, raising concerns about inconsistent application and potential for public charge determinations to be applied in a discriminatory manner.

The proposed rule would reshape the structure of our legal immigration system and redefine who is 'worthy' of being an American – shifting immigration away from working people from all over the world who strive for a better life and greater opportunity for themselves and their family, and towards those with high incomes and financial assets.

2. The proposal will lead to worse health outcomes for immigrants and their families, harming their ability to support themselves and contribute to their communities.

The four categories of benefits specified in § 212.21(b) of the NPRM -- Medicaid, SNAP, public housing supports, and Medicare Part D subsidies – were all designed to keep individuals and families safe and healthy, so that they can thrive, contribute to their communities, and reach their full potential. However, this NPRM would create significant negative immigration consequences for immigrants who qualify for and use these benefits. The fear of triggering such consequences *is already* deterring individuals from enrolling in, or staying enrolled in, these and other public programs. CCALAC's member clinics regularly report that patients are asking to disenroll from Medi-Cal, California's Medicaid program. The result of people withdrawing from coverage programs and declining to seek services will be worse health outcomes and lower productivity, reducing individuals' ability to be self-sufficient and contribute positively to their communities.

The impact of the NPRM will extend far beyond legal immigrants who plan to seek a green card in the near future and the four benefits programs specified. The proposal is already causing a significant "chilling effect" – meaning that individuals are withdrawing from, or not applying for, benefits and programs for which they are eligible, even though using these benefits would have no impact on their immigration status. A similar chilling effect was widely observed following the passage of the Personal Responsibility and Work Opportunity Act (PRWOA) of 1996 as rumors about potential changes and immigration impacts began circulating.[4] "Following the passage of PRWOA, researchers documented extensive "statistical evidence of a withdrawal from benefits among populations whose eligibility was

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[3] Drew Altman, *It's not just the uninsured — it's also the cost of health care*, 2017, https://www.axios.com/not-just-uninsured-cost-of-health-care-cdcb4c02-0864-4e64-b745-efbe5b4b7efc.html.

[4] Francisco I. Pedraza and Ling Zhu, "The 'Chilling Effect' of America's New Immigration Enforcement Regime," Pathways, Spring 2015, https://inequality.stanford.edu/sites/default/files/Pathways_Spring_2015_Pedraza_Zhu.pdf.

unchanged by the law, including refugees and U.S. citizen children."[5] According to the Kaiser Family Foundation, an estimated 2.1 million to 4.9 million Medicaid/CHIP enrollees could disenroll, if the proposed rule leads to disenrollment rates between 15 percent and 35 percent.[6]

Due to the chilling effect, individuals are refraining from using benefits today that are not currently considered in public charge determinations due to misplaced concerns that doing so could harm their immigration status in the future. Individuals are also fearful of using *any* programs, not just those specified in the NPRM. Health centers are reporting that patients are asking to withdraw from programs that are not even included in the NPRM due to concerns about the potential immigration consequences.[7]

The chilling effect also extends to programs that address the "social determinants" of health, such as nutrition and food security. For example, the Women, Infants and Children (WIC) program is widely agreed to "save lives and improve the health of nutritionally at-risk women, infants and children."[8] Although the NPRM does not propose to include WIC in public charge determinations, this past summer WIC agencies in at least 18 states reported drops of up to 20 percent in enrollment, which they attributed largely to fears about the immigration policy.[9]

The chilling effect will cause individuals who are not subject to public charge determinations – such as refugees, asylees, green card holders and US citizens with immigrant family members – to refrain from using benefits due to concerns and confusion about potential impacts on their immigration status. Health centers are seeing this already, with many of our member clinics sharing stories of patients who are already Lawful Permanent Residents asking to withdraw from programs. Despite the best efforts of health center staff to educate patients about the proposed changes and reassure them that they are not subject to public charge, the patients are so fearful that in many cases they go through with disenrolling from coverage.

Family members of immigrants who are, or think they may be, subject to public charge will also be negatively impacted. When an individual is afraid to use benefits due to concerns about immigration consequences, their family members often refrain from using benefits as well, even if they are not subject to public charge themselves. This will especially impact California, where one of every two children has an immigrant parent and over half of all children are enrolled in the state's Medicaid program.[10] In California, the Children's Partnership estimates that between 269,000 to 628,000 children would lose Medicaid coverage and 113,000 to 311,000 children would lose food assistance,

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[5] https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families

[6] Samantha Artiga, Raphael Garfield, and Anthony Damico "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid" (Washington, DC: Kaiser Family Foundation, 2018). https://www.kff.org/disparities-policy/issue-brief/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaid/.

[7] For examples, see https://www.latimes.com/business/hiltzik/la-fi-hiltzik-public-charge-20180824-story.html and https://www.rollcall.com/news/politics/immigration-crackdown-raises-fears-seeking-health-care

[8] https://www.fns.usda.gov/wic/about-wic-how-wic-helps

[9] https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292

[10] California Department of Health Care Services Research and Analytic Studies Division. January 2016. Proportion of California Population Certified Eligible for Medi-Cal by County and Age Group – September 2015. Medi-Cal Statistical Brief. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Penetration_Brief_ADA.PDF

despite remaining eligible, if the proposed rule is finalized.[11] If a parent is afraid to apply for SNAP for fear of immigration consequences, their family goes hungry. If a mother is afraid to apply for WIC, her baby is at increased risk of low birth weight and other problems. If a parent is afraid to enroll themselves in Medicaid, they may be fearful of enrolling their children too, putting the health of the entire family at risk.

The Children's Health Insurance Program (CHIP)

At 83 FR 51174, the Department specifically requests comment on whether the Children's Health Insurance Program (CHIP) should be included in a public charge determination. For many of the same reasons that we oppose the inclusion of Medicaid, we unwaveringly oppose the inclusion of CHIP. CHIP assists working families who earn too much to be eligible for Medicaid without a share of cost. Making the receipt of CHIP a negative factor in the public charge assessment or including it in the public charge definition, would further exacerbate the problems with this rule by extending its impact to even more moderate-income working families.

As indicated previously, the NPRM will discourage parents from seeking health care for their children. Including CHIP in public charge determinations would further exacerbate this impact. According to multiple studies, children enrolled in Medicaid in their early years not only do better in childhood than children without health insurance, but also have better health, educational, and employment outcomes in adulthood.[12] Additionally, according to research in the Journal of the American Medical Association, and cited by the Centers for Disease Control and Prevention (CDC), uninsured children are less likely to receive preventive care and necessary treatment when they are sick or injured, and are generally less healthy compared to children with health insurance.[13]

Including CHIP in public charge determinations would run counter to Congress' intent in expanding coverage to lawfully present children and pregnant women. Section 214 of the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states the option to cover, with federal matching dollars, lawfully residing children and pregnant women under Medicaid and CHIP during their first five years in the U.S. In so doing, Congress recognized the public health, economic, and social benefits of ensuring that these populations have access to care. Since its inception, CHIP has enjoyed broad, bipartisan support based on the recognition that children need access to health care services to ensure their healthy development. In California, CHIP beneficiaries are, by definition, over income for Medicaid, meaning this program provides an extra layer of support for low-income working families. Historically, a public charge is someone *primarily* dependent on the government, not working people and families.

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[11] The Children's Partnership "Potential Effects of Public Charge on California Children" (Los Angeles, CA: The Children's Partnership, November 2018) https://www.childrenspartnership.org/wp-content/uploads/2018/11/Potential-Effects-of-Public-Charge-Changes-on-California-Children-Brief.pdf.

[12] Rourke O'Brien and Cassandra Robertson, *Medicaid and Intergenerational Economic Mobility*, University of Wisconsin—Madison, Institute for Research on Poverty, 2015, https://search.library.wisc.edu/catalog/9910223409002121

[13] Amanda R. Kreider, Benjamin French, Jaya Aysola, et al., "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families," *JAMA Pediatrics* 170 (2016), https://www.cdc.gov/rdc/data/b6/poi150069.pdf

If CHIP were considered in public charge determinations, it would greatly increase the number of parents and children who would be faced with the untenable choice of having to decide between a future green card and current health and well-being. Therefore, CCALAC strongly opposes including CHIP in the public charge determination.

In summary, both the direct and "chilling" effects of this NPRM will lead to worse health outcomes for immigrants and their families, in both in the immediate term and the long term. This is acknowledged in the language of the NPRM itself, which states that the rule could "increase poverty of certain families and children, including U.S. citizen children" and lead to "worse health outcomes... especially for pregnant and breastfeeding women, infants, and children", "reduced prescription adherence," and "increased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated." These impacts are inconsistent with the health center mission, which is to *improve* the health of the underserved and vulnerable populations they serve.

3. The NPRM would increase uncompensated care costs for health centers and other safety net providers, potentially putting their financial stability at risk.

In addition to the direct harm to the health and well-being of immigrants and their families, this proposal would place significant financial strain on health centers and other safety net providers by increasing their uncompensated care costs while decreasing their revenues. This will occur in at least three ways:

- As discussed above, and as CCALAC member health centers are already seeing, this proposal will deter immigrants from enrolling themselves and their children in Medicaid. Since health centers turn no one away, regardless of ability to pay or insurance status, health centers will continue to care for these individuals, but will no longer receive Medicaid reimbursement to cover their costs.
- People who are uninsured tend to delay seeking care longer than people with insurance coverage, mostly due to financial concerns.[14] By the time many uninsured people finally seek care, they are often sicker and more expensive to treat – and more likely to end up in an emergency room or the hospital. They are also more likely to develop prolonged, aggravated and even lifelong conditions that early medical intervention could have prevented or ameliorated.
- Numerous studies point to the positive long-term effects of receipt of health, nutrition and housing programs.[15] Access to stable housing and adequate nutrition are critical factors impacting a person's ability to maintain and improve their health. Children whose families receive housing assistance are more likely to have a healthy weight and to rate higher on measures of well-being—especially when housing assistance is accompanied by food assistance.[16] This NPRM would prevent people from accessing key nutrition and housing programs. This will negatively impact theirs and their families' health and productivity, likely leading to worse health status and greater health care needs and costs in the long run.

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[14] https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

[15] Tazra Mitchell and Arloc Sherman, *Economic Security Programs Help Low-Income Children Succeed Over Long Term, Many Studies Find*, Center on Budget and Policy Priorities, 2017, https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-help-low-income-children-succeed-over.

[16] Kathryn Bailey, Elizabeth March, Stephanie Ettinger de Cuba, et al., *Overcrowding and Frequent Moves Undermine Children's Health*, Children's HealthWatch, 2011, www.issuelab.org/resources/13900/13900.pdf.

Financial Impact on Los Angeles Health Centers

The factors above will result in higher uncompensated care costs, greater long-term health care costs and lower reimbursement for health centers, safety net hospitals and emergency rooms. Health centers generally operate on margins of less than one percent, any loss of revenue will have to be made up with federal grants or by tapping into funding streams that support specific programs, staff or services.

In 1996, immigration and welfare reform laws were passed that, while they did not change public charge rules, created a similar climate of fear and caused immigrants to shy away from coverage programs. In a 2018 research brief, The Migrant Policy Institute found that during this time period there was a sharp decline in immigrants' use of public benefit programs like Medicaid & CHIP.[17] We can look to the consequences of the 1996 laws to estimate the impact of this NPRM on enrollment in public programs and potential impact to safety net providers.

According to California's Office of Statewide Health Planning and Development (OSHPD) data, clinics and health centers in Los Angeles County served 1.7 million patients in 2017 and slightly more than 1 million of them, about 60 percent, were covered by Medi-Cal, California's Medicaid program.[18] Using the California Department of Health Care Services' estimate that about 17 percent of Medicaid enrollees in the state are non-citizens, and average Los Angeles County health center reimbursement and utilization rates, we project that the disenrollment that will result from this NPRM will result in an annual loss of $16 million to $37 million in Medicaid reimbursement to Los Angeles clinics and health centers. These estimates assume that between 15 percent and 35 percent of non-citizen enrollees will elect to disenroll from California's Medicaid program despite being legally eligible-- disenrollment estimates based on what occurred following enactment of the 1996 laws.[19]

Medicaid is the largest source of funding for community health centers in both Medicaid expansion states and non-expansion states, making this funding indispensable.[20] This loss of reimbursement will negatively impact the financial stability of health centers, jeopardizing the programs and services they provide their communities.

4. This proposal will harm local and state economies and increase costs for US taxpayers.

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[17] Batalova, Jeanne, Michael Fix, and Mark Greenberg. 2018. Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use. Washington, DC: Migration Policy Institute.

[18] https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data/resource/13c1903b-aea7-4eb4-9409-e5fdc4b3b1cf

[19] Manatt Health "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard" (New York, NY: Manatt Health, October 2018), https://www.manatt.com/insights/articles/2018/public-charge-rule-potentially-chilled-population; and Samantha Artiga, Rachel Garfield, Anthony Damico "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid" (Washington, DC: KFF, October 2018), http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid.

[20] Community Health Centers: Recent Growth and the Role of the ACA (Kaiser Family Foundation Issue Brief, 2017) https://www.kff.org/report-section/community-health-centers-recent-growth-and-the-role-of-the-aca-issue-brief/

Significant disenrollment from SNAP and Medicaid will have devastating economic ripple effects on communities nationwide. If individuals and families withdrawal from SNAP, it will mean less dollars spent in their local markets and grocery stores, and when families stop using Medicaid, health care providers lose income. When businesses have less revenue, whether supermarkets or medical clinics, they will be forced to compensate by reducing their workforce, hours of operation or services. In addition, when families struggle to pay for food and health care, they will reduce spending in other areas, further exacerbating the economic impact. As a result of the economic loss, the Fiscal Policy Institute estimates that the U.S. could lose approximately 99,000 to 230,000 jobs.[21]

In addition to the economic impact on health care providers who serve immigrant populations, this NPRM will also lead to increased administrative costs for state and local agencies that administer health, nutrition, and housing programs. The proposed rule will create new challenges for these agencies including providing documentation of benefit receipt to green card applicants as required by draft form I-944, responding to consumer inquiries related to the new rule, modifying existing communications and forms related to public charge, training staff on the rule changes and adapting to increased workload resulting from disenrollment requests. Furthermore, the inclusion of Medicaid and SNAP in public charge review will undermine state efforts to reduce administrative costs by streamlining enrollment processes between different public assistance programs.

In addition to the economic impacts described above, this NPRM would increase taxpayer costs and reduce tax revenue. This could occur in several ways:

- *Increased costs for emergency Medicaid:* As mentioned previously, individuals who delay medical care due to financial concerns and/or lack of coverage are more likely to end up in an emergency room or hospital. To the extent that this care is covered under emergency Medicaid, US taxpayers will be the ones covering the costs – costs which could have been lower if timely care was received.
- *Increased costs due to lack of prenatal care (short and long term):* We anticipate this NPRM will discourage immigrants from seeking prenatal care and utilizing WIC services. This is likely to result in more children born prematurely and/or at a low birth weight (LBW). According to 2009 data from the March of Dimes, during the first year of life a premature/LBW infant incurred over $50,000 more in medical bills on average than an infant born at full weight.[22] To the extent that these children are US citizens, or they require emergency treatment, the increased costs will often be borne by Medicaid or CHIP. In addition, LBW babies have a higher risk of physical and mental disabilities, including blindness, chronic lung disease and cerebral palsy.[23] Such disabilities will result in higher taxpayer costs throughout the child's life, in the form of higher medical costs, increased education costs, and disability payments. Disabilities may also reduce a child's ability to become a self-sufficient adult, necessitating more taxpayer supports in their adult years.
- *Increased costs to control the spread of communicable diseases*: To the extent that individuals delay seeking care to avoid or treat communicable diseases, the health of their communities is placed at risk, leading not only to increased illness but also higher costs. One of CCALAC's member

[21] Fiscal Policy Institute "Only Wealthy Immigrants Need Apply: How A Trump Rule's Chilling Effect Will Harm the U.S." (New York, NY: FPI, 2018) http://fiscalpolicy.org/public-charge .
[22] https://www.marchofdimes.org/news/premature-babies-cost-employers-127-billion-annually.aspx
[23] http://www.ncsl.org/research/health/low-birthweight-births.aspx

clinics shared that patients have expressed fear of using programs that help pay for HIV and AIDS related prevention, treatment and care. HIV/AIDS treatment is prohibitively expensive in the United States without assistance. This NPRM will likely result in individuals forgoing their medical regimen due to fear of immigration consequences. This will not only be devastating to the health of the individual, but will also have negative public health consequences, as disruptions in HIV care and treatment—especially resulting in medication rationing or reduced adherence—can lead to drug resistant strains of HIV. The proposed rule could have disastrous consequences for communicable diseases, including HIV/AIDS.

- *Decreased tax revenues due to lower productivity from individuals who delay care*: As discussed above, individuals who delay care are more likely to develop prolonged, aggravated and even lifelong conditions that could have been lessened or prevented with early medical intervention. For example, patients who arrive at the emergency room within 3 hours of their first symptoms often have less disability 3 months after a stroke than those who received delayed care.[24] Delayed medical care that increases a person's level of disability reduces their ability to work and pay taxes.
- *Decreased tax revenue from businesses that serve immigrants:* As discussed previously, if individuals and families are fearful of using benefits such as SNAP and Medicaid, they will be forced to spend more out-of-pocket on food and health care, which leaves less for spending on other goods and services.

5. This proposal significantly underestimates the impact of the changes being proposed.

The NPRM's cost-benefit analysis significantly underestimates the drop in participation in public benefits that will result from these proposed changes; it also fails to account for many significant costs that will result for safety net health care providers and other organizations.

In the Regulatory Impact Analysis (RIA), the Administration assumes that the regulation, if implemented as proposed, would lead to a 2.5 percent drop in enrollment in the four programs to be added to public charge determinations. CCALAC contends that the RIA significantly underestimates the decline in participation in public benefits programs, for the following reasons:

- The 2.5 percent disenrollment rate is far below actual disenrollment rates recorded after the passage of PRWOA. The administration estimates the number of individuals likely to disenroll from or forego enrollment in a public benefit program as equal to 2.5 percent of the number of foreign-born non-citizens. By the administration's own account, this estimate is significantly less than actual rates of disenrollment following the passage of PRWORA, which ranged from 21 to 54 percent, depending on the program.
- The RIA estimates consider only the four benefits programs proposed in the NPRM; as discussed above, the chilling effect will also lead to reduced enrollment in other types of benefits programs. CCALAC members are already seeing the chilling effect extend beyond the programs in the NPRM.

[24] Fang J, Keenan NL, Ayala C, Dai S, Merritt R, Denny CH. Awareness of stroke warning symptoms—13 states and the District of Columbia, 2005. *MMWR,* 2008;57: 481–5. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5718a2.htm

We argue that contrary to what the RIA indicates, the effects of the proposal would be radical, not just a modest change or clearer definition or "improved efficiency" as the summary suggests. Estimates by independent researchers all show large impacts – up to 26 million people could be affected by the chilling effect, refusing to enroll themselves or their children in programs they are eligible for, and up to 4.9 million individuals, including U.S. citizen children, could lose health coverage.[25]

Due to the shortcomings of the RIA, CCALAC requests that the Administration reconsider both its estimated rates of disenrollment, and the number of public programs that it considers in its RIA.

We are also concerned that the NPRM's cost-benefit analysis fails to include estimates for the increase in uncompensated care costs for safety net providers, as well as many other indirect costs discussed above that would inevitably result if the rule were implemented as written. The NPRM explicitly lists several types of costs, including reduced revenues for, "healthcare providers participating in Medicaid, pharmacies that provide prescriptions to participants in the Medicare Part D Low Income Subsidy (LIS) program, companies that manufacture medical supplies or pharmaceuticals, grocery retailers participating in SNAP, agricultural producers who grow foods that are eligible for purchase using SNAP benefits, or landlords participating in federally funded housing programs."

Despite giving examples of some of the potential downstream costs, the NPRM fails to provide any numerical estimates for them. Many of these costs would be possible to estimate, at least to some degree, particularly given the data collected following the passage of PRWORA. We therefore request that the Administration appropriately estimate and consider these costs when analyzing the costs and benefits of this proposal. Such an analysis, we believe, will show that the costs of implementing the proposal far exceed any purported benefit.

For the reasons stated above CCALAC implores you to withdraw this proposal and instead advance policies that strengthen the ability of our communities to thrive.

Please feel free to contact me with any questions.

Sincerely,

Louise McCarthy, MPP
President & CEO

[25] Manatt Health "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard" (New York, NY: Manatt Health, October 2018), https://www.manatt.com/insights/articles/2018/public-charge-rule-potentially-chilled-population; and Samantha Artiga, Rachel Garfield, Anthony Damico "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid" (Washington, DC: KFF, October 2018), http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid.