Federation of American Hospitals®

Charles N. Kahn III
President and CEO

December 10, 2018

The Honorable Kirstjen Nielsen
Secretary
Department of Homeland Security
Washington, DC 20528

RE: Inadmissibility on Public Charge Grounds; DHS Docket No. USCIS– 2010–0012

Dear Secretary Nielsen,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment on the Department of Homeland Security; Inadmissibility on Public Charge Grounds Proposed Rule (Proposed Rule).

Under current law, individuals who are deemed likely to become a "public charge" can be denied admission to the U.S. or, if they are already in the country legally, may be denied the ability to receive a green card as a lawful permanent resident. The Department's Proposed Rule would change how the agency makes public charge determinations in several key ways including potentially barring an individual's entry to the U.S. or denying a change in immigration status based on an individual's lawful enrollment in Medicaid or, potentially, the Children's Health Insurance Program (CHIP). ***Given the negative impact such a policy would have on our patients and the hospitals that serve them, we urge the Department to exclude Medicaid and CHIP enrollment as factors for public charge determinations.***

Today, public charge policy applies only to individuals who are seeking to enter the country legally and to immigrants already here who are seeking to adjust their status to obtain a green card. The Proposed Rule would apply public charge determinations to these individuals as well as to immigrants who are attempting to extend their stay or change their status, generally.

Under current guidance, receipt of cash assistance or institutionalization for long-term care services at government expense (e.g., Medicaid long-term care) are treated as evidence that a person may become a public charge. The Proposed Rule seeks to include benefits

beyond those currently considered, proposing to count in public charge determinations, among other programs, most Medicaid services. The Department indicates that it is also considering including CHIP for purposes of public charge determinations and seeks comment on its inclusion.

In addition to expanding the number of programs to be used for public charge determinations, the proposal also would expand on the extent or frequency of use of the benefits covered by the proposal. Under the Proposed Rule, irregular or limited benefit use could result in a public charge determination – a change from the current standard that the individual be "primarily dependent" on the public benefit. The Proposed Rule also provides discretion to immigration officials to weigh various factors when they make a public charge determination.

Given the significant negative consequences to accessing public benefits, including Medicaid (and potentially CHIP), the Proposed Rule would likely have a significant "chilling effect" on Medicaid and CHIP enrollment. It is likely that if finalized, the policy will prompt many immigrants to either drop coverage or not apply for coverage for which they are legally eligible. It is also likely that this impact would not be limited to the categories of immigrants subject to the proposed changes. The chilling effect is likely to impact immigrants in immigration categories not subject to public charge determinations as well as immigrants' citizen family members. This is likely the case even though the proposal does not consider direct receipt of benefits by citizen children or other citizen family members as a factor in an immigrant parent's public charge determination. ***Unfortunately, the complexity of the proposal and concern about its consequences are likely to overwhelm any benefit the proposal's exemptions may seek to impart, likely resulting in the loss of Medicaid and CHIP coverage for those both subject and not subject to the proposal.***

If immigrants and their family members drop their coverage in key health programs, negative effects are likely. ***The impact of the chilling effect will be particularly acute for patients and the hospitals that serve them.*** Medicaid and CHIP are critical to the financial stability of hospitals and other healthcare providers. Together the programs account for nearly 1 out of 5 healthcare dollars nationwide and, among Medicaid and CHIP enrollees, 1 out of every 3 program dollars are spent on hospital-based care. ***Based on a recent study published by Manatt (attached) using 2016 data, approximately $17 billion a year in Medicaid and CHIP payments to hospitals could be at risk under the proposal.*** The potential loss of this funding would do substantial harm to community hospitals and the ability to serve all of our patients – not just those impacted by the rule. Beyond the loss of payments, hospital uncompensated care costs, would likely increase as these individuals continue to seek necessary medical care, putting additional financial and operational strain on hospitals. DHS itself acknowledges the likelihood of increased uncompensated care and also states that hospitals would experience an impact as individuals disenroll from public programs. While the impact is likely to be harmful to all hospitals, it would be especially acute to hospitals in states with large immigrant populations – states like Florida and Texas.

In addition to the financial impact on hospitals, the loss of Medicaid and CHIP coverage would be extremely harmful for impacted individuals' medical and financial health. Medicaid and CHIP play an important role in keeping both children and adults healthy and in addressing the needs of people with disabilities and chronic illnesses. Adult enrollees report a higher likelihood of having a usual source of care and a lower likelihood of delaying medical care. Individuals with a usual source of care are less likely to use emergency department

services. By promoting access to primary care, preventive services and chronic disease management, Medicaid supports beneficiaries' ability to work and can help lift families above the poverty threshold. Federal policy should encourage, not discourage eligible individuals from enrolling.

For all of the above reasons, we urge the Department to refrain from finalizing its proposal to include Medicaid in public charge decisions, and also to not include CHIP in a potential final rule. Should you have questions regarding these comments, please feel free to contact me or Paul Kidwell, Vice President, Policy at (202) 624-1500.

Sincerely,

ATTACHMENT

manatt

NOVEMBER 2018

Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule

Cindy Mann, Partner
April Grady, Director
Allison Orris, Counsel

This report was prepared on behalf of America's Essential Hospitals, the Association of American Medical Colleges, the American Hospital Association, the Catholic Health Association of the United States, the Children's Hospital Association, and the Federation of American Hospitals.

Acknowledgments

Manatt Health thanks the following individuals for their contributions to this report:

Laura Braslow
Director

Alice Lam
Director

Kevin McAvey
Senior Manager

Devin Stone
Manager

Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule

Table of Contents

Executive Summary

A new proposed rule issued by the U.S. Department of Homeland Security (DHS) that scrutinizes certain immigrants' use of Medicaid coverage could deter enrollment in Medicaid and very likely the Children's Health Insurance Program (CHIP) and, as a result, children and adults who are lawfully in the country could become uninsured. The loss of coverage would result in poorer health and health outcomes for affected individuals. It also could lead to reduced Medicaid payments and drive up uncompensated care costs for the nation's hospitals, causing financial strain, particularly for hospitals in states and communities with large immigrant populations. This analysis estimates the overall Medicaid and CHIP funds and hospital payments at risk if the proposed DHS rule is finalized.

Under long-standing immigration law and guidance, individuals who are likely to become a "public charge"—or likely to rely on the government for financial support—can be denied admission to the U.S. or, if they are already in the country legally, may be denied the ability to adjust their status and get a green card as a lawful permanent resident.[1] DHS's proposed rule, *Inadmissibility on Public Charge Grounds*, would make several key changes to how DHS makes public charge determinations and to whom they would apply.[2] These changes include expanding the types of public benefits that would be considered in a public charge determination. If finalized, the rule would direct DHS to consider immigrants' enrollment in Medicaid when making public charge determinations (under current policy, Medicaid is not considered in public charge determinations, other than Medicaid benefits for institutional long-term care services). Not all immigrants who are eligible to enroll in Medicaid would be subject to a public charge determination, but this policy change is nonetheless very likely to cause many immigrants to avoid enrolling in Medicaid. It is also likely to deter enrollment in CHIP, which is both a financing source for Medicaid coverage (most CHIP-funded children were covered through Medicaid in 2016) and a standalone source of coverage that families often find difficult to distinguish from Medicaid. Based on past experience, these effects would be seen broadly across the immigrant community, including citizens who are part of mixed status families.

If immigrants and their family members forgo healthcare coverage as a result of the rule due to concerns or confusion about the immigration consequences of program participation—referred to as a "chilling effect"—their health would be adversely affected. In addition, states will lose Medicaid and CHIP funding that they rely on, and hospitals across the country are likely to experience a significant loss of Medicaid payments followed by an increase in uncompensated care for those who do seek care. The consequences of these financial changes will likely have a negative impact on the way hospitals deliver services to their entire communities; many hospitals operate with thin margins and, if Medicaid funding drops and uncompensated care rises, they are likely to make changes that could impact all patients, not just immigrants targeted by the new rules.

Because the proposed rule does not alter eligibility for Medicaid and CHIP, it is not possible to know exactly how many people would forgo coverage in response to concern about

the immigration consequences of using Medicaid. As such, the analysis in this paper estimates overall Medicaid and CHIP enrollment, funding, and hospital payments that are subject to the chilling effect created by the rule if it is finalized.[3] Key findings include:

- The potentially affected Medicaid and CHIP population is estimated at 13.2 million as of 2016. This includes 4.4 million noncitizen adults and children who receive Medicaid or CHIP coverage, as well as 8.8 million citizen adults and children with Medicaid or CHIP coverage who are the family members of a noncitizen. This does not count all legal immigrants and family members who are eligible for Medicaid or CHIP, but only those who actually receive coverage.
- These enrollees accounted for an estimated $68 billion in Medicaid and CHIP health-care services in 2016, including enrollees who are noncitizens ($26 billion) and those who are citizen family members of a noncitizen ($42 billion). All dollar estimates in this analysis are one-year numbers and represent combined federal and state spending; the health and financial implications of this rule would extend indefinitely.
- Because hospitals provide a substantial share of the care delivered to Medicaid and CHIP enrollees, their payments at risk under the public charge proposed rule total an estimated $17 billion in 2016 ($7 billion for noncitizen enrollees and $10 billion for citizen enrollees who have a noncitizen family member).

The healthcare needs of the individuals and families who drop coverage or forgo enrollment in coverage as a result of this immigration rule would not disappear. While they are likely to forgo preventive and routine care, some people would still turn to hospitals for services—particularly for expensive acute care and inpatient procedures as people defer or delay care due to lack of insurance coverage—thereby increasing uncompensated care costs. Overall, the public charge proposed rule would have a significant negative impact on hospitals and the communities that rely upon them, particularly in areas with large immigrant populations. As uncompensated care costs rise, the destabilizing impact of the rule could threaten the investments hospitals make in serving their entire communities.

Background on Public Charge Policy

Under long-standing immigration law, individuals who are deemed likely to become a "public charge" can be denied admission to the U.S. or, if they are already in the country legally, may be denied the ability to receive a green card as a lawful permanent resident.[4] The DHS proposed rule would change how the agency makes public charge determinations in several key ways that would influence use of certain public benefits by immigrants and their citizen family members.

Notably, federal law already significantly limits immigrant access to public benefits, including Medicaid. Only certain categories of immigrants can access public benefits, and, in many cases, only after they have been in the country for a certain amount of time.[5] For example, many lawfully present immigrants must wait five years before they are eligible to receive Medicaid or CHIP benefits. However, states have the option

to lift these Medicaid or CHIP waiting periods for lawfully present pregnant women and children under the age of 21; as of January 2018, 33 states had elected this option for children and 25 had done so for pregnant women.[6] As discussed below, the proposed public charge rule would penalize immigrant women and children for using Medicaid, despite both Congress and the majority of states recognizing the value of coverage.

Some of the key changes in the DHS proposed rule include:

- Today, public charge policy applies only to individuals who are seeking to enter the country legally and to immigrants already here who are seeking to adjust their status to obtain a green card. The proposed rule would apply public charge determinations to these individuals as well as to immigrants who are attempting to extend their stay or change their status (e.g., moving from a student visa to an employment visa).
- The rule proposes to vastly expand the public benefits that would be considered when DHS makes a public charge determination. Under current guidance in effect for nearly 20 years, receipt of cash assistance or institutionalization for long-term care services at government expense (e.g., Medicaid long-term care) are treated as evidence that a person may become a public charge. The proposed rule would reach well beyond those benefits, proposing to count in public charge determinations most Medicaid services, Medicare Part D subsidies for low-income individuals, the Supplemental Nutrition Assistance Program (SNAP), and various forms of housing assistance. With respect to Medicaid, the proposed rule specifically excludes treatment for emergency medical conditions, Medicaid school-based services, Medicaid services offered pursuant to the Individuals with Disabilities Education Act (IDEA) and coverage for foreign-born children of U.S. citizen parents who would be automatically eligible to become citizens.

  CHIP and Marketplace subsidies are not included in the list of public benefits, but DHS indicates CHIP is under active consideration for inclusion and seeks comment. Non-means-tested benefits provided to the entire community (e.g., free vaccinations) are not included in the proposed rule.[7]
- In a departure from current policy, even intermittent or limited benefit use could result in a public charge determination because the proposed rule replaces the current standard of whether an immigrant is likely to be "primarily dependent" on a narrow set of public benefits by instead proposing to define "public charge" as someone who uses one or more public benefits.[8] Under current policy, the use of cash assistance or government-funded long-term care is of concern only if the immigrant is primarily dependent on the benefit for his or her support.

The rule also vests broad discretion with immigration officials to weigh various factors when they make a public charge determination; that discretion could exacerbate the chilling effect of the rule. Immigration officials must also consider a person's benefit use as well as age; health; family status; assets, resources and financial status; and education and skills. The complexity and discretion adds to the "unknowns" for immigrants and their families, increasing the likelihood that, if finalized, the rule would significantly deter eligible people and their family members from accessing critical public benefits,

like Medicaid. This is particularly true in an environment characterized by increased fear and uncertainty among immigrant families, beyond those directly affected by the changes.[9]

As noted above, the proposed rule exempts Medicaid benefits to treat emergency medical conditions, but families would need to apply for Medicaid to receive that coverage and it is likely many would refrain from doing so.[10] In addition, even if CHIP is excluded from the final rule, the rule is likely to deter enrollment in the program, which is both a financing source for Medicaid coverage (with nearly 60 percent of CHIP-funded children enrolled in Medicaid in 2016[11]) and a standalone source of coverage that families find difficult to distinguish from Medicaid.[12] Even when families know that separate programs exist, a single application is required by federal law to be used to apply for both, and they may be unaware of whether their income level would qualify them for coverage that is funded with Medicaid versus CHIP dollars.

By attaching significant negative consequences to accessing public benefits, including Medicaid, the rule would prompt many immigrants to either drop coverage or not apply for coverage for which they are eligible. The concern and fear would not be limited to the categories of immigrants who are seeking to adjust, change, or extend their status. Indeed, following release this spring of a leaked 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; however, the proposed rule released by DHS does not include WIC among programs that would count as public benefits.[13] Similarly, lawfully present immigrants in immigration categories not subject to public charge determinations as well as immigrants' citizen family members may also be deterred from accessing benefits. This is the case even though the proposed rule does not consider direct receipt by citizen children or other citizen family members as a factor in an immigrant parent's public charge determination. The complexity of the rule and concern about its consequences suggest that many immigrant parents would be reluctant to enroll their citizen dependents.

If immigrants and their family members drop their coverage in key health, nutrition and housing programs, short- and long-term effects are likely. In the preamble to the proposed rule, DHS itself acknowledges that the rule could decrease the disposable income and increase the poverty of families and children—including U.S. citizen children—and that immigrants forgoing benefits could experience lost productivity, adverse health effects, medical expenses due to delayed healthcare and increased disability claims.[14] Over time, if participation in Medicaid, CHIP and other health and human service benefits programs declines, children in particular could experience developmental delays and reduced educational attainment,[15] unwinding years of progress that the federal government, states and communities have made in extending Medicaid and CHIP coverage and reducing uninsurance rates among children.[16]

Medicaid and CHIP Spending and Hospital Payments at Risk Under the Public Charge Proposed Rule

The total one year (2016) Medicaid and CHIP spending subject to a chilling effect under the public charge proposed rule is estimated at $68 billion—$26 billion for noncitizens (4.4 million individuals) and $42 billion for the citizen family members of a noncitizen (8.8 million individuals). Of this amount, hospital payments were an estimated $17 billion ($7 billion for noncitizen enrollees and $10 billion for enrollees who are family members of a noncitizen). As described in further detail below, the magnitude of the actual loss of payments is unknown since it depends not only on how people respond to the rule, but also on the combination of the consequences that attach to enrollment, the complexity of the rule and the discretion granted to immigration officials under the proposed rule. These factors suggest that the impact could be substantial, putting individuals, healthcare providers and the communities they serve at risk.

Box 1. Approach to Estimating Medicaid and CHIP Spending and Hospital Payments at Risk

The basic approach used in this analysis to estimate the one-year amount of Medicaid and CHIP spending and hospital payments at risk under the public charge proposed rule involves the following steps (see Appendix for additional details on data and methods):

- Identify the number of individuals reporting Medicaid and CHIP coverage in the American Community Survey (ACS) who are noncitizens or the citizen family members of a noncitizen, with breakouts by age, disability status and geographic characteristics. Because individuals with benefits that are limited in scope may be less likely to recognize and report this coverage as health insurance when responding to the ACS, these Medicaid and CHIP enrollment figures are assumed to generally exclude those with emergency Medicaid (i.e., individuals who cannot qualify for full Medicaid based on their immigrant status and who are eligible for coverage only for emergency medical conditions).
- Estimate overall Medicaid and CHIP spending for each of these groups based on average per enrollee figures by eligibility category (aged, disabled, other children, other adults) from administrative data, with an adjustment reflecting the fact that immigrants have lower average healthcare spending per capita compared to those born in the United States. Both federal and state spending are reflected in the per-enrollee numbers.

- Using hospital-level Medicaid and CHIP payments from Medicare cost report data, apply an "at-risk" percentage to these amounts to project hospital impacts. This calculation is based on the share of Medicaid and CHIP enrollees who are subject to a chilling effect in the area where a given hospital is located, adjusted to account for their relative Medicaid and CHIP hospital spending. Hospitals in areas with higher concentrations of immigrants have a higher share of their payments at risk.

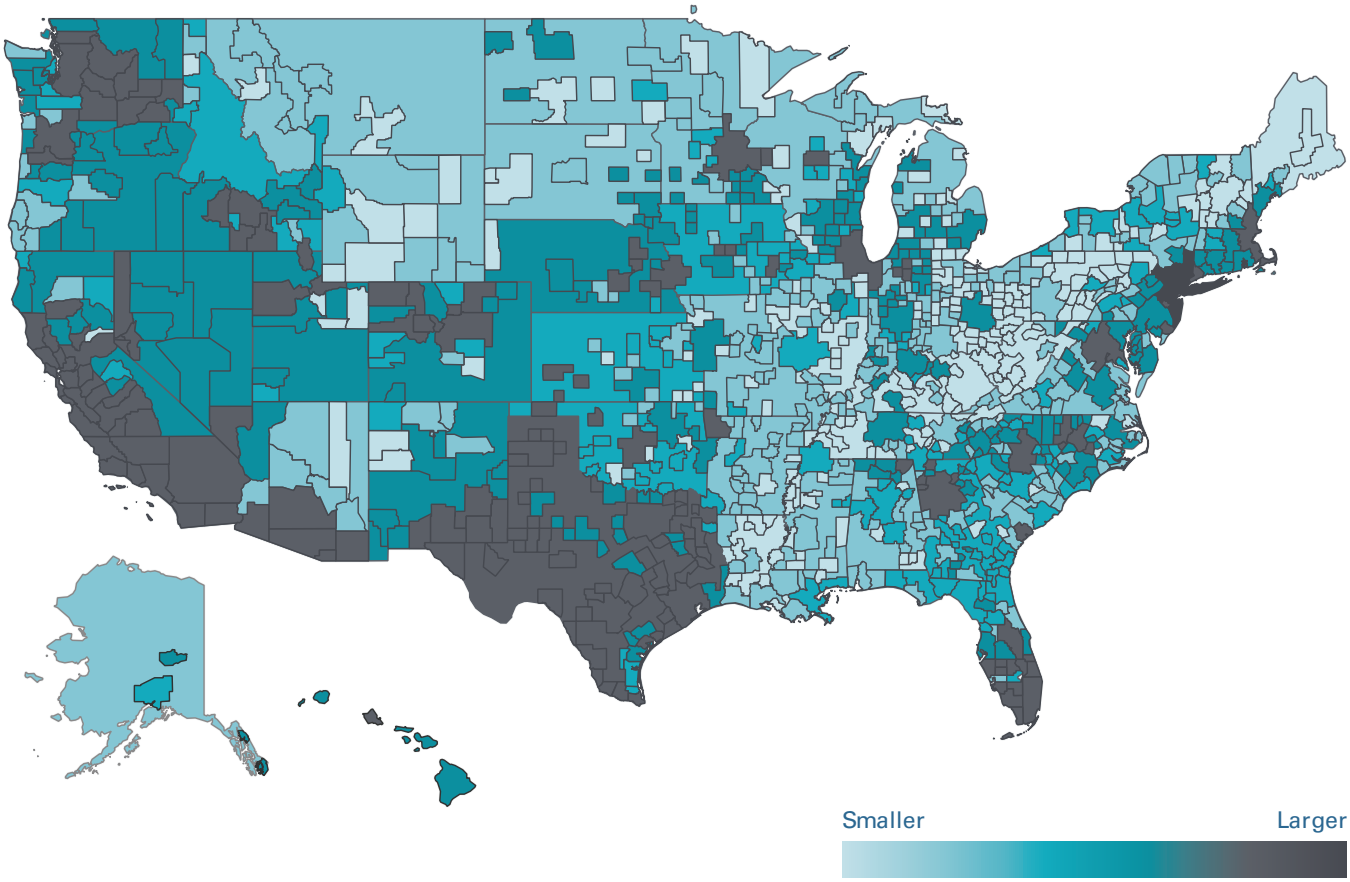
Size of the Affected Population. In this analysis, the population subject to a chilling effect is the universe of people who are covered by Medicaid and CHIP but might disenroll. This does not count all legal immigrants and family members who are eligible for Medicaid or CHIP—only those who actually receive coverage. Adults comprise the largest group of noncitizens potentially affected, but the number of potentially affected citizen children is even larger (Exhibit 1). In addition, the number of Medicaid and CHIP enrollees subject to chilling varies widely both across and within states (Exhibit 2).

Exhibit 1. Medicaid and CHIP Enrollees Subject to Chilling Effect, by Age and Citizen Status (2016; millions)

Age	Noncitizens	Citizen family members of a noncitizen	Total
Adults, 19 or older	3.6	2.1	5.7
Children, under age 19	0.9	6.7	7.6
Total	**4.4**	**8.8**	**13.2**

Note: Estimates reflect 2016 data from the American Community Survey Public Use Microdata Sample (ACS/PUMS). Sums of components may not equal totals due to rounding.

Exhibit 2. Share of Medicaid and CHIP Enrollees Subject to Chilling Effect, by Area (2016)



Note: Estimates reflect 2016 data from the American Community Survey Public Use Microdata Sample (ACS/PUMS) and administrative sources. Reflects core-based statistical areas used by the U.S. Census Bureau, consisting of one or more counties that are socioeconomically tied to an urban center of at least 10,000 people. Counties that do not belong to a CBSA are grouped together within each state.

Within the population subject to a chilling effect, the likelihood of disenrollment or forgone enrollment in Medicaid and CHIP as a result of the public charge rule is unknown. As noted earlier, recent evidence suggests that immigrants are already withdrawing from the WIC and SNAP programs in light of concerns about impending changes in public charge rules. In practice, Medicaid and CHIP disenrollment rates may vary based on a variety of factors. (See Box 2 for a discussion of research on the chilling effect.) In light of this variation, the estimates in this analysis focus on the overall population of individuals at risk for coverage loss under the public charge proposed rule, serving as a reference point for potential impacts.

Box 2. Research on Chilling Effects

In the preamble to the proposed public charge rule, DHS explicitly acknowledges that previous policy restrictions on immigrant eligibility for benefits led to a chilling effect, driving disenrollment among individuals not directly impacted by changes in law or regulation. However, DHS estimates disenrollment only among individuals who it projects are directly affected by the proposed rule and does not consider a broader chilling effect. Instead, DHS assumes that (over a five-year period) 2.5 percent of the noncitizen population would seek to adjust their status and then assumes a 2.5 percent rate of disenrollment or forgone enrollment among noncitizens enrolled in impacted public benefit programs, concluding that approximately 324,000 people each year would likely disenroll or forgo enrollment.[17]

Various researchers studied the use of public benefits following passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 and found that use of benefits by immigrants who were not made ineligible by the law dropped sharply, suggesting that the impact of the public charge rule could similarly impact enrollment.[18] For example:

- While food stamp use in noncitizen families fell 43 percent between 1994 and 1998, it fell 60 percent among refugees even though PRWORA did not restrict their eligibility for food stamps.
- Another study covering the same period found that Medicaid use among refugees fell by 39 percent, compared to 17 percent among other noncitizens, even though refugees remained eligible for Medicaid after PRWORA.[19]

Synthesizing this body of research regarding the impacts of immigration-related welfare reform changes on Medicaid participation, the Kaiser Family Foundation suggests that the chilling effect could be substantial. Kaiser's analysis modeling Medicaid and CHIP enrollment impacts under the proposed rule assumes that the chilling effect could drive disenrollment rates ranging from 15 percent to 35 percent for affected groups.[20]

Overall Medicaid and CHIP Spending for the Affected Population. Under the public charge proposed rule, an estimated $68 billion in healthcare services for Medicaid and CHIP enrollees who are noncitizens ($26 billion) or the citizen family members of a noncitizen ($42 billion) would be at risk of chilling impacts. These amounts reflect one-year data for 2016. As a share of total Medicaid and CHIP spending at the state level, amounts range from less than 5 percent to 20 percent or more (Exhibits 3 and 5). California, Nevada and Texas are among the states with the largest percentages of Medicaid and CHIP spending at risk. In dollar terms, New York, Florida, Massachusetts, New Jersey, Arizona, Illinois, Washington, Pennsylvania and Maryland also have funds at risk in excess of $1 billion. Among the Medicaid and CHIP spending at risk, more than one-third is attributable to children, and the children's share is largest among the citizen family members of a noncitizen (Exhibit 4).

Exhibit 3. Medicaid and CHIP Spending Subject to Chilling Effect, by State (2016; dollars in millions)

State	Medicaid and CHIP spending subject to chilling effect			Medicaid and CHIP spending for all enrollees	Percentage subject to chilling effect
	Noncitizens	Citizen family members of a noncitizen	Total		
Alabama	$22	$139	$161	$5,298	3%
Alaska	$23	$84	$107	$1,815	6%
Arizona	$763	$1,220	$1,984	$11,351	17%
Arkansas	$22	$156	$179	$5,215	3%
California	$8,953	$12,930	$21,882	$85,179	26%
Colorado	$256	$605	$861	$8,107	11%
Connecticut	$346	$462	$808	$7,484	11%
Delaware	$29	$97	$126	$1,979	6%
District of Columbia	$61	$48	$109	$2,446	4%
Florida	$1,542	$2,151	$3,692	$21,216	17%
Georgia	$166	$667	$833	$10,192	8%
Hawaii	$153	$157	$310	$2,121	15%
Idaho	$25	$90	$115	$1,820	6%
Illinois	$578	$1,259	$1,838	$17,563	10%
Indiana	$164	$302	$466	$10,426	4%
Iowa	$84	$134	$217	$4,788	5%
Kansas	$65	$219	$284	$3,244	9%
Kentucky	$95	$191	$287	$9,995	3%
Louisiana	$45	$91	$136	$8,837	2%
Maine	$30	$17	$47	$2,474	2%
Maryland	$413	$708	$1,121	$9,565	12%
Massachusetts	$1,144	$999	$2,143	$16,001	13%
Michigan	$432	$528	$960	$16,897	6%
Minnesota	$330	$483	$812	$11,270	7%
Mississippi	$7	$53	$60	$5,191	1%
Missouri	$57	$225	$282	$10,488	3%
Montana	$9	$23	$31	$1,909	2%
Nebraska	$61	$102	$163	$1,978	8%
Nevada	$198	$634	$832	$3,472	24%
New Hampshire	$53	$46	$98	$2,017	5%
New Jersey	$784	$1,262	$2,045	$14,527	14%
New Mexico	$159	$425	$584	$5,464	11%
New York	$4,602	$4,662	$9,264	$59,552	16%
North Carolina	$159	$724	$883	$13,919	6%

State	Medicaid and CHIP spending subject to chilling effect			Medicaid and CHIP spending for all enrollees	Percentage subject to chilling effect
	Noncitizens	Citizen family members of a noncitizen	Total		
North Dakota	$6	$18	$24	$1,155	2%
Ohio	$186	$306	$492	$22,292	2%
Oklahoma	$47	$300	$347	$4,791	7%
Oregon	$300	$551	$851	$8,605	10%
Pennsylvania	$522	$677	$1,200	$26,333	5%
Rhode Island	$138	$166	$305	$2,771	11%
South Carolina	$37	$162	$199	$5,614	4%
South Dakota	$11	$18	$29	$839	3%
Tennessee	$67	$315	$383	$9,952	4%
Texas	$2,344	$5,925	$8,269	$37,745	22%
Utah	$49	$144	$193	$2,333	8%
Vermont	$21	$6	$27	$1,769	2%
Virginia	$186	$481	$667	$8,891	7%
Washington	$568	$826	$1,394	$11,235	12%
West Virginia	$7	$14	$21	$3,753	1%
Wisconsin	$112	$224	$337	$8,157	4%
Wyoming	$0	$3	$3	$533	1%
Total	**$26,432**	**$42,029**	**$68,461**	**$550,566**	**12%**

Note: Estimates reflect 2016 enrollment and spending per enrollee data from survey and administrative sources. Includes federal and state spending. Figures used in calculations exclude administrative costs and Medicaid spending on Medicare premiums, the Vaccines for Children program and individuals with limited-benefit coverage (e.g., payment only for emergency services, family planning, or assistance with Medicare costs). Disproportionate share hospital payments are excluded from spending per enrollee data, but included in the total Medicaid and CHIP spending column. Sums of components may not equal totals due to rounding.

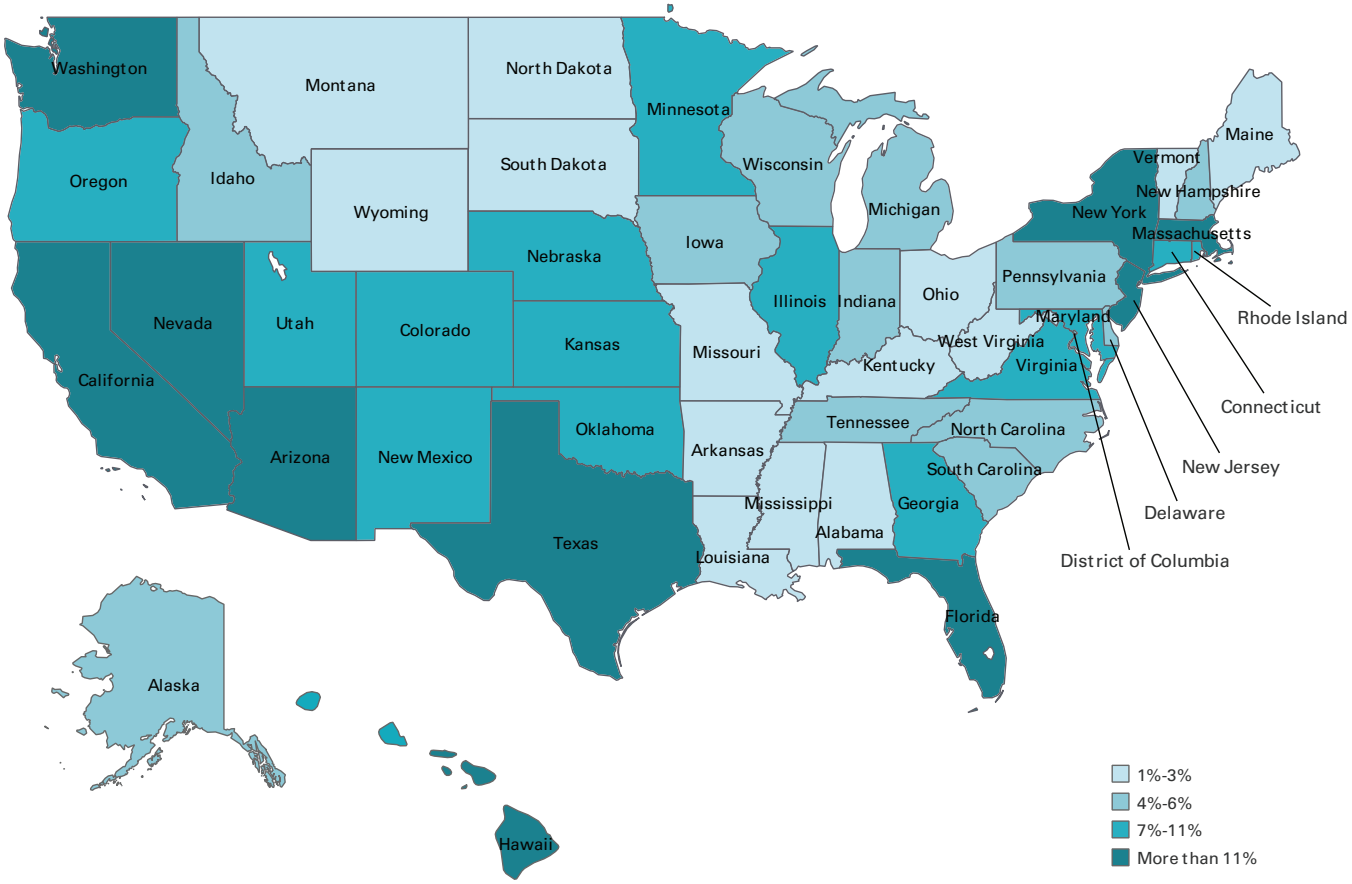
Exhibit 4. Share of Medicaid and CHIP Spending Subject to Chilling Effect That Is Attributable to Children, by State (2016)

State	Share of Medicaid and CHIP spending subject to chilling effect that is attributable to children			Share of Medicaid and CHIP spending for all enrollees that is attributable to children
	Noncitizens	Citizen family members of a non-citizen	Total	
Alabama	14%	68%	61%	34%
Alaska	15%	38%	33%	29%
Arizona	9%	57%	38%	26%
Arkansas	13%	83%	75%	31%
California	10%	48%	32%	25%
Colorado	11%	56%	42%	25%
Connecticut	11%	42%	29%	21%
Delaware	6%	60%	48%	28%
District of Columbia	12%	51%	29%	20%
Florida	10%	44%	30%	29%
Georgia	12%	70%	59%	35%
Hawaii	9%	38%	24%	21%
Idaho	12%	63%	52%	28%
Illinois	15%	60%	46%	33%
Indiana	16%	61%	45%	27%
Iowa	19%	61%	45%	30%
Kansas	14%	69%	56%	38%
Kentucky	18%	58%	44%	22%
Louisiana	15%	62%	46%	24%
Maine	34%	54%	41%	23%
Maryland	14%	50%	37%	27%
Massachusetts	10%	45%	26%	21%
Michigan	14%	42%	29%	26%
Minnesota	16%	55%	39%	21%
Mississippi	14%	76%	68%	34%
Missouri	30%	69%	61%	40%
Montana	13%	47%	38%	26%
Nebraska	19%	69%	50%	30%
Nevada	11%	55%	44%	31%
New Hampshire	10%	51%	29%	31%
New Jersey	11%	46%	33%	21%
New Mexico	7%	51%	39%	28%
New York	9%	34%	21%	19%
North Carolina	19%	76%	66%	32%

State	Share of Medicaid and CHIP spending subject to chilling effect that is attributable to children			Share of Medicaid and CHIP spending for all enrollees that is attributable to children
	Noncitizens	Citizen family members of a noncitizen	Total	
North Dakota	13%	80%	63%	23%
Ohio	11%	44%	31%	22%
Oklahoma	13%	72%	64%	45%
Oregon	9%	47%	34%	18%
Pennsylvania	15%	57%	39%	29%
Rhode Island	10%	41%	27%	21%
South Carolina	19%	67%	58%	31%
South Dakota	29%	53%	44%	35%
Tennessee	16%	68%	59%	29%
Texas	12%	68%	52%	45%
Utah	12%	77%	61%	36%
Vermont	12%	36%	17%	23%
Virginia	15%	57%	45%	34%
Washington	14%	47%	34%	22%
West Virginia	2%	25%	18%	23%
Wisconsin	14%	44%	34%	18%
Wyoming	0%	100%	100%	33%
Total	**11%**	**52%**	**36%**	**27%**

Note: Estimates reflect 2016 enrollment and spending per enrollee data from survey and administrative sources. Includes federal and state spending. Figures used in calculations exclude administrative costs and Medicaid spending on Medicare premiums, the Vaccines for Children program and individuals with limited-benefit coverage (e.g., payment only for emergency services, family planning, or assistance with Medicare costs). Disproportionate share hospital payments are excluded from spending per enrollee data, but included in the total Medicaid and CHIP spending column (with children assumed to account for a proportionate share of those payments).

Exhibit 5. Share of Medicaid and CHIP Spending Subject to Chilling Effect, by State (2016)



Note: Estimates reflect 2016 enrollment and spending per enrollee data from survey and administrative sources. See Exhibit 3 for dollar amounts. Approximately one-quarter of states fall within each of the percentage ranges shown.

Medicaid and CHIP Hospital Payments for the Affected Population. Hospitals account for a large share of overall Medicaid and CHIP spending, and their payments subject to a chilling effect under the public charge proposed rule total an estimated $17 billion (Exhibits 6 and 7). Many states have one-year Medicaid and CHIP hospital payments at risk in the hundreds of millions, with some in excess of $1 billion. In the New York City area alone, payments at risk total more than $3 billion (among 162 hospitals), followed by Los Angeles at $2 billion (130 hospitals) and five other areas with amounts of at least $500 million.

Exhibit 6. Medicaid and CHIP Hospital Payments Subject to Chilling Effect, by State (2016; dollars in millions)

State	Number of hospitals	Medicaid and CHIP hospital payments subject to chilling effect			Total Medicaid/ CHIP hospital payments
		Noncitizens	Citizen family members of a noncitizen	Total	
Alabama	111	$8	$40	$48	$1,554
Alaska	25	$5	$18	$23	$355
Arizona	103	$158	$225	$383	$2,197
Arkansas	97	$4	$20	$24	$806
California	406	$2,248	$2,920	$5,168	$20,768
Colorado	100	$72	$162	$234	$2,080
Connecticut	40	$68	$95	$163	$1,509
Delaware	13	$12	$19	$31	$501
District of Columbia	13	$43	$74	$117	$736
Florida	253	$337	$449	$785	$4,608
Georgia	168	$49	$194	$243	$2,911
Hawaii	25	$24	$27	$51	$394
Idaho	48	$6	$20	$27	$432
Illinois	204	$174	$380	$554	$5,075
Indiana	166	$44	$73	$117	$1,985
Iowa	121	$24	$33	$57	$1,170
Kansas	150	$12	$28	$40	$614
Kentucky	114	$33	$53	$85	$2,570
Louisiana	207	$20	$31	$52	$2,588
Maine	37	$5	$2	$7	$433
Maryland	60	$88	$165	$254	$3,270
Massachusetts	95	$250	$207	$457	$3,700
Michigan	164	$121	$126	$246	$4,137
Minnesota	143	$68	$89	$157	$2,152
Mississippi	110	$3	$14	$17	$1,552
Missouri	142	$17	$75	$93	$2,460

State	Number of hospitals	Medicaid and CHIP hospital payments subject to chilling effect			Total Medicaid/ CHIP hospital payments
		Noncitizens	Citizen family members of a noncitizen	Total	
Montana	65	$1	$5	$6	$465
Nebraska	96	$12	$20	$32	$401
Nevada	52	$51	$172	$223	$930
New Hampshire	29	$14	$10	$25	$330
New Jersey	97	$285	$323	$608	$3,713
New Mexico	53	$35	$91	$126	$1,269
New York	199	$1,314	$1,397	$2,710	$15,745
North Carolina	129	$46	$170	$216	$3,213
North Dakota	49	$2	$5	$7	$318
Ohio	228	$68	$101	$170	$6,408
Oklahoma	151	$15	$82	$98	$1,148
Oregon	62	$71	$115	$186	$1,831
Pennsylvania	225	$92	$124	$216	$4,603
Rhode Island	14	$23	$28	$51	$522
South Carolina	81	$12	$42	$54	$1,530
South Dakota	61	$3	$2	$5	$226
Tennessee	141	$19	$77	$96	$2,212
Texas	594	$574	$1,348	$1,923	$8,862
Utah	58	$19	$51	$70	$859
Vermont	16	$2	$1	$3	$188
Virginia	108	$39	$73	$112	$1,870
Washington	100	$148	$181	$329	$2,662
West Virginia	60	$4	$4	$8	$898
Wisconsin	146	$27	$41	$68	$1,540
Wyoming	29	$0	$1	$1	$95
Total	**5,958**	**$6,769**	**$10,002**	**$16,771**	**$132,393**

Note: Estimates reflect 2016 payment data from Medicare cost reports. Sums of components may not equal totals due to rounding.

Exhibit 7. Medicaid and CHIP Hospital Payments Subject to Chilling Effect, by Area (2016; dollars in millions)

Area	Number of hospitals	Medicaid and CHIP hospital payments subject to chilling effect			Total Medicaid/ CHIP hospital payments
		Noncitizens	Citizen family members of a noncitizen	Total	
Atlanta-Sandy Springs-Roswell, GA	55	$40	$143	$183	$1,647
Baltimore-Columbia-Towson, MD	29	$47	$89	$136	$2,321
Boston-Cambridge-Newton, MA-NH	56	$205	$159	$365	$2,282
Chicago-Naperville-Elgin, IL-IN-WI	106	$172	$375	$548	$3,786
Dallas-Fort Worth-Arlington, TX	143	$110	$311	$421	$1,767
Denver-Aurora-Lakewood, CO	32	$57	$112	$169	$1,226
Detroit-Warren-Dearborn, MI	53	$60	$76	$136	$1,834
El Paso, TX	14	$45	$111	$156	$393
Fresno, CA	7	$93	$121	$214	$924
Houston-The Woodlands-Sugar Land, TX	93	$220	$414	$634	$2,204
Las Vegas-Henderson-Paradise, NV	30	$36	$97	$132	$582
Los Angeles-Long Beach-Anaheim, CA	130	$843	$1,135	$1,978	$6,191
McAllen-Edinburg-Mission, TX	9	$32	$92	$124	$322
Miami-Fort Lauderdale-West Palm Beach, FL	65	$234	$295	$529	$1,610
Minneapolis-St. Paul-Bloomington, MN-WI	41	$58	$78	$136	$1,390
New York-Newark-Jersey City, NY-NJ-PA	162	$1,500	$1,612	$3,113	$15,289
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	85	$98	$134	$232	$3,190
Phoenix-Mesa-Scottsdale, AZ	56	$122	$179	$301	$1,510
Portland-Vancouver-Hillsboro, OR-WA	21	$54	$83	$137	$1,086
Riverside-San Bernardino-Ontario, CA	35	$223	$349	$572	$2,664
Sacramento–Roseville–Arden-Arcade, CA	19	$91	$107	$198	$1,364
San Antonio-New Braunfels, TX	31	$50	$131	$181	$1,269
San Diego-Carlsbad, CA	24	$152	$235	$387	$1,571
San Francisco-Oakland-Hayward, CA	45	$262	$244	$506	$2,217
San Jose-Sunnyvale-Santa Clara, CA	14	$175	$190	$365	$1,257
Seattle-Tacoma-Bellevue, WA	33	$87	$91	$178	$1,324
Washington-Arlington-Alexandria, DC-VA-MD-WV	52	$94	$162	$256	$1,617
Yuba City, CA	2	$56	$58	$115	$675
All other	4,516	$1,549	$2,816	$4,365	$68,882
Total	**5,958**	**$6,769**	**$10,002**	**$16,771**	**$132,393**

Note: Estimates reflect 2016 payment data from Medicare cost reports. Reflects core-based statistical areas used by the U.S. Census Bureau, consisting of one or more counties that are socioeconomically tied to an urban center of at least 10,000 people. Sums of components may not equal totals due to rounding. "All other" category consists of areas with less than $100 million in Medicaid and CHIP payments subject to chilling effect.

Implications of Proposed Public Charge Policy Changes

Medicaid and CHIP play a key role in keeping both children and adults healthy and in addressing the needs of people with disabilities and chronic illnesses. Adult enrollees report substantially better access to care for almost every measure analyzed compared to similarly situated uninsured individuals, including a higher likelihood of having a usual source of care (e.g., through a particular clinic or doctor's office) and a lower likelihood of delaying medical care in the last year.[21] Individuals with a usual source of care are less likely to use emergency department services.[22] By promoting access to primary care, preventive services and chronic disease management, Medicaid supports beneficiaries' ability to work and can help lift families above the poverty threshold.[23] State Medicaid programs are focused on promoting primary care and providing care management through delivery system and payment reform, not only to improve health outcomes but also to reduce costly and avoidable care.[24] For children, Medicaid coverage not only helps ensure access to coverage but can also promote positive long-term health, educational and earnings outcomes.[25] Over the past 15 years, through federal, state and local efforts, the uninsured rate among children in this country has dropped below 5 percent, with the improvements achieved largely through Medicaid and CHIP coverage.[26]

The proposed public charge rule could jeopardize these critical health benefits, coverage gains and efforts to bring greater value for dollars spent. If low-income immigrant parents and their children forgo Medicaid and CHIP coverage as a result of the public charge rule and become uninsured because private coverage is not available or affordable to them, health outcomes could decline and emergency department or acute care use could rise, along with associated costs. And, while some number of individuals might enroll in Medicaid when they become ill, episodic coverage undermines efforts to reduce avoidable hospitalizations and other high-cost care. In terms of hospital impact, a significant portion of this preventable hospital care would be uncompensated, thereby potentially affecting hospitals' financial stability. DHS acknowledges the likelihood of increased uncompensated care in the preamble to the proposed rule and also states that hospitals—as well as state agencies and other organizations that provide direct assistance to immigrants and their households—would experience an impact as individuals disenroll from public programs.[27] Hospitals and other healthcare providers with uncompensated care growth could face financial challenges that make it difficult to maintain their services for the community as a whole, suggesting that the rule could have a reach far beyond immigrants seeking to avoid a public charge determination.

Medicaid and CHIP are critical to the financial stability of hospitals and other healthcare providers. Together the programs account for nearly 1 out of 5 healthcare dollars nationwide, paying for care that ranges from routine checkups and prescription drugs to hospital stays for serious illnesses. Among Medicaid and CHIP enrollees, 1 out of every 3 program dollars are spent on hospital-based care.[28] Following

passage of the Affordable Care Act, uncompensated care has fallen as coverage has become available through Medicaid and the Marketplace. If the DHS rule is finalized, Medicaid and CHIP payments will drop and uncompensated care levels could quickly rise, most acutely in areas of the country with large immigrant populations.

Conclusion

If finalized, proposed revisions to the standards governing public charge determinations are likely to deter immigrants and their citizen family members who are in the country legally from using Medicaid and CHIP benefits that they are eligible to receive. While most work, their jobs often do not offer affordable coverage, and they are likely to become uninsured.[29] As a result, hospitals would see a drop in Medicaid and CHIP payments followed by an increase in uncompensated care. The effect of these trends could be particularly acute for hospitals in areas with high concentrations of immigrant populations. Immigrants and their family members who do seek care could be sicker and require more expensive treatment if they have forgone preventive and chronic care management services, undermining broader efforts to bring down healthcare costs.

Appendix: Data and Methods

The estimates presented in this report are based on an analysis of 2016 data from the following sources:

- **ACS/PUMS.** Medicaid and CHIP enrollment information is obtained from the 2016 American Community Survey Public Use Microdata Sample (ACS/PUMS). Individuals who are noncitizens or the citizen family members of a noncitizen are identified, and breakouts are obtained by age, disability and geographic characteristics.
- **Medicaid and CHIP Administrative Data.** State-level Medicaid enrollment and spending per full-year equivalent (FYE) enrollee for 2016 are from Manatt's Medicaid Financing Model, which draws from a variety of administrative sources that include CMS-64, Medicaid Statistical Information System (MSIS) and Medicaid Analytic eXtract (MAX) data. CHIP data are also drawn from administrative sources. Individuals with full-benefit Medicaid coverage are broken out by eligibility group (aged, disabled, other adults, other children). Enrollment and spending for those with limited-benefit coverage (e.g., payment only for emergency services, family planning or assistance with Medicare premiums and cost sharing) are excluded from the analysis, along with administrative costs and Medicaid spending on Medicare premiums and the Vaccines for Children program. Disproportionate share hospital (DSH) payments are excluded from spending per enrollee data used to estimate overall Medicaid spending subject to a chilling effect, but are included in total Medicaid spending figures. Both federal and state spending are reflected in the per enrollee numbers.
- **Medicare Cost Reports.** Hospital-specific total, Medicaid and CHIP payments contained in Medicare cost report data from the Healthcare Cost Report Information System (HCRIS) are used. Medicaid DSH payments cannot be reliably separated out and are included in the amounts for each hospital. Total and Medicaid inpatient discharges are also obtained from this source.

Key inputs and assumptions used to develop estimates are as follows:

- **Medicaid and CHIP Enrollees Subject to Chilling Effect.** Individuals reporting noncitizen status and Medicaid or CHIP coverage are identified using ACS/PUMS data, as were citizens with Medicaid or CHIP coverage who are living with a noncitizen family member. Because individuals with limited benefits may be less likely to recognize and report this coverage as health insurance when responding to the ACS, these Medicaid and CHIP enrollment figures are generally assumed to exclude those with Emergency Medicaid and other partial benefits that individuals may receive. Due to the wording of the ACS (which asks about "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability"), coverage may include some other state and local programs. However, figures used for the estimates in this paper may still be conservative, given that the ACS is known to undercount immigrants, as well as Medicaid and CHIP enrollment overall.

  Age and self-reported disability characteristics were used to assign each individual to an eligibility group (aged, disabled, other adult, other child) for purposes of attaching

appropriate spending per enrollee estimates in a later step of the analysis. Each individual's geography of residence was identified by Public Use Microdata Areas (PUMAs), which were crosswalked to counties based on the distribution of residence addresses within each PUMA that fall within a given county, based on postal service data. An aggregation was then made to core-based statistical areas (CBSAs) used by the U.S. Census Bureau, which aggregate one or more counties that are socioeconomically tied to an urban center of at least 10,000 people (depending on population size, CBSAs are also referred to as metropolitan and micropolitan areas). Counties that do not belong to a CBSA were grouped together within each state.

- **Total Medicaid and CHIP Enrollees.** Because the ACS and other surveys are known to undercount Medicaid and CHIP coverage relative to administrative sources, administrative data are used for total program enrollment in this analysis. The administrative enrollment figures are later combined with per enrollee spending to estimate aggregate spending on all full-benefit Medicaid and CHIP enrollees, which serves as a point of comparison for spending on ACS-based numbers of Medicaid and CHIP enrollees subject to a chilling effect. Administrative enrollment figures were allocated by county within each state based on the distribution of total Medicaid and CHIP enrollees observed in the ACS, and were then aggregated to CBSAs.
- **Overall Medicaid and CHIP Spending.** Average spending per enrollee for individuals with full-benefit coverage is obtained from administrative data as described above, by state and eligibility group. Per FYE figures are used (rather than spending per person ever enrolled) because the enrollment figures in this analysis reflect averages during the year. For citizens versus noncitizens in this analysis, an adjustment factor of 71 percent was applied to account for the fact that immigrants have lower public (and overall) healthcare spending per capita compared to those born in the United States. Per FYE figures are multiplied by enrollment to obtain aggregate Medicaid and CHIP spending for all enrollees and those subject to a chilling effect.
- **Medicaid and CHIP Hospital Payments.** Hospital-specific Medicaid and CHIP payments were obtained from Worksheet S-10 in the Medicare cost report data. For those not reporting S-10 data (e.g., most children's hospitals), overall patient payments were obtained from Worksheet G-3 and multiplied by an imputed Medicaid and CHIP percentage. The imputation calculated the share of total discharges paid by Medicaid from Worksheet S-3 and applied a discount of 50 percent, to account for the fact that Medicaid would typically pay substantially less than the hospital's overall average that includes both Medicare and private insurance.

Amounts subject to a chilling effect were calculated for each hospital by multiplying their Medicaid and CHIP payments by an "at-risk" percentage. The at-risk percentage reflects the share of Medicaid and CHIP enrollees who are subject to a chilling effect in the CBSA where a given hospital is located, adjusted to account for their relative Medicaid and CHIP hospital spending. Relative Medicaid and CHIP hospital spending calculations use Medical Expenditures Panel Survey (MEPS) data to estimate the share of overall Medicaid and CHIP spending attributable to hospital care by eligibility group.

Estimated Medicaid and CHIP hospital spending derived for at-risk calculations described above will vary from Medicaid and CHIP hospital payments obtained from Medicare cost report data for a variety of reasons. For example, while Medicare cost report S-10 instructions direct hospitals to net out provider contributions that help to finance the non-federal share of Medicaid payments, other administrative sources and survey data would typically reflect gross Medicaid payments to hospitals (i.e., amounts prior to accounting for any Medicaid provider tax expenses that reduce the net value of payments received). In addition, different data sources may include varying components of hospital spending (e.g., facility versus physician fees).

[1] Refugees, asylees, survivors of trafficking and domestic violence and other specified groups of noncitizens are not subject to the public charge test.

[2] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (Oct. 10, 2018), https://www.gpo.gov/fdsys/pkg/FR-2018-10-10/pdf/2018-21106.pdf. For a summary of the public charge proposed rule, see Kaiser Family Foundation, Proposed Changes to "Public Charge" Policies for Immigrants: Implications for Health Coverage (Sept. 24, 2018), https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage.

[3] All estimates include both Medicaid and CHIP. As described earlier, CHIP dollars can be used to fund both Medicaid and standalone CHIP coverage.

[4] Refugees, asylees, survivors of trafficking and domestic violence and other specified groups of noncitizens are not subject to the public charge test.

[5] The public charge rule would primarily impact lawfully present immigrants; unauthorized immigrants are already ineligible for most means-tested public benefits. Many lawfully present immigrants must wait five years before they can access benefits. Some categories of lawful immigrants – like refugees and asylees – are not subject to these waiting periods.

[6] Kaiser Family Foundation, Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women (Jan. 1, 2018), https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women.

[7] In addition to these exclusions, other "earned" benefits connected to work or military service continue to be excluded from public charge determinations under the proposed rule.

[8] *See* 83 Fed. Reg. at 51289 (proposing 8 C.F.R. § 212.21(a)). While the rule includes monetary and durational thresholds that establish when an individual would be deemed to have used "one public benefit," these thresholds are not only modest but also would be hard for individuals to calculate, adding to the likelihood that immigrants would forgo benefits rather than assume the risk of using them.

[9] *See, e.g.*, Samantha Artiga & Petry Ubri, Kaiser Family Foundation, Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health (Dec. 13, 2017), https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health; Jeanne Batalova et al., Migration Policy Institute, Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use (Jun. 2018), https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families.

[10] The exemption in the proposed rule is for "emergency medical conditions," not "emergency Medicaid." Emergency Medicaid is available for treatment of emergency medical conditions for people who meet all Medicaid eligibility criteria other than citizenship and immigration status. Emergency Medicaid is not available for immigrants who are eligible for Medicaid, including immigrants who are eligible for Medicaid but drop their coverage as a result of the proposed public charge rule.

[11] Medicaid and CHIP Payment and Access Commission (MACPAC), "Exhibit 32: Child Enrollment in CHIP and Medicaid by State, FY 2016," *MACStats*, https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-32.-Child-Enrollment-in-CHIP-and-Medicaid-by-State-FY-2016.pdf.

[12] For example, one analysis of matched administrative and survey data found that less than a third of enrollees with standalone CHIP coverage accurately identified it as such. See Jacob Klerman et al., "CHIP reporting in the CPS," 2 *Medicare & Medicaid Res. Rev.* E1 (Jul. 31, 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006394/pdf/mmrr2012-002-03-b01.pdf.

[13] *See* Helena Bottemiller Evich, "Immigrants, Fearing Trump Crackdown, Drop Out of Nutrition Programs," *Politico* (updated Sept. 4, 2018), https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292; Emily Baumgaertner, "Spooked by Trump Proposals, Immigrants Abandon Public Nutrition Services," *N. Y. Times* (Mar. 6, 2018), https://www.nytimes.com/2018/03/06/us/politics/trump-immigrants-public-nutrition-services.html; 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.

[14] 83 Fed. Reg. at 51234-35 & 51270.

[15] Karina Wagnerman et al., Georgetown University Center for Children and Families, Medicaid is a Smart Investment in Children (Mar. 13, 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

[16] Jennifer Haley et al., Urban Institute, Uninsurance and Medicaid/CHIP Participation Among Children and Parents: Variation in 2016 and Recent Trends (Sept. 2018), https://www.urban.org/sites/default/files/publication/99058/uninsurance_and_medicaidchip_participation_among_children_and_parents_updated_1.pdf.

[17] 83 Fed. Reg. at 51266.

[18] For a review of past research, *see* Batalova et al., *supra* note 9.

[19] Michael Fix & Jeffrey Passel, Urban Institute, Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97 (Mar. 1999), https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf.

[20] Samantha Artiga et al., Kaiser Family Foundation, Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid (Oct. 2018), http://files.kff.org/attachment/Issue-Brief-Estimated-Impacts-of-the-Proposed-Public-Charge-Rule-on-Immigrants-and-Medicaid.

[21] MACPAC, "Access and Quality/Key Findings on Access to Care," https://www.macpac.gov/subtopic/measuring-and-monitoring-access (last visited Nov. 7, 2018).

[22] Winston Liaw et al., "The Impact of Insurance and a Usual Source of Care on Emergency Department Use in the United States," *Int. J. Family Med.* (Feb. 9, 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3941574/pdf/IJFM2014-842847.pdf; Tina Hernandez-Boussard et al., "The Affordable Care Act Reduces Emergency Department Use By Young Adults: Evidence From Three States," 33 *Health Affairs* 1648 (Sept. 2014), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0103.

[23] Karina Wagnerman, Georgetown University Center for Children and Families, Medicaid: How Does it Provide Economic Security for Families? (Mar. 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf; Julia Paradise, Kaiser Family Foundation, Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid (Mar. 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid.

[24] *See, e.g.*, Kathleen Gifford et al., Kaiser Family Foundation, States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019 (Oct. 2018), https://www.kff.org/medicaid/report/states-focus-on-quality-and-outcomes-amid-waiver-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2018-and-2019; National Association of Medicaid Directors, State Medicaid Operations Survey: Sixth Annual Survey of Medicaid Directors, FY 2017 (Sept. 2018), http://medicaiddirectors.org/wp-content/uploads/2018/09/NAMD-Survey-Report_General_FINAL.pdf.

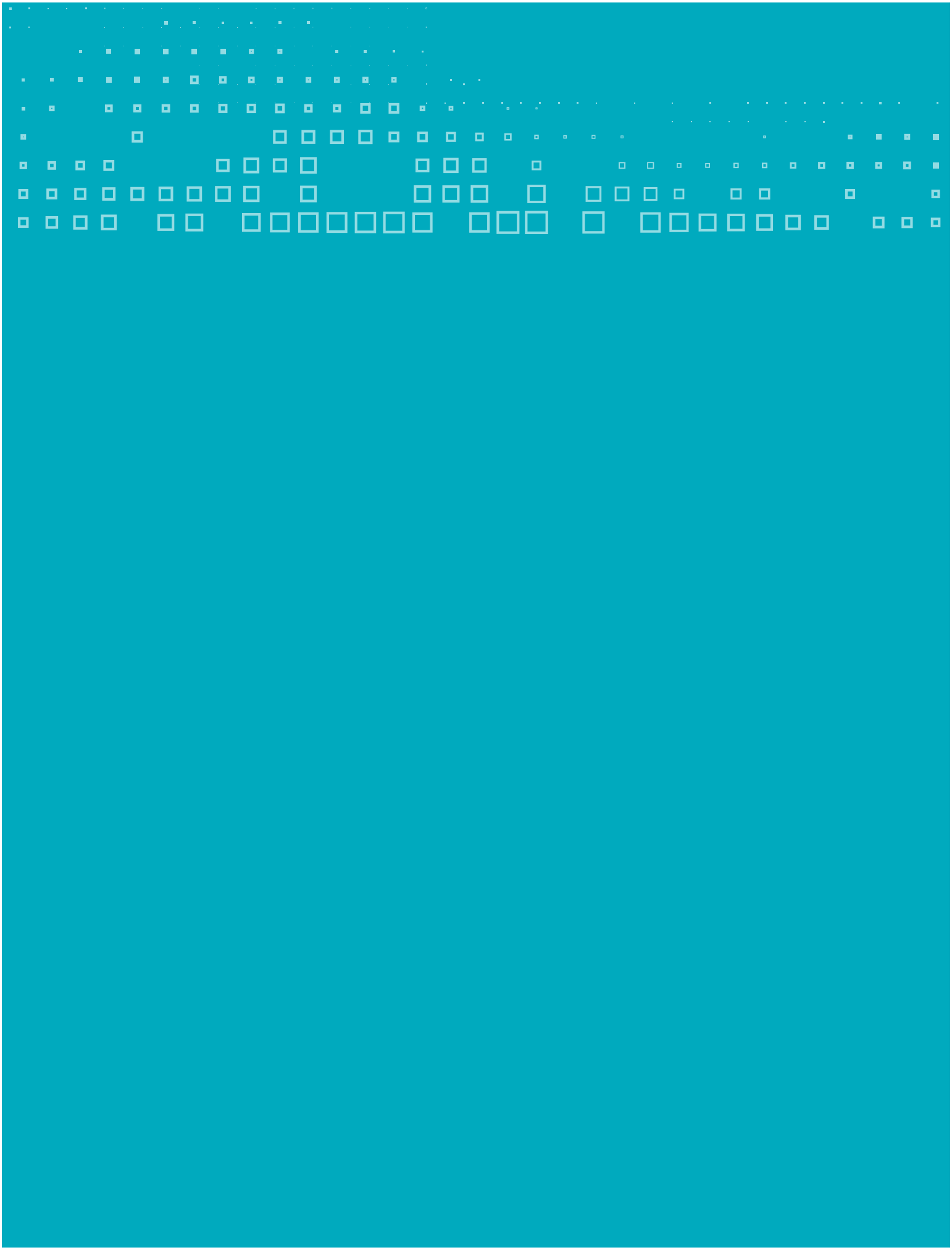
[25] *See* Paradise, *supra* note 23; Wagnerman et al., *supra* note 15; Andrew Goodman-Bacon, National Bureau of Economic Research, "The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes," Working Paper 22899 (Dec. 2016), https://www.nber.org/papers/w22899.pdf.

[26] Haley et al., *supra* note 16.

[27] 83 Fed. Reg. at 51260 & 51270.

[28] MACPAC, "Exhibit 3. National Health Expenditures by Type and Payer, 2016," *MACStats* (Apr. 2018) https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-3.-National-Health-Expenditures-by-Type-and-Payer-2016.pdf. The Medicaid and CHIP hospital payments in this report are a somewhat smaller share of total Medicaid and CHIP spending due to differences in data sources and definitions of hospital-based care.

[29] Rachel Garfield et al., Kaiser Family Foundation, Implications of Work Requirements in Medicaid: What Does the Data Say? (Jun. 2018), https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say.



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