NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 10, 2018

Samantha Deshommes
Chief, Regulatory Coordination Division, Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Re: DHS Docket No. USCIS-2010-0012

Dear Ms. Deshommes:

The New York State Department of Health (NYSDOH) submits the following comments in response to the notice in the Federal Register (83 FR 51114) soliciting comments on the proposed rule regarding "Inadmissibility on Public Charge Grounds." NYSDOH supervises the administration of a wide range of programs that provide services and support to low-income families and individuals, including services for refugees and other non-citizens. The mission of NYSDOH is to protect, improve and promote the health, productivity and well-being of all New Yorkers.

Thank you for the opportunity to comment.

Sincerely,

Howard Zucker MD.

Howard A. Zucker, M.D., J.D.
Commissioner

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New York State Department of Health
Comments in Response to the U.S. Department of Homeland Security's Notice of Proposed Rulemaking

I. EXECUTIVE SUMMARY

The New York State Department of Health (NYSDOH) strongly opposes the proposed rule changes as outlined in the U.S. Department of Homeland Security's (DHS) Notice of Proposed Rulemaking titled, "Inadmissibility on Public Charge Grounds."[1] The rule as proposed will dramatically deteriorate the longstanding public health and policy goal of maximizing enrollment of eligible individuals in health insurance. Finalizing the definition of "public charge" as set forth in the proposed rule would deter legal immigrants and their families from utilizing public benefits they are entitled to receive under federal law. The harm caused by this deterrence would be irreparable because consistent enrollment in these programs is critical to ensure access to healthcare, financial stability, and secure employment. Additionally, the proposed rule would create barriers to HIV and hepatitis services, which could lead to increased transmission of communicable disease and unnecessary harm to community health. NYSDOH strongly opposes the proposed rule and recommends no changes be made to the current language defining "public charge" set forth in the Field Guidance.[2]

In short, the proposed rule will compel certain immigrants to choose between enrolling in health insurance coverage that they are legally entitled to, or pursuing a specific immigration status. NYSDOH anticipates this will cause a significant decline in immigrant Medicaid enrollment, regardless of which immigrants the proposed rule directly impacts. Approximately 70,000 Medicaid enrollees in the state may be impacted by the proposed change. However, the anticipated impact extends far beyond this group to vulnerable families, friends, and communities.

Panicked consumers are already flooding New York's health insurance marketplace with public charge related questions to the marketplace customer service center, participating health plans, and Navigator agencies, asking if they should cancel their Medicaid or other health insurance as a result of this proposed rule. The "chilling effect" of this proposal has the potential to endanger health insurance coverage of more than 1.3 million New York State residents.

The proposed public charge rule would have destructive and far-reaching consequences primarily stemming from the reduction in health insurance coverage the rule will likely incite.

The proposed rule will negatively impact New Yorkers by:

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[1] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (proposed October 10, 2018) (to be codified at 8 CFR Parts 103, 212, 213, 214, 245 and 248).
[2] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689 (May 26, 1999).

- Deteriorating the overall health of immigrants and their family members;
- Decreasing access to care;
- Increasing uninsurance and worsening children's health;
- Increased cost-shifting;
- Decreased employment and workforce productivity;
- Harming financial well-being; and
- Creating barriers to HIV and hepatitis prevention and care.

The proposed rule will also negatively impact health care providers, specifically by:

- Reversing recent reductions in uncompensated care;
- Endangering hospitals' financial health; and
- Increasing labor shortages

Finally, the State will also withstand negative impacts from the proposed rule including:

- Increased administrative burdens on the state; and
- Increased public health concerns

For these reasons discussed in depth below, we urge the proposed rule be withdrawn.

II. OVERALL IMPACT OF THE PROPOSED PUBLIC CHARGE RULE

As written, the rule will have a harmful impact in the following ways:

Impacts on New Yorkers

a. Diminish overall health of immigrants and their family members
b. Decrease access to care
c. Increase uninsurance and worsen health among children
d. Increase cost-shifting of health care costs
e. Decrease employment and workforce productivity
f. Harm financial well-being
g. Create barriers to HIV and hepatitis prevention and care

Impacts on Health Care Providers

h. Reverse recent reductions in uncompensated care
i. Worsen hospitals' financial performance
j. Increase labor shortages

Impacts on the State

k. Increase administrative burdens on the state
l. Increase public health concerns

Impact on New Yorkers

a. **Diminish overall health of the Population.** The proposed rule will disincentivize enrollment in health insurance and cause fewer individuals to seek the care they need,

potentially leading to more acute and costly conditions in the future. Having health insurance increases the likelihood of people having both a usual source of care and access to care when they need it, and improves the chance patients receive recommended and potentially life-saving care.[3] Studies have also shown expanded Medicaid is associated with positive outcomes including lower mortality rates, higher cancer detection rates, and lower infant mortality rates.[4] The proposed rule will stall these positive outcomes and worsen the overall health of many New Yorkers.

b. **Decrease access to care.** The proposed rule will likely cause an increase in the number of uninsured New Yorkers and reverse important progress that has made health care more accessible in recent years. New York has seen a significant reduction in the rate of uninsured, from 10% in 2013 when the NY State of Health Marketplace opened to below 5% in 2017. According to a recent Commonwealth Fund Survey:
    - Nationally, in 2012 the share of individuals who reported they could not access needed care due to cost was 43%. This share dropped to 34% in 2016 nationally, and in New York the percentage dropped to 29% in 2016.
    - Nationally, in 2012 the share of individuals who reported having trouble paying their medical bills was 41%. This share dropped to 37% in 2016, and in New York the number dropped to 28%.[5]

c. **Increase uninsurance and worsen health among children.** Studies show a parent's poor health and lack of access to health insurance can jeopardize a child's health and performance in school.[6] A reduction in the number of insured parents instigated by the proposed rule could lead to a reduction in insurance coverage among their children, regardless of whether their children may be directly impacted by the proposed rule. Several studies suggest expanding coverage eligibility to adults has, in some cases, caused significant reductions in children's uninsured rates.[7] Children with insured parents are less likely to experience gaps in coverage and more likely to receive recommended care.

   NYSDOH strongly disagrees that Medicaid (with the exception of long-term care) should be included as a public benefit that would constitute a designation as a public charge. In New

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[3] Baicker, Katherine, et al. 2013. "The Oregon Experiment – Medicaid's Effects on Clinical Outcomes." New England Journal of Medicine 368, no. 18: 1713□1722. https://www.nejm.org/doi/full/10.1056/NEJMsa1212321

[4] Antonisse, L., et al. "The effects of Medicaid expansion under the ACA: updated findings from a literature review. San Francisco (CA): Henry J. Kaiser Family Foundation; 2018 Mar. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

[5] Declaration of Dr. Howard A. Zucker ISO Motion to Intervene of State of California, et al., (18-cv-167), April 6, 2018.

[6] Institute of Medicine Committee on the Consequences of Uninsurance, "Family Well-Being and Health Insurance Coverage," Health Insurance Is a Family Matter, (Washington, DC: National Academics Press, 2002), available online at https://www.ncbi.nlm.nih.gov/books/ NBK221008/.

[7] "Medicaid Expansion: Good for Parents and Children." 2014. Center for Children and Families, Georgetown University Health Policy Institute. http://ccf.georgetown.edu/wp-content/uploads/2013/12/Expanding-Coverage-for-Parents-Helps-Children-2013.pdf

York, the impact of that determination will fall most heavily on pregnant women and children.

Discouraging parents from enrolling eligible children in Medicaid coverage could negatively impact long-term outcomes such as education and employment, both of which contribute to self-sufficiency. Lack of primary care not only jeopardizes the long-term health and development of children but also, it puts other children at risk, for example when immunizations are skipped and communicable diseases are spread.

Including Medicaid in a public charge determination will impact access to health care for many children whose parents will fear enrolling their children in this benefit. Without coverage, children will likely suffer the consequences of inconsistent well-child visits and primary care, resulting in potentially serious health issues. Parents may be forced to take time off from work to care for children who are sicker than they should be from lack of preventive care, which negatively impacts the parent's self-sufficiency. Instead of early treatment for illness, children without health coverage will resort to emergency room visits for treatment of more serious conditions, at a greater cost than doctor's office visits.

Including Medicaid as a public benefit for purposes of a public charge determination is also likely to force immigrant pregnant women to choose between getting crucial prenatal care or risking a public charge determination.

Inadequate prenatal care increases the risk of premature birth, low birth weight, and a range of poor health outcomes for babies who, in many instances, will be U.S. citizens. The cost of care in the Neonatal Intensive Care Unit for babies that are born premature or at low birth weight far exceeds the cost of routine, preventative, prenatal care.

As a result of the proposed public charge rule, immigrant families will likely be too afraid to enroll in Medicaid. Unfortunately, many immigrant families have limited access to employer sponsored insurance. If there is access to employer sponsored health coverage, it is often unaffordable to individuals with incomes below the Medicaid income level. For example, it would cost a household of three about 20% of household income to enroll in employer sponsored health insurance.

d. **Increase cost-shifting of health care costs.** The proposed public charge rule will reduce access to health care and increase the financial burden borne by the insured, the hospitals, and state and local governments. It is well documented that stripping individuals of their access to health care does not reduce their health care needs, and individuals without coverage still need and receive care. However, without primary and preventative care, and

with no way to pay for care received, those costs are shifted to the insured, hospitals, and state and local governments.[8]

e. **Decrease employment and workforce productivity.** Removing stable, affordable health insurance from lower-income populations as the proposed rule would will also have a deleterious effect on New York's workforce. Working individuals who receive Medicaid report performing better in their jobs and feeling better prepared to seek a new or better job.[9] Likewise, jobseekers report feeling better prepared to enter the workforce when they enjoy Medicaid coverage. Without Medicaid coverage, and the preventative care it provides, these lower income individuals are likely to spend more time suffering serious preventable illness, missing work, which creates instability in the work force.

f. **Harm financial well-being.** Individuals without health insurance have a more difficult time paying their medical bills and, at least in part as a result, have a worse financial health overall than those with coverage. Medicaid promotes self-sufficiency by providing workers with access to preventive health services so they can stay healthy and remain on the job. As stated above, most of these individuals are not offered employment-based health insurance, and it is cost prohibitive for the few who are. Medicaid provides an affordable alternative and in doing so, improves health, allows individuals to work regularly and reduces absenteeism. Numerous studies document the positive effects that the Affordable Care Act (ACA), and particularly Medicaid expansion, has played in improving financial well-being of previously uninsured individuals. Notably, financial security and self-sufficiency are improved when a person is able to pay their medical bills and Medicaid coverage puts full payment within reach for many.[10] Other studies have shown that insurance coverage results in higher credit scores, lower medical debt, and reduces the probability of new bankruptcy filings.[11]

If immigrants are forced to choose between health coverage and improving their immigration status, they will drop health coverage. Dropping health coverage reduces health status and the ability to work. This impact will permeate immigrant communities by reducing provider

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[8] Coughlin, Teresa A. "Uncompensated care for the uninsured in 2013: A detailed examination." (2014). https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

[9] Tipirneni, Renukha et al. 2017. "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches." Institute for Health Care Policy & Innovation, University of Michigan. http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

[10] Hu, Luojia and Kaestner, Robert and Mazumder, Bhashkar and Miller, Sarah and Wong, Ashley, The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing (2016-09-21). FRB of Chicago Working Paper No. WP-2016-10. Available at SSRN: https://ssrn.com/abstract=2857533
Baicker, Katherine, et al. 2013. "The Oregon Experiment – Medicaid's Effects on Clinical Outcomes." New England Journal of Medicine 368, no. 18: 1713□1722. https://www.nejm.org/doi/full/10.1056/NEJMsa1212321
Institute of Medicine. 2003. *Hidden Costs, Value Lost: Uninsurance in America.* Washington, DC: The National Academies Press. https://doi.org/10.17226/10719.

[11] Antonisse, L., et al. "The effects of Medicaid expansion under the ACA: updated findings from a literature review. San Francisco (CA): Henry J. Kaiser Family Foundation; 2018 Mar. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

payments and increasing uncompensated care as individuals wait longer to seek care during a health crisis, leading to more costly services. State and local public health programs and community health centers will withstand significant financial strain as immigrants rely on these services instead of Medicaid.

g. **Create barriers to HIV and hepatitis prevention and care.** The proposed rule also would undermine the State's approach to combating HIV/AIDS and hepatitis C. New York has made great strides towards ending the AIDS and hepatitis C epidemics in the state. The care and treatment of persons living with HIV leads to viral suppression, which improves health and prevents transmission of HIV. The care and treatment of persons at risk for HIV with pre-exposure prophylaxis (PrEP) prevents acquisition of HIV. Hepatitis C is curable with new direct acting antivirals.

   The proposed rule would threaten public health by creating barriers to HIV and hepatitis prevention and care services. The proposed rule would prevent the State from achieving its public health goals of ending AIDS and eliminating hepatitis C because it creates a disincentive for vulnerable populations to access basic health care. The rule would mean that accessing healthcare could jeopardize a person's U.S. residency status. Accordingly, the proposed rule would lead to increased transmission of communicable disease and would jeopardize the community health in entirely unnecessary ways. The administration should weigh the serious public health consequences of punishing individuals for accessing prevention, care, and treatment.

Impact on Health Care Providers

h. **Reverse recent reductions in uncompensated care.** This policy will increase the number of uninsured New Yorkers, which in turn increases the fiscal and human costs of uncompensated care across the state. Since implementation of the ACA, New York has drastically decreased the number of uninsured people in the State. New York hospitals have reported a dramatic decrease in self-pay hospital utilization because patients have gained insurance - a usual source of payment. New York State Institutional Cost Reports show a 23% reduction in self-pay hospital emergency room visits, a 40% reduction in self-pay inpatient services and a 17% reduction in self-pay outpatient visits. Having a usual source of payment for patients reduces the risk of uncompensated care costs.[12] The proposed rule would endanger these usual sources of payment and the benefits that come with having a regular and reliable source of payment for healthcare costs.

i. **Endanger hospitals' financial health.** Reducing the number of insured patients will weaken the improved financial footing hospitals have experienced since the implementation of the ACA's Medicaid Expansion. A recent study found that Medicaid expansion was associated with fewer hospital closures and stronger hospital financial performances,

[12] Declaration of Dr. Howard A. Zucker ISO Motion to Intervene of State of California, et al., (18-cv-167), April 6, 2018.

particularly in rural areas with higher rates of uninsured adults.[13] The contraction of coverage that is likely to result from implementation of this rule could result in more hospital closures, particularly in rural areas.

j. **Increase labor shortages.** The health care industry may also face a labor shortage as a result of the proposed rule. Nursing homes and home health agencies employ many immigrants with few employer benefits. Making it more difficult for immigrants to enter and remain in the country will negatively impact the labor force of the health care industry.

Impacts on the State

k. **Increase administrative burdens.** The proposed rule will require the NY State of Health, the state's insurance marketplace, to make changes to its online eligibility platform and consumer notices to ensure immigrant applicants are informed of the potential risk applying for health insurance may pose to their immigration status. Federal law requires the health insurance Marketplaces to first determine Medicaid eligibility for anyone applying for subsidized health insurance coverage. This means all applicants for Marketplace programs, including individuals seeking to apply for enrollment in the Children's Health Insurance Program, the Basic Health Program or a Qualified Health Plan with an Advanced Premium Tax Credit (APTC), must first be determined ineligible for Medicaid before they may be found eligible for the other programs. As such, the state's information technology system is currently set up in such a way that a Medicaid application is a threshold requirement, before applications for other programs are permitted. Changing this platform would be tremendously costly for the State, and would take a long time to implement.

   Marketplaces are legally constrained from only determining eligibility for a particular coverage program, and must evaluate eligibility for all potential subsidized programs, including Medicaid. Even if federal law is changed such that determining Medicaid eligibility is no longer required prior to determining financial assistance for other health insurance benefits offered through health insurance Marketplaces, modifying information technology systems to allow immigrants not to apply for Medicaid will be cost prohibitive.

l. **Increase public health concerns.** Including Medicaid as a public benefit for purposes of a public charge determination is likely to force individuals to choose between getting necessary care or having Medicaid enrollment risk a public charge determination. Lack of primary care not only jeopardizes long-term health, but also can put entire populations at risk. For example, if immunizations are skipped the spread of communicable diseases can increase.

[13] Lindrooth, Richard C., et al. "Understanding the relationship between Medicaid expansions and hospital closures." *Health Affairs* 37.1 (2018): 111-120. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976

III. COMMENTS AND RECOMMENDATIONS ON SPECIFIC SECTIONS OF THE PROPOSED RULE

DHS asks for specific comments on sections of the proposed rule. NYSDOH's responses to these requests are below.

a. Proposed Rule Section V(B)(2)(a): Types of Public Benefits

i. Proposed Rule

DHS analyzed certain data detailing the participation rates for various cash and non-cash public benefits programs and the results conclude that receipt of non-cash benefits is more prevalent than cash benefits, regardless of a person's immigration status or citizenship. DHS seeks comments on the use of its data and the availability of alternative data sources.

ii. NYSDOH Comments

The proportion of Medicaid beneficiaries who are receiving cash assistance is about 20%. With expanded Medicaid coverage and enrollment through Health Insurance Marketplaces established under the ACA, many people may be determined to be Medicaid eligible and offered Medicaid coverage, even if their intention was not to seek a public benefit. The fact that these enrollees are not seeking cash programs indicates that they are financially self-sufficient. It also indicates that they do not have access to employer based health insurance or other affordable health insurance.

iii. NYSDOH Recommendation

The plain meaning of the data presented by DHS is that many more people need non-cash benefits than cash assistance. Many studies pre-and post-ACA have determined health insurance is unaffordable to many low-wage workers. Expanded Medicaid eligibility filled that gap and the coverage gains should not be erased by using data in a way that was not intended.

b. Proposed Rule Section V(B)(2)(b): Consideration of Monetizable and Non-Monetizable Public Benefits

i. Proposed Rule

The proposed rule categorizes public benefits as either "monetizable" or "non-monetizable" and sets forth durational and monetary thresholds, which vastly depart from the standard set forth in the 1999 INS proposed rule and Field Guidance, which define "primarily dependent" on public benefits, as an individual for whom public benefits represent more than 50% of their income and support.

The rule proposes to consider receipt of monetizable benefits where the cumulative value of one or more benefits exceeds 15% of the Federal Poverty Guidelines (FPG) for a household of one within a 12-month period based on the per-month FPG for the months during which the benefits are received. For receipt of non-monetizable benefits, the rule proposes to consider benefits received for more than 12 months in the aggregate within a 36-month period. If an individual

receives a combination of monetizable benefits equal to or below the 15% threshold together with one or more non-monetizable benefit, the threshold for duration of receipt of the non-monetizable benefits would be 9 months (as opposed to 12 months) within a 36-month period.

ii. NYSDOH Comments

The existing public charge standard of "primarily dependent" (i.e. more than 50% of a person's income and support comes from public benefits) more closely aligns with other federal and state agency definitions of "dependence" than the proposed "threshold" rules for use of monetized and non-monetized benefits. Studies demonstrate that poor health among the uninsured correlates with higher rates of unemployment, absenteeism and lower rates of job retention.[14] Health coverage contributes to better health status and self-sufficiency and should constitute a positive factor in determining whether someone is likely to become a public charge. Enrollment in subsidized health coverage - whether Medicare, Medicaid, or other health coverage programs - does not demonstrate a likelihood that someone will require cash assistance or other welfare benefits.[15]

iii. NYSDOH Recommendation

NYSDOH strongly recommends that no changes be made to the existing public charge standard as the 50% threshold more closely aligns with other federal and state agency definitions of "dependence" than the proposed "threshold" rules for use of monetized and non-monetized benefits. Further, the proposed threshold is a complicated approach which will likely result in

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[14] When factors related to finding employment, work absenteeism, and job loss were assessed, significantly higher rates of health-related (own, child's, and other family member) and child-care–related barriers were reported for most measures among those not currently working. Specifically, compared with employed women, significantly more women not currently employed reported that they experienced difficulty finding work owing to their own health (36% vs. 64%), their child's health (44% vs. 56%), and lack of child care (38% vs. 62%). Similarly, greater job loss among currently unemployed women was associated with their own health (34% vs. 70%), their child's health (43% vs. 57%), the health of another family member (38% vs. 62%), and lack of child care (41% vs. 59%). Moreover, examination of the effect of these barriers to finding work showed that rates of barriers regarding child health (72% vs 34%), mother's own health (42% vs 20%), the health of other family members (30% vs 15%), and child care (58% vs 40%) were twice as high among those who had wanted or tried to work in the previous 3 years but had not been able to do so as among those who were currently employed or who had been employed within the past 3 years (data not shown). AJPH, Welfare to Work? Impact of Maternal Health on Employment Diana RomeroPhD, MA, · Wendy ChavkinMD, MPH, · Paul H. WiseMD, MPH, · Lauren A. SmithMD, MPH, and ·Pamela R. WoodMD

[15] In California, Medicaid covers 10 % of all full-time workers in the state and 20 % of all part-time workers. Bay Area Council Economic Institute, "Mainstreaming Medi-Cal: Investing in Patient Access, Improving Economic Productivity," June 2016, http://www.bayareaeconomy.org/files/pdf/MainstreamingMedi-Cal.pdf.; A recent study found that people in states with more generous Medicaid eligibility levels and benefits are more likely to leave a job for another position with greater growth potential. This research indicates that comprehensive Medicaid coverage can support work and help beneficiaries take advantage of promising job opportunities without worrying about losing their coverage. Ammar Farooq and Adriana Kugler, "Beyond Job Lock: Impacts of Public Health Insurance on Occupational and Industrial Mobility," NBER, March 2016

confusion as to whether the public benefit recipient is close to reaching these threshold limits. The 50% threshold is a clear, established standard that individuals can more easily adhere to.

c. Proposed Rule Section V(B)(2)(f): Unenumerated Benefits

i. Proposed Rule

DHS seeks comment as to whether the list of public benefits designated in this proposed rule should be expanded to include additional benefits other than those proposed.

ii. NYSDOH Comments

NYSDOH strongly believes the newly expanded public benefit programs included in this proposed rule are overly expansive and will likely cause irreparable harm.

iii. NYSDOH Recommendation

NYSDOH strongly recommends no changes be made to the current language set forth in the Field Guidance, which only allows the receipt of public cash assistance for income maintenance or institutionalization for long-term care to be considered in a public charge determination.

d. Proposed Rule Section V(B)(2)(g): Request for Comment Regarding the Children's Health Insurance Program (CHIP)

i. Proposed Rule

DHS seeks comment as to whether the Children's Health Insurance Program should be included as a public benefit in the final rule.

ii. NYSDOH Comments

NYSDOH strongly believes the Children's Health Insurance Program should not be included as a public benefit in any public charge determination.

The group of children enrolled in New York's Child Health Plus (CHPlus) program who would be impacted if the Children's Health Insurance Program (CHIP) is added to the list of public benefits in a public charge determination, are certain lawfully residing children who receive coverage because New York chose to take up a federal option.

Pursuant to a federal option under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states were given the option to cover certain pregnant women and children lawfully residing in the U.S. through their Medicaid and CHIP, if otherwise eligible. If states chose to adopt this provision, they were required to do so for both their Medicaid and separate CHIP programs. At that time, states were specifically informed the cost of Medicaid or CHIP for this population would not be considered "as an unreimbursed cost associated with the 'public charge' provisions." (SHO# 10-006, CHIPRA #17). New York State pursued this option and began covering immigrant pregnant women and children through its Medicaid and CHIP programs, and is locked into that option due to maintenance of effort (MOE) provisions.

The MOE provision requires states to maintain Medicaid and CHIP eligibility standards, methodologies, and procedures for children no more restrictive than those in effect on March 23, 2010. The MOE requirement was first implemented under the American Recovery and Reinvestment Act (ARRA) and extended by the ACA. Section 3002 of the HEALTHY Kids Act extends the MOE requirements for children in CHIP and Medicaid through Federal Fiscal Year (FY) 2023, and Section 50101 of the ACCESS Act extends the MOE requirements for children in CHIP and Medicaid through FY 2027. Due to the CHIP MOE, New York cannot reverse the option to allow pregnant women and children to purchase coverage through the Marketplace, instead of enrolling in Medicaid or CHIP.

If the regulations are finalized with the definition of public charge broadened to include Medicaid, the Trump administration should allow states to reverse the option to cover children and pregnant women in CHIP and Medicaid and allow that population to purchase health insurance through the Marketplace.

States may not have selected to adopt this option if they felt that it was putting children and families in jeopardy. Other children enrolled in CHIP would not be impacted as they are exempt from these regulations.

Children are a vulnerable population. Without health insurance coverage, they are less likely to have a regular medical provider and seek preventive health care. Children that are sick will likely put off receiving care until their condition becomes more serious. They may also seek care in a setting that is costlier, such as a hospital emergency department. This will put a strain on the hospital financing system. The CHPlus program has made significant strides in reducing uncompensated care and improving health outcomes. For children to become self-sufficient as adults, they need to have a healthy start in life. If children are sick, they are unable to attend school which will ultimately impact their education and long-term productivity. In addition, children who are not seeking medical care may negatively impact other children they are going to school with by spreading illness and disease. Extending this provision to CHIP would harm all children, not just those directly impacted by the regulation.

iii. NYSDOH Recommendation

NYSDOH strongly recommends against including CHIP as a public benefit in a public charge determination. As a nation, we should seek to provide health insurance to all children within our borders.

e. **Proposed Rule Section V(B)(2)(h): Request for Comment Regarding Public Benefit Receipt by Certain Alien Children**

i. Proposed Rule

DHS seeks comment on ways in which to administer public charge determinations for individuals who received public benefits while under the age of majority.

ii. NYSDOH Comments

There is evidence that children with health insurance are more likely to have routine health care, improved health outcomes, and improved success in education. In New York, the proposed regulation principally affects children and pregnant women. As such, it would penalize young adult immigrants for benefits they used as children. According to research presented in "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Health Insurance Expansions,"[16] access to health coverage through Medicaid leads to better long-term outcomes not only in health but in education and employment. Vulnerable populations are exempt from the public charge regulations. Children and pregnant women are also vulnerable populations and should be exempt from the regulations based on the same rationale.

iii. NYSDOH Recommendation

NYSDOH strongly recommends pregnant women and children be exempt from the public charge determination.

f. Proposed Rule Section V(B)(2)(i): Request for Comment Regarding Potential Modifications by Public Benefit Granting Agencies

i Proposed Rule

DHS seeks comment regarding the potential modifications to enrollment processes and/or program documentation that agencies may implement if the proposed rule is finalized; including how long it would take to make such modifications and the resources required.

ii NYSDOH Comments

Individuals should not be penalized or otherwise subjected to a "public charge" determination as a result of applying for health coverage through a federal or state Marketplace. Marketplaces are required by federal law to first determine potential Medicaid eligibility for anyone applying for subsidized Marketplace coverage, including where an individual may only be seeking enrollment in a program such as the Children's Health Program or enrollment in a Qualified Health Plan with an Advanced Premium Tax Credit (APTC). Marketplaces are legally constrained from only determining eligibility for a particular coverage program, and must evaluate eligibility for all potential subsidized programs, including Medicaid. Moreover, potential eligibility for coverage cannot under any circumstances constitute "receipt" of a public benefit for purpose of application of a public charge determination.

iii. NYSDOH Recommendation

NYSDOH strongly recommends no change to the definition of public charge as it appears in the 1999 Field Guidance. Even if federal law is changed such that Medicaid eligibility is no longer required prior to determining financial assistance for health insurance benefits through health insurance Marketplaces, the cost of modifying information technology systems to allow immigrants not to apply for Medicaid will be prohibitive.

[16] Cohodes, Sarah R., et al. "The effect of child health insurance access on schooling: Evidence from public insurance expansions." *Journal of Human Resources* 51.3 (2016).

g. Proposed Rule Section VI(A)(4)(c): Transfer Payments and Indirect Impacts of Proposed Regulatory Changes

i. Proposed Rule

DHS recognizes that the proposed rule may result in indirect impacts not yet anticipated, therefore the Department seeks comment on other potential consequences that may occur if the proposed rule is finalized.

ii. NYSDOH Comments

Federal law currently requires all applicants for health insurance to be determined ineligible for Medicaid before they can be assessed for any other health insurance affordability program that they may be entitled to under federal law. It is impossible to determine the impact of the proposed regulatory changes by DHS on states given the current federal rules. To eliminate any potential harm to immigrant applicants who could be impacted by the DHS proposed rule, health insurance marketplaces would have to remove the required Medicaid determinations from the application system. This would be a major systems overhaul and would require changes to federal law and guidance before states could accurately estimate cost.

IV. CONCLUSION

The public charge rule as proposed would negatively impact public health and public policy in New York State. Legal immigrants and their families would be deterred from pursuing and using public benefits they are eligible to receive under federal law, causing detrimental and far reaching effects as discussed above.

NYSDOH strongly opposes the proposed changes and recommends the proposed rule be withdrawn.

We thank the Department for this opportunity to comment.