America's Health Insurance Plans
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December 7, 2018

Ms. 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

Via email to www.regulations.gov

Re: DHS Docket No. USCIS–2010–0012 "Public Charge" Proposed Rule

Dear Ms. Deshommes:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on the Department of Homeland Security's (DHS) Notice of Proposed Rule Making (Proposed Rule), Docket No. USCIS–2010–0012, published in the *Federal Register* on October 10, 2018.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. AHIP and our members are committed to improving and protecting the health and financial security of American consumers, families, business, communities and the nation, and we stand ready to work with DHS, Congress and the Administration toward achieving those goals.

DHS proposes, among other actions, to expand the types of public benefits that are considered in public charge determinations conducted in immigration proceedings for lawfully present immigrants. Currently, the types of public benefits counted in public charge determinations include cash benefits, such as Supplemental Security Income (SSI), Temporary Aid for Needy Families (TANF), and Medicaid coverage of institutional long-term care/nursing home care. We are concerned that the Proposed Rule would expand that list to include use of Medicaid and Medicare Part D low income subsidies (LIS).

Further, DHS seeks comment on whether to include the Children's Health Insurance Program (CHIP) on the expanded list.

The Proposed Rule would effect a fundamental change in the way that the "public charge" ground of inadmissibility is administered. Traditionally, the analysis has focused on whether a person would be or become primarily dependent upon public benefits. However, under the Proposed Rule, the U.S. Citizenship and Immigration Services within DHS would instead find a person to be inadmissible if the individual has accepted a minimal disqualifying sum of public benefits with the trigger set at an especially low level—only 15 percent of Federal Poverty Guidelines (FPG) for a household of one.

AHIP and its members have serious concerns about these proposed changes, which would impact hardworking Americans and legally present immigrant individuals, as well as their families. Based on our industry's experience, we believe such changes would have serious negative consequences for public health and the U.S. economy, including: sicker people, including seniors and children; weaker communities, resulting from sicker populations and weakened hospital systems; weaker American businesses, resulting from a sicker employee base; and higher taxes, as federal and state costs increase for emergency care and premiums go up for everyone. Moreover, the Proposed Rule includes only a basic economic analysis of the impact of the major changes proposed by DHS. Changes of this magnitude hold the strong potential for unanticipated negative consequences—especially if carried out without the necessary level of economic analysis—and we are concerned this Proposed Rule presents just such a risk.

For these reasons, we recommend that DHS should <u>not</u>:

- Include use of Medicaid or Medicare Part D LIS as negative factors in public charge determinations.
- Include use of the Children's Health Insurance Program in public charge determinations.
- Consider premium tax credits for purchasing individual market coverage in a public charge determination (following DHS' broader question about factors that may be considered in public charge determinations).

Our concerns about this Proposed Rule are outlined in more detail in the attached, and include:

- **The Proposed Rule is inconsistent with the nation's goal of encouraging a healthier population.** In November 2017, Alex Azar, Secretary of Health and Human Services (HHS), noted that "The mission of HHS is to enhance and protect the health and the well-being of all Americans, through programs that touch every single American in some way, every single day." The Proposed Rule would discourage people from obtaining the health coverage they are legally permitted to receive. Health coverage increases access to care, helps people maintain their overall health and improves outcomes for those with chronic conditions. Discouraging people from getting covered conflicts with a core national priority of improving health by increasing access to health care.

- **The Medicaid and Medicare Part D LIS provisions in the Proposed Rule would result in poorer health outcomes and increases in costly and uncompensated care in the most expensive settings.** The Proposed Rule would cause many vulnerable Americans, including seniors, pregnant women, and children to avoid obtaining health coverage and seek care only when an emergency develops. This would reduce their use of necessary preventive and primary care services, vaccines, and prescription drugs. The result would be poorer health outcomes and greater reliance on costly emergency room and hospital services. It would also likely force providers to deliver more uncompensated care, weakening doctors and hospitals, which are essential to the health of every community, particularly in our nation's rural areas.

- **While the Proposed Rule asserts its provisions simply govern decisions relating to the admissibility of foreign nationals, all Americans would bear the burden of poorer health and less cost-effective care.** The cost analysis presented in the Proposed Rule only accounts for costs to the Federal Government related to immigration processes. As a result, we believe this analysis falls short and paints an incomplete picture by not accounting for the myriad downstream financial and economic effects across the health system caused by less efficient use of health care resources and across the broader economy. We identify a number of these costs, including increased costs for states, higher health insurance premiums for American citizens and businesses, and adverse financial impacts on health care providers in our detailed comments.

We also note a range of other impacts not considered in the Proposed Rule, such as new implementation costs for states and the loss of state autonomy and flexibility in structuring health programs for their residents.

Thank you for the opportunity to comment on the important issues raised in the Proposed Rule. We would welcome the opportunity to discuss our comments with DHS and please do not hesitate to contact us if we can provide any clarifying information or answer any questions.

Sincerely,

Keith Fontenot
Executive Vice President of Policy and Strategy

Attachment

ATTACHMENT
Detailed Comments

I. Background on Health Coverage

Comprehensive health coverage ensures that people have access to health care, including doctor or emergency room visits, prescription drugs, routine vaccinations and tests, surgeries, and mental health care. Different types of health care coverage include Medicaid, Medicare, employer-provided insurance, and coverage that people buy on their own through the individual insurance market.

All health insurance, generally, works the same way. People pay into a health plan or program – either by paying an insurance premium, or through the investment of tax dollars. Those funds are "pooled" to pay for the medical care that all the people in the coverage group actually receive. Healthier people in the coverage group contribute to the pool but use fewer expensive medical services, and their contributions lower the cost of coverage for everyone in the group. By sharing risk and costs in this way, health coverage and federal health programs enable Americans to obtain routine preventive and primary care and protect them from medical costs that would otherwise create severe financial hardship or leave them without access to care.

Existing federal law[1] requires hospitals to provide emergency care regardless of a person's health coverage or ability to pay the bill. When people without health coverage receive emergency services, the costs incurred are typically much higher than if the person had health coverage and had received preventive or primary care in lower-cost settings. These individuals are rarely, if ever, able to pay those expenses. As a result, to ensure the health system remains financially viable, those costs are typically passed on to other participants in the health system in the form of higher prices for health care services. Therefore, the more people who have health coverage, the more our communities, hospitals, and families can enjoy improved health as well as financial stability. If fewer legally present immigrants obtain health coverage, they are more likely to resort to emergency care, increasing costs for all American taxpayers and patients (see *Section IV).*

[1] 42 U.S. Code § 1395dd; added by the *Emergency Medicaid Treatment and Labor Act of 1986* (EMTALA)

II. The Proposed Rule Would Reduce Health Coverage

As a matter of immigration law, we understand that public charge determinations will generally not apply to certain groups of people who legally are able to obtain Medicaid or Part D low income subsidies. This group would include most immigrants who already have obtained "green cards," as well as people who enter the country through certain pathways, such as asylum seekers and refugees.

However, many other Medicaid-eligible people would be subject to the Proposed Rule, including pregnant women and children in other immigration categories that states have chosen to include in Medicaid as permitted by federal law.

We also have serious concerns that the proposed regulation's impact would discourage other people from getting health coverage. Our nation's immigration laws, regulations, systems, administrative processes, and forms are complex, having developed and evolved over decades to address a variety of historical, social, military and migratory events and circumstances. And like our immigration system, the American health care system—and public health programs like Medicare and Medicaid in particular—is quite complex.

The challenges that would be created by the Proposed Rule are especially daunting for lawfully present immigrants who must navigate and make decisions across the health and immigration systems. The confusion and uncertainty among lawfully present immigrants surrounding the Proposed Rule would result in a significant "chilling effect" on enrollment in Medicaid and other forms of health coverage by many immigrants deciding to forego coverage to protect their chances of staying in America.

There is precedent that demonstrates that such a "chilling effect" is likely. Studies show that changes resulting from the welfare reform law in the 1990s reduced the use of public benefits by people who technically were not subject to the law, but nevertheless chose to forego benefits because of confusion and uncertainty.[2] DHS does not provide data or examine the scope of these

[2] 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.

potential chilling effects and, as such, likely does not accurately consider the Proposed Rule's actual economic effects.

Indeed, such a "chilling effect" is already being observed. Based on feedback from our members, some health insurance providers are already receiving calls asking about the Proposed Rule as their enrollees consider whether to forego health coverage because of the perceived risk to their immigration status. Some insurance providers already have data showing reductions in enrollment and utilization of health care as a result of the Proposed Rule. This includes U.S. citizens who have legally present immigrant family members, even though the Proposed Rule provides that use of benefits by citizen children should be disregarded for purposes of determining whether an immigrant parent is or would become a public charge.

III. Effects on Public Health

For many years, our nation's health policy has been informed by research and evidence that encourages better health through regular preventive care; continuity of care; and identification and management of diseases in their early stages before they become more serious, difficult, and expensive to treat.[3] Medicaid is essential in ensuring that low-income people have access to these preventive and primary care services to keep them healthy, such as prenatal care, well-child check-ups, and recommended vaccinations. In addition, screening and treatment programs run by Medicaid health plans help identify and manage diseases in their early stages before they become more serious, difficult, and expensive to treat.

- By discouraging enrollment in Medicaid (or encouraging enrollment only when an emergency arises), the Proposed Rule would cause people to forego health coverage and postpone necessary care. The likely outcome would be sicker babies and children, and more people experiencing a worsening of their health conditions. This will lead to more people seeking far more expensive care in emergency rooms and hospitals.

  For example, pregnant women who are lawfully present immigrants may decide against enrolling in Medicaid out of fear of jeopardizing their immigration status, regardless of whether the Proposed Rule

[3] Freundlich N, *et al.* "Primary Care: Our First Line of Defense"; Commonwealth Fund, Jun 2013; accessed 11/16/2018 at https://www.commonwealthfund.org/publications/publication/2013/jun/primary-care-our-first-line-defense

applies to their specific circumstances. Some of those women would experience pregnancy complications that require advanced care and hospitalizations that could have been avoided with proper prenatal care. Further, some newborn children would experience low birth weight or other neonatal complications that will require neonatal intensive care unit services and result in them being enrolled in Medicaid after birth. In both cases, these kinds of avoidable complications ultimately would increase costs for providers, Medicaid, and taxpayers.

- Many lawful immigrant parents would avoid seeking preventive care for their children, resulting in fewer receiving necessary vaccinations, well-child checkups, and primary care for minor illnesses and infections. During childhood, the Centers for Disease Control recommends children receive a series of vaccinations for 14 different infectious diseases, including flu, measles, mumps, and chicken pox.[4] Vaccinations are highly effective in preventing these illnesses. However, if parents avoid enrolling their children in Medicaid because of this Proposed Rule, the incidence of these easily preventable diseases will rise, affecting all Americans, immigrants and citizens alike.
- During well-child visits, pediatricians examine children for signs of a host of physical and development abnormalities, such as anemia, lead poisoning, obesity, autism, and behavioral disorders. The Proposed Rule would discourage lawfully present immigrant parents from enrolling in Medicaid or other health programs to get primary care services for their children, inevitably driving up health system costs when children manifest full-blown diseases and need more advanced and expensive care.

Inadequate use of available health care resources would have other collateral impacts beyond health. For example, undiagnosed/untreated learning disabilities would stifle educational achievement, harm job prospects, and potentially increase crime. These consequences affect the stability of families, communities, and businesses. All Americans would pay the price, not just immigrants to whom the Proposed Rule is directed.

IV. Financial and Other Impacts of the Proposed Rule

DHS does acknowledge in its impact statement that the Proposed Rule could increase rates of poverty among lawfully present immigrant families. It notes

[4] https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf; accessed 11/12/2018

that lawfully present immigrants who decide to forego benefits could experience adverse health effects, losses in productivity, increased medical expenses resulting from delays in seeking health care, and reduced educational achievement. However, DHS should also consider the extent to which the burdens of these higher costs are shifted to all American citizens, and stakeholders like hospitals, employers, and state governments.
When people lack health coverage and avoid seeking preventive and primary care, emergency care becomes the only option to take care of conditions that could have been treated earlier, effectively, and less expensively in primary care settings. Emergency rooms are required by federal law to treat patients experiencing emergencies under the Emergency Medical Treatment and Active Labor Act (EMTALA). That statutory requirement would not be changed by the Proposed Rule.

And when people forego preventive and primary care only to obtain emergency care later for their conditions, two scenarios would likely play out: 1) Some people would be enrolled in Medicaid to cover their emergency care, but at increased costs to state and federal governments because the acute specialty and hospital care they receive is much more expensive than primary care would have been. 2) Other people might not enroll in Medicaid to cover their care, but hospitals would still be obligated under EMTALA to provide necessary care, even though they would not be paid by Medicaid or other insurance. The adverse impacts of such developments would be significant:

Medicaid Costs
When people defer primary care for routine conditions and later access care in more complex settings like emergency rooms, costs inevitably increase. With respect to differences in the costs of care delivered in different settings, one study found that up to 27 percent of emergency room visits could be handled in primary care settings, with a potential cost savings of more than $4 billion annually.[5] Additionally, it costs a health insurance provider about $12,000 annually to cover preventive and primary services for an adult with well-controlled diabetes. However, if that person's diabetes becomes uncontrolled due to a lack of monitoring or failure to take maintenance medications, costs of their care can escalate to more than $100,000 annually.[6] Multiply these

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[5] Weinick, RM, *et al;* "Many emergency department visits could be managed at urgent care centers and retail clinics"; *Health Affairs*, Sep 2010; accessed 11/16/2018 at https://www.ncbi.nlm.nih.gov/pubmed/20820018/

[6] Freundlich N, *et al.* "Primary Care: Our First Line of Defense"; Commonwealth Fund, Jun 2013; op. cit.

financial impacts by thousands of lawfully present immigrants deferring preventive and primary care and the result would be billions of dollars of excess costs for our health system each year. These results will accrue as a direct and indirect result of the Proposed Rule, but DHS has not quantified those effects or considered them in light of the Proposed Rule's benefits.

Federal Budgets

The Medicaid program is a state/federal partnership, which means that higher costs impact both states and the federal government. On average, the federal government pays about 57 percent of the costs of the Medicaid program, with states paying the remainder from state budget funds.[7] DHS should take into account that the Proposed Rule would actually increase federal Medicaid expenditures for the federal Department of Health and Human Services.

Health Insurance Premiums for American Citizens

Studies demonstrate that, as a group, immigrants covered by employer-sponsored health plans pay more into the health care system than they use in health care, essentially subsidizing coverage for American citizens.[8] When individual immigrants with health coverage do use services, their coverage ensures that doctors and hospitals are paid for the care they provide and those immigrant patients can stay healthy, continue working to support their families, and contributing to our national economy.

The Proposed Rule's Regulatory Impact Analysis estimates reductions of $9.65 billion in federal Medicaid matching funds over 10 years, due to a reduction in annual enrollment of more than 295,000 individuals. If the Proposed Rule is finalized as proposed, the "chilling effects" likely would extend well beyond Medicaid to other health coverage programs, with the potential that hundreds of thousands of immigrants ultimately will forego coverage. Without the contributions made by those immigrants to the system, both through taxes and payment of health insurance premiums, premiums can be expected to rise for Americans who rely on that coverage. The Proposed Rule neither mentions nor considers these costs to U.S. citizens in its economic analysis.

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[7] https://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/; accessed 11/12/2018

[8] J. Stimpson, *et al;* "Trends in Health Care Spending for Immigrants in the United States"; *Health Affairs*, March 2010; accessed 11/16/2018 at https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0400

State Budgets and Operational Considerations

If lawfully present immigrants decide to forego Medicaid coverage, states would experience significant reductions in direct Medicaid payments. Compounding reduced Medicaid enrollment, a considerable number of people who forego routine primary care would develop severe illnesses and medical conditions that require advanced treatment in emergency rooms and hospitals. For such individuals that enroll in Medicaid for their acute illness, both federal and state Medicaid expenditures would increase unnecessarily. And as noted earlier, some people would be treated without Medicaid coverage, placing the additional financial burden on state or local government budgets.

State and local governments would also experience costs in adapting and reworking their Medicaid information systems to support data exchanges envisioned by the Proposed Rule. We are not aware of any additional federal appropriation or funds tied to the Proposed Rule that would reimburse states for making these infrastructure changes, raising the possibility that the Proposed Rule may effectively act as an unfunded mandate on state governments and taxpayers. In the absence of federal funding to ensure that states can provide the kinds of information DHS would rely on in making determinations, it is very doubtful that the savings DHS anticipates from "reductions in transfer payments" could possibly materialize.

State Autonomy

The Medicaid program was designed by Congress to allow states to administer the program in a manner that best accommodates local needs and circumstances. States make specific decisions to design and deliver Medicaid services that ensure public and rural hospitals can remain open to serve all their residents. They structure eligibility policies so any pregnant woman can receive recommended prenatal care, and parents can send their children to school knowing that proven public health approaches for preventing serious childhood illnesses are in place.

The Administration prioritizes state autonomy and flexibility in health programs. Recently, the Department of Health and Human Services implemented several policies, such as promoting state flexibility on Medicaid work and community engagement requirements and new flexibility for state relief and empowerment waivers under section 1332 of the Affordable Care Act. The goal of these policies to empower states to design health programs for their residents, including legally present immigrants, would be undermined if DHS finalizes a rule that diminishes states' flexibility.

Health Care Providers

As a result of lawfully present immigrants foregoing care, many health providers—including physicians, outpatient clinics, federally qualified health centers, hospitals, and pharmacies—would see reductions in Medicaid-funded patients and revenues. DHS explicitly acknowledges this result in the Proposed Rule's executive summary. In effect, the "reduction in transfer payments" that DHS anticipates will come at direct costs to health providers, who will be required by law to continue providing services even to those who have foregone health coverage.

For those individuals who later develop more severe or advanced illnesses, the costs fall on acute care providers, especially safety-net providers like emergency rooms and hospitals, many of which are operated by local governments. As was noted earlier, for those who are not enrolled in Medicaid, many providers would be forced to absorb those costs as charity care or uncompensated care. While this would impose a financial hardship on providers in the short run, some of the uncompensated care incurred by hospitals later would be reimbursed by the federal government in the form of Medicare and Medicaid "disproportionate share hospital" or "DSH" payments.[9] This is another instance of unintended cost shifting and financial impacts that would be created by the Proposed Rule, and seriously undermines and renders illusory the anticipated savings described in the Proposed Rule's impact analysis.

Direct Care Service Workers

We are concerned the Proposed Rule would have significant negative downstream effects on the number and availability of direct care service workers, such as home health aides, personal care aides, and nursing assistants. Immigrants comprise a significant part of the direct care service workforce that provides personal and supportive care to older Americans and Americans with disabilities. In fact, 25 percent of the estimated 4 million direct care workers in the U.S. are immigrants, including those who work for agencies or are employed directly by their clients.[10] Further, a significant

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[9] For more information, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html and https://www.medicaid.gov/medicaid/finance/dsh/index.html

[10] Robert Espinoza, PHI, "Immigrants in the Direct Care Workforce" (Jun. 2017); https://phinational.org/wp-content/uploads/2017/06/immigrants_and_the_direct_care_workforce_-_phi_-_june_2017.pdf accessed 11/12/2018

number rely on government health programs like Medicaid and health exchanges for their own health coverage.[11]

Meanwhile, the number of people aged 65 and older and people with disabilities is increasing dramatically. One estimate found that the population in the older adult category alone will increase from 48 million in 2015 to 88 million by 2050.[12] By 2024, the Bureau of Labor Statistics estimates that one million additional direct service workers will be needed to meet demand. Yet, the supply of direct care service workers is not keeping up with demand, particularly in rural areas. The dwindling supply of workers is in part due to low wages. The Medicaid program pays for about 42 percent of long term services and supports (LTSS) in the United States,[13] including direct care services in nursing facilities and enrollees' homes.

As a result of the Proposed Rule, we are concerned that lawfully present immigrants who are direct care service workers would conclude that being in this profession would jeopardize their immigration status, whether due to receipt of Medicaid benefits or to confusion that being paid with Medicaid funds would count against them. Further, the Proposed Rule would depress the rate of legal immigration at a time when more workers are needed. Either scenario would decrease the number of direct care service workers and exacerbate the impending direct care shortage, making it more likely that older Americans and people with disabilities will have to receive care in nursing facilities instead of remaining in their homes with personal supports. Nursing facility care is more expensive than home-based care, so state and federal Medicaid budgets would be negatively impacted in this regard as well.

Health Insurance Providers

We have significant concerns that the Proposed Rule, including its chilling effect on enrollment, would significantly hurt the ability of Medicaid health plans to deliver high quality, cost-effective care. For example, uncertainty about the magnitude of impacts from the chilling effect of the Proposed Rule

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11 W. Parmet and E. Ryan; "New Dangers for Immigrants and the Health Care System" *Health Affairs,* April 2018; accessed 11/16/2018 at https://www.healthaffairs.org/do/10.1377/hblog20180419.892713/full/

12 Robert Espinoza, PHI, "8 Signs the Shortage in Paid Caregivers is Getting Worse" (Feb. 2017); https://phinational.org/wp-content/uploads/2017/11/workforce-shortages-phi60issues01.pdf accessed 11/12/2018

13 Congressional Research Service, "Who Pays for Long Term Services and Supports?" Aug. 2018; https://fas.org/sgp/crs/misc/IF10343.pdf accessed 11/12/2018

would make it more difficult for state Medicaid programs to forecast costs of care and ensure that Medicaid health plan capitation rates are actuarially sound as required by Medicaid regulations.[14]

People are enrolled in Medicaid on a monthly basis. For each month of enrollment, the health insurance provider receives a fixed capitation payment and is responsible for providing and/or paying for all the person's Medicaid benefits. A considerable portion of people who defer obtaining preventive and primary care out of concern for their immigration status would later develop more serious conditions that must be treated in more expensive settings like emergency rooms. Some percentage of these people would enroll in Medicaid for a month to have their treatment paid for and then disenroll from Medicaid.

In 2014, the national average cost per Medicaid enrollee was $5,736 per year, or $478 per month.[15] That means if deferred care results in emergency room and hospital services that cost the Medicaid health plan $25,000, for example, but it only receives $478 in capitation for the month the person is enrolled and received care, this creates a severe financial shortfall. Multiply that shortfall by potentially thousands of lawfully present immigrants and the cumulative costs are considerable. This would impact the financial viability of Medicaid health plans in the short term and increase the overall state and federal costs of the Medicaid program over the long term.

V. Application of Proposed Rule to the Children's Health Insurance Program (CHIP)

We support DHS' decision not to include CHIP on the list of public programs implicating public charge determinations in the Proposed Rule. CHIP serves as a vitally important safety net for more than 9 million children whose families have modest incomes. They depend on CHIP for health coverage and access to care it provides.

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[14] See 42 CFR 438.4, which requires states to ensure that capitation rates paid to Medicaid health plan be actuarially sound, meaning that rates are projected to provide for "all reasonable, appropriate, and attainable costs that are required under the terms of the contract" for the time period and covered populations.

[15] Kaiser Family Foundation, Medicaid Spending per Enrollee (Full or Partial Benefit) 2014; https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel= %7B%22colId%22:%22-Location%22,%22sort%22:%22asc%22%7D accessed 11/14/2018

The value of pediatric health coverage by Medicaid or CHIP is clear and compelling – children with public health coverage are more likely to have a usual source of care (97% vs. 73%), receive well-child check-ups (85% vs. 56%), and see a doctor for specialty care (13% vs. 7%) over a 12-month period, as compared with children without health coverage.[16] The same analysis found that children with CHIP or Medicaid coverage are less likely to delay or forego medical care due to cost concerns, less likely to go more than two years without seeing a doctor, and less likely to have dental needs that are not addressed due to cost concerns.

Additional research has demonstrated that CHIP and Medicaid coverage has helped achieve reductions in both avoidable hospitalizations and child mortality,[17] and that improved health among children enrolled in CHIP and Medicaid programs "translates into gains in school performance and educational attainment over the longer term, with potentially positive implications for both individual economic well-being and productivity in the overall economy".[18]

Considering the chilling effect of the Proposed Rule with respect to all children, we have serious concerns that the Proposed Rule would discourage lawfully present immigrant parents from getting their children coverage through any government funded health programs. As noted above, this would create collateral impacts on children's school performance, educational attainment, and long-term positive engagement as American workers and taxpayers.

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[16] Kaiser Commission on Medicaid and the Uninsured, "Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future," June 2016.

[17] Embry Howell and Genevieve Kenney, "The Impact of the Medicaid/CHIP Expansions on Children: A Synthesis of the Evidence," *Medical Care Research and Review 69(4),* August 2012.

[18] Kaiser Commission on Medicaid and the Uninsured, "The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" June 2014.