VIEWPOINT

The "Public Charge" Proposal and Public Health
Implications for Patients and Clinicians

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On September 22, 2018, the Department of Homeland Security (DHS) proposed a change to immigration policy that would make receipt of certain public assistance, such as health coverage through Medicaid, grounds for denying immigrants lawful permanent residence in the United States.[1] The proposed policy applies to lawfully present immigrants who hope to become legal permanent residents as well as foreign-born persons seeking to move to the United States (eg, to be reunified with family members and to work), but not to asylees (persons in the United States or at a port of entry who cannot return to their country because of persecution) or refugees (persons outside of their country of nationality who cannot return to that country because of concerns about persecution).

Requiring that persons not be a "public charge," a term used by US immigration officials for individuals considered likely to become primarily dependent on the government for subsistence, is not a new policy; it dates back to 1882. However, this policy has been previously interpreted primarily in terms of cash assistance.

> If enacted as proposed, this public charge provision could decrease access to medical care and worsen the health of individuals, threaten public health, and undercut the viability of the health care system.

The new proposal also considers noncash benefits including Medicaid, Medicare Part D prescription drug assistance, the Supplemental Nutrition Assistance Program (SNAP), and certain housing vouchers as reasons to withhold permanent residency, also known as green card status.

Direct Effects on Immigrant Families

Many immigrants in the United States are supporting themselves and their families through working low-wage jobs but depend on Medicaid for their health care or SNAP to help feed their families. Approximately 10.5 million children in families receiving such public assistance have at least one noncitizen parent.[2] Many mothers and fathers would have to choose between accepting help for basic human needs (such as food, medicine, and shelter) and keeping their families together.

The magnitude of direct effect is as yet uncertain: in the new proposal, DHS estimated that 382 600 green card applications and 517 500 applications for other types of visas would be subject to the new public charge criteria annually.[1] Immigration officials would have wide latitude in when to deem an individual a "public charge." For instance, low income, age older than 65 years, and having a health condition, but also not having health insurance, are all considered "negative factors" in the public charge determination.[1]

Indirect Effects on Immigrant Families

Even before the publication of this rule, there have been reports of immigrants avoiding health care for concern of being considered a public charge.[3] With the release of the rule, and the accompanying publicity, more immigrants are likely to avoid services because of concern about compromising their immigration status. Negative effects could reverberate beyond the population targeted by the regulation, due to complexity and confusion around precisely who will be affected, and in which programs. After the 1996 welfare reform law, for example, use of public assistance by refugees declined steeply, despite the protections for refugees incorporated into welfare reform (and refugees and asylum-seekers are also intended to be exempt in the proposed "public charge" rule).[4] Similarly, although children who were US citizens were still eligible for SNAP after welfare reform, participation among children with at least one noncitizen parent declined by 37% (from about 1 251 000 to 742 000) in the year after welfare reform was implemented.[5] As with the effect of Medicaid work requirements in some states, the indirect consequences of the "public charge" rule could result in broader disenrollment from services. Due in part to the shifting convolutions of programs targeted in various drafts of the rule, forgone services may include pediatric vaccine assistance and food support for pregnant women, even though these programs are not considered part of "public charge" in the current proposal.

Effects on Public Health

The proposed rule describes "follow-on effects" including worse health outcomes, such as an increased prevalence of obesity and malnutrition and reduced prescription adherence; increased prevalence of communicable diseases; increased rates of poverty and housing instability; and reduced educational attainment.[1] Avoiding needed health care, such as immunizations, could increase the chance of outbreaks of transmissible pathogens. Meanwhile, even as the medical community discusses how to better address social determinants

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of health like homelessness and food insecurity, the "public charge" policy would hinder uptake of proven housing and nutrition programs in a vulnerable population.

Effects on Clinicians and the Health System

Physicians and other clinicians are trusted sources of information for patients. This may be especially true for immigrant populations who are unfamiliar with the US medical system. However, if this revision to the public charge rule goes forward, it may be difficult for physicians and others to provide sound health care counsel. For example, what will physicians advise the 50-year-old woman who has a limited visa, with 2 children born in the United States, who has hypertension and type 2 diabetes? Should she forgo her oral medications, a visit to the ophthalmologist to check for retinal disease, a mammogram, and cervical cancer screening so that she can increase her chances of staying with her children? If she presents with a cough, should she be advised to go to the emergency department (because emergency services are exempted from the proposed public charge provision) and hope that emergency clinicians also titrate her blood pressure medicine? How can physicians and other health care professionals help her balance concerns about her health and her family? Can she even be advised about whether to remain enrolled in Medicaid without an immigration attorney in the room?

Patients disenrolling from Medicaid and instead having to seek care under the Emergency Medical Treatment and Labor Act (EMTALA) would be antithetical to the sound practice of medicine. In an extreme case, undocumented patients with end-stage renal disease who receive emergency dialysis have higher mortality than patients who receive scheduled maintenance dialysis.[6] At the other extreme, patients are very unlikely to receive age-appropriate cancer screening and preventive health counseling during emergency department visits.

At the system level, increased visits would further strain emergency departments with nonurgent patients. Greater numbers of uninsured patients will further shift costs of care to safety-net health systems, for which financial viability is already in peril.[7]

Looking Ahead

How should clinicians navigate these challenging circumstances with and on behalf of immigrant patients? First, clinicians should deliver a clear message that because the public charge rule is not yet final (and will not be retroactive if promulgated) patients can continue using those benefits to which they are entitled. Second, clinicians can enter into or expand medical-legal partnerships, such as with collaborative interventions that embed lawyers into health care settings to address legal issues that affect health.[8] Third, clinicians can lend their voices to the public debate around the proposed rule, particularly during the 60-day public comment period. At the end of this period, DHS must provide detailed responses to the comments it receives and may take steps to mitigate the harm related to public charge in a final version of the rule.

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and the American Psychiatric Association, collectively representing 400 000 physicians, have already released a joint statement opposing the "public charge" proposal.[9] For individual physicians, the American Medical Association Code of Medical Ethics provides 2 principles applicable to the public charge issue. "A physician shall support access to medical care for all people," and "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."[10] If enacted as proposed, this public charge provision could decrease access to medical care and worsen the health of individuals, threaten public health, and undercut the viability of the health care system.

ARTICLE INFORMATION

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