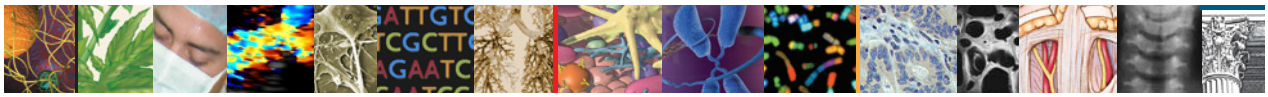

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Perspective

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A New Threat to Immigrants' Health — The Public-Charge Rule

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The United States is making major changes to its immigration policies that are spilling over into health policy. In one such change, the Trump administration is drafting a rule on "public charges" that could have important consequences for access to medical care and the health of millions of immigrants and their families.[1] The concept of a public charge dates back to 19th-century immigration law. Under current guidelines, persons labeled as potential public charges can be denied legal entry to the United States. They can also be prevented from adjusting their status from a nonimmigrant visa category (e.g., a student or work visa) to legal permanent resident status. In addition, if they become public charges within the first 5 years after their admission to the United States, for reasons that existed before they came to the country, in rare cases they can be arrested and deported. Immigrants and their families consequently have strong incentives to avoid being deemed public charges.

Current guidelines define a public charge as a person who is primarily dependent on the government for more than half of personal income. In evaluating whether a person is likely to become a public charge, immigration officials take account of factors such as age, health, financial status, education, and skills. The use of cash assistance for income maintenance (e.g., Supplemental Security Income or Temporary Assistance for Needy Families) and government-funded long-term care are considered in making these determinations.[1] Other noncash benefits such as health and nutrition programs are specifically excluded from consideration, and use of cash-assistance benefits by the immigrant's dependents is not currently factored in.

The Trump administration is proposing sweeping changes to these guidelines. A draft rule from the Department of Homeland Security (DHS) would substantially expand the definition of a public charge to include any immigrant who "uses or receives one or more public benefits." Not just cash assistance but nearly all public benefits from federal, state, or local governments would be considered in public-charge determinations, including nonemergency Medicaid, the Children's Health Insurance Program (CHIP), and subsidized health insurance through the marketplaces created

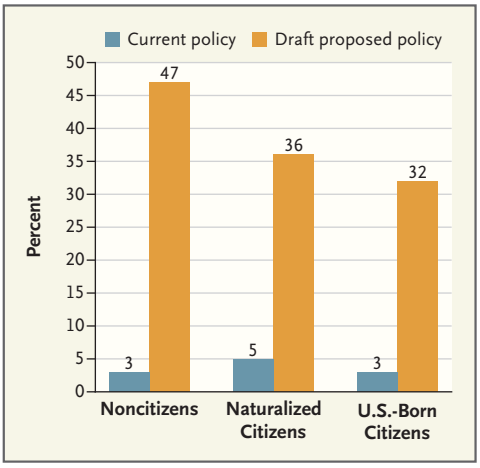

Figure 1. Percentage of Persons for Whom Benefits Use Could Be Considered in a Public-Charge Determination, 2014 through 2016.

The public benefit programs include public cash assistance or welfare from state or local welfare offices, including Temporary Assistance for Needy Families and General Assistance; Supplemental Security Income; Supplemental Nutrition Assistance Program; and Medicaid and the Children's Health Insurance Program. Adapted from Batalova et al.[2] Reprinted with permission from the Migration Policy Institute.

by the Affordable Care Act (ACA); Medicare would be excluded. The DHS draft notes that in making these determinations, "having subsidized insurance will generally be considered a heavily weighted negative factor."[1] The broadened definition of public charge would also encompass food assistance (the Supplemental Nutrition Assistance Program [SNAP] and the Women, Infants, and Children Program [WIC]), programs designed to assist low-income workers (e.g., the Earned Income Tax Credit [EITC]), housing assistance (Section 8 vouchers), and the Low Income Home Energy Assistance Program.[1] Moreover, not only immigrants' use of public assistance but use of these programs by any dependents, including U.S.-born citizen spouses and children, would also be considered. Already, the State Department has revised instructions to its officials abroad who process applications to enter the United States that incorporate this broader definition.

The potential impact of these changes is enormous. In 2016, about 43.7 million immigrants lived in the United States. If enacted, the new regulations would affect people seeking to move to the United States to be reunified with family members and to work, as well as lawfully present immigrants who hope to become legal permanent residents (green-card holders). One estimate suggests that nearly one third of U.S.-born persons could have their use of public benefits considered in the public-charge determination of a family member (Fig. 1).[2] This includes "10.4 million citizen children with at least one noncitizen parent."[3] Notably, unauthorized immigrants are not the primary target of the draft rule, since they are already ineligible for most federally funded public assistance. Instead, lawfully present immigrants would bear the brunt, as well as persons living in "mixed-status" families (those in which some members are citizens and others are not) and persons living abroad who wish to immigrate to the United States.

Research on federal welfare reform, local immigration-enforcement efforts, and state-level policies excluding immigrants from access to public services and benefits suggests that the new rule could have negative health consequences.[4] It would probably result in lower rates of health insurance coverage not only for immigrants but also for their U.S.-born children and other dependents. An estimated 19% of noncitizen adults and 38% of noncitizen children were enrolled in Medicaid or CHIP in 2016.[5] In addition, 5.8 million citizen children with a noncitizen parent received Medicaid or CHIP that year.[3] If 25% of currently enrolled noncitizen adults, noncitizen children, and U.S.-citizen children disenroll from Medicaid and CHIP — a level of disenrollment that occurred after welfare reform was enacted in 1996 — and do not obtain alternative coverage, the number of uninsured people could rise by more than 1 million. Disenrollment of these populations from subsidized ACA insurance could increase the uninsured population even more.

Furthermore, the research suggests that the new rule would probably reduce enrollment in other essential public benefits that affect health, including SNAP. An estimated 15% of noncitizen adults, 20% of noncitizen children, and 25% of U.S.-born children with noncitizen parents receive SNAP benefits.[5] A 28% decline in SNAP use for each of these populations — again, such disenrollment occurred after the 1996 welfare-reform law — would mean that more than 1 million people would lose food assistance and become food insecure. Reduced enrollment in public benefit programs will be magnified by increased fear, mistrust, and avoidance of government officials and confusion among immigrants regarding the applicability of public-charge rules. Although several categories of immigrants (e.g., refugees, asylees, and immigrants with temporary protected status) are exempt from public-charge rules, confusion regarding appli-

cability could deter even exempted immigrants from applying for essential benefits. The new policies would have a chilling effect on lawfully present immigrants' use of public programs.

Research also suggests that the regulation could result in lower rates of health care utilization and poorer health among some immigrants and their dependents.[4] Lower rates of insurance coverage would reduce the use of prenatal and postnatal care and could therefore lead to higher rates of low birth weight, infant mortality, and maternal morbidity. They might well also result in forgone preventive care such as well-child visits, routine checkups, immunizations, and cancer screenings. The effect of losses in insurance coverage on morbidity and mortality among both children and adults would only be amplified by eroding access to other benefits that affect health as well as increases in the poverty rate among households headed by noncitizen immigrants. Reductions in the use of tax credits and housing energy assistance would increase poverty rates among noncitizen immigrants, potentially pushing millions of adults and children into poverty. Poverty is a primary determinant of risk for illness and death. Numerous studies demonstrate that benefits such as EITC, WIC, and SNAP improve health throughout the life course and increase self-sufficiency in adulthood.[6]

Finally, for health care providers such as federally qualified health centers and public hospitals, the expanded public-charge rule could lead to more patients lacking health coverage and higher costs from uncompensated care. It could also create confusion among patients from immigrant families and jeopardize progress that has been made in improving access to health care among language-minority populations. If immigrants are to understand the crucial implications of the new rule, summaries of the changes and cautions would need to be disseminated through websites, public-service announcements, hotlines, and community outreach. In communicating with immigrant patients, health care providers, too, may need to explain the potential implications of the new rule.

We believe that the draft public-charge regulation represents a substantial threat to lawfully present immigrants' access to public programs and health care services. What modifications may be made is uncertain — after the rule is formally proposed, there will be a public comment period, and revisions could be made before it is finalized. But if this rule takes effect, it will most likely harm the health of millions of people and undo decades of work by providers nationwide to increase access to medical care for immigrants and their families.

Disclosure forms provided by the authors are available at NEJM.org.

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