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The Trump Administration's New Public Charge Rule: Implications For Health Care & Public Health

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Although recent discussions about the Trump Administration's immigration policies have focused on the treatment of undocumented migrants and asylum-seekers at the border and in detention, the Administration has also sought to curtail *legal* immigration and make conditions more onerous for non-citizens who are lawfully present. The most

recent example of these restrictive efforts is the long-anticipated public charge rule, which was published in the Federal Register by the Department of Homeland Security (DHS) on August 14. Unless halted by litigation, the rule will take effect on October 15, creating punishing new challenges for immigrant patients and their health care providers.

The proposed rule purports to implement a longstanding provision of the Immigration and Nationalization Act (INA) that requires most immigrants (excluding refugees, asylees, and certain other groups granted special humanitarian status), to show that they are "not likely to become a public charge," in order to gain entry into the United States or attain permanent resident status once they are here. Under a guidance issued by the Clinton Administration in 1999, the receipt of non-cash benefits, except to support institutional or long-term care, does not render one a "public charge." As a result, non-citizens who are eligible for Medicaid or other public benefits (it is worth noting that federal law already restricts many non-citizens from receiving most federal benefits) have had no cause to worry that the receipt of such benefits would undermine their chances of obtaining permanent resident status.

Since President Trump's inauguration, his Administration has sought to override the 1999 guidance. In January 2017, a draft executive order that would have required DHS to revise the definition of public charge was leaked and widely circulated. That draft was never signed, but in January 2018, the State Department revised the manual used by consular offices for issuing visas to include in the definition of public charge the use of non-cash health benefits, including Medicaid and the Children's Health Insurance Program (CHIP). That change alone has led to a significant decline in the number of visas issued.

Then in October 2018, DHS published proposed public charge regulations. Under the sweeping proposal, the definition of public charge was expanded to include receipt of certain non-cash federally-funded benefits, including Medicaid, the Supplemental Nutrition Assistance Program (food stamps), Medicare Part D subsidies, and federal housing subsidies. The complex regulations would also have required DHS to consider past use of such benefits, as well as cash assistance, and an immigrants' health and health insurance status, in determining whether an immigrant was likely to become a public charge by using such benefits in the future.

Over 260,000 individuals and institutions filed comments responding to the proposed rule. The vast majority opposed it. Many warned that the rule would lead millions of immigrants to drop their own health care coverage, as well as coverage for their children. Commenters also cited numerous studies predicting that the proposal would lead to

more uncompensated care, increased financial hardship for safety-net providers, and a decline in public health.

The Final Regulations

The regulations that were published this month do not go quite as far as those that were proposed last fall. Most importantly, they exclude from the definition of public charge the use of Medicaid by immigrants under the age of 21 or by pregnant women up to 60 days post-partum. The final rule also removes Medicare Part D subsidies from the definition of public charge and clarifies that benefits used by individuals while they are in an exempt status, such as being a refugee, will not be held against them if their visa status changes. The final rule also follows the proposal in excluding CHIP and state-funded benefits from the definition of public charge.

Despite these important revisions, the final rule will dramatically alter the long-standing interpretation of public charge, turning that provision in the INA into a vehicle for reducing legal immigration and preventing millions of lawfully present immigrants from obtaining permanent residence status. In addition, the rule will harm the health care system and endanger public health by creating substantial new barriers to immigrants' use of Medicaid and other benefits that redress the social determinants of health.

Most relevant to health, the rule treats receipt of Medicaid, food stamps, or housing benefits for an aggregate of 12 months out of 36 as a public charge, and directs DHS officials to review past use of such benefits for any period of time (though not prior to the rule's effective date) when determining if an immigrant is likely to become a public charge (i.e. use such benefits for an aggregate of 12 months) at any time in the future. The final rule also treats the presence of a medical condition that is likely to require extensive medical treatment alongside the absence of private health insurance as a heavily weighted negative factor in the public charge determination. In contrast, having private health insurance (not including insurance that is subsidized by tax credits under the ACA) is a heavily weighted positive factor.

A Far-Reaching Chill

As a result of these provisions, many non-citizens will face strong pressure to forgo Medicaid and ACA tax credits, as well as SNAP and housing supports. Immigrants may also feel pressure to avoid being diagnosed with a serious or chronic medical condition. Critically, the fear of using public benefits or being diagnosed with a medical condition is likely to drive many non-citizens who are not actually subject to the public charge determination to forgo public insurance and the health care system. Indeed, reports

suggest that many immigrants dis-enrolled from government benefit programs and have avoided seeking care even before the rule was published. The rule's complexity, and the heated environment in which it is being promulgated, compound the risk that the rule's chill will reach far wider than its actual provisions.

The rule's reach may be extended as a result of additional rules that the Department of Justice (DOJ) is designing. Under current law, a public charge determination is not relevant to the naturalization process and can result in deportation only in a very limited set of circumstances. Moreover, non-citizens who become permanent residents are not subject to public charge determinations except when they leave the country for an extended stay.

DHS's commentary to the August 14 proposed rules, as well as news reports, state that DOJ is working on its own public charge rules that will align the definitions of public charge used by the two departments. DOJ's regulations have yet to be proposed, so their exact content remains uncertain. Regardless of their specific provisions, however, proposed DOJ regulations are apt to magnify the fear and chill created by the already published DHS regulations.

Challenges to the health care system from these regulatory changes will be significant. Fearful of the real or imagined immigration consequences, many patients are likely to forgo coverage and avoid care until they face an emergency (interestingly the rule exempts so-called Emergency Medicaid from the definition of public charge). Uncompensated costs -- especially for safety net providers in communities with large numbers of immigrants -- will almost certainly rise. Health will also suffer as patients face increased housing and food instability, as a result of forgoing SNAP or housing subsidies. All of this will occur as immigrant patients and their families contend with the stresses created by the Administration's other anti-immigrant policies, and its heated anti-immigrant rhetoric.

In addition, many health care workers will be unable to escape the rule's impact on their own lives. Almost 17 percent of health care workers , and 23 percent of home health care workers and nursing aides, were born outside of the U.S. Many of these workers rely on Medicaid and will worry about remaining insured. Others may worry that the rule will prevent members of their family from joining them in the U.S.

The rule may also send dangerous signals about health, health care, and self-sufficiency. By treating the diagnosis of a serious medical condition, and the receipt of publicly-funded insurance as evidence that one is likely to become a public charge, the rule stigmatizes both illness and Medicaid, sending the false and destructive message that

only those who are healthy and can afford their own health care are productive members of society. Although they may not be subject to the public charge determination, all Americans who receive Medicaid or have a serious illness may feel the brunt of the message that they are lacking in self-sufficiency.

Looking Ahead

It remains unclear whether the DHS rule will take effect or what the DOJ rule may propose. The DHS rule may well be delayed or struck down as a result of the litigation that will commence shortly. Whatever happens, the overall impact of both sets of rules may well depend upon the extent of the chill and stigma they portend. In this regard, health care workers can help mitigate the dangers by reassuring the many patients who are not subject to the public charge determination that they need not worry and should continue receiving health insurance and health care. Providers can also refer patients who may be in jeopardy to community organizations or legal providers who can help them assess their individual risk. In addition, health care professionals, through their places of practice and professional organizations can participate in the regulatory process by reading about and filing comments concerning the DOJ regulations, once they are proposed. And health care professionals can counter the stigma amplified by the DHS rule by treating all patients with respect and speaking out about the dignity and worth of *all* patients. As vexing as it may seem, in the current climate, health care providers must consider public education as central to their mission as prescribing medicines, washing wounds, and counseling patients.

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