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Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid

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Executive Summary

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to obtain legal permanent resident (LPR) status. The proposed rule would expand the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs, including Medicaid. It also identifies characteristics DHS could consider as negative factors that would increase the likelihood of someone becoming a public charge, including having income below 125% of the federal poverty level (FPL) ($25,975 for a family of three as of 2018). This analysis provides new estimates of the rule's potential impacts. Using 2014 Survey of Income and Program Participation data, it examines the (1) share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination and (2) number of individuals who would disenroll from Medicaid under different scenarios:

Nearly all (94%) noncitizens who originally entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination. Over four in ten (42%) have characteristics that DHS could consider a heavily weighted negative factor and over one-third (34%) have income below the new 125% FPL threshold. Under the proposed rule, individuals with lower income, a health condition, less education, and/or who use or are likely to use certain health, nutrition, and housing programs, including Medicaid, would face increased barriers to adjusting to LPR status because DHS could consider these characteristics as negative factors.

If the proposed rule leads to Medicaid disenrollment rates ranging from 15% to 35% among Medicaid and CHIP enrollees living in a household with a noncitizen, between 2.1 to 4.9 million Medicaid/CHIP enrollees would disenroll. These estimates reflect disenrollment among noncitizens without LPR status who would disenroll because participation in the program could negatively affect their chances of adjusting to LPR status as well as disenrollment among a broader group of enrollees in immigrant families, including their primarily U.S. born children, due to increased fear and confusion. The disenrollment rates draw on previous research on the chilling effect welfare reform had on enrollment in health coverage among immigrant families. Decreased participation in Medicaid would increase the uninsured rate among immigrant families, reducing access to care and contributing to worse health outcomes. Coverage losses also would result in lost revenues and increased uncompensated care for providers and have spillover effects within communities.

Introduction

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to enter the U.S. or adjust to legal permanent resident (LPR) status (i.e., obtain a "green card"). A previously published fact sheet describes key provisions of the proposed rule. Based on Kaiser Family Foundation analysis of 2014 Survey of Income and Program Participation (SIPP) data, this analysis provides new estimates of the:

- Share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination, and
- Number of individuals who could disenroll from Medicaid under different scenarios in response to the proposed rule.

Background

The proposed rule would broaden the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs. Under longstanding policy, if authorities determine that an individual is likely to become a public charge, they may deny that person's application for LPR status or entry into the U.S.[1] The proposed rule would define a public charge as an "alien who receives one or more public benefits" and would define public benefits to include cash assistance for income maintenance, government-funded institutionalized long-term care, and certain health, nutrition, and housing programs that were previously excluded from public charge determinations. These programs would include non-emergency Medicaid, the Medicare Part D Low-Income Subsidy Program, the Supplemental Nutrition Assistance Program (SNAP), and several housing support programs.

Officials consider the totality of a person's circumstances in a public charge determination. At a minimum, officials must take into account an individual's age; health; family status; assets, resources, and financial status; and education and skills. In the proposed rule and its preamble, DHS describes how it would consider each factor and identifies characteristics it would deem as positive factors that would reduce the likelihood of an individual becoming a public charge and negative factors that would increase the likelihood of becoming a public charge. The proposed rule would establish a new income standard of 125% of the federal poverty level (FPL) ($25,975 for a family of three as of 2018) for considering an individual's assets, resources, and financial status and would consider family income below that standard to be a negative factor.[2] The proposed rule also identifies certain heavily weighted negative or positive factors. One of these heavily weighted negative factors is current enrollment in or approval for enrollment in a public benefit or enrollment in a public benefit within the previous 36 months. In general, DHS would find an individual "inadmissible" and deny him or her adjustment to LPR status or entry into the U.S. if the person's negative factors outweigh his or her positive factors.

The proposed rule would directly affect noncitizens seeking to obtain LPR status.[3] DHS data show that 1.1 million individuals obtained LPR status in 2017, including about 550,000 living within the U.S.

who adjusted to LPR status and about 580,000 who entered the U.S. as a new arrival. [4] About 380,000 of the 550,000 individuals who adjusted to LPR status within the U.S. did so through a pathway that would likely be subject to a public charge determination.[5] Some groups, including refugees and asylees, are exempt from public charge determinations.

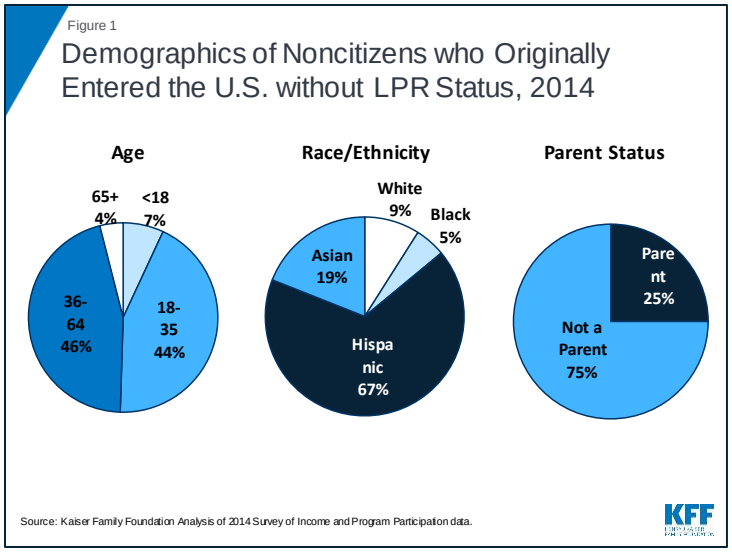
The proposed rule would likely lead to disenrollment from Medicaid and other programs among noncitizens who intend to seek LPR status as well as among a broader group of individuals in immigrant families, including their primarily U.S.-born children. Noncitizens without LPR status would likely disenroll from Medicaid and other programs because enrollment could negatively affect their chances of obtaining LPR status under the proposed rule. In addition, previous experience and recent research suggest that the proposed rule would have a "chilling effect" that would likely lead to disenrollment among a broader group of individuals in immigrant families even though the proposed rule would not directly affect them.[6] This research suggests that individuals may forgo enrollment in or disenroll themselves and their children from public programs because they do not understand the rule's details and would fear their or their children's enrollment could negatively affect their or their family members' immigration status. DHS recognizes evidence of a chilling effect and notes that previous studies examining the effect of welfare reform changes in 1996 showed enrollment reductions ranging from 21% to 54% from public programs due to this chilling effect.[7] However, in its estimates of program participation changes due to the proposed rule, DHS assumes only individuals directly affected by the rule (i.e., those applying to adjust status) drop coverage. It does not assume disenrollment among their family members or other noncitizen families, noting uncertainty related to estimating prospective disenrollment and that the proposed rule changes enrollment incentives versus eligibility policy.

Key Findings

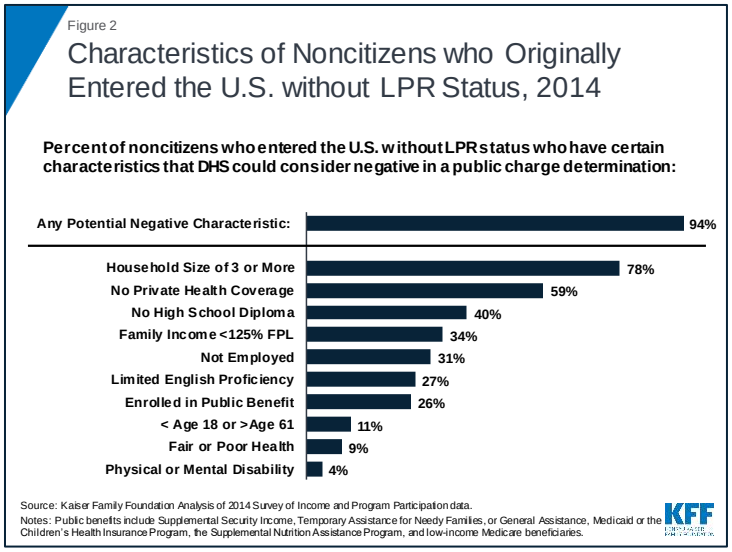
Characteristics of Noncitizens without LPR status

Using 2014 SIPP data, we show characteristics of noncitizens who originally entered the U.S. without LPR status that DHS could potentially consider in a public charge determination under the proposed rule. These estimates illustrate the share of noncitizens living in the U.S. who might face barriers to adjusting to LPR status under the proposed rule based on certain characteristics. Due to data limitations, they do not provide a precise count of the number of people within the U.S. who would be subject to public charge determinations. The estimates do not account for people who DHS could deny entry into the U.S. due to a public charge determination and do not account for all factors that DHS could consider in a public charge determination. As noted, officials would take into account the totality of an individual's circumstances, and no single factor would govern a determination. How DHS would operationalize its assessment of factors may differ from SIPP's measurement of characteristics. (See Appendix A: Methods for more detail.)

Noncitizens who entered the U.S. without LPR status include individuals across different ages, races/ethnicities, and family statuses. Although many were nonelderly Hispanic adults without a dependent child**,** 7% are a child, one in four is a parent (25%), and one-third (33%) is another race or ethnicity, including nearly one in five (19%) who is Asian (Figure 1).[8]



Nearly all (94%) noncitizens who entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination under the proposed rule. The most common characteristics that DHS could consider negative factors are a household size of three or more (78%), no private health coverage (59%), and no high school diploma (40%) (Figure 2 and Appendix B). In addition, over one-third (34%) have income below the 125% FPL[9] standard the proposed rule would establish. Just over one in four (26%) are enrolled in a public program that the rule identifies as a public benefit. This data may overestimate the share who are using a public program because the proposed rule would establish minimum thresholds for use of public benefits to be considered a negative factor that are not reflected in these measures. Moreover, some reported use of public benefits in the survey data may not be considered a public benefit under the proposed rule. For example, some individuals reporting Medicaid may be relying on emergency Medicaid, which would not be considered a public benefit under the proposed rule.



Over four in ten (42%) noncitizens who originally entered the U.S. without LPR status have characteristics that DHS could consider a heavily weighted negative factor. Potential heavily weighted negative factors examined in this analysis include current enrollment in a public benefit (26%), not being employed and not a full-time student (and aged 18 or older) (27%), and having a disability that limits the ability to work and lacking private health coverage (3%). The proposed rule identifies other heavily weighted negative factors that were not included in this analysis, including receipt of a public benefit within the previous 36 months and being found previously inadmissible or deportable on public charge grounds. Those with characteristics that DHS could potentially consider a heavily weighted negative factor are significantly more likely to be a parent (65% vs. 34%) and to be a woman (59% vs. 27%) compared to those without characteristics that DHS could consider a heavily weighted negative factor (data not shown).

Nearly nine in ten (89%) of all citizens (U.S. born and naturalized) also had one or more characteristics that DHS could potentially weigh negatively if they were subject to a public charge determination. Citizens were more likely than noncitizens who entered the U.S. without LPR status to have certain characteristics that DHS could consider negative, including being a child or older than age 61 and reporting fair or poor health and having a physical or mental disability that limits their ability to work (Appendix B).

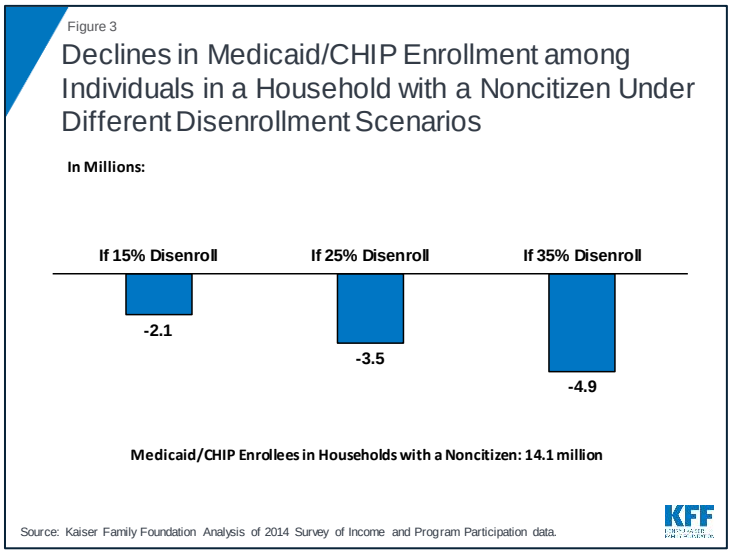
Impact on Medicaid Enrollment

We used SIPP data to illustrate the number of Medicaid and CHIP enrollees living in a family with at least one noncitizen who would disenroll under different potential disenrollment scenarios. As noted, previous experience and recent research suggests that the proposed rule may lead to broader disenrollment among individuals in families with immigrants beyond those the rule directly affects. We applied disenrollment rates of 15%, 25%, and 35%. Although it is difficult to predict the effect of the policy change, these disenrollment rates illustrate a range of potential impacts and draw on previous research on the chilling effect welfare reform had on enrollment in health coverage among immigrant families, and are consistent with earlier analysis of potential disenrollment among citizen children from Medicaid/CHIP.[10]

According to the SIPP data, there were over 14 million Medicaid/CHIP enrollees living in a household with at least one noncitizen, and half of these enrollees were citizen children. Although CHIP was not included as a public benefit in the proposed rule, DHS requested comment on its inclusion. Moreover, many individuals are not able to distinguish between their enrollment in Medicaid versus CHIP, and SIPP data do not provide separate Medicaid and CHIP coverage measures.

This analysis finds that, if the proposed rule leads to Medicaid disenrollment rates ranging from 15% to 35%, between 2.1 million and 4.9 million Medicaid/CHIP enrollees living in a family with at least one noncitizen would disenroll (Figure 3). These estimates reflect disenrollment among noncitizens without LPR status who would be directly affected by the rule[11] as well as disenrollment due to chilling effects among enrollees in immigrant families, including their primarily citizen children. The

estimates provide illustrative examples and, due to data limitations, may reflect both an undercount of noncitizens and an overestimate of noncitizens receiving Medicaid. (See Methods for more detail.)



These estimates of Medicaid disenrollment vary from DHS estimates because they take into account potential chilling effects among immigrant families and rely on different a different data source and methods. Using administrative and survey data, DHS estimated that about 142,000 individuals would disenroll from Medicaid per year and that this would lead to a $1.1 billion annual decrease in federal Medicaid expenditures. (See Appendix C for more detail on their approach.) Although DHS recognizes previous research showing that chilling effects led to enrollment reductions, it does not account for a chilling effect in its estimates. Instead, DHS assumes that all individuals directly affected by the public charge rule (i.e., those applying to adjust status) drop coverage but no disenrollment effects among their family members or among other noncitizen families.

Implications

Under the proposed rule, individuals with lower incomes, a health condition, less education, and/or who are enrolled or likely to enroll in certain health, nutrition, and housing programs would face increased barriers to obtaining LPR status. As such, the rule would have implications for future immigration opportunities for individuals and families, making it more difficult for low-income individuals and those with health conditions to obtain a green card. For example, a full-time worker in a family of three earning the minimum wage would not have sufficient annual income ($15,080) to meet the new income standard established in the rule, which would be $25,975 for a family of three. The increased barriers to obtaining a green card would disproportionately limit future opportunities for low-income families and individuals with health needs. It also could increase barriers to family reunification and potentially lead to family separation, for example, if DHS denies an individual a green card due to a public charge determination and that individual loses permission to remain in the U.S.

Reduced participation in Medicaid and other programs would negatively affect the health and financial stability of immigrant families and the growth and healthy development of their children, who are predominantly U.S.-born. Coverage losses would reduce access to care for families, contributing to worse health outcomes. Reduced participation in nutrition and other programs would likely compound these effects. In addition, the losses in coverage would lead to lost revenues and increased uncompensated care for providers and have broader spillover effects within communities. In the preamble to the proposed rule, DHS recognizes that disenrollment or foregone enrollment in public benefit programs could lead to worse health outcomes, especially for pregnant or breastfeeding women, infants, or children; reduced prescription adherence; increased emergency room use and emergent care due to delayed treatment; increased prevalence of diseases; increased uncompensated care; increased rates of poverty and housing instability; and reduced productivity and educational attainment.[12] Moreover, DHS indicates that the rule may decrease disposable income and increase poverty of certain families and children, including U.S. citizen children.[13] DHS also identifies potential impacts on communities, including decreased revenues to health care providers, pharmacies, grocery retailers, agricultural producers and landlords, as well as new direct and indirect costs for individuals and organizations serving immigrant families.[14]

This brief was prepared by Samantha Artiga and Rachel Garfield, with the Kaiser Family Foundation, and Anthony Damico, an independent consultant to the Kaiser Family Foundation.

Appendix A: Methods

The findings presented in this brief are based on Kaiser Family Foundation analysis of Wave #2 the 2014 Survey of Income and Program Participation (SIPP). SIPP enables us to directly measure individuals' immigration status at the time they entered the U.S. and health coverage and includes measures of health status. This approach differs from that used by DHS (described in detail in Appendix C), which was based on a combination of multiple administrative data sets and applied a number of broad assumptions. While SIPP has the advantage of directly measuring citizenship and immigration status, 2014 is the most recent year of data available. Because 2014 was a year of substantial transition for Medicaid due to the implementation of the Affordable Care Act, we also ran our analysis using the 2016 American Community Survey (ACS) to see if the time lag in data was affecting our results. The ACS analysis examined citizens versus non-citizens and led to very similar results.

We classified people as not having LPR status when originally entering the U.S. based on a SIPP question that asks, "What was [respondent's] immigration status when he/she first moved to the United States?" In addition to measuring people who might adjust to LPR status in the future, who would be subject to a public charge determination (unless they fall into an exempt category), this measure includes noncitizens who have adjusted to LPR status since arriving into the U.S. It also includes nonimmigrants and undocumented immigrants who do not have a current pathway to adjust to LPR status. Our testing of different citizenship measures led to overall similar patterns. The 2014 SIPP shows 20 million noncitizens, including 8.7 million of whom originally entered the country without LPR status. It also shows an additional 18.8 million citizens living in a household with a noncitizen (10.1 million of whom live in a household with a noncitizen who entered the country without LPR status). Due to underreporting of noncitizens and legal immigration status in the SIPP, these estimates may reflect an undercount of the total noncitizen population and especially the undocumented population. Given this potential undercount—and that the group of noncitizens without LPR status includes some individuals who have since adjusted to LPR status as well as nonimmigrants and undocumented immigrants who do not have a pathway to adjust to LPR status— our analysis of characteristics that DHS could consider negative in public charge determinations focuses on shares rather than absolute numbers of affected individuals.

For the estimates of the share of noncitizens without LPR status living within the U.S. who have characteristics that DHS could weigh negatively in a public charge determination under the proposed rule, we used SIPP to measure age, household size, poverty and work status, insurance status, enrollment in public programs, education, English proficiency, and health status and classified each factor as positive or negative based on the proposed rule's description of how DHS would consider the characteristic. DHS' implementation and operationalization of its assessment of factors may differ from SIPP's measurement of characteristics. In the preamble to the rule, DHS provided some data analysis of characteristics of the noncitizen population compared to citizens and discussed how certain characteristics correlate with enrollment in public benefit programs. They relied on older SIPP data (Wave 1 of the 2014 SIPP, which reflects 2013) and, in most cases, did not break out the non-LPR population in tables presented. Thus, their estimates are not directly comparable with ours.

In our analysis of household income, we use 125% of the Census poverty threshold, or $23,819 for a family of three in 2014. Census poverty thresholds are measured slightly differently than HHS poverty guidelines but lead to similar poverty levels for incomes of similar household size. In the proposed rule, DHS proposes a specific definition of a household to be used in the calculation of household income and notes that, while similar in concept to rules used by some government programs, their proposed definition varies in some ways. Thus, the final income cutoff for a particular family to meet the 125% of poverty rule as implemented may differ from our measurement or that used by other programs.

SIPP includes monthly measures of health insurance coverage. We coded individuals with at least one month of Medicaid or CHIP coverage during the 2014 calendar year as a Medicaid/CHIP recipients. Our analysis of 2014 SIPP finds 67.8 million total Medicaid/CHIP enrollees. This figure is low compared to current administrative estimates of 76 million, largely reflecting a well-documented "undercount" of Medicaid enrollment in survey data. Our analysis also finds that 14.1 million Medicaid/CHIP enrollees lived in a household with a noncitizen, 4.7 million of whom are noncitizen Medicaid enrollees. These data on Medicaid enrollees reflect both an undercount of noncitizens in the survey data (as noted above) as well as an overestimate of the share of noncitizens participating in Medicaid as it includes some who may be reporting emergency Medicaid or other state or local health assistance programs as Medicaid coverage.

For estimates of potential changes in coverage due to public charge policies, we present several scenarios using different disenrollment rates for Medicaid and CHIP. These disenrollment rates drew on previous research that showed decreased enrollment in Medicaid and CHIP among immigrant families after welfare reform.[15] For example, Kaushal and Kaestner found that after new eligibility restrictions were implemented for recent immigrants as part of welfare reform, there was 25% disenrollment among children of foreign-born parents from Medicaid even though the majority of these children were not affected by the eligibility changes and remained eligible.[16] Using this 25% disenrollment rate as a mid-range target, we assume a range of disenrollment rates from a low of 15% to a high of 35%. However, it remains uncertain what share of individuals may disenroll from Medicaid and CHIP in response to the proposed rule. Although the welfare reform experience is instructive of chilling effects among immigrant families broadly, it was associated with changes to program eligibility for immigrants. In contrast, this rule would change the potential consequences of participating in programs on an individual's immigration status.

Appendix B

Characteristics that DHS Could Consider in Public Charge Determinations by Citizenship Status, 2014					
	Potential Positive or Negative Factor?	Heavily Weighted?	Non-LPR Noncitizen	Total Noncitizens	Citizens
Age					
17 or younger	Negative		7%	9%	24%
18 to 61	Positive		89%	83%	57%
62 or older	Negative		5%	8%	19%
Family Size					
Less than Three People in Household	Positive		22%	21%	38%
Three or More People in Household	Negative		78%	79%	62%
Health Status					
No Physical or Mental Health Disability	Positive		96%	95%	87%
Physical or Mental Health Disability	Negative		4%	5%	13%
Excellent, Very Good, or Good Health	Positive		91%	91%	87%
Fair or Poor health	Negative		9%	9%	13%
Physical or Mental Health Disability and No Private Coverage	Negative	Y	3%	4%	7%
Family Income					
Less than 125% Federal Poverty Level (FPL)	Negative		34%	29%	18%
125% to less than 250% FPL	Positive		33%	32%	22%
250% FPL or more	Positive	Y	33%	38%	59%
Health Coverage					
Private Coverage	Positive		41%	45%	70%
No Private Coverage	Negative		59%	55%	30%
Public Benefits					
TANF or General Assistance	Negative	Y	4%	3%	4%
Medicaid/CHIP	Negative	Y	20%	23%	21%
SNAP	Negative	Y	10%	12%	14%
SSI	Negative	Y	1%	1%	3%
Low-Income Medicare beneficiary	Negative	Y	1%	2%	4%
Receiving Any Public Benefit	Negative	Y	26%	29%	27%
Not Receiving Any Public Benefit	Positive		74%	71%	73%
Employment					
Employed (and age 18+)	Positive		62%	59%	47%
Not employed (and age 18+)	Negative		31%	32%	29%
Not employed and not a full time student	Negative	Y	27%	29%	27%
Education					
Has high school diploma or higher (and age 18+)	Positive		53%	56%	68%
No high school diploma (and age 18+)	Negative		40%	35%	8%
English Proficiency					
Does Not Have Limited English Proficiency	Positive		73%	76%	99%
Limited English proficiency	Negative		27%	24%	1%
Any Negative Factor			**94%**	**94%**	**89%**
Any Heavily Weighted Negative Factor			**42%**	**47%**	**45%**

Notes: For each individual subject to a determination, DHS would take into account the totality of his her circumstances and would retain discretion on how to weigh specific circumstances and factors; no single factor would govern a determination. How DHS would implement and operationalize its assessment of factors under the rule may differ from how SIPP measures characteristics.
Source: Kaiser Family Foundation analysis of 2014 Survey of Income and Program Participation data.

Appendix C: Summary of DHS's Medicaid Estimates

Using administrative and survey data, DHS estimated that about 142,000 individuals would disenroll from Medicaid per year and that this would lead to a $1.1 billion annual decrease in federal Medicaid expenditures. As discussed below, DHS included a number of broad assumptions in its analysis. DHS does not account for a chilling effect in its estimates of disenrollment noting uncertainty related to estimating prospective disenrollment and that the proposed rule changes enrollment incentives versus eligibility policy. Instead, DHS assumes that all individuals directly affected by the public charge rule (i.e., those applying to adjust status) drop coverage but no disenrollment effects among their family members or among other noncitizen families. However, DHS recognizes that, "when eligibility rules change for public benefits programs there is evidence of a chilling effect that discourages immigrants from using public benefits programs for which they are still eligible." It also notes that previous studies examining the effect of welfare reform changes showed enrollment reductions ranging from 21% to 54% due to this chilling effect, it does not account for a chilling effect in its estimates of disenrollment.

Number of Medicaid Beneficiaries Impacted

Appendix C Table 1 shows how DHS estimates the number of Medicaid beneficiaries impacted by the proposed rule:

- DHS starts with an estimate of average annual Medicaid enrollment of 64,281,954. They report that they draw this figure from a 5-year average annual calculation based on the most recent 5 years of administrative data available. However, when calculated based on the cited data, we find average annual Medicaid enrollment of 72,215,654 from January 2014-July 2018, the most recent month available. Even if DHS is using an earlier period that includes 2013 data (which would result in an artificially low estimate, since 2013 is before the Affordable Care Act Medicaid expansion), the average annual enrollment number we calculate is 68,701,856.
- DHS then estimates the number of *households* that may be receiving Medicaid by multiplying its estimate of total Medicaid recipients by the average household size nationwide. This calculation assumes that household size is the same across households with and without Medicaid enrollees.
- DHS then estimates the number of households with a noncitizen who may be receiving Medicaid by multiplying its household estimate by the share of the total population that is noncitizen. This calculation assumes that households with a Medicaid enrollee have the same proportion of noncitizens as the general population.
- Finally, DHS multiples this estimated number of households with a noncitizen who may be receiving Medicaid by the average size of households that include noncitizens to estimate that 5,685,422 Medicaid enrollees live in a household with a noncitizen. This calculation assumes that households with a noncitizen receiving Medicaid are the same size as households with a noncitizen who is not receiving Medicaid. As described above, our analysis of SIPP revealed a much larger number of Medicaid enrollees reside in a household with a noncitizen.

Appendix C Table 1: DHS Methods to Estimate Number of Medicaid Enrollees Affected by the Proposed Rule			
Measure	**Data Point Used**	**Calculation**	**Calculation Method**
Medicaid Average Total Number of Recipients	64,281,954		Based on 5-year average from Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Data. Each annual total calculated by averaging the monthly enrollment population over each year.
Households that May be Receiving Medicaid	24,349,225	64,281,954/2.64	Divided the number of people receiving Medicaid by the Census estimated average household size of 2.64 for the total population.
Households with at least One Noncitizen who may be receiving Medicaid	1,697,141	24,349,225 x 6.97%	Multiplied the estimated number of households receiving Medicaid by the share of the total U.S. population that is a noncitizen (6.97%)
Medicaid Recipients Who are Members of Households Including Non-Citizens	5,685,422	1,697,141 x 3.35	Multiplied the estimated number of households with at least one noncitizen receiving Medicaid by the average household size for those who are foreign-born using the Census estimate (3.35)

Number of Medicaid Disenrollees

Appendix C Table 2 shows how DHS estimates the number of individuals that would disenroll from Medicaid under the proposed rule:

- DHS estimates the share of individuals that would disenroll from public programs by dividing the five-year annual average of the total number of people who adjusted to LPR status by the total noncitizen population, finding that 2.5% of noncitizens apply to adjust status each year.
- DHS applies this 2.5% disenrollment rate to its previously calculated estimate of Medicaid recipients who are members of households including noncitizens to estimate an annual enrollment decline of 142,136. This calculation assumes that everyone applying for adjustment of status within a year would disenroll. It does not account for any chilling effects that would lead to disenrollment among a broader group of individuals.

Appendix C Table 2: DHS Methods to Estimate Number of Medicaid Disenrollees			
Measure	**Data Point Used**	**Calculation**	**Calculation Method**
Anticipated share of Disenrollees	2.5%	544,246/22,214,947	Divided the number of immigrants that adjusted to LPR status annually by the total non-citizen population
Number of Medicaid Disenrollees	142,136	5,685,422 x 2.5%	Multiplied previous estimate of Medicaid recipients with a noncitizen in the household by the anticipated share of disenrollees (2.5%)

Reductions in Medicaid Expenditures

Appendix C Table 3 shows how DHS estimates reductions in Medicaid expenditures associated with Medicaid disenrollment under the proposed rule:

- Using administrative data, DHS estimates total annual Medicaid spending of $477 billion. They then divide this average annual spending amount by their earlier estimate of average total annual

enrollment to estimate average annual spending of $7,426 per enrollee. The Office of the Actuary (OACT) for the Centers for Medicare and Medicaid Services projects that average per enrollee Medicaid spending was approximately $7,200 in 2013, rising to $7,648 in 2017. These figures are a weighted average across all eligibility groups in Medicaid. There is wide variation in Medicaid spending per enrollee across eligibility groups, as DHS notes. Noncitizen Medicaid enrollees are more likely to be enrolled in low-cost enrollment groups such as adults without disabilities than the overall Medicaid population; thus, their average per enrollee spending is likely lower than the overall average for the Medicaid population.

- To estimate the reduction in Medicaid expenditures, DHS multiples their previous estimate of the anticipated annual enrollment decline (142,136) by their estimate of average per enrollee spending ($7,427). The estimate that DHS uses for average per enrollee spending is similar to that reported by (OACT) as well as other administrative data for total (federal and state) spending. Further, the total Medicaid payment amount used by DHS appears to include both federal and state spending. However, DHS indicates that their initial calculation just represents declines in federal expenditures and later inflates their overall estimated expenditure decreases across all programs by 50% to reflect estimated additional reductions in state expenditures to account for state matching funds.

Appendix C Table 3:
DHS Methods to Estimate Reductions in Medicaid Expenditures

Measure	Data Point Used	Calculation	Calculation Method
Average Annual Medicaid Payments	$477,395,691,240		5-year average based on Expenditure Reports from MBES/CBES
Average Annual Medicaid Payment per Person	$7,426.59	$477,395,691,240/ 64,281,954	Divided average annual Medicaid payments by previous estimate of average annual total number of Medicaid recipients
Anticipated Reduction in Medicaid Expenditures	$1.1 billion	142,136 x $7,426.59	Multiplied previous estimate of anticipated number of disenrollees by the average annual benefit per person

ENDNOTES

[1] Becoming a public charge may also be a basis for deportation in extremely limited circumstances. "Public Charge Fact Sheet," U.S. Citizenship and Immigration Services, https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet, accessed February 12, 2018.

[2] Under the proposed rule, if an individual has income below this standard, DHS would assess whether the total value of the individual's household assets and resources is at least five times the difference between the household's annual income and the federal poverty guidelines for his or her household size.

[3] The proposed changes would also affect certain people seeking to extend or adjust their non-immigrant status while in the U.S as well as LPRs seeking to return to the U.S. after a departure of six months or longer. The preamble clarifies that the proposed rule interprets public charge as it relates to inadmissibility, but not public charge deportability grounds, which will continue to be governed by Department of Justice precedent decisions.

[4] "Table 6. Persons Obtaining Lawful Permanent Resident Status by Type and Major Class of Admission: Fiscal Years 2015 to 2017," 2017 Yearbook of Immigration Statistics, Department of Homeland Security, https://www.dhs.gov/immigration-statistics/yearbook/2017/table6 , accessed October 8, 2018.

[5] Ibid.

[6] Findings show that recent immigration policy changes have increased fears and confusion among broad groups of immigrants beyond those directly affected by the changes. See Samantha Artiga and Petry Ubri, Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health, (Washington, DC: Kaiser Family Foundation, December 2017), https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/ and Samantha Artiga and Barbara Lyons, Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being (Washington, DC: Kaiser Family Foundation, September 2018), https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/. Similarly, earlier experiences show that welfare reform changes increased confusion and fear about enrolling in public benefits among immigrant families beyond those directly affected by the changes. See. Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[7] 83 *Fed. Reg.* 51114-51296 (October 10, 2018) available at https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds, accessed October 10, 2018.

[8] Kaiser Family Foundation analysis of 2014 SIPP data.

[9] In our data analysis, we use the Census poverty threshold, which was $23,819 for a family of three in 2014. Census poverty thresholds are measured slightly differently than HHS poverty guidelines but lead to similar poverty levels for incomes of similar household size. See Methods for more detail.

[10] Earlier experiences show that welfare reform changes increased confusion and fear about enrolling in public benefits among immigrant families beyond those directly affected by the changes. See. Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After*

Welfare Reform, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[11] Because of existing Medicaid eligibility restrictions for immigrants, there are few groups of noncitizens who do not already have LPR status who can enroll in Medicaid. These groups primarily include certain pregnant women and children in states that have adopted an option to cover lawfully residing immigrant pregnant women and children. See: https://www.healthcare.gov/immigrants/lawfully-present-immigrants/

[12] 83 *Fed. Reg.* 51114-51296 (October 10, 2018) available at https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds, accessed October 10, 2018.

[13] Ibid.

[14] Ibid.

[15] Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[16] Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/