XAVIER BECERRA
Attorney General of California
MICHAEL L. NEWMAN
Senior Assistant Attorney General
CHEROKEE DM MELTON
Supervising Deputy Attorney General
JENNIFER C. BONILLA
LISA CISNEROS
JULIA HARUMI MASS
ANITA GARCIA VELASCO
BRENDA AYON VERDUZCOS
ANNA RICH, State Bar No. 230195
Deputy Attorneys General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: 510-879-0296
Fax: 510-622-2270
E-mail: Anna.Rich@doj.ca.gov
Attorneys for Plaintiff State of California

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, DISTRICT OF COLUMBIA, STATE OF MAINE, COMMONWEALTH OF PENNSYLVANIA and **STATE OF OREGON,**

Plaintiffs,

v.

U.S. DEPARTMENT OF HOMELAND SECURITY; KEVIN MCALEENAN, in his official capacity as Acting Secretary of Homeland Security; **U.S. CITIZENSHIP AND IMMIGRATION SERVICES;** and **KENNETH T. CUCCINELLI**, in his official capacity as Acting Director of U.S. Citizenship and Immigration Services,

Defendants.

CASE NO. 3:19-cv-04975

DECLARATION OF NINEZ PONCE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Ninez Ponce, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth below.

2. I am the Director at the UCLA Center for Health Policy Research, the Principal Investigator of the California Health Interview Survey ("CHIS"), and a Professor in the Department of Health Policy and Management in the UCLA Fielding School of Public Health. I received my Bachelor's Degree of Science in Nutrition and Food Sciences from UC Berkeley in 1984, my Master's Degree in public policy in International Development from Harvard University in 1988, and a Ph.D. in Health Services from UCLA in 1998.

3. My research is focused on immigrant and global health, survey-based research, social determinants of health, and health disparities. I helped develop the first CHIS in 2001 and have led numerous pioneering efforts in multicultural survey research, including measures of racial/ethnic identity, acculturation, generational status and discrimination.

4. I have served as the deputy director of the Asian and Pacific Islander American Health Forum, a national advocacy organization promoting the health of Asian, Native Hawaiian, and Pacific Islander communities in the United States and U.S. territories.

5. I have contributed extensively to professional societies and committees focused on racial/ethnic disparities research, such as the National Academy of Medicine Subcommittee on the Standardized Collection of Race, Ethnicity, and Language Data. I was also previously a board member of the California Pan-Ethnic Health Network, and board vice-chair of the National Health Law Program. I have co-chaired the National Quality Forum Disparities Standing Committee, and served on the Multicultural External Advisory Council of the Nielsen Company (U.S.). I currently serve on the Board of Scientific Counselors of the National Center for Health Statistics, which conducts most major federal health surveys in the United States.

6. I have attached a true and complete copy of my curriculum vitae as Exhibit A to this Declaration, which includes a list of all of my publications over the past 17 years.

7. All of the opinions expressed here are my own.

//

Public Charge Inadmissibility

8. I am familiar with the Public Charge Rule, "Inadmissibility on Public Charge Grounds," (hereinafter "the Rule") issued on August 14, 2019 by the Department of Homeland Security (DHS).

9. I understand the Rule will expand the universe of public benefits that are considered for purposes of the "public charge" test (which currently only includes cash assistance and long-term institutional care) to include certain healthcare, housing and nutrition assistance benefits.

The Chilling Effect

10. Empirical research shows that a significant number of immigrants disenrolled from public benefits after the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) due to fear and confusion among the immigrant community. *See* Michael Fix, et al., "Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997," (1999) (finding significant disenrollment in public benefits by immigrants who actually had no change in eligibility for these benefits), a true and correct copy is attached hereto as Exhibit B; *see also* Michael Fix and Jeffrey Passel, "The Scope and Impact of Welfare Reform's Immigrant Provisions" (Jan. 2002) (showed Medicaid disenrollment rate of up to 58 percent among low-income refugees, as opposed to citizen disenrollment rate of 8 percent), a true and correct copy is attached hereto as Exhibit C. This phenomenon is known as the "chilling effect."

11. My estimates are evidence based and conservative, due to the uncertainty of how the Rule will be perceived by the immigrant community, implemented and enforced. I provide a range of estimates, 15 percent, 25 percent and 35 percent—to provide decision makers and the public a low, mid and high point for assessing the impact a "chilling effect" could have on the economy and public benefit systems. To estimate the effects of the "chilling effect" I use the Fix Study's estimation that there was a 22 percent decline in use of Medicaid among all noncitizen households and a 19 percent decline of Medicaid use in households below 200 percent of the Federal Poverty Level to draw a conservative estimate of 15 percent at the lowest level. Since the Fix Study, Exhibit C, also showed that there was a 35 percent disenrollment rate among all public

benefits in all categories of noncitizens, and because there is evidence in another study of a higher SNAP disenrollment, 54 percent[1], the 35 percent as a high range estimate is justifiable. I set a midpoint of 25 percent, in order to give a midpoint estimation for a full analysis of the "chilling effect" impacts.

12. Recent research relating to the Rule itself also shows a strong chilling effect. One study used national internet-based survey results to find that the chilling effect was twice for Latino adults, with the following percentages of respondents reporting that they avoided public benefit programs due to fear about the Rule:

- 20.6 percent of Latino adults in immigrant families;
- 8.5 percent of non-Latino white adults in immigrant families; and
- 6 percent of adults from other minority groups in immigrant families.

See Bernstein, et al. "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018" ("One in Seven Study"), Urban Institute (May 22, 2019), a true and correct copy is attached hereto as Exhibit D.

13. The One in Seven Study also found that, although the Rule would not actually impact them, individuals with LPR and citizenship status exhibited chilling effects, including:

- 7 percent of adults in families where all noncitizen members had LPR status; and
- 9 percent of adults in families where all members were naturalized citizens.

14. Additionally, the One in Seven Study found that adults in immigrant families living with children under age 19 were almost twice as likely to be subject to chilling effects, meaning that families *with* children are more likely to be impacted. Specifically, the Study found 17.4 percent of adults with children in the household reporting this as opposed to only 8.9 percent of adults without children in the household.

15. Almost two out of three adults in immigrant families reported an awareness of the proposed Public Charge Rule, at 62.9 percent.

16. Adults who heard "a lot" about the proposed rule were highly likely (31 percent) to report chilling effects in their families.

[1] Jenny Genser, (1999). Who is leaving the Food Stamps Program: An analysis of Caseload Changes from 1994 to 1997. Washington, D.C.: U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation. Available at https://www.fns.usda.gov/snap/who-leaving-food-stamp-program-analysis-caseload-changes-1994-1997

17. Significant numbers of adults in immigrant families nationally are avoiding routine activities—including visits to their healthcare professionals—due to fear of being asked about their immigration status. Bernstein, et al., "Adults in Immigrant Families Report Avoiding Routine Activities Because of Immigration Concerns" (July 2019) ("Avoiding Routine Activities Survey") (finding that 17 percent of adults in immigrant families reported that they or a family member avoided routine activities in which they might be asked about their citizenship, with 6 percent avoiding visiting a doctor or a clinic), a true and correct copy is attached hereto as Exhibit E.

18. The same survey found a higher rate among individuals in families with less secure immigration status, with 32.8 percent of adults in families with one or more relatives who are not permanent residents or citizens reporting that they have avoided routine activities (and 7.8 percent avoiding healthcare visits) as opposed to 11.7 percent of adults in families where all members have LPR or citizenship status (with 5.6 percent avoiding healthcare visits).

Chilling Effect in California

19. I analyzed the above data (particularly the almost 33 percent figure in the paragraph immediately preceding this one) to establish a high-end estimate of the potential chilling effect in California of 35 percent. California has a higher proportion of families potentially subject to a chilling effect figure because of the state's high proportion of households with mixed immigrant status.

20. In December 2018, I published a study entitled "Proposed Changes to Immigration Rules Would Cost California Jobs, Harm Public Health" in collaboration with Laurel Lucia and Tia Shimada, a true and correct copy is attached hereto as Exhibit F (hereinafter referred to as "December 2018 Study"). In this study, we estimated the population of Californians affected by the Rule.

21. We focused our analysis on the size of the population potentially subject to a "chilling effect," i.e, those who may disenroll or forego enrollment due to fear, worry and confusion about the implication of receiving benefits on their legal status.

22. Our December 2018 study is still valid based on the finalized Rule. The final Rule excludes Medicare, and our December 2018 study did not include this. Although CHIP is excluded in the final rule, the chilling effects for this group is still valid given CHIP's integration into the Medi-Cal program. Additional exclusion for certain categories of Medi-Cal such as for pregnant women are still subject to the chilling effect.

23. In the study, my co-authors and I defined the chilling effect population as non-citizens who may be indirectly affected because of fear, confusion or worry over the regulation, including:

a. Non-citizens in California who are eligible for and enrolled in CalFresh and/or full-scope Medi-Cal with federal funding, including:
   i. LPR adults over the 5-year bar;
   ii. LPR children and pregnant women under the 5-year bar, because California gets federal funding for these groups;
   iii. Other non-citizens eligible for full benefits; and
   iv. Refugees and asylees who are exempt from the proposed Rule, but who are also likely to experience a chilling effect.

b. This chilling effect population also includes citizen children with at least one non-citizen parent.

24. Approximately 2.2 million Californians in immigrant families fit into the categories described in the preceeding paragraph, and are potentially subject to a chilling effect.

25. Based on the Fix study and other factors discussed above, we project that disenrollment rates from benefits programs due to the "chilling effect" could reach as high as 35 percent. We also analyzed the potential impact based on lower projected disenrollment rates of 15 and 25 percent.

26. Based on the results of our December 2018 study that the "chilling effect" could impact up to 2.2 million Californians in immigrant families.

27. California has intentionally been more inclusive in its safety net programs than the federal government, extending eligibility to noncitizens, including children and the young adult population up to age 26 regardless of immigration status.

28. Our December 2018 study focused on how Californians enrolled in federally-financed programs for full-scope Medi-Cal would be affected by the Rule. Our analysis included an estimate of the lost federal dollars to California and the economic impact of those losses, as discussed in the Declaration of Laurel Lucia also submitted in support of this motion. The actual population potentially subject to the chilling effect, however, is broader, because it includes individuals who receive state-only financed healthcare services.

29. Based upon CHIS data, I estimate that an additional 228,000 Californians enrolled in Medi-Cal through state-only financing might be chilled from accessing health insurance by the Rule, bringing the total to 2.34 million Californians.

30. Based on a total of 2.34 million Californian, the following disenrollment scenarios would apply:

c. At a 15 percent rate, 351,000 people;
d. At a 25 percent rate, nearly 585,000 people; and
e. At a 35 percent rate, over 819,000 people.

31. Other important findings of the December 2018 study were:

f. Nearly 70 percent of the California residents projected to disenroll from healthcare and nutrition assistance benefits would be children.
g. Across California, disenrollment from CalFresh and Medi-Cal due to a chilling effect would most significantly impact Latinos, up to 88 percent, and Asians, up to 8 percent.

32. The loss of benefits caused by the Rule will make it harder for low-income immigrant families to achieve food security and healthcare.

33. Food insecurity means having limited, uncertain, or inconsistent access to the quality and quantity of food that is necessary to live a healthy life. Having sustained access to enough food is tied to positive social, physical, and mental health outcomes. *Id.*

34. Disenrollment from Medicaid is likely to result in adults and children lapsing into the financially vulnerable state of not having insurance, making it much harder to obtain health care. Medi-Cal enrollees are 1.8 times more likely to have a usual place to get health care and 1.5 times more likely to have had a preventive care visit in the past year, compared with people who were uninsured. An individual's having a usual source of care and gaining access to a preventive visit is strongly associated with better health outcomes and reduced costs to the health system.

35. Lack of health insurance does not affect all immigrants equally. Latino and low-income families are more likely to be uninsured.

Children's Health Insurance Program Will Be Impacted by the Rule

36. The Children's Health Insurance Program ("CHIP") is a federal and state partnership to expand health insurance coverage to uninsured low-income children.

37. Over 4 million U.S. citizen children in California have at least one immigrant parent, and 2 million of these children are enrolled in Medi-Cal and CHIP. "State Immigration Data Profiles: California", Migration Policy Institute, https://www.migrationpolicy.org/data/state-profiles/state/demographics/CA, (last visited Aug. 23, 2019). Together, they represent 25 percent of all CHIP enrollees in the country. 61 percent of these children are Latino.

38. Although CHIP is not included in the Rule, eligible beneficiaries will still likely be chilled from accessing it, because California has integrated CHIP with Medi-Cal. Thus, enrollees in CHIP may disenroll out of fear of an adverse public charge determination, although they would not actually be considered public charges on the basis of CHIP usage alone. Accordingly, our December 2018 study includes CHIP in our analysis of disenrollment scenarios.

39. Currently in California, the federal government pays 88 percent of the costs for children enrolled in CHIP, Petek, G., "The 2019-20 Budget: Analysis of the Medi-Cal Budget", California Legislative Analyst Office, (February 13, 2019), at 4. This would leave the state with fewer resources with which to ensure that its children specifically and its residents more broadly have access to healthcare.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge and expert opinion.

Executed on August 26, 2019, in Los Angeles, California.

Ninez A. Ponce

Exhibit A

CURRICULUM VITAE

Ninez Alafriz PONCE

Professor
Department of Health Policy and Management
650 Charles E. Young Drive, room 31-236C
Fielding School of Public Health
University of California, Los Angeles,
Los Angeles, CA 90095
USA

Director
UCLA Center for Health Policy Research
10960 Wilshire Boulevard, suite 1550
Fielding School of Public Health
University of California, Los Angeles
Los Angeles, CA 90024
USA

I. EDUCATION

Bachelor of Science	Nutrition and Food Sciences (1984), University of California, Berkeley, CA
Master in Public Policy	International Development (1988), Harvard University, Cambridge, MA
Doctor of Philosophy	Health Services (1998), University of California, Los Angeles, CA *Field in Labor Economics*

Training

AHRQ Pre-Doctoral Fellow, Health Services, University of California, Los Angeles, CA 1992-1995

Research Assistant, National Bureau of Economic Research, Cambridge, MA, 1995

AHRQ Post-Doctoral Fellow, Health Policy and Management, University of California, Berkeley, CA, 1998-1999

II. PROFESSIONAL EXPERIENCE

1999 to present University of California Los Angeles, CA

Faculty Appointments:

Professor, Department of Health Policy & Management (2013-present)
Associate Professor, Department of Health Services (2008-2013) (tenured)
Associate Professor-In Residence, Department of Health Services (2007-2008)
Assistant Professor-In Residence, Department of Health Services (1999-2007)

Administrative Appointments:

Director, UCLA Center for Health Policy Research (2018-present)
Director, Center for Global and Immigrant Health, UCLA (2014-2018)
Vice-Chair, Department of Health Policy and Management (2016-2018)
Associate Center Director, UCLA Center for Health Policy Research (2014-2018)
Senior Research Scientist, UCLA Center for Health Policy Research (1999-2013)
Associate Director, Asian American Studies Center (2011-2012)

Research Affiliations:

Associate Director, UCLA Bridging Research, Training, and Education in Minority Health Disparities Solutions, NIH/NIMHD Center (2013-2015)

Faculty Associate, Division of Cancer Control and Prevention Research, Jonsson Comprehensive Cancer Center (2002-2014)

Faculty Associate, UCLA Asian American Studies Center (2000-2018)

Faculty Executive Committee, UCLA Asia Pacific Center (2016-2018)

Faculty Associate, UCLA Department of Women's Studies (2008-2014)

Faculty Associate, UCLA Department of Southeast Asian Studies (2005-2018)

1999 - 2005 Community Voices-Oakland/ La Clinica de la Raza & Asian Health Services

Research Consultant

Conduct program evaluation, survey research and public policy analysis for a W.K. Kellogg Foundation national initiative on improving health care for the underserved. Community Voices-Oakland focuses on developing affordable health insurance products for low-income Latino and Asian immigrant groups in Alameda County.

1996 - 1998 RAND Skopje, MACEDONIA

Policy Adviser

Advised the Ministry of Health, Republic of Macedonia on national health insurance reforms, including developing a minimum benefits package, setting cost-sharing policies, and introducing capitation in primary care. Wrote the proposal with the principal investigator to supplement original grant with $575,000 to continue technical assistance and to conduct a social experiment testing the effect of capitation on access, utilization, provider behavior and cost of services.

1988 - 1992 Asian & Pacific Islander American Health Forum San Francisco, California

Deputy Director

Co-directed a national advocacy and policy research non-profit organization whose mission is to advance the health of all Asians and Pacific Islanders in the U.S. and Trust Territories. Developed the strategy for improving health statistics for Asians and Pacific Islanders, wrote grant proposals for program development and policy papers for legislative education. Prepared the primary text for the Asian American Health Care Act of 1992 that mandated the collection of Asian American subgroup ethnicities in all federal data collection efforts.

III. TEACHING

HPM= (Health Policy and Management)

1. HPM 249-1 *Health Economics: Low- and Middle-Income Country Perspectives*

   MPH-level elective hybrid online course, synchronous with University of the Philippines, Manila, College of Public Health, Department of Health Policy and Administration (Winter/Spring 2018, 2019)

2. HPM 249-2 *Global Health: Frameworks, Policy and Practice*

   MPH-level elective hybrid online course, synchronous with University of the Philippines, Manila, College of Public Health, Department of Health Policy and Administration (Winter/Spring 2018)

3.	HPM 237C	*Issues in Health Services Methodologies* (Spring 2011 - Spring 2015; Spring 2017) (Winter/Spring 2018) MS/PhD-level required course in applied econometrics.
4.	HPM 237B	*Introduction to Health Services Research Methods* (Winter 2007; Winter 2008) MS/PhD-level required course in applied econometrics.
5.	HPM 226A	*Readings in Health Services Research* (Fall 2010 co-taught with Jack Needleman; Winter 2011-2012; Fall 2013) MS/PhD-level required seminar.
6.	HPM 226B	*Readings in Health Services Research* (Winter 2011 co-taught with Jack Needleman; Winter 2012) MS/PhD-level required seminar.
7.	HPM M236	*Microeconomic Theory of the Health Sector*, (Winter 2000; Winter 2001; Winter 2004; Winter 2005; Spring 2009) MPH-level required course in health management and health policy.
8.	HPM 249E; PS 266	*Advanced Topics in Health Economics,* (Winter 2003) MPH/PhD-level elective.
9.	Health Services M233	*Health Policy Analysis*, (Spring 2002; Spring 2003 co-taught with Robert Nordyke; Spring 2011) MPH-level required course in health policy
10.	Health Services 400	*Master's Student's course on Consulting Report*, (Fall 2000) MPH-level required course in health management and health policy.

Guest Lectures:

1. "Surveys, Questionnaire Design, and a Sample of Sampling" for Professor Deborah Freund, Claremont Graduate University (Fall 2018)
2. "CHIS and Health Disparities" for UCLA National Clinician Scholars Pressing Health Issues Los Angeles Seminar, (Summer 2018)
3. "CHIS and Southern California Health Disparities" for UCLA National Clinician Scholars Pressing Health Issues Los Angeles Seminar, (Summer 2017), with Professor Gerald Kominski.
4. "Surveys and Small Area Estimation: Complementary Strategies to Measure the Health of Populations" for RCMAR/CHIME and Project EXPORT Methodological Seminar and Work in Progress (WiP) Session, March 20, 2017, with Dr. Yueyan Wang.
5. "Cost Containment" for HS200A Robert Wood Johnson Clinical Scholars Program Professor José Escarce (Fall 2006, Fall 2007, Fall 2008; Fall 2010-Fall 2016)
6. "Surveys, Questionnaire Design, and a Sample of Sampling" for HPM 225A, Professor James Macinko (Fall 2016)
7. UCLA School of Medicine Comparative Effectiveness Research Module: "Community Characteristics: Measuring Neighborhood Effects and the Use of Geo-coded Variables" with Professor Arleen Brown (Winter 2012-2015)
8. "Quantitative research methods for policy analysis" for Health Policy Analysis (HS 233), Professor Jack Needleman (Spring 2004, Spring 2012-Spring 2014)
9. "Multicultural Survey Research" for Nursing School, Professor Margaret Compton, Winter 2012.
10. "Aging across Cultures" for VA Geriatrics Fellowship Program, Professor Josea Kramer Winter 2012.

11. "Healthcare Disparities" for Health Services Organization (HS 200B), Professor E. Richard Brown (Winter 2008; Winter 2009); Professors E. Richard Brown and Arturo Vargas Bustamante (Winter 2011); Arturo Vargas Bustamante (Winter 2012)
12. "Coverage and the Safety Net" for Health Services Organization (HS 200A), Professor Leah Vriesman (Fall 2006), Professor E. Richard Brown (Fall 2007, Fall 2008); Professors E. Richard Brown and Arturo Vargas Bustamante (Fall 2010)
13. "The U.S. National Health Care System " for PH 150, Professor Roger Detels (Fall 2006, Fall 2007, Fall 2008)
14. "Inequities in Health" for Ethics and Public Health class, Professors Emily Abel & Ruth Roemer (Winter 2001); Patricia Parkerton (Winter 2002); Professors Patricia Ganz (Fall 2003; Winter 2005; Winter 2006; Winter 2007; Winter 2008).
15. "Vulnerable Populations and Managed Care" for Managed Care (HS 442), Professor Patricia Parkerton (Spring 2007)
16. "Health Care Financing" for Introduction to Health Services Organization (HS 100A), Professor Margaret Wang (Spring 2007)
17. "Cost Benefit Analysis" for Health Policy Analysis (HS 233), Professor Jack Needleman (Spring 2006)
18. "Physician and Hospital Payments" for Health Economics (HS 236), Professor Thomas Rice (Winter 2006)
19. "Economics of Disparities" for Advanced Topics in Health Economics (HS 249E), Professor Thomas Rice (Spring 2005)
20. "Public Finance" for Health Policy Analysis (HS 233), Professor Jack Needleman (Spring 2004)
21. "The State of Health Insurance in California: The Evidence, the Consequences, The Fixes" for Health Services Organization (HS 200A), Professor Amardeep Thind (Fall 2003; Fall 2004)
22. "Medical Malpractice" for Microeconomic Theory of the Health Sector, Professor Stuart Schweitzer (Fall 2002)
23. "Health Status and Health Behaviors of Ethnic Groups" for Ethical Considerations in Conducting Research with Minority Populations, Professor Vickie Mays (Winter 2001; Winter 2002)
24. "Cost-Benefit & Cost-Effectiveness Analysis" for Evaluation, Professor Roshan Bastani (Spring 2001; Spring 2002)
25. "A Primer on Health Economics in Developing Countries" for Professor Peabody (Spring 2002)
26. "Asian American and Pacific Islander Women's Health: Measurement Issues in Disparities Research" for Professor Emily Abel (Winter 2002; Fall 2002; Fall 2004)
27. "Drug Development Cost Estimates: How Precise Are They, How Are They Used?" With Robert Nordyke, for Pharmaceutical Economics Seminar, Professors William Comanor and Stuart Schweitzer (Spring 2002)

1. Dissertation Chair:
    1. Jeanne Black (PhD, 2007; Senior Researcher, Cedars Sinai Health Systems)
    2. Janet Cummings (PhD 2009); Associate Professor, Emory University
    3. Kimberly Enard (PhD 2010); Assistant Professor, St. Louis University
    4. Melissa Gatchell (PhD 2012); Assistant Professor, Oregon Health Sciences University
    5. Michelle Ko (PhD 2012); UCSF Assistant Professor, UC Davis
    6. Jacqueline Tran (DrPH, 2013); OCAPICA

7. Annalyn Valdez (DrPH 2014); UCLA; co-chair with Prof Kagawa-Singer
8. Chikarlo Leak (DrPH 2014); co-chair with Prof McCarthy
9. Alice Villatoro (PhD 2014); co-chair with Prof Mays; Latino Research Institute, UT Austin)
10. Catherine Chanfreau (PhD 2015), VA, Los Angeles
11. Andrew Siroka (PhD 2016), Health Economist, WHO, Geneva
12. Lauren Gase (PhD 2016), Senior Researcher, SPARK Policy Institute, Denver, CO
13. Joseph Viana (PhD 2018), Consultant, Los Angeles County Department of Health
14. Linda Diem Tran (PhD 2018), Post-Doctoral Fellow, VA Palo Alto
15. Natalie Bradford (PhD student) co-chair Prof Chandra Ford
16. Dahai Yue, (PhD student) co-Chair Prof Adriana Lleras-Muney (Economics)

Thesis/Dissertation Committee Member:

1. Thy Bich Nguyen, (Asian American Studies, MA, 2001)
2. Judith Connell, (Health Services, DrPH, 2002)
3. Soonim Huh, (Health Services, PhD 2005) Associate Professor, University of Seoul, Department of Public Affairs and Economics
4. Katherine Hoggatt, (Epidemiology, PhD 2005) Researcher, VA Los Angeles
5. Laura D'Anna, (Community Health Sciences, PhD 2006) Assistant Professor Cal State Long Beach
6. France Nguyen, (Asian American Studies, MA 2005)
7. Richard Hector, (Health Services, PhD, 2007)
8. Cynthia Mojica, (Health Services, PhD, 2007)
9. Shana Alex Lavarreda (Health Services, PhD 2009); Assistant Professor, Cal State Fullerton
10. Catherine Aqua (Health Services, MS, 2010)
11. Neetu Chawla (Health Services, PhD 2011) Researcher, VA Los Angeles
12. JoKay Ghosh, (Epidemiology, PhD 2011)
13. Mona Au-Young (Health Services, PhD 2013)
14. Selena Ortiz (Health Policy and Management, PhD 2013) Assistant Professor, Penn State
15. Brittnie Bloom (Community Health Sciences, MS 2014)
16. Alison Wong (Health Services, MS, 2014)
17. Jeremiah Garza (Health Policy and Management, PhD 2014)
18. Yan Kim (Health Policy and Management, PhD 2015)
19. Folasade May (Health Policy and Management, PhD 2015)
20. Charlene Hsuan (Health Policy and Management, PhD 2016) Assistant Professor, Penn State
21. Kimberly Narain (Health Policy and Management, PhD 2016)
22. Anna Davis (Health Policy and Management, PhD 2016) Research Fellow, Kaiser, Southern California
23. Christabel Cheung (Social Welfare, PhD 2017) Assistant Professor, Social Welfare, University of Hawaii, Manoa

Independent Study Student Supervision:

1. Ramogi Huma (MPH), Health Services, 2001
2. Estee Liebross (MPH), Health Services, 2005
3. Christabel Cheung (PhD), Social Welfare, 2015
4. Thalia Portney (Harvard PhD) Health Policy, 2015, 2016
5. Angelo Mendoza (undergraduate) Internet Research Incubator mentee, 2018

Research Grant Sponsor:

1. Dahai Yue (HPM PhD student) UCLA Summer Mentorship 2017
2. Joseph Viana (HPM 2018) UCLA Graduate Research Mentorship 2016
3. Christabel Cheung (Social Welfare 2017) Graduate Research Mentorship 2015
4. Jennifer Tsui (Health Services PhD 2012) UCLA Summer Mentorship 2009
5. Melissa Gatchell (Health Services PhD 2012) UCLA JCCC Seed Grant 2008-2009
6. Kimberly Enard (Health Services PhD 2010) UCLA Research Mentorship 2008
7. Neetu Chawla (Health Services, PhD 2011) UCLA Summer Research Mentorship 2007
8. Andrew Barnes (Health Services, PhD 2011) UCLA Research Mentorship 2007
9. Janet Cummings (Health Services PhD 2009) NIMH F-31 Dissertation Grant 2008-2010
10. Jeanne Black (Health Services, PhD 2007) AHRQ Dissertation Grant 2003-2005

Robert Wood Johnson Clinical Scholars:

1. Kristina Cordasco, MD, MPH
2. Rashmi Shetgiri, MD
3. Kara Odom Walker, MD
4. Christoph Lee, MD
5. Luwam Semere, MD

Robert Wood Johnson Multicultural Health Scholars:

1. Aimee Afable-Munsuz, PhD (Associate Professor, SUNY downstate Brooklyn)
2. Victoria Ojeda, PhD (Associate Professor, UC San Diego)
3. Edna A. Viruell-Fuentes, PhD (Associate Professor, University of Illinois, Urbana-Champaign)
4. Annalijn Conklin, PhD (Assistant Professor), University of British Columbia, Vancouver, CA

Robert Wood Johnson Health Policy Research Scholars 2016-present:

1. Seciah Aquino, (Harvard, DrPH 2018)
2. Mary Keovisai (University of Illinois, PhD Candidate)
3. Erica Browne (UC Berkeley, DrPH Candidate)
4. Bukola Bakare (North Dakota State, PhD Candidate)

PhD Adviser:

1. Soonim Huh, (Health Services, PhD 2005)
2. Andrew Barnes (Health Services, PhD 2011) Associate Professor, Virginia Commonwealth University
3. Jennifer Tsui (Health Services, PhD 2013) Assistant Professor, Rutgers University
4. Selena Ortiz (Health Policy and Management, PhD 2013) Assistant Professor, Penn State Health Policy and Administration
5. Sandhya Shimoga (Health Services, PhD 2014) Assistant Professor, Cal State University, Northridge

6. Geoffrey Hoffman (Health Policy and Management, PhD 2015) Assistant Professor, University of Michigan School of Nursing
7. Selene Mak (Health Policy and Management, PhD Candidate)
8. Linh Chuong (Health Policy and Management, PhD Candidate)

IV. PEER REVIEWED ARTICLES & BOOK CHAPTERS

PUBLICATIONS:

Peer-reviewed articles

1. **Ponce NA**, and Penserga L. Language access in health: why the policy and practice inertia? Harvard Health Policy Review. 2002:3(2): 47-53.
2. Mays VM, **Ponce NA**, Washington DL, Cochran SD. Classification of race and ethnicity: implications for public health. Annu Rev Public Health. 2003;24:83-110.
3. **Ponce NA,** Lavarreda SA, Yen W, Brown ER, DiSogra C, Satter DE. The California Health Interview Survey 2001: translation of a major survey for California's multiethnic population. Public Health Rep. 2004 Jul-Aug;119(4):388-95.
4. Etzioni DA, **Ponce NA**, Babey SH, Spencer BA, Brown ER, Ko CY, Chawla N, Breen N, Klabunde CN. A population-based study of colorectal cancer test use: results from the 2001 California Health Interview Survey. Cancer. 2004 Dec 1;101(11):2523-32.
5. Yancey AK, Kumanyika SK, **Ponce NA**, McCarthy WJ, Fielding JE, Leslie JP,Akbar J. Population-based interventions engaging communities of color in healthy eating and active living: a review. Prev Chronic Dis. 2004 Jan;1(1):A09. PMCID: PMC2396989.
6. **Ponce N**, Nordyke RJ, Hirota S. Uninsured working immigrants: a view from a California county. J Immigr Health. 2005 Jan;7(1):45-53.
7. Rice T, Lavarreda SA, **Ponce NA**, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev. 2005 Apr;62(2):231-49.
8. **Ponce NA**, Hoggatt KJ, Wilhelm M, Ritz B. Preterm birth: the interaction of traffic-related air pollution with economic hardship in Los Angeles neighborhoods. Am J Epidemiol. 2005 Jul 15;162(2):140-8.
9. **Ponce NA**, Huh S, Bastani R. Do HMO market level factors lead to racial/ethnic disparities in colorectal cancer screening? A comparison between high-risk Asian and Pacific Islander Americans and high-risk whites. Med Care. 2005 Nov;43(11):1101-8.
10. Peabody JW, Nordyke RJ, Tozija F, Luck J, Munoz JA, Sunderland A, Desalvo K, **Ponce N**, McCulloch C. Quality of care and its impact on population health: a cross-sectional study from Macedonia. Soc Sci Med. 2006 May;62(9):2216-24.
11. **Ponce NA**. Gatchell M. Singhs, Watanabes, Parks and Nguyens: A comparison of surname-list samples to probability samples using the California Health Interview Survey, 2001. AAPI Nexus: Asian Americans & Pacific Islanders Policy, Practice, and Community. 2006 4(1):61-79
12. Spencer BA, Babey SH, Etzioni DA, **Ponce NA**, Brown ER, Yu H, Chawla N, Litwin MS. A population-based survey of prostate-specific antigen testing among California men at higher risk for prostate carcinoma. Cancer. 2006 Feb 15; 106(4):765-74.
13. **Ponce NA**, Hays RD, Cunningham WE. Linguistic disparities in health care access and health status among older adults. J Gen Intern Med. 2006 Jul; 21(7):786-91.

14. **Ponce NA**, Ku L, Cunningham WE, Brown ER. Language barriers to health care access among Medicare beneficiaries. Inquiry. 2006 Spring; 43(1):66-76.

15. **Ponce NA**, Chawla N, Babey SH, Gatchell MS, Etzioni DA, Spencer BA, Brown ER, Breen N. Is there a language divide in Pap test use? Med Care. 2006 Nov; 44(11):998-1004.

16. Pourat N, **Ponce NA**, Wyn R. Assessment of the state of ethnic-specific health survey data. AAPI Nexus: Asian Americans & Pacific Islanders Policy, Practice, and Community. 2006 5(1):97-106.

17. Mojica C, Bastani R, Boscardin J, **Ponce NA**. Low-income women with breast abnormalities: system predictors of timely diagnostic resolution. Cancer Control. 2007 Apr; 14(2):176-82.

18. **Ponce NA**, Afable-Munsuz A, Nordyke RJ. Conceptualising the impact of genetic testing on cancer disparities in the United States. International Journal of Health Technology and Management. 2007;8:5:536-548.

19. Kagawa-Singer M, Pourat N, Breen N, Coughlin S, McLean TA, McNeel TS, **Ponce NA**. Breast and Cervical Cancer Screening Rates of Subgroups of Asian American Women in California. Med Care Res Rev. 2007 Dec, 64(6):706-30.

20. Mojica C, Bastani R, **Ponce NA**, Boscardin J. Latinas with abnormal breast findings: patient predictors of timely diagnostic resolution. Journal of Women's Health 2007 Dec;16(10):1468-77.

21. Hector RD, Anderson JP, Paul RCP, **Ponce N**, Hays RD, Weiss RE, Kaplan RM. Evaluation of the validity of the Quality of Well-being Scale in Trinidad and Tobago. West Indian Med J 2008 Mar; 57 (2): 135-140.

22. Kratz, RE, **Ponce NA**, Yancey A. Process evaluation of the Los Angeles Unified School District Nutrition Network. Preventing Chronic Diseases. 2008 Apr;5(2):A42.1-9.

23. **Ponce NA**, Cochran, SD, Mays VM, Chia J, Brown ER. Health coverage of low-income citizen and noncitizen wage earners: sources and disparities. Journal of Immigrant and Minority Health. 2008 Apr;10(2):167-76.

24. Lavarreda SA, Gatchell, MS, **Ponce, NA** Chia J, Brown ER Switching health insurance and its effects on access to physician services. Med Care. 2008 Oct;46(10):1055-63

25. Phillips KA, Liang, SY , Van Bebber S, The CANPERS (Cancer and Personalized Medicine) Research Group, Afable-Munsuz A, Elkin E, Haas J, Hassett M, Knight SJ, Kulin N, Kuppermann M, Ladabaum U, Marshall D, **Ponce N**, Walsh J. Challenges to the translation of genomic information into clinical practice and health policy: utilization, preferences, and economic value. Curr Opin Mol Ther. 2008 June; 10(3): 260–266. PMCID: PMC2910510

26. Afable-Munsuz A, Liang SY, **Ponce NA**, Walsh JM. Acculturation and colorectal cancer screening among older Latino adults: differential associations by national origin. J Gen Intern Med. 2009 Aug;24(8):963-70. PMCID: PMC2710471

27. Shariff-Marco S, Gee GC, Breen N, Willis G, Reeve BB, Grant D , **Ponce NA**, Krieger N, Landrine H, Williams DR, Alegria M, Mays VM, Johnson TP, Brown ER. A mixed-methods approach to developing a self-reported racial/ethnic discrimination measure for use in multiethnic health surveys. Ethnicity & Disease 2009 Autumn;19(4):447-53.

28. Gee GC, **Ponce N**. Associations between racial discrimination, limited English proficiency, and health-related quality of life among 6 Asian ethnic groups in California. Am J Public Health. 2010 May;100(5):888-95. PMCID: PMC2853608

29. Lee S, Satter DE, **Ponce NA**. Effect of race and ethnicity classification on survey estimates: Anomaly of the weighted totals of American Indians and Alaska Natives. Am Indian Alsk Native Ment Health Res. 2009;16(3):1-15.

30. D'Anna L, **Ponce, NA**, Siegel J. Racial and Ethnic Health Disparities: Evidence of discrimination's effects across the SEP spectrum. Ethnicity and Health 2010 Feb 2:1-23. No federal funding for this study.

31. Afable-Munsuz A, **Ponce NA**, Rodriguez M, Perez-Stable EJ. Immigrant generation and physical activity among Mexican, Chinese & Filipino adults in the U.S. Soc Sci Med. 2010 Mar 16. PMCID: PMC3042273

32. Cummings, JC, **Ponce, NA**, Mays VM. Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. Journal of Adolescent Health. 2010 Jun;46(6):603-6. PMCID: PMC2872636

33. **Ponce NA**, Cochran SD, Pizer JC, Mays VM. The effects of unequal access to health insurance for same-sex couples in California. Health Aff (Millwood). 2010 Aug;29(8):1539-48.

34. Shetgiri R, Kataoka S, **Ponce N**, Flores G, Chung PJ. Adolescent fighting: racial/ethnic disparities and the importance of families and schools. AcadPediatr. 2010 Sep-Oct;10(5):323-9.

35. Cordasco, K, **Ponce NA**, Gatchell M, Traudt B, Escarce, J. English language proficiency and geographical proximity to a safety net clinic as a predictor of health care access. J Immigrant and Minority Health 13(2): 260–267. PMCID: PMC3056133

36. Shariff-Marco S, Breen N, Landrine H, Reeve B, Krieger N, Gee GC, Williams DR, Mays VM, **Ponce NA**, Alegrıa M, Liu B, Willis G, and Johnson TP. Measuring everyday racial/ethnic discrimination in health surveys: how best to ask the questions, in one or two Stages, across multiple racial/ethnic groups? Du Bois Review. Social Science Research on Race. 2011 ; 8(10) 159-178.

37. **Ponce NA.** What a Difference a Dataset and Advocacy make for AAPI Health. AAPI Nexus, Special Issue on Forging the Future: The Role of New Research, Data, and Policies for Asian Americans, Native Hawaiians, and Pacific Islanders. (Invited Commentary) 2011 Oct; 9(1&2) 159-162.

38. Wang G, Beattie MS, **Ponce NA**, Phillips KA. Eligibility criteria in private and public coverage policies for BRCA genetic testing and genetic counseling, Genet Med. 2011 Dec;13(12):1045-50.

39. Lavarreda SA, **Ponce NA**, Cabezas L, Brown ER. Access to Job-Based Insurance for California's Workers and their Families: The effect of the Great Recession and double-digit unemployment in California. California Journal of Politics and Policy. 2011 Nov ;8(4) :1–13.

40. Odierna DH, Afable-Munsuz A, Ikediobi O, Beattie M, Knight S, Ko M, Wilson A, **Ponce NA**. Early developments in gene-expression profiling of breast tumors: potential for increasing black-white patient disparities in breast cancer outcomes? Per Med. 2011 Nov;8(6):669-679. PMCID: PMC3242007

41. **Ponce NA**, Tsui J, Knight SJ, Afable-Munsuz A, Ladabaum U, Hiatt RA, Haas JS. Disparities in cancer screening in individuals with a family history of breast or colorectal cancer. Cancer. 2012 Mar 15;118(6):1656-63. PMCID: PMC3262934

42. Russ LW, Takahashi LM, Ho W, Tseng W, **Ponce NA**. Bridging academic-legislative divides: Models of policy-relevant health research and practice by the University of California. Progress in Community Health Partnerships: Research, Education, and Action Volume 6, Issue 1, Spring 2012, pp. 95-102.

43. Viruell-Fuentes E, **Ponce NA**, Alegría M. Neighborhood context and hypertension outcomes among Latinos in Chicago. Journal of Immigrant and Minority Health, 2012 Apr 18.

44. Ko, M. and **Ponce, NA**. Community residential segregation and the local supply of federally qualified health centers. Health Services Research, 2013, 48: 253–270.

45. Lee CI, **Ponce NA,** Ettner SL, Kahn KL, Bassett LW, Forman HP. Ordering of CT by emergency department provider type: analysis of a nationally representative sample. American Journal of Roentgenology 2012 Nov;199(5):1054-9.

46. Phillips KA, Sakowski JA, Liang SY, **Ponce NA**. Economic perspectives on personalized health care and prevention. Forum for Health Economics and Policy. July 2013.16(2):2194-6191.

47. Ko M, Needleman J, Derose KP, Laugesen MJ, **Ponce NA**. Residential segregation and the survival of U.S. urban public hospitals. Med Care Res Rev. 2014 Jun;71(3):243-60.

48. Shariff-Marco S, Yang J, John EM, Sangaramoorthy M, Hertz A, Koo J, Nelson DO, Schupp CW, Shema SJ, Cockburn M, Satariano WA, Yen IH, **Ponce NA**, Winkleby M, Keegan TH, Gomez SL. Impact of neighborhood and individual socioeconomic status on survival after breast cancer varies by race/ethnicity: the neighborhood and breast cancer study. Cancer Epidemiol Biomarkers Prev. 2014 May;23(5):793-811.

49. Shim S, Kagawa-Singer M**, Ponce NA.** Federally Qualified Health Centers—A Prescription for Health Equity. (Editor's Note) Asian Americans & Pacific Islanders Policy, Practice, and Community. 2014: 12:1 & 2: xi-xiv.

50. Pourat N, Wallace SP, Hadler MW, **Ponce N**. Assessing Health Care Services Used By California's Undocumented Immigrant Population In 2010. Health Aff (Millwood). 2014 May;33(5):840-7.

51. Gomez SL, Lichtensztajn DY, Parikh P, Hasnain-Wynia R, **Ponce N**, Zingmond D. Hospital Practices in the Collection of Patient Race, Ethnicity, and Language Data: A Statewide Survey, California, 2011. Journal of Hlth Care for the Poor and Underserved. 2014 Aug;25(3):1384-96.

52. Ko M, Needleman J, Derose KP, **Ponce NA**. Whose social capital matters? The case of U.S. urban public hospital closures and conversions to private ownership. Social Science & Medicine 2014 Aug;114:188-96. doi: 10.1016/j.socscimed.2014.03.024. Epub 2014 Mar 25.

53. Johnson T, Shariff-Marco S, Willis G, Ho C, Breen N, Gee G, Krieger N, Grant D, Alegria M, Williams D, Landrine H, Liu B, Reeve B, Takeuchi D, **Ponce NA.** Sources of interactional problems in a survey of racial and ethnic discrimination. International Journal of Public Opinion Research. 2015 Summer;27(2):244-263.

54. AuYoung M, Duru, MD, **Ponce NA**, Mangione CM, Rodriguez HP. Frontline experiences of a practice redesign to improve self-management of obesity in safety net clinics. Journal of Ambulatory Care Management. 2015 Apr-Jun;38(2):153-63.

55. Kanzaria HK, Probst MA, **Ponce NA**, Hsia RY. The association between advanced diagnostic imaging and emergency department length of stay. The American Journal of Emergency Medicine. 2014 Oct;32(10):1253-8

56. Scales CD Jr, Lin L, Saigal CS, Bennett CJ, **Ponce NA**, Mangione CM, Litwin MS; NIDDK Urologic diseases in America project. Emergency department revisits for patients with kidney stones in California. Acad Emerg Med. 2015 Apr; 22(4): 468-74.

57. Oneha, MF, DeCambra H, Ieong L, Song H, Quach T, Chang-Weir R, **Ponce NA**, Enos Sim S, Kagawa-Singer M. Creating community criteria for research participation at community health center. AAPI Nexus: Asian Americans & Pacific Islanders Policy, Practice, and Community. 2014: 12:1 & 2: 1-20.

58. Quach T, Gilmer TP, Hirota S, , **Ponce NA**. Risk adjustment with social determinants of health and implications for federally qualified health centers under the Affordable Care Act. AAPI Nexus: Asian Americans & Pacific Islanders Policy, Practice, and Community. 2014: 12:1 & 2: 73-82.

59. Li V, Song H, Meng YY, **Ponce NA**, Weir RC. The impact of enabling services on improving health outcomes at community health centers. Harvard Asian American Policy Review. 25th volume 2015.

60. Almario CV, May FP, **Ponce, NA**, Spiegel BMR. Racial and ethnic disparities in colonoscopic examination of individuals with a family history of colorectal cancer. Clinical Gastroenterology and Hepatology. 2015 Feb 28.

61. Molitor F, Sugerman S, Biehl M, Yu H, Aydin M, Levy M, **Ponce NA**. Reach of Supplemental Nutrition Assistance Program-Education (SNAP-Ed) interventions and nutrition and physical activity-related outcomes. Preventing Chronic Disease, Public Health Research, Practice and Policy. 2015 Mar 12;12:E33.

62. Jans M, Viana J, Grant D, Cochran SD, Lee AC, **Ponce NA**. Trends in sexual orientation missing data over a decade of the California Health Interview Survey. The American Journal of Public Health. May 2015, Vol. 105, No. 5, pp. e43-e50.

63. Guerrero A, **Ponce NA**, Chung PJ. Obesogenic dietary practices of Latino and Asian subgroups of children in California: an analysis of the California Health Interview Survey, 2007-2012. American Journal of Public Health. 2015 Aug;105(8). Epub 2015 Jun 11.

64. **Ponce NA**, Ko M, Coffinier-Chanfreau C, Liaing SY, Armstrong J, Toscano M, Haas JS. Early diffusion of gene expression profiling in breast cancer patients associated with areas of high income inequality. Health Affairs. April 2015 vol. 34 no. 4 609-615.

65. May FP, Almario CV, **Ponce N**, Spiegel BM. Racial minorities are more likely than whites to report lack of provider recommendation for colon cancer screening. Am J Gastroenterol. 2015 May 12. doi: 10.1038/ajg.2015.138. [Epub ahead of print]PMID: 25964227

66. Kim Y, Kleerup EC, **Ponce NA**, Ganz PA, Lorenz KA, Needleman J. Medicare payment policy creates incentives for long-term care hospitals to time discharges for maximum reimbursement. Health Affairs. 2015 Jun;34(6):907-15.

67. Ortiz S, Perez D, **Ponce NA**. The quality of diabetes management among Mexican Adults in California: does generational status matter? Medical Care. 2015 Sep;53(9):792-9.

68. Zingmond DS, Parikh P, Louie R, Lichtensztajn DY, **Ponce N**, Hasnain-Wynia R, Gomez SL. Improving hospital reporting of patient race and ethnicity--approaches to data auditing. Health Serv Res. 2015 Aug;50 Suppl 1:1372-89. Epub 2015 Jun 15.

69. Wang Y, **Ponce NA**, Wang P, Opsomer JD, Yu H. Generating health estimates by zip code: a semi-parametric small area estimation approach using the California Health Interview Survey. Am J Public Health. 2015 Dec;105(12):2534-40.

70. **Ponce NA**, Bautista R, Sondik EJ, Rice D, Bau I, Ro MJ, Tseng W. Championing partnerships for data equity. J Health Care Poor Underserved. 2015 May;26(2 Suppl):6-15.

71. Ko M, Cummings JR, **Ponce NA**. Changes in the supply of us rural health centers, 2000-2011: implications for rural minority communities. Journal of Rural Health. 2015 Sep 16. Epub ahead of print]

72. AuYoung M, **Ponce NA,** Duru, MD, Mangione CM, Rodriguez HP. Patient activation is inconsistently associated with positive health behaviors among obese safety net patients. Journal of Immigrant and Minority Health 2015 Oct 1.

73. Siroka A, **Ponce NA**, Lönnroth K. Association between spending on social protection and tuberculosis burden: a global analysis. Lancet Infectious Disease. 2016; 16(4): 473–479.

74. Garza JR, Glenn BA, Mistry RS, **Ponce NA**, Zimmerman FJ. Subjective social status and self-reported health among us-born and immigrant Latinos. J Immigr Minor Health. 2016 Feb 19. [Epub

ahead of print] PubMed PMID: 26895151.

75. Conklin AI, **Ponce NA**, Frank J, Nandi A, Heymann J. Minimum wage and overweight and obesity in adult women: a multilevel analysis of low and middle income countries. PLoS One. 2016 Mar 10;11(3):e0150736. doi:10.1371/journal.pone.0150736. eCollection 2016. PubMed PMID: 26963247; PubMed Central PMCID: PMC4786275.

76. Gase LN, Kuo T, Lai E, Stoll MA, **Ponce N**. The impact of two Los Angeles County teen courts on youth recidivism: comparing two informal probation programs. J Exp Criminol. 2016 Mar;12(1):105-126.

77. Charles SA, **Ponce N**, Ritley D, Guendelman S, Kempster J, Lewis, J, Melnikow J. Health benefits mandates and their potential impacts on racial/ethnic group disparities in insurance markets. J Immigr Minor Health. 2016 May 25. [Epub ahead of print]

78. Almario CV, May FP, Maxwell AE, Ren W, **Ponce NA**, Spiegel BM. Persistent racial and ethnic disparities in flu vaccination coverage: Results from a population-based study. Am J Infect Control. 2016 Sep 1;44(9):1004-9. Epub 2016 Jun 29.

79. Siroka A, Law I, Floyd K, Banda RP, Hoa N, Tsolmon B, Chanda-Kapata P, Gasana M, Thandar-Lwin, S, Mbazi TE, **Ponce NA**. The effect of household poverty on tuberculosis. Int J Tuberc Lung Dis. 2016 Dec;20(12):1603-1608.

80. Gase LN, Glenn BA, Gomez LM, Juo T, Inkelas M, **Ponce NA.** Understanding racial and ethnic disparities in arrest: the role of individual, home, school, and community characteristics**.** Race Soc Probl. 2016 Nov06.

81. May F, Glenn BA, Crespi C, **Ponce N**, Spiegel B, Bastani R. Decreasing Black-White disparities in colorectal cancer incidence and stage at presentation in the United States. Cancer Epidemiol Biomarkers Prev. 2016 Dec 29. pii: cebp.0834.2016. doi: 10.1158/1055-9965.EPI-16-0834. [Epub ahead of print]

82. Gase LN, Glenn BA, Gomez LM, Juo T, Inkelas M, **Ponce NA.** Relationships between student, staff, and administrative measures of school climate and student health and academic outcomes. J School Hlth. 2017 May;87(5)319–328

83. Narain K, Bitler M, **Ponce N**, Kominski G, Ettner S. The impact of welfare reform on the health insurance coverage, utilization and health of low education single mothers. Soc Sci Med. 2017 May;180:28-35. doi: 10.1016/j.socscimed.2017.03.021. Epub 2017 Mar 11.

84. Conroy SM, Shariff-Marco S, Koo J, Yang J, Keegan TH, Sangaramoorthy M, Hertz A, Nelson DO, Cockburn M, Satariano WA, Yen IH**, Ponce NA**, John EM, Gomez SL. Racial/Ethnic Differences in the impact of neighborhood social and built environment on breast cancer risk: the Neighborhood and Breast Cancer Study. Cancer Epidemiol Biomarkers Prev. 2017 Apr;26(4):541-552. doi: 10.1158/1055-9965.EPI-16-0935. Epub 2017 Feb 14.

85. McMenamin SB, Shimkhada R, Hiller SP, Corbett G, **Ponce N**. Addressing discriminatory benefit design for people living with HIV: a California case study. AIDS Care. 2017 Apr 9:1-4. doi: 10.1080/09540121.2017.1313385. [Epub ahead of print]

86. Tran, LD, **Ponce, NA**. Who Gets Needed Mental Health Care? Use of Mental Health Services among Adults with Mental Health Need in California. Californian Journal of Health Promotion. 2017;15(1):36-45.

87. **Ponce, NA**, Glenn B, Shimkhada R, Scheitler AJ, Ko M. An examination of the barriers to breast cancer care in California. Am J Medical Res 2017;4(2): 73–126.

88. Villatoro, A, Mays V, **Ponce NA**, Aneshensel A. Perceived Need for Mental Health Care: The Intersection of Race, Ethnicity, Gender, and Socioeconomic Status. Society and Mental Health. Aug

2017.

89. Hsuan C, Horowitz J, **Ponce NA**, Hsia R, Needleman J. Complying with the Emergency Medical Treatment and Labor Act (EMTALA): challenges and solutions. Journal of Healthcare Risk Management. 2017 Nov 8. doi: 10.1002/jhrm.21288.

90. Holtby, S, Lordi N, Park R, **Ponce NA.** Families with young children in California: findings from the California Health Interview Survey, 2011-2014**.** American Journal of Medical Research.

91. **Ponce N**, Shimkhada R, Raub A, Daoud A, Nandi A, Richter L, Heymann J. The association of minimum wage change on child nutritional status in LMICs: A quasi-experimental multi-country study. Glob Public Health. 2017 Aug 2:1-15. doi: 10.1080/17441692.2017.1359327. [Epub ahead of print]

92. Cain C, Wallace SJ, **Ponce NA**. Helpfulness, trust, and safety of neighborhoods: social capital, household income, and self-reported health of older adults, The Gerontologist. 2017. gnx145, https://doi.org/10.1093/geront/gnx145

93. Conklin AI, **Ponce NA**, Crespi CM, Frank J, Nandi A, Heymann J. Economic policy and the double burden of malnutrition: cross-national longitudinal analysis of minimum wage and women's underweight and obesity. Public Health Nutr. 2017 Dec 6:1-8.

94. Yu H, Wang Y, Opsomer J, Wang P, **Ponce NA**. A design-based approach to small area estimation using semiparametric generalized linear mixed model. Journal of the Royal Statistical Society. Volume181, Issue 4, October 2018 Pages 1151-1167.

95. Yue D, Rasmussen PW, **Ponce NA**. Racial/Ethnic Differential Effects of Medicaid Expansion on Health Care Access. Health Serv Res. 2018 Oct;53(5):3640-3656. doi: 10.1111/1475-6773.12834. Epub 2018 Feb 22. PubMed PMID: 29468669; PubMed Central PMCID: PMC6153163.

96. Anderson AC, O'Rourke E, Chin MH, **Ponce NA**, Bernheim SM, Burstin H. Promoting Health Equity and Eliminating Disparities Through Performance Measurement and Payment. Health Aff (Millwood). 2018 Mar;37(3):371-377. doi: 10.1377/hlthaff.2017.1301. PubMed PMID: 29505363.

97. Conklin AI, Daoud A, Shimkhada R, **Ponce NA**. The impact of rising food prices on obesity in women: a longitudinal analysis of 31 low-income and middle-income countries from 2000 to 2014. Int J Obes (Lond). 2018 Aug 17. doi: 10.1038/s41366-018-0178-y. [Epub ahead of print] PubMed PMID: 30120427.

98. Hoffman GJ, Hsuan C, Braun T, **Ponce N**. Health Equity and Hospital Readmissions: Does Inclusion of Patient Functional and Social Complexity Improve Predictiveness? J Gen Intern Med. 2018 Aug 24. doi: 10.1007/s11606-018-4635-z. [Epub ahead of print] PubMed PMID: 30143978.

99. Ko M, Sanders C, de Guia S, Shimkhada R, **Ponce NA**. Managing Diversity to Eliminate Disparities: A Framework for Health. Health Aff (Millwood). 2018 Sep;37(9):1383-1393. doi: 10.1377/hlthaff.2018.0438. PubMed PMID: 30179560.

100. Davis AC, Shen E, Shah NR, Glenn BA, **Ponce N**, Telesca D, Gould MK, Needleman, J. Segmentation of High-Cost Adults in an Integrated Healthcare System Based on Empirical Clustering of Acute and Chronic Conditions. J Gen Intern Med. 2018 Sep 4. doi: 10.1007/s11606-018-4626-0. [Epub ahead of print] PubMed PMID: 30182326.

101. Wang P, Meng YY, Lam V, **Ponce N**. Green space and serious psychological distress among adults and teens: A population-based study in California. Health & Place. 2019 Mar;56:184-190. doi: 10.1016/j.healthplace.2019.02.002. Epub 2019 Feb 21. PMID: 30797185.

102. Hsuan C, Hsia RY, Horwitz JR, **Ponce NA**, Rice T, Needleman J. Ambulance diversions following public hospital emergency department closures. Health Serv Res. 2019;00:1–10. https://doi.org/10.1111/1475-6773.13147.

Peer-reviewed books, book chapters, Editor's Note &Invited Commentaries

1. **Ponce NA** and Guillermo T. (1993). Health Policy Framework. in Zane, Takeuchi et al. Confronting Health Issues in the Asian and Pacific Islander American Community. Sage Publications.
2. **Ponce NA**, Gertler P and Glewwe P. (1998). Will Viet Nam Grow Out of Malnutrition? in Glewwe et al. Viet Nam: Household Welfare and Transition to a Market Economy. World Bank, Policy Research Department.
3. Mays V, Cochran S, **Ponce NA**. (2004) Thinking About Race and Ethnicity in Population-Based Studies of Health. In Beech B, Goodman M. Race & Research, Perspectives on Minority Participation in Health Studies. Washington DC: American Public Health Association; 79-100.
4. **Ponce, NA.** (2009) Health Insurance. In Trinh-Shevrin, Islam and Rey. Asian American Communities and Health: Context, Research, Policy, and Action. New York University. Jossey–Bass publishers; 344-363.
5. **Ponce NA,** Ko M. (2013) Multilevel social determinants of health. In Gerald Kominski. Changing the U.S. Healthcare System, 4th ed. Jossey–Bass publishers; 135-155.

Published abstracts

1. **Ponce N**. (1989) Public Health Statistics for Asian and Pacific Islander Americans. Challenges for Public Health Statistics in the 1990s. Proceedings of the 1989 Public Health Conference on Records and Statistics. July 17-19, 1989. Mayflower Hotel, Washington, DC November 1989. 500 pp. (PHS) 65-68. available at *http://www.cdc.gov/nchs/products/pubs/pubd/other/phcrs/phcrs.htm*
2. Luck J, Peabody J, Nordyke R, Tozija F, Pecelj G, and **Ponce N**. (1999) A comparison of the quality of care between the U.S. and a developing country. Journal of General Internal Medicine; 14(Supp. 2):106.

Monographs/Technical Reports at UCLA

1. Rice T, **Ponce NA,** Teleki S, Brown ER. "What Accounts for California's Low Job-Based Coverage?" UC Berkeley Center for Health and Public Policy Studies and UCLA Center for Health Policy Research, May 2000 Policy Alert.
2. Brown ER, **Ponce NA**, Rice, T, The State of Health Insurance in California, Recent Trends, Future Prospects. UCLA Center for Health Policy Research, January 2001.
3. **Ponce NA**, Conner, T, Barrera P, Suh D, Advancing Universal Coverage in Alameda County UCLA Center for Health Policy Research Summary Report, September 2001.
4. Brown ER, **Ponce NA**, Rice T, Lavarreda SA The State of Health Insurance in California, Findings from the California Health Interview Survey. UCLA Center for Health Policy Research, January 2002
5. **Ponce NA**, Black JT. The Role of Race, Ethnicity & Language in Access to Basic Health Care for Californians. California Program on Access to Care. University of California Office of the President. September 2003.
6. **Ponce NA**, Gatchell M, Brown EB. Cancer Screening in California. UCLA Center for Health Policy Research. November 2003.
7. **Ponce NA**, Teleki S, Brown ER, "California's Uninsured Children: A Closer Look at the Local Level." UC Berkeley Center for Health and Public Policy Studies and UCLA Center for Health Policy Research, March 2000 Policy Alert.
8. Babey S, **Ponce NA**, Etzioni, D, Spencer B, Brown ER, Chawla N. Cancer Screening in California. Racial and

Ethnic Disparities Persist. UCLA Center for Health Policy Research. September 2003.

9. **Ponce NA**, Babey S, Etzioni D, Spencer B, Brown ER, Chawla N. Cancer Screening in California. UCLA Center for Health Policy Research. November 2003.
10. **Ponce NA**, Gatchell M, Brown ER. Asian Cancer Screening in California. UCLA Center for Health Policy Research. November 2003.
11. Lavarreda SA, Brown ER, **Ponce N.** Insurance rates of Asian American and Pacific Islander Children Vary Widely. UCLA Center for Health Policy Research. June 2005.
12. Brown ER, Lavarreda SA, **Ponce N**, Yoon J, Cummings J, Rice T. The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey. Research Report. July 2007.
13. Brown ER, **Ponce N**, Lavarreda SA. Job-Based Insurance Declines for Moderate- and Low-Income Workers. UCLA Center for Health Policy Research. Policy Brief July 2007.
14. Gatchell M, Lavarreda SA, and **Ponce N**. 7.6 Million Californians Rely on the Safety Net of Health Care Providers for Regular Care. UCLA Center for Health Policy Research. Policy Brief September 2007.
15. **Ponce NA,** Tseng W, Ong P, Shek YL, Ortiz S, Gatchell MS. The state of Asian American, Native Hawaiian and Pacific Islander health in California report : prepared for the Honorable Mike Eng. Los Angeles : UC AAPI Policy Multi-Campus Research Program, April 2009.
16. Brown ER, Kronick R, **Ponce NA**, Kincheloe JR, Lavarreda SA, Peckham E. The State of Health Insurance in California: Findings from the 2007 California Health Interview Survey. UCLA Center for Health Policy Research. Policy Brief July 2009.
17. **Ponce N**, Lavarreda SA, Cabezas L. The impact of health care reform on California's children in immigrant families Policy Brief. UCLA Center for Health Policy Research. 2011 Jun;(PB2011-8):1-6.
18. Meng YY, Rahman T, Pickett MC, **Ponce NA**. Health and Health Behaviors of Japanese Americans in California: A Sign of Things to Come for Aging Americans? Los Angeles, CA: UCLA Center for Health Policy Research, 2015
19. Adebiyi A, Alimat A, Chanfreau C, Haas J, **Ponce N.** Missed Opportunity? Twenty Percent of Breast Cancer Patients Don't Know Their Recurrence Risk Status Los Angeles, CA: UCLA Center for Health Policy Research, May 2015
20. **Ponce N**, Scheitler AJ, Shimkhada R, Ko M. The Status of Evaluations and Research on Effective Interventions Serving Boys and Men of Color. A report for RISE for Boys and Men of Color. 2017
21. **Ponce N**, Glenn B, Shimkhada R, Scheitler AJ, Ko M. Barriers to Breast Cancer Care in California. A report presented to the California Breast Cancer Research Program. 2017.
22. **Ponce N**, Scheitler AJ, Shimkhada R. Understanding the Culture of Health for Asian American, Native Hawaiian and Pacific Islanders (AANHPIs): What Do Population-Based Health Surveys Across the Nation Tell Us About the State of Data Disaggregation for AANHPIs? A report presented to the Robert Wood Johnson Foundation. 2017
23. Holtby, S, Lordi N, Park R, **Ponce N.** Families with young children in California: findings from the California Health Interview Survey, by Geography and Home Language, 2011-2014**.** 2017 Los Angeles, CA: UCLA Center for Health Policy Research.
24. Becker T, McLaughlin K, Wang Y, Yu, H, Hughes T, Ponce **NA**. Assessing community health over the first five years of Building Healthy Communities. A report presented to the California Endowment. 2017.
25. Milevska-Kostova N, Chichevalieva S, **Ponce N**, van Ginneken E, Winkelmann J. The former Yugoslav Republic of Macedonia: Health system review. Health Syst Transit. 2017 May;19(3):1-160.

26. Becker T, McLaughlin K, Wang Y, Yu, H, Hughes T, Ponce **NA**. Assessing community health over the first five years of Building Healthy Communities. Supplementary Analyses: A report presented to the California Endowment. 2018.

Monographs predating UCLA

1. **Ponce NA**, and Peabody JW, "Technical Assistance Packet for Communications Strategy for Health Care Reform in Macedonia." RAND, Santa Monica, CA, DRU 1642-WB, May 1997.
2. Peabody JW, **Ponce NA**, and Molyneaux JW, "Disease Burden and Costs of Treatment: Establishing Policy Priorities for Health Care Reform in Macedonia." RAND, Santa Monica, CA, DRU-1638-ADB, May 1997.
3. Cahill KR, **Ponce NA**, and Peabody JW, "Actuarial Analysis of Basic Benefits Package Options of Health Care Reform in Macedonia." RAND, Santa Monica, CA, DRU-1616-1-WB, May 1997.
4. Paterson MA, **Ponce NA**, and Peabody JW, "Integrated Information Systems: Managing Decisions, Informing Policy & Measuring Quality of Health Care Reform in Macedonia." RAND, Santa Monica, CA, DRU-1615-1-WB, May 1997.
5. Carter, GM, **Ponce NA**, and Peabody JW, "Considerations for a Capitation Payment System for Primary Care Providers in Macedonia: Promoting Quality, Equity and Efficiency." RAND, Santa Monica, CA, DRU 1641-WB, May 1997.
6. Peabody JW, Gertler PJ, and **Ponce NA**, "Macedonia Health Sector Policy Reform: Technical Assistance Inception Report." RAND, Santa Monica, CA, DRU-1460-WB, August 1997.
7. Carter GM, **Ponce NA**, and Peabody JW, "Implementing a Capitation System for Primary Care in Macedonia." RAND, Santa Monica, CA, DRU-1710-WB, September 1997.
8. Farley DOF, and Ponce NA, "Model of Basic Benefits Package and Options with Actuarial Analysis." RAND, Santa Monica, CA, DRU-1707-WB, September 1997.
9. **Ponce NA**, Peabody JW, Dewallens F, "A Legislative Framework for Health Care Reform in Macedonia: Short and Long Term Solutions." RAND, Santa Monica, CA, DRU-1704-WB, June, 1998.
10. Lubick-Goldzweig C, **Ponce NA**, and Peabody JW, "Developing Primary Care Practice in a Transitional Economy." RAND, Santa Monica, CA, DRU-1911-WB, August 1998.
11. Carter GM, **Ponce NA,** and Peabody JW, "Options for Payment of Hospital and Services in Macedonia." Santa Monica, CA, DRU-1912-WB, August 1998.

V. GRANTS (selected list)

Preserving Health Coverage for Immigrants: Economic & Health Implications of Proposed Public Charge Rules on California and Local Jurisdictions
Ninez A. Ponce (PI)
09/01/18 – 12/31/18
(ACTIVE)
The UCLA Center for Health Policy Research (CHPR), with the UC Berkeley (UCB) Labor Center, and the California Food Policy Advocates (CFPA), proposes to estimate the health and economic impact of the proposed change in the public charge rules for California and its local jurisdictions.
Funder: California Health Care Foundation

Total Amount: $161,045

Integrating non-communicable disease (NCD) management in primary health care: a population health survey and action initiative
Ninez A. Ponce (PI)
10/1/2017 –9/30/ 2019
(ACTIVE)
Synopsis: With the University of the Philippines School of Public Health, Manila, the study will provide technical assistance for the design, conduct, and analysis of a population-based health survey on a national scale, and use these results to inform the development of a primary care tool on readiness of primary care centers to prevent and control non-communicable diseases.
Funder: Republic of the Philippines, Philippine Commission on Higher Education
Total Amount: $424,851

Improving Data Capacity for American Indian/Alaska Native (AI/AN) Populations
Ninez A. Ponce (PI)
9/30/2016 – 09/ 30/ 2018
(ACTIVE)
Synopsis: Misclassification and undercount of AI/ANs in population based surveys is of particular importance and may affect sample size of this group, as this is a small population that is often dropped from analysis for lack of statistical significance, omitted from national reports, and subsequently overlooked as recipients of needed resources. The purpose of this project is to: 1) Identify the current approaches to code AI/AN participants for race and ethnicity in selected population-based HHS surveys and the California Health Interview Survey; 2) Examine the current coding used in selected surveys to analyze the percentage of AI/AN only, AI/AN mixed race, Hispanic AI/AN and any mention of AI/AN; 3) Examine variations in classifying, coding, and tabulating AI/ANs and the implications of variations in classification and tabulation for the development of survey weights and post stratification adjustments for the AI/AN population; 4) Evaluate how improper classification and post weight adjustments can affect rates and counts of key indicators of health status, health behaviors, utilization and access to healthcare for the AI/AN population.
Funder: DHHS – Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation
Total Amount: $318,000

RWJ Health Policy Research Scholar Program
Gail Wyatt (UCLA PI), Ninez A. Ponce-UCLA faculty; Thomas La Veist (PI), Harolyn Belcher (Co-PI)
(ACTIVE)
4/1/2016 - 8/31/2017; affiliated faculty in 2018
Synopsis: The Health Policy Research Scholars program is a new national change leadership development opportunity for full-time doctoral students from underrepresented populations or historically disadvantaged backgrounds, entering the first or second year of their doctoral program, from any academic discipline who are training to be researchers and are interested in health policy research. UCLA faculty—Drs. Gail Wyatt, Gilbert Gee and Ninez Ponce are core faculty from UCLA that advise the program Principal Investigators, Dr. Thomas LaVeist (George Washington University) and Dr. Harolyn Belcher (Johns Hopkins University). UCLA is one of the field sites for the program.
Funder: Robert Wood Johnson Foundation/Prime: Johns Hopkins University
Total Amount: $ $55,559

California Health Interview Survey (CHIS)
9/01/2013 – 08/31/2017; ~$9,000,000 annually
Ninez Ponce (PI)
(ACTIVE)
Synopsis: CHIS is a population-based health survey of over 50,000 Californians. Currently, CHIS is offered in English, Spanish Cantonese, Mandarin, Vietnamese, Korean and Tagalog.
Funders: California Department of Public Health, California Department of Health Care Services, The California Endowment, Kaiser Permanente Community Benefits, The California Wellness Foundation, Centers for Disease Control, The California Healthcare Foundation, First Five California, Agency for Health Care Research and Quality
Total Amount: ~$9,000,000 annually; $18,000,000 for a 2-year survey cycle

Completed Awards

Studying health data collection, analysis, and reporting for Asian Americans, Native Hawaiians, and Pacific Islanders to better explain disparities
Ninez A. Ponce (PI)
9/15/2015 – 09/ 14/ 2017; total ~$100,000
Synopsis: The study examined the state of data collection for Asian Americans, Native Hawaiians and Pacific Islanders in state and federal surveys nationwide. We conducted key informant interviews of survey leaders and literature and legislative review to present recommendations on how survey leaders can implement more disaggregated data collection for the Asian American, Native Hawaiian and Pacific Islander population.
Funder: Robert Wood Johnson Foundation

Disparities in Utilization of Gene Expression Profiling and Subsequent Chemotherapy Decisions
Ninez Ponce (PI); Patricia Ganz (Co-I); Jennifer Haas, Harvard University (Co-I)
July 15, 2012- December 31, 2017; direct ~$410,000
Synopsis: We conducted a mailed survey, with option of responding via a weblink, of women covered by Aetna who received GEP identified from 2010 claims data. The target sample is 200 English-speaking white women and 200 English-speaking non-white women diagnosed in 2010 with early stage breast cancer and a paid claim for GEP testing. We hypothesize that key patient and provider characteristics that motivate the use of GEP differ for whites and nonwhite women, and that the use of GEP to inform treatment decisions also differ by race/ethnicity. For example, the acceptability of GEP as a basis for forgoing adjuvant chemotherapy may be governed by issues of knowledge of and attitudes toward the test and chemotherapy, provider counseling, provider trust, healthcare satisfaction, perceived discrimination, and ability to communicate and self-advocate. Among minority patients, these issues have been identified as major sources of disparities in receiving quality healthcare in general and in shaping attitudes towards genetic testing and therapeutic decisions in particular.
Funder: Aetna Corporation

Barriers to Breast Cancer Care
Ninez Ponce (PI); Beth Glenn (Co-I)
November 1, 2015-May 30, 2018; direct ~$135,456
Synopsis: Our study team of health policy and cancer researchers, in consultation with community advocates, answered the question: *What are the significant barriers or challenges to access to breast cancer oncology care in California if you are uninsured, underinsured, on public or private health insurance?* Our team produced a report, a peer-reviewed article, fact sheets, a policy briefing in Sacramento and one-on-one visits with policy makers that presented our findings from 3 key tasks – (1) a synthesis of the peer reviewed literature, news media, reports and policy briefs, (2) an analysis of social media, and (3) case studies from key informant interviews.
Funder: California Breast Cancer Research Program, University of California Office of the President

Patient-Centered Outcomes Research in Community Health Centers
Ninez Ponce (PI); Marjorie Kagawa-Singer (Co-I);
April 1, 2012- August 31, 2017; direct $95,000
Synopsis: The Association of Asian and Pacific Community Health Organizations (AAPCHO) subcontracted with UCLA as an academic partner to help build the scientific infrastructure for its member community health centers to conduct patient-centered outcomes research. The key domains of the UCLA engagement were scientific leadership participation as a Steering Committee member, planning and development of research proposals with the community health center network espousing community based participatory research principles, and building human and scientific capital within AAPCHO community health centers through training, curriculum development, study design and statistical consultation, and research dissemination of results through publications.
Funder: Association of Asian and Pacific Community Health Organizations (AAPCHO) /DHHS HRSA

California Health Benefits Review Program
Ninez Ponce, co-Vice Chair with Nadereh Pourat
September 2017-July 2018; Annual amount: $280,000
September 2014-July 2017; Annual amount: $240,000
Ninez Ponce, Vice Chair
September 2013-July 2014; Annual amount: $240,000
Synopsis: Established in 2002 to implement the provisions of its authorizing statute, the California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. As the Vice Chair of cost, I led the cost team and worked with actuarial consultants to complete each analysis during a 60-day period, usually before the Legislature begins formal consideration of a mandate bill.
Funder: University of California, Office of the President

Field Scans on the Status of Evaluation and Research on Effective Interventions Serving Boys and Men of Color (BMOC)
03/14/ 2016 – 12/ 16/ 2016; $40,000
Ninez A. Ponce (PI)
Synopsis: Our project highlighted the current state of understanding of programs, policies and practices that target health and education outcomes in early and middle childhood, with a broader frame that these interventions will impact boys and men of color (BMOC) over the life course. Drawing upon the Chandler framework, we will produce a literature synthesis that identifies promising solutions to disparities faced by BMOC and calls out the remaining gaps. We will pay close attention to how the literature on health and education programs addresses special populations - Native American, and sub-ethnic populations of Black, Latino, and Asian and Pacific Islanders. These findings will be key inputs to improving access to high quality literature on health and education programs for BMOC.
Funder: Equal Measure: RISE for Boys and Men of Color

National Healthcare Disparities Report (NHDR)
Ninez Ponce (PI),
09/01/2013 – 08/31/2016; ~$50,000 annually
Synopsis: We provided California Health Interview Survey (CHIS) data for the 2014-2015 National Healthcare Disparities Report (NHDR) to show trends of health care quality and disparities for Pacific Islanders, American Indians and Alaska Natives, Asian and Hispanic subpopulations, populations with limited English proficiency and LGBT populations.
Funder: Agency for Healthcare Research & Quality

Improving Reporting of Race, Ethnicity, and Language in California
David Zingmond (PI); Ninez Ponce (Co-I)
September 1, 2010-August 31, 2013; direct ~$3,000,000
Synopsis: A team of allied researchers led by investigators from the University of California in collaboration with the leadership of the California Office of Statewide Health Planning and Development, conducted a three-year programmatic intervention to improve the reliability, validity, and completeness of self-reported race, ethnicity, and primary language provided by hospitals in the three databases that are currently within OSHPD's regulatory mandate.
Funder: Agency for Healthcare Research and Quality/ARRA

Medi-Cal Monitoring with the California Health Interview Survey
Ninez Ponce (PI)
Synopsis: We conducted a comparison of key access and utilization indicators between Medi-Cal enrollees and those with employment sponsored coverage. We based our analysis on data collected in the California Health Interview Survey (CHIS). Utilizing a framework for monitoring access to care, we produced estimates in at least six different constructs to inform the use of, and areas of need for, Medi-Cal recipients.
March 1, 2014- March 31, 2016; direct ~$150,000
Funder: California HealthCare Foundation

Personalized Medicine for Colorectal & Breast Cancer
Kathryn Phillips (PI); Ninez Ponce (Core Director & UCLA PI)
September 2008-August 2012; direct $31,171
Synopsis: The program objective was to use an integrated, interdisciplinary approach to obtain evidence about key aspects of the translation of genomic information for breast and colorectal cancer into clinical practice and health policy. As the principal investigator of the ***Measurement in Diverse Populations Core***, I provided the leadership to improve methods for conducting research, for measurement, for recruitment of research subjects, and for drawing statistical interpretations and conclusions for diverse populations.
Funder: National Cancer Institute; UCSF School of Pharmacy (Subcontract)

Do Safety Net Clinics Narrow the Disparity in Cervical Cancer Screening for Low-Income Women?
Ninez Ponce (PI, Faculty Sponsor) Melissa Gatchell (co-PI)
September 2008-June 2009; direct ~$21,000
Synopsis: This project determined whether closer proximity to a safety net clinic (measured by the distance to the closest safety net clinic providing pap tests) improves the likelihood that a low-income woman of appropriate age receives a pap test for detection of cervical cancer during the interval recommended by the Unites States Preventive Services Task Force (USPSTF). We used CHIS 2005 data, along with data collected on safety net clinics in California to determine the association between distance to a safety net clinic and likelihood of cervical cancer screening.
Funder: Jonsson Comprehensive Cancer Foundation

Do socio-ecological variables influence cancer screening behaviors? A multi-level modeling study using the California Health Interview Survey (1 K07 CA100097)
Ninez Ponce (PI); primary mentor: Roshan Bastani
September 2004-August 2010 $ 588,484 direct; $47,079 indirect, totaling $635,563
Synopsis: This study examined whether and to what extent socio-ecological predictors have an effect on population-based cancer screening behaviors, specifically for breast, cervix, colorectal and prostate cancers. The study sought to understand the relationship between individual and socio-ecological variables and to determine if and to what extent these socio-ecological variables mediate individual decisions to seek preventive cancer screening services, particularly among ethnic minority populations. The K07 is a mentored career award program that provided 75% salary support over 5 years for the PI and additional research funds to hire a research assistant, to procure data, and to purchase/upgrade computing resources.
Funder: National Cancer Institute K07 Award program

Network on Multicultural Health & Healthcare Research
William Vega and Michael Rodriguez (Directors), Ninez Ponce (Senior Investigator) ~$12,000/year for mentorship, of junior faculty and program leadership
November 2007-October 2010
Synopsis: I was one of the Senior Investigators in this 3-year healthcare quality research network established at UCLA Department of Family Medicine to address the problem of healthcare disparities among minorities and underserved populations. The Network was composed of distinguished expert faculty from a variety of national universities. The Network will also support five Healthcare Quality Scholars each year to address the health and quality of care issues affecting people from underserved groups with a primary focus on diabetes/obesity, cardiovascular disease, and cancer. These findings were widely disseminated in order to inform strategies for eliminating healthcare disparities. The Network prioritized research on intra-group determinants (acculturation, ethnic subgroup, language preference, demographic factors, etc.) of quality of care in Latino and American Indian populations.
Funder: The Robert Wood Johnson Foundation

California Health Interview Survey 2007 - CHIS 2007 - Subethnicity & Acculturation Module
E. Richard Brown (PI), Ninez Ponce (co-PI)
April 2007-December 2009 Direct Costs: $211,312
Synopsis: Inclusion of questions on the 2007 California Health Interview Survey to gather detailed information from a very large ethnically, linguistically and geographically diverse sample of California adults, teens and children to examine how acculturation affects quality of care, health status, chronic diseases and conditions among ethnic subgroups.
Funder: The Robert Wood Johnson Foundation

Policy Implications of the Role of Race, Ethnicity and Language for the Health of Californians
Ninez Ponce (PI); Jeanne Black (Co-I) April 2003- September 2003 ~$41,541.00
Synopsis: The specific aim was to measure the extent to which race/ethnicity and English language proficiency contribute to disparities in health status, health care access and utilization, using data from the 2001 California Health Interview Survey (CHIS) and weighted multivariate logit or probit models. Findings from this analysis helped inform the policy agenda on language access policies, and Proposition 54, an initiative that would have eliminated the government's collection of race and ethnicity data. Proposition 54 was defeated in the October 2003 recall election. We tested how the omission of race/ethnicity affects the predictive power of the models for health status, health care access, and utilization, and we will determine the extent of the bias on other predictor variables such as income or education. This analysis informed policy makers as to whether race/ethnicity information is necessary in order to obtain a true understanding of the factors that lead to health disparities.
Funder: California Program on Access to Care, University of California Office of the President.

California Health Interview Survey
E. Richard Brown (PI), Ninez Ponce (co-PI), Jeff Luck (co-PI)
Synopsis: CHIS 2001 is a population-based health survey of over 55,000 California households. CHIS 2001 was offered in English, Spanish Cantonese, Mandarin, Vietnamese, Korean and Khmer. I chaired the Multicultural Health Technical Advisory Group and initially, the Survey and Sampling Technical Advisory Group. As co-PI I led the conceptualization and implementation of oversampling, linguistic and cultural adaptation, and measurement of race/ethnicity, acculturation and discrimination.
Funders: (1) National Cancer Institute, July 1999-June 2001; $2.5 million
(2) The California Endowment, July. 2001-Dec. 2002; $3 million

County of Alameda Uninsured Survey
Ninez Ponce (PI), Michael Jang, Institute for Scientific Research (Co-PI), Sherry Hirota, Asian Health Services (Co-PI) April 2000-April 2001;
$200,000

Synopsis: I developed the survey questionnaire, designed the sampling frame and contracted the survey research firm to conduct this random-digit dial telephone population-based survey on Alameda County's uninsured adults. Latinos and Asian American and Pacific Islanders (AAPI) were oversampled and the survey was conducted in Spanish, Cantonese, Mandarin, Vietnamese, Korean and Dari. This activity was part of an evaluation study of an affordable health insurance product for low to moderate-income AAPI and Latino immigrants, regardless of documentation status, residing in Alameda County.
Funders: Community Voices/Asian Health Services/Kellogg Foundation/County of Alameda,

VI. AWARDS

AcademyHealth, Health Services Research Impact Award, 2019

Health Affairs Editor's pick for top ten articles of 2015 (see publication: Early diffusion of gene expression profiling in breast cancer patients associated with areas of high income inequality.)

Changemaker Award, presented by the community organization CYPHER-Conscious Youth Promoting Health and Environmental Readiness, 2014

Favorite Professor Award, presented by the Public Health Student's Association, UCLA, 2013

Favorite Professor Award nominee, presented by the Public Health Student's Association, UCLA, 2012

AcademyHealth Dissertation Chair of Outstanding Dissertation (Janet Cummings, PhD), 2010

Filipino American Services Group, American Dream Award, 2010

National Finalist for the 2009 ASPH/Pfizer Award for Teaching Excellence.

Dean's Award for Distinguished Teaching, 2009

Graduate Division , Excellence in Summer Mentorship, 2009

Royal Morales Community Achievement Award, UCLA Pilipino Alumni Association, 2009

National Institutes of Health Merit Award for Multicultural Survey Research, 2008

Distinguished Professor Award, presented by the Public Health Student's Association, UCLA, 2008

Outstanding Abstract in Disparities, AcademyHealth Meeting, Boston, 2007

Outstanding Abstract in Disparities, AcademyHealth Meeting, Boston, 2005

Rising Star in Cancer Disparities Research, National Cancer Institute, National Institutes of Health, 2004

Chancellor's Faculty Career Development Award, UCLA, 2003

Outstanding Community Researcher Award, the Asian and Pacific Islander American Health Forum (a national health advocacy organization), 2001

Delta Omega Public Health Honor Society, 2001

Distinguished Professor Award, presented by the Public Health Student's Association, UCLA, 2000

Agency for Health Care Policy and Research Postdoctoral Fellowship, 1998-1999

Agency for Health Care Policy and Research Fellowship (now AHRQ), 1992-1995

University of California Dissertation Fellowship, 1996-1997

University of California Research Fellowship, 1995-1996

VII. SCIENTIFIC CONFERENCES—PODIUM PRESENTATIONS (since 2007)

1. Ponce NA. "What do population-based health surveys across the nation tell us about the state of data disaggregation for AANHPIs?" American Public Health Association Annual Meeting, San Diego, CA. November 12, 2018.
2. Ponce NA. "Capturing Racial/Ethnic Diversity in Population-Based Surveys: The Importance of Data Disaggregation." American Public Health Association Annual Meeting, San Diego, CA. November 13, 2018.
3. Ponce NA. "Improving Data Capacity for American Indian/Alaska Native (AI/AN) Populations." AcademyHealth, Seattle, WA. June 24, 2018.
4. Ponce NA, "Opportunities for China-California Immigration Studies." 2017 Annual Symposium of the China-USA Research Center for Life Sciences on Interdisciplinary Research with Global Public Health, Chinese Academy of Sciences Beijing, China, November 13, 2017.
5. Ponce NA, session co-organizer: "Migration, Health and Health Systems: Frameworks Organized session" presenter: "The California Health Interview Survey CHIS: A tool for Monitoring Immigrant Health". International Health Economics Association Meeting, Boston, MA, USA July 10, 2017.
6. Ponce NA, "So You've Earned a PhD." AcademyHealth, New Orleans, CA, June 26, 2017.
7. Ponce NA, session organizer. "How Many People are Uninsured? Variation in National and State-level Survey Estimates." American Public Health Association, Denver, CO, November 1, 2016.
8. Ponce NA with David Grant, Royce Park, Gerald Kominski, Hongjian Yu, Yueyan Wang, Matt Jans, Tara Becker, Kevin McLaughlin and Todd Hughes. "Do uninsured rates suffer from nonresponse bias? Evidence from the California Health Interview Survey (CHIS)" American Public Health Association, Denver, CO, November 1, 2016.
9. Ponce NA. "Minimum Wage Policies and Child Nutritional Status in Low to Middle Income Countries" International Health Economics Association Meeting, Milan, Italy July 15, 2015.
10. Ponce NA, Shimkhada R. "Does Income Inequality Make Us Sick?" Panel on Building a Social Movement to Become the Healthiest Nation in One Generation, American Public Health Association meeting, New Orleans, LA November 19, 2014.
11. Ponce NA, Becker T. "Place Matters. Data Matters. AA & NHPI Hotspots" Panel on Becoming the healthiest nation in a generation, American Public Health Association meeting, New Orleans, LA November 18, 2014.
12. Ponce NA, Kil J. "California Health Interview Survey: Meeting the demand for population-based health data on AA NHPIs" Panel on Evidence-based research and policy for health equity among Asian and Pacific Islander communities. American Public Health Association meeting, New Orleans, LA November 17, 2014.
13. Ponce NA. National Library of Medicine panelist. "Build, Don't Duplicate" AcademyHealth Research meeting , San Diego, CA June 08, 2014.
14. Ponce NA., Cancer Prevention and Control in the US: Learning from the Past and Moving into the Future, International Health Economics Association Meeting, Sydney, Australia July 9, 2013.
15. Ponce NA. Panel leader/organizer. "Use of State Population Health Survey Data to Inform Health Care Coverage Policy" AcademyHealth meeting ,Baltimore MD June 22, 2013
16. Ponce NA. Panel leader/organizer. "Hospital/Facility-Level Variations: Implications for Disparities" AcademyHealth meeting, Boston, MA June 28, 2010

17. Ponce NA. Panel leader/organizer. "Health Care System Interventions to Reduce Chronic Disease Disparities" AcademyHealth meeting, Boston, MA June 27, 2010
18. Ponce NA. Moderator and discussant. "Advances in Health Disparities Research Methods" Disparities Interest Group meeting, AcademyHealth meeting, Boston, MA June 26, 2010
19. Ponce NA, Cochran S, Mays V. "For richer or poorer, in sickness and in health: do same-sex marriage bans increase health insurance disparities? AcademyHealth meeting, Washington, DC June 2009.
20. Ponce NA. "State of Health Insurance in Asian America." NIH Summit: The Science of Eliminating Health Disparities, National Harbor, MD, December 16, 2008.
21. Ponce NA. "Wealthier but not healthier: Latino enclave effects on cancer screening." American Public Health Association Meetings, San Diego, CA October 28, 2008.
22. Ponce NA. "Disparities in Health Insurance and Cancer Screening for Asian American Women. American Association for the Advancement of Science–Pacific Division Asian And Asian American Women: Health and Welfare Session. Waimea, Hawaii, June 15-19, 2008.
23. Ponce NA. "Measuring ethnic enclave to study associations with cancer screening among older adults." Gerontological Society of America, San Francisco, CA. November 17, 2007.
24. Ponce NA. "Ethnic enclaves, safety net location and cancer screening: Amenity or Penalty?" International Health Economics Meeting, 6th World Congress, Copenhagen, Denmark. July 10, 2007.
25. Ponce NA. " In Sickness and in Health." 7th Annual Economic Research Initiative on the Uninsured (ERIU) Summer Research Conference, Ann Arbor, June 28-29, 2007.
26. Ponce NA. "Do safety net clinics reduce ethnic enclave risk in cancer screening?" AcademyHealth meeting, Orlando, FL. June 3, 2007 (Outstanding Abstract).

VIII. INVITED SPEAKING ENGAGEMENTS/ TESTIMONIES/WEBINARS/MEDIA (since 2007)

1. Ponce NA, Lucia L, Shimada, T. "How Proposed Changes to the '**Public Charge**' Rule Will. Affect Health, Hunger and the Economy in California." UCLA Center for Health Policy Research, Los Angeles, CA, November 7, 2016.
2. Ponce NA. "Immigration as Social Determinant of Health." Invited Speaker. Health Services Research Colloquium. Center for Health Care and Policy Research. Department of Health Policy and Administration. Penn State. State College, PA, October 22, 2018**.**
3. Ponce NA. "The California Health Interview Survey: Science & Data for Public Health Action." 2018 Women in Science Conference. University of Notre Dame, October 6, 2018.
4. Ponce NA. "California Health Interview Survey, Population Health Data for Health Policy." Invited lecture. World Health Organization, Geneva. July 4, 2018
5. Ponce NA, "Immigration as Social Determinant of Health." Keynote Speaker. Los Angeles County Department of Public Health. The California Endowment**,** Los Angeles, CA, April 12, 2018**.**
6. Ponce NA, "Data for Policy Impact—California." Invited Speaker for National Academy of Medicine Workshop, "Immigration as Social Determinant of Health." Oakland, CA, November 28, 2017.
7. Ponce NA. Policy Café: "Breaking Barriers: Policy Implications from the California Health Interview Survey." Community Clinic Association of Los Angeles. December 1, 2017.
8. Ponce NA. Research quoted in People Magazine. "Julia Louis-Dreyfus Said She's 'Lucky' to Have

Insurance — Here's What It's Like to Have Breast Cancer Without It". October 5, 2017.

9. Ponce NA. "Protecting Immigrants' Access to Vital Services: The Impact of Public Charge on Our Immigrant Communities." California State Capitol, with Assembly members Rob Bonta and David Chiu 15 September 2017.
10. Ponce NA. "Using the results of the California Health Interview Survey." Managed Care Essentials, video hosted by the hosted by the American Journal of Managed Care." August 4, 2017 edition.
11. Ponce, NA. "ACA Repeal Panel." Moderated by Cliff Goodman, with Avik Roy and Sally Pipes. ACO and Emerging Healthcare Delivery Coalition Spring Live Meeting, hosted by the American Journal of Managed Care, Scottsdale, Arizona, May 7, 2017.
12. Ponce NA. Quoted in Self Magazine. "ICE Took an Undocumented Mom with a Brain Tumor from the Hospital." February 24, 2017.
13. Ponce NA, "Benefits of Data Warehousing Clinical and Social Determinants of Health." Association of Asian Pacific Community Health Organization, Washington, DC**,** 28 March 2017.
14. Ponce NA: "Improvements in the Health of Californians under the ACA: What's at Risk?" in The Future of Health Reform in California: The ACA at Risk. Plenary session. Insuring the Uninsured Project, Sacramento, CA, 7 February 2017.
15. Ponce NA, "Moving towards Population Health." Keynote Speaker, Keiro Inaugural Grants Luncheon, Japanese American National Museum**,** Los Angeles, CA, 22 April 2017.
16. Ponce NA. Research featured and quoted in Sacramento Bee. "What's blocking women from timely breast cancer treatment? UCLA study asks lawmakers to eliminate hurdles." January 12, 2017.
17. Ponce NA: "Breaking the Barriers to Breast Cancer Care: Exploring Policy Options." Legislative Briefing with Senator Richard Pan, Sacramento, CA, 12 January 2017.
18. Ponce NA. "Socio-Economic Factors that Impact Health and Healthcare." Providence Holy Cross. Los Angeles, CA, 16 December 2016.
19. Ponce NA with Todd Hughes. ""CHIS 2015: What's New from the Nation's Largest State Health Survey." UCLA Center for Health Policy Research, Los Angeles, CA, December 14, 2016.
20. Ponce NA. "Race and Ethnicity Trends in California: 'What Is the 'Landscape of Opportunity?" UCLA Center for Health Policy Research, Los Angeles, CA, November 29, 2016
21. Ponce NA. "Snapshot of Health in California." Opening Plenary. California Pan Ethnic Health Network Annual Conference: Voices for Change: Seizing the Momentum for Health Equity. Los Angeles, CA October 18, 2016.
22. Ponce NA with Brian Smedley. "Demographic Change, Health Equity, and a Culture of Health." Plenary session, Fall Leadership Institute, Robert Wood Johnson Foundation. Princeton, NJ September 27, 2016.
23. Ponce NA and Ying-Ying Meng. "CHIS Overview." Presentation to Keiro Foundation community advisors, Keiro Foundation. The California Endowment. Los Angeles, CA August 16, 2016.
24. Ponce NA, "Global Health @UCLA." Global Health Development Strategy Advisory Committee Meeting. Fudan University. Shanghai, China. June 20, 2016.
25. Ponce NA. "Global vs. Local: A False Dichotomy?" The Oldenborg Luncheon Colloquium and Medicine, Education, and Development for Low-Income Families Everywhere. Pomona College. April 7, 2016.
26. Ponce NA. "Value of In-Language Surveys for Public Health." in Social Determinants of Health—Public Health Minute with Bill Latimer. Lehrman College. Audio available at:

http://wp.lehman.edu/public-health-minute-with-william-latimer/social-determinants-of-health-ninez-ponce-mph-phd-ucla-fielding-school-of-public-health/ 9 December 2015.

27. Ponce NA. "Balancing Broad Dissemination and Respondent Confidentiality." National Science Foundation- National Center for Science and Engineering Statistics Expert Panel on Confidentiality Protection, Arlington, VA, September 17, 2015.
28. Ponce NA and Rau, Bogdan. "A Policy Tool to Assess Immigrant Health Access, Health and Integration." 10th Summer Institute on Migration and Global Health, The California Endowment, Oakland, CA June 22, 2015.
29. Ponce NA. "Immigrant Health." Global Health: Meeting the Greatest Challenges." UCLA Health Forum, Los Angeles, CA February 27, 2015.
30. Ponce NA. "Minimum Wage Policies and Child Nutritional Status in Low to Middle Income Countries." Division of GIM-HSR Friday Noon Seminar Series, UCLA, Los Angeles, CA, February 20, 2015.
31. Ponce NA. "Emerging Markets." Modernizing Healthcare for the New Age, Healthcare Business Association 1st Annual Conference, UCLA Anderson School of Management, Los Angeles, CA, February 13, 2015.
32. Ponce NA. "Disparities in Utilization of Gene Expression Profiling and Subsequent Chemotherapy Decisions." Grand Rounds, City of Hope, Duarte, CA, February 10, 2015.
33. Ponce NA. panelist "Pass or Fail in Cambodia Town." Moderated by Maria Hinojosa, National Public Radio series on "America by the Numbers." The California Endowment. November 10, 2014.
34. Ponce NA. Panel leader/organizer. "Population Health & Health Equity." AcademyHealth pre-conference sessions, San Diego, CA June 06, 2014.
35. Ponce, NA, "Overview of CHIS and BRFSS Data Sources." California Department of Public Health. Webinar. May 14, 2014.
36. Ponce, NA, "Social Determinants and Health." Fielding School of Public Health "Continuing the Conversation" Webinar. March 13, 2013 .
37. Ponce, NA, "Social Determinants in Health." Plenary speaker invitation. "Advancing Equity: (Re)Emerging Perspectives on Health and Health Policy." The Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico: Fall 2012 Symposium.
38. Ponce NA, Invited Panelist, "Aging Across Cultures." 34th Annual Kaiser Permanente National Diversity Conference, October 27, 2011.
39. Ponce, NA. "Health Data needs for Asian Americans and Pacific Islanders." White House Asian American and Pacific Islander Initiative (invitation only event). December 9, 2010.
40. Ponce NA. "Data and Policy Needs to advance Asian and Pacific Islander Health." Panel organizer and moderator, November 13, 2008, California State Capitol, Room.
41. Ponce, NA. "What's the Buzz on AB 1195?" Philippine Medical Association of Southern California. Healthcare & Illness of Filipino Immigrants in America. Long Beach, CA. November 4, 2007. (Invited Speaker)
42. Ponce NA. "Health care reform and communities of color." Meeting our Needs: Health Care Reform Briefing, August 21, 2007, California State Capitol, Room. (Invited Briefing)

IX. SERVICE

UCLA Service

Campus-Wide

1.	Member, Committee on International Education	2016-2019
2.	Review Committee for Dean of Anderson School of Management	2015-2016
3.	Committee member, Undergraduate Global Health Minor	2015-present
4.	Divisional representative on the Academic Assembly	2014-2018
5.	Alternate divisional representative on the Academic Assembly	2011-2014
6.	Hellman Fellows Fund Selection Committee	2011-201
7.	Jonsson Comprehensive Cancer Center	
	• Member	2001-present
	• Asian American Network for Cancer Awareness, Research and Training	2000-2007
	• Seed Grant Reviewer	2005, 2007
8.	Asia Pacific Center, International Institute	
	• Executive Committee, Faculty Associate	2016-present
9.	Asian American Studies, Institute for American Cultures	
	• Associate Director	2011-2012
	• Faculty Associate, Asian American Studies program	2000-present
	• Institute of American Cultures grant reviewer	2002, 2005, 2007
10.	Center for Southeast Asian Studies, International Institute	
	• Faculty Associate	2003-present
11.	Center for the Study of Women	
	• Faculty Associate	2007-present
12.	UCLA Student Organizations (Faculty Advisor)	
	• Samahang Pilipino Education and Retention (SPEAR)	2003-2008
	• Samahang Pilipino Advancing Community Empowerment (SPACE).	2003-2008

Department of Health Policy and Management

1.	Director, PhD Program	2016-2018
2.	Chair, Admissions	2014-2015
3.	Chair, Search Committee HPM	2014-2015
4.	Chair, Search Committee HPM	2013-2014
5.	Vice Chair	2013-2014
6.	Standing Personnel Committee	2012
7.	EMPH Advisory Committee	2012
8.	Acting PhD Program Director (Spring Quarter)	2011
9.	EMPH Steering committee	2010-2011
10.	EMPH/EMHA Self-Sustaining Program Committee, Chair	2010-2011

Fielding School of Public Health

1.	Search Committee: Global Environmental Change & Health FSPH	2018
2.	Undergraduate Programs Committee	2016-2018
3.	Search Committee: Global Health Equity FSPH	2015-2016
4.	Search Committee: Global Health Management FSPH	2014-2015
5.	International Health Committee	2014-2016
6.	Undergraduate Programs Committee	2011-2014
7.	Global Health Task Force	2010-2011
8.	International Health Committee	2008-2009
9.	Committee for Alumni Hall of Fame	2008

10. Search Committee: Director of the ERC (Education and Research Center) 2007-2008
11. Search Committee: Community Health Sciences/Health Education 2006-2007
12. Search Committee: Global Health 2003-2004
13. Student Affairs Committee, School of Public Health 2002-2003
14. Bixby Program grant reviewer, School of Public Health 2001
15. Faculty Executive Committee, Secretary, School of Public Health 1999-2000

Center for Global and Immigrant Health

1. Director 2014-9/2018
2. Faculty Affiliate 9/2018-present

Center for Health Policy Research

1. Center Director 7/2018-present
2. Associate Center Director 2014-6/2018
3. Programming Subcommittee 2001-2002
4. Research Management Committee 2000-2002

Extramural Service

1. Commissioner, One Nation AAPI 2019
2. National Advisory Board, Center for Health Policy, Meharry Medical College 2019
3. Member: World Health Organization Healthy Ageing Network 2018-2019
4. Technical Advisory Panel member 2018-2019
   RAND/ Center for Medicare and Medicaid Services Star Rating
5. Expert Advisory Panel member
   Brigham and Women's Center for Surgery and Public Health 2018-2019
   Metrics for Equitable Access and care in SURgery (MEASUR)
6. Technical Expert Panel member: 2018-2019
   Yale Center for Outcomes Research and Evaluation /
   Center for Medicare and Medicaid Services Hospital Outcome Measurement
   for Patients with Social Risk Factors
7. Advisory Board: California Program on Access to Care 2018-2019
8. Advisory Board: Insuring the Uninsured Project 2018-2019
9. Advisory Board: UC Center Sacramento Faculty Council 2018-2019
10. Health Affairs, planning panel on California Special Issue 2017
11. Board of Scientific Counselors, National Center for Health Statistics
    of the Centers for Disease Control and Prevention (CDC) 2017-present
12. Health Affairs invited panel on Health Equity Special Issue 2016
13. National Institutes of Minority Health and Health Disparities—Workgroup on
    Visioning Process on Health Disparities Measurement and Methods 2016-2018
14. California Vital Statistics Advisory Committee 2016-present
15. National Quality Forum, co-Chair with Marshall Chin, U of Chicago
    Disparities Standing Committee 2015-2019
16. National Quality Forum, Expert Committee on Risk Adjustment
    for Sociodemographic Factors 2014
17. Multicultural Advisory Board, Nielsen Inc. 2015-2019
18. Institute of Medicine, subcommittee on Race, Ethnicity, Language Data 2009
19. Blue Ribbon Commissioner, Los Angeles Alliance for a New Economy 2006
20. Executive Committee Board member, National Health Law Program 2005-2009
21. Trustee, New Heights Charter School, Los Angeles, CA 2006-2009
22. Academic Advisory Group, Asian Pacific American Legal Center 2005-2009
23. Policy Committee, California Pan Ethnic Health Network 2003-2009
24. Member of Methods, Measurement and Reporting Expert Panel:

Trans-HHS Cancer Health Disparities Progress Review Group, National Cancer Institute, National Institutes of Health, U.S. DHHS	2003
25. Office of the Patient Advocate, Cultural/Linguistic Committee Member	2002-2007
26. Harvard Civil Rights Project, Advisory Committee	2002-2003
27. Core Committee to preserve race/ethnicity in public health data collection	2001-2004
28. Research Advisory Board member, Asian & Pacific Islander Health Forum	1999-2000
29. Asian American and Pacific Islander Health National Policy Committee	2000-2002
30. Member, Filipino Task Force on AIDS, San Francisco, CA	1998-1999
31. Grant Reviewer, Office of Minority Health, USDHHS	1992,1994, 1998
32. Volunteer, South Central Los Angeles Women's Shelter	1994-1996
33. Board Member, Filipinos for Affirmative Action, Oakland, CA	1990-1992
34. Volunteer, Vacaville Prison Project, Vacaville, CA	1982-1984
35. Community Health Worker, Berkeley Free Clinic, Berkeley, CA	1980-1984

X. PROFESSIONAL MEMBERSHIPS

1. AcademyHealth	1993-2019
• Annual Meeting Chair 2020	2019-2020
• Planning Committee, National Health Policy Conference	2014-2015; 2019
• Global Public Health Systems Innovations	2014-2015
• Aetna Foundation Scholars in Residence Mentor	2014-2015
• Executive Planning Committee for Annual Meeting	2014-2015
• Disparities Theme Leader	2013-2014
• Aetna Minority Scholars Mentor	2010-2012
• Executive Planning Committee for Annual Meeting	2009-2010
• Disparities Theme Leader	2009-2010
• Outstanding Abstracts Judge	2009
• Disparities Interest Group founding & co-Chair	2006-2009
2. American Public Health Association	1988-2018
• APHA Access to Care Workgroup	
• Asian and Pacific Islander American Caucus	
-Treasurer	2003-2007
-Annual Meeting Scientific Program Abstract Reviewer	2004-2006
• Medical Care Section (2004-2005)	
• Statistics Section member (1988-2003)	
3. International Health Economics Association	1998-2015
• Scientific Abstract Reviewer	2015

XI. REVIEWER OF PEER REVIEWED JOURNALS/PROGRAM ABSTRACTS

1. Health Services Research	2003/2007-2015/2017/2019
2. Journal of the American Medical Association	2007/2018
3. New England Journal of Medicine	2017
4. American Journal of Public Health	1998/2005/2006/2015/2017
5. Health Affairs	2005/2007/2009-2011/2014/2015/2019
6. Medical Care	2004/2005/2006/2007/2017/2018
7. BMC Public Health	2008/2017/2018
8. Journal of General Internal Medicine	2005/2006/2019

9. Medical Care Research & Review	2015/2018
10. Social Science and Medicine	2008/2012/2018
11. International Journal of Health Equity	2012
12. Evaluation & the Health Professions	2011
13. Journal of Policy Analysis and Management	2011
14. Annual Review of Public Health (Guest Editor)	2008
15. Cancer Epidemiology, Biomarkers and Prevention	2007
16. Social Science Quarterly	2006
17. American Journal of Managed Care	2006
18. Inquiry	2005
19. Journal of Health Policy, Politics and Law	2003
20. Journal of Health Care for the Poor and Underserved	2003
21. Harvard Health Policy Review	2002
22. Journal of Health and Social Behavior	2002/2016
23. AcademyHealth Scientific Program	2006-2010/2014
24. American Public Health Association Scientific Program	2005/2006
25. International Health Economics Association	2015
26. UC Global Health Day	2015

Exhibit B

Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform

1994-97

Michael E. Fix, Jeffrey S. Passel

This analysis was funded by the Ford and Andrew W. Mellon Foundations. Support has also been provided by the Office of the Assistant Secretary for Planning and Evaluation, the Administration for Children and Families, and the Health Care Financing Administration, U.S. Department of Health and Human Services; the Food, Nutrition, and Consumer Services and the Economic Research Service, U.S. Department of Agriculture; and the Immigration and Naturalization Service.

Document date: March 01, 1999
Released online: March 01, 1999

The authors would like to thank Scott Anderson for his excellent research support and Wendy Zimmermann, Leighton Ku, and Karen Tumlin for helpful comments.

Background

With the enactment of the 1996 welfare reform act,(1) Congress imposed broad new restrictions on legal immigrants' access to public benefits, set new time limits on refugees' eligibility for many federal benefits, and introduced new bars on the access of "unqualified immigrants" to services.(2) But perhaps more important than these changes in eligibility are welfare reform's chilling effects which may discourage immigrants from using health, nutrition, or other types of benefits, despite the fact that many remain eligible. These effects originate, among other things, in confusion on the part of immigrants and providers about who is eligible for benefits and in fears relating to the application of the public charge doctrine.(3)

An earlier study by the Urban Institute found evidence of such chilling effects in Los Angeles County.(4) In that study, approved applications of legal noncitizen families for Medi-Cal and Temporary Assistance for Needy Families (TANF) fell 71 percent between January 1996 and January 1998, while there was no decline among citizens. The drop occurred even though there was no change in legal immigrants' eligibility for these programs in California and denial rates in the county remained steady during the period examined.

In this brief report we use the Census Bureau's Current Population Survey (CPS) to document *national* trends in immigrants' use of public benefits in the period following welfare reform. Specifically, we examine changes in participation between 1994 and 1997 reflected by the March CPS.(5) During 1994 changes in welfare rules were just beginning to be broadly debated. By the end of 1997, welfare reform had been in place for a year and a half, although full implementation was not complete. In addition, the CPS for both years provides comparable data on benefit use for the entire nation.

The current analysis builds on methods developed by the Urban Institute over the past decade that permit us to distinguish refugees, naturalized citizens, and temporary immigrants from other legally present immigrants.(6) Such distinctions are important for two reasons. First, conventional comparisons between the benefit use rates of natives and the foreign born mask substantial variation in rates and trends among substantively different segments of the foreign-born population. Second, following welfare reform, citizenship status has become an increasingly important determinant of eligibility for public benefits.

We should emphasize that most legal immigrants and refugees remained eligible for welfare and Medicaid benefits throughout the period examined (1994 through 1997).(7) The same cannot be said for federal food stamps, however: many legal immigrants' eligibility was supposed to end as of September 1997, while new noncitizen applicants became ineligible in October 1996. Finally, while most immigrants arriving after welfare reform's enactment are barred from federal means-tested public benefits for at least five years,(8) these "future" immigrants represented a small share of the noncitizen population at the time of the March 1998 CPS.

Principal Findings

- When viewed against the backdrop of overall declines in welfare receipt for all households, ***use of public benefits among noncitizen households (9) fell more sharply (35 percent) between 1994 and 1997 than among citizen households (14 percent)***. These patterns hold for welfare (defined here as TANF, SSI, and General

Assistance), food stamps, and Medicaid.

- ***Refugees experienced declines (33 percent) that were at least as steep as those within the noncitizen population***--despite the protections for refugees incorporated into welfare reform and the fact that few refugees had lost their eligibility for benefits by March 1998.(10)
- ***For low-income populations (i.e., with incomes below 200 percent of poverty), program usage also fell faster for noncitizen than citizen households***.
- ***Welfare use in noncitizen households with children also fell faster (36 percent) than in households with children where all adults are citizens (23 percent).***
- One result of these trends is that ***noncitizens accounted for a disproportionately large share of the overall decline in welfare caseloads that occurred between 1994 and 1997***. While 23 percent of the drop in welfare caseloads can be ascribed to noncitizens, they represented only 9 percent of households receiving welfare in 1994.
- ***Welfare use among elderly immigrants and naturalized citizens did not appear to change between 1994 and 1997.***
- ***When welfare use among all households is examined, noncitizen participation levels were higher than citizens' in both 1994 and 1997,*** despite rapid declines in noncitizen use rates. But when we look at ***poor households (i.e., with incomes under 200 percent of poverty), noncitizens' participation rates in 1994 were no different from those of citizens; by 1997, however, levels had declined so that noncitizens had lower participation rates than citizens*** (14.5 versus 17.9 percent). When we examine ***poor households with children, noncitizen rates were lower for both 1994 and 1997--falling to almost half of the level of citizens in 1997*** (14.0 versus 25.8 percent).
- ***Neither naturalization nor rising incomes accounted for a significant share of noncitizens' exits from public benefit use.***

In the following section we examine patterns of benefit use in three different ways. First, we examine benefit use by *household,* disaggregating by all households, by households with incomes below 200 percent of poverty, and by those containing children. We then present findings for *individuals,* distinguishing use patterns for working-age adults (age 18 to 64) and the elderly (age 65 and over). We conclude the section by disaggregating trends by *legal status*, most notably program participation by refugees and naturalized citizens. In each instance, differing units of observation reveal different relative levels and trends in benefit use by citizens and noncitizens.

The analysis examines the use of welfare, food stamps, and Medicaid. While complete results are set out in the figures and tables included in this report, selected outcomes are highlighted in the narrative below. Since trends in food stamp and Medicaid use generally parallel those for welfare, we usually report results for only welfare.

DETAILED FINDINGS

A. Household-Level Analyses

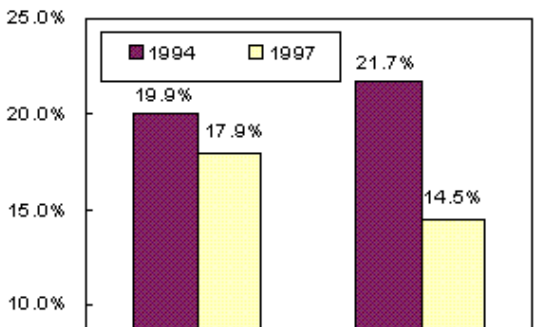
Relative benefit use rates for citizens and noncitizens differ greatly depending on whether we focus on all households, poor households, or households with children. The reasons for these differences are straightforward. Poor households are far more likely to be eligible for and use benefits, and noncitizens are more likely to be poor. Fifty-four percent of noncitizen households have incomes below 200 percent of poverty, compared with 31 percent of citizen households (Table 4).

While controls for poverty have occasionally been taken into account in discussions of immigrant welfare use,(11) differences between households with and without children have been less frequently invoked. Yet such differences are significant because households with children are considerably more likely to use benefits, and immigrant households are more likely to contain children. Of households headed by noncitizens of working age, 55 percent include children, compared with 35 percent of comparable citizen households. As we report below, when we separately control for poverty and the presence of children, differences in program use rates between citizens and noncitizens diminish and, in some instances, disappear altogether. When we control for both poverty and the presence of children, noncitizen use of benefits is consistently lower than that of citizens, both before and after welfare reform.

All Households. Welfare receipt by noncitizen households fell much faster (35 percent) than citizens' receipt (14 percent) between 1994 and 1997. However, despite these steeper declines, noncitizen use of welfare remained higher than citizens' in 1997--9.0 versus 6.7 percent (Table 1 and Figure 1). By 1997, far more immigrants had lost their eligibility for food stamps than welfare. But our data show that noncitizens' participation in each program declined at roughly the same rate, with a marginally faster decline in welfare than in food stamps (35 percent versus 30 percent).

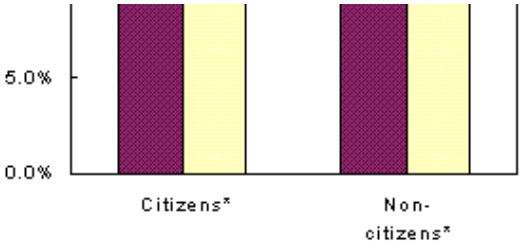
Households below 200 Percent of Poverty. The picture of higher welfare use by noncitizens shifts significantly when we control for poverty. By 1997, noncitizens with incomes below 200 percent of poverty had use rates that were significantly *lower* than citizens' rates--14.5 versus 17.9 percent (Chart A). Here again, noncitizen participation rates dropped faster than citizens' between 1994 and 1997 (33 versus 10 percent). For both food stamps and Medicaid, noncitizens' use also fell faster than citizens' during the same period, so by 1997 relative participation levels within each program were effectively the same for both groups (Table 1 and Figure 1).

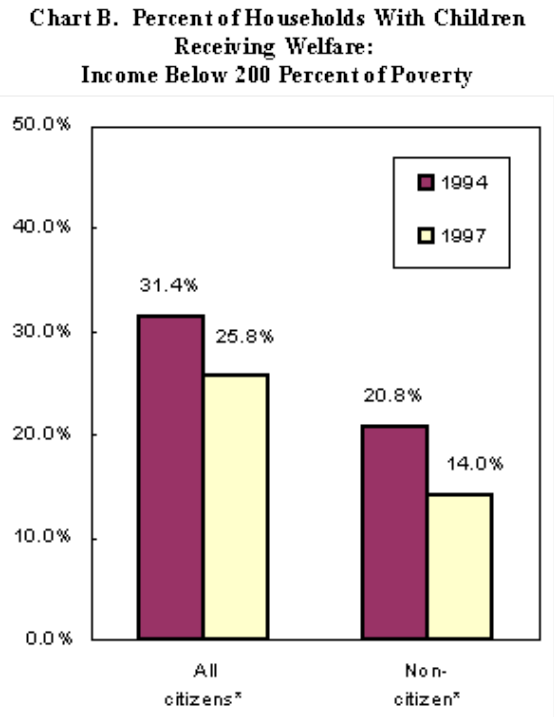
Chart A. Percent of Households Receiving Welfare: Income below 200 Percent of Poverty



Households with Children. When we control for the presence of children, we also see declines to the point where noncitizen welfare usage rates in households with children are not significantly different from citizens'rates (8.9 versus 9.6 percent, in Table 3). Rates for both declined rapidly between 1994 and 1997--35 percent for noncitizens and 23 percent for

citizens--but the difference in the rate of decline is not statistically significant (Table 3 and Figure 3).





In households with noncitizen adults, many of the children are citizens, in most cases because they were born in the United States. In fact, there is at least one citizen child in 85 percent of noncitizen households with children. These mixed-status households are of substantial demographic importance in the United States, as about one in 10 American children lives in a household where one or more of the parents is a noncitizen and one or more of the children is a citizen.(12)

Households with Children and with Incomes below 200 Percent of Poverty. Given the large share of noncitizen households that are poor and contain children, one approach to assessing relative benefits is to control for both poverty and the presence of children. When we do so, we see much lower use among noncitizen households, both before and after welfare reform. With the rapid declines that occurred for both groups, noncitizen welfare use in 1997 is about half the rate for citizens--14.0 versus 25.8 percent. (See Chart B, Table 3, and Figure 3.)

B. Individual-Level Analyses

Individual-level analyses of welfare use among citizens and noncitizens produce results that differ from results of aggregate household-level analyses because of patterns of welfare reporting in the CPS, differences in welfare use, and structural differences in the populations.(13) "Welfare use" for an individual in the CPS is defined as having income from TANF, General Assistance, or SSI; a household "uses welfare" if anyone in the household has welfare income. One issue in reconciling individual and household use rates, as well as comparing survey with administrative data, is the fact that income data in the CPS is collected only for persons age 15 and over. Thus, if a child is receiving public assistance income, the income will either be ascribed to the parent or missed.

This income-based measure of welfare use means that most households report welfare participation as though there were only a single welfare recipient. For example, a single mother with two children receiving TANF income is only counted as one welfare unit or recipient, not three. The individual-level analysis differs from the household approach by ascribing use to only the reported welfare recipient, not to other household members who are not reported as receiving welfare. One reason it is important to examine individual level benefit use is that noncitizen households are significantly larger than citizen households.

Because there are almost twice as many adults (197 million, see detailed table B) as households (103 million, see Detailed Table A), welfare use rates for individuals should be lower than for households. In addition, noncitizen households are larger than citizen households and are more likely to contain children. Thus, we would expect larger differences in usage rates between households and individuals among noncitizens; the data support this.

Our analysis below focuses on two important subpopulations: working-age adults, age 18 to 64, and the elderly, age 65 and over.

Working-Age Adults. Working-age noncitizens' use of welfare fell roughly three times faster than citizens' between 1994 and 1997--41 versus 15 percent (Table 2). A similar pattern is evident for Medicaid.(14) By 1997, there is no statistical difference between citizen and noncitizen participation rates for welfare (4.0 versus 3.3 percent) or Medicaid (6.7 versus 7.2 percent). See Table 2 and Figure 2.

Elderly Immigrants. In sharp contrast to most of the other components of the analysis reported here, we find no statistically significant decline in either welfare or Medicaid use on the part of elderly noncitizens. In fact, we find no significant change in welfare receipt among the elderly overall, regardless of citizenship status (Table 2 and Figure 2).

Elderly noncitizen use of welfare and other benefits is much higher than is the case for citizens. In 1997, only 3.7 percent of elderly citizens used welfare, compared to 19.0 percent of noncitizens (Table 2 and Figure 2). Higher use of welfare (primarily SSI) and Medicaid among elderly noncitizens can be attributed to the fact that many have not worked in the United States long enough to qualify for Social Security or Medicare. Moreover, the absence of a decline in usage since 1994 may be explained, at least in part, by the restoration of SSI benefits to pre-enactment immigrants.

One result that emerges from the analysis is an *apparent* rise between 1994 and 1997 in the number and share of *naturalized* elderly receiving welfare benefits--from 99,000 or 5.9 percent, to 167,000 or 9.0 percent (Detailed Table B). During the same period, there is a commensurate decline in the number of *noncitizen* elderly receiving benefits (from 213,000 to 163,000). One hypothesis is that the decline in noncitizen participation for this subpopulation may be attributable in part to naturalization. However, these numerical changes are not statistically significant, so the results cannot be treated as definitive.(15)

C. Benefit Use by Immigrant Status

Historically, immigration status has been a strong predictor of immigrant use of public benefits. This is partly because

the foreign-born population consists of groups with varied eligibility for benefits. While naturalized citizens and refugees are eligible for benefits on the same terms as native-born citizens, legal permanent residents' use of benefits has been conditioned by deeming and public charge restrictions; temporary immigrants and the undocumented are largely barred from services. Further, the socioeconomic characteristics of the groups differ substantially, resulting in different needs.(16) The importance of disaggregating the foreign-born population by status can be seen in the analysis of household use rates (Table 1).

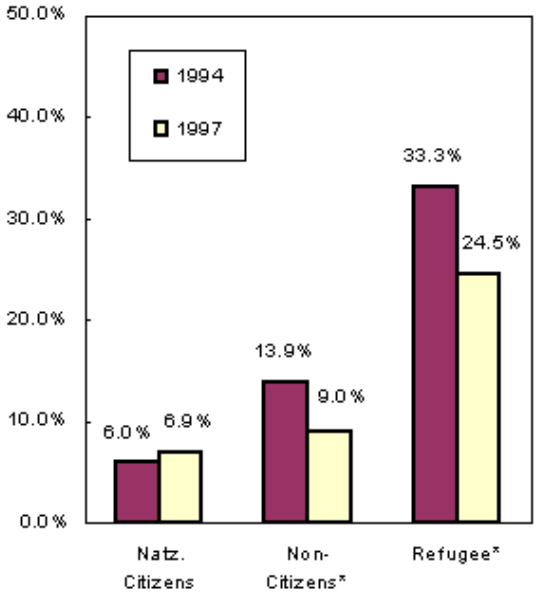
Foreign-Born Population. Between 1994 and 1997, welfare use in households headed by all foreign-born persons fell by 21 percent or 2.5 percentage points (from 11.7 percent to 9.2 percent). However, this general trend masks very different levels and trends among the various immigrant groups.

Refugees. Refugees, who have historically had the highest levels of public benefit use among the foreign born, account for 8 percent of immigrant-headed households, but for 21 percent of immigrants' welfare use (Detailed Table A). Their use rate remained high--24.5 percent in 1997--but even this level represented a decline of 8.8 percentage points from the pre-reform level of 33 percent (Chart C).

Naturalized Citizens. Naturalized citizens, who have historically had the lowest levels of public benefit use among legally present immigrant populations, represent the other extreme. While naturalized citizens make up 41 percent of immigrant households, they account for only 31 percent of immigrants' welfare use. Their use of benefits was virtually identical to that of native citizens and did not change significantly between 1994 and 1997.

Noncitizens. The residual foreign-born subpopulation, noncitizens, had a large decline of 4.9 percentage points to 9.0 percent in 1997, but their use rate remained somewhat higher than that of citizens.

Chart C. Percent of Immigrant Households Receiving Welfare, by Immigration Status



General Observations

Chilling Effects versus Eligibility Changes

- Because comparatively few legal immigrants were ineligible for public benefits as of December 1997, it appears that the steeper declines in noncitizens' than citizens' use of welfare, food stamps, and Medicaid owe more to the "chilling effect" of welfare reform and other policy changes than they do to actual eligibility changes. In addition, the fact that welfare use among noncitizens dropped as steeply as food stamp use (where new restrictions extended far more broadly) suggests that eligibility changes in one program may chill noncitizens' use of other programs. Over time, eligibility changes will become more important as most immigrants admitted after August 22, 1996, will be ineligible for most means-tested public benefits for at least five years after their entry to the country.

Noncitizens Do Not Appear to Be Naturalizing to Retain Benefits

- The consistently low share and number of naturalized immigrants who receive benefits indicate that few immigrants are becoming citizens in order to retain benefits. If most immigrant benefit recipients were naturalizing to retain benefits, the number of naturalized citizens receiving benefits would have grown substantially more than it did. (17)

Rising Incomes Do Not Explain Lower Program Participation Rates among Noncitizens

- One possible explanation for the faster declines in program participation among noncitizens than among citizens could be that incomes are rising faster for noncitizens. To address this issue, we use demographic standardization techniques (described below) to partition changes in program participation over the 1994-97 period into the share attributable to changes in income and the share attributable to changes in income-specific participation rates. Our analysis finds that most of the change is *not* due to rising incomes. Only 6 percent of the decline in welfare use among noncitizens, versus 30 percent of the decline among citizens, can be explained by rising incomes; similar results hold for food stamps and Medicaid (Table 4).

Reduced Use of Health and Other Benefits among Populations Not the Focus of Welfare Reform

- While the apparent decline in welfare use among noncitizens of working age may be an intended and positive policy outcome, these data also reveal sharp declines in the use of health, nutritional, and cash assistance within populations that are thought to be more vulnerable and were not a focus of welfare reform. These vulnerable populations include refugees and the citizen children of noncitizens. As the data presented above indicate, there have been sharp declines in benefits use for both populations. At the same time, health uninsurance rates for noncitizens (46 percent) remain much higher than among citizens (16 percent).(18) Persistently high uninsurance rates, coupled with the decline in program participation documented here, have broad implications for targeting outreach efforts to expand enrollment in programs like California's Healthy Families initiative and for other state efforts to expand enrollment in Medicaid and the Child Health Insurance Program.(19)

Noncitizens Do Not Demonstrate a Greater Propensity to Receive Benefits

- The data indicate that higher benefit use rates on the part of noncitizen versus citizen households are due to the fact that immigrant households are poorer and more likely to contain children, not because noncitizens have a greater

disposition towards receiving benefits. In fact, among poor households with children, immigrants have lower use rates for welfare, food stamps, and Medicaid both before and after welfare reform.

Notes on the Analysis

Legal Status Distinction. This analysis employs imputation techniques developed by the Urban Institute that make it possible to assign some legal statuses (notably refugee and nonimmigrant status) to foreign-born persons included in the Current Population Survey. These techniques enable us to disaggregate changes in immigrants' benefit use by legal status--despite the fact that the CPS only distinguishes citizens from noncitizens. Disaggregating the immigrant population in this manner is important because usage patterns vary considerably by legal status and, following welfare reform, legal status has become an increasingly important determinant of immigrants' eligibility for public benefits. Specifically, the rules below have applied following welfare reform:

- *Naturalized citizens* remain eligible for public benefits on the same terms as native-born citizens.
- *Noncitizen refugees* retain eligibility for means-tested federal benefits, including food stamps, Child Health Insurance Program (CHIP), Medicaid, TANF, and SSI, for five to seven years following their entry into the United States.
- *Legal immigrants entering before August 22, 1996,* retain eligibility for several major means-tested public benefit programs: Medicaid, TANF, and the Child Health Insurance Program. Each is jointly funded by the states and the federal government. Welfare reform gave the states the option to extend TANF and Medicaid to pre-enactment legal immigrants and virtually all states have chosen to do so.

Pre-enactment legal immigrants' eligibility for *federal* food stamps remains limited to the elderly, disabled, and children. California and other states have extended state-funded food stamps to working-age immigrants left out by the federal program.

While pre-enactment immigrants' eligibility for SSI was largely eliminated by the 1996 legislation, it has been restored to disabled or elderly immigrants who were receiving SSI when welfare reform passed or who subsequently become disabled.

- *Legal immigrants entering after August 22, 1996,* have been barred from receiving federal means-tested benefits, including TANF, Medicaid, CHIP, SSI, and food stamps, for at least five years after entry and effectively until they naturalize.
- *Undocumented immigrants* remain generally ineligible for most major public benefits.

Partitioning the Change in Welfare Use. The percentage of a group (e.g., citizens, noncitizens, natives) using welfare can be thought of as the product of two sets of percentages or rates: the income distribution of the group and the percentage of each specific income category who receive welfare. To cite a specific, but simplified, example using data from tables 1 and 4, 6.7 percent of citizen households received welfare in 1997. We arrived at this percentage from the following calculation: 17.9 percent of citizen households with incomes below 200 percent of poverty received welfare, and these households represent 30.7 percent of citizen households; of the 69.3 percent of citizen households with incomes above 200 percent of poverty, only 1.7 percent receive welfare. Thus, 6.7 = 17.9 x 0.307 + 1.7 x 0.693. For noncitizen households, 9.0 percent received welfare in 1997 (9.0 = 14.5 x 0.541 + 2.6 x 0.459). In other words, poor noncitizen households are less likely to use welfare than poor citizen households (14.5 percent versus 17.9 percent), but poor households are much more common among noncitizens than citizens (54.1 percent versus 30.7 percent), so overall noncitizen households are more likely to use welfare than are citizen households.

We can think of two extreme explanations for the change in welfare use between 1994 and 1997. At one extreme, the 35 percent reduction in use for noncitizens (from 13.9 to 9.0 percent) could occur because the rate of welfare use at every income level for noncitizens fell by 35 percent; were this to occur, the overall rate decline would be explained completely by changes in usage rates. On the other hand, the rate of welfare use could stay constant for each income group of noncitizens, but incomes could rise so that more of the noncitizen population fell into higher income groups which use less welfare. In this case, the overall rate decline would be due entirely to changes in income level. In practice, neither extreme occurs; a combination of the two accounts for the change.

A demographic technique called standardization permits us to partition the overall change in welfare use into a portion attributable to changes in usage rates and a portion attributable to changes in income distribution. The standardization requires four sets of percentages, two for each year: the percentage of the population falling into each income category in 1994 and 1997 (i.e., the income distributions), and the percentage of each income category receiving welfare in 1994 and 1997 (i.e., the use rates). For the partition results shown in Table 4, we use eight household income categories: incomes less than 50% of poverty, 50-74%, 75-99%, 100-124%, 125-149%, 150-174%, 175-199%, and 200% of poverty or more.

The 1997 income distribution multiplied by the 1994 detailed use rates gives the percentage that would have received welfare in 1997 if use rates had not changed (i.e., only incomes had shifted). Subtracting this hypothetical rate from the actual 1997 overall use rate gives a measure of change attributable to income changes. We can calculate another measure of the income effect by subtracting the actual 1994 overall use rate with the hypothetical rate computed with the 1994 income distribution and the 1997 detailed use rates. The average of these two estimates is the amount of change between 1994 and 1997 attributable to changes in income. Any remaining change is the share attributable to changes in welfare usage patterns.(20)

Coverage of welfare use in the CPS. Finally, we should note that the CPS data on benefits use employed in this analysis were reported by the Census Bureau. Both welfare use and welfare income are known to be underreported, possibly substantially, in the CPS. We do not correct for either type of underreporting in our analysis. Further, the data have not been adjusted to take into account program eligibility rules or the misreporting of public benefit use on the part of immigrants and native citizens. Our uncorrected comparisons assume, in effect, that reporting patterns did not change between the 1995 and 1998 CPS. Despite these limitations, CPS data are conventionally used to characterize trends in

benefit use.[21] There is no reason to believe that the trends documented in this report are biased or otherwise invalid.

Tables and Figures

Table 1. Percent of Households Receiving Welfare, Food Stamps, and Medicaid, by Citizenship of Household Head and by Poverty Status: 1994 and 1997

	All Households				*Households Below 200% of Poverty*			
	Percent with Any Participation				Percent with Any Participation			
			'94–'97 Change				'94–'97 Change	
Population	1994	1997	Amt.	Pct.	1994	1997	Amt.	Pct.
Welfare (AFDC/TANF, SSI, GA)								
Total	8.3%	6.9%	-1.4% *	-16%	20.3%	17.9%	-2.5% *	-12%
Citizen	**7.8%**	**6.7%**	**-1.1% ***	**-15%**	**19.9%**	**17.9%**	**-2.0% ***	**-10%**
Native	7.9%	6.6%	-1.2% *	-16%	20.2%	18.1%	-2.1% *	-10%
Naturalized**	6.0%	6.9%	0.9%	--	13.5%	14.9%	1.4%	--
Noncitizen**	**13.9%**	**9.0%**	**-4.9% ***	**-35%**	**21.7%**	**14.5%**	**-7.2% ***	**-33%**
Refugee	33.3%	24.5%	-8.8% *	-27%	49.1%	40.2%	-9.0%	--
Foreign-Born	11.7%	9.2%	-2.6% *	-22%	21.2%	16.6%	-4.6% *	-22%
Noncitizen --Citizen Difference	**6.1% ***	**2.4% ***	**-3.7% ***	(x)	**1.8%**	**-3.5% ***	**-5.2% ***	(x)
Food Stamps								
Total	9.0%	7.1%	-1.9% *	-22%	24.3%	20.6%	-3.7% *	-15%
Citizen	**8.5%**	**6.8%**	**-1.8% ***	**-21%**	**23.8%**	**20.5%**	**-3.3% ***	**-14%**
Native	8.7%	6.8%	-1.8% *	-21%	24.2%	20.8%	-3.4% *	-14%
Naturalized**	5.5%	5.4%	0.0%	--	15.0%	14.8%	-0.2%	--
Noncitizen**	**15.4%**	**10.8%**	**-4.6% ***	**-30%**	**26.3%**	**19.1%**	**-7.1% ***	**-27%**
Refugee	35.3%	22.1%	-13.2% *	-37%	52.0%	41.9%	-10.1%	--
Foreign-Born	12.5%	9.3%	-3.2% *	-26%	24.7%	19.4%	-5.2% *	-21%
Noncitizen --Citizen Difference	**6.8% ***	**4.0% ***	**-2.8% ***	(x)	**2.4% ***	**-1.4%**	**-3.8% ***	(x)
Medicaid								
Total	14.3%	13.2%	-1.1% *	-8%	31.3%	30.5%	-0.8%	--
Citizen	**13.5%**	**12.6%**	**-0.9% ***	**-7%**	**30.3%**	**30.0%**	**-0.3%**	**--**
Native	13.5%	12.5%	-1.0% *	-7%	30.5%	30.1%	-0.4%	--
Naturalized**	11.9%	13.6%	1.7%	--	23.8%	28.3%	4.5%	--
Noncitizen**	**26.5%**	**20.8%**	**-5.7% ***	**-22%**	**39.8%**	**32.0%**	**-7.8% ***	**-19%**
Refugee	42.5%	35.8%	-6.7%	--	58.8%	58.5%	-0.3%	--
Foreign-Born	21.3%	18.7%	-2.6% *	-12%	36.1%	32.7%	-3.4% *	-9%
Noncitizen --Citizen Difference	**13.0% ***	**8.2% ***	**-4.8% ***	(x)	**9.5% ***	**2.0%**	**-7.5% ***	(x)

* Significant at p < 0.10.
** Excludes refugees and non-immigrants. See text for definition.
-- Change not significant.
(x) Not applicable.

Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants. See Detailed Table A for population data.

Table 2. Percent of Individuals Participating in Welfare and Medicaid, by Citizenship and Age: 1994 and 1997

Population	*Age 18–64*				*Age 65 and Over*			
	Individuals with Program Participation				Individuals with Program Participation			
			'94–'97 Change				'94–'97 Change	
	1994	1997	Amt.	Pct.	1994	1997	Amt.	Pct.
Welfare (AFDC/TANF, SSI, GA)								
Total	4.9%	4.0%	-0.9% *	-18%	4.9%	4.4%	-0.5%	--
Citizen	**4.7%**	**4.0%**	**-0.7% ***	**-15%**	**4.2%**	**3.7%**	**-0.5%**	**--**
Native	4.8%	4.1%	-0.7% *	-15%	4.1%	3.4%	-0.7%	--
Naturalized**	2.5%	2.1%	-0.4%	--	5.9%	9.0%	3.1%	--
Noncitizen**	**5.6%**	**3.3%**	**-2.3% ***	**-41%**	**20.9%**	**19.0%**	**-1.8%**	**--**
Refugee	19.2%	10.4%	-8.8% *	-46%	48.1%	51.0%	2.9%	--
Foreign-Born	5.5%	3.5%	-2.1% *	-37%	13.2%	14.7%	1.5%	--
Noncitizen --Citizen Difference	**0.8%**	**-0.7%**	**-1.6%**	(x)	**16.6% ***	**15.3% ***	**-1.3%**	(x)
Medicaid								
Total	7.9%	6.9%	-1.0% *	-13%	9.3%	9.0%	-0.3%	--
Citizen	**7.5%**	**6.7%**	**-0.8% ***	**-10%**	**8.4%**	**8.1%**	**-0.3%**	**--**
Native	7.6%	6.8%	-0.8% *	-10%	8.3%	7.7%	-0.6%	--
Naturalized**	4.4%	4.2%	-0.2%	--	11.1%	14.9%	3.8%	--
Noncitizen**	**10.3%**	**7.2%**	**-3.1% ***	**-30%**	**28.2%**	**28.2%**	**0.1%**	**--**
Refugee	33.1%	17.8%	-15.3% *	-46%	64.8%	69.7%	4.9%	--
Foreign-Born	10.2%	7.1%	-3.0% *	-30%	19.7%	22.4%	2.8%	--
Noncitizen --Citizen Difference	**2.8% ***	**0.5%**	**-2.3% ***	(x)	**19.7% ***	**20.1% ***	**0.4%**	(x)

* Significant at p < 0.10.
** Excludes refugees and non-immigrants. See text for definition.
-- Change not significant.
(x) Not applicable.

Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants. See Detailed Table B for population data.

Note: Welfare use is defined by individual reports of welfare income from persons age 15 and over. The data do not represent cases or the full number of individuals on welfare rolls. For example, if a mother and two children are receiving TANF income, the income would be reported by the mother only and would appear in the table as one recipient, not three.

Table 3. Percent of Households with Children Participating in Welfare, Food Stamps, and Medicaid, by Citizenship of Adults and Children and by Poverty Status: 1994 and 1997

Program and Household Composition (status of adults and children)	*All Households*				*Below 200 Percent of Poverty*			
	Percent with Any Participation				Percent with Any Participation			
			'94–'97 Change				'94–'97 Change	
	1994	1997	Amt.	Pct.	1994	1997	Amt.	Pct.
Welfare (AFDC/TANF, SSI, GA)								
Households with children	12.8%	9.7%	-3.2% *	-25%	30.1%	24.0%	-6.1% *	-20%
All citizen adults	**12.4%**	**9.6%**	**-2.8% ***	**-23%**	**31.4%**	**25.8%**	**-5.6% ***	**-18%**
Some noncitizen adults**	**13.8%**	**8.9%**	**-4.9% ***	**-35%**	**20.8%**	**14.0%**	**-6.7% ***	**-32%**
All noncitizen** children	8.5%	4.2%	-4.2% *	-50%	11.6%	5.9%	-5.6%	--
Some citizen children	14.8%	9.6%	-5.1% *	-35%	22.5%	15.3%	-7.2% *	-32%
Difference from "all citizen" households								

Some noncitizen adults**	**1.4%**	**-0.7%**	**-2.1%**	**(x)**	**-10.7% ***	**-11.8% ***	**-1.1%**	**(x)**
All noncitizen** children	-3.9% *	-5.4% *	-1.4%	(x)	-19.9% *	-19.9% *	0.0%	(x)
Some citizen children	2.4% *	0.0%	-2.3%	(x)	-8.9% *	-10.5% *	-1.6%	(x)
Food Stamps								
Households with children	16.0%	12.3%	-3.6% *	-23%	39.6%	32.9%	-6.7% *	-17%
All citizen adults	**15.3%**	**12.1%**	**-3.2% ***	**-21%**	**40.9%**	**34.7%**	**-6.2% ***	**-15%**
Some noncitizen adults**	**19.2%**	**13.6%**	**-5.6% ***	**-29%**	**30.7%**	**23.3%**	**-7.4% ***	**-24%**
All noncitizen** children	9.8%	7.4%	-2.4%	--	14.0%	12.0%	-2.0%	--
Some citizen children	20.8%	14.5%	-6.4% *	-31%	33.9%	25.1%	-8.8% *	-26%
Difference from "all citizen" households								
Some noncitizen adults**	**3.9% ***	**1.5%**	**-2.4%**	**(x)**	**-10.2% ***	**-11.4% ***	**-1.2%**	**(x)**
All noncitizen** children	-5.5% *	-4.6% *	0.9%	(x)	-26.9% *	-22.7% *	4.2%	(x)
Some citizen children	5.5% *	2.4% *	-3.1% *	(x)	-7.0% *	-9.6% *	-2.6%	(x)
Medicaid								
Households with children	17.5%	14.4%	-3.1% *	-18%	38.4%	33.5%	-4.8% *	-13%
All citizen adults	**16.8%**	**14.0%**	**-2.7% ***	**-16%**	**39.2%**	**35.1%**	**-4.1% ***	**-11%**
Some noncitizen adults**	**21.1%**	**16.2%**	**-4.8% ***	**-23%**	**31.1%**	**24.9%**	**-6.1% ***	**-20%**
All noncitizen** children	15.7%	10.7%	-4.9%	--	21.8%	15.4%	-6.4%	--
Some citizen children	22.0%	17.0%	-5.0% *	-23%	32.8%	26.5%	-6.4% *	-19%
Difference from "all citizen" households								
Some noncitizen adults**	**4.3% ***	**2.2% ***	**-2.1%**	**(x)**	**-8.2% ***	**-10.2% ***	**-2.0%**	**(x)**
All noncitizen** children	-1.1%	-3.3%	-2.2%	(x)	-17.5% *	-19.7% *	-2.2%	(x)
Some citizen children	5.2% *	3.0% *	-2.2%	(x)	-6.4% *	-8.7% *	-2.2%	(x)

* Significant at p < 0.10. ** Excludes refugees and non-immigrants. See text for definition. -- Change not significant. (x) Not applicable. Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants. Universe is households headed by persons 18–64 with children under age 18. See Detailed Table C for population data.

Table 4. Partition of 1994–97 Change in Household Participation in Welfare, Food Stamps, and Medicaid into Portions Due to Changes in Poverty Prevalence and Welfare Use Rates, by Citizenship

Population	Percent of Households				Partition of '94–'97 Change in Participation***			
	Below Specified Level of Poverty		Participating in Program		Total Change	Due to Use Rates	Due to Poverty Rates	Pct. of Change from Usage
	1994	1997	1994	1997				
Welfare (AFDC/TANF, SSI, GA)								
100 Percent of Poverty								
Total	13.9%	12.7%	8.3%	6.9%	-1.4% *	-0.9%	-0.5%	66%
Citizen	**13.0%**	**11.8%**	**7.8%**	**6.7%**	**-1.1% ***	**-0.7%**	**-0.5%**	**60%**
Native	13.0%	11.7%	7.9%	6.6%	-1.2% *	-0.7%	-0.5%	59%
Naturalized**	11.0%	12.5%	6.0%	6.9%	0.9%	--	--	--
Noncitizen**	**27.3%**	**25.9%**	**13.9%**	**9.0%**	**-4.9% ***	**-4.6%**	**-0.3%**	**94%**
Refugee	31.9%	25.4%	33.3%	24.5%	-8.8% *	-5.3%	-3.5%	60%

Foreign-Born	21.4%	20.4%	11.7%	9.2%	-2.6% *	-2.2%	-0.3%	87%
Food Stamps								
125 Percent of Poverty								
Total	18.9%	17.5%	9.0%	7.1%	-1.9% *	-1.4%	-0.6%	70%
Citizen	**17.7%**	**16.4%**	**8.5%**	**6.8%**	**-1.8% ***	**-1.2%**	**-0.6%**	**68%**
Native	17.8%	16.3%	8.7%	6.8%	-1.8% *	-1.2%	-0.6%	66%
Naturalized**	16.2%	17.6%	5.5%	5.4%	0.0%	--	--	--
Noncitizen**	**35.7%**	**34.8%**	**15.4%**	**10.8%**	**-4.6% ***	**-4.1%**	**-0.5%**	**89%**
Refugee	41.1%	32.7%	35.3%	22.1%	-13.2% *	-8.4%	-4.8%	64%
Foreign-Born	28.5%	27.5%	12.5%	9.3%	-3.2% *	-2.7%	-0.5%	85%
Medicaid								
200 Percent of Poverty								
Total	34.3%	32.1%	14.3%	13.2%	-1.1% *	-0.5%	-0.7%	42%
Citizen	**32.8%**	**30.7%**	**13.5%**	**12.6%**	**-0.9% ***	**-0.3%**	**-0.6%**	**28%**
Native	32.9%	30.5%	13.5%	12.5%	-1.0% *	-0.3%	-0.7%	31%
Naturalized**	32.2%	33.6%	11.9%	13.6%	1.7%	--	--	--
Noncitizen**	**55.9%**	**54.1%**	**26.5%**	**20.8%**	**-5.7% ***	**-5.1%**	**-0.6%**	**90%**
Refugee	60.6%	49.9%	42.5%	35.8%	-6.7%	--	--	--
Foreign-Born	47.1%	45.0%	21.3%	18.7%	-2.6% *	-2.1%	-0.6%	78%

* Significant at p < 0.10.
** Excludes refugees and non-immigrants. See text for definition.
*** Partition uses poverty-specific welfare rates for intervals of 25 percentage points for 50–200 percent of poverty (i.e., <50%, 50–74%, 75–99%...175–199%, 200% or more). See text for details.
-- Total change not significant.

Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants.

Detailed Table A. Household Receipt of Welfare, Food Stamps, and Medicaid, by Citizenship of Household Head and by Poverty Status: 1994 and 1997

(Populations in thousands)

Population	***All Households***						***Households Below 200 Percent of Poverty***					
	Program Participation in Household?						Program Participation in Household?					
	1994			1997			1994			1997		
	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes
Welfare (AFDC/TANF, SSI, GA)												
Total	8,188	99,106	8.3%	7,091	102,584	6.9%	6,903	33,960	20.3%	5,877	32,888	17.9%
Citizen	**7,257**	**92,989**	**7.8%**	**6,400**	**96,169**	**6.7%**	**6,084**	**30,525**	**19.9%**	**5,287**	**29,493**	**17.9%**
Native	7,031	89,248	7.9%	6,096	91,748	6.6%	5,920	29,320	20.2%	5,065	28,007	18.1%
Naturalized*	225	3,741	6.0%	304	4,421	6.9%	163	1,205	13.5%	222	1,486	14.9%
Noncitizen*	**723**	**5,209**	**13.9%**	**474**	**5,246**	**9.0%**	**632**	**2,910**	**21.7%**	**411**	**2,841**	**14.5%**
Refugee	202	606	33.3%	213	872	24.5%	180	367	49.1%	175	435	40.2%
Foreign-Born	1,157	9,858	11.7%	995	10,837	9.2%	983	4,640	21.2%	811	4,881	16.6%
Food Stamps												
Total	8,949	99,106	9.0%	7,263	102,584	7.1%	8,240	33,960	24.3%	6,773	32,888	20.6%
Citizen	**7,924**	**92,989**	**8.5%**	**6,500**	**96,169**	**6.8%**	**7,275**	**30,525**	**23.8%**	**6,044**	**29,493**	**20.5%**
Native	7,720	89,248	8.7%	6,261	91,748	6.8%	7,095	29,320	24.2%	5,824	28,007	20.8%
Naturalized*	204	3,741	5.5%	239	4,421	5.4%	180	1,205	15.0%	220	1,486	14.8%

Noncitizen*	**801**	**5,209**	**15.4%**	**567**	**5,246**	**10.8%**	**764**	**2,910**	**26.3%**	**543**	**2,841**	**19.1%**
Refugee	214	606	35.3%	193	872	22.1%	191	367	52.0%	182	435	41.9%
Foreign-Born	1,228	9,858	12.5%	1,003	10,837	9.3%	1,145	4,640	24.7%	949	4,881	19.4%
Medicaid												
Total	14,189	99,106	14.3%	13,523	102,584	13.2%	10,630	33,960	31.3%	10,027	32,888	30.5%
Citizen	**12,533**	**92,989**	**13.5%**	**12,102**	**96,169**	**12.6%**	**9,243**	**30,525**	**30.3%**	**8,852**	**29,493**	**30.0%**
Native	12,088	89,248	13.5%	11,499	91,748	12.5%	8,956	29,320	30.5%	8,432	28,007	30.1%
Naturalized*	445	3,741	11.9%	603	4,421	13.6%	287	1,205	23.8%	420	1,486	28.3%
Noncitizen*	**1,379**	**5,209**	**26.5%**	**1,090**	**5,246**	**20.8%**	**1,158**	**2,910**	**39.8%**	**910**	**2,841**	**32.0%**
Refugee	258	606	42.5%	312	872	35.8%	216	367	58.8%	254	435	58.5%
Foreign-Born	2,101	9,858	21.3%	2,024	10,837	18.7%	1,674	4,640	36.1%	1,595	4,881	32.7%

* Excludes refugees and non-immigrants. See text for definition.
Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants.

Detailed Table B. Individual Welfare and Medicaid Participation, by Citizenship and Age: 1994 and 1997

(Populations in thousands)

Population	Individual Participation in Program, ***Age 18–64***						Individual Participation in Program, ***Age 65 and Over***					
	1994			1997			1994			1997		
	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes
Welfare (AFDC/TANF, SSI, GA)												
Total	7,856	160,217	4.9%	6,632	165,329	4.0%	1,549	31,350	4.9%	1,419	32,082	4.4%
Citizen	**6,939**	**146,620**	**4.7%**	**6,047**	**151,104**	**4.0%**	**1,277**	**30,207**	**4.2%**	**1,160**	**31,037**	**3.7%**
Native	6,808	141,270	4.8%	5,908	144,513	4.1%	1,178	28,536	4.1%	993	29,188	3.4%
Naturalized*	132	5,350	2.5%	139	6,591	2.1%	99	1,671	5.9%	167	1,849	9.0%
Noncitizen*	**651**	**11,713**	**5.6%**	**385**	**11,772**	**3.3%**	**213**	**1,019**	**20.9%**	**163**	**857**	**19.0%**
Refugee	257	1,340	19.2%	197	1,890	10.4%	60	124	48.1%	96	188	51.0%
Foreign-Born	1,048	18,947	5.5%	725	20,817	3.5%	372	2,814	13.2%	426	2,894	14.7%
Medicaid												
Total	12,698	160,217	7.9%	11,372	165,329	6.9%	2,919	31,350	9.3%	2,901	32,082	9.0%
Citizen	**11,011**	**146,620**	**7.5%**	**10,165**	**151,104**	**6.7%**	**2,551**	**30,207**	**8.4%**	**2,528**	**31,037**	**8.1%**
Native	10,773	141,270	7.6%	9,886	144,513	6.8%	2,364	28,536	8.3%	2,251	29,188	7.7%
Naturalized*	238	5,350	4.4%	279	6,591	4.2%	186	1,671	11.1%	276	1,849	14.9%
Noncitizen*	**1,211**	**11,713**	**10.3%**	**853**	**11,772**	**7.2%**	**287**	**1,019**	**28.2%**	**242**	**857**	**28.2%**
Refugee	443	1,340	33.1%	336	1,890	17.8%	81	124	64.8%	131	188	69.7%
Foreign-Born	1,925	18,947	10.2%	1,486	20,817	7.1%	554	2,814	19.7%	650	2,894	22.4%

* Excludes refugees and non-immigrants. See text for definition.
Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants.

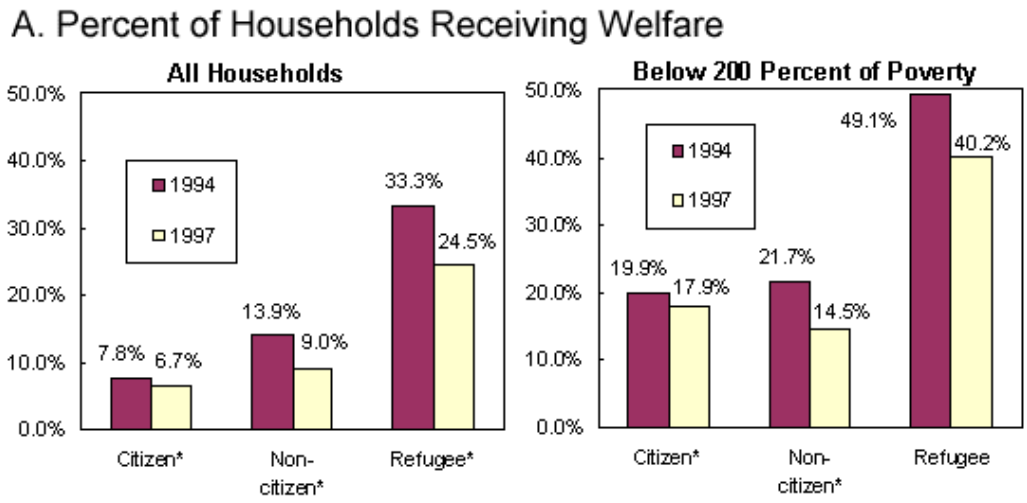
Detailed Table C. Welfare, Food Stamp, and Medicaid Participation of Households with Children, by Citizenship of Adults and Children and by Poverty Status: 1994 and 1997 (Populations in thousands)

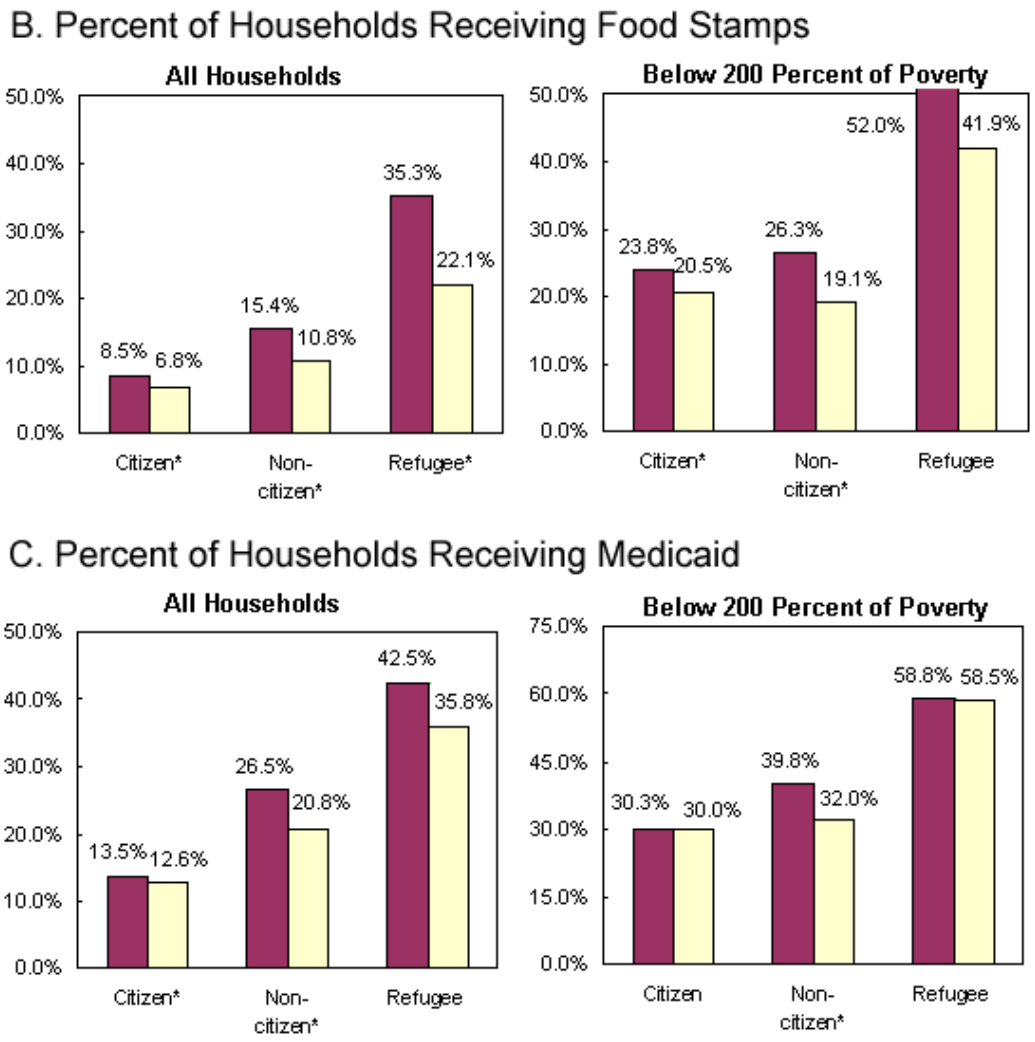
Program and Household Composition (Adults-Children)	***All Households***						***Households Below 200 Percent of Poverty***					
	1994			1997			1994			1997		
	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes	Yes	Total	% Yes
Welfare (AFDC/TANF, SSI, GA)												

Households with children	4,713	36,784	12.8%	3,600	37,286	9.7%	4,160	13,818	30.1%	3,156	13,138	24.0%
All citizen adults	**4,031**	**32,498**	**12.4%**	**3,142**	**32,747**	**9.6%**	**3,550**	**11,294**	**31.4%**	**2,755**	**10,670**	**25.8%**
One or more noncitizen* adults	524	3,785	13.8%	346	3,880	8.9%	466	2,243	20.8%	304	2,165	14.0%
All noncitizen* children	47	560	8.5%	21	497	4.2%	42	359	11.6%	18	297	5.9%
One or more citizen children	**476**	**3,225**	**14.8%**	**325**	**3,383**	**9.6%**	**424**	**1,885**	**22.5%**	**287**	**1,868**	**15.3%**
Food Stamps												
Households with children	5,872	36,784	16.0%	4,601	37,286	12.3%	5,477	13,818	39.6%	4,323	13,138	32.9%
All citizen adults	**4,969**	**32,498**	**15.3%**	**3,949**	**32,747**	**12.1%**	**4,622**	**11,294**	**40.9%**	**3,702**	**10,670**	**34.7%**
One or more noncitizen* adults	726	3,785	19.2%	526	3,880	13.6%	689	2,243	30.7%	504	2,165	23.3%
All noncitizen* children	55	560	9.8%	37	497	7.4%	50	359	14.0%	36	297	12.0%
One or more citizen children	**671**	**3,225**	**20.8%**	**489**	**3,383**	**14.5%**	**639**	**1,885**	**33.9%**	**469**	**1,868**	**25.1%**
Medicaid												
Households with children	6,447	36,784	17.5%	5,368	37,286	14.4%	5,302	13,818	38.4%	4,405	13,138	33.5%
All citizen adults	**5,453**	**32,498**	**16.8%**	**4,596**	**32,747**	**14.0%**	**4,433**	**11,294**	**39.2%**	**3,748**	**10,670**	**35.1%**
One or more noncitizen* adults	797	3,785	21.1%	630	3,880	16.2%	697	2,243	31.1%	540	2,165	24.9%
All noncitizen* children	88	560	15.7%	53	497	10.7%	78	359	21.8%	46	297	15.4%
One or more citizen children	**709**	**3,225**	**22.0%**	**576**	**3,383**	**17.0%**	**619**	**1,885**	**32.8%**	**495**	**1,868**	**26.5%**

* Excludes refugees and non-immigrants. See text for definition.
Source: Urban Institute tabulations from March Current Population Surveys of 1995 and 1998, with imputations for refugees and non-immigrants.

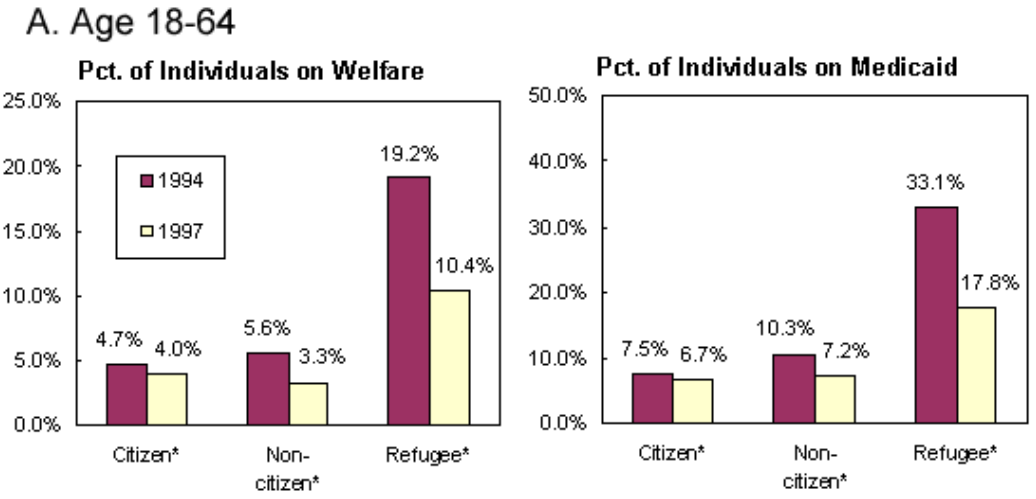
Figure 1. Percent of Households Receiving Welfare, Food Stamps, and Medicaid, by Nativity of Household Head and by Poverty Status

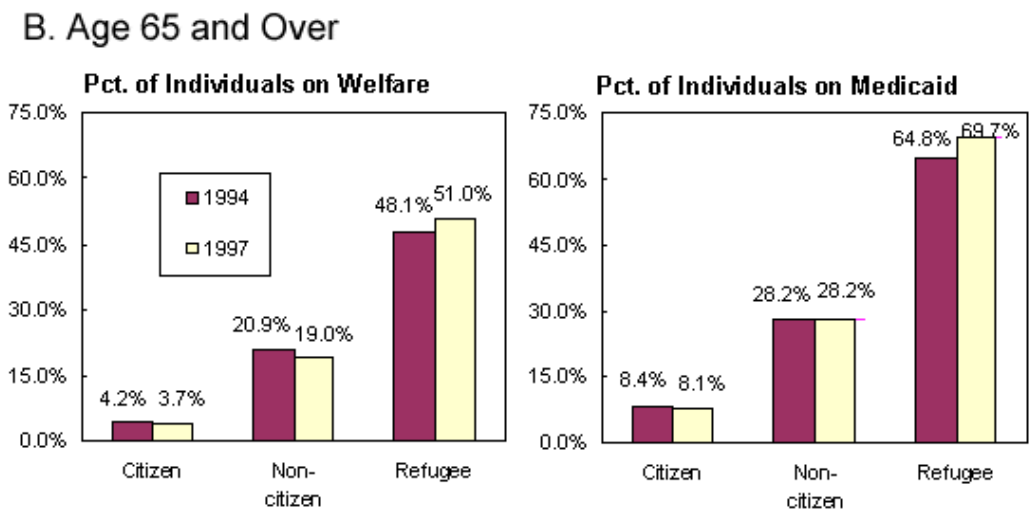




Source: Table 1.
Note: Noncitizen group excludes refugees and non-immigrants. See text.
* 1994-97 change is significant at p < 0.10.

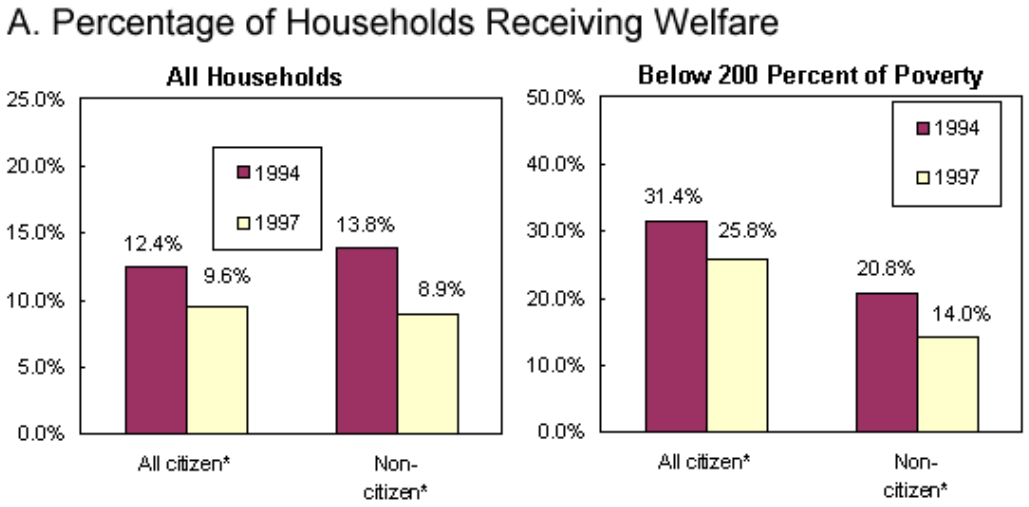
Figure 2. Percent of Individuals Participating in Welfare and Medicaid, by Age and Citizenship: 1994 and 1997

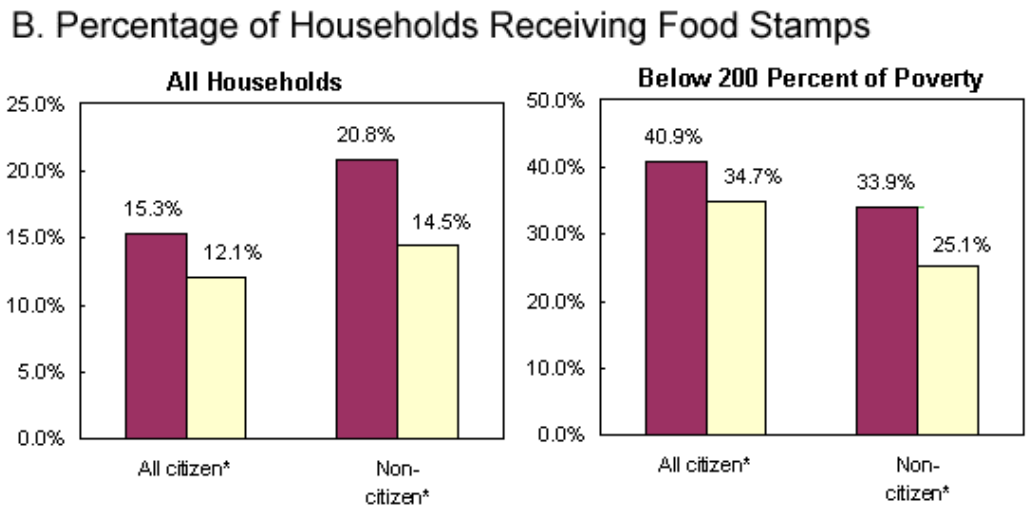


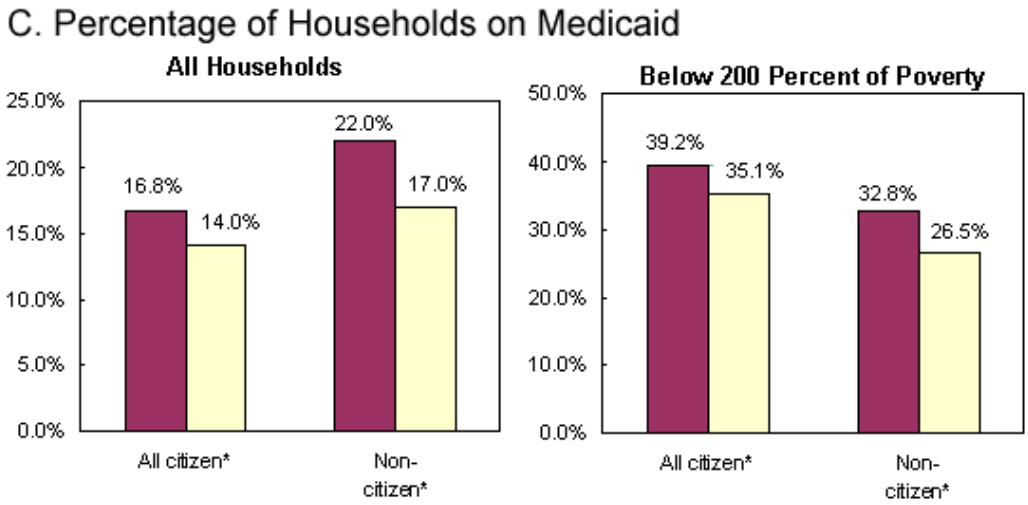


Source: Table 2.
Note: Noncitizen group excludes refugees and non-immigrants. See text.
* 1994-97 change is significant at p < 0.10.

Figure 3. Percent of Householods with Children Receiving Welfare, Food Stamps, and Medicaid, by Citizenship of Adults and Children and by Poverty Status: 1994 and 1997







Source: Table 3. Includes only households with children headed by persons 18-64 years old.
Note: Noncitizen group excludes refugees and non-immigrants. See text ofr definition of groups.
* 1994-97 change is significant at $p < 0.10$.

BIBLIOGRAPHY

Das Gupta, Prithwis. 1993. *Standardization and Decomposition of Rates: A User's Manual*. U.S. Bureau of the Census, Current Population Reports, Series P23-186. Washington, D.C.: U.S. Government Printing Office. September.

Ellwood, Marilyn R., and Leighton Ku. 1998. "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid." *Health Affairs* 17 (3): 137-51. May/June.

Fix, Michael, and Wendy Zimmermann. 1998. "The Legacies of Welfare Reform's Immigrant Restrictions." *Interpreter Releases*. November 16.

Fronstin, P. 1998. "Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 1998 Current Population Survey." EBRI Issue Brief 204. December.

National Research Council. 1998. *From Generation to Generation, The Health and Well-Being of Children in Immigrant Families.* Washington, D.C.: Institute of Medicine, National Academy Press.

Passel, Jeffrey S., and Rebecca Clark. 1998. "Immigrants in New York: Their Legal Status, Incomes, and Taxes." Washington, D.C.: The Urban Institute. April.

Van Hook, Jennifer, Jennifer E. Glick, and Frank D. Bean. 1999. "Public Assistance Receipt Among Immigrants and Natives: How the Unit of Analysis Affects Research Findings." *Demography* 36 (1): 111-20. February.

Zimmermann, Wendy, and Michael Fix. 1998. "Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County." Washington, D.C.: The Urban Institute. July.

Notes

1. The Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. 104-193 (1996).

2. While most of these unqualified immigrants are undocumented immigrants, many unqualified immigrants are legally present in the United States and have work authorization. See, generally, Michael Fix and Wendy Zimmermann, "The Legacies of Welfare Reform's Immigrant Restrictions," *Interpreter Releases,* November 16, 1998.

3. "Public charge" is a term used by the Immigration and Naturalization Service (INS) and the State Department to describe someone who is, or is likely to become, dependent on public benefits. Public charge considerations have historically been a factor in the admissibility of aliens (i.e., grant of a green card) and, only rarely, in the deportation of aliens who have been in the United States less than five years.

In the past several years, public charge has been inappropriately invoked in some instances where noncitizens have attempted to reenter the United States and where immigrants have sought to naturalize. In some cases, noncitizens seeking to adjust status, naturalize, or reenter the country have been asked to repay public benefits. The legality of compelling repayment in these contexts is suspect.

4. See Wendy Zimmermann and Michael Fix, "Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County," The Urban Institute, July 1998.

5. The CPS collects information on program use and income in March for the preceding *calendar* year. Thus, the information collected in the March 1995 CPS pertains to calendar year 1994; and the March 1998 CPS, to calendar year 1997. Throughout this document, we use the CPS data from March 1995 and 1998 for reference years 1994 and 1997. The data from the March 1995 CPS have been reweighted to correct for an error in the official weights (Jeffrey S. Passel and Rebecca Clark, "Immigrants in New York: Their Legal Status, Incomes, and Taxes," The Urban Institute, April 1998).

The CPS data used here are not corrected for underreporting of welfare use or welfare income. (See "Coverage of Welfare Use in the CPS.")

6. See Passel and Clark, 1998.

7. Welfare reform gave the states the option of barring legal immigrants in the United States before August 22, 1996, from TANF and Medicaid. However, virtually all states extended benefits to these pre-enactment immigrants. See Fix and Zimmermann, 1998.

8. "Federal means-tested public benefits" have been determined to be Temporary Assistance for Needy Families (TANF), Medicaid, the Child Health Insurance Program (CHIP), Supplemental Security Income (SSI), and food stamps.

9. Unless otherwise noted, the comparisons of citizens and noncitizens exclude refugees and temporary immigrants (i.e. "nonimmigrants" according to immigration law), which are treated separately. *Citizens* include natives, persons born in Puerto Rico and other outlying areas, and immigrants who have acquired citizenship through naturalization. *Noncitizens* include aliens admitted as lawful permanent residents and undocumented immigrants.

10. A refugee is defined legally as a person outside his/her country of nationality who is unable to return because of a well-founded fear of persecution. Because their departure from their home country is involuntary and unplanned and because many suffer physical or mental trauma, refugees have been made eligible for most public benefits from the date of their arrival.

We assign refugee status based on country of birth and period of entry to the United States. For persons entering after 1980, we define a "refugee country" as one where refugees and asylees account for more than 40 percent of total admissions of legal permanent residents, refugees, and asylees during any two-year period. See Passel and Clark, 1998.

11. See, for example, *From Generation to Generation, The Health and Well-Being of Children in Immigrant Families,* National Research Council, Institute of Medicine, National Academy Press, Washington D.C., 1998.

12. See Fix and Zimmermann, 1998.

13. See Jennifer Van Hook, Jennifer E. Glick, and Frank D. Bean, "Public Assistance Receipt Among Immigrants and Natives: How the Unit of Analysis Affects Research Findings," *Demography* 36 (1, February 1999): 111-20.

14. In the CPS, food stamp usage is a household-level variable, so we do not report individual usage patterns.

15. They are, however, consistent with administrative data, specifically the Food Stamp Program Quality Control data for fiscal years 1994 and 1997.

16. See, for example, Passel and Clark, 1998.

17. The data in Detailed Table B show that the number of naturalized citizens age 18 and over reporting welfare income rose by only 75,000 between 1994 and 1997, while the number of naturalized citizens increased by 1,419,000. During that period, the number of noncitizens reporting welfare use fell by 316,000.

18. P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: An Analysis of the March 1998 Current Population Survey," EBRI Issue Brief 204, December 1998.

19. We should note that declines in Medicaid caseloads affect more populations than just noncitizens and can also be viewed as an unintended effect of welfare reform. See Marilyn R. Ellwood and Leighton Ku, "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid," *Health Affairs* 17 (3, May/June 1998): 137-51.

20. This second difference can be shown to be equivalent algebraically to the average of two separate estimates of change attributable to difference in usage rates. One measure compares the actual 1997 overall use rate with a hypothetical rate computed as the 1997 detailed use rates multiplied by the 1994 income distribution. The other subtracts actual 1994 overall use rate from the hypothetical rate based on the 1994 detailed use rates and the 1997 income distribution. For more information on standardization and partition, see Prithwis Das Gupta, *Standardization and Decomposition of Rates: A User's Manual*, U.S. Bureau of the Census, Current Population Reports, Series P23-186, Washington, D.C.: U.S. Government Printing Office, September 1993.

21. See, for example, Fronstin, 1998. Planned Urban Institute reports that take into account patterns of underreporting and program eligibility rules are expected in the summer of 1999.

Other Publications by the Authors

- Michael E. Fix
- Jeffrey S. Passel

Exhibit C

Discussion Papers

The Scope and Impact of Welfare Reform's Immigrant Provisions

Michael Fix
Jeffrey Passel

02–03

January
2002

Assessing the New Federalism

An Urban Institute Program to Assess Changing Social Policies

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and database are available free of charge on the Urban Institute=s Web site: http://www.urban.org. This paper is one in a series of discussion papers analyzing information from these and other sources.

The project has received funding from The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Robert Wood Johnson Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The David and Lucile Packard Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, its funders, or other authors in the series..

The authors would like to thank Kenneth Finegold and Alan Weil for helpful comments.

Publisher: The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

THE SCOPE AND IMPACT OF WELFARE REFORM'S IMMIGRANT PROVISIONS

by

Michael Fix and Jeffrey S. Passel

TABLE OF CONTENTS

FIGURES

TABLES

THE SCOPE AND IMPACT OF WELFARE REFORM'S IMMIGRANT PROVISIONS

by

Michael Fix and Jeffrey S. Passel

INTRODUCTION

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) not only overhauled the nation's welfare system, it redefined immigrants' access to public benefits. Indeed the law's immigrant provisions — to which an entire title is dedicated (Title IV) — can be viewed as a watershed in the related domains of immigrant integration and immigration policy, as well as the federalism issues the new provisions raise.[1]

In this paper, we discuss the background and character of the changes introduced by this comprehensive, far-reaching law and then sketch the post-enactment responses of the Congress, the states, and the courts. We further explore the impacts that the law has had on benefit use among immigrants, highlighting the changes in usage among different immigrant groups and factors related to these changes, such as naturalization and rising incomes. We conclude by discussing a number of issues that may be examined within the context of welfare reauthorization.

Summary

For immigrants, welfare reform went well beyond conditioning access to cash benefits on work. Rather, the law set out a comprehensive scheme for determining immigrant eligibility for a wide range of social benefits that are provided by governments at all levels. Reform

[1] The law's impacts on immigrants and their families are not confined to Title IV. PRWORA's restructuring of TANF, the imposition of time limits, new incentives to work, and the many other changes introduced affect low-income immigrant families eligible to receive benefits.

represented a major departure from prior policy by making citizenship more central to the receipt of benefits, by granting the states rather than the federal government the power to determine immigrant eligibility for benefits, and by drawing a sharp distinction between immigrants arriving before and after PRWORA's enactment on August 22, 1996.

Our recently completed analysis of the 1995 and 2000 Current Population Surveys (CPS) reveals a number of striking trends in immigrants' use of public benefits:

- There were substantial declines between 1994 and 1999 in legal immigrants' use of all major benefit programs: TANF (-60 percent), food stamps (-48 percent), SSI (-32 percent), and Medicaid (-15 percent).
- By 1999, low-income legal immigrant families with children had lower use rates for TANF and food stamps than their low-income citizen counterparts. Medicaid use rates for these *families* did not vary by citizenship, testifying, perhaps, to the success of policies intended to broaden the health insurance coverage among children.
- Nonetheless, *individual*-level analyses reveal that low-income, working-age noncitizens had substantially larger declines in Medicaid use rates than their citizen counterparts. Loss of Medicaid is not being made up by other forms of health coverage, but rather is resulting in a total loss of health insurance.
- Benefit use rates among U.S. citizen children in low-income immigrant families (i.e., in poor mixed-status families) were substantially lower than for citizen children of native parents in poor families.
- Declines in benefit participation were especially steep among low-income refugee families whose use rates for TANF, food stamps, and Medicaid were comparable to citizens by 1999.
- Declines in immigrants' use of benefits are evident across all areas of the country. They are especially steep among poor families living in states that make few benefits available to immigrants, but which have rapidly rising immigrant populations.
- In general, the declining benefit use occurring between 1994 and 1999 was *not* accounted for by increased naturalizations or by rising incomes within immigrant families.

Despite reduced use of public benefits, half of immigrant families were poor in 1999; poor legal immigrants were far more likely to be uninsured than their citizen counterparts; and immigrant children were more likely to be food insecure than children of citizens (Capps 2001).

With a recession descending and welfare reform reauthorization looming, these precipitous declines in the face of continuing high poverty rates raise important questions. As this is written, some participants in the reauthorization debate, concerned that that the reforms went too far, have proposed restoring food-stamp eligibility to legal immigrants and granting states the authority to extend Medicaid and the State Children's Health Insurance Program (SCHIP) to some post-enactment immigrants. These measures would grant non-cash aid to many families and place immigrants arriving before and after welfare reform on a more equal footing. Proposed restorations raise issues regarding the extent of sponsors' responsibility for immigrants, welfare reform's impact on successfully integrating immigrant residents into the broader society, substantially altered incentives to naturalize, equitable intergovernmental cost sharing, and the limits to delegating federal immigration control powers to the states, especially in an era of global competition.

Background

At the time of welfare reform's passage, some researchers contended that the availability of public benefits was increasingly influencing immigrants' migration decisions, explaining in part a perceived decline in the quality of new immigrants — that is, their education, incomes, and propensity to use benefits (Borjas and Hilton 1995). In fact, the power of the so-called "welfare magnet," the perceived decline in the quality of immigrants, and even the disproportionately high use of benefits among noncitizen populations were all heavily contested in the literature (Duleep and Regets 1994; Fix and Passel 1994; Van Hook, Glick, and Bean 1999). Nonetheless, the influence of this linkage of welfare to immigration flows can be seen in

PRWORA's departing premise that "self-sufficiency has been a basic principle of United States *immigration* policies"[2] (emphasis added).

While often associated with fiscally conservative Republicans, political interest in restricting immigrants' access to welfare evolved in a bipartisan manner through the mid-1990s. Initial proposals limiting noncitizens' access to SSI[3] and, eventually, to other public benefits originated in the Democratically-controlled House of Representatives and the Clinton Administration. In due course, more far-reaching restrictions were written into The Contract With America (Gingrich and Armey 1994), the policy blueprint for the Republican Congress elected in 1994. Finally, the redefinition of immigrants' rights to benefits that was eventually codified in Title IV of PRWORA, was drafted by a Republican Congress and signed into law on August 22, 1996 by a somewhat uneasy President Clinton who, despite his intent on "ending welfare as we know it," expressed reservations about the bill's immigrant provisions.

The political context within which PRWORA's immigrant restrictions were created should also be recalled. The law was enacted during a period of anti-immigrant sentiment, one that witnessed the enactment of two broad laws — The 1996 Antiterrorism and Effective Death Penalty Act[4] and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996[5] — that, among other things, limited noncitizens' rights of residence and judicial appeal as well as the ability of undocumented immigrants to adjust to legal status.

---

[2] 8 U.S.C. Section 1601(1) (Supp. V 1999).

[3] The proposal was to extend the deeming period during which a sponsor's income is ascribed to the immigrant from 3 to 5 years.

[4] Pub.L. 104-132 (1996).

[5] Pub.L. 104-208 (1996).

PRWORA'S IMMIGRANT PROVISIONS: A BRIEF OVERVIEW

Comprehensive Revision of Immigrant Eligibility

For immigrants, PRWORA represented more than a simple regulation of access to cash benefit programs. Rather, the law's immigrant provisions were a comprehensive revision of the nation's laws governing access by legal immigrants, refugees, and illegal immigrants to virtually all federal, state, and local benefits for which eligibility is in some ways restricted. In this respect, the law departed from the piecemeal, program-by-program establishment of immigrant eligibility that had been typical in the past.

Differing Goals for Immigrants

The law's immigrant provisions were driven by a somewhat different logic than the rest of PRWORA. That is, there was little imperative to discourage out-of-wedlock births and to encourage able-bodied adults to work. After all, low-income immigrants were more likely to live in intact families and to be employed than natives.[6] Rather, PRWORA's immigrant restrictions incorporated other goals. One, alluded to above, was to alter immigration flows by discouraging immigrants likely to seek public benefits from entering the United States. A second was to shift responsibility for the support of immigrants away from the government and onto newcomers' sponsors. A third powerful goal was to realize a large, new stream of cost savings. Altogether, the Congressional Budget Office estimated that the immigrant restrictions would generate roughly 40 percent of welfare reform's overall savings of $54 billion — despite the fact that in 1996 immigrants represented only 15 percent of all welfare recipients in the United States. (Congressional Budget Office 1997)

[6] Among immigrants, 65 percent of low-income families with children were two-parent families in the 1996 CPS versus only 40 percent among natives. About 80 percent of working-age immigrant males in low-income families were in the labor force versus less than 70 percent for the corresponding group of natives.

Eligible Immigrant Populations

Prior to welfare reform, legal immigrants living in the United States were eligible for public benefits on more or less the same terms as citizens. Following reform, eligibility for federal means-tested public benefits depends more on citizenship than in the past. By rationing access to benefits in this way, the law elevates the importance of citizenship for societal membership in a manner that is unusual by international standards (Fix and Laglagaron 2001).

PRWORA's comprehensive redefinition of immigrant eligibility for benefits involved the creation of three separate "bright lines." One divides "qualified" and "unqualified" immigrants. The class of unqualified aliens is composed mostly, but not exclusively, of undocumented immigrants who are eligible only for a small, enumerated set of federal and state benefits.[7] Qualified immigrants, by contrast, are eligible for a wide range of "federal public benefits" with restricted eligibility, including Social Security, Pell Grants for higher education, and the Earned Income Tax Credit.[8]

Title IV drew a second bright line between legal "qualified" immigrants and naturalized citizens. Unlike the more restricted eligibility rules for qualified immigrants, PRWORA allowed naturalized citizens to maintain full access to all noncontributory programs defined as "means-tested federal benefits." These programs include Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), food stamps, Medicaid, and SCHIP.

A third "bright line" was drawn between legal immigrants entering the United States before August 22, 1996 and those entering after. The law granted states the option of extending

[7] These include emergency Medicaid, immunizations, diagnosis and treatment of communicable diseases, and the school lunch and breakfast programs.

[8] "Federal public benefits" include any retirement, welfare, health, disability, public or assisted housing, post-secondary education, food assistance, unemployment benefit, or any similar benefits to which payment or

TANF, Medicaid, and SCHIP to the former but not to the latter. Over time, this distinction has meant that tougher restrictions are imposed on the rapidly-growing population of post-enactment immigrants. There are, as of this writing, roughly 3 million post-enactment immigrants in the U.S., representing about one-third of all legal permanent resident (LPR) aliens in the country.

In drawing these lines, PRWORA's comprehensive new scheme of eligibility largely exempted three noncitizen populations with strong equitable claims on benefits: refugees during their first 5 to 7 years in the United States; immigrants with 40 quarters of work history[9]; and noncitizens who had served in the U.S. military.

Sponsorship

PRWORA required for the first time that immigrants' sponsors — whether legal immigrants or citizens — have incomes that exceed a minimum level, set at 125 percent of the federal poverty threshold.[10] In addition, the law required that sponsors sign a legally-enforceable affidavit of support, pledging to support the entrant until they naturalize or work 40 quarters. Sponsors remain liable for reimbursing most public benefits used by the immigrant during this period. While roughly similar support requirements were on the books prior to PRWORA, courts had found them legally unenforceable. Sponsors' new income requirements and open-ended support obligations can be viewed as a back door reform of legal immigration intended to keep out the poorest and presumably most welfare-prone of immigrants, thereby reinforcing PRWORA's immigration control thrust.

---

assistance is provided to an individual, household, or family eligibility unit by an agency of the United States by appropriated funds of the United States (Pub. L. 104-193, Section 401c).

[9] Benefit claimants must be able to prove that they, their spouses, or their parents have collectively worked 40 quarters (ten years) in the United States.

[10] The poverty thresholds are defined, in part, on the basis of family size. For assessing the sponsorship criteria, the threshold is based on the numbers of adults and children in the *combined* families of the sponsored immigrant and the sponsor, thus increasing the amount of income required of the sponsor.

Shift in Responsibility to the States

The law's redrawing of immigrant rights involved the devolution of broad new powers to the states. Following reform, states could choose to discriminate against legal immigrants in federal and state benefit programs, a power previously denied them by the courts.[11] At the same time, the law authorized, but did not require, states to offer food, cash, and health-related benefit programs that might substitute for lost federal benefits, benefits that would have to be financed with state dollars. Finally, the law requires that state or local governments providing benefits to undocumented immigrants must pass a law after August 22, 1996, affirmatively establishing their eligibility, a mandate that is proving increasingly significant. This provision has proved to be a powerful tool in limiting undocumented immigrants' access to benefits. The federal government invoked the provision to strike down the State of New York's extension of prenatal care to undocumented mothers[12] and the Texas State Attorney General used it to bar Houston's public hospitals from providing nonemergency services to undocumented immigrants.[13]

Taken together, then, PRWORA's immigrant provisions represent: (1) a comprehensive scheme of reform that goes beyond cash assistance to almost all programs extended by the welfare state; (2) a redefinition of the meaning of citizenship; (3) a sharp expansion in the states' power to determine legal immigrants' eligibility for public benefits; (4) a parallel reduction in states' authority to extend to state-funded benefits to the undocumented; and (5) a redefinition of the requirements for, and obligations of, sponsorship.

[11] See, generally, *Graham v. Richardson*, 403 U.S. 365 (1971) holding that state discrimination against legal noncitizens in welfare programs violates equal protection.

[12] *Lewis v. Grinker*, USCA 2d. May 22, 2001. Docket No. 00-6104

[13] See, Office of the Attorney General, State of Texas, Opinion No. JC-0394, July 10, 2001.

MAJOR CHANGES SINCE ENACTMENT

Following welfare reform, Congress, the states, and immigrants themselves actively sought to mitigate some of the law's potential impacts. Nonetheless, many of the law's central provisions remain on the books, with far-reaching effects that may deepen in a recessionary economy.

Congressional Restorations

In 1997, Congress restored SSI and derivative Medicaid benefits to all elderly and disabled immigrants receiving SSI at the time reform was enacted and to all legal immigrants in the U.S. at the date of enactment who might become disabled in the future.[14] Later that year, Congress extended food stamp benefits to legal immigrant children and to elderly and disabled immigrants in the U.S. at the time of PRWORA's signing.[15] However, the food stamp restoration left out working-age adults, who constituted roughly three-quarters of the 935,000 noncitizens who lost benefits. Moreover, neither the food stamp nor SSI restoration bills extended any benefits to the rapidly growing population of post-enactment immigrants, thereby deepening the divide between the legal endowments of pre- and post-enactment immigrants.

Administrative Responses

In 1999, the federal government released guidance that clarified for the first time the implication of noncitizen use of public benefits for becoming a public charge, i.e., an immigrant who has become dependent on public benefits and is therefore ineligible to receive a green card. The guidance established that public charge issues would apply to applicants for green cards, not

[14] The Balanced Budget Act of 1997, Pub. L. No. 105-33.
[15] The Agriculture, Research, Extension and Education Reform Act, P.L. 105-185 (1998).

to applicants for naturalization. The guidance also established that public charge issues would arise primarily in the context of long-term dependence on cash assistance; they would not be tied to receipt of food stamps, Medicaid, or SCHIP. In addition, public charge issues would not arise as a result of benefits use by a green card applicant's family members.[16]

The States' Responses

To the surprise of many observers, the states almost uniformly employed their newfound powers to extend Medicaid, SCHIP, and TANF to pre-enactment immigrants. To the extent that a "race to the bottom" might have been feared, it did not develop through the 1990s. At the same time, though, states have been more reluctant to extend benefits to post-enactment immigrants, with responses varying widely across states (Zimmermann and Tumlin 1999).

The limits of state generosity are evident when the responses of the seven states with the most immigrants are examined. Together, seven large immigrant-receiving states (California, New York, Texas, Florida, Illinois, New Jersey, and Arizona) account for three quarters of the nation's foreign-born population. California is alone among the seven in providing substitutes in the areas of health, cash assistance, and nutrition. Of the other six states, three now offer substitute health programs, but little else. Even the most generous states in the nation, like Massachusetts, condition immigrants' access to substitute programs in ways that reduce their availability and, in some circumstances, would be illegal if applied to citizens.[17]

States' differential treatment of pre- and post-enactment immigrants reflects the fiscal incentives built into PRWORA. Under the current law, the federal governments contributes to state expenditures on pre-enactment immigrants. Expenditures on legal post-enactment

[16] See, 8 CFR Parts 212, 237, P.28676 (1999).

immigrants are fully financed with state tax dollars. The patchwork of state responses that has evolved under this financing scheme has meant that noncitizen eligibility for public benefits has been reduced more than citizens' and that noncitizens face wider variation across states in their access to safety net services.

The Courts' Responses

While PRWORA's immigrant restrictions were initially somewhat unstable politically, they have generally fared better in courts, where they have withstood numerous legal challenges. This stability can be traced to their origins in the Congress' *immigration* powers. As a result, the restrictions have been viewed by courts as involving questions of foreign policy and national sovereignty and within the special expertise of the Congress and the Executive.[18] Some constitutional scholars have questioned whether the federal government's immigration powers are delegable to the states — an issue to which we return later (Wishnie 2001).

Legal challenges at the state court level have produced more mixed results. In the most significant legal reversal of PRWORA's immigrant restrictions to date, a New York State Court of Appeals found that PRWORA does not authorize New York State to bar post-enactment immigrants from the state-funded Medicaid program.[19] However, the ruling is based in large part on the New York State Constitution and may be of limited precedential value in other states.

---

[17] The new conditions include deeming and residency requirements; shorter time limits for receipt; and mandates that claimants pursue naturalization.

[18] This treatment is in sharp contrast to cases of alienage discrimination that do *not* raise immigration considerations and are, as a result, subject to higher levels of scrutiny. An example is the new durational residency requirements applied to citizens and noncitizens alike that were introduced by PRWORA. These requirements limited the amo unt of benefits available to welfare recipients who were new residents of a state to the amount they received in their prior state of residence. These requirements were found to violate the right to travel and struck down by the U.S. Supreme Court (*Saenz v. Roe,* 526 U.S. 489, 1999).

[19] *Aliessa v. Novallo,* 20001 NY Int. 59. June 5, 2001.

Like their federal counterparts, however, the state courts have generally upheld new, PRWORA-derived immigrant restrictions. For example, a Massachusetts court upheld the state's imposition of a six-month residency requirement for the state's immigrant-specific cash assistance program. The court reasoned that the state was under no legal obligation to create this immigrant-only program in the first place and could condition its largesse in ways that were reasonable.[20]

In sum, federal restorations, coupled with generous state eligibility rules, provided pre-1996 immigrants with legal safeguards against many of PRWORA's new immigrant restrictions. However, the rapidly growing population of post-1996 immigrants confronts a patchwork of widely varying state programs, with many states — including some of the largest immigrant-receiving states — offering few benefits. Moreover, it is unclear whether the safety net erected by generous states will remain intact as the economy slows and state revenues fall.

PRWORA'S IMPACT ON IMMIGRANT BENEFIT USE

Early Evidence — "Chilling" Effects

PRWORA's framers clearly succeeded in reducing immigrants' overall use of public benefits. Several early studies found that noncitizen use of public benefits not only declined, but did so at a faster rate than citizens'. Zimmermann and Fix (1998) found that noncitizen use of public benefits in Los Angeles County fell precipitously following welfare reform and was declining at a faster rate than that of citizens. Aggregate national data from the Current Population Survey also documented declines in welfare use for both citizens and noncitizens (Fix and Passel 1999). Overall, the decreases for noncitizens were greater than for citizens. While

[20] The judge in the case noted, "It may indeed be true in life that no good deed goes unpunished, but it need not be a principle of judicial review regarding legislative good deeds." *Jane Doe et al. v. Claire McIntire,* Sup. Ct. of Mass. ,

decreases in use rates for citizens and noncitizens in households *with children* were roughly the same, by 1997, noncitizen families with children were only about two-thirds as likely to be receiving benefits as citizen families.

Subsequent studies, most notably by the Department of Agriculture, confirmed these results, finding that food stamp use among noncitizens fell 72 percent between 1994 and 1998 (Genser 1998). The Department of Agriculture study found that the effects of benefit cuts fell not just on the noncitizens who were the targets of welfare reform, but on the U.S. citizen children who live in their families. Between 1994 and 1998, food stamp use fell by 53 percent among citizen children in immigrant families (i.e., families with a noncitizen parent).

The declines documented in these various studies could not be accounted for by shifts in eligibility because most noncitizens in the studies had arrived before 1996 and retained their eligibility for the programs in question. Rising incomes also fail to explain the degree of change. We have contended that the greater drops in usage among noncitizens are attributable, in part, to welfare reform discouraging some immigrants from using benefits regardless of eligibility. These "chilling effects" likely reflect confusion among immigrants about who is eligible for benefits and fears about the legal consequences of seeking assistance.[21]

New Analyses of Immigrant Program Participation

In the balance of this section, we report the results of our most recent analyses that draw on the Current Population Surveys for March 1995 through 2000.[22] Our principal focus is on

---

2001 Mass. Super. Lexis 153, January 25, 2001.

[21] By this definition, "chilling effects" is simply used to connote steep benefit declines among an eligible population that are not accounted for by denials or by income gains.

[22] Compared with administrative data on caseloads, the March Supplements to the Current Population Survey are known to understate participation. Further, there has apparently been some deterioration in coverage in recent years (Wheaton and Giannarelli 2000). Nonetheless, the CPS data track overall trends in participation fairly well (O'Neill and Hill 2001). In general, our work compares immigrants with natives (or citizens), so that only differential

families of legal noncitizens in comparison with citizen families, but we draw attention to other key groups including refugees, naturalized citizens, and undocumented immigrants.[23]

The analysis reported here differs from our earlier study of declining immigrant participation rates (Fix and Passel 1999) in three critical ways. First, while our earlier analysis differentiated refugee from other immigrant households, we did not distinguish between legal and undocumented immigrants, as we do here. Second, unlike our earlier study, we focus most of our analyses here on families with children whose incomes are below 200 percent of poverty, comparing usage patterns of low-income legal noncitizen families with those of low-income citizen families. These families have substantial practical and policy import where TANF reauthorization is concerned as they are the ones most likely to need and to be eligible for public assistance. (For Medicaid, however, we expand our analysis to focus on individuals in addition to families.) Third, this analysis updates our earlier study by relying on 1995–2000 CPSs *versus* only the 1995–1998 CPSs, thus allowing for two additional years of welfare reform, and importantly, SCHIP implementation.

Overall Declines

We first note that the broad patterns found in the early studies cited above are still apparent. Among families with one or more adult(s) who are legal noncitizens (also referred to

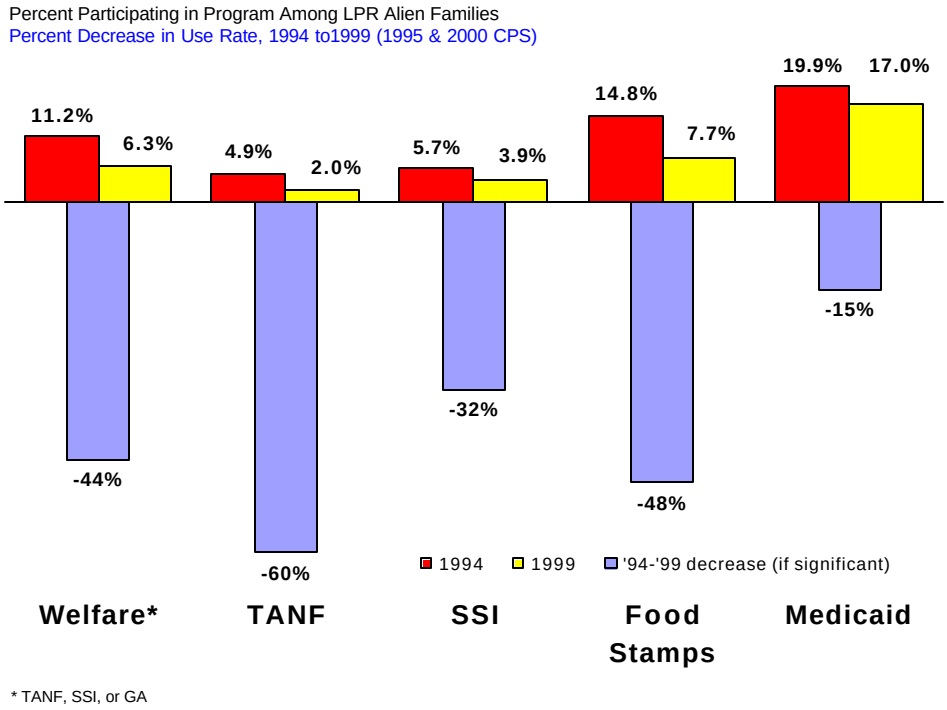
---

changes would affect our conclusions. In that light, work on participation of immigrants in the CPS suggests that this group is much *better* covered in the March 2000 CPS than in earlier years (Passel 2001a). Consequently, the conclusions based on CPS analyses of immigrant-native trends should not be affected by CPS undercoverage of program participation. Note also that the CPS reports population numbers for the year of the survey, but asks about benefit use for the use preceding the survey. Hence, the population and participation figures are for different years.

[23] The analyses employ Urban Institute-generated datasets that correct for over-reporting of naturalized citizens and identify four groups of noncitizens: (1) refugee entrants based on country of birth and year of entry; (2) legal nonimmigrants (i.e., temporary residents) based on occupation, year of entry, and other characteristics; (3) likely undocumented immigrants based on occupation, country of birth, year of entry, age, and state; and (4) legal permanent residents (LPRs). See Passel and Clark (1998) for a description of the assignment methods. Families are classified on the basis of the head and spouse (if present) as undocumented, refugee alien, LPR alien, naturalized citizen, native, and legal nonimmigrant.

as legal permanent resident aliens or LPR aliens), there was a notable decline in noncitizen use of TANF, SSI, food stamps and Medicaid programs from 1994 through 1999. The sharpest decrease occurred in TANF use, with legal noncitizens' participation rate falling from 4.9 percent in 1994 to 2.0 percent in 1999.[24] The drop in Medicaid usage was the least dramatic, at 2.9 percent. (See Figure 1.) Further, the overall declines in participation rates for legal noncitizen families exceeded the declines experienced by citizen families for TANF, SSI, and food stamps, but not Medicaid.

Figure 1. Participation in Means-Tested Benefit Programs for Legal Permanent Resident Alien Families: 1994 and 1999

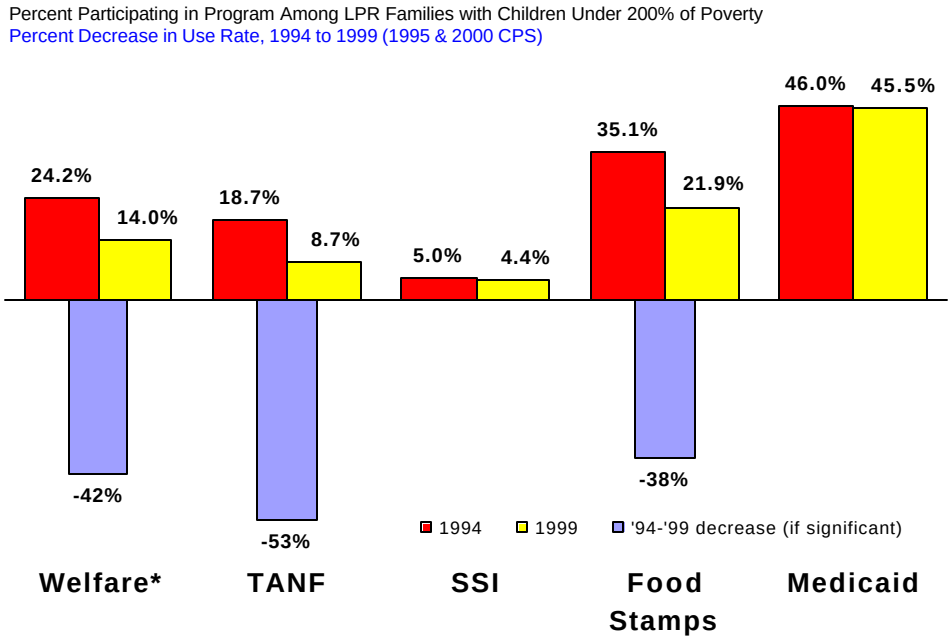


[24] The 60 percent decrease from 1994 to 1999 is computed as the difference in participation rates (2.9 percentage points—4.9 percent in 1994 minus 2.0 percent in 1999) divided by the 1994 participation rate (4.9 percent). We report one decimal place on participation rates and round the percentage decrease to whole percents. We use the terms "participation rate," "usage rate," and "use rate" interchangeably as the number of program participants divided by the population at issue. The terms are not meant to denote eligibility.

Low-Income Families with Children

When we focus on these low-income families with children, a somewhat different picture emerges than for the overall legal noncitizen population. Low-income families with children experienced large declines in TANF and food stamp use between 1994 and 1999, with legal noncitizen families' use of TANF falling 53 percent from 18.7 to 8.7 percent and food stamps 38 percent from 35.1 to 21.9 percent. (See Figure 2.) Participation in Medicaid — 46.0 percent in 1994 and 45.5 percent in 1999 — remained essentially (and statistically) unchanged.

Figure 2. Participation in Means-Tested Benefit Programs for Low-Income Legal Permanent Resident Alien Families with Children: 1994 and 1999

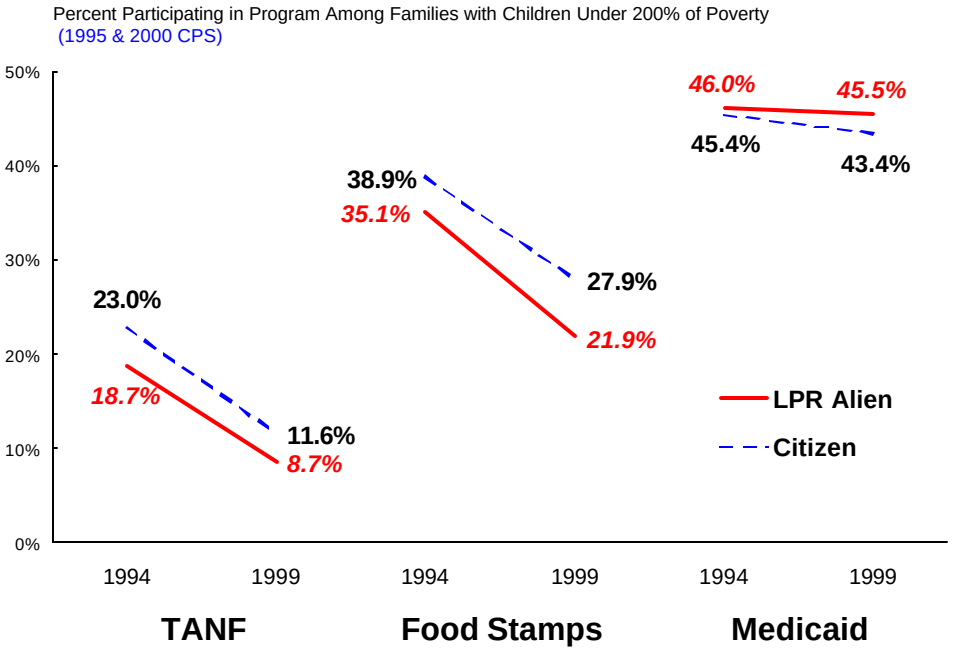


* TANF, SSI, or GA

Declines for these low-income legal immigrant families with children were not significantly different from those experienced by similarly-situated citizen families. Thus, the steep early declines that characterized the immigrant population are now evident for noncitizens and citizens alike. However, we should also note that when we stratify in this way the program

participation rate for low-income legal noncitizen families is substantially lower than citizen benefit use for TANF, SSI, and food stamps; for Medicaid, the use rates are no different. (See Figure 3.) When we use individuals rather than families as the unit of analysis in Medicaid, however, use rates for noncitizens are lower.

Figure 3. Participation in Means-Tested Benefit Programs for Low-Income Legal Permanent Resident Alien and Citizen Families with Children: 1994 and 1999



Mixed Status Families

PRWORA not only reduced benefit use among the noncitizens targeted by reform, it also reduced participation among the U.S.-citizen children who live in immigrant families. The U.S.-citizen children of immigrants are a demographically important group. About one in 10 American children live in a household where one or more of the parents is a noncitizen and one or more of the children is a citizen (Fix and Passel 1999); about three-quarters of all children living in immigrant-headed households are U.S. citizens (Fix and Zimmermann 2001**).** By law,

children born in the United States to immigrant parents (even undocumented immigrants) qualify for public benefits on the same terms as children of native-born citizens. Yet, our analysis shows that U.S.-born children of immigrants are much less likely than children of native-born citizens to participate in public benefits programs.

Among low-income immigrant[25] families with children who are U.S. citizens, 7.8 percent received TANF in 1999 compared with 11.6 percent of low-income citizen families with children. Similarly, the mixed-status immigrant families are considerably less likely to receive food stamps than citizen families — 19.8 percent versus 27.9 percent. For both programs, the mixed-status families experienced significant declines in participation from 1994 to 1999. Medicaid is again an exception as the two groups of mixed status, low-income families did not experience a decline in usage and ended in 1999 with participation rates essentially equal to the citizen families — 42.7 versus 43.4 percent.

Refugees

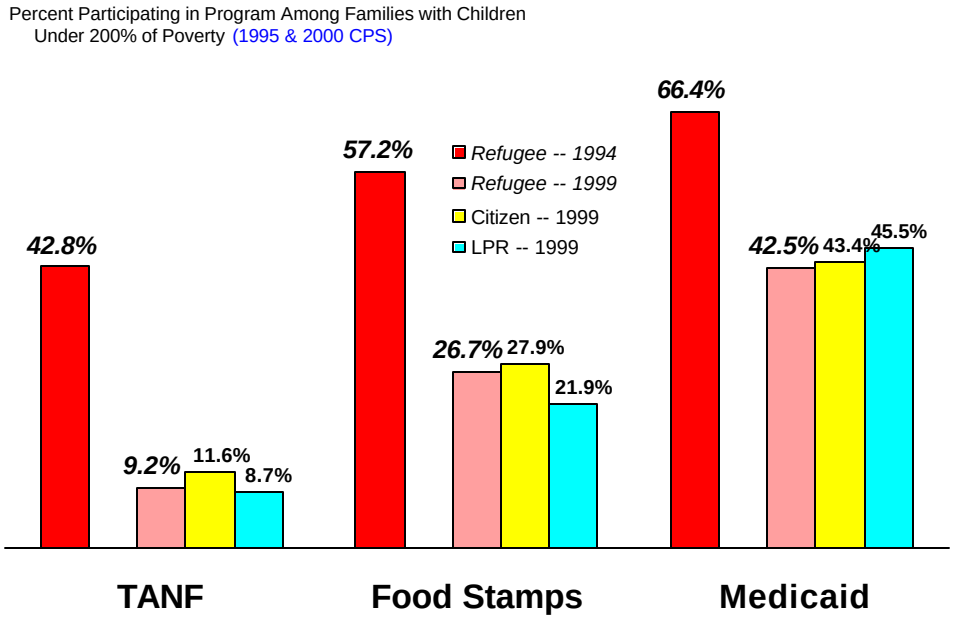
Sharp declines in the use of public benefits have not been confined to legal permanent residents, they are also visible among refugees. Again, focusing on families with children and incomes under 200 percent of poverty, we see extraordinarily large decreases in participation among refugees[26] from 1994 to 1999: food stamps, -53 percent; TANF, -78 percent; and Medicaid, -36 percent. Before PWRORA, participation rates for low-income refugee families with children were much higher than the rates for either citizen or LPR alien families. For some

[25] We include here LPR aliens and undocumented aliens because the eligibility of their U.S.-born children is not affected by the status of the parents.

[26] We use the term "refugees" to refer to noncitizens who were admitted as refugees (in 1980 or later) without regard to their current immigration status or eligibility status. Almost all of the refugees adjust their legal status to legal permanent resident alien after one or two years in the country, but they retain their special access to benefits. In our refugee population, many have been in the United States longer than the period during which refugee arrivals have special access. (Persons admitted as refugees but who have acquired U.S. citizenship by naturalization are included in our citizen population.)

programs, refugee participation rates were more than double those for LPR families. By 1999, the rates for refugee families had fallen to roughly the same level as those of citizens for TANF, food stamps, and Medicaid. (See Figure 4.) These results are especially striking because refugees are a protected population under PRWORA, as they are exempted for five to seven years from the law's bars on federal means-tested public benefits.

Figure 4. Participation in Means-Tested Benefit Programs for Low-Income Families with Children: Refugee Aliens — 1994 and 1999; Citizens and LPR Aliens — 1999



Change in TANF Caseloads and the Recipient Population

What have these changes in benefit use meant for the composition of the recipient population between 1994 and 1999? Changes in both immigrant and citizen benefit usage between 1994 and 1999 have led to a large overall drop in families receiving TANF benefits. These remaining families may prove to be difficult to move off TANF, especially if they face

barriers to work such as limited English language ability or low educational levels (Zimmermann and Tumlin 2001).

During this period, the CPS shows a drop of 55 percent in the number of all families receiving TANF benefits from 4.0 to 1.8 million (Table 1). Among immigrants, two groups experienced extremely large decreases in recipients: LPR families dropped by 216,000 or 62 percent and refugee alien families fell by 97,000 or 76 percent. At the same time, the number of naturalized citizen families on TANF increased by 24,000 or 45 percent. The number of undocumented families remained essentially unchanged.

As a result of these shifts, the composition of the immigrant population remaining on TANF has been substantially altered since the passage of welfare reform. Naturalized citizens accounted for 9 percent of foreign-born recipient families in 1994 but 25 percent in 1999 (Table 1). The share of immigrant TANF recipients in LPR and refugee alien families dropped from 80 to 53 percent; as a share of *all* recipient families, these two groups dropped from 12 to 9 percent. PRWORA seems to have succeeded in reducing both the number and share of legal immigrants on welfare.

To some degree, the changes in composition of immigrant TANF recipients reflect underlying dynamics in the immigrant population itself, but the large reductions in use have occurred in spite of substantial increases in some components of the immigrant population. Overall, the foreign-born population grew by 16 percent from 24.5 million in the 1995 CPS to 28.4 million in the 2000 CPS.[27] But the growth differed substantially across the different legal

[27] The results of Census 2000 have created considerable uncertainty about the size of the foreign-born population and, more specifically, the undocumented immigrant population. The March 2000 CPS which shows 28.4 million immigrants is based on the 1990 Census. The total population from Census 2000, 281.4 million, exceeded pre-census estimates by 5–7 million with much of the excess thought to be unmeasured immigration (Passel, 2001). When the March 2000 CPS is re-weighted to agree with the results of Census 2000, it shows 30.1 million immigrants. Another survey, the Census 2000 Supplementary Survey, taken during 2000 with a sample size

status categories. The number of naturalized citizen families increased by 28 percent from 5.2 million to 6.7 million and now represent over one-third of all immigrant families (Table 1).

When new legal immigrants enter the country, they become part of the LPR alien population; when they naturalize, however, they depart the LPR alien population. In recent years, the number of new LPRs has been insufficient to replace those shifting into the naturalized citizen category. As a result, the number of LPR alien families actually decreased by 400,000 or 6 percent to 6.6 million in the 2000 CPS. In sum, shifts in the make-up of the immigrant TANF population are the products of: (1) increases in the number of naturalized citizens; (2) a slight increase in the rate of benefit use by naturalized citizens; and (3) declines in benefit use among noncitizens. These compositional changes are also driven by the fact that additions to the number of naturalized citizens come from the population of legal noncitizens, reducing its size.

The remaining two categories of immigrants—refugees and undocumented immigrants—show demographic changes that are dramatically at odds with the TANF use patterns. The number of refugee alien families increased by 13 percent between the March 1995 and March 2000 CPSs in contrast to the 76 percent drop in refugee families on TANF. For undocumented immigrants, the number of families increased by 1.2 million or 41 percent over the five-year period as a result of both a substantial influx of undocumented immigrants and better coverage of the group in the 2000 CPS. Notwithstanding this very large increase in the undocumented population, the number of undocumented families on TANF (i.e., receiving benefits for their citizen children) remained essentially unchanged over the period as a result of substantially decreased usage.

---

14 times larger than the March 2000 CPS, showed an even larger foreign-born population of 30.5 million. Almost all of the difference in the various measures of the foreign-born population can be attributed to the number of undocumented immigrants estimated to be represented in the different surveys (Passel 2001a).

Medicaid Use and Health Insurance

Medicaid Participation of Families. Changes in Medicaid and SCHIP[28] participation follow quite different trajectories from the other programs. Overall decreases in family Medicaid/SCHIP participation are smaller than for the other programs. Moreover, among low-income families with children there was virtually no change in Medicaid use between 1994 and 1999 for either citizens or LPR aliens (e.g., Figure 2). In addition, use of Medicaid among low-income LPR and refugee families with children was virtually identical to the use rates for equivalent citizen families.

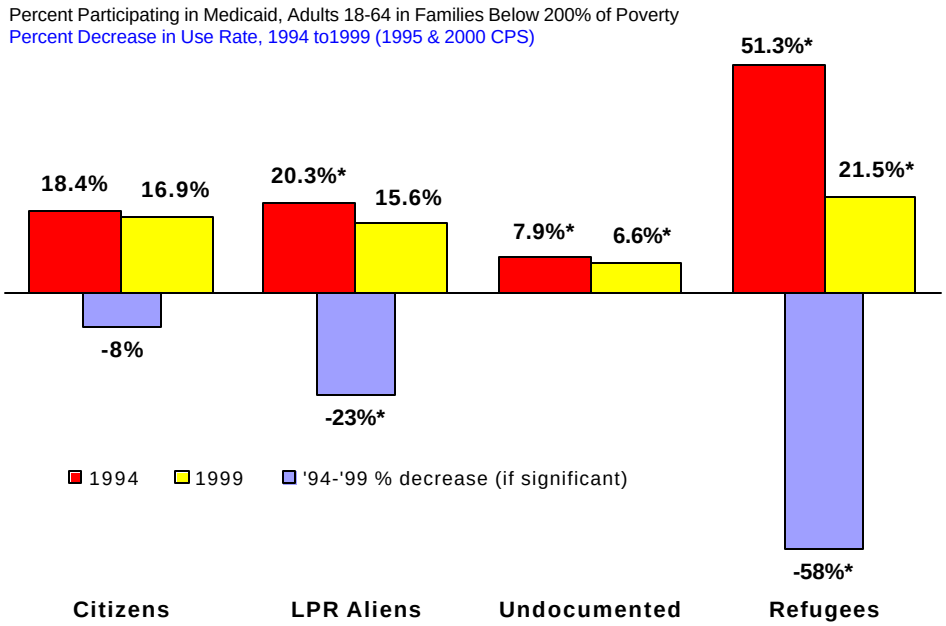
There are a number of policy–related explanations for these stable Medicaid use rates among low-income immigrant families with children. These include the introduction of expanded health care coverage under SCHIP, stepped up state and local outreach for child health insurance, and the impact of new federal guidance clarifying that use of health benefits would not be a bar to obtaining a "green card" or citizenship. In addition, Medicaid providers (doctors, hospitals, and clinics) have incentives to keep both immigrants and natives enrolled in government health programs to ensure the payment of medical bills. Other welfare programs do not have third parties who have such direct incentives to make sure low-income families are signed up for welfare benefits. Another possible explanation for the fact that Medicaid did not decline among noncitizens may be increased use of emergency Medicaid by legal immigrant family members.

[28] The CPS data on Medicaid are based mainly on individual responses to questions on health insurance, but also include imputations based on other items (e.g., TANF recipients are assigned to Medicaid). In part because of the data collection methods, CPS groups Medicaid, emergency Medicaid, state Medicaid-like programs and supplemental programs, and SCHIP together. The data reported in this paper thus cover Medicaid, emergency Medicaid, and SCHIP.

Individual Medicaid Participation and Lack of Health Insurance. Health care services are qualitatively different from the other benefits in that they can be delivered directly to the individual in ways that TANF, SSI, and food stamps cannot. Health insurance can only be used by the individual beneficiary; cash and food stamps are fungible and can provide a benefit for the whole family. Accordingly, we focus our Medicaid/SCHIP analysis on individuals, examining use patterns among low-income working-age individuals (18–64 years) and children (under 18 years). With this view, a clearer picture of welfare reform's overall effects on immigrants' benefit usage emerges. In particular, the generally high and sustained levels of participation observed for low-income *families* are not found for individuals.

Among low-income working-age adults, Medicaid use declined significantly between 1994 and 1999 for citizens (18.4 to 16.9 percent), LPR aliens (20.3 to 15.6 percent), and refugee aliens (51.3 to 21.5 percent). (See Figure 5.) In a departure from the pattern for families, the

Figure 5. Participation in Medicaid for Low-Income Working-Age Adults (18-64), by Nativity and Legal Status: 1994 and 1999



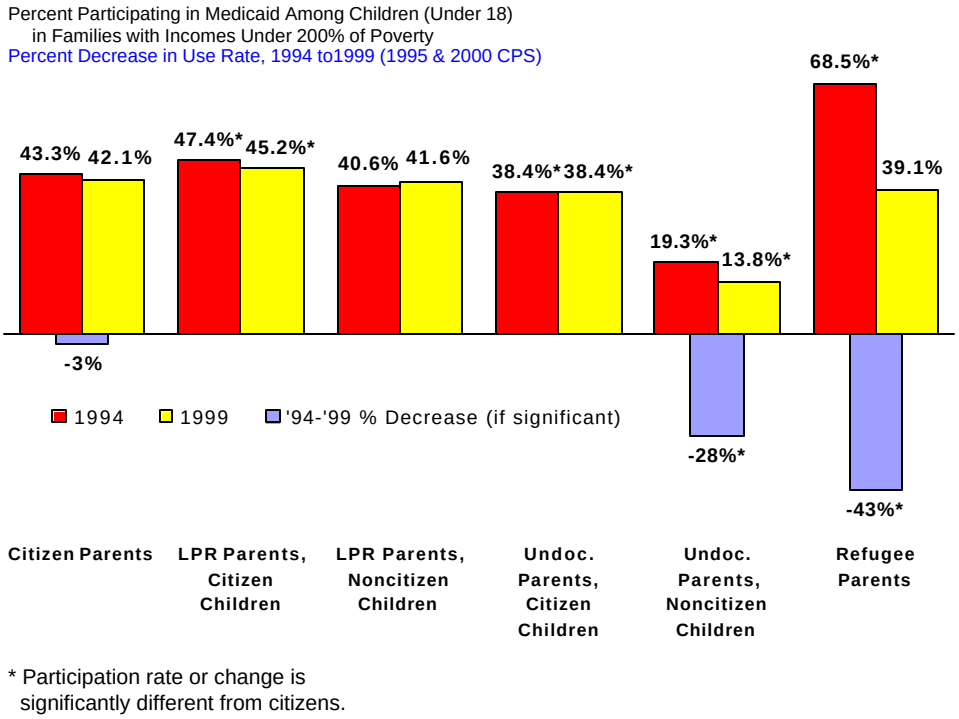
* Participation rate or change is significantly different from citizens.

decreases experienced by low-income LPR and refugee adults of working age were greater than for citizens

These declines in Medicaid participation did not occur because former recipients acquired other forms of health insurance. In fact, the declines in Medicaid participation were offset almost entirely by increases in the proportion of the population without health insurance — 1.1 percentage points for citizens, 4.5 for LPRs, and 16.2 for refugees. Thus, the reductions in Medicaid use are not being made up by other forms of health insurance, but rather are leading to the total loss of health insurance. Further, notwithstanding equal or higher rates of participation in Medicaid among immigrants, every immigrant group has substantially higher proportions of low-income working-age adults who were uninsured in 1999 than do U.S. citizens. Among citizens, 31.6 percent of working-age adults were uninsured in 1999 compared with 56.3 percent of legal permanent residents, 68.0 percent of undocumented immigrants, and 44.6 percent of refugees.

Children in low-income families have much higher rates of participation in Medicaid than working-age adults. Of children in low-income U.S. citizen families, 42 percent were participating in Medicaid in 1999, a very slight decline from 43 percent in 1994. (See Figure 6.) Children in low-income LPR alien families showed no significant decrease from 1994 to 1999, and had about the same degree of participation as children in citizen families regardless of their own citizenship (45.2 percent for U.S. citizen children and 41.6 percent for noncitizen children). Children of refugees, however, experienced a large decrease in Medicaid participation over the period from a level well above that of citizens in 1994 (69 percent) to roughly the same level in 1999 (39 percent).

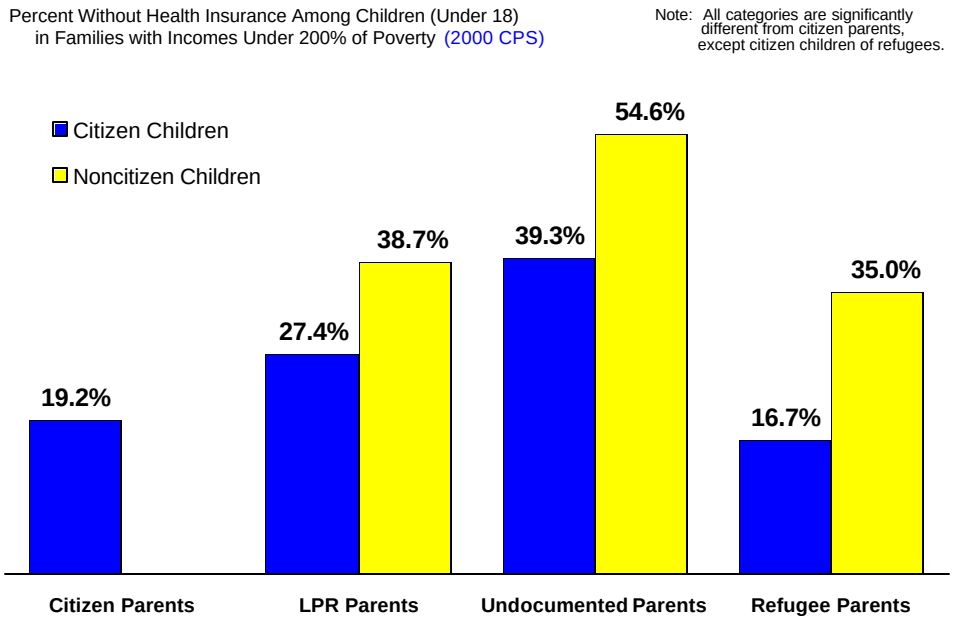
Figure 6. Participation in Medicaid for Low-Income Children (under 18), by Nativity and Status of Parents and Children: 1994 and 1999



* Participation rate or change is significantly different from citizens.

Not surprisingly, given the steady, high levels of Medicaid participation, uninsurance rates for low-income children changed very little between 1994 and 1999. However, the levels of uninsurance are much higher for children of immigrants than for children of citizens. Less than 20 percent of low-income children of U.S. citizens were uninsured in 1994 and 1999 (Figure 7). The U.S. citizen children of LPRs and undocumented immigrants experienced high uninsurance rates of 27.4 and 39.3 percent, respectively, in 1999. The situation of noncitizen children was even worse as the noncitizen children for each immigrant group had even greater rates of uninsurance.

Figure 7. Health Insurance Coverage for Low-Income Children (under 18), by Status of Parents and Children: 1999



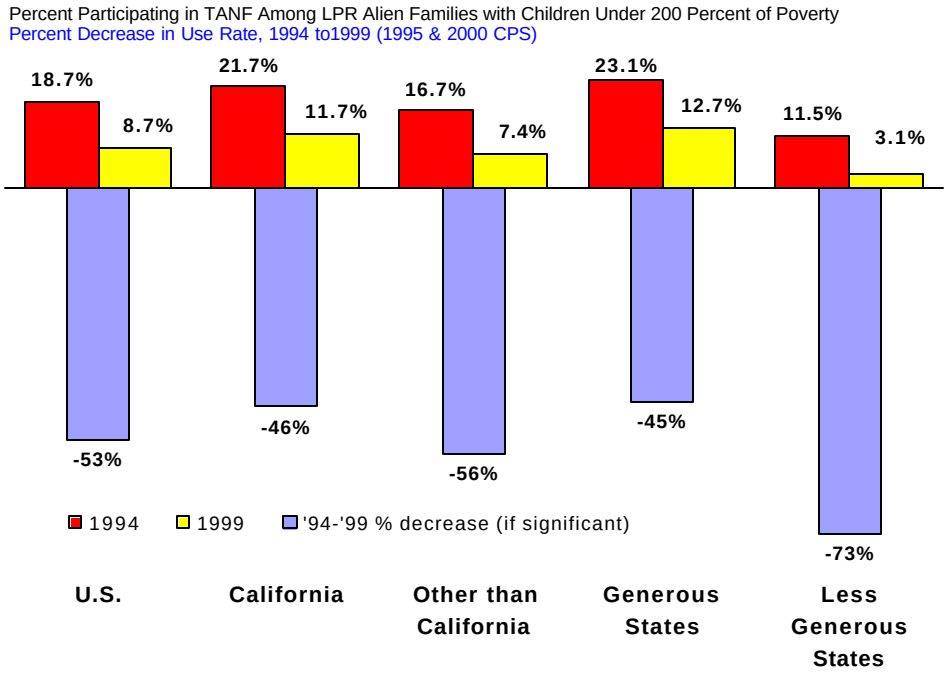
State Level Changes

The large declines in participation noted among legal immigrants and refugees are evident not just for the nation as a whole, but can generally be found in all parts of the country. Figure 8 shows TANF decreases for low-income LPR families for several groups of states. Substantial decreases occurred both in California (46 percent decrease) and outside of California (56 percent decrease). Most striking, however, is the decrease that occurred in states that the Urban Institute has identified as being among the least generous in providing benefits to immigrants[29] (Zimmermann and Tumlin 1999; Passel and Zimmermann 2001). In this group of states, TANF participation by low-income LPR families with children dropped 73 percent

[29] In their analysis of state policies determining immigrant eligibility for public benefits Zimmermann and Tumlin (1999) group the fifty states into four categories: those where benefits are "most available," "somewhat available," "less available," and "least available." For our purposes the less generous states are those that fall into

compared with the 45 percent decline in the other, more generous states. The larger percentage drop occurred despite initial participation rates in these less generous states being only about half the initial rate in the more generous states — 11.5 percent participation in 1994 compared with 23.1 percent for the more generous states. (See Figure 8.) Thus, immigrant participation levels across states widened following welfare reform.

Figure 8. Participation in TANF for Low-Income Legal Permanent Resident Alien Families with Children: U.S., California, and Selected Groups of States, 1994 and 1999



While benefit use rates have been falling sharply within these less generous states, their immigrant populations have been growing rapidly. Throughout the United States, the number of foreign-born families with children rose by 15 percent nationwide between 1995 and 2000. In the less generous states, they increased by 31 percent, but in the more generous states, they rose

the "less" and "least available" categories and the more generous states are those where benefits are "most" or "somewhat available."

by only 7 percent. In California, which offers legal immigrants one of the most generous packages of public benefits, the number of foreign-born families grew by only 2 percent during this period.

These differential growth patterns are the result of two demographic trends. First, more immigrant families moved out of the more generous states into less generous states than vice versa. Second, the percentage of newly-arrived immigrants from abroad settling in the less generous states increased during the late 1990s, notwithstanding the states' more limited generosity. (See Passel and Zimmermann 2001 for an exploration of these patterns.) Taken together, these eligibility and migration trends call into question the theory underlying PRWORA's Title IV that welfare benefits play a large role in determining where immigrants choose to live.

Rapid growth in immigrant populations outside the traditional receiving communities may produce strains on state and local governments, particularly in the areas of education and health. These strains may even be felt by states in comparatively strong economic shape. Further, these new settlement patterns lead to questions about the potential effects of a recession and a tightening labor market on these noncitizen families, many of whom might find themselves excluded from increasingly localized safety nets.

Explaining the Trends in Immigrant Program Participation

How do we explain these steep declines in public benefit use among noncitizens? To what extent are they attributable to increased naturalization and the transformation of noncitizen benefit users into citizen benefit users? To rising incomes among immigrant families? To behavioral shifts among noncitizens — i.e., that result from legal exclusions or to a reduced propensity to participate in benefits programs?

Naturalization Rates and Benefits Use

Between 1994 and 1999 there was a substantial increase in the number of naturalized citizen families in the United States. Underlying the rapid increase is the demographic fact that 2. 7 million immigrants acquired legal immigrant status around 1990 under the 1986 Immigration Reform and Control Act and thus became eligible to naturalize in the mid-1990s. In addition, rates of naturalization increased, but not just because of new, policy-driven incentives to acquire citizenship set in motion by welfare reform. The increases also resulted from reactions to California's Proposition 187 (which barred illegal immigrants from public schools and other public benefits) and to limits on noncitizens' procedural rights embedded in the 1996 illegal immigration reform law.

The rise in naturalizations was accompanied by a proportionately greater increase in the number of naturalized families receiving some means-tested benefits, and a concomitant increase in the rate of benefits receipt in these programs. For SSI, the number of naturalized citizen families receiving benefits increased from 133,000 in 1994 to 298,000 in 1999; the rate of SSI use by naturalized citizen families increased by 75 percent (from 2.5 percent to 4.5 percent). Medicaid showed a more modest increase in use rates of 28 percent (from 8.1 percent to 10.4 percent). The changes in TANF and food stamp participation by naturalized citizens were not statistically significant.

Notwithstanding the increases in usage by naturalized citizen families, the share of the naturalized population receiving benefits remains relatively modest and the increases account for a small fraction of the reductions in usage among legal noncitizens. The CPS reports that while the number of families containing a naturalized citizen grew by 1.5 million between 1994 and

1999, the number of such families participating in welfare programs[30] rose by only 170,000. At the same time, the number of legal immigrant[31] families on welfare programs dropped by 480,000. Thus, while retention of benefits may be a factor motivating naturalization, it falls well short of offsetting decreases in usage among noncitizens.

The shift of individuals out of the legal alien categories through naturalization appears to play almost no role in the decreasing TANF use among legal immigrants. While the number of naturalized citizen families with children increased by 480,000 between 1994 and 1999, the number participating in TANF rose by only 16,000.[32] In contrast, the number of legal immigrant families receiving TANF dropped by 300,000.

Similar patterns can be seen in California, which experienced a sharp rise in naturalizations between 1994 and 1999. The CPS shows that the number of families with a naturalized citizen adult rose by over 60 percent (from 1.2 million to 1.9 million) during the period — more than three times the national rate (18 percent). While program participation rates for California's naturalized citizen families appear to be higher in 1999 than in 1994 for all programs, the measured changes are not statistically significant. Here, too, the increase in naturalized citizen families receiving welfare — 72,000 — is much smaller than declines in legal noncitizen families' participation — 238,000.

These trends in California and the United States suggest that, while an interest in retaining access to public benefits may have played a role in some naturalizations, their dramatic

[30] Defined as TANF, SSI or General Assistance (GA).

[31] Because the naturalized citizen population includes both refugee and LPR entrants, the legal noncitizen population for the comparisons here combines refugee aliens and LPR aliens.

[32] An alternative assumption might be that the use rate among naturalized citizen families might have decreased at the same rate as among native or noncitizen families. Compared with this alternative, the "additional" participation by naturalized citizen families in 1999 would be 40,000 — a figure still well short of the drop in TANF participation among legal noncitizen families.

increase was not broadly driven by the goal of retaining benefits. Moreover, the results indicate that naturalization rates did *not* vitiate the substantial declines in immigrants' benefit use that occurred in the wake of PRWORA, as some commentators have claimed (Borjas 2001).

Income Changes

If naturalizations account for at most a small part of the sharp decline in legal noncitizen use of public benefits, do increased incomes explain it? Nationwide, the share of foreign-born families with children whose incomes are below 200 percent of poverty fell by 5 percentage points between 1994 and 1999. While this drop, which amounted to a 10 percent decrease in the proportion with low incomes, could explain a drop in participation, it is unlikely to account for the much larger decreases in participation shown in Figure 1. The parallel declines in citizen participation noted earlier are mirrored by a 5 percentage point drop in low-income families among natives. Nonetheless, by 1999, at the peak of the nation's boom economy, 50 percent of all foreign-born families with children had incomes below 200 percent of the federal poverty line[33] versus 35 percent of citizen families.

We have already noted that overall participation rates drop faster among LPRs than citizens, while differences in rates of decline between *low-income* citizen and LPR families are not significant. Thus, differences and changes in income composition between LPR families and citizen families must play a role in affecting the overall trends, but how much? The demographic technique called standardization offers a means of answering such questions.

Standardization techniques permit the analyst to partition the change in a rate over time or the difference in rates between two populations into portions due to various factors (Das

[33] The share of foreign-born families with children with incomes below the poverty line falls to 42 percent when families with an undocumented adult are excluded.

Gupta 1993). The method enables us to apportion differences in two groups' usage rates to differences in group income,[34] differences in family structure,[35] and differences in a group's propensity to participate in a benefit program.

When we partition the changes in overall participation rates for the various means-tested programs for each of the citizen and noncitizen groups, it becomes starkly apparent that PRWORA succeed in changing usage patterns, and presumably behavior, for all of the groups. For TANF and food stamps, only about one-quarter of the reduction in the participation rates for *both citizens and LPR families* is explained by changes in income between 1994 and 1999 (Table 2); an insignificant amount of the reduction -- about 10 percent -- is attributable to changes in family composition. Remarkably, however, about two-thirds of the reduction between 1994 and 1999 for LPR families and citizen families is attributable to changes in their propensity to participate in the programs.

Behavioral changes show up for other groups and other programs as well. For LPR aliens, the reduction in SSI use, albeit small, is largely (about two-thirds) due to a reduction in the propensity to use SSI rather than income improvements (Table 2). For natives, there was no significant change in use from 1994 to 1999, but the propensity of native families to use SSI actually increased while income improvements led to an offsetting reduction in use. Refugee families experienced both larger reductions in participation rates than the other groups and larger increases in incomes. For refugees, too, however, the largest factor accounting for the usage decreases was the propensity to use the programs followed by income increases.

[34] For income, families are grouped according to (non-welfare) income relative to the federal poverty level in 8 categories: <50% of the federal poverty level, 50–74%, 75–99%, 100–124%, 125–149%, 150–174%, 175–199%, and 200% and above.

[35] Families are grouped into 5 exhaustive categories for family composition: (1) couples (married or unmarried partners) with children; (2) female-headed families with children; (3) other families with children; (4) couples without children; and (5) all other families without children.

The Medicaid program is, again, quite different from the others when we examine the factors behind the change, or lack thereof, between 1994 and 1999. Income increases play a principal role here as three-quarters of the overall LPR reduction in participation and virtually all of the citizen reduction is attributable to income factors (Table 2). The share due to change in usage patterns is not statistically significant for either group. Therefore, we conclude on the basis of this analysis, too, that there was no change in the propensity of legal immigrants and citizens to use Medicaid.

Citizen-LPR Differences in Program Participation

Which group is more likely to participate in means-tested programs, LPR alien families or citizen families? Superficially, it appears that LPRs are more likely to participate because their overall use rates are higher. However, when we take into account the differences in income and family structure between the two groups, a quite different picture emerges.

In fact, the principal factor explaining differences in participation is income. Because LPR families have lower incomes than citizen families, the overall participation rate in TANF, food stamps, and Medicaid for LPR alien families is higher than the rate for citizen families. However, the different income distributions account for *more* than the entire difference between the groups for TANF, SSI, and food stamps. (See Table 3.) On the other hand, differences in the propensity to participate in the programs leads to *lower* participation rates in 1999 on the part of LPR alien families for TANF, SSI, and food stamps. Family structure differences play a much smaller, and generally insignificant, role.

Medicaid is again slightly different. Income differences remain important factor, but account for only two-thirds of the difference in LPR and citizen family use rates. Family structure makes more of a difference here than in any other case, accounting for about

one-quarter of the LPR-citizen difference. The propensity to use Medicaid is not significantly different between the two groups and accounts for about 10 percent of the difference.

The analysis of participation rates subdivided by income and family distributions paints a clear picture of the factors leading to differences between citizen families and LPR alien families. The overall participation rates for LPR alien families are higher almost entirely because the aliens have lower incomes than citizens. In fact, if the two groups had the same income distributions and the same distributions by family type, then the LPR alien families would actually have slightly *lower* overall participation rates than citizens in TANF, SSI, and food stamps.

CONSIDERING REFORM

Welfare reform's devolution of immigrant policy to the states has led to a widening divide in both the generosity of state benefits and immigrants' participation levels in safety net programs. The new divisions emerge at a time of rapid migration to states with the least, rather than the most, generous safety nets. These migration patterns raise doubts about the continuing power of the welfare magnet — the theory on which the PRWORA's immigrant restrictions were at least partially based, and upon which they have been defended in the courts as elements of the nation's *immigration* not *welfare* policies. They also raise concerns that many immigrants will find themselves in places with extremely porous local safety nets in a recessionary period.

If the upcoming reauthorization of welfare reform directly addresses the law's impacts on immigrant populations, it seems likely that the debate will begin by revisiting the restoration of benefits to both pre- and post-enactment immigrants. Proposals that continue to await action include the following:

Restoring food stamps to working-age adults in the United States at the time of the law's enactment and to the families of post-enactment immigrants. Unlike the other means-tested federal programs, food stamps remain barred to working-age, *pre-enactment* immigrants who had no notice of the bars at the time they became legal permanent residents. As a result of the restrictions' wide scope, we have seen steep declines in immigrant use of food stamps. Our analyses indicate that these declines are not, for the most part, accounted for by increases in income. Like declines in other benefit programs, their effects have been felt by refugees and by citizen children — populations largely protected by the law. Further, the restrictions' continuing impacts take place against the backdrop of high levels of disadvantage among the children of immigrants. According to the 1999 National Survey of American Families (NSAF), children of immigrants are substantially more likely than children of natives to live in families that worried about, or encountered difficulties affording food — 37 percent versus 27 percent (Capps 2001).

Granting states the same right to elect to provide post-enactment immigrants with Medicaid and SCHIP that the states have been granted for pre-enactment immigrants. Welfare reform's restrictions on Medicaid and SCHIP represented a particularly sharp departure from prior policy. Unlike other means-tested federal programs, Medicaid was extended to legal immigrants from the date of their receipt of legal status, whereas the other programs were deemed for 3 to 5 years, essentially requiring that immigrants had to wait that long after admission to receive benefits. Our individual-level analysis of immigrants' use of Medicaid benefits in the wake of welfare reform indicates that noncitizens' use declined faster than citizens' and that noncitizen use rates in 1999 were lower than those of citizens. The analysis also shows that immigrants who left Medicaid did not do so because they found private insurance. Rather, they became uninsured once they lost Medicaid coverage.

Again, these developments take place against a backdrop of comparative disadvantage for immigrant populations. According to NSAF, 22 percent of immigrant children versus 10 percent of native children are uninsured (Capps 2001). The impacts of uninsurance on children are well-documented — including fewer doctor visits and increased use of high-cost emergency health care — and can lead to long-term health problems for individuals and greater tax burdens for communities.

Providing immigrants admitted after 1996 with SSI eligibility if they should become disabled after entry. Finally, the restoration of SSI to post-enactment immigrants who become disabled after their entry to the United States would provide benefits to individuals whose disabling conditions were clearly unanticipated at the time of entry immigration and who may find it difficult — if not impossible — to naturalize. Proposals advanced at the close of the Clinton Administration would have extended SSI benefits to post-enactment immigrants who had lived in the United States for 5 years.

Key Design Issues. All of these proposals to restore or expand benefits also raise a number of common, fundamental policy-design issues that may be debated at the time of reauthorization. One is the merit of continuing to use citizenship, rather than legal residence, to ration access to important public benefits. It could be argued that legal immigrants, like citizens, are compelled to pay taxes, serve in the military in dangerous times, obey all laws, and are subject to the vicissitudes of the market. Making safety net and work-support services contingent on naturalization creates incentives to naturalize that depart from loyalty and other nation-building goals. Further, to the extent that benefit restrictions are intended to affect the flow of incoming legal immigrants, it is arguably more efficient to introduce the desired criteria

directly into admissions standards — that is, to use the "front door" of immigration policy rather than the "back door" of immigrant policy to alter the characteristics of the immigrant stream.

Second, proposals to restore benefits to noncitizen families raise the important, if difficult, issue of how immigrant support obligations should be shared between sponsors and the government. Following PRWORA's enactment, the current system shifts the full burden onto sponsors. Does it go too far? The central issues raised are: (1) whether sponsor deeming and liability should be limited to a specific number of years and (2) whether sponsor deeming should be extended beyond cash transfer programs to health insurance. With regard to the former, it could be argued that the current law effectively extends the sponsor's support obligation until an immigrant attains citizenship, creating, in effect, a potentially open-ended liability for the sponsor. With regard to the second issue, we would note here that Australia and Britain introduced new sponsor-deeming requirements at the same time the U.S. did, but excluded health insurance from sponsor obligations (Fix and Laglagaron 2001).

Third, welfare reform has gone some distance toward remaking the welfare system into an engine of mobility rather than an agent of dependence. Yet working, low-income noncitizens are excluded, both from the safety net and from such work supports as health insurance, job training, and transportation subsidies. The successful adaptation of immigrants and the integration of immigrants and their children into American society are cherished American ideals and, arguably, are or should be the goals of immigrant and immigration policy. The exclusion of legal immigrant families from the reformed welfare system runs directly counter to this desired outcome.

Finally, immigration is increasingly an essential feature of national competitiveness in a global economic system where nations vie for talented immigrants. Determination of policies

related to immigration, like trade, are appropriately within the purview of the federal government. In upholding PRWORA's immigrant restrictions, the courts have said that states are making congressionally-authorized choices in immigration — not welfare — policy. We suggest that in this global era, it does not make sense to shift the power to determine the incentives for entry and content of citizenship from the national government to the states.

REFERENCES

Borjas, George, J. 2001. "Welfare Reform and Immigration." In Blank, Rebecca and Ron Haskins (eds.), *The New World of Welfare*. Washington, DC: The Brookings Institute.

Borjas, George J. and Lynette Hilton. 1995. "Immigration and the Welfare State: Immigrant Participation in Means Tested Entitlement Programs." Cambridge, MA: National Bureau of Economic Research.

Capps, Randy. 2001. "Hardship among Children of Immigrants: Findings from the 1999 National Survey of America's Families." Washington, DC: The Urban Institute. *Assessing the New Federalism Policy Brief* Series B, No. B-29.

Congressional Budget Office. 1997. *Federal Budgetary Implications of The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* Washington, DC. December.

Das Gupta, Prithwis. 1993. *Standardization and Decomposition of Rates: A User's Manual*. Current Population Reports, Series P23-186. Washington, DC: U.S. Bureau of the Census.

Duleep, Harriet Orcutt and Mark Regets. 1994. "The Elusive Concept of Immigrant Quality." Discussion Paper PRIP-UI-28, Program for Research on Immigration Policy. Washington, DC: The Urban Institute.

Fix, Michael and Laureen Laglagaron. 2001. "Report of the Working Group on Social Rights and Citizenship." In Alienikoff, T. Alexander and Douglas Klusmeyer (eds.), *Citizenship Policies for an Age of Migration*. Washington, DC: The Carnegie Endowment for International Peace. Forthcoming, winter 2002.

Fix, Michael and Jeffrey S. Passel. 1994. *Immigration and Immigrants: Setting the Record Straight*. Washington, D.C.: The Urban Institute.

Fix, Michael and Jeffrey S. Passel. 1999. "Trends in Citizens' and Noncitizens' Use of Public Benefits Following Welfare Reform, 1994–1997." Washington, DC: The Urban Institute.

Fix, Michael and Wendy Zimmermann. 2001. "All Under One Roof, Mixed Status Families in an Era of Reform." *International Migration Review* 35 (134, Summer).

Genser, Jenny. 1998. "Who is Leaving the Food Stamp Program: An Analysis of Caseload Changes from 1994 to 1997." Office of Analysis, Nutrition and Evaluation, The Food and Nutrition Service. Washington, DC: U.S. Department of Agriculture.

Gingrich, Newt and Richard Armey. 1994. *Contract With America*. New York City: Times Books, Random House.

O'Neill, June E. and M. Anne Hill. 2001. "Gaining Ground? Measuring the Impact of Welfare Reform on Welfare and Work." *Civic Report* No. 17. New York: Center for Civic Innovation, Manhattan Institute for Policy Research.

Passel, Jeffrey S. 2001. "An Evaluation of Demographic Analysis in Census 2000." In *Final Report of the Census 2000 Monitoring Board, President Members*. Washington, DC.

Passel, Jeffrey S. 2002. "Estimates of Undocumented Immigrants Living in the United States." Washington, DC: The Urban Institute (forthcoming)

Passel, Jeffrey S. and Rebecca L. Clark. 1998. "Immigrants in New York: Their Legal Status, Incomes, and Taxes." Washington, DC: The Urban Institute.

Passel, Jeffrey S. and Wendy Zimmermann. 2001. "Are Immigrants Leaving California? Settlement Patterns of Immigrants in the Late 1990s." Washington D.C.: The Urban Institute.

Van Hook, Jennifer, Jennifer E. Glick and Frank D. Bean. 1999. "Public Assistance Receipt Among Immigrants and Natives: How the Unit of Analysis Affects Research Findings." *Demography* 36 (1): 111-20.

Wheaton, Laura and Linda Giannarelli. 2000. "Coverage of Social Benefit Programs in the Current Population Survey." Paper presented at the annual meetings of the American Statistical Association. August.

Wishnie, Michael. 2001. "Laboratories of Bigotry? Devolution of the Immigration Power, Equal Protection and Federalism." 76 New York University Law Review. 493.

Zimmermann, Wendy and Michael Fix. 1998. "Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County." Washington, DC: The Urban Institute.

Zimmermann, Wendy and Karen C. Tumlin. 1999. *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform. Assessing the New Federalism* Occasional Paper No. 24. Washington, DC: The Urban Institute.

Zimmermann, Wendy and Karen C. Tumlin. 2001. "What Does *Work First* Mean for Immigrants on TANF in New York, Los Angeles, and Houston?" Paper presented at the annual meeting of the Association for Public Policy and Management. Washington, DC: The Urban Institute. November.

Table 1. Number of Families and Families Receiving TANF, by Citizenship of Head and Spouse: 1994 and 1999

Status of Family Head/Spouse	Families (in thousands)				Percent Distribution			
			'94-'99 Change		Of Total		Of Foreign-Born	
	1994	1999	Amt.	Pct.	1994	1999	1994	1999
Families Receiving TANF								
Total	**4,041**	**1,835**	**-2,206**	**-55%**	**100**	**100**	**(x)**	**(x)**
Citizen	3,502	1,607	-1,895	-54%	87	88	(x)	(x)
Native	3,450	1,531	-1,918	-56%	85	83	(x)	(x)
Naturalized	52	76	24	45%	1	4	9	25
Noncitizen	411	197	-213	-52%	10	11	70	65
Legal	347	132	-216	-62%	9	7	59	43
Undocumented	63	66	2	4%	2	4	11	22
Refugee Alien	127	30	-97	-76%	3	2	21	10
All Families								
Total	**132,000**	**138,813**	**6,812**	**5%**	**100**	**100**	**(x)**	**(x)**
Citizen	120,828	126,591	5,763	5%	92	91	(x)	(x)
Native	115,585	119,889	4,304	4%	88	86	(x)	(x)
Naturalized	5,243	6,702	1,459	28%	4	5	32	35
Noncitizen	9,927	10,734	807	8%	8	8	60	57
Legal	7,019	6,626	-394	-6%	5	5	43	35
Undocumented	2,908	4,108	1,201	41%	2	3	18	22
Refugee Alien	846	952	106	13%	1	1	5	5

(x) — not applicable.

Source: Urban Institute tabulations from March 1995 and 2000 Current Population Surveys with immigration status imputed using methods based on Passel and Clark (1998).

Note: "Refugee Alien" represents persons admitted as refugees since 1980 who have not become naturalized citizens regardless of current status. "Legal" includes all persons who are not citizens and who were admitted as legal permanent residents (LPR) except those admitted as refugees. "Legal Nonimmigrants" or "Legal Temporary Residents" are persons with valid entry visas who are considered U.S. residents, such as foreign students, intracompany transfers, or H-1B "hi-tech" guest workers; to the extent that such persons are in the CPS, they appear in the totals but are not shown separately.

Table 2. Partition of 1994-1999 Change in Use of Welfare, Food Stamps, and Medicaid into Effects of Poverty-Family-Specific Use Rates, Poverty Distribution, and Presence of Children Distribution, Using Standardization Techniques for Families in the United States: By Nativity and Status

Program and Group	Percent of Families Participating in Program			Amount of Change in Participation Due to …			Percent of Change Due to …		
	1994	1999	'94-'99 Change	Use Rates	Poverty Distrib.	Family Distrib.	Use Rates	Poverty Distrib.	Family Distrib.
By Nativity and Legal Status									
Citizen									
Welfare[1]	6.5	4.8	-1.7 *	-0.8 *	-0.8 *	-0.1	45	47	8
TANF	2.9	1.3	-1.6 *	-1.1 *	-0.4 *	-0.2 *	68	22	10
SSI	3.4	3.4	0.0	0.4 *	-0.4 *	0.0	--	--	--
Food Stamps	9.0	5.5	-3.5 *	-2.3 *	-0.9 *	-0.2	68	27	6
Medicaid	11.6	10.4	-1.2 *	0.2	-1.2 *	-0.3	-21	98	23
LPR Alien									
Welfare[1]	11.2	6.3	-4.9 *	-3.1 *	-1.5 *	-0.4	63	30	7
TANF	4.9	2.0	-3.0 *	-1.8 *	-0.7	-0.4	62	24	14
SSI	5.7	3.8	-1.9 *	-1.2 *	-0.7	0.1	66	37	-3
Food Stamps	14.8	7.7	-7.1 *	-5.0 *	-1.6 *	-0.5	70	22	7
Medicaid	19.9	17.0	-2.9 *	-0.3	-2.1 *	-0.4	12	74	14
Undocumented Alien									
Welfare[1]	2.7	2.5	-0.2	-0.3	0.0	0.1	--	--	--
TANF	2.2	1.6	-0.6	-0.6	0.0	0.0	--	--	--
SSI	0.2	0.3	0.0	0.0	0.0	0.0	--	--	--
Food Stamps	8.3	5.9	-2.3 *	-2.1 *	-0.3	0.1	89	13	-2
Medicaid	13.2	12.9	-0.3	0.1	-0.6	0.3	--	--	--
Refugee Alien									
Welfare[1]	29.6	14.4	-15.1 *	-7.5 *	-7.0 *	-0.5	50	47	4
TANF	15.0	3.2	-11.8 *	-5.2 *	-4.1 *	-2.5	44	35	21
SSI	13.4	9.2	-4.2	-2.7	-3.1	1.6	--	--	--
Food Stamps	38.0	17.2	-20.8 *	-12.9 *	-6.7 *	-1.3	62	32	6
Medicaid	40.7	23.1	-17.6 *	-8.9 *	-7.4 *	-1.3	51	42	8

(continued)

Table 2. Partition of 1994-1999 Change in Use of Welfare, Food Stamps, and Medicaid into Effects of Poverty-Family-Specific Use Rates, Poverty Distribution, and Presence of Children Distribution, Using Standardization Techniques for Families in the United States: By Nativity and Status

Program and Group	Percent of Families Participating in Program			Amount of Change in Participation Due to …			Percent of Change Due to …		
	1994	1999	'94-'99 Change	Use Rates	Poverty Distrib.	Family Distrib.	Use Rates	Poverty Distrib.	Family Distrib.
				(continued)					
By Program									
Welfare[1]									
Citizen	6.5	4.8	-1.7 *	-0.8 *	-0.8 *	-0.1	45	47	8
LPR Alien	11.2	6.3	-4.9 *	-3.1 *	-1.5 *	-0.4	63	30	7
Undocumented	2.7	2.5	-0.2	-0.3	0.0	0.1	--	--	--
Refugee	29.6	14.4	-15.1 *	-7.5 *	-7.0 *	-0.5	50	47	4
TANF									
Citizen	2.9	1.3	-1.6 *	-1.1 *	-0.4 *	-0.2 *	68	22	10
LPR Alien	4.9	2.0	-3.0 *	-1.8 *	-0.7	-0.4	62	24	14
Undocumented	2.2	1.6	-0.6	-0.6	0.0	0.0	--	--	--
Refugee	15.0	3.2	-11.8 *	-5.2 *	-4.1 *	-2.5	44	35	21
SSI									
Citizen	3.4	3.4	0.0	0.4 *	-0.4 *	0.0	--	--	--
LPR Alien	5.7	3.8	-1.9 *	-1.2 *	-0.7	0.1	66	37	-3
Undocumented	0.2	0.3	0.0	0.0	0.0	0.0	--	--	--
Refugee	13.4	9.2	-4.2	-2.7	-3.1	1.6	--	--	--
Food Stamps									
Citizen	9.0	5.5	-3.5 *	-2.3 *	-0.9 *	-0.2	68	27	6
LPR Alien	14.8	7.7	-7.1 *	-5.0 *	-1.6 *	-0.5	70	22	7
Undocumented	8.3	5.9	-2.3 *	-2.1 *	-0.3	0.1	89	13	-2
Refugee	38.0	17.2	-20.8 *	-12.9 *	-6.7 *	-1.3	62	32	6
Medicaid									
Citizen	11.6	10.4	-1.2 *	0.2	-1.2 *	-0.3	-21	98	23
LPR Alien	19.9	17.0	-2.9 *	-0.3	-2.1 *	-0.4	12	74	14
Undocumented	13.2	12.9	-0.3	0.1	-0.6	0.3	--	--	--
Refugee	40.7	23.1	-17.6 *	-8.9 *	-7.4 *	-1.3	51	42	8

* Significant at $p < 0.10$

-- Total change not significant, so distribution not computed.

[1] Welfare receipt is defined as receipt of Temporary Assistance for Needy Families, Aid to Families with Dependent Children, Supplemental Security Income, ***or*** General Assistance.

Source: Urban Institute tabulations from March 1995 and 2000 Current Population Surveys with immigration status imputed with methods based on Passel and Clark (1998). See text for description of partition methods and definitions of categories of immigrants, poverty, and family status.

Table 3. Partition of Citizen-LPR Difference in Use of Welfare, Food Stamps, and Medicaid into Effects of Poverty-Family-Specific Use Rates, Poverty Distribution, and Presence of Children Distribution, Using Standardization Techniques for Families in the United States: 1994, 1999

Program and Date	Percent of Families Participating in Program			Amount of Difference in Participation Due to …			Percent of Difference Due to …		
	Citizen	LPR Alien	Diff.	Use Rates	Poverty Distrib.	Family Distrib.	Use Rates	Poverty Distrib.	Family Distrib.
By Year									
1999									
Welfare[1]	4.8	6.3	1.5 *	-1.1 *	2.4 *	0.2	-77	164	13
TANF	1.3	2.0	0.7 *	-0.3	0.8 *	0.2	-35	109	26
SSI	3.4	3.8	0.4	-1.2 *	1.6 *	0.0	--	--	--
Food Stamps	5.5	7.7	2.2 *	-0.8 *	2.6 *	0.4	-36	118	18
Medicaid	10.4	17.0	6.5 *	0.7	4.3 *	1.5 *	10	67	23
1994									
Welfare[1]	6.5	11.2	4.7 *	0.2	4.1 *	0.4	4	87	9
TANF	2.9	4.9	2.0 *	-0.5	2.0 *	0.6	-26	98	27
SSI	3.4	5.7	2.3 *	0.4	2.0 *	-0.1	19	86	-5
Food Stamps	9.0	14.8	5.9 *	0.3	4.8 *	0.7	5	82	12
Medicaid	11.6	19.9	8.2 *	1.3 *	5.5 *	1.5 *	15	67	18
By Progam									
Welfare[1]									
1999	4.8	6.3	1.5 *	-1.1 *	2.4 *	0.2	-77	164	13
1994	6.5	11.2	4.7 *	0.2	4.1 *	0.4	4	87	9
TANF									
1999	1.3	2.0	0.7 *	-0.3	0.8 *	0.2	-35	109	26
1994	2.9	4.9	2.0 *	-0.5	2.0 *	0.6	-26	98	27
SSI									
1999	3.4	3.8	0.4	-1.2 *	1.6 *	0.0	--	--	--
1994	3.4	5.7	2.3 *	0.4	2.0 *	-0.1	19	86	-5
Food Stamps									
1999	5.5	7.7	2.2 *	-0.8 *	2.6 *	0.4	-36	118	18
1994	9.0	14.8	5.9 *	0.3	4.8 *	0.7	5	82	12
Medicaid									
1999	10.4	17.0	6.5 *	0.7	4.3 *	1.5 *	10	67	23
1994	11.6	19.9	8.2 *	1.3 *	5.5 *	1.5 *	15	67	18

* Significant at $p < 0.10$

-- Total change not significant, so distribution not computed.

[1] Welfare receipt is defined as receipt of Temporary Assistance for Needy Families, Aid to Families with Dependent Children, Supplemental Security Income, ***or*** General Assistance.

Source: Urban Institute tabulations from March 1995 and 2000 Current Population Surveys with immigration status imputed with methods based on Passel and Clark (1998). See text for description of partition methods and definitions of categories of immigrants, poverty, and family status.

Exhibit D

URBAN INSTITUTE

One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018

Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman

May 2019

Immigration policy has been at the center of public debate for many years, but the debate has intensified since the 2016 presidential election. In October 2018, after months of anticipation, the administration published a proposed rule altering "public charge" determinations that would make it harder for immigrants to get a green card (i.e., establish permanent residency). After a public comment period that closed in December, the rule is being finalized. If implemented, the rule would make it more difficult for immigrants to get green cards if they have received certain noncash public benefits or have low incomes or other characteristics considered to increase their likelihood of using benefits in the future. Beyond reducing future immigration numbers, there is widespread concern this revised public charge rule would have "chilling effects" on low-income immigrant families by discouraging them from applying for and receiving public benefits for which they are eligible, for fear of risking future green card status.[1] This chilling effect could spill over to many people, including US citizen children.

So far, evidence on this chilling effect has largely been based on anecdotal reports from service providers.[2] In this brief, we use unique data from a nationally representative, internet-based survey conducted in December 2018 to provide the first systematic evidence on the extent of chilling effects among immigrant families before release of a final public charge rule.[3] The survey included nearly 2,000 nonelderly adults who are foreign born or live with one or more foreign-born family members (hereafter called "adults in immigrant families"), who make up about one-quarter of all nonelderly adults in the US, according to the 2017 American Community Survey. We provide here the first estimates of self-

reported chilling effects on participation in public benefit programs associated with the proposed public charge rule. These findings complement projections that other researchers have developed to model expected chilling that will follow a final rule (Artiga, Damico, and Garfield et al. 2018; Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018; Fiscal Policy Institute 2018; Kenney, Haley, and Wang 2018; Laird et al. 2019; Zallman and Finnegan 2018).[4]

We find the following:

- About one in seven adults in immigrant families (13.7 percent) reported "chilling effects," in which the respondent or a family member did not participate in a noncash government benefit program in 2018 for fear of risking future green card status. This figure was even higher, 20.7 percent, among adults in low-income immigrant families.
- Though the proposed rule would only directly affect adults who do not yet have a green card (i.e., lawful permanent residence), we observed chilling effects in families with various mixes of immigration and citizenship statuses, including 14.7 percent of adults in families where all noncitizen members had green cards and 9.3 percent of those in families where all foreign-born members were naturalized citizens.
- Hispanic adults in immigrant families were more than twice as likely (20.6 percent) as non-Hispanic white and non-Hispanic nonwhite adults in immigrant families (8.5 percent and 6.0 percent, respectively) to report chilling effects in their families.
- Though the proposed rule would only directly apply to adults, many households with children experienced chilling effects. Adults in immigrant families living with children under age 19 were more likely to report chilling effects (17.4 percent) than adults without children in the household (8.9 percent).
- Most adults in immigrant families reported awareness of the public charge rule (62.9 percent). Adults who had heard "a lot" about the proposed rule were the most likely to report chilling effects in their families (31.1 percent).

Background on Public Charge

The administration has advanced sweeping changes to federal immigration policy, including heightened immigration enforcement, termination of temporary protections against deportation, and cuts to refugee and asylee admissions. In 2018, the administration also proposed expanding the criteria used in "public charge" determinations, in which immigration officials may deny applications for permanent residency (green cards) or temporary visas to immigrants who are deemed "likely to become a public charge."[5]

The new approach would make it more difficult for immigrants to get green cards or temporary visas if they received or are deemed likely to receive cash and noncash public benefits. Departing from past practice where only primary reliance on cash benefits or long-term medical institutionalization were considered in public charge determinations, under the proposed rule, officials would consider an

applicant's use of either cash or noncash benefits as "negative factors," as well as several personal characteristics, including income level, age, English proficiency, educational attainment, employment status, family size, health status, credit score, and other financial resources. The proposed rule, posted for public comment in October 2018, expanded the list of benefits to be considered in future public charge determinations to include the Supplementary Nutrition Assistance Program (SNAP, formerly known as food stamps), Medicaid, Section 8 housing assistance, public housing, and subsidies for drug benefits under Medicare Part D.

The proposed rule would affect applicants adjusting from another immigration status who already live in the US and people applying from abroad through family sponsorship or other pathways (Capps et al. 2018). The rule specifically excludes certain groups, such as refugees and other humanitarian entrants, and clarifies that benefits received by eligible children will not be considered in adults' future immigration applications. However, there remains confusion about when and how the final rule will be implemented and what aspects of the proposed rule will carry over to the final version. In the meantime, a parallel change to the public charge test in the Foreign Affairs Manual, used by consular officials considering visa applications filed abroad, was implemented in January 2018, and recent data show that admissions decisions have already been affected; refusals of applications on public charge grounds quadrupled to 13,500 during the 2018 fiscal year.[6] News outlets have also recently reported that the Department of Justice is preparing to publish a rule on deporting green card holders on public charge grounds.[7]

The proposed rule could have pervasive effects for immigrant families, given the complicated nature of the regulation and widespread uncertainty about how or when it will go into effect. Already many immigrant families are reportedly avoiding interaction with public authorities and dropping out of or being reluctant to enroll themselves or their children in critical safety net programs like Medicaid and the Children's Health Insurance Program (CHIP), SNAP, or the Special Supplemental Nutrition Program for Women, Infants, and Children, even though the latter is not on the list of benefits in the proposed rule.[8] Immigrant-serving organizations are reporting heightened reluctance and fear in immigrant communities to receive public benefits for which adults and children are eligible, including programs that would not be considered in public charge determinations (Greenberg, Feierstine, and Voltolini 2019). There is also evidence of far-reaching fear and insecurity among immigrant families in the context of the administration's immigration policy changes and rhetoric; for example, psychological effects are widespread not only for undocumented people or temporary visa holders but among naturalized US citizens (Cervantes, Ullrich, and Matthews 2018; Roche et al. 2018).

Though these reports help clarify the impact of the broader immigration climate, there is no information yet on systematic changes to participation in safety net programs among immigrant families in the context of the debate around the proposed public charge rule. This brief provides new insight into the extent to which immigrant families avoided participating in these programs because of concerns about future green card status in 2018, as this proposed rule was debated. This includes both people who would be directly affected by the rule and have not yet applied for a green card and would receive

the revised public charge test in the future, as well as others who perceive potential risk despite the rule not directly applying to them.

Data and Methods

Data and Sample

We draw on data from the December 2018 round of the Well-Being and Basic Needs Survey (WBNS), a nationally representative survey of adults ages 18 to 64 launched in December 2017. This analysis is based on the WBNS core sample and an oversample of noncitizens. For each round of the WBNS, the core sample is a stratified random sample drawn from Ipsos' KnowledgePanel, a probability-based online panel recruited primarily from an address-based sampling frame, and includes a large oversample of adults in low-income households.[9] In December 2018, the survey also included an oversample of noncitizens to support analyses of current policy issues affecting immigrant families. The panel includes only respondents who can complete surveys that are administered in English or Spanish, and adults without internet access are provided laptops and free internet access to facilitate participation.

To assess chilling effects and other immigration policy issues, we constructed a set of weights for analysis of the population of nonelderly adults who are foreign born or living with a foreign-born relative in their household. The weights are based on the probability of selection from the KnowledgePanel and benchmarks from the American Community Survey for nonelderly adults in immigrant families who are English proficient or primarily speak Spanish.[10] The language criterion is used in the weighting to reflect the nature of the survey sample, because the survey is only administered in English or Spanish.

Our final analytic sample consists of 1,950 adults in immigrant families. When assessing the types of programs for which respondents reported chilling, we limit the sample to the 314 adults in immigrant families who reported any chilling effect on participation in public programs.

Measures

SELF-REPORTED CHILLING EFFECTS WITHIN A FAMILY

Our main outcome is self-reported chilling effects on participation in public programs *within a family*. We define these chilling effects as either not applying for or stopping participation in a noncash government benefit program, such as Medicaid/CHIP, SNAP, or housing subsidies, within the previous 12 months because of concerns that the respondent or a family member could be disqualified from obtaining a green card.[11] For this measure, a respondent could have defined family as both their immediate family and other relatives who may be living with them or in another household; we have learned from some initial qualitative follow-up work that some respondents took into account family members living in other households when they reported chilling effects. Respondents may also have reported chilling for a program for which they themselves may not have been eligible. For instance,

some parents may have reported chilling effects on the program participation of a citizen child, or a higher-income respondent may have reported chilling affecting a relative with lower income.

AWARENESS OF PROPOSED PUBLIC CHARGE RULE

To assess awareness of the proposed public charge rule published in October 2018, we asked respondents to report how familiar they were with a proposed rule that would make it harder for immigrants to enter the United States or become permanent residents of the US if they have low incomes or use public benefits such as Medicaid, SNAP, or housing subsidies. Respondents could make one selection from the options "a lot," "some," "only a little," or "nothing at all."[12]

Limitations

One limitation of the WBNS is its low response rate, which is comparable to other panel surveys that account for nonresponse at each stage of recruitment. However, studies assessing recruitment for the KnowledgePanel have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008), and WBNS estimates are generally consistent with benchmarks from federal surveys (Karpman, Zuckerman, and Gonzalez 2018). WBNS survey weights reduce, but do not eliminate, the potential error associated with sample coverage and nonresponse, and this is likely to be larger for the subgroup of adults in immigrant families. Though the weights are designed to produce nationally representative estimates for adults in immigrant families, the survey's design implies that our analytic sample of 1,950 adults in immigrant families has precision comparable to a simple random sample of approximately 800 adults, increasing the sampling error around our estimates. We only report differences across subgroups of adults in immigrant families that are statistically significant at the 0.05 level or lower.

In addition, because the WBNS is only administered in English and Spanish, our analytic sample does not describe the experiences of the full spectrum of adults in immigrant families. Our study excludes adults with limited English proficiency whose primary language is not Spanish. We estimate that the excluded adults who do not speak English or Spanish represent between 5 and 15 percent of all nonelderly adults in immigrant households as defined for this brief; according to the 2017 American Community Survey, 5 percent of this group speaks English less than "well"[13] and speaks a primary language other than Spanish.

Some measurement error is likely for questions related to citizenship statuses of respondents and relatives in the household, particularly among adults who are undocumented or have been in the US for a short time (Van Hook and Bachmeier 2012). It is also possible that respondents conflated awareness of the public charge rule with overall awareness of an increasingly hostile political climate toward immigrants, which may have resulted in overreported awareness of the proposed public charge rule. Moreover, follow-up qualitative interviews with respondents for a related project suggested that some respondents did not understand the distinction between two separate survey items: "not applying for a program" versus "stopping participating in a program." Consequently, we have opted to combine

responses to report on the questions in combination: either not applying for or dropping out of a noncash assistance program.

Analysis

We assess chilling effects within a family, overall and by the following characteristics: annual family income as a percentage of the 2018 federal poverty level, citizenship and immigration status of family members living in the household, race and ethnicity of the respondent, presence of children under age 19 in the household, and respondents' awareness of the proposed public charge rule. We impute missing responses for family income, marital status, and number of children in the household using a multiple-imputation regression approach. We allocate missing citizenship status data for respondents using their responses to the Ipsos panel profile question on citizenship; absent that information, we impute respondent citizenship status. All estimates are weighted to be representative of the national population of nonelderly adults in immigrant families (as described above) and account for the complex survey design.

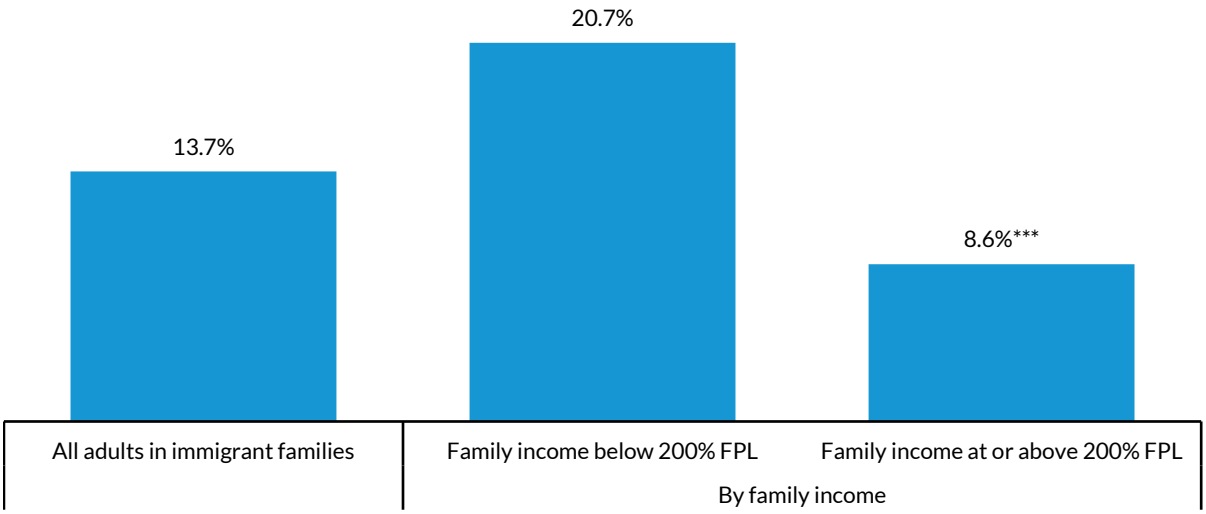
Findings

About one in seven adults in immigrant families (13.7 percent) reported "chilling effects," in which the respondent or a family member did not participate in a noncash government benefit program in 2018 for fear of risking future green card status. This figure was even higher, 20.7 percent, among adults in low-income immigrant families.

Adults in immigrant families across the income distribution reported chilling effects on their participation in noncash public benefit programs for fear of disqualification from obtaining a green card. Overall, one in seven (13.7 percent) reported chilling effects in his or her family (figure 1). Among adults in low-income immigrant families (i.e., those with family incomes below 200 percent of the federal poverty level), over one in five (20.7 percent) reported chilling, compared with 8.6 percent of adults in immigrant families with higher incomes.

FIGURE 1

Share of Adults in Immigrant Families That Avoided Noncash Public Benefits in the Past Year Because of Green Card Concerns, Overall and by Family Income, December 2018



URBAN INSTITUTE

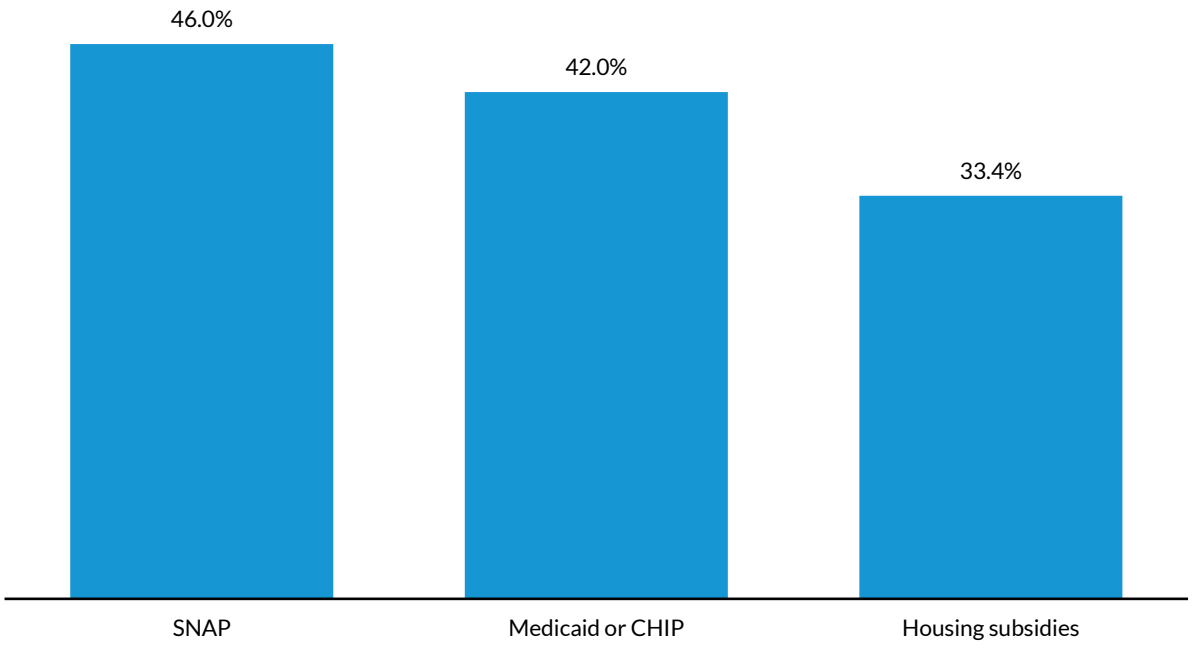
Source: Well-Being and Basic Needs Survey, December 2018.
Notes: FPL = federal poverty level. Adults are ages 18 to 64. Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.
*** Estimate differs significantly from adults in immigrant families with family incomes below 200 percent of FPL at the 0.01 level, using two-tailed tests.

Among adults in immigrant families reporting any chilling effects, nearly half (46.0 percent) reported that someone in their family did not apply for or stopped participating in SNAP, making it the most common program for which chilling was reported among the programs assessed in this survey (figure 2). Medicaid or CHIP was second, with a share of 42.0 percent among adults in immigrant families who reported chilling. One in three (33.4 percent) adults reporting chilling within his or her family reported not applying for or stopping participation in housing subsidies. A smaller share of adults in immigrant families (8.6 percent) experiencing chilling reported stopping participation or not applying for other programs, offering responses such as federal Marketplace subsidies for health insurance and energy bill assistance programs (data not shown).

One in six (16.7 percent) adults who reported chilling effects indicated that the implicated program was specifically Medicaid or CHIP benefits for a child in their family (data not shown). Though this detail is not available for the other noncash programs, we know that SNAP and housing subsidies affect the entire household, and we found chilling effects disproportionately among households with children.

FIGURE 2

Share of Adults in Immigrant Families in Which Someone Did Not Participate in SNAP, Medicaid/CHIP, or Housing Subsidies, among Those That Avoided Noncash Public Benefits in the Past Year Because of Green Card Concerns, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: SNAP = Supplemental Nutrition Assistance Program. CHIP = Children's Health Insurance Program. Adults are ages 18 to 64. Because respondents could report multiple programs, the program categories displayed are not mutually exclusive. Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.

Though the proposed rule would only directly affect adults who do not yet have a green card (i.e., lawful permanent residence), we observed chilling effects in families with various mixes of immigration and citizenship statuses, including 14.7 percent of adults in families where all noncitizen members had green cards and 9.3 percent of those in families where all foreign-born members were naturalized citizens.

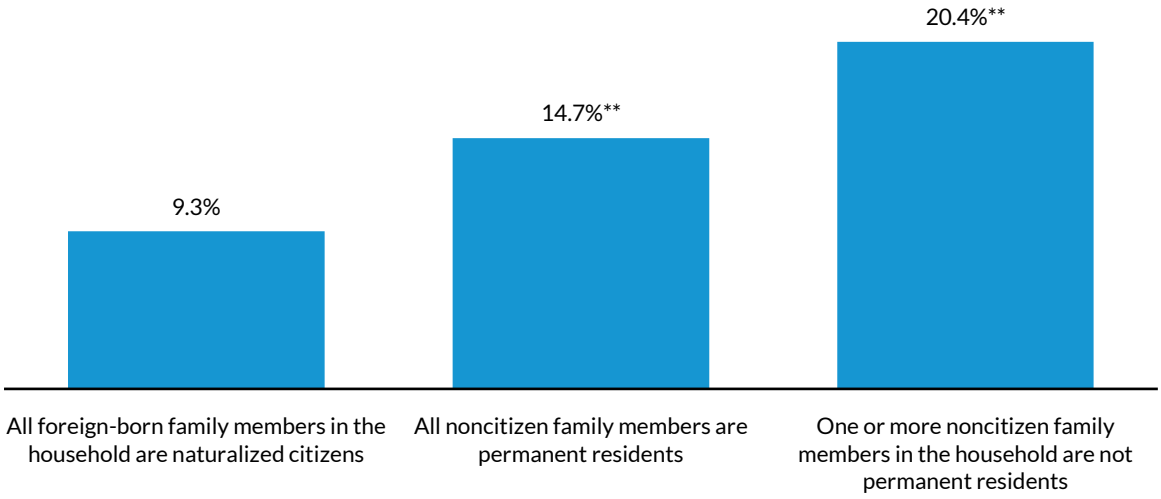
Immigrant families often include a wide range of citizenship and immigration statuses, including US-born citizens, naturalized US citizens, green card holders, and foreign-born people without permanent residence. Among households where one or more noncitizen family members was not a permanent resident, 20.4 percent of adults reported chilling effects (figure 3). The share was slightly lower but still substantial (14.7 percent) for respondents in households where all noncitizen relatives were permanent residents.

Some respondents living in what should be the least vulnerable households, in which all foreign-born family members are naturalized US citizens, also seem to be affected, with 9.3 percent of these adults reporting chilling effects within their family in the previous year. This suggests spillover effects

on people who will not be subject to future public charge determinations but may be confused about the rule and who it applies to, or fear it could impair their ability to sponsor other family members for green cards.

FIGURE 3

Share of Adults in Immigrant Families That Avoided Noncash Public Benefits in the Past Year Because of Green Card Concerns, by Household Citizenship and Immigration Status, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Categories are constructed around the citizenship and immigration status of the foreign-born family members in the household, but each group may contain US-born family members (including the respondent). Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.
** Estimate differs significantly from adults in households where all foreign-born family members are naturalized citizens at the 0.05 level, using two-tailed tests.

Hispanic adults in immigrant families were more than twice as likely (20.6 percent) as non-Hispanic white and non-Hispanic nonwhite adults in immigrant families (8.5 percent and 6.0 percent, respectively) to report chilling effects in their families.

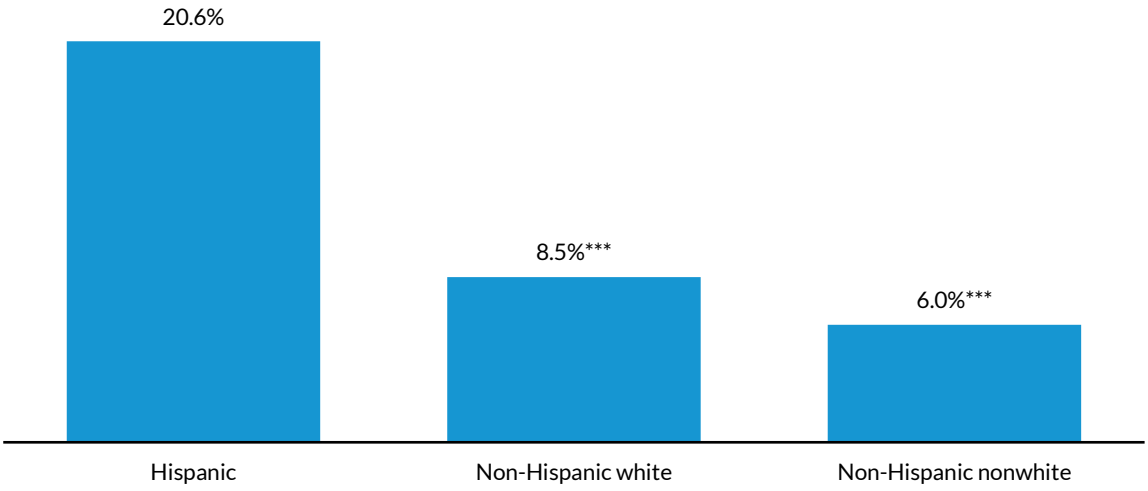
About 1 in 5 Hispanic adults in immigrant families (20.6 percent) reported chilling effects within his or her family, compared with fewer than 1 in 10 non-Hispanic white adults in immigrant families (8.5 percent; figure 4). Hispanic adults also reported chilling effects at a higher rate than non-Hispanic nonwhite respondents, of whom only 6.0 percent reported that they or a family member experienced chilling effects on their use of noncash public benefits because of concern over future green card status.

However, we may underestimate reported chilling effects among non-Hispanic nonwhite adults because WBNS respondents do not include adults who do not speak Spanish or English well enough to

complete the survey. This means we cannot observe chilling effects that may have occurred within this group.

FIGURE 4

Share of Adults in Immigrant Families That Avoided Noncash Public Benefits in the Past Year Because of to Green Card Concerns, by Race and Ethnicity, December 2018



URBAN INSTITUTE

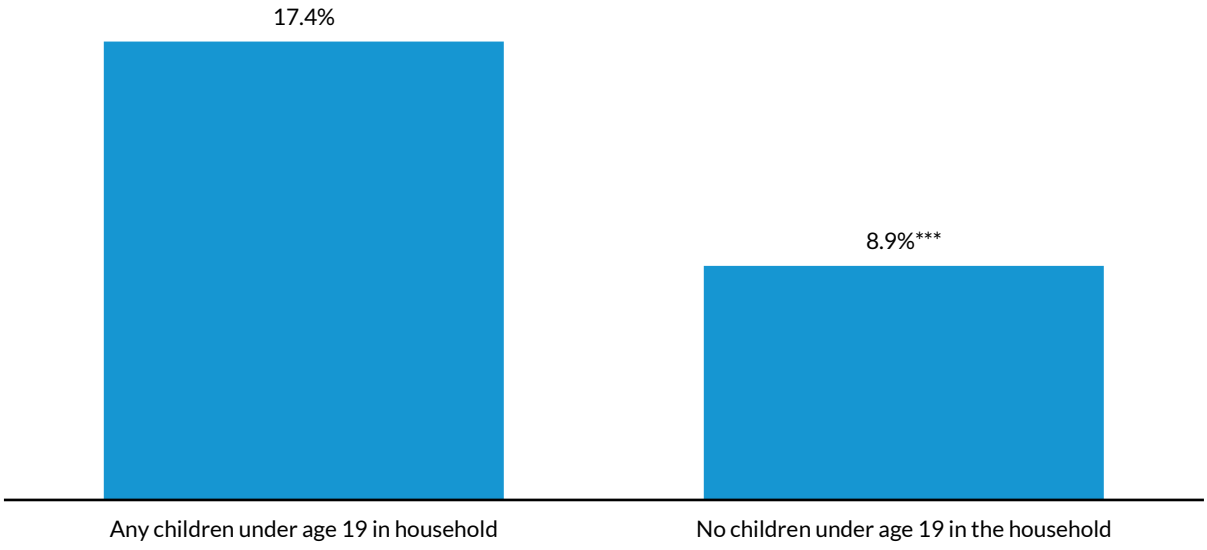
Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. The non-Hispanic nonwhite category includes non-Hispanic respondents who either do not identify as white or identify as more than one race. Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.
*** Estimate differs significantly from Hispanic adults at the 0.01 level, using two-tailed tests.

Though the proposed rule would only directly apply to adults, many households with children experienced chilling effects. Adults in immigrant families living with children under age 19 were more likely to report chilling effects than adults without children in the household.

As shown in figure 5, about one in six (17.4 percent) adults in immigrant families living with children under age 19 reported chilling effects within his or her family, a share about twice as high as that of adults without children in the household (8.9 percent).[14]

FIGURE 5

Share of Adults in Immigrant Families That Avoided Noncash Public Benefits in the Past Year Because of Green Card Concerns, by Presence of Children in the Household, December 2018



URBAN INSTITUTE

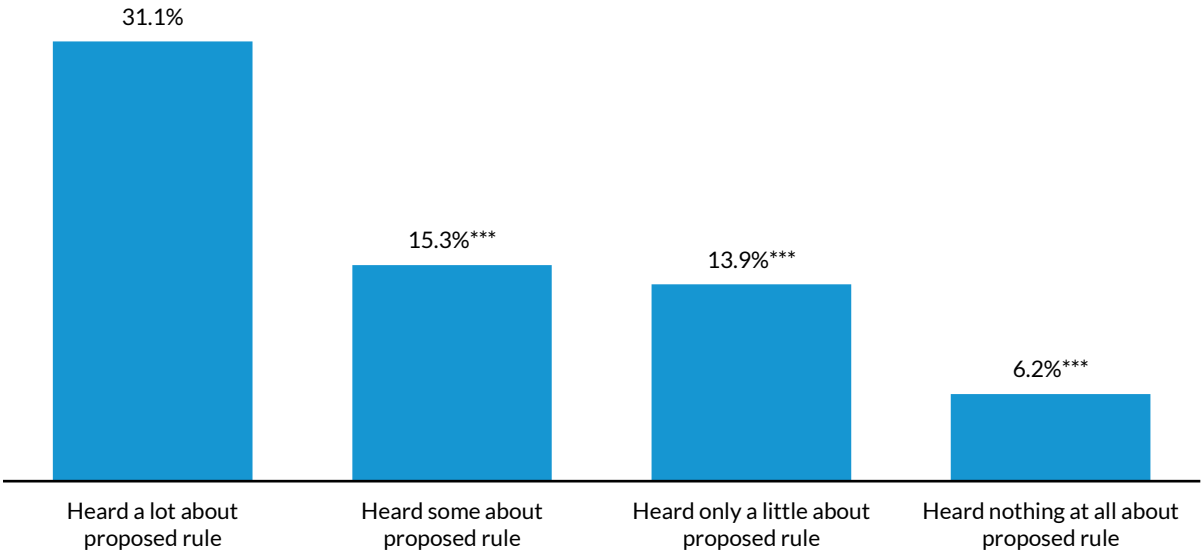
Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.
*** Estimate differs significantly from adults with any children under age 19 in the household at the 0.01 level, using two-tailed tests.

Most adults in immigrant families reported awareness of the public charge rule (62.9 percent). Adults who had heard "a lot" about the proposed rule were the most likely to report chilling effects in their families (31.1 percent).

Most adults in immigrant families reported awareness of the public charge rule, with 62.9 percent having heard at least "a little" about the rule (data not shown). Adults reporting greater awareness of the proposed rule were about five times more likely to report chilling effects on family members' use of public benefits than adults reporting no awareness. Among the adults in immigrant families who had heard a lot about the proposed rule, nearly one-third (31.1 percent) reported chilling, compared with only 6.2 percent among those who had heard nothing at all about the proposed policy. This suggests that more publicity about the rule when it becomes final could further increase chilling effects and avoidance of public benefits by immigrant families, including those not directly affected by the rule.

FIGURE 6

Share of Adults in Immigrant Families That Avoided Noncash Public Benefits in the Past Year Because of Green Card Concerns, by Awareness of the 2018 Proposed Public Charge Rule, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Respondents reported that either they or someone in their family did not apply for *or* stopped participating in noncash public benefits because they worried it would disqualify them or a family member from obtaining a green card.
*** Estimate differs significantly from adults who heard "a lot" about the proposed rule at the 0.01 level, using two-tailed tests.

Discussion

This report provides the first national data on the scope of chilling effects related to the public charge policy debate in 2018, as the proposed rule was being developed, published, and commented on. The data were collected before the rule was finalized, and it is reasonable to expect that chilling effects will likely expand further if the rule is implemented. It is notable that even these early results show strong evidence of chilling effects, aligning with the on-the-ground perspectives reported by organizations working with immigrant families across the country (Greenberg, Feierstine, and Voltolini 2019) and new state-level data documenting increased reluctance to engage safety net resources (O'Rourke 2019). We find that one in seven nonelderly adults in immigrant families reported "chilling effects," in which the respondent or a family member did not participate in one or more noncash government benefit programs in 2018 for fear of risking future green card status. These decisions were more common among families most in need of safety net support, with one in five adults with family incomes below 200 percent of the federal poverty level reporting chilling effects. Though most research projections of potential chilling have assumed several scenarios, with drops in program participation of 15, 25, or 35 percent, those estimates project chilling rates after implementation of a final rule (Artiga, Damico, and

Garfield 2018; Artiga, Garfield, and Damico 2018; Batalova, Fix, and Greenberg 2018; Fiscal Policy Institute 2018; Kenney, Haley, and Wang 2018; Laird et al. 2019; Zallman and Finnegan 2018).[15] The evidence we collected showing high chilling rates even before release of the final rule suggests that rates could be even larger following implementation.[16]

The confusion and fear around when and how the proposed public charge rule could be finalized and who it would affect appear to be leading to spillover, extending beyond people directly affected by the rule, who have not yet applied for green cards and will receive the revised public charge test when they do. Immigrant households often include people with a variety of immigration, residency, and citizenship statuses, and the survey results show chilling effects in families including US-born citizens, naturalized US citizens, green card holders, and people who lack permanent residence.[17] Though chilling effects were highest in families where one or more noncitizen family members were not permanent residents (20.4 percent), rates were also high in less vulnerable families: 14.7 percent in families where all noncitizen members had green cards and 9.3 percent where all foreign-born members were naturalized citizens. Many people live in households with complex combinations of status and belong to family networks extending across households. These family interconnections are critical for understanding the impacts of the revised public charge rule and other restrictive immigration policy measures on the well-being of families across the US.

In December 2018, most adults in immigrant families reported awareness of the public charge rule (62.9 percent). And the survey results show that people with greater awareness were more likely to report chilling effects, reflecting the fear and confusion around the rule that advocates and service providers have observed. Reports from the field suggest widespread confusion about actual details of the rule (Greenberg, Feierstine, and Voltolini 2019). Under the previous public charge regulations, service providers could convey a clear message, because all noncash benefits were excluded from consideration in public charge determinations. The proposed regulation poses new challenges of understanding and communication, both for the public and legal and other service providers.

Providing families accurate information and guidance as the debate on the proposed public charge rule continues could help mitigate further chilling effects. Investing in educating service providers who may interact with immigrant families could also combat misconceptions and ensure families receive the information they need to make informed choices on their and their children's behalves. This applies to government social services staff and practitioners in community-based organizations, as well as to staff at schools and early childhood education providers, faith leaders, employers, and other sites where families who are afraid of interacting with government authorities may be reached. Initiatives to support advocacy efforts and educate providers face the challenge of accessing vulnerable and hard-to-reach families on a national scale. Education through innovative channels, such as social media, faith-based institutions, and schools, may help reach scale.

Though these survey results provide new insight into the potential scope of chilling effects under the proposed public charge rule, a forthcoming brief drawing on interviews with adults in families that experienced chilling will provide additional qualitative information on the mechanisms and context in which these decisions were made. In addition, such self-reported evidence of chilling should be verified

in administrative data sources, if possible. Local and state government agencies could shed light on changing program participation numbers by examining their own data. Community-based organizations encountering immigrant families could also monitor family experiences. This real-time evidence on the impacts of anticipated and implemented policy changes on the ground is critical to inform policymakers and practitioners developing effective strategies to reduce harm.

Losing access to programs can affect not only adults but children in the household, many of whom are US citizens. Discouraging families from using benefits for which they are eligible will likely increase the risk of material hardship, which can have negative long-term effects on health and well-being, particularly among children.

Our evidence suggests that even without a final rule, chilling effects have already occurred, both in families who would be directly affected by the revised rule and in spillover to immigrant families more broadly. Potential consequences for health and well-being will be important to monitor. Educating service providers and immigrant families is one key strategy to combat misinformation and mitigate harm.

Notes

[1] Hamutal Bernstein and Archana Pyati, "Expanding the 'Public Charge' Rule Jeopardizes the Well-Being of Immigrants and Citizens," *Urban Wire* (blog), Urban Institute, October 3, 2018, https://www.urban.org/urban-wire/expanding-public-charge-rule-jeopardizes-well-being-immigrants-and-citizens.

[2] Emily Baumgaertner, "Spooked by Trump Proposals, Immigrants Abandon Public Nutrition Services," *New York Times*, March 6, 2018, https://www.nytimes.com/2018/03/06/us/politics/trump-immigrants-public-nutrition-services.html; Caitlin Dewey, "Immigrants Are Going Hungry So Trump Won't Deport Them," *Washington Post*, March 16, 2017, https://www.washingtonpost.com/news/wonk/wp/2017/03/16/immigrants-are-now-canceling-their-food-stamps-for-fear-that-trump-will-deport-them/?utm_term=.6cc2529d5e00; Helena Bottemiller Evich, "Immigrants, Fearing Trump Crackdown, Drop out of Nutrition Programs," *Politico*, September 3, 2018, https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292. One exception is recent research by Children's Health Watch (Bovell-Ammon et al. 2018), which collects data in emergency rooms and primary care clinics in Baltimore, Boston, Little Rock, Minneapolis, and Philadelphia. Their data collection showed reported SNAP receipt declined in the first half of 2018 for immigrant families, especially among recent arrivals. They note limitations in sample size, however, and given the time frame of the drop, from 2017 to the first half of 2018, the connection to the public charge debate is unclear. Some state-level data have also suggested drops in participation or increased reluctance to engage in safety net resources (O'Rourke 2019).

[3] In forthcoming work, we will analyze results from complementary qualitative data collection through semistructured interviews with a portion of survey respondents who reported chilling effects.

[4] "Potential Effects of Public Charge Changes on California Children," The Children's Partnership and KidsData.org, accessed May 15, 2019, https://www.childrenspartnership.org/wp-content/uploads/2018/11/Potential-Effects-of-Public-Charge-Changes-on-California-Children-Brief.pdf; "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt, October 11, 2018, https://www.manatt.com/Insights/Articles/2018/Public-Charge-Rule-Potentially-Chilled-Population.

[5] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (Oct. 10, 2018).

[6] Yeganeh Torbati and Kristina Cooke, "Denials of US Immigrant Visas Skyrocket after Little-Heralded Rule Change," *Reuters*, April 15, 2019, https://www.reuters.com/article/us-usa-immigration-visas-insight-idUSKCN1RR0UX.

[7] Yeganeh Torbati, "Exclusive: Trump Administration Proposal Would Make It Easier to Deport Immigrants Who Use Public Benefits," *Reuters*, May 3, 2019, https://www.reuters.com/article/us-usa-immigration-benefits-exclusive/exclusive-trump-administration-proposal-would-make-it-easier-to-deport-immigrants-who-use-public-benefits-idUSKCN1S91UR.

[8] Emily Baumgaertner, "Spooked by Trump Proposals, Immigrants Abandon Public Nutrition Services," *New York Times*; Caitlin Dewey, "Immigrants Are Going Hungry So Trump Won't Deport Them," *Washington Post*; Helena Bottemiller Evich, "Immigrants, Fearing Trump Crackdown, Drop out of Nutrition Programs," *Politico*; Emily Moon, "Why Is Participation in Food Assistance Programs like WIC Declining?" *Pacific Standard*, May 8, 2019, https://psmag.com/news/why-is-participation-in-food-assistance-programs-like-wic-declining.

[9] For additional information on the survey design and weighting in the WBNS, see Karpman, Zuckerman, and Gonzalez (2018).

[10] We define adults with English proficiency as those who speak English at least "well," as classified in the American Community Survey. Adults with limited English proficiency are those who speak English less than "well." This is a broader measure than is commonly used to define English proficiency; in most analyses, a person must speak English "very well" to be classified as having English proficiency (Wilson 2014). We use the following measures for weighting: gender, age, race and ethnicity, educational attainment, presence of children under age 18 in the household, census region, homeownership status, family income as a percentage of the federal poverty level, access to the internet, and family composition. We benchmark non-Hispanic "other race" respondents by two categories: (1) other race born in Asia and (2) multiple races or other race not born in Asia.

[11] We draw on measures developed by researchers at the University of California, Los Angeles, for an immigrant follow-up survey to the California Health Interview Survey.

The exact wording of the two questions on chilling effects in the WBNS were as follows:

Question A: *Was there a time in the past 12 months when you or someone in your family **decided not to apply** for one or more non-cash government benefits, such as Medicaid or CHIP, SNAP (formerly known as food stamps), or housing subsidies, because you were worried it would disqualify you or a family member or relative from obtaining a green card?* [Response options: *yes/no*]

Question A1: *Which benefits did you or someone in your family decide not to apply for because you were worried it would disqualify you or a family member or relative from obtaining a green card? Check all that apply.* [Response options: *Medicaid or CHIP; SNAP (formerly known as food stamps); Housing subsidies; Other (please specify)*]

Question A2: *Did you decide not to apply for Medicaid or CHIP for **your children** because you were worried it would disqualify you or a family member or relative from obtaining a green card?* [Response options: *yes/no*]

Question B: *Was there a time in the past 12 months when you or someone in your family **stopped participating** in any non-cash government benefits, such as Medicaid or CHIP, SNAP (formerly known as food stamps), or housing subsidies, because you were worried it would disqualify you or a family member or relative from obtaining a green card?* [Response options: *yes/no*]

Question B1: *Which benefits did you or someone in your family stop participating in because you were worried it would disqualify you or a family member or relative from obtaining a green card? Check all that apply*. [Response options: *Medicaid or CHIP; SNAP (formerly known as food stamps); Housing subsidies; Other (please specify)*]

Question B2: *Did **your children** stop participating in Medicaid or CHIP because you were worried it would disqualify you or a family member or relative from obtaining a green card?* [Response options: *yes/no*]

[12] The exact wording for the question on awareness of the proposed public charge rule in the WBNS was as follows:

A proposed rule would make it harder for immigrants to enter the United States or become permanent residents of the United States if they have low income or use public benefits such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps), or housing subsidies. How much have you heard about this proposed rule? [Response options: *a lot, some, only a little, nothing at all*]

This question was asked later in the survey than the questions on chilling effects.

[13] See endnote 10 for a definition of English proficiency.

[14] Though our analysis did not consider the eligibility of individuals or family members for different public programs, we know that in general, adults living in families with children are more likely to have a family member who is eligible for a public program, which increases their exposure to potential chilling effects relative to adults who do not live with children.

[15] "Potential Effects of Public Charge Changes on California Children," The Children's Partnership and KidsData.org; "Public Charge Proposed Rule: Potentially Chilled Population Data Dashboard," Manatt.

[16] Those estimates drew on lessons from the 1996 Personal Responsibility and Work Authorization Act, which eliminated access to federal assistance for most immigrants during their first five years of residence (Fix and Passel 2002).

[17] In fact, amongst survey respondents, one in five respondents lived in a household where one or more noncitizen family members were not permanent residents (22.9 percent), one in three (33.8 percent) lived in households where all noncitizen family members were permanent residents, and around 43 percent lived with all naturalized US citizen, foreign-born relatives.

References

Artiga, Samantha, Anthony Damico, and Rachel Garfield. 2018. "Potential Effects of Public Charge Changes on Health Coverage for Citizen Children." San Francisco: Henry J. Kaiser Family Foundation.

Artiga, Samantha, Rachel Garfield, and Anthony Damico. 2018. "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid." San Francisco: Henry J. Kaiser Family Foundation.

Batalova, Jeanne, Michael Fix, and Mark Greenberg. 2018. *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use*. Washington, DC: Migration Policy Institute.

Bovell-Ammon, Allison, Stephanie Ettinger de Cuba, Diana Cutts, and Sharon Coleman. 2018. "Trends in Food Insecurity and SNAP Participation among Immigrant Families of US-Born Young Children." Presentation given at American Public Health Association Annual Meeting and Expo, San Diego, November 10–14.

Capps, Randy, Mark Greenberg, Michael Fix, and Jie Zong. 2018. "Gauging the Impact of DHS' Proposed Public-Charge Rule on US Immigration." Washington, DC: Migration Policy Institute.

Cervantes, Wendy, Rebecca Ullrich, and Hannah Matthews. 2018. *Our Children's Fear: Immigration Policy's Effects on Young Children*. Washington, DC: Center on Law and Social Policy.

Fiscal Policy Institute. 2018. "'Only Wealthy Immigrants Need Apply': How a Trump Rule's Chilling Effect Will Harm the US." Latham, NY: Fiscal Policy Institute.

Fix, Michael, and Jeffrey Passel. 2002. "The Scope and Impact of Welfare Reform's Immigrant Provisions." Washington, DC: Urban Institute.

Garrett, J. Joe, Michael Dennis, and Charles A. DiSogra. 2010. "Non-Response Bias: Recent Findings from Address-Based Panel Recruitment." Presented at the Annual Conference of the American Association for Public Opinion Research, Chicago, May 13–16.

Greenberg, David M., Sara Feierstein, and Patricia Voltolini. 2019. "Supporting the Resilience of America's Immigrant Communities: How Community Organizations Are Responding to Federal Policy Changes." Washington, DC: Local Initiatives Support Corporation.

Heeren, Timothy, Erika M. Edwards, J. Michael Dennis, Sergei Rodkin, Ralph W. Hingson, and David L. Rosenbloom. 2008. "A Comparison of Results from an Alcohol Survey of a Prerecruited Internet Panel and the National Epidemiologic Survey on Alcohol and Related Conditions." *Alcoholism: Clinical and Experimental Research* 32 (2): 222–9.

Kenney, Genevieve M., Jennifer M. Haley, and Robin Wang. 2018. "Proposed Public Charge Rule Could Jeopardize Recent Coverage Gains among Citizen Children." Washington, DC: Urban Institute.

Karpman, Michael, Stephen Zuckerman, and Dulce Gonzalez. 2018. "The Well-Being and Basic Needs Survey: A New Data Source for Monitoring the Health and Well-Being of Individuals and Families." Washington, DC: Urban Institute.

Laird, Jennifer, Isaac Santelli, Jane Waldfogel, and Christopher Wimer. 2019. "Forgoing Food Assistance out of Fear: Simulating the Child Poverty Impact of Making SNAP a Legal Liability for Immigrants." *Socius: Sociological Research for a Dynamic World* 5: 1–8.

O'Rourke, Lena. 2019. "Trump's Public Charge Proposal Is Hurting Immigrant Families Now, Even Though DHS' Proposed Regulation Is Not Final." Washington, DC: Protecting Immigrant Families Campaign.

Roche, Kathleen M., Elizabeth Vaquera, Rebecca M. B. White, and Maria Ivonne Rivera. 2018. "Impacts of Immigration Actions and News and the Psychological Distress of US Latino Parents Raising Adolescents." *Journal of Adolescent Health* 62 (5): 525–31.

Van Hook, Jennifer, and James D. Bachmeier. 2013. "How Well Does the American Community Survey Count Naturalized Citizens?" *Demographic Research* 29 (1): 1–32.

Wilson, Jill H. 2014. *Investing in English Skills: The Limited-English Proficient Workforce in US Metropolitan Areas*. Washington, DC: Brookings Institution.

Zallman, Leah, and Karen Finnegan. 2018. "Changing Public Charge Immigration Rules: The Potential Impact on Children Who Need Care." Oakland, CA: California Health Care Foundation.

About the Authors

Hamutal Bernstein is a senior research associate in the Income and Benefits Policy Center at the Urban Institute, where her research focuses on immigration and integration, workforce development and education, and program evaluation. She has wide expertise in mixed-methods research, including original survey development, secondary data analysis, and qualitative data collection and analysis. She is a principal investigator on the Annual Survey of Refugees and Survey Redesign for the US Department of Health and Human Services. Her other areas of research focus on immigrant upskilling, immigrant inclusion at the local level, and other human services topics. Before joining Urban, Bernstein was a program officer at the German Marshall Fund of the United States and a research associate at the Institute for the Study of International Migration at Georgetown University. Bernstein received her BA in international relations from Brown University and her PhD in government from Georgetown University

Dulce Gonzalez is a research analyst in the Health Policy Center at the Urban Institute. Gonzalez has worked at Los Angeles-based organization Maternal and Child Health Access, where she evaluated health and well-being outcomes for its perinatal home visiting program. She currently supports quantitative analyses of the Urban Institute's Well-Being and Basic Needs Survey. Before joining Urban, she was a graduate intern at the Georgetown University Center for Children and Families. Gonzalez received her MPP from Georgetown University.

Michael Karpman is a senior research associate in the Health Policy Center. His work focuses primarily on the implications of the Affordable Care Act, including quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. His work includes efforts to help coordinate and analyze data from the Urban Institute's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Stephen Zuckerman is a senior fellow and vice president of the Health Policy Center. He has studied health economics and health policy for 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services and studying the implementation and impact of the Affordable Care Act. Before joining Urban, Zuckerman worked at the American Medical Association's Center for Health Policy Research. He received his PhD in economics from Columbia University.

Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation and Heising-Simons Foundation through their support for Urban's From Safety Net to Solid Ground initiative. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

We are grateful for advice from Ignatius Bau, Julia Gelatt, Katrina Goering, David Kallick, Francisco Pedraza, Katherine Roche, and Holly Straut-Eppsteiner. We also thank Ninez Ponce and Steven P. Wallace from the California Health Interview Survey. It has been immensely valuable to be included in conversations to convene researchers organized by Renato Rocha and David Kallick, through the Protecting Immigrant Families campaign cochaired by the National Immigration Law Center and the Center for Law and Social Policy. We also wish to thank our colleagues Genevieve M. Kenney, Rob Santos, Timothy Triplett, Elaine Waxman, and Doug Wissoker, as well as Randy Capps, Katherine Hempstead, Giridhar Mallya, and Jackie Vimo for their review of an earlier draft. We thank Rachel Kenney for editing.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Exhibit E

URBAN INSTITUTE

Adults in Immigrant Families Report Avoiding Routine Activities Because of Immigration Concerns

Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman

July 2019

Changes in federal immigration policies and heightened immigration enforcement over the last several years have caused fear and insecurity for many immigrant families across the country. In addition to stories of rising fear among families reported in the press,[1] several studies have documented evidence of widespread anxiety and instability among immigrant families and children (Artiga and Ubri 2017; Cervantes, Ullrich, and Matthews 2018; The Children's Partnership and California Immigrant Policy Center 2018; Gándara and Ee 2018; Roche et al. 2018; Rogers 2017). A recent Urban Institute study shows that nearly one in seven adults in immigrant families report that they or a family member did not participate in a noncash government benefit program in 2018 for fear of risking future green card status as the administration considered changing rules for "public charge" determinations (Bernstein et al. 2019). Beyond avoiding participation in public programs, many immigrant families may be changing how they go about their daily lives. Reports show immigrant families increasingly avoiding routine activities, such as interacting with teachers or school officials, health care providers, and the police,[2] which poses risks for their well-being and the communities in which they live.

In this brief, we use the Well-Being and Basic Needs Survey (WBNS), a nationally representative, internet-based survey conducted in December 2018, to examine immigrant families' reported avoidance of activities in various public settings (box 1). The survey included nearly 2,000 nonelderly

adults who are foreign born or live with one or more foreign-born family members (hereafter called "adults in immigrant families"), who make up about one-quarter of all nonelderly adults in the US, according to the American Community Survey. In addition to questions about "chilling effects" on participation in public assistance programs, the 2018 WBNS collected information on respondents' avoidance of routine activities because they did not want to be asked or bothered about citizenship status. This information allows us to document how adults in immigrant families are changing their daily lives within the current immigration policy context.

We find the following:

- About one in six adults in immigrant families (17.0 percent) reported that they or a family member avoided activities in which they could be asked or bothered about citizenship status during 2018. The activities avoided most were those that risk interaction with police or other public authorities, such as driving a car (9.9 percent), renewing or applying for a driver's license (9.0 percent), and talking to the police or reporting crime (8.3 percent). Other avoided activities included going to public places, like parks, libraries, or stores (7.8 percent); visiting a doctor or clinic (6.3 percent); using public transportation (5.8 percent); and talking with teachers or school officials (4.7 percent).
- About one in three adults in immigrant families with a more vulnerable visa and citizenship status—where one or more foreign-born relatives in the household do not have a green card (i.e., are not permanent residents) or US citizenship—reported that they or a family member avoided at least one routine activity. Meanwhile, over one in nine adults in families where all foreign-born family members have green cards or US citizenship reported this behavior.
- Among adults in immigrant families, Hispanic adults were nearly three times more likely (24.2 percent) than non-Hispanic white adults (8.5 percent) to report avoiding some activities.
- Controlling for observable characteristics, adults in immigrant families who avoided at least one activity were also more likely to report serious psychological distress.

BOX 1

Activities Captured by the Survey

For this measure, respondents were asked if they or someone in their family avoided any of the following activities in the past 12 months because they or the family member did not want to be asked or bothered about citizenship status:

- visiting a doctor or clinic
- talking with teachers or school officials
- talking to police or reporting crime
- renewing or applying for a driver's license
- driving a car
- using public transportation
- going to public places, such as parks, libraries, or stores

Background

Evidence shows that immigration policy developments are leading to increased fear and anxiety and avoidance of public space and interaction with authorities to avoid potential immigration enforcement (Artiga and Ubri 2017; Cervantes, Ullrich, and Matthews 2018; The Children's Partnership and California Immigrant Policy Center 2018; Gándara and Ee 2018; Roche et al. 2018; Rogers 2017). Some families, especially those with undocumented members, are making significant changes in their day-to-day behavior, with some parents avoiding leaving the house and keeping their children home to avoid potential interaction with immigration authorities or police (Artiga and Ubri 2017). Findings from a survey of California parents highlight this fear: many respondents, especially parents of young children and Latinos, reported that they "feel unsafe no matter where they are" (The Children's Partnership and California Immigrant Policy Center 2018). In surveys of service providers, most report that families were expressing fear about taking their children to school or going to parks or participating in other recreational activities. Immigrant-serving organizations report rising fear in immigrant communities and have identified a need for enhanced engagement by community-based organizations to reassure families, because they often serve as trusted sources to bridge families to public institutions and programs (Greenberg et al. 2019).

Data and Methods

Data and Sample

We draw on data from the December 2018 round of the Well-Being and Basic Needs Survey, a nationally representative survey of adults ages 18 to 64 launched in December 2017. This analysis is based on the WBNS core sample, as well as an oversample of noncitizens. For each round of the WBNS, the core sample is a stratified random sample drawn from Ipsos's KnowledgePanel, a probability-based online panel recruited primarily from an address-based sampling frame, and includes a large oversample of adults in low-income households.[3] In December 2018, the survey also included an oversample of noncitizens to support analyses of current policy issues affecting immigrant families. The panel includes only respondents who can complete surveys administered in either English or Spanish, and adults without internet access are provided laptops and free internet access to facilitate participation.

We constructed a set of weights for analysis of the population of nonelderly adults who are foreign born or living with a foreign-born relative in their household. The weights are based on the probability of selection from the KnowledgePanel and benchmarks from the American Community Survey for nonelderly adults in immigrant families who are proficient in English or primarily speak Spanish.[4] The language criterion is used in the weighting to reflect the nature of the survey sample, because the survey is only administered in English or Spanish.

Key Measures

SHARE OF ADULTS AVOIDING SELECT ACTIVITIES

We focus on the share of adults in immigrant families reporting that they or someone in their family avoided routine activities in the past 12 months because they or a family member did not want to be asked or bothered about citizenship status. This survey question was drawn from the National Latino Health and Immigration Survey conducted by Latino Decisions, with some minor modifications.[5] Respondents could self-define family as either their immediate family or other relatives, who may or may not live with them in the same household.

SERIOUS PSYCHOLOGICAL DISTRESS

We assess differences in reported serious psychological distress between respondents whose families avoided one or more activities asked about in the survey and respondents whose families did not avoid these activities, controlling for the individual and household characteristics of these two groups. Serious psychological distress is measured using the six-item Kessler Psychological Distress Scale (K6 scale), which was designed to assess prevalence of nonspecific psychological distress in population surveys (Kessler et al. 2002).[6]

Analysis

We compare weighted estimates of the rate of self-reported avoidance of select activities across racial and ethnic groups and across types of households, defined according to the immigration and citizenship status of the family members living in the household. For analyses of psychological distress, we use multiple regression to adjust estimates for observable characteristics using the method of recycled predictions.[7]

We measure annual family incomes as a percentage of the 2018 federal poverty level. We impute missing responses for family income, marital status, and number of children in the household using a multiple-imputation regression approach. We allocate missing citizenship status data for respondents using their responses to the Ipsos panel profile question on citizenship and impute respondent citizenship status if that information is also missing. All estimates are weighted to be representative of the national population of nonelderly adults in immigrant families (as described above) and to account for the complex survey design.

Limitations

One limitation of the WBNS is its low response rate, which is comparable to other panel surveys that account for nonresponse at each stage of recruitment. However, previous studies assessing recruitment for the KnowledgePanel have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008), and WBNS estimates are generally consistent with benchmarks from federal surveys (Karpman, Zuckerman, and Gonzalez 2018). WBNS survey weights reduce, but do not eliminate, the potential error associated with sample coverage and nonresponse, and this is likely larger for the subgroup of adults in immigrant families. Though the weights are designed to produce nationally representative estimates for adults in immigrant families, this weighting approach implies that our analytic sample of 1,950 adults in immigrant families has precision comparable to a simple random sample of approximately 800 adults because of the design effect, increasing the sampling error around our estimates.

In addition, because the WBNS is only administered in English and Spanish, our restricted analytic sample does not describe the experiences of the full spectrum of adults in immigrant families. Our study excludes adults with limited English proficiency whose primary language is not Spanish, so the experiences of adults with limited English proficiency who speak other languages are not captured. We estimate that the excluded adults who do not speak English or Spanish represent between 5 and 15 percent of all nonelderly adults in immigrant households, as defined for this brief; according to the 2017 American Community Survey, 5 percent of this group speaks English less than "well"[8] and speaks a primary language other than Spanish.

Some measurement error is likely for questions related to respondent citizenship status and that of relatives in the household, particularly among adults who are undocumented or have been in the US for a short time (Van Hook and Bachmeier 2013).

Because the question about avoidance of routine activities because of immigration concerns was not included in the previous round of the WBNS, we do not have a baseline from which to measure changes in these behaviors over time, nor can we directly assess the extent to which avoidance of these activities is caused by recent changes in immigration policy and enforcement.

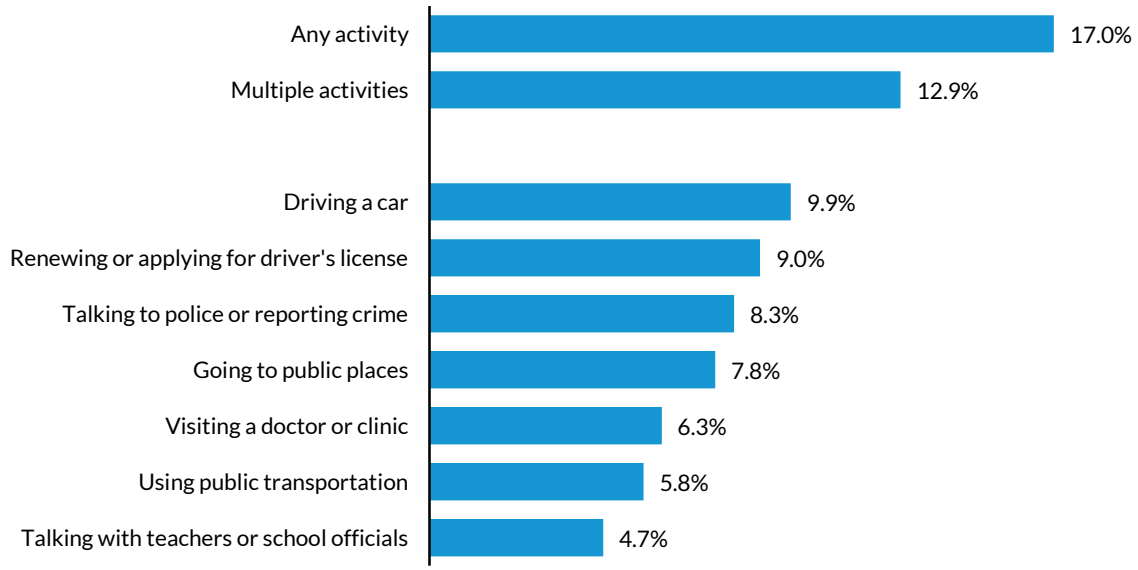
Findings

About one in six adults in immigrant families (17.0 percent) reported that they or a family member avoided activities in which they could be asked or bothered about citizenship status during 2018. The activities avoided most were those that risk interaction with police or other public authorities, such as driving a car (9.9 percent), renewing or applying for a driver's license (9.0 percent), and talking to the police or reporting crime (8.3 percent). Other avoided activities included going to public places, like parks, libraries, or stores (7.8 percent); visiting a doctor or clinic (6.3 percent); using public transportation (5.8 percent); and talking with teachers or school officials (4.7 percent).

Overall, 17.0 percent of adults in immigrant families reported that they or a family member avoided at least one of the activities identified in the survey during 2018 (figure 1). About one in eight (12.9 percent) reported avoiding more than one activity during the year.

FIGURE 1

Share of Adults in Immigrant Families in Which Someone Avoided the Following Activities in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Respondents could report avoidance of activities for themselves or someone else in their family.

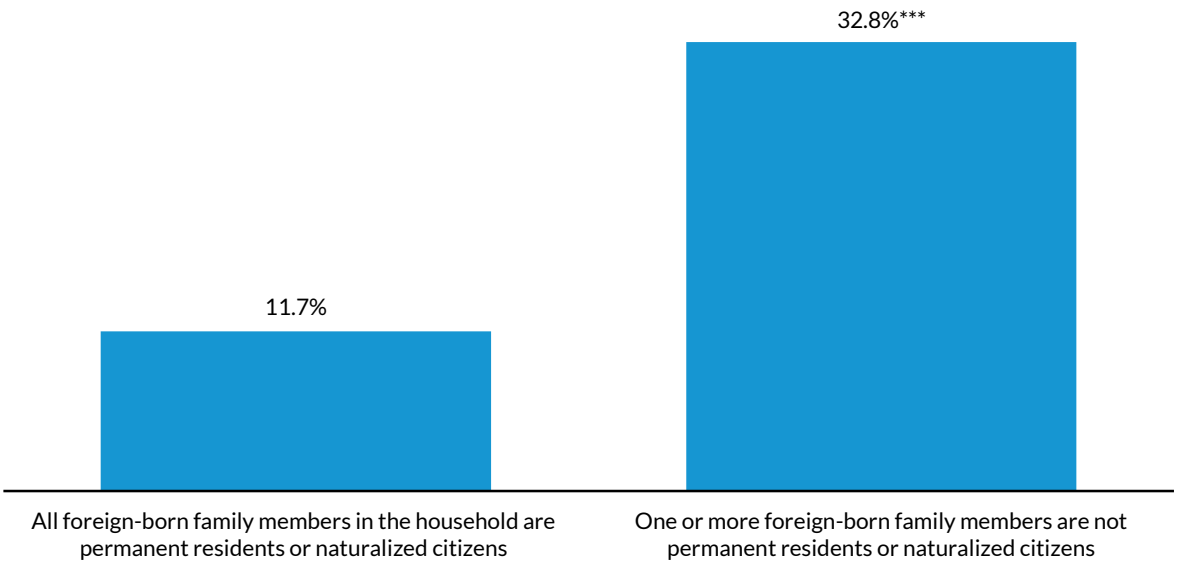
About one in three adults in immigrant families with a more vulnerable visa and citizenship status—where one or more foreign-born relatives in the household do not have a green card (i.e., are not permanent residents) or US citizenship—reported that they or a family member avoided at least one activity. Meanwhile, over one in nine adults in families where all foreign-born family members have green cards or US citizenship reported this behavior.

Avoidance of some activities was especially common among adults in families in which one or more foreign-born relatives are not permanent residents or citizens, at 32.8 percent (figure 2). This group was nearly three times more likely to report avoiding these activities than adults in relatively secure families (where all foreign-born relatives have permanent residency or are naturalized US citizens).[9]

However, this retreat from public spaces also occurs among immigrant families with more secure immigration and citizenship statuses. Even within families where all foreign-born relatives have green cards or are naturalized, more than one in nine adults (11.7 percent) reported that they or their relatives had avoided specified activities in the previous year.

FIGURE 2

Share of Adults in Immigrant Families in Which Someone Avoided At Least One Select Activity in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, by Household Immigration and Citizenship Status, December 2018



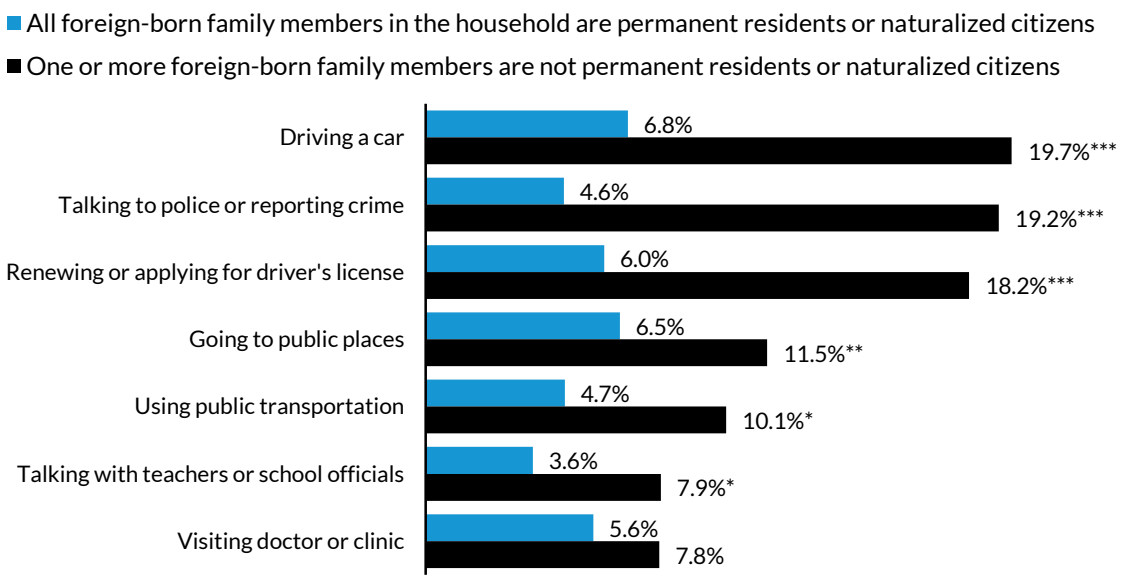
URBAN **INSTITUTE**

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Activities include visiting a doctor or clinic, talking with teachers or school officials, talking to police or reporting crime, renewing or applying for a driver's license, driving a car, using public transportation, or going to public places, such as parks, libraries, or stores. Respondents could report avoidance for themselves or for someone else in their family. Households are classified by the citizenship and immigration status of foreign-born members, and native-born members (including the respondent) may be included in each group.
*/**/*** Estimate differs significantly from adults in households where all foreign-born family members are permanent residents or naturalized citizens at the 0.10/0.05/0.01 level, using two-tailed tests.

Adults in families with less secure immigration statuses, where one or more foreign-born relatives do not have green cards or naturalized citizenship, reported avoiding certain activities at higher rates. Nearly one in five (19.7 percent) adults in this group reported that they or a family member avoided driving a car, almost three times the rate for adults whose foreign-born family members are all permanent residents or naturalized citizens (6.8 percent; figure 3).[10] Around one in five adults in the less secure group reported avoiding talking to the police (19.2 percent) or renewing or applying for a driver's license (18.2 percent); smaller shares reported avoiding going to public spaces (11.5 percent), using public transportation (10.1 percent), or talking to teachers or school officials (7.9 percent). For five of the seven activities, these rates were two to four times higher than those reported by adults in families with more secure statuses, where all foreign-born relatives are permanent residents or naturalized citizens.

FIGURE 3

Share of Adults in Immigrant Families in Which Someone Avoided the Following Activities in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, by Household Immigration and Citizenship Status, December 2018



URBAN INSTITUTE

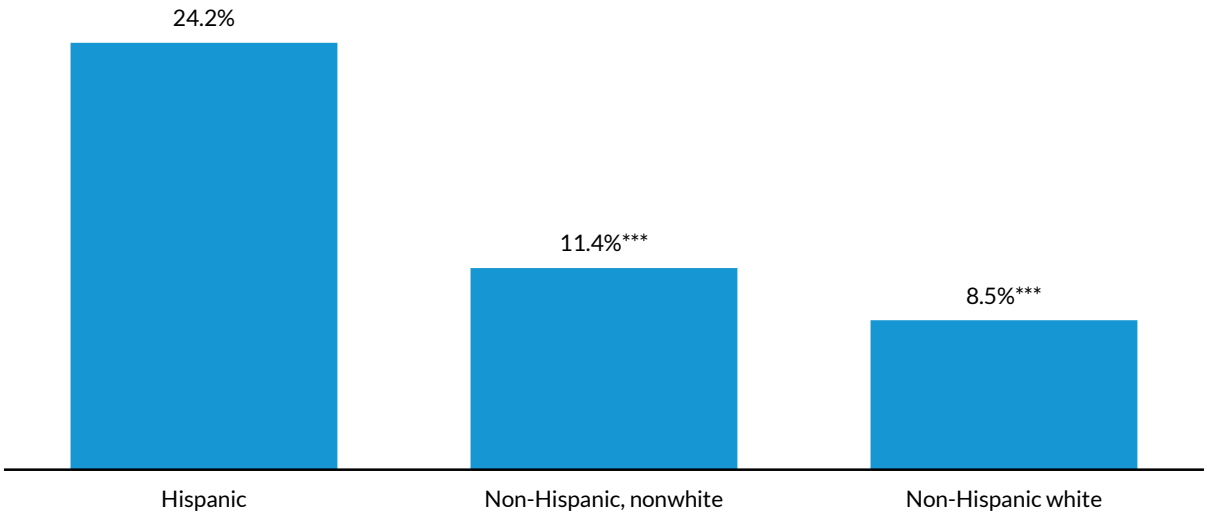
Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Public places include parks, libraries, or stores. Respondents could report avoidance of activities for themselves or for someone else in their family. Households are classified by the citizenship and immigration status of foreign-born members, and native-born members (including the respondent) may be included in each group.
*/**/*** Estimate differs significantly from adults in households where all foreign-born family members are permanent residents or naturalized citizens at the 0.10/0.05/0.01 level, using two-tailed tests.

Among adults in immigrant families, Hispanic adults were nearly three times more likely (24.2 percent) than non-Hispanic white adults (8.5 percent) to report avoiding some activities.

Compared with other racial and ethnic groups, Hispanic adults were more likely to avoid some activities. About one in four Hispanic adults (24.2 percent) reported that they or a family member avoided the specified activities in the past year (figure 4). Hispanic adults were also more likely than their non-Hispanic, nonwhite counterparts to report avoiding these activities (24.2 percent versus 11.4 percent).

FIGURE 4

Share of Adults in Immigrant Families in Which Someone Avoided At Least One Select Activity in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, by Respondent Race and Ethnicity, December 2018



URBAN INSTITUTE

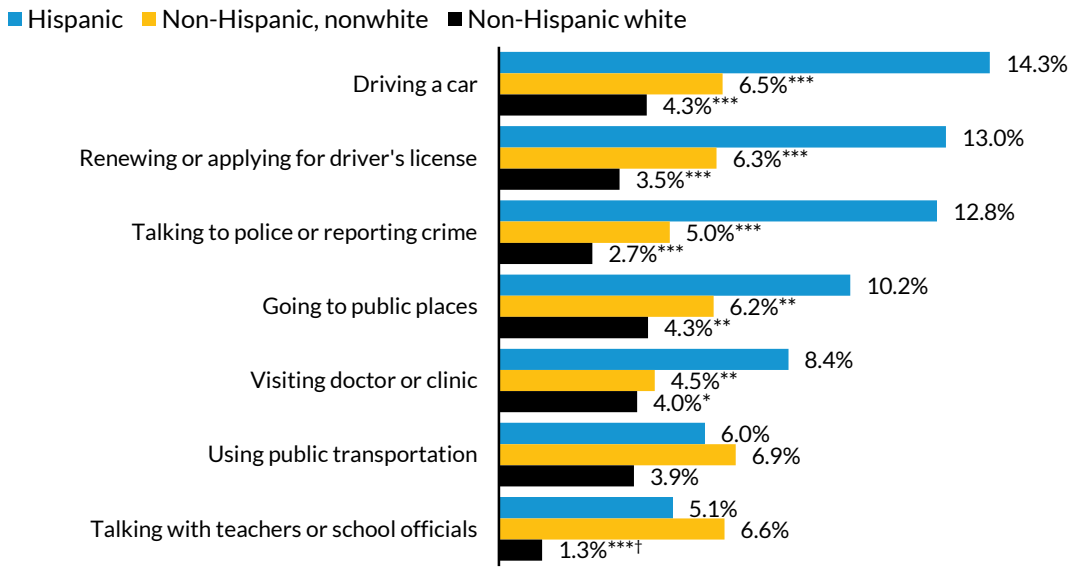
Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Activities include visiting a doctor or clinic, talking with teachers or school officials, talking to police or reporting crime, renewing or applying for a driver's license, driving a car, using public transportation, or going to public places, such as parks, libraries, or stores. Respondents could report avoidance of activities for themselves or for someone else in their family. Non-Hispanic, nonwhite includes respondents who are black and other or multiple races.
*/**/*** Estimate differs significantly from Hispanic adults at the 0.10/0.05/0.01 level, using two-tailed tests.

Among Hispanic adults in immigrant families, 14.3 percent reported avoiding driving a car, 13.0 percent reported avoiding renewing or applying for a driver's license, and 12.8 percent reported avoiding talking to the police or reporting crime (figure 5). Some also reported avoiding going to public spaces (10.2 percent), visiting a doctor or clinic (8.4 percent), using public transportation (6.0 percent), and talking to teachers or school officials (5.1 percent).

For three of the seven activities surveyed, Hispanic adults were more than twice as likely as non-Hispanic, nonwhite adults to report avoidance. For six of the seven, Hispanic adults were two to five times more likely than non-Hispanic white adults to report that someone in their family avoided such activities.

FIGURE 5

Share of Adults in Immigrant Families in Which Someone Avoided the Following Activities in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, by Respondent Race and Ethnicity, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.

Notes: Adults are ages 18 to 64. Public places include parks, libraries, or stores. Respondents could report avoidance of activities for themselves or someone else in their family. Non-Hispanic, nonwhite includes respondents who are black or other or multiple races.

*/**/*** Estimate differs significantly from Hispanic adults at the 0.10/0.05/0.01 level, using two-tailed tests.

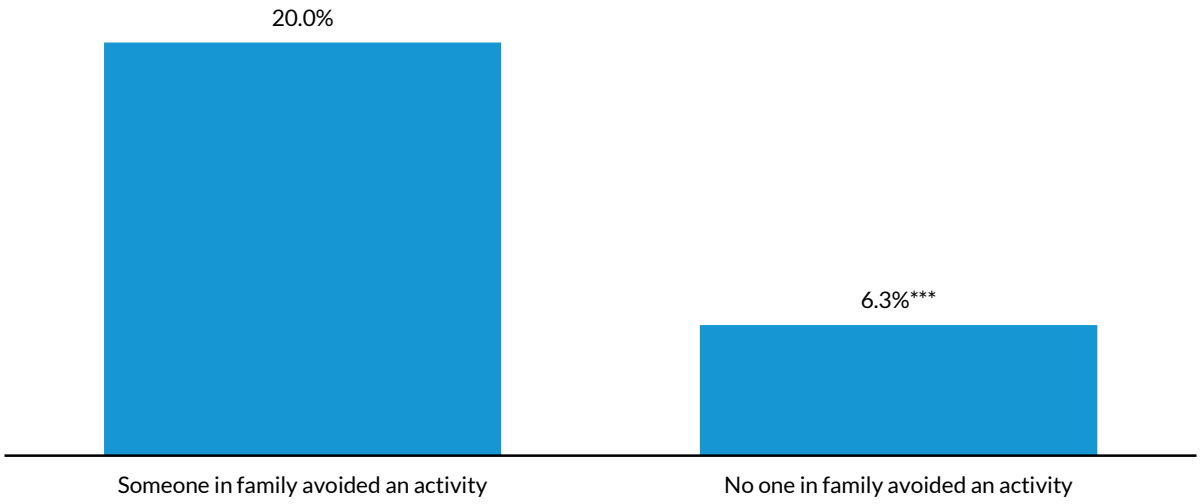
† Estimate for avoiding talking with teachers or school officials among non-Hispanic white adults does not differ significantly from zero.

Controlling for observable characteristics, adults in immigrant families who avoided at least one activity were also more likely to report serious psychological distress.

Adults in immigrant families that avoided surveyed activities were three times more likely to report experiencing serious psychological distress than adults in immigrant families who did not avoid these activities. Controlling for observable characteristics, one in five (20.0 percent) reported a score of 13 or higher on the K6 scale, indicating serious psychological distress (figure 6). In contrast, 6.3 percent of adults in immigrant families who did not report avoidance of such activities reported serious psychological distress.

FIGURE 6

Share of Adults in Immigrant Families Reporting Serious Psychological Distress in the Past 30 Days, by Avoidance of Select Activities in the Past Year Because They Did Not Want to Be Asked or Bothered about Citizenship Status, December 2018



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2018.
Notes: Adults are ages 18 to 64. Estimates are regression adjusted. Serious psychological distress means a respondent reported a score of 13 or higher on the K6 scale of psychological distress. Activities include visiting a doctor or clinic, talking with teachers or school officials, talking to police or reporting crime, renewing or applying for a driver's license, driving a car, using public transportation, or going to public places, such as parks, libraries, or stores. Respondents could report avoidance of activities for themselves or someone else in their family.
*/**/*** Estimate differs significantly from adults in families where someone avoided any activity at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Our findings show that about one in six adults in immigrant families reported that in 2018, they or a family member avoided routine activities, such as driving a car, talking to police or reporting crime, or going to public places, because of concerns about being asked or bothered about their citizenship status. Respondents saying that their families avoided these activities were also more likely to report serious psychological distress, suggesting that the current immigration policy climate may be affecting people beyond such changes to their daily lives; however, it is not possible to draw a causal link from these data.

We find that nearly one-third of adults in families with less secure immigration statuses reported that they or a family member avoided one or more specified activities in the past year. However, the results for adults in families with relatively "safe" immigration status are even more striking: more than one in nine adults in immigrant families where all foreign-born family members in the household have green cards or are naturalized citizens reported that they or someone in their family avoided these

activities in 2018. This illustrates the ripple effects of immigration policies and the generalized fear within immigrant communities; even green card holders and naturalized citizens experience insecurity. In addition, many immigrant families contain multiple immigration and citizenship statuses, including a combination of US-born citizens, naturalized citizens, green card holders, and foreign-born people who lack permanent residency status. Individuals may perceive a threat to themselves or to their relatives: of immigration enforcement (i.e., deportation); risks to future visa adjustment, continuation of green card status, or naturalization; or harassment or discrimination along ethnic lines.

We find that Hispanic respondents are significantly more likely than non-Hispanic respondents to avoid these activities. This aligns with evidence that Hispanic people, regardless of immigration status, suffer mental and physical health impacts from immigration enforcement policies and experience fear around interaction with public authorities through "racialized legal status" (Asad and Clair 2018; Pedraza, Cruz Nichols, and LeBrón 2017; Perreira and Pedroza 2019).

Many reports show families avoiding seeking medical care or participating in public assistance programs for fear of immigration consequences, especially in the context of proposed changes to the "public charge" rule (Bernstein et al. 2019; New York City Department of Social Services and Mayor's Office of Immigrant Affairs 2019).[11] Health and well-being outcomes may be affected by this reluctance to interact with medical providers, schools, police, and other key institutional settings in communities where adults and children receive services and engage in routine activities. If people are afraid to leave their houses or drive their cars, it may threaten their access to jobs and a steady income, their children's schools and healthy development, necessary medical services, and social connections essential for well-being. This affects not only the members of immigrant families, but other community members who benefit from all residents having basic needs met, being able to work, and reporting crimes to support public safety.

Some states and localities have taken proactive steps to reassure immigrant families who feel vulnerable. Cities and counties have come together in coalitions like Cities for Action or Welcoming America that include an array of measures, including legal assistance programs, know-your-rights educational campaigns, citizenship promotion and education, and engagement and outreach efforts to strengthen relationships with police departments and local government agencies (New York City Mayor's Office of Immigrant Affairs 2019). At the local level, some school districts are advancing efforts to support students in immigrant families in school and early childhood care settings by creating safety plans, family education materials, and community dialogues.[12] States and attorneys general have enacted legislation or issued guidance or executive orders on protecting schools, hospitals and clinics, workplaces, and courts as spaces safe from immigration enforcement by specifying guidance for people working in those spaces on asking about immigration status and providing information to or otherwise cooperating with federal immigration enforcement authorities (National Immigration Law Center 2018). In addition, immigrant-serving providers, including medical professionals, educators, and business leaders, are taking steps to support immigrant communities by educating members, building public awareness, and adopting safe-space policies. Such efforts may help mitigate fear and patterns of withdrawal from public spaces caused by immigration policy developments.

Federal immigration policies appear to be having widespread ripple effects, with fear and retreat from routine activities occurring in immigrant families regardless of specific immigration and citizenship status. Our evidence suggests that many adults in immigrant families may be changing the way they live their daily lives in their communities. In future work, it would be valuable to assess whether immigrant families are less likely to avoid these everyday activities in places that have invested in efforts to create welcoming and safe communities and to assess which strategies prove most effective. Potential consequences and impacts for health and well-being, for immigrant families and the broader communities where they reside, will be important to monitor.

Notes

[1] Sara Knuth, "They Stay Home for Days, Give Up Driving, and Won't Sign Their Name to Documents. For Immigrants and Refugees in Greeley, Life Can Be Defined by Fear," *Greeley (CO) Tribune*, February 17, 2019, https://www.greeleytribune.com/news/they-stay-home-for-days-give-up-driving-and-wont-sign-their-name-to-documents-for-immigrants-and-refugees-in-greeley-life-can-be-defined-by-fear/.

[2] Ike Swetlitz, "Immigrants, Fearing Trump's Deportation Policies, Avoid Doctor Visits," *Stat News*, February 24, 2017, https://www.statnews.com/2017/02/24/immigrants-doctors-medical-care/; Nicole Acevedo, "Immigration Policies, Deportation Threats Keep Kids out of School, Report States," *NBC News*, November 20, 2018, https://www.nbcnews.com/news/latino/immigration-policies-deportation-threats-keep-kids-out-school-report-states-n938566; Chantal Da Silva, "Immigration Group Sees Nearly 80 Percent Spike in Reports of 'Abusive Partners' Threatening to Call ICE to Stop Victims from Pressing Charges," *Newsweek*, April 16, 2019, https://www.newsweek.com/immigration-group-sees-nearly-80-spike-reports-abusive-partners-threatening-1398082.

[3] For additional information on the WBNS's design and weighting, see Karpman, Zuckerman, and Gonzalez (2018).

[4] We define adults with English proficiency as those who speak English at least "well," as classified in the American Community Survey. Adults with limited English proficiency are those who speak English less than "well." This is a broader measure than is commonly used to define English proficiency; in most analyses, a person must speak English "very well" to be classified as having English proficiency (Wilson 2014). We use the following measures for weighting: gender, age, race and ethnicity, educational attainment, presence of children under age 18 in the household, census region, homeownership status, family income as a percentage of the federal poverty level, access to the internet, and family composition. We benchmark non-Hispanic "other race" respondents by two categories: (1) other race born in Asia and (2) multiple or other races not born in Asia.

[5] "RWJF Center for Health Policy at UNM Releases Major National Survey of Latino Health and Immigration," Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico, accessed July 11, 2019, http://healthpolicy.unm.edu/node/570671. The exact phrasing of the survey question was: "We hear a lot these days about people getting questions about their immigration status just because of how they look or how they talk. For some people, this has changed how they go about their daily life. In the past 12 months, have you or anyone in your family ever avoided doing any of the following because you did not want to be bothered or asked about your citizenship status? Visiting a doctor or clinic; Talking with school teachers or officials; Talking to police or reporting crime; Renewing or applying for a driver's license; Driving a car; Using public transportation; Going to public places, such as parks, libraries, or stores."

[6] Though not diagnostic of any one disorder, psychological distress is often characterized by symptoms typical of depression and anxiety (Drapeau et al. 2012). The K6 scale includes a series of questions that asks respondents how often they felt the following in the past 30 days: nervous, hopeless, restless or fidgety, so sad that nothing could cheer them up, that everything was an effort, worthless. The scores for each response item range from 0 (low) to 4 (high), with a cumulative score ranging from 0 to 24. Scores of 13 to 24 indicate serious psychological distress. Some research suggests that achieving measurement equivalence across linguistically diverse groups is challenging when using the K6 scale (Kim et al. 2016).

[7] Characteristics include age, gender, race and ethnicity, urban or rural residence, census region, educational attainment, family income, family composition, family size, presence of children in the household, presence of noncitizens in the household, respondent citizenship status, chronic conditions, primary language, and self-reported health status.

[8] See endnote 4.

[9] Among survey respondents, about 76 percent lived in households where all foreign-born family members in the household are permanent residents or naturalized citizens, and about 23 percent lived in households where one or more foreign-born family members are not permanent residents or naturalized citizens.

[10] This group may include some undocumented immigrants. In most states, undocumented immigrants are not eligible for driver's licenses. Several states are considering changing this policy, as New York did recently. See Alexandra Villarreal, "States Consider Driver's Licenses for Undocumented Immigrants Amid Ramped Up Immigration Enforcement," *NBC*, April 23, 2019, https://www.nbcwashington.com/news/politics/States-Drivers-Licenses-Undocumented-Immigrants-Immigration-Enforcement-508824221.html; Vivian Wang, "Driver's Licenses for the Undocumented Are Approved in Win for Progressives," *New York Times*, June 27, 2019, https://www.nytimes.com/2019/06/17/nyregion/undocumented-immigrants-drivers-licenses-ny.html.

[11] Emily Baumgaertner, "Spooked by Trump Proposals, Immigrants Abandon Public Nutrition Services," *New York Times*, March 6, 2018, https://www.nytimes.com/2018/03/06/us/politics/trump-immigrants-public-nutrition-services.html; Caitlin Dewey, "Immigrants Are Going Hungry So Trump Won't Deport Them," *Washington Post*, March 16, 2017, https://www.washingtonpost.com/news/wonk/wp/2017/03/16/immigrants-are-now-canceling-their-food-stamps-for-fear-that-trump-will-deport-them/?utm_term=.1f0c672c0586; Helena Bottemiller Evich, "Immigrants, Fearing Trump Crackdown, Drop out of Nutrition Programs," *Politico*, September 3, 2018, https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292.

[12] See reference materials supporting schools and educators on the Teaching Tolerance website: https://www.tolerance.org/moment/supporting-students-immigrant-families.

References

Artiga, Samantha, and Petry Ubri. 2017. "Living in an Immigrant Family in America: How Fear and Toxic Stress Are Affecting Daily Life, Well-Being, and Health." Menlo Park, CA: Henry J. Kaiser Family Foundation.

Asad, Asad L., and Matthew Clair. 2018. "Racialized Legal Status As a Social Determinant of Health." *Social Science & Medicine* 199 (February 2018): 19–28.

Bernstein, Hamutal, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman. 2019. "One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018." Washington, DC: Urban Institute.

Cervantes, Wendy, Rebecca Ullrich, and Hannah Matthews. 2018. *Our Children's Fear: Immigration Policy's Effects on Young Children*. Washington, DC: Center for Law and Social Policy.

The Children's Partnership and California Immigrant Policy Center. 2018. *Healthy Mind, Healthy Future: Promoting the Mental Health and Wellbeing of Children in Immigrant Families in California*. Washington, DC: The Children's Partnership.

Drapeau, Aline, Alain Marchand, and Dominic Beaulieu-Prévost. 2012. "Epidemiology of Psychological Distress." In *Mental Illnesses: Understanding, Prediction and Control*, edited by Luciano L'Abate, 105–34. London: IntechOpen.

Gándara, Patricia, and Jongyeon Ee. 2018. "US Immigration Enforcement Policy and Its Impact on Teaching and Learning in the Nation's Schools." Los Angeles: University of Southern California Civil Rights Project.

Garrett, Joe, J. Michael Dennis, and Charles A. DiSogra. 2010. "Non-Response Bias: Recent Findings from Address-Based Panel Recruitment." Presented at the Annual Conference of the American Association for Public Opinion Research, Chicago, May 13–16.

Greenberg, David M., Sara Feierstein, and Patricia Voltolini. 2019. "Supporting the Resilience of America's Immigrant Communities: How Community Organizations Are Responding to Federal Policy Changes." Washington, DC: Local Initiatives Support Corporation.

Heeren, Timothy, Erika M. Edwards, J. Michael Dennis, Sergei Rodkin, Ralph W. Hingson, and David L. Rosenbloom. 2008. "A Comparison of Results from an Alcohol Survey of a Prerecruited Internet Panel and the National Epidemiologic Survey on Alcohol and Related Conditions." *Alcoholism: Clinical and Experimental Research* 32 (2): 222–9.

Karpman, Michael, Stephen Zuckerman, and Dulce Gonzalez. 2018. "The Well-Being and Basic Needs Survey: A New Data Source for Monitoring the Health and Well-Being of Individuals and Families." Washington, DC: Urban Institute.

Kessler, Ronald C., Gavin Andrews, Lisa J. Colpe, Eva Hiripi, Daniel K. Mroczek, Sharon-Lise T. Normand, et al. 2002. "Short Screening Scales to Monitor Population Prevalences and Trends in Nonspecific Psychological Distress." *Psychological Medicine* 32 (6): 959–76.

Kim, Giyeon, Jamie DeCoster, Ami N. Bryant, and Katy L. Ford. 2016. "Measurement Equivalence of the K6 Scale: The Effects of Race/Ethnicity and Language." *Assessment* 23 (6): 758–68.

National Immigration Law Center. 2018. "Flexing Their Executive Muscle: How Governors and Attorneys General Can Use Their Authority to Support and Protect Immigrants." Los Angeles: National Immigration Law Center.

New York City Department of Social Services and Mayor's Office of Immigrant Affairs. 2019. "SNAP Enrollment Trends in New York City." New York: Department of Social Services and Mayor's Office of Immigrant Affairs.

New York City Mayor's Office of Immigrant Affairs. 2019. *State of Our Immigrant City: MOIA Annual Report for Calendar Year 2018*. New York: New York City Mayor's Office of Immigrant Affairs.

Pedraza, Francisco I., Vanessa Cruz Nichols, and Alan M. W. LeBrón. 2017. "Cautious Citizenship: The Deterring Effect of Immigration Issue Salience on Health Care Use and Bureaucratic Interactions among Latino US Citizens." *Journal of Health Politics, Policy, and Law* 42 (5): 925–60.

Perreira, Krista, and Juan M. Pedroza. 2019. "Politics of Exclusion: Implications for the Health of Immigrants and their Children." *Annual Review of Public Health* 40: 147–66.

Roche, Kathleen M., Elizabeth Vaquera, Rebecca M. B. White, and Maria Ivonne Rivera. 2018. "Impacts of Immigration Actions and News and the Psychological Distress of US Latino Parents Raising Adolescents." *Journal of Adolescent Health* 62 (5): 525–31.

Rogers, John. 2017. *Teaching and Learning in the Age of Trump: Increasing Stress and Hostility in America's High Schools*. Los Angeles: University of Califorinia, Los Agneles, Institute for Democracy, Education, and Access.

Van Hook, Jennifer, and James D. Bachmeier. 2013. "How Well Does the American Community Survey Count Naturalized Citizens?" *Demographic Research* 29(1): 1–32.

Wilson, Jill H. 2014. *Investing in English Skills: The Limited-English Proficient Workforce in US Metropolitan Areas*. Washington, DC: The Brookings Institution.

About the Authors

Hamutal Bernstein is a senior research associate in the Income and Benefits Policy Center at the Urban Institute, where her research focuses on immigration and integration, workforce development and education, and program evaluation. She has wide expertise in mixed-methods research, including original survey development, secondary data analysis, and qualitative data collection and analysis. She is a principal investigator on the Annual Survey of Refugees and Survey Redesign for the US Department of Health and Human Services. Her other areas of research focus on immigrant upskilling, immigrant inclusion at the local level, and other human services topics. Before joining Urban, Bernstein was a program officer at the German Marshall Fund of the United States and a research associate at the Institute for the Study of International Migration at Georgetown University. Bernstein received her BA in international relations from Brown University and her PhD in government from Georgetown University.

Dulce Gonzalez is a research analyst in the Health Policy Center at the Urban Institute. Gonzalez has worked at Los Angeles-based organization Maternal and Child Health Access, where she evaluated health and well-being outcomes for its perinatal home visiting program. She currently supports quantitative analyses of the Urban Institute's Well-Being and Basic Needs Survey. Before joining Urban, she was a graduate intern at the Georgetown University Center for Children and Families. Gonzalez received her MPP from Georgetown University.

Michael Karpman is a senior research associate in the Health Policy Center. His work focuses primarily on the implications of the Affordable Care Act, including quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. His work includes efforts to help coordinate and analyze data from the Urban Institute's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Stephen Zuckerman is a senior fellow and vice president of the Health Policy Center. He has studied health economics and health policy for 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services and studying the implementation and impact of the Affordable Care Act. Before joining Urban, Zuckerman worked at the American Medical Association's Center for Health Policy Research. He received his PhD in economics from Columbia University.

Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation as part of their support for the From Safety Net to Solid Ground initiative. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

We are grateful for advice from Francisco Pedraza and our colleagues Genevieve M. Kenney, Archana Pyati, and Elaine Waxman, as well as for David Kallick's and Mayra Alvarez's review of an earlier draft. It has also been valuable to be included in conversations to convene researchers organized by Renato Rocha and Jackie Vimo through the Protecting Immigrant Families campaign cochaired by the National Immigration Law Center and the Center for Law and Social Policy. We thank Rachel Kenney for editing.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Exhibit F

UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Fact Sheet

December 2018

Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health

Ninez A. Ponce, Laurel Lucia and Tia Shimada

Changes to "public charge" rules proposed by the U.S. Department of Homeland Security could lead to losses of up to $1.67 billion in federal benefits for California and even greater economic losses across the state.

Photo credit: iStock.com/GOLFX

What is the "Public Charge" Test?

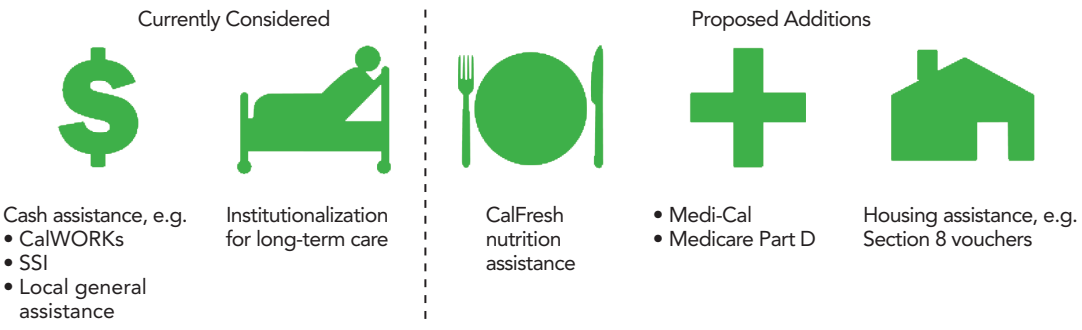
When a person applies for lawful permanent residency (a "green card") or for a visa to enter the United States, U.S. immigration officials conduct what is called a "public charge" test to determine if that person may become primarily dependent on the government to meet their basic needs.

What Changes are Proposed to the Public Charge Test?

Currently, only two public benefits—cash assistance and long-term institutional care—are considered for the public charge test. Under the proposed changes to federal immigration rules, people could be denied status as lawful permanent residents if they've received certain health care, housing or nutrition assistance benefits (Figure 1).

Figure 1

Public Programs and Public Charge



Take Action: Submit a Public Comment

Public comments about the proposed changes to the public charge test can be submitted through December 10, 2018; all comments must be counted and considered by public officials before a final rule is issued. Visit the Protecting Immigrant Families website at *https://protectingimmigrantfamilies.org/* to learn more. Any individual, agency, or organization can submit a comment, and commenting on the proposed rule is not considered lobbying.

In addition, the proposed rule adds harsher standards for personal circumstances that make someone less likely to receive a green card, such as having limited English proficiency, limited educational attainment, low income, being a child or being a senior.

Negative Effects on Health and Hunger

The proposed changes to immigration rules are complex and could lead to misinformation, confusion and fear about enrollment in public programs. Analysis indicates that this "chilling effect" could impact up to 2.2 million Californians in immigrant families, most of whom would not actually be legally subject to the proposed new public charge test.

If just 15 to 35 percent of those Californians in immigrant families disenroll from public programs, that is a loss of federal benefits for up to 765,000 people across the state.

Disenrollment would increase poverty, hunger and poor health in communities statewide by reducing the resources that California residents have for health care, food and other basic necessities.

Regardless of employment, among California's immigrant adults potentially impacted by the proposed rule:

- Medi-Cal enrollees are 1.8 times more likely to have a usual place to get health care, and are 1.5 times more likely to have had a preventive care visit in the past year, compared with people who are uninsured, but eligible for Medi-Cal.

- More than 400,000 adults are food insecure, which means that they lacked consistent access to enough food at some point in the past year. Disenrollment from CalFresh could increase food insecurity in California.

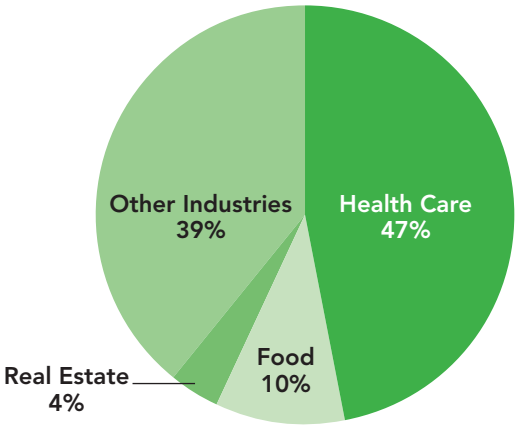
Nearly 70 percent of California residents projected to disenroll from health care and nutrition assistance benefits would be children.

Across California, disenrollment from CalFresh and Medi-Cal would most significantly impact Latinos (88 percent) and Asians (8 percent).

"California could lose up to $1.67 billion in federal benefits, yielding an even greater loss of spending throughout the broader state economy – $2.8 billion – as the loss of those federal dollars has an economic ripple effect across multiple industries."

Figure 2

Lost Jobs



If proposed changes to the 'public charge' test go into effect, up to 17,700 jobs across California will no longer exist.

Negative Economic Effects Across California

Analysis shows that if just 35 percent of those touched by the "chilling effect" disenroll from Medi-Cal and CalFresh:

- California could lose up to $1.67 billion in federal benefits, yielding an even greater loss of spending throughout the broader state economy—$2.80 billion—as the loss of those federal dollars has an economic ripple effect across industries.
- As many as 17,700 jobs could be eliminated statewide (Figure 2). An estimated 57 percent of the job losses would come from California's health care sector (8,400 jobs) and food-related industries (1,800 jobs).

Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health: Data Tables

The following data tables contain state, regional and county estimates from our analyses on the potential effects of proposed changes to the "public charge" test. These findings focus on potential effects to CalFresh nutrition assistance and Medi-Cal health insurance enrollment, related economic impacts, hunger and health.

Chilling Effects of Proposed Changes to the Public Charge Test

The proposed changes to immigration rules are complex and could lead to misinformation, confusion and fear about enrollment in public programs. Analysis indicates that this "chilling effect" could impact up to 2.2 million Californians in immigrant families enrolled in CalFresh nutrition assistance and/or Medi-Cal health insurance, most of whom would not actually be legally subject to the proposed new public charge test.

Table 1. Chilling Effect Population

Location	CalFresh	Medi-Cal	CalFresh and/or Medi-Cal
California statewide	**860,000**	**2,116,000**	**2,185,000**
Northern and Sierra region*	**12,000**	**39,000**	**39,000**
Sacramento region	**14,000**	**63,000**	**63,000**
Sacramento County	11,000	38,000	39,000
El Dorado, Placer and Yolo counties (grouped)**	3,000	25,000	25,000
Bay Area region	**131,000**	**279,000**	**289,000**
Alameda County	25,000	46,000	46,000
San Francisco County	35,000	58,000	58,000
San Mateo County	17,000	43,000	43,000
Santa Clara County	28,000	58,000	58,000
Solano County	5,000	9,000	10,000
Sonoma County	12,000	21,000	30,000
Contra Costa, Marin and Napa counties (grouped)**	9,000	45,000	45,000
Central Coast region	**42,000**	**134,000**	**141,000**
Monterey County	11,000	39,000	39,000
Ventura County	22,000	37,000	44,000
San Benito, San Luis Obispo, Santa Barbara and Santa Cruz counties (grouped)**	9,000	58,000	58,000
San Joaquin region	**152,000**	**361,000**	**366,000**
Fresno County	55,000	120,000	121,000
Kern County	17,000	84,000	84,000
Kings County	6,000	12,000	13,000
Madera County	13,000	21,000	21,000
Merced County	8,000	22,000	22,000
San Joaquin County	8,000	27,000	27,000
Stanislaus County	10,000	30,000	33,000
Tulare County	35,000	45,000	46,000
Los Angeles County	**283,000**	**708,000**	**727,000**
Other Southern California region	**227,000**	**532,000**	**559,000**
Imperial County	6,000	28,000	28,000
Orange County	44,000	116,000	126,000
Riverside County	48,000	122,000	125,000
San Bernardino County	70,000	137,000	144,000
San Diego County	59,000	129,000	137,000

Population estimates are rounded to the closest 1,000 individuals. Estimates may not sum to totals due to rounding.

* Northern and Sierra region includes Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties.

** We generated county-level estimates for counties with sufficient samples and statistically stable estimates. Counties for which estimates were not generated were grouped together by region.

Demographics of the Populations Impacted by the Chilling Effect

Across California, children make up the majority of people who would be impacted by the chilling effect of proposed changes to the public charge test (Table 2). Among racial/ethnic groups, Latinos and Asians would be most significantly impacted (Table 3).

Table 2. Percent of the Chilling Effect Population Who Are Children

Location	CalFresh	Medi-Cal	CalFresh and/or Medi-Cal
California statewide	**75%**	**67%**	**67%**
Northern and Sierra region	83%	65%	65%
Sacramento region	80%	78%	78%
Bay Area region	70%	63%	61%
Central Coast region	50%	68%	64%
San Joaquin region	76%	66%	66%
Los Angeles County	80%	69%	69%
Other Southern California region	76%	66%	66%

Table 3. Percent of the Chilling Effect Population Who Are Latino or Asian

Location	CalFresh		Medi-Cal		CalFresh and/or Medi-Cal	
	% Latino	% Asian	% Latino	% Asian	% Latino	% Asian
California statewide	**91%**	**7%**	**88%**	**8%**	**88%**	**8%**
Northern and Sierra region	100%	0%	91%	5%	91%	5%
Sacramento region	–	–	47%	38%	47%	39%
Bay Area region	82%	18%	76%	20%	77%	19%
Central Coast region	99%	–	92%	–	93%	–
San Joaquin region	97%	3%	93%	4%	93%	5%
Los Angeles County	91%	6%	90%	8%	90%	8%
Other Southern California region	95%	2%	93%	4%	93%	4%

– Suppressed due to insufficient sample size to make statistically reliable estimates

Decreased access to food and health care as a result of proposed changes to the public charge test

Analysis shows that if 35 percent of Californians impacted by the chilling effect disenroll from Medi-Cal and CalFresh, 765,000 people across the state will lose much-needed federal benefits that support health and fight hunger.

Table 4. Changes in CalFresh and Medi-Cal Enrollment if 35 Percent of the Chilling Effect Population Disenrolls from CalFresh Nutrition Assistance and Medi-Cal Health Insurance Programs

Location	CalFresh	Medi-Cal	CalFresh and/or Medi-Cal
California statewide	**-301,000**	**-741,000**	**-765,000**
Northern and Sierra region*	**-4,000**	**-14,000**	**-14,000**
Sacramento region	**-5,000**	**-22,000**	**-22,000**
Sacramento County	-4,000	-13,000	-14,000
El Dorado, Placer and Yolo counties (grouped)**	-1,000	-9,000	-9,000
Bay Area region	**-46,000**	**-98,000**	**-101,000**
Alameda County	-9,000	-16,000	-16,000
San Francisco County	-12,000	-20,000	-20,000
San Mateo County	-6,000	-15,000	-15,000
Santa Clara County	-10,000	-20,000	-20,000
Solano County	-2,000	-3,000	-3,000
Sonoma County	-4,000	-8,000	-10,000
Contra Costa, Marin and Napa counties (grouped)**	-3,000	-16,000	-16,000
Central Coast region	**-15,000**	**-47,000**	**-49,000**
Monterey County	-4,000	-14,000	-14,000
Ventura County	-8,000	-13,000	-15,000
San Benito, San Luis Obispo, Santa Barbara and Santa Cruz counties (grouped)**	-3,000	-20,000	-20,000
San Joaquin region	**-53,000**	**-126,000**	**-128,000**
Fresno County	-19,000	-42,000	-42,000
Kern County	-6,000	-29,000	-29,000
Kings County	-2,000	-4,000	-4,000
Madera County	-4,000	-7,000	-7,000
Merced County	-3,000	-8,000	-8,000
San Joaquin County	-3,000	-9,000	-9,000
Stanislaus County	-4,000	-11,000	-11,000
Tulare County	-12,000	-16,000	-16,000
Los Angeles County	**-99,000**	**-248,000**	**-254,000**
Other Southern California region	**-80,000**	**-186,000**	**-196,000**
Imperial County	-2,000	-10,000	-10,000
Orange County	-15,000	-41,000	-44,000
Riverside County	-17,000	-43,000	-44,000
San Bernardino County	-25,000	-48,000	-50,000
San Diego County	-21,000	-45,000	-48,000

Disenrollment estimates are rounded to the closest 1,000 individuals. Estimates may not sum to totals due to rounding.

* Northern and Sierra region includes Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties.

** We generated county-level estimates for counties with sufficient samples and statistically stable estimates. Counties for which estimates were not generated were grouped together by region.

Economic losses from proposed changes to public charge test

Disenrollment from CalFresh and Medi-Cal will harm individuals, families and entire communities. California could lose up to $1.67 billion in federal benefits (Table 5), yielding an even greater loss of spending throughout the broader state economy—$2.80 billion—as the loss of those federal dollars has a negative economic ripple effect across industries (Table 6). State and local governments could lose up to $151 million in state and local tax revenue as fewer dollars circulate through the economy and less sales tax, income tax and other tax revenue is generated (Table 7).

Table 5. Reduction in Federally-funded Benefits to California if 35 Percent of the Chilling Effect Population Disenrolls from CalFresh Nutrition Assistance and Medi-Cal Health Insurance Programs

Location	CalFresh	Medi-Cal	CalFresh and/or Medi-Cal
California statewide	**$488 million**	**$1.19 billion**	**$1.67 billion**
Northern and Sierra region*	**$6 million**	**$20 million**	**$26 million**
Sacramento region	**$8 million**	**$34 million**	**$42 million**
Sacramento County	$6 million	$21 million	$27 million
El Dorado, Placer and Yolo counties (grouped)**	$2 million	$13 million	$15 million
Bay Area region	**$74 million**	**$157 million**	**$232 million**
Alameda County	$14 million	$26 million	$40 million
San Francisco County	$20 million	$33 million	$52 million
San Mateo County	$10 million	$24 million	$34 million
Santa Clara County	$16 million	$33 million	$49 million
Solano County	$3 million	$5 million	$8 million
Sonoma County	$7 million	$12 million	$19 million
Contra Costa, Marin and Napa counties (grouped)**	$5 million	$25 million	$30 million
Central Coast region	**$23 million**	**$77 million**	**$100 million**
Monterey County	$2 million	$11 million	$13 million
Ventura County	$4 million	$10 million	$14 million
San Benito, San Luis Obispo, Santa Barbara and Santa Cruz counties (grouped)**	$18 million	$56 million	$73 million
San Joaquin region	**$83 million**	**$204 million**	**$287 million**
Fresno County	$30 million	$68 million	$98 million
Kern County	$10 million	$48 million	$57 million
Kings County	$3 million	$7 million	$10 million
Madera County	$7 million	$12 million	$19 million
Merced County	$4 million	$12 million	$16 million
San Joaquin County	$5 million	$15 million	$20 million
Stanislaus County	$6 million	$17 million	$23 million
Tulare County	$19 million	$25 million	$44 million
Los Angeles County	**$165 million**	**$406 million**	**$571 million**
Other Southern California region	**$126 million**	**$289 million**	**$415 million**
Imperial County	$4 million	$15 million	$19 million
Orange County	$24 million	$63 million	$88 million
Riverside County	$26 million	$66 million	$93 million
San Bernardino County	$39 million	$74 million	$113 million
San Diego County	$33 million	$70 million	$103 million

Disenrollment estimates are rounded to the closest 1,000 individuals. Estimates may not sum to totals due to rounding.

* Northern and Sierra region includes Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties.

** We generated county-level estimates for counties with sufficient samples and statistically stable estimates. Counties for which estimates were not generated were grouped together by region.

Table 6. Lost Jobs and Lost Economic Output if 35 Percent of the Chilling Effect Population Disenrolls from CalFresh Nutrition Assistance and Medi-Cal Health Insurance Programs

Location	Jobs Eliminated	Lost Economic Output
California statewide	**17,700**	**$2.80 billion**
Northern and Sierra region*	**300**	**$37 million**
Sacramento region	**400**	**$73 million**
Sacramento County	300	$46 million
El Dorado, Placer and Yolo counties (grouped)**	100	$27 million
Bay Area region	**2,100**	**$397 million**
Alameda County	400	$68 million
San Francisco County	500	$89 million
San Mateo County	300	$58 million
Santa Clara County	400	$83 million
Solano County	100	$14 million
Sonoma County	200	$32 million
Contra Costa, Marin and Napa counties (grouped)**	200	$52 million
Central Coast region	**1,100**	**$159 million**
Monterey County	100	$20 million
Ventura County	200	$22 million
San Benito, San Luis Obispo, Santa Barbara and Santa Cruz counties (grouped)**	800	$117 million
San Joaquin region	**2,900**	**$432 million**
Fresno County	1,000	$147 million
Kern County	600	$89 million
Kings County	100	$15 million
Madera County	200	$28 million
Merced County	200	$25 million
San Joaquin County	200	$30 million
Stanislaus County	200	$34 million
Tulare County	400	$64 million
Los Angeles County	**6,200**	**$992 million**
Other Southern California region	**4,700**	**$714 million**
Imperial County	200	$33 million
Orange County	1,000	$151 million
Riverside County	1,100	$160 million
San Bernardino County	1,300	$193 million
San Diego County	1,200	$177 million

Job loss estimates are rounded to the closest 100 jobs. Estimates may not sum to totals due to rounding.

* Northern and Sierra region includes Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba counties.

** We generated county-level estimates for counties with sufficient samples and statistically stable estimates. Counties for which estimates were not generated were grouped together by region.

Table 7. Lost State and Local Tax Revenue if 35 Percent of the Chilling Effect Population Disenrolls from CalFresh Nutrition Assistance and Medi-Cal Health Insurance Programs

Location	Lost State and Local Tax Revenue
California statewide	**$151 million**
Northern and Sierra region	$2 million
Sacramento region	$4 million
Bay Area region	$20 million
Central Coast region	$9 million
San Joaquin region	$24 million
Los Angeles County	$53 million
Other Southern California region	$39 million

Acknowledgments

The authors wish to thank the following contributors to this work: Riti Shimkhada, AJ Scheitler, Xiao Chen, Dahai Yue, Jared Call and Josue Chavarin.

These analyses were conducted by the UCLA Center for Health Policy Research in partnership with the UC Berkeley Labor Center and California Food Policy Advocates, with support from the California Health Care Foundation and The California Endowment.

Suggested Citation

Ponce NA, Lucia L, Shimada T. December 2018. *Proposed Changes to Immigration Rules Could Cost California Jobs, Harm Public Health*. Los Angeles, CA: UCLA Center for Health Policy Research, UC Berkeley Labor Center & California Food Policy Advocates.