THE STATE OF CALIFORNIA
OFFICE OF THE ATTORNEY GENERAL

THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

ROB BONTA
ATTORNEY GENERAL

LETITIA JAMES
ATTORNEY GENERAL

October 22, 2021

***Via Federal eRulemaking Portal***

The Honorable Alejandro Mayorkas
Secretary of the U.S. Department of Homeland Security
Washington, DC 20528

Director Ur M. Jaddou
U.S. Citizenship and Immigration Services
Department of Homeland Security
Attn: USCIS-2021-0013
5900 Capital Gateway Drive
Camp Springs, MD 20746

RE: Advance Notice of Proposed Rulemaking: "Public Charge Ground of Inadmissibility" [RIN: 1615-AC74; CIS No. 2696-21; DHS Docket No. USCIS-2021-0013]

Dear Secretary Mayorkas and Director Jaddou:

The undersigned Attorneys General of California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington (the States) write in response to the U.S. Department of Homeland Security (DHS) and the U.S. Citizenship and Immigration Services' (USCIS) Advance Notice of Proposed Rulemaking seeking feedback to inform a future regulatory proposal on the "Public Charge Ground of Inadmissibility" that will be "fully consistent with law," "will reflect empirical evidence to the extent relevant and available" and will "not cause undue fear among immigrant communities or present other obstacles to immigrants and their families accessing public services available to them, particularly in light of the COVID-19 pandemic and the resulting long-term public health and economic impacts in the United States."[1]

As we explained in litigation challenging the prior federal administration's rulemaking,[2] the 2019 Rule was contrary to law and an unreasonable, unwarranted interpretation of Section

[1] 86 Fed. Reg. 47,025 (Aug. 23, 2021).

[2] *See, e.g.*, Appellees' Answering Br., *New York v. Dep't of Homeland Security* (2d Cir. Jan. 24, 2020) (No. 19-3591); Appellees' Answering Br., *California v. Dep't of Homeland Security* (9th Cir. Jan.

212(a)(4) of the Immigration and Nationality Act (INA).[3] Although the 2019 Rule has been removed from the Code of Federal Regulations,[4] it has burdened the States with additional healthcare costs and harmed the public health and economic well-being of our residents—disproportionately impacting communities of color and people with disabilities. And the 2019 Rule hobbled the States' ability to respond to a historic pandemic. We therefore urge DHS to move expeditiously to propose and finalize a new regulation on public charge that mitigates these harms.

As described below, the States retain a strong interest in ensuring that the federal government does not interpret the INA's public charge provision in a manner that disrupts state operations or the ability to provide public benefits for all the States' residents, including immigrants and their families, in times of need. We respectfully request that DHS consider our comments opposing the 2019 Rule as well as the legal analysis and evidence submitted in support of the States' motions for injunctive relief in proposing and finalizing its regulation.[5]

## I. PUBLIC CHARGE POLICY SHOULD BE CONSISTENT WITH ITS WELL-SETTLED MEANING, AND CONGRESS'S SUBSEQUENT EXPANSION OF PUBLIC BENEFITS

The previous federal administration enacted a novel public charge policy that created unprecedented barriers for those seeking admission to the U.S. or to adjust immigration status. In contrast to the unlawful 2019 Rule, any policy regarding public charge should not be stretched beyond the long-established meaning of the term that Congress incorporated into the INA in 1952.

### A. Under Federal Law "Public Charge" Has A Narrow and Well-Settled Meaning.

Under federal immigration law, "public charge" is a term of art with a well-established common law meaning that Congress adopted and maintained for more than a century and that, until the 2019 Rule, federal immigration agencies had consistently applied. Under that well-

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17, 2020) (No. 19-17214). Appellees' Answering Br., *Washington v. Dep't of Homeland Security* (9th Cir. Jan. 17, 2020) (No. 19-35914) (all challenging *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (hereinafter the 2019 Rule)).

[3] 8 U.S.C. § 1182(a)(4).

[4] *Inadmissibility on Public Charge Grounds; Implementation of Vacatur*, 86 Fed. Reg. 14,221 (Mar. 15, 2021).

[5] *See, e.g.*, Pls. Mot. for Prelim. Inj., *California et al. v. U.S. Dep't of Homeland Sec., et al.*, (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Pls. Mot. for Prelim. Inj., *Washington et al. v. U.S. Dep't of Homeland Sec. et al.*, (E.D. Wash. Sept. 8, 2019); Pls. Notice of Mot. for Prelim. Inj. & Stay, *State of New York, et al. v. U.S. Dep't of Homeland Sec., et al.* (S.D.N.Y. Sept. 9, 2019); Pls. Notice of Mot. for Prelim. Inj. & Stay, *State of New York, et al. v. U.S. Dep't of Homeland Sec., et al.* (S.D.N.Y. Apr. 28, 2020) (No. 19-cv-7777).

settled understanding, the term public charge means an individual who is or is likely to become *primarily and permanently* dependent on the government for subsistence. This meaning derives from over a century of common-law interpretation that Congress borrowed in 1952, when it chose to codify a totality of circumstances test in the INA. And—except for the unlawful 2019 Rule—in the 70 years since the INA's enactment, Congress, federal immigration authorities, and courts have continued to recognize that the term "public charge" does *not* include those who receive temporary, supplemental, non-cash benefits like subsidized healthcare, food stamps, housing assistance, and other benefits that promote well-being and upward mobility. Under this narrow and well-settled meaning, a public charge finding has been the exception, not the rule. Indeed, between 1882, when Congress first enacted the public charge provision, and 1980 (the last year for which exclusion data is publicly available) less than one percent of immigrants were excluded on public charge grounds.[6]

Congress first incorporated the term "public charge" into federal law[7] to address concerns about European governments sending "undesirable" individuals who would be permanent drains on the public fisc. Congress rendered "convicts, lunatics, idiots, and any person unable to take care of [themselves] without becoming a public charge" excludable and prevented them from entering the country.[8] "Public charge" thus adhered to an accepted meaning that referred to the fraction of immigrants likely to "become *life-long dependents* on our public charities."[9]

Congress did not exclude immigrants who might be poor or require some public assistance to promote their well-being or upward mobility. As legislators explained, such immigrants, despite their lack of wealth, contributed to the economy and could "become a valuable component part of the body-politic."[10] And, as the States had, Congress decided not only to admit such immigrants, but also to provide public support for them. In the same statute that incorporated the public charge provision into federal law, Congress also directed the collection of a per-person tax "for the support and relief" of immigrants who "may fall into distress or need public aid."[11] This federal immigration fund was used in part "for protecting and caring for"

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[6] *See* Dep't of Homeland Sec., *Table 1. Persons Obtaining Lawful Permanent Resident Status: Fiscal Years 1820 to 2016* (Dec. 18, 2017), https://www.dhs.gov/immigration-statistics/yearbook/2016/table1; Immigration and Naturalization Serv., *2001 Statistical Yearbook of the Immigration and Naturalization Service* Tables 1, 66 (2003), https://www.dhs.gov/sites/default/files/publications/Yearbook_Immigration_Statistics_2001.pdf.

[7] Immigration Act of 1882, ch. 376, 22 Stat. 214, 47th Cong. (1882).

[8] *Id.*

[9] 13 Cong. Rec. 5109 (statement of Rep. Van Voorhis) (emphasis added).

[10] *Id.* at 5108.

[11] Immigration Act of 1882 §§ 1-2, 22 Stat. at 214.

immigrants from "when they arrive…until they can proceed to other places or obtain occupation for their support."[12]

From 1891 to 1951, Congress repeatedly reenacted public-charge provisions substantially similar to the one in the 1882 Act.[13] Throughout, the scope of the term "public charge" remained limited to the small number of individuals who were not just poor but unable to support themselves and were thus likely to depend almost entirely on the government for subsistence.[14] "Public charge" did not include immigrants "able to earn [their] own living," even if they were not wealthy and were receiving some form of public assistance.[15]

Against this background of nearly a century of statutory and administrative application of the "public charge" term, Congress enacted the INA's public charge provision in 1952, providing that, immigrants who "are likely at any time to become public charges" are inadmissible.[16] Congress understood that "public charge" was a term of art that had been interpreted and applied in court and agency decisions and prior state and federal laws. But rather than redefining the term or devising a new standard for federal immigration law, Congress instead consciously decided to incorporate "public charge" without modification into the INA. As courts and federal immigration agencies consistently explained after the 1952 enactment, Congress's decision incorporated the well-established meaning of "public charge" into the INA, preserving that term's narrow application to immigrants who were "incapable of earning a livelihood" and thus depended primarily on public support to survive long term,[17] not working immigrants who might receive modest amounts of public assistance.[18]

In 1996, Congress directed DHS to consider certain factors in making public charge determinations—i.e., an immigrant's age, health, family status, financial resources, and

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[12] 13 Cong. Rec. 5106 (1882) (Rep. Reagan).

[13] *See* Immigration Act of 1891, ch. 551, § 1, 26 Stat. 1084, 1084; Immigration Act of 1907, ch. 1134, § 2, 34 Stat. 898, 898-99; Immigration Act of 1917, ch. 29 § 3, 39 Stat. 874, 876.

[14] *See Gegiow v. Uhl*, 239 U.S. 3, 10 (1915) ("public charge" means individuals unable to work due to "permanent personal objections"); *Howe v. United States*, 247 F. 292 (2d Cir. 1917) (Congress meant "to exclude persons who were likely to become occupants of almshouses for want of means with which to support themselves"); *Ex parte Hosaye Sakaguchi*, 277 F. 913, 916 (9th Cir. 1922) (public charge does not include "able-bodied woman" with "disposition to work"); *Lam Fung Yen v. Frick*, 233 F. 393, 396 (6th Cir. 1916) ("public charge" means persons without "permanent means of support, actual or contemplated").

[15] *Ex parte Mitchell*, 256 F. 229, 230 (N.D.N.Y. 1919).

[16] Act of June 27, 1952, Pub. L. No. 414, § 212(a)(15), 66 Stat. 163, 183.

[17] *In re Harutunian*, 14 I.&N. Dec. 583, 589 (B.I.A. 1974).

[18] *In re Martinez-Lopez*, 10 I.&N. Dec. 409, 421-22 (A.G. 1964) ("A healthy person in the prime of life cannot ordinarily be considered likely to become a public charge.").

education and skills.[19] But Congress did not alter the established meaning of "public charge." To the contrary, that same year Congress rejected a proposal that would have altered public charge in the deportability context to mean receipt of any supplemental benefits within 12 months.[20] And in 2013, considered in the admissibility context, Congress rejected a similar attempt to expand the meaning of "public charge" to encompass the use of modest amounts of supplemental benefits designed to promote public health and economic mobility.[21] Thus, the underlying concept of "public charge" retained the well-settled meaning that had developed after more than a century of usage when Congress decided to incorporate it without modification into the 1952 Act.

Until the 2019 Rule, federal agencies had likewise affirmed the narrow meaning of public charge as those who are or who are likely to become primarily and permanently dependent on the government for subsistence. In 1999, after welfare reforms led immigrants and their families to withdraw from non-cash benefits programs for which they remained eligible, INS issued guidance (the "1999 Field Guidance") that formally acknowledged this primarily dependent standard and specifically concluded that "non-cash benefits (other than institutionalization for long-term care) are by their nature supplemental and do not, alone or in combination, provide sufficient resources to support an individual or family."[22] In so doing, INS consulted "extensively" with agencies charged with administering public benefit programs.[23] And until the 2019 Rule's unprecedented departure from the well-settled meaning of public charge, the Department of Justice also recognized that "public charge" means primarily dependent, adopting the same standard in the context of deportation, acknowledging that this meaning "ha[d] been part of U.S. immigration law for more than 100 years."[24]

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[19] Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), Pub. L. No. 104-208, 110 Stat. 3009, 3009-674.

[20] H.R. Rep. No. 104-828, at 138, 241 (1996) (Conf. Rep.).

[21] *See* S. Rep. No. 113-40, at 42 (2013).

[22] *Inadmissibility and Deportability on Public Charge Grounds*, 64 Fed. Reg. 28,686-88, 28,689 (May 26, 1999).

[23] *Id.* at 28,692.

[24] U.S. Dep't of Justice, Public Charge Fact Sheet, 2009 WL 3453730 (Oct. 29, 2009); *see also U.S. Dep't of Justice, Final Rule: Adjustment of Status for Certain Aliens*, 54 Fed. Reg. 28, 442-01, 29,444 (July 12, 1989) (Department of Justice rule confirming that an applicant may not be deemed a public charge if he "has a consistent employment history which shows the ability to support himself" even if the applicant earns "below the poverty level").

### B. The 2019 Rule Unlawfully Targeted Immigrants Who May Use Benefits Designed to Promote Public Health and Boost Economic Mobility.

The 2019 Rule's interpretation of "public charge" was well outside the established historical understanding of that term of art for several reasons, and any agency interpretation going forward must not repeat the mistakes of that misguided policy.

First, as Congress and the expert federal benefit-granting agencies made clear in 1996, under the established meaning of the term public charge, the supplemental benefits targeted by the 2019 Rule (federally funded Medicaid, Supplemental Nutrition Assistance Program (SNAP), and housing subsidies) do not serve only those likely to remain permanently dependent. Rather, to further its "broad public policy decisions" about improving public health, nutrition, and economic opportunities for middle- and low-income individuals, Congress made public programs available to many employed individuals who have "incomes far above the poverty level."[25] The supplemental benefits targeted by the 2019 Rule were thus not limited to individuals who are unable to work and dependent on the public for their subsistence. To the contrary, in the undersigned jurisdictions, a large majority of adult Medicaid recipients work.[26] Nor do the targeted benefits —even cumulatively—provide support sufficient to constitute an adult's primary means of survival.[27]

Second, the 2019 Rule's 12-months-in-36-months threshold and aggregate-counting rule, which counted the use of three benefits in one month as three months of benefits use, meant that noncitizens would be considered "public charges" based on the likelihood of using multiple benefits—however de minimis the amount or duration—to address an acute period of financial strain or emergency.[28] But short-term use of any amount of supplemental benefits, particularly by employed individuals, bears no resemblance to the types of long-term dependency, such as almshouses, that have traditionally been the sole bases for finding an applicant to be a public charge. Such long-term support is designed to serve destitute individuals who are "extremely unlikely" to meet their "basic subsistence requirements" without relying primarily on the

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[25] 64 Fed Reg. at 28,692. *See* 7 U.S.C. § 2011 (SNAP "safeguard[s] the health and well-being of the Nation's population by raising levels of nutrition among low-income households"); 42 U.S.C. § 5301(b) (housing-assistance programs, including Section 8, "improve the living environment of low- and moderate-income families"); *see also* Ticket to Work and Work Incentives Improvement Act of 1888, Pub. L. No. 106-170, § 2, 113 Stat. 18609, 1862-63 (Medicaid enables "individuals with disabilities" to "maintain employment"); *id.* § 201, 113 Stat. at 1981-94 (expanding state authority to offer Medicaid to individuals with disabilities who earn incomes far above poverty line).

[26] Kaiser Family Foundation, *Medicaid State Fact Sheets* (Oct. 17, 2019), available at https://www.kff.org/interactive/medicaid-state-fact-sheets/.

[27] *See New York*, 969 F.3d at 83-84 (explaining that the goals and eligibility criteria of the targeted programs demonstrate that they provide supplemental rather than subsistence support).

[28] *See* 84 Fed. Reg. at 41,501.

government.[29] The type of temporary reliance on supplemental benefits that the 2019 Rule considered as disqualifying for admission is no indication that an applicant will rely primarily and permanently on the government, such as the historical meaning of "public charge" was intended to identify.

Finally, defenders of the 2019 Rule were wrong in claiming that policy statements in the Personal Responsibility and Work Opportunity Act of 1996 (the Welfare Reform Act or PRWORA) supported the 2019 Rule. None of PRWORA's provisions altered the well-established meaning of "public charge." To the contrary, they reflect Congress's decision to regulate certain admitted legal permanent residents' (LPRs') use of specific public benefits in particular ways and to restrict federal aid eligibility for other categories of immigrants, not a legislative attempt to increase the likelihood that immigrants could be denied admission to the United States in the first instance by drastically expanding the established understanding of "public charge." Specifically, PRWORA's policy statements did not relate to the threshold meaning of "public charge." Instead, in the Welfare Reform Act Congress effectuated the goals of furthering "[s]elf-sufficiency" in "immigration policy" and preventing "the availability of public benefits" from incentivizing immigration by limiting immigrants' use of specific benefits in particular ways, such as by imposing a waiting period for already admitted LPRs to access certain benefits and denying benefits altogether to undocumented immigrants.[30] Furthermore, in PRWORA Congress expressly gave *States*—not the Department of Homeland Security—authority to decide whether to provide additional state-funded public benefits to noncitizens.[31] The same Congress pointedly did *not* pursue these "self-sufficiency" goals through amending the threshold public charge provision. Although Congress in 1996 made many other changes to federal immigration law through IIRIRA, such as expanding the criminal grounds for inadmissibility, it affirmatively rejected a proposal to transform the meaning of "public charge" in the deportation context to mean an immigrant's receipt of any amount of public benefits within a short time period.[32] And, as described above, in 2013, Congress again rejected an attempt to make a similar change to the meaning of "public charge" in the admissibility context.[33]

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[29] 64 Fed. Reg. at 28,678; *see id.* at 28,687 (SSI protects "vulnerable people . . . from complete impoverishment").

[30] 8 U.S.C. § 1601.

[31] *See, e.g.*, 8 U.S.C. §§ 1612(b) (States may decide whether to provide or deny Medicaid to most qualified immigrants who were in the U.S. before August 22, 1996, and to those who enter the U.S. on or after that date, once they have completed the federal five-year bar), 1621(d) (authorizing discretion for States to provide nonqualified noncitizens with state and local benefits not otherwise restricted by federal law).

[32] H.R. Rep. No. 104-828, at 138, 241.

[33] *See* S. Rep. No. 113-40, at 42 (2013).

Indeed, importing the 1996 Act's policy statements into the public-charge provision would run counter to Congress's judgment in PRWORA. Unlike the 2019 Rule, any new regulation must be consistent with the long-standing meaning of public charge, and Congress's subsequent legislative enactments.

## II. DHS SHOULD WEIGH AND AVOID CHILLING EFFECTS ON PUBLIC BENEFIT USAGE WHEN PROMULGATING PUBLIC CHARGE POLICY

The 2019 Rule (and leaked preliminary drafts of that Rule) caused serious chilling effects on the public's willingness to participate in public benefit programs, impacting programs that DHS attempted to carve out (like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)), and deterring even those to whom public charge inadmissibility determinations do not actually apply (like refugees, asylees, and children of immigrants who are U.S. citizens). Experts and community groups warned that the 2019 Rule would have these types of chilling effects, with serious consequences for vulnerable groups. DHS itself predicted some of this result, estimating that, the 2019 Rule's expanded criteria for finding inadmissibility would cause a 2.5% reduction in Medicaid enrollment by individuals in households with a noncitizen[34] and a $1.46 to $4.37 billion reduction in federal Medicaid payments to states.[35]

The available evidence strongly suggests that DHS underestimated the 2019 Rule's disenrollment effects, despite significant mitigation efforts on behalf of the States and the complicating factor of the pandemic. This is not surprising: the 2019 Rule generally failed to quantify or weigh the impact that chilling effects would have on immigrants who are not subject to it[36] or their participation in both state and federal public benefit programs that are ostensibly exempted from consideration under the Rule. It did so even though the record before the agency amply demonstrated the likelihood of such chilling effects, and the serious health consequences associated with avoidance of health, nutritional, and housing supports.[37]

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[34] 84 Fed. Reg. at 41,463 (Aug. 14, 2019). Note that many households with a noncitizen also include citizen children; in California alone, 20% of all individuals under 18 were living in mixed-status families, meaning they were undocumented themselves or living with someone who was. California Immigrant Data Portal, *Mixed-status Families: Diverse immigration statuses are prevalent even within the same household* (2020), available at https://immigrantdataca.org/indicators/mixed-status-families#/.

[35] *See* Exhibit A of Decl. of Lisa Cisneros, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975) (hereinafter Cisneros Decl.) at 97-98.

[36] For example, Legal Permanent Residents (LPRs), "green card" holders, are subject to public charge determinations when seeking admission. *Compare* Lisa Cisneros Decl. Ex. A at 15-16 *with* Cisneros Decl. Ex K at 75-80, Ex. S at 79-80, Ex. G at 54-55. The chilling effect of this low frequency, but high stakes scenario was not calculated as part of the 2019 Rule.

[37] *See* Cisneros Decl. Ex. K at 59-73, Ex. E at 1-2.

When the 2019 Rule came into effect in February 2020, increasing numbers of immigrants began to refrain from Medicaid coverage and other publicly funded healthcare benefits based on concerns that using such benefits will render them a "public charge" and thus jeopardize their ability to obtain LPR status and, eventually, citizenship.[38] Immigrants increasingly began to decline to use SNAP benefits, as well as other nutrition programs, such as WIC, that are not implicated in the public-charge analysis,[39] leading to a "nationwide decrease of approximately 260,000 enrollees in child Medicaid and 21,000 enrollees" in WIC.[40] These deterrent effects have not been limited to LPR applicants or to the Rule's enumerated public benefit programs. Instead, immigrants and their family members avoided state-funded health insurance programs, reduced their use of medical services, and refrained from using other public benefits not covered by the Rule.[41]

The States' benefit granting agencies report that because the public charge inadmissibility formula in the 2019 Rule is so complex and layered, it was extraordinarily difficult for immigrants and service providers to understand whether or how it applied to them. Many immigrants avoided benefits, even important benefits like medical care during a pandemic, out of fear and confusion.[42] After the 2019 Rule took effect, medical personnel, state and local officials, and staff at nonprofit organizations encountered many immigrants who refused to enroll in Medicaid or other publicly funded healthcare coverage based on concerns that receiving such coverage would increase the risk of being deemed a public charge under the Rule.[43] In particular, the 2019 Rule led to avoidance of primary care. Despite healthcare workers' perception and

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[38] *See* Decls. of Lisa Newstrom and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

[39] *See* Decls. of Janel Heinrich, Lisa Newstrom and Jack Newton, *New York,* (S.D.N.Y. Apr. 28, 2020); *see also* Helena Bottemiller Evich, *Immigrants, Fearing Trump Crackdown, Drop Out of Nutrition Programs*, Politico (Sept. 3, 2018), https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292 (last visited Sept. 30, 2018).

[40] Alma Guerrero, M.D., M.P.H, et al., *Forgoing Healthcare in a Global Pandemic: The Chilling Effects of the Public Charge Rule on Health Access Among Children in California*, UCLA Latino Policy & Politics Initiative (Apr. 07, 2021), https://latino.ucla.edu/wp-content/uploads/2021/08/LPPI_Foregoing-Healthcare-in-a-Global-Pandemic_04.07.2021.pdf; Leslie Berestein Rojas, *Thousands Of LA Immigrant Families Are No Longer Enrolled In Public Benefits. A Pending Trump Rule Could Be Why*, LAist (Aug. 02, 2019), https://laist.com/news/thousands-of-la-immigrant-families-are-no-longer-enrolled-in-public-benefits-a-pending-trump-rule-co.

[41] *See* Decls. of Sarah Nolan, Lisa Newstrom and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

[42] *See* Decls. of Leighton Ku, Alejandra Aguilar, Camille Kritzman, and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

[43] *See, e.g.*, Decl. of Rachel Pryor (patients at health clinics in Virginia refusing to participate in financial screening needed for care because screening involves Medicaid application), Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

effort to ensure that primary care clinics were "safe spaces," they remained underutilized due to fear, misinformation, and misperceptions regarding the availability of coverage and immigration policies.[44]

In California alone, one quarter of immigrant adults with incomes below 200% of the federal poverty level avoided public programs "out of fear that [participating] would negatively impact immigration status."[45] It was those most in need who were impacted; those avoiding public benefits out of fear were more likely to be uninsured and more likely to be food insecure.[46] Forty-three percent of those who avoided public programs over concerns about negative impacts on immigration status were citizens who are never subject to a public charge determination or green card holders who are highly unlikely to be subject to a public charge determination, evidence that the 2019 Rule's impact was caused by fear and confusion.[47] These findings were echoed by an Urban Institute study that found that although a large majority of California's immigrant families were aware of the prior administration's public charge policy, and almost 70% described themselves as "confident" in their understanding of the Rule, "only 22.5 percent knew it [did] not apply to citizenship applications, and only 18.2 percent knew children's enrollment in Medi-Cal [would] not be considered in their parents' public charge determinations."[48] DHS's prediction that it would ameliorate this confusion through its public information channels were unfounded.[49]

These chilling effects are grossly disproportionate compared to the 2019 Rule's relatively minimal direct impacts on public charge inadmissibility determinations. As DHS explained in a brief to the U.S. Supreme Court, "[r]eal-world experience with the 2019 Rule" did not bear out the "speculation that the Rule would substantially reduce the number of noncitizens eligible for

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[44] Matthew Yu, et al., *Challenges for Adult Undocumented Immigrants in Accessing Primary Care: A Qualitative Study of Health Care Workers in Los Angeles County*, 4 Health Equity 1 (Aug. 10, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7484891/.

[45] Susan H. Babey, Joelle Wolstein, Riti Shimkhada, and Ninez A. Ponce, *One in 4 Low-Income Immigrant Adults in California Avoided Public Programs, Likely Worsening Food Insecurity and Access to Health Care*, UCLA Center for Health Policy Research Health Policy Brief (Mar. 2021), https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/publiccharge-policybrief-mar2021.pdf.

[46] *Id*.

[47] *Id*.

[48] Hamutal Bernstein, et al., *Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019*, Urban Inst. (May 2020), https://www.urban.org/sites/default/files/publication/102221/amid-confusion-over-the-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-in-2019_3.pdf.

[49] 84 Fed. Reg. at 41,470 (Aug. 14, 2019).

public benefits within [the applicant State] jurisdictions."[50] In formulating a new rule and deciding how to weigh past receipt of public benefits, DHS should carefully consider the impact of widespread chilling effects on the costs and benefits of new regulatory action.

## III. DHS SHOULD INCORPORATE LESSONS LEARNED FROM THE 2019 RULE'S NEGATIVE IMPACT ON THE STATES' RESPONSE TO THE COVID-19 PUBLIC HEALTH EMERGENCY

Since the 2019 Rule was promulgated, a global pandemic has starkly illustrated the unnecessary barriers and complications it imposed on the States' public health responsibilities. The prior administration acknowledged the potential of the 2019 Rule to worsen infectious disease outbreaks.[51] But the Rule's implementation during a historic pandemic has led to negative outcomes even more devastating than anticipated. The novel coronavirus SARS-CoV-2 (COVID-19) has afflicted more than 45 million people in the United States with a potentially lethal illness, resulting in more than 728,000 deaths.[52] It has caused a nationwide public health crisis and wreaked havoc on the economy. Federal, state, and local authorities, including the undersigned States, have undertaken extraordinary efforts to stop the spread of COVID-19 and protect the health and well-being of our residents. But none of these have been sufficient to remedy the pernicious effects of the 2019 Rule.

### A. The 2019 Rule Impeded Public Health Responses to the Pandemic.

As described in Section II above, the 2019 Rule led to an avoidance of Medicaid and other publicly funded healthcare programs. From the perspective of the States, as described in the 2019 administrative record, access to healthcare generally benefits public health, but during a novel disease pandemic it becomes even more important.

Lack of access to health insurance, such as Medicaid, reduces the likelihood of individuals receiving testing or treatment for COVID-19, materially impeding public-health officials' efforts to stem the disease. When the pandemic began, doctors and others working on the front lines saw many immigrants avoid COVID-19 testing and treatment altogether, even if they might be able

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[50] U.S. Opp. 23, 24, *Texas v. Cook Cty*., No. 20A150 (Apr. 9, 2021) (three out of 47,500 applicants were denied admission based on adverse public charge determination in one-year period rule was in effect).

[51] *See* 83 Fed. Reg. 51,114 at 51,270 (Oct. 10, 2018) (acknowledging that expansion of public charge policy could lead immigrants who are otherwise eligible for certain public benefits to disenroll or forgo enrollment in those programs, and that such withdrawal or avoidance "could lead to . . . [i]ncreased prevalence of communicable diseases, including among members of the U.S. citizen population who are not vaccinated").

[52] Ctrs. for Disease Control and Prevention, *Covid Data Tracker*, https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days (last checked Oct. 20, 2021).

to obtain publicly funded care, due to the substantial fear generated by the 2019 Rule.[53] Uninsured individuals are much less likely to obtain necessary treatment for COVID-19 because of the prohibitive costs of medical care and hospital stays.[54]

The 2019 Rule further impeded the States' attempts to stem the COVID-19 crisis by deterring immigrants and their family members from obtaining needed medical treatment for preexisting conditions that either make individuals more vulnerable to the virus or make their COVID-19 symptoms worse. Individuals who decline Medicaid or other health insurance coverage because of the Rule often stop seeking primary care for conditions like diabetes, asthma, and heart disease.[55] But these conditions put patients at higher risk of suffering severe symptoms or death from COVID-19.[56] And rather than risk their immigration status, noncitizens who declined Medicaid coverage and did not treat their serious medical conditions were more likely to fall extremely ill with COVID-19.[57]

### B. DHS's Exemptions to Public Charge Policy Relating to COVID-19 Services Were Insufficient.

DHS's 2020 decision to exempt COVID-19 vaccines and treatment from public charge determinations was not sufficient to ameliorate confusion and anxiety among immigrant communities needing to access public health services and other benefits during a crisis.

On March 13, USCIS issued an alert that purported to limit the severe deterrent effects of the 2019 Rule by providing that "USCIS will neither consider testing, treatment, nor preventative care (including vaccines, if a vaccine becomes available) related to COVID-19 as part of a public charge inadmissibility determination . . . even if such treatment is provided or paid for by one or more public benefits, as defined in the rule (e.g. federally funded Medicaid)." But the alert simultaneously and confusingly continued to treat as an automatic negative factor an application for or receipt of public benefits "that may be used to obtain testing or treatment for COVID-19," including federally funded Medicaid. In other words, an LPR applicant who applied for

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[53] *See* Decls. of Eden Almasude, Bitta Mostofi, Pedro Moreno, Aaron Coskey Voit, Rachel Pryor, and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

[54] *See* Decls. of Eden Almasude, Bitta Mostofi, Pedro Moreno, Aaron Coskey Voit, Rachel Pryor, and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020). A recent report from a nonprofit organization that analyzes healthcare costs estimated that a six-day hospital stay for COVID-19 treatment will cost approximately $73,300. FAIR Health, *COVID-19: The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System* 2, 8, 13, 16 (Mar. 25, 2020), https://tinyurl.com/xdzzab3k.

[55] *See* Decl. of John Paul Newton, *New York,* (S.D.N.Y. Apr. 28, 2020).

[56] *See* Decls. of Leighton Ku and John Paul Newton, *New York,* (S.D.N.Y. Apr. 28, 2020).

[57] *Id.*; *see also* Nolan Decl. (staff at New York Legal Assistance Group have seen clients declining or delaying medical treatment based on concerns about the Public Charge Rule).); Safiya Richardson, Jamie S. Hirsch, and Mangala Narasimhan, *Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized with COVID-19 in the New York City Area*, JAMA (Apr. 22, 2020).

federally-funded Medicaid would have had that application count against them under the 2019 Rule, even if COVID-19 treatment paid for by that federally-funded Medicaid did not itself count in the public-charge inquiry. But deterring immigrants from accessing the public benefits they need to get healthcare effectively prevented them from getting necessary testing and treatment for COVID-19.

Moreover, the alert failed to provide clear assurances that immigrants would not be penalized in a future public-charge determination for accessing critical healthcare during the COVID-19 crisis. For example, the alert was unclear as to how or if public charge would apply to an individual who received Medicaid-funded medical treatment for COVID-19-like symptoms but was never tested or confirmed—even as the country faced significant shortage of testing kits. And under the alert, an LPR applicant continued to be penalized for having Medicaid coverage to obtain treatment for medical conditions such as asthma, diabetes, or heart disease, even though those conditions place patients at high risk of suffering more severe symptoms or death if they contract COVID-19. Additionally, although the alert clarified that the 2019 Rule would not apply to state or local benefits, it was unclear how an immigrant was supposed to discern or control whether federal, state, or local benefits apply—especially if they may have required urgent or emergency care. Even after DHS posted the alert on its website, the 2019 Rule continued to deter immigrants from accessing needed medical care during the pandemic. For example, in the weeks following DHS's issuance of the alert, physicians and others working on the front lines of the emergency continued to see many immigrants and their family members express fear about and decline to obtain COVID-19 testing and treatment based on ongoing concerns about the 2019 Rule.[58] Overall, in 2020, 13.6% of adults in immigrant families reported that they or a family member avoided a noncash government benefit program, such as Medicaid, the Children's Health Insurance Program, SNAP, or housing assistance, because of concerns about future green card applications.[59]

### C. The 2019 Rule Harmed the States' Public Health During the COVID-19 Crisis.

The 2019 Rule made the unprecedented public-health disaster caused by the COVID-19 pandemic even worse. By deterring immigrants and their family members from obtaining publicly funded health insurance and medical care, the Rule undermined the States' efforts to slow the spread of the virus, putting our communities—and the entire nation—at higher risk of infection.

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[58] *See, e.g.*, Exhibits 11, 14, 21, 22, & 24 of Decl. of Elena Goldstein, *State of New York, et al. v. U.S. Dep't of Homeland Sec., et al.* (S.D.N.Y. Apr. 28, 2020) (No. 19-cv-7777).

[59] Hamutal Bernstein et al., *Immigrant Families Continued Avoiding the Safety Net during the COVID-19 Crisis*, Urban Inst. (Feb. 2021), https://www.urban.org/sites/default/files/publication/103565/immigrant-families-continued-avoiding-the-safety-net-during-the-covid-19-crisis.pdf.

As with other highly infectious diseases, testing and medical treatment for COVID-19 are critically important to slowing infection rates, preserving hospital capacity and medical equipment, and saving lives.[60] Without proper testing and treatment, immigrants and their family members who become infected are more likely to suffer severe illness or death from the virus.[61] Those who lack testing and treatment are also more likely to spread the virus to other people inadvertently, contributing to growth of infection rates, new variants, and fatalities.[62] Underutilization of primary care, one documented result of the 2019 Rule, causes problems for public health efforts in other ways as well: those without a relationship with a primary care doctor are less likely to access vaccinations or other preventive health services, making public health responses to infectious diseases more difficult.[63] And according to the National Institutes of Health, "fear of seeking out health care during the pandemic" may well be a cause of excess (non-COVID) deaths in 2020.[64]

All of these public health harms have been heightened during the pandemic because immigrants make up a large proportion of essential workers. While other sectors were on lockdown, workers in essential industries continued to work outside of their homes and interact with others by, for example, providing healthcare, preparing and delivering food to residences, cleaning hospitals and public spaces, and caring for the sick or aging. Indeed, in New York City, an initial epicenter of the COVID-19 crisis, noncitizens make up approximately 42.4% of home health aides, 42.3% of cooks, 37.1% of food preparation workers, and 26.9% of janitors and building cleaners.[65] And in other areas of the country, large numbers of noncitizens continue to work in essential industries such as agriculture or food packing and distribution.[66] These workers

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[60] *See* Decls. of Oxiris Barbot, MD and Leighton Ku, *New York,* (S.D.N.Y. Apr. 28, 2020).

[61] *See* Decls. of Leighton Ku, Eden Almasude, Pedro Moreno, and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

[62] *Id*.; *see also* Washington State Dep't of Health, *Testing for COVID-19* (last visited Apr. 12, 2020), https://www.doh.wa.gov/Emergencies/COVID19/TestingforCOVID19 (testing allows public-health officials to "keep people with COVID-19 and their contacts away from others to prevent spread of the virus").

[63] Matthew Yu, et al., *supra* note 44.

[64] National Institutes of Health, *NCI study highlights pandemic's disproportionate impact on Black, American Indian/Alaska Native, and Latino adults*, News Release (Oct. 4, 2021) https://www.nih.gov/ news-events/news-releases/nci-study-highlights-pandemics-disproportionate-impact-black-american-indian-alaska-native-latino-adults.

[65] *See* Decl. of Sabrina Fong, *New York,* (S.D.N.Y. Apr. 28, 2020).

[66] *See* Decls. of Aaron Coskey Voit, Lawrence L. Benito, and Dana Kennedy, *New York,* (S.D.N.Y. Apr. 28, 2020).

are more likely to be exposed to the virus, and, without adequate testing and treatment, are more likely to suffer worse health outcomes and to spread the virus to others inadvertently.[67]

Increased spread of COVID-19 caused by chilling effects carries additional costs. People who lack health insurance are more likely to shift costs to state and local governments and private providers by relying on emergency care when they experience acute medical conditions, or by relying on state-funded public health clinics and school-based health services.[68] Delayed healthcare can lead to worsening medical conditions and complications that will ultimately require more expensive medical treatment.[69] The resulting reliance on emergency services burdens the healthcare system and the States, recreating the problems that States who have chosen to expand Medicaid programs intended to avoid.[70] During the COVID-19 crisis, these consequences are more dire, as uninsured individuals wait to seek medical care until their condition gets serious,[71] further straining hospitals and clinics that may be reaching capacity and facing challenges obtaining ventilators or other critical medical supplies.

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[67] *See* Decls. of Leighton Ku and Eden Almasude, *New York,* (S.D.N.Y. Apr. 28, 2020); *see also* Kennedy Decl. (immigrant workers in Colorado meatpacking plants and dairies are essential workers at high risk of contracting and spreading COVID-19).

[68] Pennsylvania, for example, estimates it will lose more than $220 million in federal Medicaid funds as a result of this drop in Medicaid enrollment, the majority of which will then be shifted to Pennsylvania hospitals. Cindy Mann, April Grady, and Allison Orris, *Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule* at 13 (Nov. 2018) https://www.manatt.com/Insights/White-Papers/2018/Medicaid-Payments-at-Risk-for-Hospitals-Under-Publ.

[69] *See* Aleli D. Kraft et al., *The Health and Cost Impact of Care Delay and the Experimental Impact of Insurance on Reducing Delays: Evidence from a Developing Country*, The Journal of Pediatrics, Aug. 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2742317/pdf/nihms102459.pdf; Ctrs. for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)* (last updated Apr. 6, 2020) (median time in intensive care unit for severely ill COVID-19 patient ranges from ten to twelve days, and median length of hospitalization among survivors ranges from ten to thirteen days); *see also* Decls. of Gifford, Maksym and Zucker, *New York*, (S.D.N.Y. Sept. 9, 2019).

[70] Henry J. Kaiser Family Foundation, *Why Does the Medicaid Debate Matter? National Data and Voices of People with Medicaid Highlight Medicaid's Role* (June 19, 2017), https://www.kff.org/medicaid/fact-sheet/why-does-the-medicaid-debate-matter-national-data-and-voices-of-people-with-medicaid-highlight-medicaids-role/.

[71] S*ee* Decls. of Leighton Ku and Rachel Pryor, *New York,* (S.D.N.Y. Apr. 28, 2020).

### D. The 2019 Rule Also Interfered with the States' Ability to Provide Effective Economic Relief During the COVID-19 Crisis.

In addition to an urgent public health emergency, the COVID-19 pandemic also triggered a severe economic crisis, with millions of workers losing significant income and thereby needing to turn to supplemental benefit programs—designed precisely for such moments—to weather this economic hardship.[72] In April 2020, the unemployment rate reached 14.8% nationwide, the highest rate observed since the federal government began collecting such data in 1948.[73] And the number of individuals seeking unemployment benefits steeply increased.[74] Immigrant workers, particularly in the hospitality and service industries, have been disproportionately impacted by layoffs and furloughs.[75]

Workers who lose their jobs because of the pandemic should be able to turn without fear to temporary supplemental benefit programs, including Medicaid and SNAP, until they can get back on their feet.[76] For example, many workers who lost their jobs and their employer-sponsored health insurance because of the pandemic were likely to need Medicaid coverage until they find another job.[77] SNAP benefits respond rapidly to changing economic conditions by allowing newly eligible individuals to obtain benefits and allowing existing participants to receive higher amounts of benefits if their incomes decrease.[78] Yet the 2019 Rule deterred access to the types of public benefits that are critical for individuals, families, and the country as a whole to weather an economic crisis. In doing so, the 2019 Rule undermined some of the States' most effective tools for protecting the public's health and wellbeing during a crisis and promoting our nation's recovery.

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[72] *See id*.

[73] Cong. Research Serv., *Unemployment Rates During the COVID-19 Pandemic* R46554 (Aug. 20, 2021), https://sgp.fas.org/crs/misc/R46554.pdf.

[74] *Id.*

[75] *See* Decls. of Bitta Mostofi (immigrants in New York have lost jobs in restaurants and as domestic workers) and Lawrence Benito (immigrants in Illinois have lost jobs as domestic workers, personal care aides, and nannies), *New York,* (S.D.N.Y. Apr. 28, 2020). And even for workers who can secure new employment in this economic crisis, those chilled from accessing preventive care afforded by public benefits are more likely to suffer preventable illnesses, resulting in missing work, again reducing economic productivity and creating further instability in our States. *See* Decls. of Gifford, Zucker, Kallick, *New York*, (S.D.N.Y. Sept. 9, 2019).

[76] *See* Decl. of Leighton Ku, *New York,* (S.D.N.Y. Apr. 28, 2020).

[77] *See id*.

[78] U.S. Dep't of Agric., *Building a Healthy America: A Profile of the Supplemental Nutrition Assistance Program* 1, 3 (Apr. 2012).

## IV. DHS SHOULD SEEK TO AVOID UNNECESSARY COSTS TO STATE OPERATIONS AND AGENCIES, AND GREATER PUBLIC HARMS

Even before COVID-19 hit, the 2019 Rule imposed unnecessary costs on state agencies and operations, many of which were identified but were not considered by DHS in its evaluation of the costs and benefits of its rulemaking.

For example, state benefit-granting agencies had to devote scarce time and resources to attempt to counteract the fear and confusion caused by the 2019 Rule. Frontline healthcare workers are generally not well equipped to address client fears and misinformation caused by federal immigration policies, and the 2019 Rule's complicated provisions regarding receipt of benefits imposed additional administrative burdens and implementation costs on the States and their localities as they diverted time and resources to help noncitizens navigate the risks and benefits of receiving health or nutrition benefits.[79] Because of the 2019 Rule's leaked drafts and lengthy administrative process, those costs started accruing even before its final implementation; one Alameda County social services agency estimated that it expended a staff cost of $500,000 to mitigate chilling effects between 2017 and 2019. [80] After the 2019 Rule took effect in February 2020, agencies and nonprofit organizations that work with immigrants experienced a substantial increase in inquiries.[81] Yet, in the face of changing federal immigration policy, investments of these resources were not as effective as they could be; as one director of a state healthcare exchange reported, the state exchanges "dedicated resources to combatting misinformation, but face an uphill battle."[82]

Moreover, disruptions in access to benefits are costly and burdensome to public agencies and state-supported healthcare providers (in addition to harming those who unnecessarily avoid care). Increased "churn" as eligible individuals and families cycle on and off benefits more

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[79] *See* Decls. of Fairborz Pakseresht ¶¶ 29-32; Susan Fanelli ¶ 40; Sarah Neville-Morgan ¶¶ 19-20; Mari Cantwell ¶ 41; Alexis Carmen Fernández ¶¶ 32-36; Antonia Jiménez ¶ 17; Patrick Allen ¶¶ 55, 86-88; ; Michelle Probert ¶ 16; Mila Kofman ¶¶ 13, 16-18; Melisa Byrd ¶¶ 22-23; Lindsey Palmer ¶¶ 13, 15, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Decls. of Grace B. Hou; S. Duke Storen, *Washington* (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

[80] *See also* Decls. of Erin Emerson; Grace B. Hou, *Washington*, (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

[81] *See* Mostofi Decl. (during February 2020, calls to New York City's immigration-related telephone hotline "increased to 2,973, a 57% increase from the monthly average in 2019," and the "number of those calls that related to the Rule also increased"); Aguilar Decl. (health educator received "more questions about public charge" during February and March than she had ever previously received), *New York*, (S.D.N.Y. Apr. 28, 2020).

[82] Rachel Schwab, et al., *Federal Policy Priorities for Preserving and Improving Access to Coverage: Perspectives from State-Based Marketplaces*, The Common Wealth Fund (Feb. 17, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/federal-policy-priorities-preserving-coverage-state-based-marketplaces

frequently, enrolling at times of great need and disenrolling to avoid risks or due to confusion, will increase the States' administrative costs.[83] Churn increases operational costs for programs like school lunch and WIC, as decreasing Medicaid and SNAP enrollment make it harder to certify eligibility.[84] And gaps in coverage from federally funded programs like Medicaid and SNAP increase stress on state- and locally-funded safety net providers. Healthcare providers of last resort will end up responsible for more costly, uncompensated emergency room care. Those who decline SNAP for fear of being deemed a public charge often turn to emergency food assistance programs, such as food pantries.[85] Those facilities must then employ more resources to keep up with demand, and in some places, they have had to close.[86]

In turn, reduced access to and lower quality of healthcare and nutritional services resulting from changes like the 2019 Rule will lead to long term costs and harms for the States and their residents. Reductions in benefits usage reduce revenues for healthcare providers participating in Medicaid,[87] including public healthcare facilities.[88] Interruptions in access to healthcare, especially primary and preventive care, lead to worse health outcomes for patients, such as increases in unintended pregnancies (which tend to have higher rates of adverse maternal and child outcomes than planned pregnancies), spread of infectious diseases, and decreasing early diagnosis and treatment of conditions such as cancer.[89] These public health harms, in turn, cause

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[83] *See* Cisneros Decl. Ex K at 57. Cisneros Decl. Ex. R at 4-5, Ex L at 1; Ex B at 2.

[84] *See, e.g.,* Decls. of Cathy Buhrig II (Medicaid); Patrick Allen; Michelle Probert; Melissa Byrd; Doug McKeever; Cathy Buhrig I (SNAP); and Mila Kofman, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975).

[85] *See* Newton and Heinrich Decls.; *see also* Decl. of Theo Oshiro, *New York*, (S.D.N.Y. Apr. 28, 2020) (Make the Road New York has been receiving many calls from immigrants seeking food assistance, including from food pantries).

[86] *See* Newton Decl.; see Heinrich Decl. (food banks and pantries are facing increased food costs and "new challenges for accepting donated food"); Benito Decl. (many food pantries in Chicago, Illinois have "either closed or are seeing a marked increase in requests for food assistance").

[87] 83 Fed. Reg. at 51,118; *see* Decls. of Doug KcKeever and Colleen Chawla, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Decl. of Grace B. Hou, *Washington* (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

[88] Appellees' Answering Br. 30, *New York* (2d Cir. Jan. 24, 2020) (No. 19-3591).

[89] *See, e.g.*, Decls. of Mari Cantwell; Patrick Allen; Jodi Hicks; David H. Aizuss; Charity Dean; Dr. Gary Gray; and Carmela Coyle, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Decl. of Lacy Fehrenbach, *Washington* (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

economic harm to the States, the insurers of last resort for most low-income populations.[90] The 2019 Rule also reduces economic activity and educational attainment.[91]

## V. ANY BENEFITS DHS CONSIDERS IN A PUBLIC CHARGE ANALYSIS SHOULD BE LIMITED, EXPLICIT, AND NOT UNDERMINE THE INTERESTS OF STATES IN PROMOTING PUBLIC HEALTH AND WELFARE

Any public charge analysis should consider at most a narrow and explicit category of federal benefits that may be indicative of primary and permanent dependence on the government for basic subsistence. Limiting consideration of such benefits in any analysis is not only consistent with the long-established meaning of public charge and decades of public charge policy prior to the 2019 Rule, but also critical to States' efforts to safeguard public health and welfare, and to further State policy goals. Based on our recent experiences, DHS should limit and explain the public benefits it intends to consider in the following ways.

First, DHS should not consider any additional benefits in a public charge determination beyond those included in the longstanding 1999 Field Guidance. As explained in Section I above, after Congress passed welfare reforms, INS issued guidance making clear that non-cash benefits (other than institutionalization for long-term care) should not be considered in any public charge determination because "participation in such non-cash programs is not evidence of poverty or dependence."[92] In so doing, the 1999 Field Guidance adhered to the historical understanding that "public charge" has only encompassed specific types of public assistance: namely, long-term support for the subsistence of an individual who is unable to provide for himself and is thus primarily dependent on public resources. The pandemic illustrates how crucial supplemental benefits like Medicaid and SNAP are to helping working individuals through sudden shocks like losing a job or incurring substantial medical bills for COVID-19 treatment.[93] Indeed, since 1999, many States have taken advantage of new opportunities offered by the Affordable Care Act to make Medicaid coverage broadly available to working adults. Any consideration of additional benefits beyond those included in the 1999 Field Guidance would run counter to the long-standing meaning of public charge incorporated into the INA described above.

Second, DHS should explicitly enumerate all public benefits that it may consider in making public charge determinations and make clear that it will not consider the application for

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[90] *See, e.g*., Decls. of Mari Cantwell; Cathy Buhrig I (Medicaid); Patrick Allen; and Carmela Coyle, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Decls. of Joshua Sharfstein; Judith Persichilli, *Washington* (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

[91] *See, e.g.,* Decls. of Laurel Lucia; Alexis Carmen Fernandez; and Cathy Buhrig II (SNAP); and Fariborz Pakseresht, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975); Decls. of Elisa Neira; Jovon Perry; Sarah K. Peterson, *Washington* (E.D. Wash. Sept. 6, 2019) (No. 19-cv-05210).

[92] 64 Fed. Reg. at 28,692.

[93] *See* Ku, Mostofi, Newton, and Benito Decls., *New York*, (S.D.N.Y. Apr. 28, 2020).

or receipt of any other current or newly created benefits (absent further rulemaking and robust public communication). As discussed above, the 2019 Rule drove immigrants and their families to forgo and disenroll from critical public assistance benefits, including both the benefits expressly covered by the 2019 Rule, and also benefits that were beyond its express scope. This predictable chilling effect—that DHS itself acknowledged in promulgating the 2019 Rule—resulted in economic and public health harms to the States. To ameliorate these chilling effects, any public charge policy should clearly enumerate the public benefits DHS intends to consider. The need for clarity is exemplified by the significant confusion and anxiety that was caused by the mixed messaging issued by DHS in its attempts to limit the application of the 2019 Rule during the COVID-19 pandemic, described in Section III above.

Third, DHS should not include consideration of any state benefits in a public charge determination, because doing so would undermine State policy goals and frustrate a consistent, predictable application of public charge determinations. The undersigned States are charged with safeguarding the public health and promoting the welfare of the people in their jurisdictions. To that end, States make independent public policy determinations, including with respect to providing public benefits to all individuals within their jurisdictions regardless of immigration status. For example, California has expanded Medi-Cal (its version of Medicaid) to all low-income children, all eligible undocumented young adults up to the age of 26, and undocumented Californians ages 50 and over.[94] New York has expanded Medicaid to cover pregnant women and individuals for emergency services regardless of immigration status, and offers health insurance programs to provide coverage to children who are ineligible for Medicaid, including undocumented children.[95] Illinois offers health benefits to low income non-citizens ages 65 and over who do not qualify for Medicaid due to immigration status even if they are undocumented, as well as to eligible minors under the age of 18 regardless of immigration status and immigrants receiving kidney transplants.[96] Many states also provided economic benefits during the COVID-19 pandemic regardless of immigration status. For example, New York provided emergency rental assistance to help low and moderate-income households at risk of experiencing homelessness or housing instability regardless of immigration status.[97] Illinois dedicated $20 million in pandemic-related emergency assistance funding to Illinois immigrants—regardless of immigration status—who are facing unemployment, loss of income, medical costs, and food and housing insecurity as a result of COVID-19.[98] Any consideration of state benefits would add

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[94] Cal. Welf. & Inst. Code § 14007.8, as amended by Stats. 205, c. 709 (S.B.4), § 2, eff. Jan. 1, 2016.

[95] N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.2(j); N. Y. Pub. Health L. § 2511.

[96] 89 Ill. Adm. Code 118.700, *et seq.*; 89 Ill. Adm. Code 118.500; 305 ILCS 5/5-5.

[97] *See* New York State, Office of Temporary & Disability Assistance, Emergency Rental Assistance Program, https://otda.ny.gov/programs/emergency-rental-assistance/.

[98] *See* Ill. Dep't of Human Servs., *COVID-19 Resources for Immigrants and Refugees* (https://www.dhs.state.il.us/page.aspx?item=124373; *see also* 2021 Or. Laws H.B. 5025 A

unwarranted consequences that would undermine the public health and welfare goals of these States' policies. Additionally, because public health and welfare policies are not uniform throughout the States, any attempt to include state benefits would frustrate the administrability and uniformity of public charge determinations throughout the country.

Fourth, in implementing any new public charge policy, to minimize additional chilling effects, DHS should ensure that its policy and all related communications are consistent and accessible to the public. This could also include limiting the scope of the public charge determination to a short, easy to measure look-back period for consideration of any public benefits that are considered relevant. DHS should clearly communicate which non-citizens are covered and which are not, and should publish lists or a table that clearly enumerates which benefits are not included in the public charge analysis, including, for clarity, benefits that have never been part of public charge, such as earned cash benefits like unemployment insurance, state disability insurance, and paid family leave. Prioritizing communication is very important given that any changes to public charge policy will undoubtedly lead to misinformation about which benefits will impact a non-citizens ability to enter the U.S. or adjust their immigration status. Uncertainty creates preventable access barriers to crucial benefits. Effective means of communication include, but are not limited to, coalition building with stakeholders, state and local governments; outreach events; media information, such as informational pamphlets, social media content, and public service announcements available in multiple languages.

## VI. DHS SHOULD MODIFY PUBLIC CHARGE POLICY TO PROVIDE EXEMPTIONS OR ACCOMMODATIONS FOR INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1974 provides that no individual "shall solely, by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination" under any activity conducted by a federal agency.[99] This provision prohibits DHS from subjecting an applicant to "a more onerous condition" based solely on disability[100]—including, as DHS's own regulation provide, different "criteria or methods of administration."[101] Moreover, individuals with disabilities "must be provided with meaningful access to" the relevant benefit and programs, and "to assure [such] meaningful access, reasonable accommodations in the [relevant] program or benefit may have to be made."[102] The 2019 Rule ran afoul of these principles by effectively excluding individuals with a

(increasing Oregon's budget for emergency medical care for non-citizens who need kidney transplants).

[99] 29 U.S.C. § 794(a).

[100] *Henrietta D. v. Bloomberg*, 331 F.3d 261, 276 (2d Cir. 2003).

[101] 6 C.F.R. § 15.30(b)(4).

[102] *Alexander v. Choate*, 469 U.S. 297, 301 (1985).

wide range of disabilities from admissibility, even if they had stable incomes and even if their disabilities could be reasonably accommodated.

Any public charge policy that automatically considers disability as a negative factor in a public charge assessment would stand in substantial tension with Section 504. Instead, DHS should recognize and accommodate the disparate impact that public charge policy may have on individuals with disabilities. DHS should carefully consider the animating purposes of Section 504 when crafting public charge policy, especially for those individuals who may be at risk of institutionalization but are able to live independently with appropriate support.

## VII. DHS SHOULD AVOID CAUSING DISPROPORTIONATE HARM TO NON-WHITE IMMIGRANTS

Finally, we note our concerns that the 2019 Rule was motivated by an intent to exclude non-White and non-wealthy immigrants. A predictive study analyzing the 2019 Rule's impact found that that immigrants of color, namely Mexicans and Central Americans, would be at substantially higher risk of receiving a public charge determination even though their rate of public benefits use is not particularly high.[103] The 2019 Rule's bright-line thresholds for income alone would disproportionately impact non-White, non-European applicants, particularly Latinos.[104] Commentary by prior senior administration officials indicates that reducing non-white immigration was indeed an objective.[105] We urge DHS to reject the 2019 Rule and its prior findings on this basis as well.

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In conclusion, the States urge DHS and USCIS to take swift action to propose and promulgate a new rule that restores the well-established and historic narrow meaning of "public charge." Such a rule would be consistent with the public interest and help the States in their efforts to protect the health, safety, and well-being of their residents.

Sincerely,

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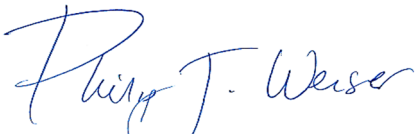
[103] Jennifer Van Hook and Kendal Lowrey, *Standing on Their Own Two Feet: How the New Public Charge Rules Could Impact Non-European LPR Applicants*, Population Research and Policy Review, 1-24 (Mar. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8010279/pdf/11113_2021_Article_9648.pdf.

[104] *Id.*

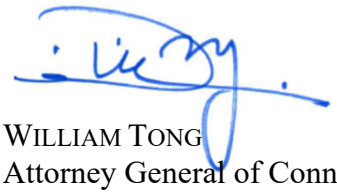
[105] *See Cook Cty. v. Wolf*, 461 F.Supp.3d 779 (N.D. Ill. 2020) (noting that plaintiffs plausibly alleged that "DHS issued the [2019] Rule knowing and intending that it would have a disproportionate negative impact on nonwhite immigrants").

ROB BONTA
Attorney General of California

LETITIA JAMES
Attorney General of New York

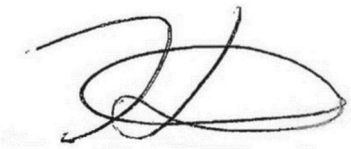


PHILIP J. WEISER
Attorney General of Colorado



WILLIAM TONG
Attorney General of Connecticut

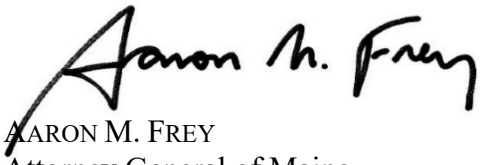
KATHLEEN JENNINGS
Attorney General of Delaware



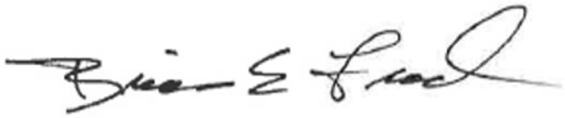
KARL RACINE
Attorney General of the District of Columbia

CLARE E. CONNORS
Attorney General of Hawaii

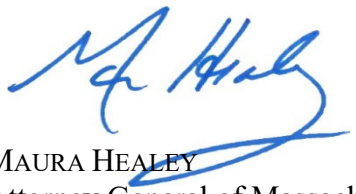
KWAME RAOUL
Attorney General of Illinois



AARON M. FREY
Attorney General of Maine



BRIAN E. FROSH
Attorney General of Maryland



MAURA HEALEY
Attorney General of Massachusetts

DANA NESSEL
Attorney General of Michigan

KEITH ELLISON
Attorney General of Minnesota

ANDREW J. BRUCK
Acting Attorney General of New Jersey

HECTOR BALDERAS
Attorney General of New Mexico

ELLEN F. ROSENBLUM
Attorney General of Oregon

JOSH SHAPIRO
Attorney General of Pennsylvania

PETER F. NERONHA
Attorney General of Rhode Island

THOMAS J. DONOVAN, JR.
Attorney General of Vermont

MARK R. HERRING
Attorney General of Virginia

BOB FERGUSON
Attorney General of Washington