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April 25, 2022

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

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

RE: Notice of Proposed Rulemaking: "Public Charge Ground of Inadmissibility" [RIN: 1615-AC74; CIS No. 2715-22; DHS Docket No. USCIS-2021-0013]

Dear Secretary Mayorkas and Director Jaddou:

The undersigned Attorneys General of California, New York, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, Vermont, 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) Notice of Proposed Rulemaking, "Public Charge Ground of Inadmissibility," proposing regulations for determining whether a noncitizen is inadmissible to the United States under Section 212(a)(4) of the Immigration and Nationality Act (INA) because they are likely at any time to become a public charge.[1]

As the States explained in litigation challenging the prior federal administration's rulemaking,[2] the 2019 Rule, 84 Fed. Reg. 41,292 (Aug. 14, 2019), was contrary to law and an

[1] 87 Fed. Reg. 10,570 (Feb. 24, 2022) (hereinafter "the Proposed Rule").

[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. 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 the 2019 Rule).

unreasonable and arbitrary interpretation of Section 212(a)(4) of the INA.[3] Although the 2019 Rule was 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. These burdens only intensified during the COVID-19 pandemic, when the 2019 Rule hobbled the States' ability to respond as effectively as possible to the health and economic needs of our residents. The States therefore commend DHS for proposing to construe "public charge" in a manner that is consistent with the well-established judicial and administrative interpretation of that term. We urge the federal government to move expeditiously to finalize the Proposed Rule to mitigate harms caused by the 2019 Rule.

As described below, the States retain a strong interest in ensuring that the federal government's interpretation of the INA and the public charge rule do not disrupt state operations or the provision of public benefits for all the States' residents, including immigrants and their families, in times of need. We request that DHS consider our prior comments in response to the 2021 Advance Notice of Proposed Rulemaking (the "Advance Notice"), 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 finalizing the current regulation.[5]

I. THE PROPOSED RULE IS CONSISTENT WITH THE WELL-SETTLED MEANING OF "PUBLIC CHARGE"

As we explained in our comment on DHS's Advance Notice, 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.[6] We agree with DHS's decision to withdraw support for the 2019 Rule and the conclusion in the Proposed Rule that the "primarily dependent" standard is consistent with the well-settled meaning of public charge, as described below.[7] We encourage DHS to further clarify that temporary use of any benefits relevant to a public charge determination does not render an individual primarily dependent on the government for subsistence.

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[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).

[6] State of California & State of New York, et al., Comment Letter on Anticipated Notice of Proposed Rulemaking at 2-5 (Oct. 22, 2021), (hereinafter "State Advance Notice Comment"), https://www.regulations.gov/comment/USCIS-2021-0013-0116.

[7] 87 Fed. Reg. at 10,606.

We also commend DHS for making clear in the proposed rule that non-cash benefits (other than institutionalization for long-term care) will not be considered in any public charge determination. As we explained in our comment to the Advance Notice, such an approach is consistent with the 1999 Guidance and adheres to the historical understanding that "public charge" has only encompassed specific types of public assistance: namely, long-term support for the subsistence of a person who cannot provide for themself and is thus primarily dependent on public resources.[8]

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 federal immigration agencies consistently applied—until the 2019 Rule. Under that well-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.[9]

Congress first incorporated the term "public charge" into federal law[10] to address concerns about European governments sending "undesirable" individuals who would permanently rely 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.[11] "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."[12]

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[8] State Advance Notice Comment at 19.

[9] *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.

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

[11] *Id.*

[12] 13 Cong. Rec. 5109 (statement of Rep. Van Voorhis) (emphasis added).

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."[13] 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."[14] This federal immigration fund was used in part "for protecting and caring for" immigrants from "when they arrive…until they can proceed to other places or obtain occupation for their support."[15]

From 1891 to 1951, Congress repeatedly reenacted public charge provisions substantially similar to the one in the 1882 Act.[16] Throughout that period, the scope of the term "public charge" remained limited to the few individuals who were not just poor but unable to support themselves and were thus likely to depend almost entirely on the government for subsistence.[17] "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.[18]

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.[19] Congress understood that "public charge" was a term of art that had been interpreted and applied in court and agency decisions and to 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

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[13] *Id.* at 5108.

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

[15] 13 Cong. Rec. 5106 (1882) (Rep. Reagan).

[16] *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.

[17] *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").

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

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

depended primarily on public support to survive long term,[20] not working immigrants who might receive modest amounts of public assistance.[21]

In 1996, Congress directed INS to consider certain factors in making public charge determinations—i.e., an immigrant's age, health, family status, financial resources, and education and skills.[22] 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 the meaning of "public charge" in the deportability context to mean receipt of any supplemental benefits within 12 months.[23] And in 2013, 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.[24] 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 limited to 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 benefit programs for which they remained eligible, INS issued guidance (the "1999 Field Guidance") that formally acknowledged this primarily dependent standard and 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."[25] In so doing, INS consulted "extensively" with agencies charged with administering public benefit programs.[26] 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 on the government for subsistence, 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."[27]

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

[21] *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.").

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

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

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

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

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

[27] 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

B. The Proposed Rule is Consistent with Legislation Regarding Benefits Designed to Promote Public Health and Boost Economic Mobility.

We agree with DHS that its 2022 proposed definition of public charge is consistent with how Congress has legislated eligibility for means-tested benefits programs.[28] As explained in our comments to the Advance Notice, the 2019 Rule's interpretation of "public charge" was well outside that established term of art for three reasons.

First, as Congress and the 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 with a need for temporary assistance who have "incomes far above the poverty level."[29] The supplemental benefits targeted by the 2019 Rule were thus not limited to individuals who are unable to work and primarily dependent on the public for their subsistence. To the contrary, in the undersigned jurisdictions, a large majority of adult Medicaid recipients work.[30] Nor do those targeted benefits —even cumulatively—provide support sufficient to constitute an adult's primary means of survival.[31] Accordingly, we agree with DHS's determination in the Proposed Rule that such supplemental benefits should not be considered in any public charge analysis.[32]

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 benefit use, meant that noncitizens would be considered "public charges" based on the likelihood of using multiple

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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").

[28] 87 Fed. Reg., at 10,607. While we acknowledge that courts have disagreed about the level of clarity with which Congress spoke in the public charge statute, *see, e.g.*, *Cook Cty. v. Wolf*, 962 F.3d 208, 226 (7th Cir. 2020), DHS's proposed interpretation is well within the bounds of reasonableness.

[29] 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).

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

[31] *See New York v. United Stated Dep't of Homeland Sec.*, 969 F.3d 42, 83-84 (2d Cir. 2020) (explaining that the goals and eligibility criteria of the targeted programs demonstrate that they provide supplemental rather than subsistence support).

[32] 87 Fed. Reg. at 10,608-11.

benefits—however de minimis the amount or duration—to address an acute period of financial strain or emergency.[33] 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 residing in 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 government.[34] As DHS now properly acknowledges in the Proposed Rule, 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.[35]

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) supported the 2019 Rule. None of the Welfare Reform Act'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 deemed inadmissible to the United States in the first instance by drastically expanding the established understanding of "public charge." Specifically, the Welfare Reform Act's policy statements did not relate to the threshold meaning of "public charge." Instead, 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.[36] Furthermore, in the Welfare Reform Act Congress expressly gave *states*—not federal immigration agencies—authority to decide whether to provide additional state-funded public benefits to noncitizens.[37] The same Congress 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 a de minimis amount of public benefits within a short time period.[38] And,

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

[34] 64 Fed. Reg. at 28,678; *see id.* at 28,687 (SSI protects "vulnerable people . . . from complete impoverishment").

[35] *See e.g.*, Fed. Reg. at 10,606-07.

[36] 8 U.S.C. § 1601.

[37] *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).

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

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.[39] Indeed, importing the 1996 Act's policy statements into the public-charge provision would conflict with Congress's judgment in the Welfare Reform Act.

II. THE PROPOSED RULE'S CLARIFICATIONS TO THE 1999 GUIDANCE ARE REASONABLE

We commend DHS for explicitly enumerating all federal public benefits that it may consider in making public charge determinations consistent with the 1999 Guidance. We also agree with DHS that defining "receipt (of public benefits) separately" provides important clarity.[40] As we raised in our comment to the Advance Notice, *supra* note 6, 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. DHS's proposal to explicitly list the public benefits it may consider is critical to ameliorate these chilling effects.[41]

Relatedly, we applaud DHS's efforts in the Proposed Rule to make clear which non-citizens are covered by public charge determinations and which are not, and which benefits are not included in the public charge analysis.[42] As we explained in our comment to the Advance Notice, clear rules for how to apply the rule and prioritizing communication are vital given that any changes to public charge policy will lead to misinformation about which benefits will impact a non-citizen's ability to enter the U.S. or adjust their immigration status.[43] Uncertainty creates preventable access barriers to crucial benefits. It also leaves too much discretion in the hands of individual federal immigration officials. We encourage DHS to continue prioritizing communication easy to apply rules and clear communication as it finalizes the proposed regulation. Effective means of communication include, but are not limited to, coalition building with stakeholders, state and local governments; outreach events; and media information, such as informational pamphlets, social media content, and public service announcements available in multiple languages.

The States also strongly agree with DHS's statement that "the presence of a disability alone is not a sufficient basis to determine whether a noncitizen is likely at any time to become a public charge."[44] Proposed section 212.22(a)(4) is both a reasonable and necessary implementation of Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability by federal agencies like DHS. The States suggest that DHS provide further

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[39] *See* S. Rep. No. 113-40, at 42 (2013).
[40] 87 Fed. Reg. at 10,615.
[41] State Advance Notice Comment at 19-20.
[42] *See, e.g.*, 87 Fed. Reg. at 10,583-84; *id.* at 10,602-05; *id.* at 10,669-70.
[43] State Advance Notice Comment at 21.
[44] 87 Fed. Reg. at 10,620.

examples to clarify what is meant by "disability alone." For example, many States offer Medicaid programs that are available to working individuals with disabilities for whom "risk of institutionalization" is an eligibility criterion, but who use those programs to purchase home and community-based services to avoid institutionalization. DHS should confirm that enrollment in such a program on the basis of disability is not sufficient basis for an adverse public charge determination.

III. We Urge DHS to Exclude Consideration of State Benefits From Any Public Charge Determination

The States appreciate DHS's clarification that special purpose and earned benefit cash assistance programs would not be considered in public charge inadmissibility determinations.[45] 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. These benefits include economic benefits. For example, Vermont enacted a first-in-the-nation program to provide COVID-19 stimulus funding for immigrants not eligible to receive federally funded stimulus checks.[46] New York and New Jersey have provided emergency rental assistance to help low- and moderate-income residents at risk of experiencing homelessness or housing instability regardless of immigration status.[47] Illinois has dedicated $20 million in pandemic-related emergency assistance funding to 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.[48]

As we raised in our comment to the Advance Notice, we encourage DHS to exclude consideration of all state benefits in a public charge determination. Considering any state benefits in the public charge analysis could undermine the States' policy goals and frustrate a consistent, predictable application of public charge determinations.[49] As DHS itself acknowledges, the provision of and administration of state benefits vary across jurisdictions.[50] Any consideration of state benefits in a public charge determination would add unwarranted consequences to the receipt or use of such benefits, thereby undermining the public health and welfare goals of the

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[45] *See, e.g.*, 87 Fed. Reg. at 10,613.

[46] *See* State of Vermont, Agency of Administration, *Submission of 2020 Act 154 Sec. B.1122(g)(2) Report, "Economic Stimulus Equity Fund,"* (Apr. 30, 2021), *https://aoa.vermont.gov/sites/aoa/files/InfoReportReleases/Economic%20Stimulus%20Equity%20Fund%20Report%20per%202020%20Act%20154%20Sec.%20B.1122%28g%29%282%29%204-30-21.pdf*.

[47] *See* New York State, Office of Temporary & Disability Assistance, Emergency Rental Assistance Program, https://otda.ny.gov/programs/emergency-rental-assistance/; New Jersey Dept. of Community Affairs, COVID-19 Emergency Rental Assistance Program, https://njdca.onlinepha.com/.

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

[49] State Advance Notice Comment at 20-21.

[50] 87 Fed. Reg. at 10,612.

States' policies – and adding confusion as to how the rule will be applied. Additionally, because public health and welfare policies are not uniform, any attempt to include state benefits in the public charge analysis would frustrate the administrability and uniformity of public charge determinations throughout the country.

IV. THE PROPOSED RULE WILL HELP AMELIORATE UNWARRANTED CHILLING EFFECTS ON PUBLIC BENEFIT USE

The States agree that the Proposed Rule will help "mitigate the possibility of widespread 'chilling effects' with respect to individuals disenrolling or declining to enroll themselves or family members in public benefit programs for which they are eligible, *especially by individuals who are not subject to the public charge ground of inadmissibility*."[51]

As explained in our Advance Notice comments, the 2019 Rule (and leaked preliminary drafts of the 2019 Rule and related federal actions) caused significant chilling effects on participation in public benefit programs, impacting programs that DHS technically carved out (like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) and deterring even those whom Congress has exempted from the public charge ground of inadmissibility (like refugees and asylum seekers) and those who would never be subject to it (e.g., children of immigrants who are U.S. citizens). Experts and community groups warned that the 2019 Rule would have these types of chilling effects, posing serious consequences for vulnerable groups. DHS itself predicted some of this result when it estimated that the 2019 Rule's expanded criteria for inadmissibility would chill participation and cause a 2.5% reduction in Medicaid enrollment by individuals in households with a noncitizen[52] and up to a $4.37 billion loss in federal Medicaid payments to states.[53]

The available evidence suggests that DHS significantly underestimated the 2019 Rule's disenrollment and chilling effects, despite significant mitigation efforts undertaken by the States and the complicating factor of the pandemic and its effect on the health and well-being of residents. This is no surprise: the 2019 Rule generally failed to quantify or weigh the impact that chilling effects would have on immigrants who were not subject to it or their participation in both state and federal public benefit programs that are ostensibly exempted from consideration under the Rule.[54] It did so even though the record before the agency amply demonstrated the

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[51] 87 Fed. Reg. at 10,571 (emphasis added).

[52] 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#/.

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

[54] For example, Lawful Permanent Residents (LPRs), "green card" holders, are subject to public charge determinations when seeking admission. *Compare* Cisneros Decl. Ex. A at 15-16

likelihood of such chilling effects and the serious health consequences associated with avoidance of health, nutritional, and housing supports.[55]

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 jeopardize their ability to obtain LPR status and, eventually, citizenship.[56] Immigrants increasingly began to decline use of SNAP benefits, as well as other nutrition programs, such as WIC, that are not implicated in the public-charge analysis,[57] leading to a "nationwide decrease of approximately 260,000 enrollees in child Medicaid and 21,000 enrollees" in WIC.[58] 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.[59] More than one-quarter of immigrant parents likely eligible for nutrition programs reported that they stopped using SNAP or other food programs between 2018 and 2020 due to immigration-related concerns, a pattern echoed by nutrition service providers.

The States' benefit-granting agencies report that because the public charge formula in the 2019 Rule was so complex and layered, it was extraordinarily difficult even for service providers to understand whether or how it applied. Confusion and fear caused many people to avoid benefits, even potentially life-saving benefits like medical care during the pandemic.[60] 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

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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.

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

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

[57] *See* Newstrom Decl.. Decls. of Janet Heinrich 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.

[58] 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.

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

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

risk of being deemed a "public charge" under the Rule.[61] In particular, the 2019 Rule led to avoidance of primary care. Despite healthcare workers' efforts to ensure that primary care clinics were "safe spaces," they remained underutilized due to fear, misinformation, and misperceptions about the availability of coverage and implications of immigration policies.[62]

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."[63] It was often 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.[64] Forty-three percent of those who avoided public programs over concerns about negative effects 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 caused substantial fear and confusion.[65] 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."[66] That data entirely undercut DHS's 2019 assertion that it would ameliorate this confusion through its public information channels.[67]

Regardless of whether DHS's 2019 or 2022 estimates of disenrollment impacts are used, the chilling effects caused by the 2019 Rule vastly exceed the Rule's direct effects on public charge inadmissibility determinations.[68] DHS correctly notes that "there is little overlap between

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[61] *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), Kennedy Decl., *New York,* (S.D.N.Y. Apr. 28, 2020).

[62] 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/.

[63] 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.

[64] *Id*.

[65] *Id*.

[66] 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.

[67] 84 Fed. Reg. at 41,470 (Aug. 14, 2019).

[68] 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).

the population regulated by the 2019 Final Rule and the public benefits considered in public charge inadmissibility determinations under the 2019 Final Rule." 87 Fed. Reg. at 10,588. There is no reason to believe that Congress intended to drive individuals who are exempt from public charge determinations, including U.S. citizen children, away from benefits for which they are eligible; avoidance of these disenrollment effects strongly favors the Proposed Rule over the 2019 Rule.

V. THE PROPOSED RULE WILL ALLOW STATES TO BETTER RESPOND TO COVID-19 AND FUTURE PUBLIC HEALTH EMERGENCIES

Since the 2019 Rule was promulgated, a global pandemic has starkly illustrated the unnecessary barriers and complications the Rule imposed on the States' public health operations. In fact, the prior administration acknowledged the likelihood that the 2019 Rule would worsen infectious disease outbreaks.[69] But the 2019 Rule's implementation during an historic pandemic led to new facts showing that the risk of such outbreaks is much more serious than DHS anticipated. COVID-19 has afflicted more than 80 million people in the United States with a potentially lethal illness, resulting in more than 987,000 deaths.[70] It has caused a nationwide public health crisis and wreaked havoc on the economy. Federal, state, and local authorities, including the States, have undertaken extraordinary efforts to reduce the spread of COVID-19 and protect the health and well-being of our residents. But none of these was sufficient to remedy the pernicious effects of the 2019 Rule, which caused vulnerable populations to avoid medical services for fear of negative immigration effects.

There is no reason to think that Congress's immigration laws have ever been aimed at or concerned with restricting states' provision of emergency relief in the face of public health disasters like a pandemic. To the contrary, all COVID-19 relief programs fall squarely within the discretion that Congress has afforded states to create new public benefits that are available to residents in need.[71] As described below, the 2019 Rule impeded the public health responses to the COVID-19 pandemic, and the Proposed Rule will better assist public health and recovery efforts in the face of such crises in the future.

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[69] *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").

[70] Ctrs. for Disease Control and Prevention, *Covid Data Tracker*, https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days (last checked April 22, 2022).

[71] *See, e.g.,* 8 U.S.C. § 1621(d).

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

As described in Section IV 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 crucial.

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 to obtain publicly-funded care, due to the substantial fear generated by the 2019 Rule.[72] Uninsured individuals are much less likely to obtain necessary treatment for COVID-19 because of the prohibitive costs of medical care and hospital stays.[73]

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.[74] But these conditions put patients at higher risk of suffering severe symptoms or death from COVID-19.[75] 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.[76]

B. DHS's COVID-19 Exemptions to the 2019 Rule 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 in immigrant communities needing to access public health services and other benefits during the pandemic.

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

[73] *See id*. 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.

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

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

[76] *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).

On March 13, 2020, USCIS issued an alert that purported to address 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, under the 2019 Rule, a noncitizen immigrant who applied for federally-funded Medicaid would have been penalized for having done so 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 the 2019 Rule's meaning of "public charge" would apply to someone who received Medicaid-funded medical treatment for COVID-19-like symptoms if that applicant was never tested or confirmed to be COVID-19 positive—even as the country faced significant shortage of testing kits. And under the alert, a noncitizen immigrant continued to be penalized in a public charge analysis 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 to discern or control whether federal, state, or local benefits apply—especially if they may have required urgent or emergency care. Moreover, the alert provided little certainty, as it could be withdrawn as quickly as it was issued.

Even after DHS posted the alert on its website in 2020, 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.[77] 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

[77] *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).

Health Insurance Program, SNAP, or housing assistance, because of concerns about future LPR (or "green card") applications.[78]

C. The Proposed Rule Will Better Assist Public Health and Relief Efforts During COVID-19 and Other Crises.

Conversely, the Proposed Rule's anticipated positive effect on healthcare enrollment, including in Medicaid and other publicly-funded and administered health insurance programs like the Affordable Care Act (ACA), will leave the States in a better position to respond to COVID-19 and future public health crises. Health insurance coverage affects access and use of primary care services, which are crucial in responding to infectious disease outbreaks. Those without a primary care doctor are less likely to access vaccinations or other preventive health services, making public health responses to infectious diseases more difficult.[79] Testing and medical treatment for diseases like COVID-19 are critically important to slowing infection rates, preserving hospital capacity and medical equipment, and saving lives.[80] 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.[81] 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.[82] And according to the National Institutes of Health, "fear of seeking out health care during the pandemic" may well have been a cause of excess (non-COVID) deaths in 2020.[83]

All these public health harms have been heightened during the pandemic because immigrants made 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

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[78] 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.

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

[80] *See* Ku Decl., Decl. of Oxiris Barbot, MD, *New York,* (S.D.N.Y. Apr. 28, 2020).

[81] *See* Almasude, Kennedy, Ku and Moreno Decls., *New York,* (S.D.N.Y. Apr. 28, 2020).

[82] *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").

[83] 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.

building cleaners.[84] 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.[85] These workers are more likely to be exposed to the virus, and, without adequate testing and treatment, are more likely to suffer worse health outcomes and inadvertently spread the virus to others.[86]

The COVID-19 pandemic also demonstrates the value of the Proposed Rule's exclusion of supplemental benefit programs that allow recipients to weather economic hardship, and are well-suited for moments of temporary crisis.[87] In April 2020, the unemployment rate reached 14.8% nationwide, the highest rate observed since the federal government began collecting such data in 1948.[88] And the number of individuals seeking unemployment benefits steeply increased.[89] Immigrant workers, particularly in the hospitality and service industries, were disproportionately impacted by layoffs and furloughs.[90]

Supplemental benefits (like Medicaid and SNAP) provide help for working individuals undergoing sudden shocks like losing a job or incurring substantial medical bills during a pandemic, and workers should be able to turn to these programs without fear until they can get back on their feet.[91] For example, many workers who lost their jobs and their employer-sponsored health insurance because of COVID-19 were likely to need Medicaid coverage until they found another job.[92] 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.[93] But community perceptions of the 2019 Rule hampered the effectiveness of these programs. In California, for example, state agencies report that public charge fears caused rural farmworker communities to be 50% less likely to apply for needed COVID-19 emergency housing relief compared to urban areas, despite

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

[85] *See* Benito, Kennedy and Voit Decls., *New York,* (S.D.N.Y. Apr. 28, 2020).

[86] *See* Ku and Almasude Decls., *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).

[87] *See id*.

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

[89] *Id.*

[90] *See* Mostofi Decl. (immigrants in New York have lost jobs in restaurants and as domestic workers) and Benito Decl. (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).

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

[92] *See id*.

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

significant effort by state agencies and local partners. Overall, 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.

VI. THE PROPOSED RULE WILL REDUCE UNNECESSARY COSTS TO STATE OPERATIONS AND AGENCIES

Compared to the 2019 Rule, the Proposed Rule will increase access to healthcare and nutritional services, resulting in long-term net benefits for the States and their residents. In the Proposed Rule, DHS describes these impacts as "indirect effects" that "implicate values such as equity, fairness, distributive impacts, and human dignity," but are "difficult to quantify." 87 Fed. Reg. at 10,666.

The States respectfully suggest that these consequences are not abstract value judgments, but are substantial, costly outcomes that justify the Proposed Rule. Abundant evidence in the administrative and litigation records for the 2019 Rule demonstrates the costs and other disadvantages resulting from decreased participation in Medicaid or other impacted programs. Reductions in benefit usage reduces revenues for healthcare providers participating in Medicaid,[94] including public healthcare facilities.[95] 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.[96] The costs of these public health harms, in turn, are born by the States, the insurers of last resort for most low-income populations.[97] The 2019 Rule's negative health consequences also likely resulted in additional downstream costs and harm.[98] Recent research shows that immigrant mothers who participated in prenatal WIC nutritional programs (which were affected by the 2019 Rule's predictable chilling effects despite being exempted from public charge determinations) had higher mean birthweights, and lower

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[94] 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).

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

[96] *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).

[97] *See, e.g.*, Cantwell, Allen, and Coyle Decls.; Decl. of Cathy Buhrig I (Medicaid), *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).

[98] *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).

risk of low birthweight, compared to those who did not participate in WIC.[99] The researchers explain that infant birthweight, in turn, is an important "predictor of children's future health and development," with low birthweight resulting in longer hospitalizations, higher perinatal healthcare costs, and "increased risk for mortality and morbidity, including developmental delays, cerebral palsy, blindness, deafness, and hydrocephaly," and "multiple chronic adult medical conditions" that lead to "high educational and health costs over time," including increased Medicaid spending.[100] In a nation where one out of every four infants is born to an immigrant parent, *id*., these are significant and troubling consequences.

Moreover, disruptions in access to benefits are costly and burdensome to public agencies and state-supported healthcare providers. As more eligible individuals and families cycle on and off benefits more often, enrolling at times of great need and disenrolling to avoid risks or due to confusion, this increased "churn" increases the States' administrative costs.[101] 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 (which may be required by the Emergency Medical Treatment and Labor Act and/or state laws). Those who decline SNAP for fear of being deemed a public charge often turn to emergency food assistance programs, such as food pantries.[102] Those facilities must then employ more resources to keep up with demand, and in some places, they have had to close.[103]

The Proposed Rule's clarification that "receipt" of public benefits means actually receiving benefits (and not applications on another's behalf, or a determination of prospective eligibility) will also alleviate confusion and simplify administrative burdens.[104] Efficient operational costs for programs like school lunch, special education, and WIC sometimes rely on certification of students' eligibility for other benefits, including Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI).[105] The Proposed Rule will make it easier for

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[99] Stephanie Ettinger de Cuba et al., *Prenatal WIC Is Associated with Increased Birth Weight of Infants Born in the United States with Immigrant Mothers*, J. of the Academy of Nutrition and Dietetics (Feb. 2022), available at https://childrenshealthwatch.org/wp-content/uploads/Updated-WIC-Paper.pdf.

[100] *Id*.

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

[102] *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).

[103] *See* Newton Decl.; *see also* 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").

[104] *See* 87 Fed. Reg. at 10,669 (proposing new section 212.21(d)).

[105] *See, e.g.,* U.S. Dept. of Agriculture, Direct Certification on the National School Lunch Program: State Implementation Progress Report to Congress (Oct. 2018), https://www.fns.usda.gov/direct-certification-national-school-lunch-program-report-congress-state-implementation-progress-1; *see also* Buhrig II, Allen, McKeever, Buhrig I Decls. Michelle Probert; Melissa Byrd; Doug McKeever; Cathy Buhrig I (SNAP); and Mila Kofman, *California* (N.D. Cal. Aug. 26, 2019) (No. 19-cv-04975).

school districts and other programs to communicate with families and community members about what is relevant to public charge determinations.

The 2019 Rule's confusion and disenrollment effects undermined the States' efforts to deepen investments in community wellbeing by expanding access to healthcare and emergency aid, 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,[106] and Vermont and New Jersey similarly expanded their Medicaid program to all income-eligible children and pregnant individuals.[107] New York has expanded Medicaid to cover pregnant women and individuals seeking emergency services, regardless of immigration status, and offers health insurance coverage to children who are ineligible for Medicaid, including undocumented children.[108] Illinois also offers health benefits to various groups regardless of their immigration status, including low-income noncitizens ages 65 and over who do not qualify for Medicaid, eligible minors under the age of 18, and immigrants receiving kidney transplants.[109] Yet many mixed status families have not engaged with these programs due to fear caused by the 2019 Rule. Many states also provided economic benefits during the COVID-19 pandemic regardless of immigration status, described in Section III above. The Proposed Rule, in contrast, does not cause the same level of interference with the States' prerogatives to support and invest in these types of new programs.

Supporters of the 2019 Rule cite the cost of state transfer payments associated with increased enrollment in Medicaid,[110] but a simplistic focus on this particular state budget line item disregards the overall fiscal impact of Medicaid coverage. First, the federal government contributes a relatively large proportion of Medicaid funding, and the federal match for working age adults is particularly high. The "sticker price" of Medicaid is also less than its actual fiscal impact on state budgets because higher overall Medicaid enrollment allows states to deliver healthcare services with relative efficiency, to reduce the costs of state-funded health services to the uninsured, and to enjoy increased revenues dues to taxes related to Medicaid expansion or "on the increased economic activity it triggers."[111] Those advocating DHS's return to the 2019

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[106] Cal. Welf. & Inst. Code § 14007.8, as amended by Stats. 205, c. 709 (S.B.4), § 2, eff. Jan. 1, 2016. California is poised to expand coverage even further. *See* Soumya Karlamangla, *California Poised to Extend Health Care to All Undocumented Immigrants*, New York Times (Jan. 12, 2022), https://www.nytimes.com/2022/01/12/us/health-care-undocumented-immigrants.html.

[107] *See* 33 V.S.A. § 2091 *et seq.*; New Jersey Department of Human Services, *Governor Murphy Highlights Cover All Kids Initiative to Provide All New Jersey Kids with Health Insurance*, https://www.nj.gov/humanservices/news/pressreleases/2021/approved/20210330.html.

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

[109] 89 Ill. Adm. Code 118.700, *et seq.*; 89 Ill. Adm. Code 118.500; 305 ILCS 5/5-5.

[110] *See* 87 Fed. Reg. at 10,663.

[111] The Commonwealth Fund, The Impact of Medicaid Expansion on States' Budgets (May 5, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets.

Rule also fail to note that it is jurisdictions that choose to offer more comprehensive access to medical services that are disproportionately affected by both the costs and the benefits associated with increased participation in Medicaid and other public health programs, and most likely to be on the receiving end of individuals crossing state borders for healthcare. Overall, evidence regarding net impacts weighs heavily against any regulatory alternative that would result in widespread chilling effects on potential Medicaid enrollees.

Increased spread of COVID-19 adds to the already-serious additional costs caused by these chilling effects. 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.[112] Delayed healthcare can lead to worsening medical conditions and complications that ultimately will require more expensive medical treatment.[113] The resulting reliance on emergency services burdens the States and their healthcare systems, recreating the problems that states who have chosen to expand Medicaid programs intended to avoid.[114] During the COVID-19 crisis, these consequences are more dire, as uninsured individuals wait to seek medical care until their condition gets serious,[115] further straining hospitals and clinics that may be reaching capacity and facing challenges obtaining ventilators or other medical supplies.

If finalized as proposed (and with the improvements laid out here), the Proposed Rule will alleviate administrative costs to state benefit-granting agencies, which were forced to devote scarce time and resources to attempt to counteract the fear and confusion caused by the 2019 Rule. Although, as DHS notes,[116] the Proposed Rule will take time and effort to explain, the

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[112] Pennsylvania, for example, estimated it would 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.

[113] *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).

[114] 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/.

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

[116] *See* 87 Fed. Reg. at 10,654.

States have largely already conformed their materials to the 2021 implementation of the *Cook County* judgment and rule implementing that judgment. We note that these costs are small in comparison to the time and resources required to help noncitizens navigate the risks and benefits of receiving health or nutrition benefits under the 2019 Rule's complicated provisions.[117] Yet, in the face of the 2019 Rule's leaked drafts and lengthy rulemaking process, 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."[118] As described in Section II above, we therefore urge DHS to work with stakeholders to ensure that any final rule is implemented in a manner that helps undo the 2019 Rule's legacy of fear and mistrust.

* *

The States applaud DHS and USCIS for proposing a regulation that is both consistent with applicable law, including the well-established and historic narrow meaning of "public charge," and considers the consequences of the rule on stakeholders. The Proposed Rule will help the States in their efforts to protect the health, safety, and well-being of our residents, and remain faithful to the Nation's values. We urge the federal government to finalize this rule swiftly.

Sincerely,

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[117] *See* Cantwell, Allen, Probert, Kofman, and Byrd Decls.; Decls. of Fairborz Pakseresht; Susan Fanelli; Sarah Neville-Morgan; Alexis Carmen Fernández; Antonia Jiménez; Lindsey Palmer, *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).

[118] 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).

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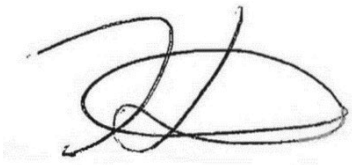

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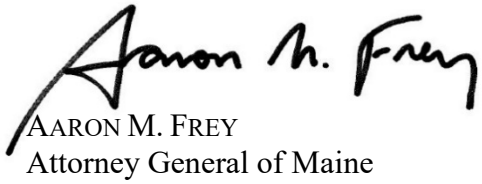

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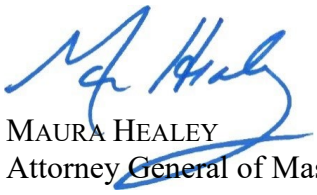

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