December 10, 2018

Ms. Samantha Deshommes
Chief, Regulatory Coordination Division
Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Ave. NW
Washington, DC 20529-2140

RE: *Inadmissibility on Public Charge Grounds*, Notice of Proposed Rulemaking, Fed. Reg. Vol. 83, No. 196; DHS Docket No. USCIS-2010-0012 ("NPRM").

The Cities of Chicago and New York City as well as the U.S. Conference of Mayors; Berkeley, CA; Long Beach, CA; Los Angeles, CA; Sacramento, CA; Santa Monica, CA; West Hollywood, CA; Boulder, CO; Boulder County Board of County Commissioners; Washington DC; Iowa City, IA; Gary, IN; Somerville, MA; Baltimore, MD; Minneapolis, MN; Kansas City, MO; St. Louis, MO; Plainfield, NJ; Rochester, NY; Columbus, OH; Dayton, OH; Portland, OR; Philadelphia, PA; Pittsburgh, PA; Central Falls, RI; Providence, RI; Austin, TX; Alexandria, VA; Burlington, VT; Seattle, WA; and Madison, WI (together, the "Signatories" submit this Comment in opposition to DHS Docket No. USCIS-2010-0012 (the "Proposed Rule").

INTRODUCTION

The Proposed Rule published by the Department of Homeland Security ("DHS") changes, without legitimate basis, centuries-old law governing who may be excluded from the United States or refused permanent legal status based upon their receipt of public benefits, otherwise known as the "public charge" rule. Because supplemental public aid programs, such as Medicaid coverage, food stamps, and housing assistance, would be included in the public charge determination, many immigrant families would choose to forgo or dis-enroll from essential services in order to protect their immigration status, even if they were otherwise eligible for such benefits. Thus, the Proposed Rule not only makes it harder for immigrants to enter the United States and for those already legally present, to adjust their status to become Legal Permanent Residents ("LPRs"), it would have wide-ranging and devastating effects on the health and financial stability of immigrants and their families, including U.S. citizens. Many of the immigrants targeted by the Proposed Rule have resided, worked and payed taxes in the United States and the signatory cities for years.

This Comment focuses on the legal failings of the Proposed Rule, which violates the Administrative Procedure Act (the "APA"), and other affirmative obligations of the rulemaking process, in several respects. First, the Proposed Rule violates the APA because it conflicts with the statutory meaning of public charge as it has existed for over one hundred years—and as embodied in both immigration law and policy. Therefore, the Proposed Rule is not in accordance with law. Second, the Proposed Rule violates the APA because it is arbitrary and capricious, as it is not supported by—and indeed runs counter to—any evidence or reasoned decision making. And third, DHS failed to adequately consider the economic impact the Proposed Rule would have on States and local governments, as well as on family wellbeing, as it is required to do under separate statutory and executive obligations. For all of these reasons, the Proposed Rule is unlawful and should not be adopted.

SUMMARY OF PROPOSED RULE

The Proposed Rule significantly changes and expands the circumstances in which an immigrant would be deemed a public charge in three primary ways.

First, the Proposed Rule expands the definition of public charge from someone who is likely to become "*primarily dependent* on the Government for subsistence. . ." (emphasis added), to "an alien who receives one or more public benefit[.]" Proposed Rule § 212.21(a), NPRM at 51289. By removing the "primarily dependent on" language, DHS considerably lowers the threshold level of reliance on public benefits to include limited or short-term receipt.

Second, the Proposed Rule broadens the category of public benefits considered when making a public charge determination to include, for the first time, non-cash benefits. *See* Proposed Rule § 212.21(b), NPRM at 51289-90. Specifically, DHS would now consider an immigrant's receipt of: (1) non-emergency Medicaid (with certain exceptions for benefits under the Individuals with Disabilities Education Act, other school-based benefits, and immunizations); (2) Supplemental Nutrition Assistance Program ("SNAP") benefits, formerly called "Food Stamps"; (3) Medicare Part D low-income subsidies; and (4) several federal housing assistance programs, including Section 8 Housing Choice Voucher Program, Section 8 Project-Based Rental Assistance, and subsidized housing under the Housing Act of 1937. *Id* at 51290.[1]

And third, while the Proposed Rule purports to maintain a "totality of the circumstances" test, it would significantly change that test– to the detriment of applicants– from the version in use for decades. Previously, an applicant's finances were considered in a totality of the circumstances test, but an Affidavit of Support could overcome a public charge determination. The Proposed Rule would impose similar financial requirements on the applicant: under the

[1] In addition, DHS seeks comment on whether benefits received under the Children's Health Insurance Program ("CHIP") should be considered. For all of the reasons discussed herein, the Signatories strongly urge DHS not to further expand the definition of public benefits to include CHIP.

Proposed Rule, immigration officers would have to consider whether the immigrant's household gross income or assets is at least 125 percent of the FPL. *See* Proposed Rule at § 212.22(b)(4)(A). In addition, the Proposed Rule would make current receipt of one or more public benefits or past receipt of public benefits within 36 months of filing application a "heavily-weighted negative factor" in the public charge determination. *Id*. at § 212.22(c)(1)-(2), NPRM at 51292. Thus, the receipt of public benefits would now weigh more strongly against the applicant than other factors considered in the totality of the circumstances test.

THE PROPOSED RULE IS UNLAWFUL IN NUMEROUS RESPECTS.

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions that are, among other things, "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see also Motor Vehicle Mfrs. Ass'n of United States v. State Farm Mut. Automobile Ins. Co*., 463 U.S. 29, 41 (1983). In addition, Executive Order 13132 and the Treasury General Appropriations Act, 1999, Public Law 105-277, impose affirmative obligations on agencies before promulgating regulations that have substantial direct effects on state and local governments or on family well-being, respectively. As explained below, the Proposed Rule should not be finalized because it is: (1) not in accordance with governing law; (2) arbitrary and capricious; and (3) does not comply with Executive Order 13132 and the Treasury General Appropriations Act, 1999, Public Law 105-277.

I. THE PROPOSED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT BECAUSE IT IS NOT IN ACCORDANCE WITH GOVERNING LAW.

An agency "does not have the power to adopt a policy that directly conflicts with its governing statute." *Maislin Indus., U.S. v. Primary Steel, Inc.*, 497 U.S. 116, 134-35 (1990); *see also United States v. Mead*, 533 U.S. 218, 228-29 (2001) (agency action cannot be "manifestly contrary to the statute"); *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 843 n.9 (1984) (courts "must reject administrative constructions which are contrary to clear congressional intent"). Thus, agency action is "not in accordance with law" where it "ignores the plain language of the statute," renders statutory language "superfluous," or "frustrate[s] the policy Congress sought to implement" in the statute. *Pacific Northwest Generating Coop v. Department of Energy*, 580 F.3d 792, 806 (9th Cir. 2009).

The Proposed Rule conflicts with the plain meaning of, and congressional policy behind, the public charge doctrine, as currently codified in 8 U.S.C. § 1182(a)(4). The term "public charge" first appeared in U.S. statutory law more than 130 years ago, and while immigration statutes have been enacted, amended, and repealed since then, public charge has always and only referred to those immigrants who rely on public cash assistance as their primary means of support. Therefore, the Proposed Rule is "not in accordance with law."

A. The Proposed Rule Conflicts with the Historical Meaning of Public Charge.

The Proposed Rule's definition of the term public charge to include the receipt of non-cash benefits, at even minimal amounts, is contrary to the origin and purpose of the term as it was first adopted into U.S. immigration law.

The term public charge originated in colonial times from "poor laws"—laws that governed who could or could not enter colonial towns, and then later, laws governing who could reside in early States like New York and Massachusetts. *See* Torrie Hester, et al., Historians' Comment, October 25, 2018;[2] Leo M. Alpert, "The Alien and the Public Charge Clauses," 49 Yale L. J. 18, 20-27 (1939). In the 1800s, the term was typically used to refer to someone who was a "charge" of the State; in other words, someone the government "had taken charge of," typically in an almshouse, and therefore who was under the care and control of the government. Historians' Comment at 2.

While the early States used the concept to exclude immigrants from their own borders, it later became part of U.S. immigration law. The United States' first immigration law, enacted in 1882, excluded "idiots, lunatics, convicts, and persons likely to become a public charge" from entering the country. Act of Aug. 3, 1882, 22 Stat. 214. A series of acts during the following years added other groups to the exclusion list: In 1893, Congress added the term "paupers" (Act of March 3, 1893, 27 Stat. 569); in 1903, "professional beggars" was added (Act of Mar. 3, 1903, 32 Stat. 1213); and in 1907, the list was expanded to exclude persons suffering from physical or mental defects whom officials deemed unable to find or maintain gainful employment (Act of Feb. 1907, 34 Stat. 888).

Eventually, these and other immigration-related provisions were incorporated into the McCarran-Walter Act of 1952, codified at 8 U.S.C. § 1101 *et seq*. (the Immigration and Nationality Act or "INA"). With respect to the classes of aliens who would be inadmissible (and aside from other excludable groups like criminals or those with communicable diseases), the INA removed all other descriptions such as paupers and beggars as redundant, and left only the phrase "likely to become a public charge." *See* 8 U.S.C. § 1182(a)(4)(A) ("Any alien who, in the opinion of the consular office at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible.").

The INA did not define public charge. However, as explained, the term's origin and usage make clear that it's intended use was to exclude immigrants who were incapable of supporting themselves (or who lacked family that would do so), and would place the burden of support on the government on an ongoing basis. The term did not extend to immigrants who

[2] *See* https://www.ilcm.org/wp-content/uploads/2018/10/Historians-comment-FR-2018-21106.pdf

received some type of public aid, but who could otherwise become productive workers, earners, and contributors to their communities and the country. By making the receipt of non-cash benefits, even on a limited or temporary basis, a "heavily-weighted negative factor" in the public charge determination, the Proposed Rule is not in accordance with this historical meaning.

B. The Proposed Rule Conflicts with Cases Interpreting Public Charge.

Nor can the Proposed Rule be harmonized with the body of immigration cases that have interpreted and applied the INA during the last 100 years. As discussed, the INA did not define the term public charge. However, Immigration and Naturalization Service ("INS") officers determined who was likely to become a public charge based on a variety of factors and individual circumstances in each case. To provide clarifying guidance regarding factors to be used to make a public charge determination, in 1964, the Attorney General, affirming a decision of the Board of Immigration Appeals ("BIA"), held that "specific circumstances, such as mental or physical disability, advanced age, or other fact reasonably tending to show that the burden of supporting the alien is likely to be case on the public, must be present." *Matter of Martinez Lopez*, 10 I. & N. Dec. 409, *410 (1964). This became known as the "totality of the circumstances" test.

Although the "totality of the circumstances" test was applied on a case-by-case basis, immigration courts employed the test consistent with the original concept of public charge; *i.e.*, total or near-total reliance on the government for support or care was required. *See, e.g.*, *Matter of Harutunian*, 14 I. & N. Dec. 583 (R.C. 1974) (70-year old woman who lacked job, education, family, or any means to support herself, and who would be entirely dependent on state "old-age assistance benefits" for support, was ineligible for adjustment of status on public charge grounds); *Matter of Perez*, 15 I. & N. Dec. 136, 137 (BIA 1974) (28 year old on welfare, living with parents and supporting three citizen children, not necessarily public charge because healthy and able to work); *Matter of Vindman*, 16 I. & N. Dec. 131, 132 (R.C. 1977) (couple who were 54 and 66, unemployed with no prospects for future employment, and who were receiving both federal social security and state welfare payments, were not eligible for adjustment of status); *Matter of A*, 19 I. & N. Dec. 867, 870 (BIA 1988) (33-year-old mother of three who had not worked since she arrived, and whose family had received welfare payments for approximately four years, was nevertheless not likely to become public charge in light of her age, her ability to earn a living, and the reason for her past unemployment, which was to care for her pre-school-age children); *Matter of X*, 2008 Immig. Rptr. LEXIS 17965 (AAO 2007) (immigrant who was employed but had received "welfare services" and food stamps for 18 years was eligible for adjustment of status).

These cases show that the understanding of the term public charge has remained constant since the 1880s: those deemed a public charge must have received cash benefits from the government for subsistence, or they must have experienced long-term institutionalized care.

None of the cases considered the receipt of short-term, non-cash benefits as evidence of someone who is or is likely to become a public charge, and this remained true even as new supplemental types of federal aid programs were introduced – such as public housing in 1937, the Food Stamp Program (now "SNAP") in 1939, and Medicaid and Medicare in 1965. Therefore, the case law solidified the original meaning of public charge as someone who relies entirely on the government for support.

C. The Proposed Rule Conflicts with 1999 Proposed Regulations and Field Guidance.

As discussed, the Proposed Rule conflicts with more than one hundred years of history and precedent. Perhaps most telling, however, is the fact that the Proposed Rule conflicts with decades of INS's own practice interpreting and enforcing the public charge doctrine.

1. INS Promulgated Regulations in 1999 to Clarify What Benefits Were Properly Considered in the Public Charge Determination.

In 1999, INS issued proposed rules and field guidance to its service officers governing the applicability of the public charge test. Significantly, these rules specified that only cash benefits (with a limited exception for long-term institutionalization) on which an immigrant "primarily depend[ed]" for support could be considered in the public charge determination. *Inadmissibility and Deportability on Public Charge Grounds*, 64 FR 28676 (May 26, 1999), at 28681-82 ("1999 Regulations"); *see also* Field Guidance, 64 FR 28689 (May 26, 1999).

Two laws enacted in 1996 prompted INS to issue these regulations: (1) the Illegal Immigration Reform and Immigrant Responsibility Act ("IIRIRA"), codified at 8 USC §1101 *et seq*.; and (2) the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"), codified at 8 U.S.C. § 1601-1646. The IIRIRA codified the totality of the circumstances test, requiring that officers look, at a minimum, at the immigrant's age, health, family status, assets, resources, financial status, education, and skills. *See* 8 U.S.C. § 1182(a)(4)(B). It also required family-member sponsors (and some employment-based sponsors) to submit binding affidavits of support on behalf of the immigrant, showing an ability to support the immigrant at an annual income of at least 125 percent of the federal poverty line. *Id*. at § 1182(a)(4)(D) (INS form I-864). Sponsors were required to list any "federal means-tested public benefits" received by them or members of their household, and agree to reimburse the government if the immigrant becomes dependent upon such benefits to reach the 125 percent threshold. *Id*.

The PRWORA imposed new restrictions on the eligibility of immigrants for many federal, state, and local benefits. In large part, the PRWORA barred "nonqualified aliens" (including illegal immigrants, tourists, students, or other temporary visitors) from receiving any

federal, state, or local public benefits, although they remained eligible for emergency medical or disaster relief. 8 U.S. C. § 1611(b)(1)(A)-(B). (However, the law also allowed the States to provide nonqualified aliens with state and local benefits that were otherwise restricted by federal law. *Id*. § 1611(b)(1)(D)). For "qualified aliens" (including legal permanent residents, asylees, and refugees), the PRWORA barred eligibility to Social Security Income and the Food Stamp Program (with some exceptions, including refugees, asylees, and children under 18), and made other federal "means-tested" public benefits (such as TANF, Medicaid, and the Children's Health Insurance Program ("CHIP") unavailable for the first five years after the immigrant entered the United States. *Id*. at § 1612. Subsequent legislation, however, has made SNAP available to most qualified aliens after five years, and many States have enacted laws allowing access to CHIP and Medicaid without the five-year waiting period.

Thus, while the IIRIRA codified the totality of the circumstance test and listed mandatory factors to be considered in the public charge analysis, it did not define the term "public charge," nor address which specific benefits or categories of benefits should be considered. In turn, while the PRWORA excluded certain classes of immigrants from eligibility for certain public benefits, it did not address, much less require, that use of the public benefits still available to immigrants be counted in the public charge context. INS issued the 1999 Regulations and Field Guidance to address the impact of the IIRIRA and the PRWORA on the public charge determination.

2. The 1999 Regulations Established Agency Policy.

While the 1999 Regulations were never formally adopted, the Field Guidance directed that they were to be immediately followed by immigration field officers. Indeed, the United States Citizenship and Immigration Services ("USCIS," the successor agency to INS) has continued to rely on the regulations and guidance to this day. *See* USCIS, Public Charge: Fact Sheet, Apr. 29, 2011.[3] Thus, the definition of public charge set forth in the 1999 Regulations and Field Guidance has been agency policy, and the *de facto* rule, for about twenty years.

In its preface to the 1999 Regulations, INS explained that it sought to allay the immigrant communities' fears that acceptance of any type of federal benefit might be included in the public charge determination, which would in turn have negative consequences not just for immigrants, but also for the wider public. "Although Congress has determined that certain aliens remain eligible for some forms of medical, nutrition, and child care services[,] . . . numerous legal immigrants are choosing not to apply for these benefits because they fear the negative immigration consequences of potentially being deemed a 'public charge.'" 1999 Proposed Regulations, 64 FR at 28676. INS found that this "chilling effect" was "creating significant, negative public health consequences across the Country," and, further, that the situation was "becoming particularly acute with respect to the provision of emergency and other medical

[3] https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet

assistance, children's immunizations, and basic nutrition programs, as well as the treatment of communicable diseases." *Id*.; *see also* Field Guidance, 64 FR at 28692 ("[C]onfusion about the relationship between the receipt of public benefits and the concept of 'public charge' has deterred eligible aliens and their families, including U.S. citizen children, from seeking important health and nutrition benefits that they are legally entitled to receive," which "has an adverse impact not just on the potential recipients, but on the public health and the general welfare."). Thus, INS issued the rule to "help alleviate the increasing, negative public health and nutrition consequences caused by the confusion over the meaning of 'public charge.'" *Id*.

The 1999 Regulations formally defined "public charge" as "an alien who has become (for deportation purposes) or who is likely to become (for admission or adjustment purposes), primarily dependent on the Government for subsistence, as demonstrated by either: (1) the receipt of public cash assistance for income maintenance; or (2) institutionalization for long-term care at government expense." 1999 Proposed Regulation § 212.102(a)(1)(i-ii), 64 FR at 28681. INS drafted this definition to be consistent with its understanding of the statutory origin, historical purpose, and development of public charge law. INS first looked to the most common dictionary meaning of "public charge," which was "the duty or responsibility of taking care of," and found that it meant "complete or near complete reliance on the Government, rather than the mere receipt of some lesser level of financial support." *Id*. at 28677. INS then stated that this definition was consistent with how the term was meant when it originally appeared in the immigration context: "Historically, individuals who became dependent on the Government were institutionalized in asylums or placed in 'almshouses' for the poor long before the array of limited-purpose public benefits now available existed. This primary dependence model of public assistance was the backdrop against which the 'public charge' concept in immigration law developed in the late 1800s." *Id*.

INS determined that the exclusion of non-cash benefits from the public charge analysis was consistent with this historical understanding, because non-cash benefits did not show primary dependence on the government for subsistence. "Non-cash public benefits are not considered because they are of a supplemental nature and do not demonstrate primary dependence on the Government." 1999 Regulations, 64 FR at 28682. As a result, both the 1999 Regulations and Field Guidance for applying those regulations specifically excluded non-cash welfare programs that provided essential supplemental services, including Medicaid and other health insurance programs; CHIP; nutrition programs such as food stamps, WIC, and school lunch programs; housing benefits; child care services; and other educational and job training programs. *Id*; *see also id*. at 28678 ("It has never been Service Policy that the receipt of any public service or benefit must be considered for public charge benefits . . . . Non-cash benefits are by their nature supplemental and frequently support the general welfare… [and] . . . serve important public interests."); Field Guidance, 64 FR at 28692 ("participation in such non-cash programs is not evidence of poverty or dependence"). The only exception was for long-term,

institutionalized care, as this represented near full reliance on the government and thus was consistent with the historical meaning of "public charge."

When promulgating the 1999 Regulations, INS sought input from federal benefit-granting agencies such as the Department of Health and Human Services ("HHS"), the Department of Agriculture ("USDA"), and the Social Security Administration ("SSA")—agencies "with expertise in subsistence matters about which types of benefit receipt would demonstrate that an individual is primarily dependent on the government for his or her support." 64 FR at 28677. In its March 25, 1999 letter responding to the inquiry, HHS provided three reasons for its conclusion that non-cash benefits should be excluded from the public charge analysis. *Id*. at 28686-87. First, it noted that individuals or families could not subsist alone on non-cash benefits because "[t]hese non-cash assistance programs typically provide only supplemental and marginal assistance (*e.g*., Food Stamps, housing assistance, energy assistance) or services (*e.g*., health insurance coverage, medical care, and child care) that do not directly provide subsistence and together are insufficient to provide primary support to an individual or family absent additional income." *Id*. at 28686. Second, HHS noted that these supplemental benefits "enable parents to work and earn income in order to be self-sufficient," *id*.; in other words, the benefits actually enable more self-reliance. And third, HHS concluded that "these non-cash services often have a primary objective of supporting the overall community or public health, by making services generally available to everyone within a community, providing infrastructure development and support, or providing stable financing for services and systems that benefit entire communities." *Id*.; *see also* April 15, 1999 USDA Letter (concurring with HHS letter and stating that "[w]e believe that neither the receipt of food stamps nor nutrition assistance provided under the Special Nutrition Programs administered by this Agency should be considered in making a public charge determination"), 64 FR 28688; May 14, 1999 SSA Letter (acknowledging that, in limited circumstances, receipt of SSI cash benefits could show primary dependence on the government), 64 FR 28687.

Thus, the 1999 Regulations were not only consistent with the historical meaning of the term public charge, but they also harmonized and advanced two other important policies: (1) providing some forms of short-term, supplemental aid helps those in need become more self-sufficient (and thus less likely to use public benefits) in the long run; and (2) providing necessary medical and health care to immigrants helps protect the health and wellbeing of all, including by preventing the spread of communicable diseases. *See* 1999 Regulations, 64 FR at 28678 (the regulations furthered "broad public policy decisions about improving general health and nutrition, promoting education, and assisting working-poor families in the process of becoming self-sufficient").

Moreover, as explained, the definition of public charge in the 1999 Regulations and Field Guidance has been agency policy for about twenty years. The Proposed Rule is an inconsistent and unacceptable departure from this established approach. It not only directly conflicts with the

previous (and correct) interpretation of public charge as primary reliance on cash benefits, but it also frustrates wider U.S. policies aimed at protecting the public health and welfare.

For all of these reasons, the Proposed Rule conflicts with the historical meaning of public charge, the public charge statute and cases interpreting it, and decades of the federal government's policy and practice, and therefore is "not in accordance with law" as the APA requires.

II. THE PROPOSED RULE VIOLATES THE ADMINISTRATIVE PROCEDURE ACT BECAUSE IT IS ARBITRARY AND CAPRICIOUS.

Under the "arbitrary and capricious" standard, DHS was required to examine relevant data and articulate a satisfactory explanation for its action, including a "rational connection between the facts found and the choice made," based upon relevant factors. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. 29 at 43; *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962). An agency rule is arbitrary and capricious if the agency has: relied on factors that Congress did not intend it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43-44. Applying these standards demonstrates that, if finalized, the Proposed Rule would violate the APA.

A. DHS Failed to Consider Important Aspects of the Problem Underlying the Proposed Rule.

According to DHS, the purpose and primary benefit of the Proposed Rule is to better ensure that applicants for admission to the United States and applicants for adjustment of status to an LPR are self-sufficient, *i.e.*, do not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their family, sponsor, and private organizations. NPRM at p. 51122. Purportedly, DHS also seeks to minimize the financial burden of immigrants on the United States social safety net. NPRM at p. 51277.

However, DHS failed to consider that the Proposed Rule would erode the stability and safety of immigrant families at significant cost to States and local governments. The Proposed Rule would likely cause hundreds of thousands of immigrants nationwide to withdraw from or forgo health, nutrition, and housing public benefits for themselves and their children, including U.S.-born children. This would force local governments to make significant expenditures to protect the health and wellbeing of their residents and may even lead to a public-health crisis. DHS' failure to consider these important aspects of the problem violates the APA.

1. DSH Failed To Account For The Substantial Costs Associated With Discouraging Immigrants From Obtaining Health Care Coverage And Services.

The Proposed Rule's inclusion of Medicaid and certain Medicare benefits in the public charge determination would encourage immigrants to dis-enroll themselves and their children (many of whom are U.S. citizens) from these and other publicly funded health insurance programs for fear of impacting their immigration status. Without insurance, immigrants are likely to forgo important preventative health care and services, including vaccinations and screening for communicable diseases. This would increase the costs of uncompensated care, burden local health care systems, increase the likelihood of an outbreak of communicable diseases,[4] and otherwise negatively impact the health and economic activity of local governments across the nation. Although the Proposed Rule offers a purported exception for immunizations and for testing and treatment for communicable diseases, NRPM at p. 51132, vaccinations and screening for infectious diseases are often component parts of other routine clinical services such as sick visits and annual check-ups which are not exempted by the Proposed Rule.

a. Discouraging Immigrants From Obtaining Public Health Insurance Would Cause Immigrants to Forgo Critical Health Care Services.

For low-income individuals in the United States, Medicaid often serves as the only source of health insurance. Having health insurance is associated with obtaining regular health care and being able to afford needed care, both of which are factors typically associated with better health outcomes.[5] For example, having health insurance plays a major role in access to primary and preventive care[6] – such as screenings for hypertension,[7] high cholesterol,[8] and HIV,[9] as well as

[4] Feiken DR, Lezotte DC, Hamman RF. Individual and community risks of measles and pertussis associated with personal exemptions to immunization. JAMA 2000;284(24):3145-3150.

[5] Shartzer A, Long SK, Anderson N. Access to care and affordability have improved following Affordable Care Act implementation; problems remain. Health Affairs 2016;35:161-168. Collins SR, Gunja MZ, Doty MM et al., the Commonwealth Fund, Americans' experiences with ACA Marketplace and Medicaid coverage: access to care and satisfaction (2016). https://www.commonwealthfund.org/publications/issue-briefs/2016/may/americans-experiences-aca-marketplace-and-medicaid-coverage Centers for Disease Control, National Center for Health Statistics Fact Sheet: Health Insurance and Access to Care (2017). https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.

[6] Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. JAMA Intern Med 2016;176:1501-1509.

[7] Alcalá, HE, Albert, SL, Roby, DH, et al., Access to care and cardiovascular disease prevention: a cross-sectional study in 2 Latino communities. Medicine 2015;94(34).

[8] Wherry LR, Miller S. Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions: a quasi-experimental study. Ann Intern Med 2016;164:795-803

cervical, prostate, and breast cancer[10] – which is associated with better heath outcomes. Health insurance is also positively associated with use of contraceptives[11] and access to prenatal care.[12] Further, having health insurance helps individuals treat and manage their mental health problems[13] and substance use disorders.[14] Finally, individuals with health insurance are more likely to be able to effectively manage and control existing chronic illnesses[15] and tend to increase utilization of prescription drugs.[16] By contrast, not having insurance and underinsurance are associated adverse health outcomes, including an increased likelihood of mortality.[17]

Despite the critical role of health insurance in maintaining and improving health, at present, immigrants are more likely to be uninsured than individuals born in the United States.[18] The Proposed Rule would exacerbate this problem. Not only would the Proposed Rule discourage immigrants from participating in the Medicaid and Medicare Part D low-income subsidies programs, it is likely to have a chilling effect on participation by the U.S.-born children of immigrants in these programs, as well as on immigrant participation in other federal health insurance programs not covered by the Proposed Rule. To illustrate, in 1996, when Congress

---

[9] Simon K, Soni A, Cawley J. The impact of health insurance on preventive care and health behaviors: evidence from the first two years of the ACA Medicaid expansions. J Policy Anal Manage 2017;36:390-417

[10] Baicker K, Taubman SL, Allen HL, et al. The Oregon experiment — effects of Medicaid on clinical outcomes. N Engl J Med 2013;368:1713-1722

[11] Culwell KR, Feinglass J. The association of health insurance with use of prescription contraceptives, Perspectives on Sexual and Reproductive Health, 2007;39(4):226-230.

[12] Braveman, P, Bennett T, Lewis C et al. Access to prenatal care following major Medicaid eligibility expansions, JAMA 1993;269(10):1285-1289.

[13] Baicker K, Allen JL, Wright BJ et al. The effect of Medicaid on management of depression: evidence from the Oregon Health Insurance Experiment. Milbank Quarterly, 2018;96(1):29-56. Maclean JC, Cook BL, Carson N et al. NBER Working Paper, Public Insurance and Psychotropic Prescription Medications for Mental Illness (2017) http://www.nber.org/papers/w23760.pdf

[14] Wu LT, Kouzis AC, Schlenger WE. Substance use, dependence, and service utilization among the U.S. uninsured nonelderly population, AM J Public Health 2003;93(12):2079-2085.

[15] Zhang, X, Bullard, KM, Gregg, EW, et al. Access to health care and control of ABCs of diabetes. Diabetes Care 2012;35(7):1566-1571. Hatch B, Marino M, Killerby M, et al. Medicaid's Impact on Chronic Disease Biomarkers: A Cohort Study of Community Health Center Patients. Journal of General Internal Medicine. 2017;32(8):940-947.

[16] Baicker K, Taubman SL, Allen HL, et al. The Oregon experiment — effects of Medicaid on clinical outcomes. N Engl J Med 2013;368:1713-1722

[17] Sommers BD. State Medicaid expansions and mortality, revisited: a cost-benefit analysis. Am J Health Econ 2017 May 17 (Epub ahead of print). Woolhandler S, Himmelstein DU, The Relationship of Health Insurance of Mortality: Is Lack of Insurance Deadly? Ann Intern Med. 2017;167(6):424-431.

[18] Ku L, Matani S. Left out: immigrants' access to health care and insurance, Health Affairs 2001;20(1);247-256.

enacted the PRWORA, which made certain changes to legal immigrants' eligibility for Medicaid, there was a 23 percent decrease in Medicaid enrollment among low-income adult LPRs and 58 percent decrease among adult refugees, even though both of these groups were exempt from the changes to the PRWORA.

Non-participation by immigrants in federal health insurance programs would undermine or even eliminate their access to health care services that allows them to maintain or improve health outcomes and protects their financial security against catastrophic health expenses. This would have an adverse impact on the health outcomes for immigrants and their U.S.-born children. For example, even if immigrants do not dis-enroll their children from Medicaid as a result of the Proposed Rule, any adverse health outcomes suffered by immigrant parents impacts their children.

b. An Increase In The Uninsured Rate Would Impose Significant Costs On Health Care Providers, Including Local Governments.

DHS claims that immigrant disenrollment from public health insurance would reduce the costs of such insurance to the government, NPRM at pp. 51168-69; 51182, but this ignores the significant costs that an increase in the uninsured rate imposes on States and local governments. By way of analogy, the evidence shows that the cost to States of expanding enrollment in Medicaid is offset by the savings associated with avoiding uncompensated medical care costs.[19] The same is true regarding the Proposed Rule: by discouraging immigrants from enrolling in Medicaid (and possibly CHIP), the Proposed Rule would impose substantial costs on hospitals and other health care systems, including health care systems run by local governments. This is so for several reasons, none of which were considered in the Proposed Rule.

First, because the uninsured tend to lack access to primary care, uninsured individuals are more likely to use emergency rooms for preventative care or nonemergency care.[20] Second, not only is the cost of emergency care greater than the cost of nonemergency care, lack of insurance is associated with an increase in costs associated with uncompensated health care. While the uninsured, on average, incur lower medical expenses than the insured due to their lower health service utilization rates, they pay for a much higher share of their care out of pocket and often cannot afford it.[21] Studies show that more than 70 percent of care provided to the

[19] *Id.*

[20] Wang L, Tchopev N, Kuntz-Melcavage K et al. Patient-reported reasons for ED visits in the urban Medicaid population. American Journal Med Qual. 2015;30(2):156-60.

[21] Coughlin TA, Holahan J, Caswell K et al., Kaiser Family Foundation, Uncompensated Care for the Uninsured in 2013: a Detailed Examination (2014). https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

uninsured is uncompensated,[22] and, in addition, that each newly uninsured individual is associated with an at least $900 increase in uncompensated care annually.[23]

Health systems, particularly hospitals and community-based providers, bear the burden of paying for the vast majority of these uncompensated care costs: in 2016, hospitals alone provided $38.3 billion in uncompensated care, with government funding offsetting only 65 percent of such costs.[24] And when local hospitals and community-based health care providers are required to pay increased amounts for uncompensated care, the resources they have to direct toward other health care services are diminished, which can have broad impacts on community health. Indeed, the evidence establishes that communities with high uninsurance rates are more likely to have unmet health needs, even for individuals who are insured, due to this spillover effect.[25]

c. An Increase In The Uninsured Rate Threatens An Outbreak Of Infectious Diseases.

The negative health impacts stemming from the Proposed Rule would perhaps be felt most in the realm of communicable diseases. Avoiding and treating these diseases requires participation by the entire population. Although the Proposed Rule offers a purported exception for immunizations and for testing and treatment for communicable diseases, NRPM at p. 51132, immigrants are unlikely to be aware of this exception. And even if they are aware, as noted above, obtaining vaccinations and screening for infectious diseases is often part and parcel of other routine clinical services such as sick visits and annual check-ups. Evidence shows that vaccination coverage differs according to whether individuals have a regular physician and/or regularly see a doctor, with both being positively associated with increased coverage.[26] As explained above, however, without publicly funded health insurance, immigrants are likely to forgo such regular services.

Not only are vaccination rates likely to decline among immigrants themselves, the Proposed Rule, if enacted, likely would discourage immigrant parents from obtaining vaccinations for their U.S.-born children. Although uninsured children may be eligible for

---

[22] *Id.*

[23] Garthwaite C, Gross T, Notowidigdo MJ. NBER Working Paper, Hospitals as insurers of last resort (2015), https://www.nber.org/papers/w21290

[24] Coughlin TA, Holahan J, Caswell et al. An estimated $84.9 billion in uncompensated care was provided in 2013; ACA payment cuts could challenge providers. Health Affairs, 2014;33(5):807-814.

[25] Pagán, JA, Pauly, MV. Community-level uninsurance and the unmet medical needs of insured and uninsured adults. Health Services Research 2006;41(3p1):788-803.

vaccines distributed through the federal Vaccines for Children program, the same reluctance to accept publicly funded health insurance, due to fear of negative immigration consequences, is likely to discourage parents from accepting publicly-funded vaccines. And, in any event, without insurance, under the Vaccines for Children program, parents would still be subject to a vaccine administration fee of up to $25.10 per vaccination, which they may be unable to afford.

The impact of the Proposed Rule on childhood vaccinations is likely to be most strongly felt with those vaccinations that, although potentially life-saving, are recommended but not required for school attendance (such as flu, pneumonia and human papilloma virus (HPV)). This could have devastating consequences. For example, during the 2017-2018 flu season, there were 185 pediatric deaths in the United States, 80 percent of which occurred in children who had not been vaccinated.[27]

Local governments rely on their residents to faithfully obtain vaccinations, as well as regular screening for infectious disease. The Proposed Rule would undermine this compact by forcing immigrants to choose between obtaining permanent residency (which could eventually enable them to become U.S. citizens) or a change in immigration status, on the one hand, and receiving medical treatment for communicable diseases, on the other. This would upend access to simple and cost-effective disease prevention tools, impacting not only immigrants but also the broader communities in which they live. Increased rates of communicable diseases would result in significant expenditures for local governments, from increased outreach to contact hard-to-reach populations (including immigrants who are scared to engage and may have low English language proficiency) to the significant resources required to control dangerous outbreaks.

2. DHS Failed To Account For The Substantial Costs Associated With An Increase In Food Insecurity.

Similarly, the Proposed Rule's inclusion of SNAP benefits in the public charge determination would discourage immigrants from utilizing these benefits, which have been shown to be associated with better health and, correspondingly, reduced health care costs. Although food-insecure households spend 45 percent more on medical care as compared to food-secure households, low-income adults enrolled in SNAP spent 25 percent less on medical care when compared to those who qualify for SNAP but are not enrolled.[28] In addition, use of SNAP

[27] Centers for Disease Control and Prevention. Summary of the 2017-2018 Influenza Season. https://www.cdc.gov/flu/about/season/flu-season-2017-2018.htm. Updated November 2, 2018. Accessed November 13, 2018.

[28] Carlson S & Keith-Jennings B. (2018). SNAP is linked with improved nutritional outcomes and lower health care costs. Center on Budget & Policy Priorities. Access at https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care.

is associated with reduced hospital admissions among older adults, and fewer sick days and outpatient visits among adults overall.[29]

As a result, discouraging immigrants from using SNAP benefits – as the Proposed Rule would do – has significant public health implications. Food-insecure households likely would have to choose between spending their limited resources on food, on the one hand, and meeting other critical needs (such as health care needs), on the other. For example, studies show that: (1) nearly one-third of households that reported low food security also reported skipping medications to save money;[30] and (2) elderly SNAP participants are less likely to report cost-related medication underuse than eligible non-participants.[31].

In short, food-insecure households are likely to have unmet medical needs, and discouraging immigrants from enrolling in SNAP would exacerbate this problem. The impact on children of immigrants, including U.S.-citizen children, may be particularly pronounced. Studies show that food-insecure children are almost twice as likely to experience poor physical and mental health compared to children in food-secure families, including increased risk for anemia, asthma, and depression.[32] Accordingly, the lack of adequate nutrition that would result from a decrease in SNAP participation would lead to significant health problems and associated costs.

3. DHS Failed To Account For The Increased Costs Associated With Housing Instability.

Finally, the Proposed Rule's inclusion of public housing benefits in the public charge determination is likely to increase the rate of homelessness among immigrant families. An increase in the rate of homelessness would have lasting adverse impacts on those families, including their U.S.-born children, and costly negative consequences for public health that would be borne by local governments and their taxpayers.

Utilization of housing subsidies, including the programs impacted by the Proposed Rule, reduces the likelihood that families will become homeless. Avoiding homelessness, in turn, is associated with improved health outcomes and decreased health care costs. The evidence shows that families with access to housing vouchers are 74 percent less likely to remain in a homeless

[29] Food Research and Action Center. (December 2017). The role of the Supplemental Nutrition Assistance Program in improving health and well-being. Accessed at http://frac.org/research/resource-library/snap-public-health-role-supplemental-nutrition-assistance-program-improving-health-well%e2%80%90being-americans.

[30] Herman, D., Afulani, P., Coleman-Jensen, A., & Harrison, G. G. (2015). Food Insecurity and Cost-Related Medication Underuse Among Nonelderly Adults in a Nationally Representative Sample. American journal of public health, 105(10), e48-59.

[31] Srinivasan, M., PhD., & Pooler, J. A., M.P.P. (2018). Cost-related medication nonadherence for older adults participating in SNAP, 2013–2015. American Journal of Public Health, 108(2), 224-230.

[32] Gunderson C. and Ziliak J. (2015). Food insecurity and health outcomes. *Health Affairs, 34(11),I 1830-1839.*

shelter or on the street than families without a housing subsidy.[33] The evidence likewise shows that homelessness is associated with adverse health outcomes. [34]

Critically, homelessness has a particularly adverse impact on children, and is associated with poor physical, social, mental health, cognitive development, and educational outcomes. [35] Approximately one half of school-age homeless children experience depression and anxiety, and one in five homeless preschoolers have emotional problems that require professional treatment. Schooling for homeless children is often interrupted and delayed, and homeless children are twice as likely to have a learning disability, repeat a grade, or be suspended from school.[36]

B. DHS's Explanations for the Proposed Rule Are Not Rational and Run Counter to Significant Evidence.

As previously explained, with the Proposed Rule, DHS proposes to drastically expand the definition of public charge beyond individuals who are "primarily dependent on the government for subsistence." *See, supra*, at. p. 2. According to DHS, the Proposed Rule would "improve upon the 1999 Interim Field Guidance by removing the artificial distinction between cash and non-cash benefits, and aligning public charge policy with the self-sufficiency principles set forth in the PRWORA." NPRM at 51123. Every part of this explanation is wrong.

1. DHS's Explanation Is Not Rational.

DHS sidesteps the inconsistencies between its Proposed Rule and the 1999 Regulations and Field Guidance by claiming that it is simply "improving upon" them. In other words, rather than acknowledge that it is changing position, DHS miscasts its action as taking the previous practice and simply making it better, not different. Failing to acknowledge and explain a change in agency position is flawed rulemaking. *See, e.g.*, *FCC v. Fox Television Stations*, 556 U.S. 502, 515 (2009) (agency must "display awareness that [it] is changing position."); *Encino Motorcars v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (in explaining its changed position, "an agency must be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account'") (internal citations omitted).

---

[33] Enterprise report "Impact of Housing on Families and Communities: A Review of the Evidence Base" at https://homeforallsmc.org/wp-content/uploads/2017/05/Impact-of-Affordable-Housing-on-Families-and-Communities.pdf

[34] Feske ML, Teeter LD, Musser JM, Graviss EA. Counting the homeless: a previously incalculable tuberculosis risk and its social determinants. *Am J Public Health*. 2013;103(5):839-848.

[35] APA. Effects of Poverty, Hunger, and Homelessness on Children and Youth at https://www.apa.org/pi/families/poverty.aspx; Page, M. (March 2017). The intergenerational transmission of poverty and the long reach of child health and nutrition programs. UC Center Sacramento: Bacon Public Lectureship and While Paper. Accessed at http://uccs.ucdavis.edu/events/event-files-and-images/BaconWhitePaper_2.23.17.pdf .

[36] APA. Effects of Poverty, Hunger, and Homelessness on Children and Youth. https://www.apa.org/pi/families/poverty.aspx

Second, DHS's claim that the distinction between cash and non-cash benefits is "artificial" is absurd. As discussed, non-cash benefits such as medical care, housing assistance, and nutrition aid have been available since the early 1930s, but have never been considered in public charge determinations, because they are of a different, supplemental nature from cash support. Such programs are used by many low-income families with low-wage jobs, at different periods in their lives, and for different lengths of time, to ensure better health and safety, which in turn allows them to be less-reliant on public benefits in the future. The distinction between these types of programs and cash assistance has been central to concept of public charge since its inception. In fact, as explained in Part I, administrative guidance from INS reveals various federal agencies have found that the use of non-cash benefits does not demonstrate "primary dependence on the Government." Instead, INS, HHS, and the USDA found that providing non-cash nutrition and health assistance helps recipients remain healthy, which in turn helps them find and keep work, which in turn helps them no longer need any federal assistance. Thus, the fact that an immigrant might utilize the health and nutrition benefits DHS proposes to include in a public charge determination does not prevent that immigrant from being self-sufficient; to the contrary, it can and is likely to make them even more self-sufficient.

Third, DHS's dependence on the language of "self-sufficiency" in the PRWORA is misplaced. *See* NPRM at p. 51123. As an initial matter, the authorizing statute for public charge regulations is 8 U.S.C. § 1182, not the PRWORA at 8 U.S.C. § 1611, and thus statements of congressional intent from the PRWORA are not relevant. More importantly, however, the 1999 Regulations and Field Guidance are themselves consistent with, and indeed were issued in part to help promote, the concept of self-reliance and sufficiency. As explained, INS found that providing non-cash nutrition and health assistance helps immigrants stay healthy, which in turn helps them find and keep work, which in turn helps them no longer need any federal assistance. *See supra* at pp. 15-16. These findings were consistent with the views of other federal agencies, including HHS and USDA. *See id.* Thus, the fact that an immigrant might receive some type of federal aid does not prevent them from being self-reliant; to the contrary, it can and is likely to make them even more self-reliant.

Moreover, to the extent, that legislative intent from other statutes should even be considered, DHS should also consider the purposes behind the supplemental aid programs it now seeks to include in the public benefit analysis. The Food Stamp program was enacted to both assure that individuals in low-income families received adequate nutrition, and to strengthen the agricultural economy. *See* Food Stamp Act, 7 U.S.C. § 2011. Medicaid and Medicare were enacted to ensure that low-income families had access to necessary medical insurance to promote the health and wellbeing of the country. *See* Pub. L. 89-97 79 Stat. 286 (1965). And public housing assistance was enacted to help "alleviate present and recurring unemployment and to remedy the unsafe and unsanitary housing conditions and the acute shortage of decent, safe, and sanitary dwellings for families of low income, in rural or urban communities, that are injurious to

the health, safety, and morals of the citizens." The Housing Act of 1937, Pub. L. 75–412, 50 Stat. 888. Thus, these programs reflect larger federal objectives meant to extend benefits to all qualifying individuals without repercussion.

Finally, DHS claims that because Congress allowed the continued receipt of some benefits to some classes of immigrants under the PRWORA, but did not specifically exempt these benefits from the public charge determination under IIRIRA, it must have intended that receipt of these benefits could be considered in the public charge analysis. *See* NPRM at 51132-3. But the statutory framework actually commands the opposite conclusion—that Congress did not intend such benefits to be part of the public charge determination. Congress did not need to specifically exclude these non-cash benefits because they had never been part of the public charge calculus in the first place. Indeed, had Congress wanted them to be considered, it could (and would) have specifically *included* them in the IIRIRA, but it did not. The PRWORA simply made federal benefits harder for immigrants to receive; it did not, expressly or implicitly, make the benefits still available to immigrants now part of the public charge analysis. And INS addressed this issue specifically in its 1999 Regulations and Field Guidance, issued three years after the IIRIRA and PWRORA were enacted: "Due to the increased restrictions of the welfare reform law[,] . . . many aliens are no longer eligible to receive some public benefits formerly available to them[.] These new laws work together to limit the potential for immigrants to become dependent on the Government. The proposed rule defining 'public charge' will not change or negatively affect the operation of these provisions." 1999 Regulations, 64 FR at 28680.

2. DHS's Explanations Are Contrary to the Evidence.

DHS's explanation for the expanded definition of public charge —to better ensure that immigrants seeking admission to or an adjustment of status within the United States are self-sufficient – is belied by significant evidence demonstrating that the use of one of the non-cash benefits impacted by the Proposed Rule does not equate to dependency on public resources.

In reality, working families in the United States seek public benefits not because they lack self-sufficiency, but due to a multitude of rising household expenses, including the cost of food, housing, health care services and insurance, transportation, and education.[37] Between 2015 and 2017, expenses incurred by U.S. households increased by more than $2,000 per year.[38] Each

[37] U.S. Department of Labor, Bureau of Labor Statistics, Consumer Expenditures— 2017 (Sept. 11, 2018) at https://www.bls.gov/news.release/cesan.nr0.htm.

[38] *See id.*

year, American households spent 7.3 percent more on food, 6.9 percent more on health care, and 5.3 percent more on housing.[39]

As noted above, INS and other federal agencies have recognized that the public benefit programs at issue are "by their nature supplemental." *See supra* at pp. 8-9. These supplemental benefits permit households to cover their numerous monthly expenses, without becoming primarily dependent on public resources. The Proposed Rule ignores the fact that immigrants may use one public benefit for one household expense, but still be able to meet all other household expenses. Indeed, utilization of public benefits does not indicate a lack of employment or other resources. In fact, the benefit programs impacted by the Proposed Rule are used in large part by immigrants who work and pay taxes, and their tax contributions contribute to the very public benefit programs DHS seeks to force them to forgo or withdraw from to protect their immigration status.

First, to qualify for federal housing subsidies, a household must have consistent income through employment or other sources. For Section 8, that income could be as high as 80 percent of the area's median income level.[40] Although there are considerable variations in the cost of living (including housing costs) and median income levels across the nation, DHS does not propose to consider these legitimate factors to make a public charge determination. However, these variations could explain why households, immigrant and citizen alike, might need housing assistance to maintain self-sufficiency.

The same is true of food assistance. Historically, SNAP has been utilized by low-income families to temporarily supplement income earned from jobs with low wages, unpredictable schedules, and no benefits such as paid sick leave — all of which contribute to high turnover and spells of unemployment.[41] SNAP participants commonly work in service occupations, such as cooks or home health aides, and sales occupations, such as cashiers.[42] For these workers, SNAP provides critical nutrition assistance and can help workers weather periods without a job. However, the income SNAP recipients receive through these occupations cannot fairly be described as inadequate to be self-sufficient, as SNAP benefits are available to families with income above 100 percent of the poverty line.[43] Moreover, SNAP benefits are structured to

---

[39] *See id.*

[40] U.S. Department of Housing and Urban Development, Office of Policy Development and Research at https://www.huduser.gov/portal/datasets/il.html

[41] *See* Henry J. Kaiser Family Foundation report, "Understanding the Intersection of Medicaid and Work," Jan. 5, 2018.

[42] *See id.*

[43] *See* Center on Budget and Policy Priorities report, "Policy Basics: The Supplemental Nutrition Assistance Program," at https://www.cbpp.org/research/policy-basics-the-supplemental-nutrition-assistance-program-snap

support and incentivize continued employment, with benefits phasing out gradually as earnings rise.[44]

With respect to Medicaid, it has often served as the only source of health insurance coverage for low-income individuals in the United States, allowing them to maintain or improve health, as explained above. *See supra* p. 11. Although immigrants are less likely to enroll in Medicaid, and more likely to be uninsured, than citizens,[45] the vast majority of immigrants who are enrolled in Medicaid are employed. Among non-elderly adults with Medicaid coverage, nearly 8 in 10 live in working families, and a majority are working themselves.[46] The industries with the largest number of workers covered by Medicaid include restaurant and food services, construction, elementary and secondary schools, grocery stores, hospitals, and home health care services.[47]

Not only are immigrants who use Medicaid likely to be employed, Medicaid provides important protection against the rising cost of health care, not to mention the potentially catastrophic costs associated with a sudden or major illness. DHS focuses on the cost of health care *for the government*, NPRM at pp. 51200-01, but ignores the enormous burden these costs have on an individual or family. In the face of these significant and rising costs, DHS does not propose to consider that an immigrant's medical condition and resulting exorbitant medical costs could be the reason for his or her use of public benefits to maintain self-sufficiency. Using DHS's logic, an immigrant could have lived, worked, paid taxes, and supported his or her family in the U.S. for ten years without use of a public benefit. Yet, because he or she suddenly develops a life-threatening illness and must take time off from work and utilize a public benefit to supplement a temporary lack of income— he or she would be a public charge.

III. DHS HAS NOT COMPLIED WITH THE EXECUTIVE ORDER 13132 OR THE TREASURY GENERAL APPROPRIATIONS ACT.

As explained above, DHS' failure to consider all aspects of the problem – specifically, the significant costs that the Proposed Rule would shift to state and local governments – violates the APA. *See supra* pp. 10-17. The requirement that DHS consider the costs to state and local governments associated with the Proposed Rule implicates not only the APA but also by Section 6 of Executive Order 13132, which mandates that:

---

[44] Elizabeth Wolkomir and Lexin Cai. (2018). *The Supplemental Nutrition Assistance Program Includes Earnings Incentives.* Washington, DC: Center on Budget and Policy Priorities. Retrieved November 11, 2018 at https://www.cbpp.org/research/food-assistance/the-supplemental-nutrition-assistance-program-includes-earnings-incentives#_ftn1

[45] Ku L, Matani S. Left out: immigrants' access to health care and insurance, Health Affairs 2001;20(1);247-256.

[46] Henry J. Kaiser Family Foundation report, "Understanding the Intersection of Medicaid and Work," Jan. 5, 2018.

[47] *See id.*

> no agency shall promulgate any regulation that imposes substantial direct compliance costs on State and local governments, . . . unless (1) funds necessary to pay the direct costs incurred by the State and local governments in complying with the regulation are provided by the Federal Government; or (2) the agency, prior to the formal promulgation of the regulation, (a) consulted with State and local officials early in the process of developing the proposed regulation; (b) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of the Office of Management and Budget (OMB) a federalism summary impact statement, which consists of a description of the extent of the agency's prior consultation with State and local officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of State and local officials have been met; and (c) makes available to the [OMB] Director any written communications submitted to the agency by State and local officials.

Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999)

DHS gives lip service to this requirement, stating, without data or analysis, that it "does not expect that this proposed rule would impose substantial direct compliance costs on State and local governments." NRPM at p. 51276. On this unsupported and speculative statement alone, DHS concludes that "in accordance with section 6 of Executive Order 13132, it is determined that this rule does not have sufficient federalism implications to warrant the preparation of a federalism summary impact statement." NPRM at 51277. DHS is incorrect.

As explained above, the Proposed Rule would likely cause hundreds of thousands of immigrants nationwide to withdraw from or forgo health, nutrition, and housing public benefits for themselves and their children, including U.S.-born children. *See supra* pp. 10-17. This would force local governments to make significant expenditures to protect the health and well-being of their residents. *See id.*. Accordingly, a federalism summary impact statement should be provided.

DHS's approach to the affirmative obligations imposed on it by the Treasury General Appropriations Act of 1999 is similarly (and improperly) dismissive. That Act provides that:

> before implementing policies and regulations that may affect family well-being, an agency shall assess whether the action — (1) strengthens or erodes the stability or safety of the family and, particularly, the marital commitment; (2) strengthens or erodes the authority and rights of parents in the education, nurture, and supervision of their children; (3) helps the family perform its functions, or substitutes governmental activity for the function; (4) increases or decreases

> disposable income or poverty of families and children; (5) is warranted because the proposed benefits justify the financial impact on the family; (6) may be carried out by State or local government or by the family; and (7) establishes an implicit or explicit policy concerning the relationship between the behavior and personal responsibility of youth, and the norms of society.

Pub. L. No. 105–277, §654(c)(1-7), 112 Stat. 2681- 528-30 (1998).

With respect to this mandate, DHS determined only that "the proposed rule may decrease disposable income and increase the poverty of certain families and children, including U.S. citizen children." NPRM at p. 51277. In DHS's view, the financial impact on immigrant families is justified by the purported benefits of the Proposed Rule— better ensuring the self-sufficiency of immigrants, and minimizing the financial burden of immigrants on the United States social safety net. To the contrary, as explained above, these purported benefits are significantly outweighed by the costs the Proposed Rule imposes not only on immigrant families but also on state and local governments and their residents. *See supra* at pp.10-17.

In addition, DHS ignores the remaining requirements of the Treasury General Appropriations Act, including the requirement that the agency assess whether the Proposed Rule strengthens or erodes the stability or safety of the family. Although the Proposed Rule is silent on this point, it would undoubtedly erode the stability and safety of immigrant families. As explained, recipients use the non-cash public benefits impacted by the Proposed Rule to supplement their income and ensure the stability and self-sufficiency of their families. *See supra* pp. 8-9, 17-19. Moreover, if, as the Proposed Rule anticipates, immigrant parents are unable to remain in the United States due to their use of even a single non-cash public benefit on a short-term basis, that may result in the parents' separation from their U.S.-born children. Those children would remain in the United States without their parents' emotional and financial support, and wholly dependent upon all the social safety net programs DHS purports to seek to reduce. DHS has not properly assessed the impact of the Proposed Rule on family wellbeing.

IV. DHS'S PROPOSAL TO WEIGH AN IMMIGRANT'S PAST USE OF BENEFITS AS A CHILD SHOULD BE REJECTED.

Finally, DHS requests public comment to inform whether and to what extent DHS should weigh an immigrant's past of use of benefits as a child as a potential indicator of likely future receipt of public benefits. According to DHS, the circumstances surrounding an immigrant's receipt of public benefits as a child, including the age at which such benefits were received, are a relevant consideration. NPRM at p. 51174. The Signatories submit that DHS should not weigh an immigrant adult's prior use of benefits as a child.

To do so would upend administrative precedents developed over the past fifty years. Indeed, DHS acknowledges that these past precedents "strongly support the forward-looking

totality of the circumstances approach" and provides no justification for departing from these precedents. NPRM at p. 51178. And none exists. To the contrary, the rule DHS contemplates would deter immigrants from obtaining food and health care assistance for their children, to avoid jeopardizing their path to citizenship. But research shows that receiving appropriate nutrition and medical care during the first few years of a child's life are crucial in establishing the child's path toward health and wellbeing across the entire lifespan.

For example, it is well established that disadvantaged children who receive food assistance in early childhood experience better health, education, and employment outcomes when compared to those who do not.[48] Undernutrition, or not getting enough to eat on a regular basis, can delay brain development and have long-term effects on a child's growth. By contrast, nourished children are better able to learn and develop life skills that help them live productive lives. In fact, access to SNAP during early childhood is associated with a greater likelihood of economic self-sufficiency in adulthood, driven largely by higher levels of educational attainment, as well as improved health.[49] One study estimated that improved health among children in immigrant households participating in SNAP recouped 42 percent of the benefit's cost.[50] Another showed that children in SNAP households are at reduced risk for poor educational outcomes such as repeating a grade,[51] more likely to have increased educational and employment outcomes, and less likely to be on public assistance.[52]

Similarly, Medicaid provides affordable and comprehensive coverage to eligible children, improving their health and well-being. When an eligible family opts-out of Medicaid for their child, the child does not receive the routine and preventative healthcare that is essential to preventing serious illness. The child would also not receive necessary mental health care, and a child's untreated mental health problems can have serious consequences for early learning, social

[48] *See* Page, M. (March 2017). The intergenerational transmission of poverty and the long reach of child health and nutrition programs. UC Center Sacramento: Bacon Public Lectureship and While Paper. Accessed at http://uccs.ucdavis.edu/events/event-files-and-images/BaconWhitePaper_2.23.17.pdf .

[49] Hoynes H., Schanzenbach D., & Almond D. (2016). Long-run impacts of childhood access to the safety net. *The American Economic Review, 106(4)*, 903-934.

[50] East C. (2017). The effect of food stamps on children's health: evidence from immigrants' changing eligibility. Accessed at https://www.chloeneast.com/uploads/8/9/9/7/8997263/east_fskids_r_r.pdf .

[51] Beharie B., Mercado M & McKay M. (2017). A protective association between SNAP participation and educational outcomes among children of economically strained households. *J Hunger Environ Nutr, 12(2),* 181-192.

[52] Hoynes H., Schanzenbach D., & Almond D. (2016). Long-run impacts of childhood access to the safety net. *The American Economic Review, 106(4)*, 903-934.

competence, and lifelong physical health, and can ultimately lead to many costly societal problems, including the failure to complete high school, homelessness, and incarceration.[53]

In short, considering an immigrant's past use of public benefits as a child in the public charge determination would deter immigrant parents from obtaining food and health care assistance for their children, which could result in adverse outcomes for the children themselves and impose significant costs on society.

For all the reasons above, the Signatories strongly oppose the Proposed Rule, and call upon DHS to withdraw it.

Sincerely,

Mayor Bill de Blasio
City of New York, NY

Mayor Rahm Emanuel
City of Chicago, IL

Tom Cochran, CEO and Executive Director
The U.S. Conference for Mayors

Mayor Jesse Arreguín
City of Berkeley, CA

Mayor Robert Garcia
City of Long Beach, CA

Michael N. Feuer, City Attorney
City of Los Angeles, CA

Mayor Darrell Steinberg
City of Sacramento, CA

Mayor Ted Winterer
City of Santa Monica, CA

Mayor John J. Duran
City of West Hollywood, CA

[53] Harvard University, Center on the Developing Child, *Early Childhood Mental Health* at https://developingchild.harvard.edu/science/deep-dives/mental-health/

Jane Brautigam, City Manager for the City of Boulder
City of Boulder, CO

Cindy Domenico, County Commissioner
Boulder County Board of County Commissioners

Mayor Muriel Bowser
District of Columbia

Karl A. Racine, Attorney General for the District of Columbia
District of Columbia

Eleanor M. Dilkes, City Attorney
Iowa City, IA

Mayor Karen Freeman-Wilson
City of Gary, IN

Mayor Joseph A. Curtatone
City of Somerville, MA

Andre M. Davis, City Solicitor
City of Baltimore, MD

Susan Segal, City Attorney
City of Minneapolis, MN

Mayor Sylvester James, Jr.
City of Kansas City, MO

Mayor Lyda Krewson
City of St. Louis, MO

Mayor Adrian O. Mapp
City of Plainfield, NJ

Mayor Lovely Warren
City of Rochester, NY

Mayor Andrew Ginther
City of Columbus, OH

Mayor Nan Whaley
City of Dayton, OH

Tracy Reeve, City Attorney
City of Portland, OR

Marcel S. Pratt, City Solicitor
City of Philadelphia, PA

Mayor Bill Peduto
City of Pittsburgh, PA

Matthew Jerzyk, Esq., City Solicitor
City of Central Falls, RI

Mayor Jorge O. Elorza
City of Providence, RI

Anne L. Morgan, City Attorney
City of Austin, TX

Mayor Allison Silberberg
City of Alexandria, VA

Eileen M. Blackwood, City Attorney & Corporation Counsel
City of Burlington, VT

Mayor Jenny A. Durkan
City of Seattle, WA

Peter S. Holmes. City Attorney
City of Seattle, WA

Mayor Paul R. Soglin
City of Madison, WI